

The Problem of Healthcare in Nigeria and its Implications on Education

مشكلة الرعاية الصحية في نيجيريا وآثارها على التعليم

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Abstract

The Nigerian healthcare is in moribundity. This truism is manifest in obvious negative indexes that could be used to assess the healthcare system of a society that are characteristics Nigerian healthcare system. Implications of such a moribund state are multifarious and have been explored by health researchers. However, the parallel line has not been clearly drawn between the bad healthcare and the country's education sector.

To this effect, this treatise underscores the menace of healthcare in Nigeria in the context of its implications on Nigeria's education. It concludes by submitting a tripartite Literacy Model it calls 'LIE' as typical configuration of implications of Nigerian healthcare problem on Nigerian education. This model expresses that literacy is limited, inadequate and exported due to problem of healthcare in the country.

Keywords: Healthcare, Nigeria, education, literacy, implications, model, moribund.

1.1 INTRODUCTION

The discussion of Nigerian healthcare would perhaps be best understood if situated in the episode of one expatriate Nigerian psychiatrist, John Nwofia, whose brother was diagnosed with acute liver disease and perthyroidism at America in 2010. He says: My younger brother was diagnosed with acute liver disease and hyperthyroidism. We spent hundreds of thousands of naira doing one test after the other. My very good friend and colleague, Dr. Ezekiel Ogunleye, thoracic surgeon at LUTH (Lagos University Teaching Hospital), took charge of it. Every test he ordered had to be done at three different sites, including abdominal ultrasound and other laboratory tests. He explained that, “this is because he could not trust one laboratory and had to depend on two out of three laboratory results being close for him to use it”. We got a CT scan but it was from an outdated 8-slice machine that was not sensitive enough. In the end we needed a test called a MRCP but we could not find a place in Lagos to get it done. The other option was for a procedure called ERCP but no gastroenterologist we knew of in Lagos could perform it. The other option was to open him up surgically in his almost moribund state to look for a cause, which by then we were worried it could be a tumour. We knew that his chances of making the surgery then were bad due to his state. We then made the difficult decision to fly him to the US. There, we had a 64-slice CT scan and MRCP and both were negative. All he had was an acute liver injury due to a commonly used anti-malaria. He responded well to high dose of steroid and is now back home. He would have definitely died in Nigeria (Adebayo, 2014).

The scenario above aptly describes the current haphazard situation that is parallel to Nigerian healthcare system, lending credence to the propriety in using the word ‘comatose’ for its state. This scenario was evidently understudied when (Eme, et al. 2014) described Nigerian hospitals as ‘consulting rooms’. This is because the derivative import from regarding Nigerian hospitals as such signifies an active function of an aspect of adequate healthcare delivery which is consultation, and this eventually leads to proper diagnosis. But in a scenario where one does not even have access to adequate diagnosis as obvious in the above case, going there for consultation is like a deliberate will to while away time and peep at afterlife.

Nonetheless, the above is just an aspect of the lopsided state of the Nigerian healthcare system. The Nigerian healthcare menace is not just about the diagnosis. Almost everything that can be attributed to functional healthcare system of a twenty-first century nation is malfunctioning. The healthcare facilities, just as said above, are bad, the government's commitment to the healthcare sector is worrisome, the medical practitioners are disproportionate to Nigerian population, and brain drain continues being a plague, amidst series of other problems. This unspeakable state has affected the country to an extent that, an average of one medical doctor is proportionate to 30,000 people and average of two hospital beds to one thousand patients as submitted by (Omoruan, et al. 2009).

Attempts have been made by different researchers and medical experts to highlight various windows from which the Nigerian healthcare problem could be perceived and effectively tackled. By and large, researchers hardly link this health travesty to the education sector. This treatise therefore seeks to explore the trajectories of Nigerian moribund healthcare via the lens of Nigerian education.

1.2 Purpose of the study:

The aim of this study is to present a critical review to the problems of Healthcare in Nigerian and to investigate its implications on Education. It seeks to answer the following main question "What is the suggested proposal to overcome the problems facing the Healthcare in Nigeria and its implications on Education?" To answer this question, the research will look at the previous researches, especially the Nigerian researches that have keen relation to the healthcare.

To meet these aims, this research has to accomplish the following theoretical, practical and objectives. First, it will outline the theoretical background and views of Health and Healthcare problems in Nigerian which will be achieved through literature review. Secondly, this research will seek to accomplish practical objectives of identifying the views held by individual educational professionals in Nigeria. This will be achieved through empirical research which will be carried out through field study.

Lastly, the outcome objective will be accomplished by providing conclusive evidence based on comprehensive analysis, interpretation and discussion of the findings of the research. This will offer tangible evidence on the Healthcare problems and its implications on education in Nigeria.

1.3 Significance of study:

WHO (2008) states that sustained economic and social development are only achievable where good human health and welfare is sustained. This major significance of this report is to inform and enlighten the Nigeria community about the healthcare and by extension the necessity for good healthcare. By reading through this report, the society, especially the medical practitioners and policy makers, will be better informed and therefore make decisions that will have a positive impact on people's health.

In addition, as an educational specialist in Nigeria, this research will enable me to develop and grow my career by understanding the views and beliefs by medical professionals.

1.4 Literature review: Concept of Health and Healthcare in Nigeria

Health experts and medical researchers have made significant attempts in defining health, considering its conceptual propriety in understanding healthcare's definition. One of the most widely accepted definitions is that supplied by the World Health Organisation which defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The adoption of this definition is not to absolve it of its generative criticism which posits that a complete health state is delusional, lending credence to the argument that health is better defined as "a matter of one's ability to adjust to one's condition". Whichever we deem most appropriate of the often tendered definitions for health, the point is, health is an acceptable state of wellbeing expected for every single person in a society.

Having understood 'health', acquaintance with the concept of healthcare comes easily. According to Eme, Uche & Uche, healthcare is "the provision of suitable environment which is aimed at the promotion and development of man's full potentials". Healthcare is therefore the conventional efforts or attempts geared towards achieving complete or physical, mental and social wellbeing.

The healthcare in Nigeria is engaged via three echelons; primary level, secondary level and tertiary level (Ademiluyi & Aluko-Arowolo, 2009). The primary level takes care of minor health problems arising from its Local Government Area residents. Such health centres are referred to as primary health centres/clinics, maternities or dispensaries. At secondary level, intermediate cases are treated. Under this we have general hospitals for whose maintenance the states are responsible. The top echelon, the tertiary level is for complex and complicated cases, and under this we have teaching hospitals, specialist hospitals, Ministry of Health and National Health Insurance Scheme (NHIS) that was established in 2005. Despite the hierarchical institutional arrangements of healthcare in Nigeria however, there is no doubt that it remains an endeavour which has not found a favourable attention from Nigerian stakeholders. A consultant anaesthetist, Dr Chizoba Peters emphasized this truism when he lamented that Nigerians deserve far better health services during the unveiling of a 25-bed facility built by his hospital in Lagos.

One major factor that has endangered the healthcare sector in Nigeria is the inappropriate budgetary allocation to the sector since the 1980s. Though the government seemed conversant with this flop by integrating itself into the 2001 Abuja Declaration that at least 15 per cent of the annual national budget of African countries should be dedicated to the sector, the Declaration has remained more of a lullaby to the wailing sector. For instance 4.1% of the national budget was marked for the sector in 2019, indicating a slight difference from 2018 when 3.95% was earmarked (The Guardian, 2019). In addition to this, corruption that permeates almost every sector of the nation has not spared the healthcare sector as the already minute budget allocation is syphoned by some self-centred Nigerian stakeholders. Still, the already siphoned allocation is further subjected to misappropriation as it concentrates on the urban settlers of the country. As pointed out by Ademiluyi and Aluko-Arowolo, (2009), sound healthcare is largely for the rich in Nigeria i.e. urban settlers, alone as the health facilities are ‘lopsidedly distributed’. This has argued further by them, was a heritage from the country’s colonialists who concentrated the vanguard health facilities at European residence areas. With all these in consideration, an average Nigerian health professional would want to seek greener pasture from another country, and this brings in the problem of brain-drain. In fact, the more patriotic ones that are not subdued by all

these would have to dance to foreign music when their salaries are not paid promptly.

Similarly, the crawling state of the economy has made it difficult for lots of Nigerians to afford three square meals a day. By implication, an average Nigerian struggling to make ends meet live from hand to mouth, and hence, sound health or proper diet is not basic to him. The consequence of such mentality and gesture is ignorance of bad health signals and nonchalance in healthcare by such a citizen.

In the same line, the poor electricity in the country continues to remain a fundamental factor challenging Nigeria's development over the years. Particularly, the healthcare sector cannot function maximally in the face of intermittent power supply that afflicts the country.

Lastly, the insecurity plague that has made the country one of the top-rated vulnerable nations has not helped the healthcare plight. Hardly is there a week in Nigeria without kidnapping or terrorist attacks, and this has further burdened the healthcare system as victims of such mishaps have to be taken to healthcare facilities. Corresponding to this is the vulnerable border which allows easy passage of counterfeited and adulterated drugs into the country.

The aggregate import of all these help fix the concept and practice of healthcare in Nigeria in a clear moribundity. It expresses the failure of the nation to offer her nationals a sound healthcare system.

The Moribund Healthcare and Its Implications on Education in Nigeria

It is a veritable fact that education is the foundation of societal progress, and it affects virtually every window of the society, healthcare inclusive. More particularly, the adequacy of healthcare sector serves a prerequisite for effective education. So in a society where the healthcare is in a quagmire, the educational development alongside its attendant scientific and technological advancements would remain in a waterloo.

The implication of such a present healthcare state on Nigerian education is multivariate, and this shall be discussed through a tripartite Literacy Model we call 'LIE';

- Literacy Limitation>
- Literacy Inadequacy.
- Literacy Exportation.

A. Literacy Limitation:

As already discussed, it is no news that the Nigerian healthcare is far below average, while sound health is a requisite to interest in knowledge acquisition. This reality therefore lends credence to limitation in knowledge circulation. In other words, an unhealthy child and his parent cannot be interested in knowledge acquisition. According to (Oyibocha et al, 2014) fifteen per cent of Nigerian babies die before their fifth birthday owing to malnutrition, malaria and diarrhoea. This expresses a manifestation of child's mortality, and obviously, a child that dies at infancy cannot be privileged to have access to education.

Asides the above, the inconsistency of some children's health state, which sometimes owe itself to poor national and community healthcare frameworks, often make some parents decide not to introduce education to their wards as early as expected. In fact in perceived extraordinary cases, some parents and guardians prefer to leave their wards at traditional medicine centres and spiritual healing places till directors of such centres discharge them. This is done due to the belief that when a child's health breakdown becomes consistent, it has to be supernatural, hence, the need for a supernatural approach to his healthcare.

In addition to this, the insecurity peril that has rendered various parts of the country, especially the north-eastern part, to vulnerability has limited provision of healthcare and education to few Nigerians. As a matter of fact, an average Nigerian doctor would prefer to abandon the medical profession than to practise in the likes of Borno, Maiduguri, Adamawa, etc. areas.

B. Literacy Inadequacy:

While literacy limitation implies how education is limited to small fraction of Nigerian populace due to poor healthcare system, literacy inadequacy expresses how poor healthcare system reduces the standard and quality of education in the country. Due to lack of sound health, a Nigerian who finds education accessible may not find it explorable. The mental wellbeing is considered a measurement of health state as obvious in our earlier definition, and education is acquired with this mental template. Thus, mental sickness automatically affects the active functioning of one's mental capacity for assimilation of education. Even without particularization to mental wellbeing, a physiological wellbeing is fundamental to literacy adequacy. For instance, an elementary school teacher at Boripe Local Government Area of Osun State affirms this when she says part of her

professional observations in Elementary School pupils is their obvious indifference to academic classes whenever they are indisposed. This often happens in minor health problems like headache, stomach upset, constipation and the likes. This however is not just a peculiarity to the primary education alone as it transits to secondary and tertiary levels. For instance in University clinics, students who got sick during examination periods are told their ailments are not sufficient reasons for missing their papers. This in fact, is often pasted across clinic walls of such institutions. Worst still, in some cases when doctors in charge feel the ailment is serious, school management would prefer to bring the question paper to the clinic for the patient-student to write. Then, one could only wonder why students should write examinations while still in obvious challenging health states. But then, it is Nigeria. This definitely affects the adequacy of education acquisition in students as the system emphasizes examination at the expense of knowledge.

C. Literacy Exportation:

Literacy exportation is another major implication of bad healthcare on education in Nigeria. While medical practitioners are already disproportionate to the Nigerian populace, majority of them still prefer to work outside the country. This we call brain drain and it has eaten deep into Nigerian healthcare personnel profiles. A fact we cannot eschew is that the medical practitioners are not to be blamed for this habit. Pursuit of health education in the country is quite expensive, and still, after acquisition the Nigerian environment is not enabling for the profession; the facilities are non-extant, infrastructures are dilapidated and services are not adequately rewarded. Conversely, these health professionals are ‘hotcakes’ abroad and therefore easily respond to a call from any appreciative country.

The import of such status quo is in that professionals who should contribute to national health education and healthcare in Nigeria relocate from the country to their practice places, and this by implication reflects literacy exportation.

1.4 Method

1.4.1 Theoretical Perspectives:

Inductive and deductive theoretical approaches were used in this research as discussed by Trochim and Donnelly (2007). As noted by Ketokivi and Mantere

(2010), inductive approach is necessary in putting research into context while drawing conclusions especially where new theories are to be developed. This research employs inductive approach in order to facilitate better discussion and conclusions on healthcare problems and its implications on Education in Nigeria.

This research also employed exploratory approach in order to offer more comprehensive explanations on the findings from the empirical research. Questionnaires were used because they are effective in presenting descriptive features of the phenomena being researched (Cassell et al., 2009). Literature review was helpful in this process and also in questionnaire formulation and in the formulating of the research process. Descriptive empirical research was also used in analysis of the collected data in order to help make informed inferences on the existing problems. This mixed or integrated research paradigm was adopted in order to reduce errors and in making the results more valid and relevant (Johnson and Onwuegbuzie, 2004). A similar approach was used in previous researches of this nature.

1.4.2. Strategy:

This research adopted strategies that have been tested in both qualitative and quantitative researches in order to ensure valid results were drawn. First, online survey methods were used instead of sending questionnaires by post or by hand in order to ease the data collection, questionnaire completion and offer respondents a simple mode of completing the questionnaires. Secondly, the variables included have been previously tested and have been accepted by researchers carrying out this kind of research.

1.4.3. Methodology:

This research utilized both the quantitative and qualitative research designs (Babbie, 1990, 2013: Babbie & Mouton, 2007: Baker, 1999). The study used questionnaires during data collection. They were used to collect views of professionals with regard to the problems of healthcare in Nigeria and its implications on Education.

1.5. Sampling Process:

1.5.1. Selection:

This study focused entirely on the Educational Professionals based in Nigerian higher institutions in Southwest part of Nigeria. Given the low number of these

institutions and their concentration in the large cities, this study was carried out in Yoruba land. Attempt to include smaller cities and cover wider geographic areas were inhibited by a variety of factors as mentioned in the prefix.

1.5.2. Data Collection:

Upon refinement of the survey questionnaire after the pilot study, it loaded on survey Monkey website. Educational professionals at the various higher institutions in southern part of Nigeria were contacted by phone to inform them about the questionnaire. Other persons such as managers and senior health officers were also contacted by phone and emails. Invitations were also sent through Facebook and WhatsApp. This was mainly because more people are using social networking websites in Nigeria and such invitations were easy to re-distribute and invite more prospective respondents.

The entire population of this study was estimated to about 1273 based on records in these institutions. However, due to the lack of verifiable information on the number of people involved directly, this research assumed that the population of people contacted was those to whom emails were sent. 623 emails were sent and this was assumed to the 100% (n=623) of the respondents. Though 39% (n=243) of the emails bounced, 87% (n=212) of the respondents whose emails bounced were contacted in person.

1.5.3. Data Analysis:

Following the successful of distribution of 623 questionnaires, 37.3% (n=233) responded. However, only 197 of these were used because 36 of them were partially completed and could not be used in the data analysis process. In order to analyse, interpret and present this data in a comprehensive manner, Statistical package for Social Sciences (SPSS) V.19 was used. It was adopted because according to Nie, (2007), SPSS is commonly used by most social science researchers. Data collected from the Survey Monkey questionnaire was tabulated into categories and attributed analysed using cross-tabulations.

1.6. Results:

Out of the 623 Educational professionals and Healthcare workers were contacted 37.4% (n=233) completed the questionnaires online at Survey Monkey. 5.8% (n=6) were incomplete in one or more sections making them unsuitable for inclusion in the analysis. The population analysed, 100% of the data, was represented by 197 respondents whose questionnaires were fully completed. A

variety of statistical tests were undertaken using SPSS v.19 for windows based. Background characteristics, gender, time spent in the profession, educational level and religious views were collected by questionnaire.

More males responded to the questionnaire, 61.9% (n=122) compared to women 38.1% (n=75) which is reflective of the Nigerian Educational profession and healthcare staff ratios. More men are into lecturing than women.

Table 1: Summary of respondents' characteristics

Variable	Number	Percentage
Respondents		
Completed	197	31.6%
Part completed	36	5.8%
Not returned	390	62.6%
Gender		
Male	122	61.9%
Female	75	38.1%
Years in service		
Over 5 years	168	85.3%
Under 5 years	29	14.7%
Healthcare staffs		
Male	14	26.9%
Female	38	73.1%
Religious		
Extremely	22	11.2%
Very	90	45.7%
Not	72	36.5%
Others	13	6.6%

In order to test the problems of Healthcare in Nigeria and its implications on education, variance analysis was used to estimate the relationship between the respondents' characteristics in table 1 and implication categories in table 2. The test score in table 2 was based ($p < .001$).

Table 2 Relationship between the respondents' characteristics and implication categories

Variable	Numbe	Behavioral	Educational	Psychologica	Psychologica
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	r	stability		achievement		l disorders		l development	
	n	Mea n	SE	Mea n	SE	Mea n	SE	Mea n	SE
Gender									
Male	122	2.09	0.028	3.90	0.029	2.01	0.030	3.87	0.034
Female	75	2.29	0.020	3.91	0.021	2.20	0.022	3.80	0.026
Years in Service									
Over 5 years	168	2.12	0.026	3.99	0.026	2.01	0.028	3.95	0.031
Under 5 years	29	2.27	0.022	3.88	0.026	2.22	0.024	3.75	0.029
Healthcare staffs									
Female	38	2.29	0.028	3.90	0.029	2.21	0.030	3.75	0.030
Male	14	2.16	0.023	3.96	0.021	2.05	0.022	3.87	0.026
Religious									
Extremely	22	2.17	0.022	3.93	0.022	2.14	0.023	3.79	0.025
Very	90	2.23	0.019	3.98	0.029	2.14	0.022	3.78	0.023
Not	72	2.24	0.021	3.99	0.022	2.15	0.019	3.77	0.022
Others	13	2.21	0.019	3.94	0.018	2.13	0.019	3.79	0.022

The respondents' views were highly indicative of the differences in implications of healthcare on education in Nigeria. As shown in table 2, Educational achievement, Psychological disorders and Psychological development had higher levels of scores irrespective of respondents' characteristics. This shows a big

vacuum in the educational sector. For example, more people believed that lack of proper healthcare in the country has negative impacts on educational achievement of student. However, behavioural stability had the least support as indicated by the negative scores.

1.7. Conclusion:

Health care is one of the basic and vital welfares of a society. The findings of this study have revealed the problem of healthcare in Nigeria and its implications on education. This was possible because of the high-quality assessment tools (in terms of reliability and validity) being used. The preparation of the assessment tools went through a rigorous and careful attention focused on ensuring that basic concepts and principles of results were integrated during the field study process.

1.8. Recommendation:

Panacea to Nigerian Healthcare Menace

Though the healthcare problem in Nigeria is age-long, a revival of the sector should not be rendered unachievable. In line with these, the following recommendations are made;

1. Government Arms and parastatals should be committed to raising Nigerian healthcare system to global standard through appropriate budgetary allocation to the healthcare sector.
2. Pursuit of healthcare outside Nigeria by Nigerian nationals should be seriously discouraged and regulated. Most especially, government officials should be dissuaded, if not barred, from seeking medical treatment outside the country.
3. There should be at least, a one year mandate for Nigerian health experts to serve the country (asides the general national youth service corps (NYSC) scheme) so as to boost professional commitment to Nigerian national healthcare.
4. Nigerian government has to find strategic measures to ensure electricity availability and regularity in the country. This is fundamental to restructuring the Nigerian healthcare facilities and mechanics.
5. Patriotic values should be integrated to the course of medical training so health trainees can be committed to sacrificing for their nationality.

6. The implementation of budget allocation of health should be proportionately distributed between urban and rural areas of the country.
7. Non-Governmental Organisations, charity groups and international philanthropists should make their charity investments in Nigerian health sector so as to positively affect the Nigerian healthcare and education simultaneously. This would also help to integrate Nigeria in the United Nations mandate that every sovereign nation should have a safe healthcare system by 2030.

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