CULTURAL CONTEXT OF HOUSEHOLD PRODUCTION AND UTILIZATION OF BIO-MEDICAL HEALTHCARE FACILITIES IN RURAL AKOKO COMMUNITIES OF ONDO STATE

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ABSTRACT

Household production in rural communities is characterized by cultural forces that are external to and coercive of individual; yet little has been done to examine how cultural context of household production implicate on utilization of biomedical facilities. In spite of policies and programmes designed to improve utilization of biomedical facilities among rural dwellers; they are yet to be secured health wise. This study investigated cultural context of household production and their implications on utilization of bio-medical facilities. Through qualitative and descriptive ethnography, Key Informant Interview (KII), Focus Group Discussion (FGD) and the textual analysis of documents, our study seeks to establish that values, customs and beliefs embedded in production strategies are principles that make productive activities more tasking and complex in rural Akoko communities. It therefore limits available time to utilize quality biomedical facilities, thus making people rely more on traditional remedies. Rural Akoko people preferred traditional remedies which allow them have more time for household productive activities. Rural Akoko people devoted more attention to work than healthcare. They utilize biomedical facilities at advanced stages of illnesses, resulting in various

health and healthcare insecurities. The cultural strategies adopted in the household production in rural Akoko communities have a strong influence in determining the utilization of biomedical facilities. The interface between household production strategies and utilization of biomedical facilities in rural communities therefore deserves more attention in order to aid the formulation of policy for health interventions. This will improve health status of rural dwellers

Keywords: Household, Production, Strategies, Healthcare, Rural, Akoko

INTRODUCTION

Household production describes creation of goods and services at micro level of human organization. In rural communities of sub-Saharan Africa, there are rules and norms that determine household system as they relate to production of economic goods and services. The rules and norms constitute standard through which one exercises appropriate behaviour towards one's kinsmen in the household (Awoyemi 2004; Odunbunmi 2012). Household production is characterized by cultural forces that are external to and coercive of individual and influence pathway to healthcare in rural communities (Cather 2014).

In rural communities, household members adopt several production strategies that are premised on allowing individual experience quality welfare that transcend good health. These strategies embedded with customs, beliefs and values that are external to and coercive of individual (Empey 2015). Thus, these values, beliefs and customs serve as underlying structures that guide productive relationship especially in the

rural household. Obviously, the effects of these cultural forces have made a large number of rural people opened to a variety of insecurities that deter them from optimizing biomedical healthcare facilities (Anwar 2009). This has adversely affected the well-being of rural dwellers by imposing low quality of life on them as 8% between 2011 and 2012, has life expectancy at birth falling from 51.6 in 2011 to 43.4 in 2012 (Iyalome 2012).

As reported by World Health Organization (2014) that 70 percent of rural dwellers experience critical health challenges that devoid of qualitative life. About 70% of those living in rural areas do not seek proper healthcare facilities (that are essential for good living), as these facilities are also poorly utilized (FMH2014). This has made the rural dwellers seek healthcare in various forms, some of which have affected their health status. Some of these effects include impaired productivity of able men and women in the community and increased rates of morbidity and mortality. This scenario is not in all ramifications exempt rural Akoko communities.

Akoko is predominantly situated in hilly and rocky areas of Ondo state, Nigeria. Akoko is an agrarian community that relies on subsistence production. Akoko topography makes productive activities rigorous and stressful thereby necessitating the need to strategise. As reported by Okoli (2013) that this challenge has made rural Akoko dwellers derive impetus to device production strategies to cope with the environmental challenges. As reported by Ondo State Health Survey (2014), that more than 70% of rural Akoko dwellers do not seek quality healthcare and 85 percent of the population rely on home remedies for health care and

underutilize biomedical healthcare facilities (that can enhance quality health). The reliance on home remedies and underutilization of biomedical healthcare facilities in rural Akoko communities has been socially constructed by Okoli as "uncivilized" "unscientific" and "dangerous" or at least in need of sustainable intervention and continual monitoring (Okoli 2013). The growing concern on improving health status of rural populace in the global south has spurred researches and interventions on utilization of healthcare facilities as sound health is a fundamental requirement for living a socially and economically productive life

Government and other parties like non-governmental organization have initiated a number of programmes to deal with poor and underutilization of biomedical healthcare facilities, including free medical care, medical grants, and health care orientations which target mostly rural dwellers. Inspite of these laudable programmes in rural areas, many rural populace is yet to be secured health-wise especially rural Akoko people. It is therefore indicative that these interventionist programmes have either not been effective or are misdirected in addressing those challenges among rural dwellers in Nigeria. Information on interface between household production strategies and utilization of biomedical healthcare facilities will have more relevance to rural health care policy formulation if more empirical studies demonstrate its essential role in rural health care development (Caleb 2015).

Thus, there has been considerable debate in the literature recently as to whether the mere provision of healthcare services/facilities will lead to optimum utilization of those

facilities (Derick 2016). Bassey (2014) argue that the mere existence of health services is not enough to lead to qualitative health care seeking. Hence, as Fatimi (2016) once observed, since utilizing a specific healthcare facilities is a consistent choice of individuals, the factors that change peoples' perception of the available alternatives and their motivation to utilize them need to be properly understood. Derrick (2016) observed that, many studies ignored the socio cultural complexity resulting from production strategies that impact on utilization of biomedical healthcare facilities. Derrick (2016) suggested that the outcome of the interface between the two needs to be taken seriously in programmes and interventions geared towards promoting health in a variety of contexts.

Previous studies show that factors that influenced utilization of biomedical healthcare facilities include cost, accessibility, educational levels, cultural beliefs and practices. Other factors include environmental conditions, socio-demographic factors, knowledge about the facilities, gender issues, political environment, and the health care system itself. Thus, how cultural context of household production influence the utilization of bio-medical facilities have been given less attention.

Previous studies (Charvas et al 2005; Coyle1999; Fabella1989; Afriat1972) on household production have been purely scientifically oriented, couched with statistical index, models, and analysis with little or no emphasis on socio-cultural variables. Therefore, limited knowledge is available on qualitative dimension of interface between cultural context of household production and utilization of biomedical healthcare

facilities. Moreover, there has been very limited ethnographic work in this area. It is against this background that this study examined household production strategies and utilization of biomedical facilities in rural communities of Akoko, Ondo state, Nigeria.

Objective of the Study

1. To examines examine cultural strategies employed in household production in rural Akoko with special attention paid to customs, values and beliefs associated with the practice.
2. To examine how the above cultural strategies influence utilization of biomedical health care facilities.

Theoretical Framework

This study adopts Rational Choice Theory (RCT) as its theoretical framework. The central explanation of this theory is a focus on individual rational action that helps to explain the aggregate behaviour in the society. According to this theory, the main task of sociologists is to focus on social system, but that such macro phenomena must be explained by examining the factors internal to them, which centers on behaviour of individuals at the micro level. Further, rational choice orientation posits that a person acts purposively towards a goal, with the goal and the actions shaped by values or preferences. Although rational choice theory recognizes that in the real world, people do not always behave rationally, but this makes little difference in the position of the theory. According to this theory, the implicit assumption is that the theoretical predictions will be substantively the same whether the actors act precisely according to rationality as conceived or deviate in the way that have been observed. Hence, given

the theoretical orientation, it follows that the focus in terms of the micro-micro issue is the micro to macro linkage, or how the combination of individual actions bring about the behaviour of the system. On the whole, the argument of rational choice theory is the rational construction of social system from the lowest level of individual. That is knowledge of macro level is best understood from primacy of micro level. This is anchored on the fact that data are usually gathered at the individual level and then aggregated or composed to yield the system level. Among other reasons for favoring a focus on the individual level is that this is where "interventions" are ordinarily made to create social change through such "interventions".

Utilizing the rational choice theory in our study, both cultural context of household production and utilization of bio-medical facilities are purposively geared towards a goal, with the goal and the actions shaped by values or preferences. To gain adequate understanding on how to improve and promote rural health care, it is highly essential to understand the cultural context of household production which constitutes predisposing factors that influence action of individual in utilizing biomedical facilities. The knowledge of interface between cultural context of household production and utilization of biomedical facilities at micro level will aid policy formulation for health care intervention at macro-level.

Ethnography of Akoko

Akoko is situated in North Eastern part of Ondo State, Nigeria. Located in an upland elevation with a hilly settlement, it shares its northern and eastern boundaries with Kogi and Edo states respectively and western boundaries with Ekiti

state. Akoko is the largest community in Ondo state with 17km wide and 35km long. Akoko lies on the latitudinal range of between $7^0 46^0$n and $7^0 52^0$n and on the longitudinal range between $3^0 85^0$e and $3^0 89^0$e to the north of Kogi. Akoko community is made up of a collection of small towns. The population is estimated to be approximately 509,113 but that number is continually being adjusted due to the high levels of in and out migration for work abroad. Two-thirds of the populations live in rural areas of Akoko community. The largest town is Ikare-Akoko. Akoko takes a large percentage of the local governments in Ondo state. Out of the present 18 Local Government Councils it takes four Local Government Areas (LGAs), viz Akoko North-west, Akoko North-East, Akoko South-West, Akoko South-East. Akoko comprises about 40 small towns, predominantly situated in rocky areas of Ondo state. The rocky terrain nevertheless, may have helped the region to become a melting pot of sorts with different cultures coming from the north, eastern and southern Yoruba towns and beyond. Akoko became one of the few Yoruba clans with no distinctive local dialect of their own.

Akoko is an agrarian community that relies on subsistence production due to its topography. Each household cultivates a number of plots scattering over the mountainous landscape, the total area of land in production each year is fragmented and small, less than one-half hectare on average. They employ the use of local agricultural implements, which require much physical exertion. In addition, rural communities in Akoko lack the economic power to revitalize their subsistence resources such as land and tools thereby putting considerable pressure on their health especially adult men and women who form the bulk of labour force. Their vegetation is characterized with

dissident forestry which favours the growth of some crops and plants use for healthcare. The use of local agricultural implements often results in poor productive performance of rural Akoko communities as reflected in declining agricultural production and local manufacturing. As a result of this, economic resources are limited, a situation that leads to intense competition among household members. In addition, the economic situation in the households has made many Akoko men to migrate to urban area in search of better working condition and this has created a new household structural management that has left a few people with the burden of taking care of the household. This situation also has adverse effect on the health of many people thereby increasing morbidity and mortality rate in the community.

METHODS AND MATERIAL

This ethnographic study was conducted in rural Akoko communities of Ondo state, Nigeria. We engaged in ethnographic fieldwork that employed multiple methods of data collection to generate qualitative data. The methods were participant observation, in-depth interview and key informant interview. The rationale was to compensate for the deficiencies in any of the methods. The study adopts both individual and household as its unit of analysis. This is as a result of holistic perception of the problem under study. Individual unit of analysis is motivated by the need to examine how household production strategies have implication on utilization of biomedical facilities.

Household unit of analysis is motivated by the need to examine group influence on individual action and on household as a body. To ensure a balanced research perspective, both

etic and emic views were carefully considered as the perspective focus for the study, but rely mostly on emic perspective. In this case, the study seeks to avoid biases, which may arise from the exclusive use of either the emic or etic perspectives. This based on the fact that both production strategies and utilization of healthcare facilities are objectively and subjectively determined within and outside household unit.

A total of 122 people (67 males, 55 females) were interviewed. The age range was 35 to 69 years. The rationale was that the people within this age range are mostly in their productive years. Respondents were purposively selected and given information about the study. The respondents are males and females from respective households and healthcare providers. The local people were chosen to provide information on study themes while healthcare practioners were selected to provide information on health status, profile, prevalent diseases and illnesses, patterns of healthcare and utilization of healthcare facilities in the community. Prior to beginning the interviews, respondents completed a consent form ensuring informed consent.

The researcher constructed the initial interview guide, which contained approximately forty-five questions, based on researcher review of literature and study themes/objectives. The interviews were conducted at locations convenient to respondents, such as their homes and work place. The interviews lasted between fifty minutes and three hours, averaging about ninety minutes. The question guide was not strictly followed in some cases as some circumstances often demanded for reflexivity. In some cases the researcher

embarked on follow-up visits to some respondents when it seemed difficult to get the required information in a single visit. Some respondents invited the researcher for re-visitation when they perceived that they were still having some more information to give. Respondents also consented to the recording of their interview and most of the fieldwork data were collected by taking copious amounts of fieldnotes. The researcher audio-recorded interview sessions and then transcribe interviews with the assistance of a professional transcriptionists. Data collection and analyses occurred concurrently over 11 months.

The process of analysis began by doing open coding and microanalysis. This process entailed deep routine interaction with data generated from the field on a daily basis throughout research phases. Immediately after fieldwork sessions, all generated data were crosschecked and, where needed, further visits to sites were undertaken to fill certain gaps in the "raw" data collection. Both the data from the research field diary and notes were extrapolated with that retrieved from the electronic devices. Sorting of the data according to the research objectives involved the writing of study objectives on separate sheets of paper, which were referred to as "objective cards" (this enables the researcher to constantly check the cohesion of his findings in line with the aims and outputs of research – one could call this a "running point" of reference). Transcripts were imported into NVivo (verion10) and then analyzed for themes. We employed an iterative analysis approach in finalizing the code list to reflect a nuanced focus on the study themes. On the other hand, direct quotation of responses (that indicate respondents/informants voices), which entails verbatim

reporting of opinions, idioms, and proverbs that support important findings in the data were done. The direct quotations of respondents were later translated into English for proper reporting.

RESULTS

Cultural Strategies Adopted in Household Production in Rural Akoko Communities

Production does not exist in a vacuum but it is guided by customs, beliefs and values which dictate the basic relationship in rural Akoko household. In all the study sites, respondents indicated that emphasis on cultural factors on this relationship is to guide any undue and unruly act, and also to ease the flow of interactions. It was gathered that strategizing is also a way of adapting to the topography of Akoko (in form of hilly and rocky environment) which constitute challenges to their economic securities. Cultural strategies adopted in household production in rural Akoko communities are anchored on two main central concepts. The concepts are "*Abo"* (system of organising services/labour) and "*Ajugba"* (system of exchanging labour for economic goods). These concepts transcend all productive activities in the household in rural Akoko communities. Strategising reduce tension and cement productive relationship. The two concepts further anchored on Kinship ideology popularly reffered to as "*Moye".*This ideology emphasis welfare creation which demands mutual assistance in productive endeavours and makes responsibilities towards one's kinsmen an obligation. Both concepts serve as mechanism through which members of household strategise and form lens through which we mirror and evaluate productive relationship in rural Akoko communities.

Strategies Adopted through the Concept of "*Abo*" and Utilization of Biomedical Facilities

Under the concept of "*Abo*", one of the production strategies is the networking in recruiting labor for production. According to respondents, it is meant to reduce stress and increase productivity in the household. A male discussant in FGDs, who is an artisan highlighted further, the purpose and importance of labour networking as he said; "*it is a sort of relief system to increase efficiency of labour to boost production. It is also meant to strengthen kinship ties and to help indigent member to ascertain reliable means of survival because not every individual have the required means for productive endeavor*". According to respondents, act of networking in recruiting labour involves a cultural defined laid down principles which make the processes contractual and socio-economically interconnected. This labor arrangement is characterize with rules and regulations anchor on some beliefs which serve as checks and balances. A discussant in FGDs clarified; *it involves labor arrangement between consenting parties, who have informally agreed to work together in rotation. The processes must go round among the consenting parties before the contract is terminated*. Another discussant highlighted the regulations and its consequences, as he clarified; "*it is a belief in this community that breaching the contract attracts a consequence. It is compulsory for someone to keep to the agreement otherwise incurs the wrath of ancestor".* According to respondents, it is this belief that makes someone serious and more law abiding in order to avoid being a victim.

In all the study sites, 93% of the respondents are more comfortable when their acts of networking are anchored on

cultural rules and regulations. A farmer expressed his feeling as he said: "*I do not entertain fear in any productive relationship as much as it involves rules and regulations accompanied by anticipated punishments*". Another discussant further pointed to the economic benefits of act of networking in recruiting labour for production purpose said, *"It reduces my cost of production and strengthens my productivity and alleviates my anxiety in recruiting labour"*. Apart from the economic benefit, there is a cultural belief as highlighted by respondents that reinforces the act especially when it involves farm production, "*our culture frowns at lavish spending on production of food resources because such act does attract the spirit of devourers and bad harvest*". We probed further asking for the implications of networking on utilization of bio-medical healthcare facilities. Information gathered revealed that it creates pressure on one's time and energy, and the possibilities of having enough time to consult bio-medical facilities like hospitals, clinics, and maternity homes, are almost hindered due to much work engagement. This makes them to seek for a more convenient alternative health care to relieve them of any health challenge. A farmer who was one of the discussants in FGDs that shared their experience on implication of the act on utilization of bio-medical healthcare facilities has this to say:

> I often engaged in various labour contracts in order to meet up with economic responsibilities ahead of me, it usually absorbs my time and energy. There was a time that I was not feeling fine that I needed to seek a proper medical attention, but because I have to redeem all the labours networking I had

> contracted. I began to manage myself by taking locally made herbal mixtures so that I would have time to work; because I must redeem all the outstanding contracts.

Another female discussants who also shared her experience claimed that they are more affected due to their position in the household as she said, "*engaging myself in much labour networking coupled with domestic chores do not allow me to have time to visit hospitals for healthcare most times I take herbs or concortion to settle any health challenges*". From the above quotation, networking in labour for production limits time to take proper care of one's health and increases incidence of morbidity in the community. Taking locally made herbal concoctions and mixtures for both preventive and curative measures are very common among respondents because they do not have sufficient time to consult western healthcare practitioners due to multiple work engagements. In a Key informant interview with a western health practioners, he comment on rural Akoko peoples' attitude towards utilizing biomedical healthcare facilities said:

> Most people in this community often fail to come for medical check-up as scheduled. Some of them will not take their drugs as prescribed. When you asked them why, they will tell you that they are very busy. At the end of the day, they will say the treatment is not okay. They are more concerned about their work than their health. They like embarking on selfcare which do not

> work for them in most cases. It even aggravates their condition. This has led to many casualties in this community.

Apart from the above version of networking, household members organize themselves as a team and pool their labor together to produce economic goods. This version of networking also involves a laid down principles which dictate and guide the relationship. A discussant like others who highlighted the nature and the purpose said, "*All my household members do jointly produce economic goods and are pooled together which later re-distributed based on specified criteria through stipulated rules of sharing. This is to alleviate insatiability in production and alleviate the incidence of poverty among members*". Another discussant highlighted the necessity and spoke in favor of the practice said, "*I cannot afford to produce all what I need for my personal consumption. I have to rely on others in order to have access to some economic resources*". After pooling the resources together, redistribution follows afer some periods of time. Each head of a household use his discretion to distribute by capitalizing on economic challenges of individual(s) or groups. This aspect of networking is meant to strengthen kinship ties and also to help indigent members to ascertain reliable means of survival. This practice is fraught with limitations as explained by a respondent as follows. " *The redistributions of the pooled resources do not favour all members in equal proportion as some people are more favored. The people that are more favoured are those who have not fully contributed their labour power due to their position of honour in the household*". We probed further asking for the implications on health utilization of biomedical facilities. It was gathered

that it creates a sort inequality in capacity to maintain a quality health care. This made some of the victim to engage home remedies as an alternative to utilize biomedical faculties to relieve them of any health challenge.

> The act of pooling resources together limits the extent I can independently generate income because I do expend a lot of time and energy in doing that. The portions allotted to me most time do not normally correspond to what I have contributed. There was a time I am down with illness due to the stress, I have to delay seeking western health care till my people settled me but has already late then. My subsequent attempt to get well by taking *Agbo* proved abortive.

The sharing of pooled resources has handicapped most respondents and has made many people delay seeking biomedical care. This has often led to casualties as indicated in key informant interview with some western health care practioners.

> In this community people do not like to utilize biomedical facilities when they are ill. Even when they are free of charge; they prefer self care. It is when they could no longer manage their condition that they will come to us. At times their condition would have been serious more than what we can handle. At times we have to refer most of them

> to General hospital in Akure or Federal medical centre in Owo. Most of them die along the line.

The concept of "*Abo*" also feature another production strategy through creating allowance for production in order to provide for one's kinsmen, to complement their productive efforts for livelihood. This strategy is reinforced by cultural norm that make welfare creation an obligation to one's kinsmen and guided by a belief that enforces a sanction. A discussant highlighted the belief which guide the practice as he said, "*I do make sure that I provide for my kinsmen in order to strengthen their welfare because anyone who fails to provide for his kinsmen incurs the wrath of ancestors. The fear of being a victim makes me conform to this act*". This act of providing for one kinsman is fraught with some challenges as explained by a respondent as he said, "*I devote much time and energy on economic activities in order provide for my kinsmen. This affects the quantity of goods I offer for sale making my generated income low*". When we asked for the implications on their utilization of biomedical facilities, 85% of respondents indicated that it exerts coercive force on their expenses and make it difficult to utilize biomedical facilities A respondent like others shared his experience as he said.

> I am economically responsible to my kinsmen by providing for them. It is not normal to fail these responsibilities; nevertheless it expends on my income when am trying to meet-up. Even I find it difficult to take good care of myself because of responsibilities that have

> chocked me. If I have any health challenges, I try to find other convenient means to get over than to go to hospital. At times I embark on faith healing when am short of cash.

Within the above strategy, providing for ones kinsmen for enhancing livelihood encourages subsistence production, which usually supports subsistence living. In most cases, production of cash crops is low, as focus is more on food crops to directly support subsistence. Few goods are often available for sales, thereby making their generated income to be relatively low because a large percentage would have been consumed at home. Most people in rural Akoko people are not salary earners, they generate most of their incomes through sale of economic goods in order to meet up their economic responsibilities. This often implicate on their ability to generate sufficient income to meet their needs. This usually has implication on their capability to reliably finance a health challenges and at times resulting to complications which sometimes lead to casualties.

> I am not a salary earner and a larger percentage of what I produce are consumed at home, only few are often available for me to offer sale and usually attracted low income, in most cases I find it difficult to generate sufficient funds to compensate for the stress and in larger extent to finance any potential ill-health. There was a time that my son felt sick I could not afford the drugs prescribed for him in

> the western hospital. I sought for a discharge and I took him home for home remedies. I started administering locally made drugs to him, eventually he later died.

Under the concepts of "*Abo*" another strategy employed is gender allocation of roles and responsibilities in production activity. This strategy bothers mostly on agro-based production because 80% of rural Akoko populace engages in farming. This strategy is anchor on traditional belief and is patriarchally wired. It is characterized by a custom which ascribe cultivation of cash crop to men and cultivation of foods crops to women. It is also anchored on a belief that men are the chief provider and women are to support the home. When asked what implication did it had utilization of bio-medical healthcare facilities, it was gathered that this cultural strategy has a gender skewed effect on income generation and differentiated implication on financial strength between men and women in the household. It was revealed the practice makes men stand a better chance to conveniently seek for a qualitative healthcare and strengthen the reliance of women on men for healthcare financing.

> My husband produces cash crops that are liable to generate large income and I produce food crops that are mostly consumed at home; it is difficult for me to generate cash to replenish the loss strength. Sometimes ago, I felt sick and not financially okay and my husband was not around. I used herbal drink as first-aid thinking that it would relieve me till

> my husband will be around. After some days I realized I was not getting better rather, it grew worse and worse. I even collapsed before my husband came. My husband took me to hospital, when we got there, the health personnel in charge alleged him of delaying proper action on time.

Still under the "*Abo*" is the customs of conserving and preserving economic goods. This strategy constitutes means of eliminating scarcity of food resources and also to adapt to the poor household economic condition. The act takes several forms including, putting harvested crops in barns and rearing of domestic animals which are meant to prepare for the future and also to cater for unanticipated expenses. When asked for the implication of that act on utilization of biomedical facilities, it was gathered that inspite of the benefits of the act; it is fraught with some health care challenges as explained by a respondent.

> Anytime I conserve harvested crop into my barn it often affects the quantity offered for sale and reduce income I generated. The little amount generated can only take me for some periods. Anytime am having health challenges I often find it difficult to take prompt quality health care action because the conserved goods could not be converted to cash at short run to finance emergency. Most times I delay seeking quality care and will go for cheaper care

to relieve me for some time before I will have enough cash for proper care.

Strategies Adopted through the Concept of "*Ajugba*" and Utilization of Biomedical Facilities

Apart from the strategy adopt through *Abo* concepts, there are some strategies adopt under Ajugba concept. One of the strategies is instituting system of exchanging economic resources. In this practice economic goods are exchanged for goods among consenting parties; and there is a negotiation between parties as regards the measurement of goods to be exchanged in order to avoid negative reciprocity. A respondent who is a hunter who highlighted the process in relation to his career explained, "*If I kill two grasscutters, I will find a farmer that has yams that need meat. We will both agree on the tubers of yam to be exchanged with a grasscutter"* The purpose and the benefits of the practice were highlighted by respondents - is a way of coping with insufficiency and unlimited wants in the household. A respondent like others who shared his experience said, " *There is no way I can produce all what I want, I have to depend on some people for some needs. I am able to consume most economic goods impossible for me to produce without incurring any cost*". This practice also bridges economic disparities among member in the household as explained by a participant, "It does not involve any cost, so everybody is bound to undergo the same process irrespective of your status". He further narrated the rules and regulations that subsumed in the contract to ensure compliance. "The culture stipulates that one should not breach any contract, it is a believed that defaulter's action attracts the wrath of ancestors". When asked if there are challenges and

limitations in that practice, respondents indicated some. A respondent who is an artisan highlighted the challenges and limitations said, *"the practice affects income generation as it does not attract cash and also very tasking and time-consuming to get someone that needed what one intend to exchange".* We probed further asking for the implications on utilization of biomedical facilities. It was gathered that it creates a sort of inequality in capacity to maintain a quality health care. This made some of the victim to utilize home remedies as alternative to biomedical facilities to relieve them of any health challenge.

> The act of exchanging economic goods is very good because it makes one to have access to some things that one is not able to have ordinarily. But the process of looking for one to exchange with is very time-consuming. Also the process do not involve cash, it is not easily possible to generate cash for healthcare. Whenever a situation like this arises I embark on self care.

Apart from the above strategies, another strategy through *Ajugba* concept is instituting power relation into household production. This strategy also draws its inspiration from patriarchal system. It is meant to balance-up any economic relationship that can obstruct welfare in the household. This is reflected in many productive endeavours in rural Akoko communities. A man has the right to stop his wife from engaging in a business or work that would not let her to have time to take care of the children and other members of the household even if the productivity generates a large income.

It was gathered that such woman do not have the right to hesitate because the culture has it that she has to submit to her husband's order.

The cultural strategy of instituting power relations in household production also impacts on the choice and utilisation of bio-medical healthcare resources in rural Akoko communities. The power relation entrenched in household production has considerable implications for the timing and the type of treatment to be sought depending on whether or not a male entity is willing and able to pay for medical care. Information from FGD revealed that the husband or father of a sick woman or child may decide to delay biomedical treatment and rely on cheaper traditional medicine for a while depending on their own assessment, adult males could also judge the illness of a woman and/or child as not serious enough to merit biomedical attention considering the economic responsibilities awaiting attention and thereby suggesting alternative. This explains why women rely more on traditional and palliative care more than men in rural Akoko communities.

DISCUSSION

In rural communities of sub-Saharan Africa, little attention has been paid to how cultural context of household production influences utilization of biomedical facilities. No notable ethnographic work has been done as regard this in Akoko. It is this gap in research that prompted the present study in rural Akoko communities of Ondo State. How cultural strategies adopted in household production influence utilisation of biomedical facilities has been succinctly argued in this study. In this study, findings revealed that household

production strategies are anchored on kinship ideology characterized with cultural norms that validate the idea of hospitality among members of household. The cultural norm is instituted to cater for the welfare of household members.

Moye concept which makes productive activities interconnected require network of economic responsibilities towards ones kinsmen, also express cultural attributes that make production activities tasking. Based on this, their economic nexus tends to be elastic because of high population of people involved in the household. And individuals are mandatorily responsible to seek the welfare of others in a reciprocal form. As population of a household keep on increasing, its economy tends to be more complex and complicated. The inter and intra relationship between units of families that constitutes the household become strengthened. The committed responsibilities of a member toward ensuring economic welfare of other members' increases and places burden on individual expenses. Hence, leaving per capital income lower than the average and reduce their chances of utilizing qualitative biomedical facilities.

The political economy of health as put forward by Parson (1972) has suggested that health related actions are determined by economic structure. The relationship between economy and healthcare system suggests that the way economy is structured affects healthcare system. In rural communities, production strategies constitute one of principles that also de-reinforce the capability of members to utilize biomedical healthcare facilities. The cultural strategies employ in the household production subjects rural Akoko dwellers to socio-economic forces that strengthen

their work engagement and reduce the available time to utilize qualitative biomedical facilities. Similarly, these strategies are characterized with values, customs and beliefs that are external to and coercive of individual in the household. This de-reinforces the capability for capital accumulation, and strengthens the reliance on home remedies as a way to prevent and cure illnesses. This buttresses the assertion of Empey (2015) which indicate that culture influences health behavior as it spells out what constitutes an illness and pattern of health care. This study shows that respondents seek for a more convenient alternative healthcare that will allow them to have time for household productive endeavours. These results are similar to findings in previous studies (Nelson, 2016; Iyalome, 2012) that rural people were found to have a tendency to adopt various methods to manage their health to suit their purpose.

This study revealed that rural Akoko people rely mostly on home remedies because it has affinities with household economy and enable to have more time for productive endeavour. More time are expended on productive activities that limit their available time to seek qualitative healthcare like biomedical facilities and make them rely more on home remedies and traditional healthcare. They are contended with home remedies because it allows them to have time for their productive activities in order to fulfill economic responsibilities for their kinsmen.

This study revealed that bio-medical facilities are not fully utilized due to several limitations imposed by household productions strategies associated with socio-economic dynamics in the household. Utilizing biomedical facilities only

when their health condition worsens, and when effort to address the health problems proves unsuccessful, have negatively impacted on their health status. This buttressed the assertion of Banti (2013) that hospital visits for health care is quite low, especially in the rural areas. Most of those who go to the hospital for health care do so at an advanced stage of the disease when the disease might have set in complications. This explains why the presence of government does not have appreciable effect on health status of rural Akoko dwellers (Okoli 2013)

CONCLUSION

Household production in rural Akoko communities does not exist in vacuum, there are rules and norms that guide and dictate productive relationship. This transcends customs, values and beliefs that make household productive activities complicated and complex in rural Akoko communities. The household productive strategies have strong influence in determining choice and utilization biomedical facilities in rural communities. Healthcare challenges in rural communities (especially in Akoko) are largely to remain the same and ever more endemic in future taking into consideration the various production strategies adopted in the household. Unless the government and NGOs recognize this, the quest for improved utilization of biomedical facilities in rural communities may be a mere dream or illusion. To urgently bring these risks to bear upon modern scholarly consciousness and health systems analysis, there is a need for coordinated intervention and research, where the energies of both private and public institutions can engage with national policies, practices, legislative design, and the regional realities which often

render these ineffective in the face of autonomous cultural trends and belief systems.

There is a need to create an enabling environment to redress household production practices (through production strategies) that impact negatively on utilization of biomedical facilities. This will require mobilizing rural people through their respective local organizations and through mass media to bring about such change. There should be a coordinated effort to design behavioral health promotion campaigns to inform and educate the rural dwellers that quality health is guaranteed by utilizing biomedical facilities. Government should put in place a policy framework that can persuasively provide the basis for the reorientation of rural dwellers towards the use of available quality biomedical facilities when necessary.

Sustainable attention should be paid to the customs, norms, values and beliefs that at play in interface between household production strategies and utilization of biomedical facilities. This would enable them to draft a comprehensive and holistic health policy for healthcare intervention. This will in turn address the increase rate of morbidity and mortality rural communities.

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