



**Socio-Cultural Factors (SCF) and Health Care Services Utilization
(HCSU) in Akwa Ibom State, Nigeria: An Assessment and Policy
Recommendations**

by

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Abstract

The study examined the impacts of socio-cultural factors (SCFs) on the utilization of Health Care Services (HCS) in Akwa Ibom State, Nigeria. Data were collected from three hundred and sixty (360) respondents. Twenty six (26) Health Care Institutions and thirteen (13) Traditional Healing Homes (THHs) were purposively selected for the study. Findings of the study show, that belief in mystical forces (witchcraft, spells, and sorceries), that some disease conditions respond faster to traditional medicine than western cures, that traditional medicine are cheaper as well as, recommendation by relatives and friends, greatly influence the utilization of traditional medicine against orthodox health services in the state. It was recommended from the study among others that, cultural education as well as incorporation of traditional medicine into orthodox medical practices among others be undertaken in order to raise the awareness of the people on the efficacy of orthodox medicine, as a way of encouragement to the people of Akwa Ibom to utilize its services in the state.

Key words: Socio-Cultural Factors, Health Care Services, Utilization, Traditional Medicine.

1. Introduction

No country can attain sustainable progress without a viable and adequate health care system (Orabuchi, 2005). It is often argued that, the economic and social growth of any nation depends largely on a vibrant health care sector. This is why many developing nations such as India, South Africa, Ghana, Saudi Arabia, Kuwait, Brazil, Argentina, etc. have taken some concrete steps to bring about effective health care delivery (Udoh, 2011 and Chikwe, 2008). Regrettably, the health care sector in most parts of Africa including Nigeria is characterized by the dual health care system – the traditional therapeutic system and the orthodox (cosmopolites) Bio-medical system (Ekong, 2006).

The Orthodox health care system is an institutionalized health sector built and managed by government or individuals with a set of formal, organized, and trained professionals (doctors, nurses, pharmacists, midwives, laboratory scientists, technicians and technologists) (Etohe, 2004 and Alibi, 2010). It is generally presumed to be more universally applicable and efficacious than the traditional system. Its operation is considered formal, standardized, scientific, and professional with empirically-based methods of diagnosing and treatment of ailments (Agunta, 2010). On the other hand, the traditional African medicine, also referred to as indigenous medicine which operates alongside orthodox medicine, is a holistic discipline made up of traditional and indigenous herbalist and African spirituality, driven by native doctors, diviners, herbalists, traditional midwives, bone –setters, pastors, prophets, as well as other pseudo-spiritual leaders who often claim to have knowledge of all kinds of ailments and its treatments or cures (Eboh and David, 1993; Ekong, 2006; and Orabuchi, 2005). The system is considered informal, unstandardized, unscientific, unprofessional, and archaic in nature. Its diagnosis is unscientific, unempirical, and technically vague especially, when compared with the methods and principles used by the orthodox medical practitioners (Stein, 1988). In addition, traditional medicine or health care claims to be more indigenous, culturally relevant, accessible, simple, practical, and more effective for treatment of diseases and illnesses especially, those diseases that orthodox practitioners claim to have no cure, such as HIV/AIDS. Also, traditional medicine practitioners continue to claim that their knowledge of the spiritual problem of individuals places them at a better position to treat ailments such as hypertension and heart related problems better than the orthodox medical professionals. (Institute of Medicine, 2002).

In Akwa Ibom State, inspite of government efforts to make orthodox health care institutions available by building the institutions in all local government headquarters, expansion of the Specialist Hospital at Uyo, and improvement of the salaries and allowances of all categories to health care workers in the state, very many people, including the elites continue to talk about the traditional health institutions. This could be explained in terms of the peoples' beliefs and values in culture, tradition and norms of the society, which is difficult to be separated or eradicated from the people. Findings by Health and Human Services (2005) showed that, traditional medical practitioners are part and parcel of the people, they live with the people, worship in the same church, attend the same family meetings and also identify with the people in their illnesses and recovery (Chute and Koo, 2002).

Generally, the health sector in Nigeria is characterized by many problems. Apart from the fact that, the orthodox system continuously competes with the traditional system, it has been observed that a large majority of people, including the city dwellers continue to have passion for traditional health care system (Mboho, 2012 and Charles, 2005). In a study on "The Rural Peoples' Attitude When in Mental Distress", it was argued that, many Nigerians, especially, those residing in rural societies first consult traditional healers, pastors or prophets when in mental distress before going to the hospital if the condition worsens (Udoh, 2013). Jegede (1994) had already observed the same situation when he explained that, among many Nigerians, ailments such as malaria, typhoid fever, hypertension, asthma, choleras, etc. are first taken to native doctors and prayer houses instead of government hospitals and many people would visit orthodox hospitals only when herbal doctors and prophets fail to provide solution to their ailments. To him, many people attribute every preventable death or illness to witches and wizards or sorcerers.

In Akwa Ibom State generally, Umoh (2013) posited that, many people seek

solutions to their health problems by mostly patronizing prayer houses. He observed that, a situation where someone suffering from ulcer or diabetes is subjected to a three-day dry fast instead of visiting an orthodox hospital for proper diagnosing and treatment is very disturbing. The same situation is also noticed in other communities around its neighbouring states. The resultant effect according to Orabuchi (2005) is that, as the prayer continues, the hernia prolapses faster which often results in sudden death of victims.

According to Ekong (2006), the attitude of seeking medical attention in prayer houses and traditional healing homes lie in the belief of the people that, every sickness, ailment or any problem for that matter, confronting man is either from witches, wizard, or an act of God. And so, the solution to any health challenge could either be provided by man himself through his agents or the supreme creator in the light of the above, the present formulation is therefore an attempt to uncover those socio-cultural factors that make people continue to seek for treatments in herbal homes and neglect orthodox health institutions.

Although there is adequate field-based information on the challenges affecting the country's health care sector, information and data relating to socio-cultural factors on health are relatively scanty. Studies by Stein (1988), Halwani (2004) and Tope – Aja (2005) often attribute the failure of the Nigerian Health Care Sector from achieving sustainable health for the people to lack of adequate health institutions, inadequate and qualified personnel, professional competition among different professional bodies, discrimination on the basis of tribe, gender and professional areas within the hospital, poor finances, poor execution of hospital projects, absence of required equipment, etc. While the above challenges are recognizable variables in various degrees, it must be reasoned that, orthodox health institutions also function and compete with traditional healing homes in rendering the same health services to the people (Berwick, 2003 and Wenger, 2005). According to Bamikale (1999), while the traditional healers employ tradition and culture in their therapeutics, the orthodox system employs scientifically-based principles for its treatment. According to Etobe (2004), culture plays a very important role in health and illness in all societies. It can be argued therefore that, the health of a society is a function of the norms and values of that society. Culture and health cannot be separated because each represents to some extent, different aspects of the same coin.

In his study of culture and health care, Okonofua (2000) asserted that, health is multi-dimensional phenomena. It includes physical, psychological and social well-being. To him, people can be healthy in some aspects of their life while being ill in others. This according to Orabuchi (2005) is consistent with cultural differences in health and recognizing that culture operates through local communities. Further attempts to demonstrate the relationship between socio-cultural factors and health are made in the context of illness behaviour where evidence abound on how social and cultural factors shape the perception of illness and the way in which various peoples act and respond to illness. (Paul, 1985).

In Akwa Ibom State, Udoh and Ekpenyong (2010) and Udoh (2013) explained that, there is a mixture of the use of both western orthodox and traditional medicine in many instances, (including spiritual remedies) in seeking health care services. Although many people continue to visit traditional healers before seeking western-orthodox health institutions, and vice-versa, as well as visits to patent medicine sellers or hawkers who travel in buses or advertize their products in open markets, while, many people visit

pharmacists to purchase drugs direct, the contributions of orthodox medicine cannot be undermined. The reasons being that, traditional healers, patent medicine shop operators and medicine hawkers are more accessible to the ordinary man on the one hand and the widespread belief in sorcery and divination powers of the traditional medicine practitioner on the other, make many people to patronize them than the orthodox medical institutions (Eboh and Ukpong, 1993; Ekong, 2006). Several studies have also shown that, there are factors that influence the choice, preference, and utilization of traditional medicine in spite of the availability of western medicine. These include:

- i. *Cultural Factors:* Many researchers agree that the concept of disease is determined by culture. Culture incorporates belief system, which in turn underlies the perception and interpretation of disease in societies. The concept of disease in western society is largely based on the germ theory and the biomedical health model. On the other hand, the belief among traditional people or Africans is largely that diseases and illness are caused by witchcraft, sorcery, mystical forces as well as natural factors. And so, while the westerners accept and use the orthodox medical services due to his beliefs and mindset, an average African will first look for interpretation and help from herbalists or prophets, and will visit the orthodox hospital as a last resort (McGuire, 2002).
- ii. *Social Factors:* According to Tabi and Evinosho, 2006, sex, education, ethnicity, income and occupation, among others greatly influence people's attitudes toward decision-making on use of health services when ill. Other studies such as Rothman (1994) and Spector, (2004) have also agreed that ethnicity and sex greatly influence the choice of treatment and utilization of health services by people.
- iii. *Educational Attainment and Economic Factors:* According to Erinoshio (1977), Roth (1969) and Ukim (2006), gender factors as well as age determine the use of health services. According to Erinoshio (1977), epidemiological studies have shown that in many societies, the use of health services is greater for female than male, and is greater for the elderly. Also, the behaviour patterns of women differ from those of men in various societies in many aspects. Recent studies in some Nigerian communities show that, women in some ethnic groups will not seek immediate help from health care agents during pregnancy except approval is sought from their spouses, while others will prefer to be examined only by female health workers (Ekong, 2006 and Etobe, 2004). Whereas, women with formal education are more likely to assume responsibility and take immediate step to seek help for themselves and their children during ill health than those who have little or no formal education (Halwani, 2004).

It is worthy to mention that, patterns and trends in the utilization of health care services and institutions change with time, while new ones emerge. In Akwa Ibom State it is argued that public health care institutions and facilities are inadequate. Both the state and federal governments attempts to improve facilities and personnel in the existing ones is ongoing, the cost of medical treatment in government hospitals makes many indigenes of the state to look for alternative sources of medical services. Again, many craps of alternative have emerged with services and activities cutting across cultural and therapeutic boundaries. As a result, the orthodox medical care services are now facing serious competition with the traditional ones, making its services unattractive to so many people. In the light of the above, the present formulation therefore attempted to critically assess those socio-cultural factors that influence health care services utilization in Akwa

Ibom State with a view to making recommendations on how to promote sustainable health care services utilization in the state.

The present study utilizes the analytical tool of the functional perspective otherwise known as the System Theory or Structural Functionalism (Parsons, 1970; Merton, 1957). The structural functional theory is hinged on the analogy between the biological organism and society. The perspective has led some health sociologists to argue that sickness, health and wealth institutions can be analysed within the framework of a dynamic social system (Durkheim, 1938). Functionalists argue that, the illness of a particular member of a given family group, community, or society may be traced to poverty or a malfunctioning of any unit within the system and such an illness is likely going to affect the entire system if not urgently attended to, treated or healed. Whatever may be the cause of the illness, the effect is that the sick member's illness behaviour has negative implication not only on the sick person, but to the family, the community or the state to which the individual belongs. (Merton, 1957).

The functionalist approach to the sociology of health and illness derived from the work of Talcott Parsons (1970), show that even the apparently biological aspects of social life could be understood through the lens of sociology. Parson's original view was that all social actions can be understood in terms of how they help society to function effectively. When an individual is sick for instance, they are unable to perform certain task or play certain roles within the system. Parsons argued that the best way to understand illness is to view it as a form of deviance, which disturbs society's functioning, in just the same manner crime (insurgence,, arm-robbery, kidnapping etc) does. Therefore, like crime and any other form of deviance, illness needed to be controlled in some way, and the sick (criminal) must be recuperated (corrected) so as to continue his social responsibilities for the survival of the society.

In order to achieve the above objectives, the study sought to answer the following questions:

1. What socio-cultural factors influence the health care services utilization in Akwa Ibom State?
2. How have these attitudes impeded the effective health care delivery services in the state?

Answers to the above questions call for a rational and in-depth assessment of issues raised in this study. It is obvious that the findings of this study will generate concrete policy suggestions that will improve health care services utilization in the state in particular and Nigeria in general.

2. Material and Method

The Study Area: The study was carried out in Akwa Ibom State in the South-South Geopolitical zone of Nigeria, with a land mass of 8,412km². It lies between latitude 40° 30¹ and 50° 30¹ and longitude 70° 25¹ and 80° 25¹ E. It has a population of about 4 million people occupying the 31 Local Government areas, with 60 percent of this population living in rural communities and engaging in agriculture, petty trading, fishing and local craft as their major occupations (Udoh, 2011, Spector, 2004).

Akwa Ibom is a multi-lingual community with more than eight different dialects mutually spoken by the various ethnic minorities living within the state. Though the people can be identified with these dialects, they also have diverse cultures which single them out from the larger Akwa Ibom community. In spite of their cultural diversity, the people are united culturally, politically and socially (Ekong, 2006, Ekpenyong, 2008 and Udoh, 2013).

The Study Design: The researchers adopted the inferential survey design in carrying out the study. This design was to help the researchers to investigate the role of socio-cultural factors on health care services utilization by Akwa Ibom people. Two variables were involved; 'socio-cultural factors' and 'utilization of health care services'. Socio-cultural factors were measured using variables such as beliefs system, family background, gender values, etc. while utilization of health care services was measured using variables such as failure of initial treatment in the orthodox hospital was unsuccessful, belief that some disease conditions respond faster to traditional medicine than to western cure, affordability and low cost of alternative/traditional medicine, reputation and popularity of service providers of alternative health care, recommendations by friends and relatives, as well as the role of churches and prophets.

Procedure: An estimated population of one thousand four hundred and sixteen (1416), comprising Traditional Healing Homes (THHs), Traditional Birth Attendance, and the general public were identified from both the Ministry of Health (Department of Alternative Medicine) and those not registered but were carrying out orthodox treatments. Of this number, 261 THHs were purposively selected for the study. To obtain the 261 – THHs, the state was stratified into three zones three Senatorial Districts (SD). In each of the Senatorial Districts, one Local Government Area was systematically selected. In this case, Ikono was selected for Ikot Ekpene SD, Ibiono Ibom was selected from Uyo SD and Esit Eket was selected from Eket SD. In each of these Local Government Areas 87 THHs were identified, making a total of 261 THHs. One respondent was interviewed. In addition 10 Traditional Birth Attendance (TBAs) were purposively identified and interviewed in each of the three selected LGAs, making a total of 30 TBAs and representing 30 TBAs representing 30 respondents. Again 23 respondents were randomly selected from each of the sampled Local Government Areas for interview, making a total of 69 respondents. On the whole 360 respondents formed the data base for this study.

Structured questionnaire consisted of twenty-five (25) structured items was used for data collection. The questionnaire was subdivided into four sections. Section 'A' elicited questions on the personal characteristics of the respondents, section 'B' elicited questions on the types of socio-cultural factors affecting the choice of health care in the state, section 'C' elicited questions on the effect of these socio-cultural factors on utilization of care services, while section 'D' elicited questions on how to bring about sustainable health care delivery services in the state.

The questionnaire items were scaled using Likert Scale of Strongly Agreed (SA), Agreed (A), Disagreed (D) and Strongly Disagreed (SD). Collected data were coded and scored from 4-1, respectively. This helped to attach numerical values to these questions. Descriptive statistics was used to interpret data. These include the Group Arithmetic Mean (GAM) and Mean Weight Values (MWV). Frequencies were performed to know how many respondents answered what question, while simple percentage was employed for interpretation. Two Field Assistants were recruited and trained to assist in questionnaire distribution and retrieval. All information were collected between October and December, 2015.

Presentation and Analysis of Results:

i) Demographic Characteristics of the Respondents

Table 1: Socio-Demographic Characteristics of the Respondents.

S/No.	Characteristics	Frequencies	Percentage (%)
i)	Sex:		
	Male: 4	251	69.5
	Female	109	30.5
	Total	360	100.0
ii)	Marital Status		
	Married	231	64.1
	Single	93	25.9
	Divorced	25	6.9
	Widow/Widower	11	3.1
	Total	360	100.0
iii)	Educational Level:		
	FSLC	75	20.8
	SSCE/NECO/WASC	108	30.0
	NCE/IND	117	32.6
	HND/DEGREE	60	16.6
	Total	360	100.0
iv)	Occupation:		
	Civil Servant	160	44.4
	Business	127	35.3
	Farming	21	5.9
	Trading	36	10.0
	Others	16	4.4
	Total	360	100.0
v)	Religious Affiliation		
	Christianity	321	89.2
	Moslems	2	0.5
	ATR	23	6.4
	Others	14	3.9
	Total	360	100.0
vi)	Age:		
	20-30	77	21.4
	31-40	171	47.5
	41-50	52	14.4
	51-60	41	11.4
	60 and above	19	5.3
	Total	360	100.0
vii)	Residential Area		
	Urban	217	60.3
	Rural	143	39.7
	Total	360	100.0

Source: Field work, 2015.

Analysis of demographic characteristics of the respondents in table I above shows that, of the 360 respondents, more than two-third (69.5 percent) were male while less than one-third (30.5 percent) were female. From the table, it could also be observed that, close to two thirds of the respondents (64.1 percent) were married, about one – quarter (25.9 percent) were single, only 6.9 percent and 3.1 percent were divorced or widow/widower, respectively. The table also highlights that, about one-fifth (20.8 percent) of the respondents obtained primary six, three tenth (30.0 percent) obtained secondary school certificate or its equivalent, about two-seventh (32.6 percent) obtained National Certificate in Education (NCE) and its equivalent while one-sixth (16.6 percent) obtained Higher National Diploma and Degrees in various areas. The table also shows that majority of the respondents were civil servants (44.4 percent) and business men/women (35.3 percent) while the remaining (20.3 percent) where either farmers, traders or other professions not listed here. From the table also, more than four-fifth (89.2 percent) were Christians while more than two-third (68.9 percent) were within the age range of 20-40 years. About three fifth of the respondents (60.3 percent) resided in the urban areas while the remaining lived in the rural or semi-urban areas.

The above picture reflects the social realities of the socio-demographic characteristics of the state in terms of gender participation in social and economic activities. All over, it could be observed that men dominate in everything and the patriarchal nature of the society is reflected in all human endeavours in the state, as is the case in table I above.

ii) Socio-cultural factors influencing people’s health care services utilization in the state: The above socio-cultural factors were discussed are shown in table 2 below.

Table 2: Distribution of Respondents According to their Perceptions on SCFS and of HCSU in the State

Point Scale Questions	4	3	2	1	Percentage		MWV	GAM	D	Remarks	
	SA	A	D	SD	A	D					
Failure of initial treatment in orthodox health institutions to improve sufferers’ conditions	87	105	94	74	53.3	46.7	115.3	141.6	- 26.3	8 th	
Belief that some disease conditions respond faster to traditional medicine than to western cures	131	197	19	13	91.1	8.7	145.7	141.6	+4.1	3 rd	
Belief that traditional medicine is cheaper, and practitioners closer to the people	121	211	20	8	92.2	7.8	145.6	141.6	+4.0	4 th	
Belief that mystical forces such as witchcraft, spells, etc. caused their conditions	138	204	11	7	95.0	5.0	149.1	141.6	+7.5	1 st	
Service providers’ regulation and popularity	113	224	20	3	93.6	6.4	143.3	141.6	+1.7	6 th	
Traditional practitioners maintain secrecy and privacy over their health conditions	106	211	36	7	88.1	11.9	142.0	141.6	+0.4	7 th	
Traditional practitioners maintain secrecy and privacy over their health conditions	133	197	22	8	91.7	8.3	146.8	141.6	+5.2	2 nd	
Acts according to socio-cultural beliefs of patients.	106	232	18	4	93.9	6.1	145.0	141.6	+3.4	5 th	
	Σ							1132.8			
Sources: <i>Field Work, 2015.</i>	<i>n</i>	=	360								

Where: MWV = Mean Weight Value (1132.8)
 GAM = Group Arithmetic Mean (141.6, Constant).
 D = Difference between MWV and GAM.

Decision: Accept if MWV is greater than GAM and the difference is positive, but reject if MWV is less than GAM and the difference is negative.

Results from table 2 above indicate that more than four-fifth (87.4 percent) of the respondents have agreed that certain socio-cultural factors actually influence the utilization of health care services in the state. Highest in the list is the belief that mystical forces such as witchcraft, spells, etc. caused their conditions which could only be treated by traditional health practitioners (95.0 percent and a difference of +7.5 percent on the Likert Scale. Other factors include, the belief that some diseases conditions respond faster to orthodox cures (91.1 percent with +4.1 percent difference), the belief that traditional medicine is cheaper, and practitioners are closer to the people)92.2 percent with +4.0 percent difference), the belief in reputation and popularity of service providers (93.6 percent) with +1.7 percent difference), belief that traditional practitioners maintain secrecy and privacy over people’s health conditions (88.1 percent with +0.4 percent difference) and recommendations by friends and relatives (91.7 percent with +5.2 percent difference).

However, the opinion on failure of initial treatment in orthodox health institutions to improve sufferer’s condition attracted a low agreement as only a half of the respondents (53.3 percent) with 26.3 percent degree of difference. Generally, the above findings confirm the influence of socio-cultural factors on the choice/utilization of health care services in the state.

iii). Impediment of Socio-Cultural Factors on Effective Orthodox Health Care Utilization in Akwa Ibom State:

A Likert Scale analyses and discussions of the above variables are as shown in table 3 below.

Table 3: Distribution of Respondents according to their perception on the impacts of socio-cultural factors on health care utilization in Akwa Ibom State

Point Questions	4	3	2	1	Percentage		MWV	GAM	D	Remarks
	SA	A	D	SD	A	D				
Insufficient knowledge and utilization of the health benefits in the orthodox hospitals	127	203	17	13	91.7	8.3	232.8	217.8	+15.0	2nd
Underutilization of health facilities provided by government at different localities and centers	112	240	26	6	97.7	2.3	235.6	217.8	+17.8	1st
Continuous incidence of high mortality rates in the community as a result of underutilization of health institutions	102	233	16	9	93.1	6.9	229.6	217.8	+11.8	3rd
Continuous spread of untested and uncertified traditional drugs and herbs with guaranteed efficacies	101	94	96	69	54.2	45.8	189.4	217.8	-28.4	4th
Continuous belief on the idea that traditional medicine can provide the needed solution to the health care needs of the community	113	102	97	48	59.7	40.3	201.8	217.8	-16.0	5 th
	Σ						1089.2			

Source: Researchers’ Field Survey, 2015.

Where: n = 360
 MWV = Mean Weight Value (1089.2)
 GAM = Group Arithmetic Mean (217.8, Constant).
 D = Difference between MWV and GAM.

Decision: Accept if MWV is greater than GAM and the difference is positive, but disagree (reject) if MWV is less than GAM and the difference is negative.

Results from table 3 above indicate that, more than three – quarters (79.3 percent) of the respondents have agreed that socio-cultural factors have some impacts on the utilization of health care services in Akwa Ibom State. Top on the lists of such consequences is the belief that such situation will lead to the underutilization of health facilities provided by government at different localities, and centres within the scale (item number 17 on the questionnaire schedule). Other adverse consequences include insufficient knowledge and utilization of the health benefits in the orthodox, health institutions (+15.0 percents difference) and continuous incidence of high mortality rate in the state (+11.8 percent difference). However, two variables were judged to house negative impact on health care utilization. These are continuous spread of untested and uncertified traditional drugs and herbs with unguaranteed efficacies (-28.4 percent difference) as well as continuous belief on the idea that traditional medicine can provide the needed solution to the health needs of the people. The negative values of the above two variable however, does not mean that those factors are not present, but their presence is not as strong as the other factors. All that the table tries to explain is that there is an adverse consequence as a result of inadequate utilization of the orthodox health facilities in the state.

iv) How to Bring about Adequate Utilization of Orthodox Health Care Services in Akwa Ibom State:

Table 4: Distribution of respondents according to their opinions on how to bring about effective health care services utilization in Akwa Ibom State is discussed in table 4 below.

Point	Scale	4	3	2	1	Percentage		MWV	GAM	D	Remarks
		SA	A	D	SD	A	D				
Introduction of cultural education to get described rural chance on the need to utilize orthodox health institutions		124	218	13	5	95.0	5.0	236.2	223.2	+13.0	
Introduction of cultural education to get described rural chance on the need to utilize orthodox health institutions		115	211	18	16	90.5	9.5	229.0	223.2	+5.8	
There should be sufficient knowledge through mass mobilization and sensitization of the people		103	231	21	5	92.8	7.2	230.4	223.2	+7.2	
Medical bills in orthodox health institutions should be reduced to make its patronage attractive to the people		121	222	15	2	95.2	4.8	236.4	223.2	+13.2	
Health personnel in the orthodox health institutions should conduct themselves well and avoid being hostile to the people		97	101	69	93	55.0	45.0	184.4	223.2	-38.8	
Orthodox health institutions should not charge any medical bill in its services throughout the state.											
								1116.4			

Source: Researchers' Field Survey, 2015.

Where: n = 360
MWV = Mean Weight Value (1116.4)
GAM = Group Arithmetic Mean (223.2, Constant).
D = Difference between MWV and GAM.

Decision: Accept if MWV is greater than GAM and the difference is positive, but disagree (reject) if MWV is less than GAM and the difference is negative.

Results from table 4 above indicate that, more than four-fifth (85.7 percent) of the respondents have agreed that effective health care utilization in the state is possible. Findings show that, 95.0 percent of the respondents mentioned that there should be an introduction of cultural education to get the desired behavioural change and to eradicate certain obnoxious cultural behaviours. Others indentified issues such as sufficient knowledge through mass mobilization and sensitization of the people (90.5 percent), reduction of medical bills in government hospitals to encourage people's patronage (92.8 percent) also dedication on the part of staff working in government health institutions (95.2 percent). However, the issue of total cancellation of medical bills in government hospital attracted a negative score on the scale meaning that the issue of total cancellation of hospital bills in government hospital was not accepted by the majority of the respondents. However, the table indicates that if concrete steps are taken, utilization of health care services in government hospitals will be improved.

3. Findings

Findings from the study indicated that certain socio-cultural factors actually influence the extent of orthodox health care utilization in Akwa Ibom State. This implied, therefore, that the people of Akwa Ibom are culture-inclined. from the onset, they were known to be people who belief in their own tradition, values, beliefs norms, myths and customs. This also agrees with the study by Ekong (2006) that the Akwa Ibom people believe in their culture and values and would not accept change easily except such change is in line with their tradition.

Again, the study unveiled that certain socio-cultural factors have some impacts on the utilization of orthodox health care services within the state. The rural people believe so much in culture. They often resist any thing that is new or against their tradition. And so, will not participate in what new or alien to their community or beliefs system, a condition that makes them continue to patronize the traditional medicine man or the traditional birth attendants.

It was also highlighted from the study that the role of the Traditional Health Care givers should not be undermined. This is exemplified in their view that to effectively encourage people to utilize orthodox medicine, close collaboration should be made between it and the traditional medicine. The above issue has been of serious concern among health experts in the state for some time now. However, the implication of the above findings is that orthodox health care services should be promoted hand-in-hand with traditional health care. it is through this strategy that the people's cultural values will be blended along the western cultural values and such is likely to promote the utilization of both health care services within the state.

Nevertheless, the present finding is not without some limitations. In the first instance, Akwa Ibom population, particularly in the rural areas still comprises of large illiterate population. This poses a serious challenge because many people could not be convinced to visit hospitals for treatment of their ailments. Secondly, the people's believe in superstition such as being bewitched or charmed by others are common. They continue

to believe that such attacks could only be repelled or cured by the traditional healers whose power is derived from the deity or spirits of dead ancestors. Also, the belief that certain diseases are natural, ancestral, demonic, or as a curse increase the people's dependence on traditional healers while the patronage of orthodox health institutions is neglected. When the above is added to the financial implications and bureaucratic demands of the orthodox hospitals, the patronage of the orthodox health institution become discouraged to the people of Akwa Ibom State. The only way to overcome these challenges is to expand the scope of western education, enlightenment programmes as well as reduction in hospital bills in order to encourage the utilization of orthodox health services in the state.

4. Conclusion and Recommendations

The findings from the present study draws attention to the fact that, despite government huge financial commitments towards providing adequate health care services to her citizenry, the services and its facilities are grossly underutilized. Findings show that the availability, accessibility, and affordability of an alternative traditional health services and prayer houses make many people to shun government health care services. The study further confirms that, socio-cultural beliefs on witchcraft, spells, and sorcery as the cause of sickness and the belief that such problem could only be treated by traditional healers make underutilization of orthodox health care services more effective.

In the light of the above, and in order to enhance effective utilization of government established health care services, the study makes the following policy recommendations:

- 1) An urgent cultural education must be undertaken to rid the people of certain obnoxious cultural beliefs. People must be made to understand that orthodox medicine has been accepted as the best way to get all ailments treated. Proper sensitization, orientation and education should be carried out using appropriate agencies like Churches, women organizations, unions, radio and television as well as town criers on the efficacy of the orthodox medical services.
- 2) As is the case in other developing societies such as India, Brazil, South Africa, and Egypt, traditional medicine should be improved and incorporated into the main stream of health care services and treatment in Nigeria. By so doing, traditional medicine will be properly assessed, researched on, improved, and its practitioners properly trained and licensed to operate hand-in-hand with orthodox medicine. The claim that one type of drug is capable of curing all types of sicknesses should also be checked and regulated.
- 3) Appraisals and evaluation of the certain parts of the health care delivery policy in the country and state should be undertaken. Such repeated appraisals will identify areas that call for urgent attention and needs. This will also check the behaviour of certain bad eggs among hospital staff that repel people from seeking treatment in government hospitals.

Put together, the above policy suggestions though not exhaustive is capable of promoting the utilization of government health care services not only in Akwa Ibom state but in the entire country if properly and sincerely implemented.

5. References

- Agunta, R. (2010). 'National Hospital Dealt Scandal'. *The Sun Newspaper*, Saturday June 5, 7(385); 8.
- Alibi, A. (2010). "Crisis of the Health Care System". Online, 8.
- Atueyi, D. D. (2012). One Million Nigerian Children Die Annually Fharmanews, *Health Journal*, 33(4):45-53.
- Bamikale, O. (1999) Mothers' Management of Childhood Diseases in Yoruba Land: The Influence of Cultural Beliefs. Ile Ife, Nigeria: Obafemi Awolowo University.
- Becker, M. H. (ed) (1974). *The Health Belief Model and Personal Health Behaviour*. New York: Charles B. Slack.
- Berwick, D. M. (2003). Dissimilating Innovations in Health Care. *Journal of American Medical Association*, 2003, 289: 1969-1975.
- Charles, J. O. (2005) *Sociological Theory: A Historic-analysis: Applied Road on Man and Society Lagos*. Serenity Press.
- Chikwe, A. (2008). *Health Sector in 2008: The Good, the Bad and the Ugly*. *Daily Sun*, Tuesday December 30 6(656):12-20.
- Chin, C. D. (1998). *Elementary Racial and Ethnic Disparities Health Care*, *American Journal of Nursing*. 10(3), pp 56-58.
- Chute, C. G. and Koo, D. (2002). Public Health, Data Standards and Vocabulary. Crucial infrastructure for Reliable Public Health Surveillance. *Journal of Public Health Management Practice*, vol. (8) pp. 151-159.
- Cohen, B. J. et al (2005). *The Human Body in Health and Disease*. 9th ed. Lippincott Williams and Wilkins, Philadelphia.
- Durkheim, E. (1938). *Rules of Sociological Method*. New York: The Free Press.
- Eboh, D. and Ukong D. (1993). *Social Studies Education for Nigeria universities* Owerri: White and Whyte Publishers.
- Ekong, E. E. (2006). *Sociology of Health and Medicine* Uyo: Dove Educational Publishers.
- Ekpenyong, S. (2008). *Elements of Sociology*. African Heritage Research and Publication Ikoyi-Lagos.
- Essien, A. (2005). *Religion and Reproductive Health in Nigeria: services in sociology of Religion*. Nigeria African Heritage Publication.
- Etobe, E. I. (2004). *Sociology of Health and Rehabilitation*. Christian Noble Publishers: Calabar.
- Gordin, G., Belanger – Gravel, A. Eccless, and J. Grimshaw (2008). "Health Care Professionals Intentions and Behaviours: A systematic Review of Studies based on social cognitive theories. *Implement of Science* (3): 26-35.
- Halwani, S. (2004). *Racism in American Health Care System*. New York: McGraw Hill Publishing Company.
- Health and Human Services (2005). Office of the National coordinator for Health Information Tech., Statement of Organization: Functions and Delegations of Authority. *In: Federal Register*: 7(10):48718-48720.
- Igebeodi, P. (2010). No Blue Print on Health Care in 50 years. *The Nation Newspaper*. Thursday April 15. 15(10): 1365 p.5.
- Institute of Medicine (2002). *The Failure of Public Health in 21st Century*. Washington D. C. *National Academy of Science*.
- Kulsoom, U. and A. Saeed (1997). Breast Feeding Practices and beliefs about weaning among matters of Infant age 0-12 month. *Journal of the Pakistan Medical Association* – 47(35): 54-60.
- McGuire, U. I. (2002). Female Circumcision as a Public Health Issue. *New England Journal of Medicine* 331(12): 712-716.
- Merton, R. K. (1957). *Social Theory and Social Structure*. New York: The Free Press.

- Meyer, J. W. and B. Rowan (2011) Institutionalized Organizations: Formal Structures as Myths and Ceremony. *American Medical Journal* 83 (40): 340-363.
- Ntekpere, N. C. (2010). *A Socio-Culture Appraisals of the Nigeria Hospitals: A Case Study of Ikot Ekpene General Hospital. An Unpublished M. Sc. Thesis*, Dept of Sociology and Anthropology, University of Uyo.
- Odebeyi, J. S. and M. Ekong (1999). Health Transition in middle Income countries: New Challenges for Health care. *Health Policy and Planning* (4) pp 29-39.
- Odebode, N. Azani, J.; Adeleji, A. and Adebayo, B (2009). *Fake Drugs: Pharmacists urge Federal Government to protect to India and China. The Punch Newspaper*. Tuesday, June 25 (17): 9.
- Okonofua, F. (2000). Health implications of Traditional Female Circumcision. *Journal of Obstetrics and Gynecology*, pp 131-143.
- Orabuchi, A. (2005). Poor Health Care Systems Niger's Moral Indifference. *Aroburchie netzero.net*. Thursday, July 14.
- Parson, T. (1970). *The Social System*. London: Routledge and Kegan Paul.
- Paul, B. (1985). "Health culture and community Rog: USA, Russel Sage Foundation.
- Rodash, M. (1982). The College of Midwifery: A Sociological Study of the Decline of a Profession. In Unpublished Ph.D Thesis, SIU Carbondale.
- Rothman, B. (1994). *Midwives in Transition: Structure of Culture Revolution*. New York. McGraw Hill.
- Spector, R. E. (2004). *Cultural Diversity in Health and Illness* (6thed.) Upper Saddle River, NJ: Pearson, Prentice Hall.
- Stein, L. (1988). The Doctor- Nurse –Game, in Henslin J. (1995). *Down to Earth Sociology: Introducing Readings* 5th ed., New York: Free Press.
- Tope-Aja, F. (2005). *A Guide to Primary Health Care Practice in Developing Countries*, Akure, Bending Grafiks Pub.
- Udoh, O. S. (2001). Determinants of Productivity in Nigeria. A Case Study of Three Farming Settlements in Ikpe Community" *In Ibom Journal of Social Issues*. 6, No. (1): 13-22.
- Udoh, O. S. (2011). Socio-Cultural Factors and Industrial Development in Akwa Ibom State: Agenda for Sustainable Women's Development in Nigeria. *Journal of Social Policy Issues*, 8, No.2 Nov. 2011.
- Udoh, O. S. (2013). Psychiatrist, Herbalists and Prophets: What Do Rural People do when in Mental Distress? *In Benin Journal of Social Sciences*, 56 (1): 124-133.
- Udoh, O. S. and Alfred, Ekpenyong (2010). Management of Disability among the Ikono people of Akwa Ibom State, South-South Nigeria: *An Assessment in Culture and Religious Review Journal*, Franklin Publishing Company, U.S.A. pp 121-125.
- Ukim, R. (2006). *Religion and Health Care Professions*. Ikot Ekpene. Tonnies Books.
- Ukwomu, B. (2010). Doctors Pharmacists Differ over Hea+dship of Health Ministry. *The Guardian Newspaper*. Monday March 29 (27): No. 1, 14-15.
- Wenger, A. F. (2005). Preface in M. Leininger (ed) *Transcultural Nursing: Concepts, Theories, Research and practice*. New York: McGraw-Hill.
- Wertz, R. (1981). *Notes on the Decline of midwives and the Rise of Medicinal Obstetric Clans. In Sociology of Health and Illness*, New York: Martins Press. Pp. 162-183.
- Winkvist, A. and a. Akhtar (1997). Images of Health and Health Care Options among low 2income women in Punjab, *Pakistan. Social Science Medicine*, 67 (45) 1483-1391.
- World Health Organization (WHO) (2007). *Eliminating Female Genital Mutilation: An Interagency Statement*. World Health Organization,
- Znanieck I, F. and W. I. Thomas (1918). *The Polish Peasant in Europe and America*. New York: Gorham.