Socio - Cultural Factors and Attitudes Affecting the Health Status of Rural Communities: A Study of Danmusa, Katsina State, Nigeria

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Abstract: ***This research paper examines the socio –cultural factors and attitudes that affects the health status of rural communities using rural Danmusa in Katsina state, Nigeria as a case study. Using cultural, social, environmental and attitudinal factors, the paper explain how these factors have contributed to the low heath status of rural societies. The social action and social suffering theories were used to explain possible occurrence of these factors affecting health. The research is a descriptive research and the population of study was selected using random and purposeful sampling techniques, while the simple percentage analytical tool was used for data analysis. The research found out that socio- cultural, environment, and attitudinal factors has a correlation with poor health status in rural societies and therefore, these factors needs to be addressed to enhance rural health status.***

Keywords: Socio- cultural, Kunun Kanwa, Traditional hot bath, poverty, health status, taboos, early marriage, traditional marks

1. Introduction

Health is not only a physical condition of a person, but rather, they are also socio-cultural conditions of people or societies. It is based on this that the world health organization in 1946 defined health ***as a state of complete, mental and social well-being and not merely the absence of disease or infirmity***. This definition underscores the major theme of this research work: health is as much a social as a biological issue. Societies with a lot of sickness and early deaths are likely to be socially organized very differently from those where people live longer lives and experience less illness, [9].

Sociologist often highlights the many social factors that play a role in producing illness. A UK government report on inequalities and health, The Acheson Report suggest a full spectrum of factors that need to be identified in understanding the main determinants of health. They range through:

- The broadest features of the society – low income and high – income societies are likely to have different disease patterns.
- Specific living conditions such as work and housing: poor work conditions and housing can be highly correlated with poor health.
- Social and community networks of support: Isolation and lack of support can trigger or exacerbate health problems.
- Individual lifestyle factors, such as drinking alcohol heavily or smoking may be linked to health disruption.
- Age, sex and constitutional factors, [9].

2. Literature Review

The socio- cultural attitudes engaged in by a group of people not only influence their state of health, but it also affects their entire affairs, diseases and health inclusive. This is because without health, there is nothing one can engage in. though not all cultural practices affect the health status of people in society negatively, most of them, do especially those that have to do with nutritional discrimination and stratification. Most of these effects are detrimental and hence should be discouraged. Apart from cultural practices that affects the health of people in rural communities, their attitudes have also been a major cause to the wide spread of diseases in these area.

However, some of these cultural practices, which have endured centuries of practice, have worked for the people who practice them. That is to say, that not all cultural/ traditional practices are bad. Some have stood the test of time and have positive values, while others may be harmless, uncertain or negatively harmful [14].

The group most vulnerable to the dangers of these cultural practices and attitudes are women and children. In rural settings, gender disparity had been observed with women generally receiving less attention than men. Poorer access to medical services is compounded by social, cultural and economic factors including gender inequality in access to food, by burden of work and by special dietary requirements such as, iron supplements. This is why many women and particularly rural women are often trapped in a cycle of ill – health exacerbated by child bearing and hard physical labour. Seclusion for example, was found to have a compounding effect on the high maternal mortality of 1000 deaths per 100, 000 live births among Hausa women in northern Nigeria, Wall cited in [1].

From available statistics it could be seen that about 60-70% of the population in Nigeria live in rural areas, so majority of the children are born and brought up there. The prevailing situations of rural life give them a start of multiple disadvantages. They suffer from illness caused by malnutrition and unsanitary conditions, iodine deficiency, poor maternal nutrition status resulting high incidence of low birth weight babies, iron- deficiency anemia and other

complications of pregnancy in the women of child bearing age.

According to [14] the high prevalence rate and mortality due to HIV/AIDS in Nigeria are largely due to some cultural practices which promotes the spread of the virus. For instance, sex is traditionally seen as a private subject. The discussion of sex with teenagers especially girls, is seen as indecent, unhealthy and unacceptable. As such, young people wallow in Ignorance as far as sexual information is concerned.

The attitude of stigmatizing and discriminating people living with HIV/AIDS (PLWHA) especially by the uninformed rural dwellers also seems to the a major problem plaguing the health status of PLWHA as these sets of people are seen as immoral people engaging in immoral behaviors and this definitely affect the attitude and behavior of people towards them.

Another practice that affects the health status of rural communities is the way they build their houses, which does not in any way protect them against the invasion of mosquito. Houses are built with thatch and mud with openings that mosquitoes easily enter through. It is a common practice for houses to store water in pots and other containers after rainfall. These encourage the breed of mosquitoes around houses. Not uncommonly, vegetations are grown around homes in a typical rural Nigerian society. These also encourage the breeding of mosquitoes, [14].

In some cultural practices in Nigeria, pregnant women and young children are restricted from taking certain foods. In some parts of Igboland women are forbidden from taken snail for fear of their children drooling saliva. Also young children are not given eggs and some certain meats for fear of becoming thieves in future. Imagine the effect of these especially in areas where snail is a major source of protein. Also in western part of the country, precisely in Ondo villages, the villagers believe that diarrhea is associated with the appearance of the anterior fontanelle and teething. In fact, many believe that every child has to experience one or two episodes of diarrhea as a sign of survival, [5].

It has also been discovered that some traditional practices predispose people to hypertension. For instanced in Udi town both men and women consume alcohol in great quantities. It was said that the symbol that greets one in the local government headquarters was palm wine tapper climbing his palm wine tree; this was identified by medical experts to be the leading cause of hypertension in the area, and also, hypertension as the leading health problem in the area.

Early age at marriage as a demographic as well as cultural compounds reproductive health of women by introducing long period of exposure to pregnancy. A UNICEF/FGN assessment reports that culturally-based limitations on the exercise of women's reproduction rights are among the key factors underlying the high levels of maternal, infant and under five mortality [2]. In Nigeria it is a common practice for parents to arrange the marriage of their daughters, particularly to older men. Marrying out children often to fifteen years is premised on the value to protect them from falling victim to teenage pregnancy. In the north for example, 26.5 percent of marriages are characterized by age difference of 15 years or more between husband and wife, Hodges [2]. Statistics show that 24.4 percent of girls between the ages of 15 and 19 are married, while the figure for boxes of the same age is just 2.2 percent. The figures for ages 20-24 show that 57. 6 percent of women are married, while only 14.2 percent of men in the same age group are married. Men marry later than women; their median age at first marriage is 26 years compared with 18 years for women [11].

The age of marriage and of sexual activity is largely culturally determined. In the Northern states, the average age is 15 years, where as in the South it is 18 and 20 years., section 18 of the marriage act at the federal level recognizes a person under 21 years of age as a minor, but allows minors to marry with parental consent.

The implications are numerous. It robs girls of power over their bodies and their freedom to make decisions about their own reproductive health. Early childbirth has negative demographic, socio-economic and socio-cultural consequences, [11].

It compounds the general inability of girls and women to claim their constitutional and universal right to education. More severe is the harmful effects of child pregnancy on the health of the mother. In the northern part of Nigeria for example, early pregnancy accounts for high incidences of maternal mortality and for every bad conditions such as Vesico-Vaginal Fistula (VVF), which results in incontinence of the bladder and bowels. VVF occur because the pelvic bones have not developed enough to cope with childbirth. Corrective operations often require the consent of the spouse and more often than not the sufferers are abandoned by their husbands and ostracized by their communities Chukuezi [1].

Furthermore, **religion** has also been a major bane to good health practices in the rural areas. According to religious practice of Purdah, women are prohibited from interacting with strangers inside and outside the home. The women are required to ask for their husbands' permission when they need to seek medical assistance. Although evidence suggests that the practice in its most fundamental form has declined, it nonetheless exists and is being re-introduced under Sharia law in various states in the North. More so, certain religions do not encourage blood transfusion and this most times leads to the death of some women after childbirth, [1].

Religious beliefs and taboos have shapen forms of behavior that lead to certain health outcomes. As an example, consider beliefs about fertility and family planning in Nigeria. People living in rural areas, tend to want to have more children and not to want to use the more modern methods of family control [1]. This has implication for population growth, the incidence of child and maternal morality and the number in the population seeking access to health care. Still, citing a UNESCO report, Kickbusch et al observed that in some parts of Africa, people believe that clean and well-dressed individuals cannot become infected or that having sexual intercourse with a virgin will cure AIDS,[6]. Ladipo et al, have also reported a study on the

perceptions of gatekeepers about sexuality and HIV/AIDS in Nigeria. Gatekeepers were defined in the study as the custodians of cultural beliefs and moral norms. From his study, he stated that culture downplayed the sexual mode of transmitting the disease; condom promotion was not accepted on religious grounds by most participants in his study,[8].

Cultural beliefs not only also shape how individuals respond to forms of disease and illness but also choices about which forms of care should be accessed for example, cultural beliefs about certain forms of disease may lead to silence and denial thus creating veritable grounds for the continuation of behaviors and actions that promote the disease (human right watch, cited in [13]). Studies of the social meaning of infertility in Nigeria have shown that beliefs about infertility play a determinant role in interpretation and treatment of infertility. Following these beliefs, most people used three treatment outlets; churches (spiritualist), traditional healers and hospitals, [13].

In addition **illiteracy** impacts upon negatively on the health status of rural dwellers. This is so because, it contributes to the higher incidence of ill-health among the uneducated and their lower capacity to take advantage of existing health facilities. According to reports from [15], illiteracy is not only related to poverty; it also has implications for malnutrition, high infant and child mortality. It has been suggested, for example, that the probability of death among illiterate mothers is two times as high as those born to literate mothers. There is also a strong correlation between education and life expectancy at birth [16]. In Nigeria the education of a mother, affects the type of antenatal care provider, neonatal, post neonatal, infant, child and under five mortality rates and type of person providing assistance during delivery [11]. What this means is that uneducated persons tends to have more health problems and therefore to experience the need to access primary health care facilities. They also tend to have a lower capacity to access existing health care facilities.

Still, **poverty** is another major factor that impedes the health status of rural communities. Given the fact that the poor also tend to use the health service provided at the primary health care level, it can only be imagined the level of pressure that large numbers of poor people with a higher disease burden will place on the resources of primary health care facilities.

Again, **unavailability of health human resources** has also been a problem to rural people in terms of them trying to access health personnel. Available data shows that there are shortages of health professionals across most of the rural areas with the shortage being highest among doctors, nurses, laboratory scientists and radiologists in rural Nigeria communities. In fact, in most rural communities in Nigeria, there is only two doctors assigned to a WHO general hospital with few nurses and one or none of the other health professionals. Hence, patients wait tirelessly in trying to seek medical help. Some get discouraged and never sought for further medical process when they become ill again. For example, Nigeria has far fewer number of birth attended to by health professionals than Ghana and South Africa [16]. The number of MDG birth attended by skilled health personnel in Nigeria was 35% and below the average for sub-Saharan Africa (41%) and Ghana (44%) as well as south Africa (84%) over the period of 1995-2003, [3]. Nigeria also has far fewer doctors per 100,000 of the population than South Africa, [4].

On this note, the rural communities have posed a great challenge to development planners, sociologists, administrators, political leaders, health care providers and even traditional rulers to map out some programs to overcome the serious health problems particular the high level of child and mother morbidity and mortality mainly caused by socio- cultural factors and attitudes of rural dwellers.

This paper is designed to discuss socio-cultural factors and attitudes associated with poor health status in rural communities, using Danmusa community as a case study.

3. Theoretical Perspectives

Health as many agree is more a bunch of problem than a discipline as such it lacks theories that can generalize findings, through an iterative process of knowledge construction, empirical testing, critique, new generalization, and so on- into the durable intellectual frameworks that can be applied not only to distinctive health problems but different contexts and future scenarios.

Nevertheless, for the purpose of this paper, the social action, and social suffering theories has been used for the study.

The social action or unintended consequences of purposive action theory introduced by Robert K. Merton holds that all social interventions have unintended consequences, some of which can be foreseen and prevented, whereas others cannot be predicted. Therefore, all social action needs to be routinely evaluated for unintended consequences that might lead to the modification of programmes, and even, if the consequences are serious enough, their termination. By implication, there are externally and internally social and cultural activities that affect the health status of society; some of these activities which the actors do not know are having a negative impact on their health status. This theory would also seem to be social science equivalent of medicine's "first, do no harm", but it goes beyond that ancient law to reason that every action can have unintended and after harmful consequences of programmes, such as those following coercive vaccination during small pox eradication campaigns in India, which led to individual and community resistance to latter vaccination campaigns. An unintended consequence of China's one child per family population control policy is the sexual revolution it created, [7].

The second theory; **Social suffering,** which provides a framework that holds four potentially useful implications for global health. First socioeconomic and sociopolitical forces can at times cause disease, as is the case with the structural violence of deep poverty creating the conditions for tuberculosis to flourish and for antibiotic resistance to develop. Second, that social institution, such as health- care bureaucracies, that are developed to respond to suffering can make suffering worse. Examples of this are hospital based medical errors or the failure of the U.S veterans'

administration clinics to adequately diagnose and treat the psychiatric trauma among soldiers returning from the wars in Iraq and Afghanistan. Third, social suffering conveys the idea that the pain and suffering of disorder is not limited to the individual sufferer, but extends at times to the family and social network, as is the case when Alzheimer's disease has created such serious cognitive impairment in the patient that he or she expresses no discomfort while the adult children experience deep loss and frustration. For global health programmes the implication is that the family and network may also be in need of health interventions and are often influential in help seeking and adherence. Finally, the theory of social suffering collapses the historical distinction between what is health problem and what is a social problem, by framing conditions that are both and that require both health and social policies, such as in urban slums and Shanty towns where poverty, broken families, and a high risk of violence are also the settings where depression, suicide, post traumatic stress disorder, and drug misuse cluster. Although there are clearly occasions when health policy and social policy have different targets, in the poorest of communities the medical, the economic, and the political may often be inseparable, [7].

4. Methodology

This study was carried out in rural Danmusa community, Danmusa local government area of Katsina state, Nigeria. Out of the twelve wards found in the local government area, two wards of Danmusa 'A" and 'B" were selected. Whereas in Danmusa 'A," Danmusa town was selected purposely, Danmusa B was selected at random. From each ward, a particular village of Unguwar Kanawa in Danmusa 'B" ward was selected randomly while Unguwar Babanlle was selected purposely because of its location as the village that house the general hospital where vital information concerning this research was sought from. One hundred and twelve (112) women of childbearing age (15-40) who had at least one living child was selected through systematic random sampling technique. 87 respondents were from Unguwar Babanlle while 25 were from Unguwar Kanawa village. The two villages were given an unequal representation because most of the respondents were sick patients and those looking after them found in the General hospital. A well designed structured questionnaire was distributed to the 120 female respondents to explore the research objective which was interpreted to them by a research assistant who was fluent in Hausa language and in English. However, respondents were allowed to give reasons for some answers and elaborate on issues where necessary. The collected data were analyzed using simple percentage statistical method.

Table 1: Socio- economic and Demographic Characteristics of the Respondents

Current Age	*Frequency*	*Percentage*
15 – 20	13	11.6
21 – 25	31	27.7
26 – 34	40	35.7
35+	28	25.0
Total	112	100.0
Age at first marriage		
13 – 19	107	95.5
20 – 25	4	3.6
26 – 30	1	0.9
31+	0	0.0
Total	112	100.0
Level of Education		
None	45	40.2
Islamic	60	53.6
Primary	5	4.5
Secondary	2	1.8
Tertiary	0	0.0
Total	112	100.0
Family income (month)		
Less than ₦3,000	0	0.0
N3, 00 – ₦ 5,000	13	11.6
N6,000 – ₦,000	9	8.0
More than ₦ 10,000	2	1.8
No actual estimate	88	78.6
Total	112	100.0
Number of children (per woman)		
1 – 3	06	5.4
4 – 7	53	47.3
8 – 10	44	39.3
10+	09	8.0
Total	112	100.0

Table 1 indicates the percentage distribution of respondents according to their socio- economic and demographic characteristics such as; current age, age at first marriage, level of education family income and number of children. From the table, we can observe that most of the respondents fell under the age bracket of 26-34 (35:7%). Also, about 107 respondents representing 95.5% stated that they got married between the ages of 13-19 which could be described as teenage marriage period. This according to health professionals is not very healthy for the respondent as such marriages could result to complications of physical, social and emotional disorder especially during child birth. Still, from the response on the level of education, we can see that majority of the respondents had no formal education about 105(93.8%), whereas, 45(40.2%) had neither Islamic nor formal education, 60(53.6%) of them had Islamic education, and Islamic education mainly border on the does and don'ts of Islam and not ways to be physically health. In essence, Islamic studies impact in them the religious moral conduct they need to live spiritually in the society. And this high level of illiteracy has so much negative impact on them in terms of health decisions.

The saying that 'poverty is a disease' could be seen here as majority monthly family income is below average even though most of them don't know their actual family income per month. The respondents all stated that none of their family income is up to N 20,000 per month. This has sever implication on them as they cant effort the enormous financial requirement to maintain a good health status even when they have the interest of keeping good health. From the table, we can also see that the large family sizes of respondent with most of them (97/86.6%) are having between 4-10 children per woman. This means an average of 16-40 children for men who are having four wives. And as it is the case, most men can't afford to provide for all the children this makes the children to carry plates and start begging on the street (almajiris) and face all the physical and social hazards associated with this, thereby endangering their health. Apart from this, most women who stated that

they are having between 4-6 children opine that they lost some of their children due to ill-health.

Table 2: Distribution of respondents according to often times they visit the Hospital for check up.

Visit to hospital for check up	*Frequency*	*Percentage*
Rarely	41	36.6
Only when sick	59	52.7
Sometimes	10	8.9
Regularly	02	1.8
Total	112	100.0

Table II shows the distribution of respondents depending on their visit to the hospital for check up. 59(52.7%) of the respondents representing majority of them stated that they may only visit the hospital when they are sick, apart from that, they don't go to the hospital for check up. Another category of respondents representing 41 (36.6%) stated that; they rarely go to the hospital even when they are sick. Pressing further to know why, they opined that they can't effort the large medical bills and that they belief more on traditional medicines which is cheaper and more efficacious. Only a minute respondent of 10 (8.9%) said they visit the hospital sometimes while 2(1.8%) of the respondents said they do visit the hospital for regular check-up however, they said it was because the doctors ask them to do so to monitor their health status which if not checked regularly could develop to some form of complications

Table 3: Distribution of respondents according to personnel they visit when sick or during delivery

Personnel	*Frequency*	*Percentage*
Medical Doctors	10	8.9
Nurses/ midwives	4	3.6
Traditional doctors/ birth attendants	98	87.5
Total	112	100.0

The above table shows that majority of the respondents (98/37.5 %) visit traditional doctors/ birth attendants during delivery. They said when asked reasons for this that they belief more on their traditional method of delivery which is less expensive and safer than modern medical system they are more familiar with. However, some of them said they do go to the hospital for delivery especially when their seems to be complications during traditional birth processes. Nevertheless, few of the respondents (10 &4) do patronize modern medical means of delivery through doctors and Nurses/ midwives.

Table 4: Distribution of respondents based on intake balanced diet

Balance diet	*Frequency*	*Percentage*
Yes	04	3.6
No	99	88.4
Sometimes	09	8.0
Total	112	100.0

Table IV shows that the percentage of those who actually take balanced diet is only 4 persons representing 3.6% of the total respondents. In contrast, a whopping sum of 99 (88.4%) respondents has not been taking balance diet. This explains why most of them have malnutrition problems and Anemia.

Table 5: Distribution of respondent based on ingestion of kunun kanwa

Ingestion of kunun	*Frequency*	*Percentage*
Yes	102	91.1
No	7	6.3
Few times	3	2.7
Total	112	100.0

Table V gives the percentage distribution of number of respondents that have been engaging in kunun kanwa ingestion. According to 91.1% of the respondents, kunun kanwa has been a major source of their diet because it is one of the cheapest meals they can easily afford and also, it is a cultural important meal. Further research also showed that some could take kunun kanwa throughout the day as their; breakfast, lunch and dinner. Only a small percentage of the respondents (6.3%) said they don't ingest kunun kanwa while (2.7%) stated that they sometimes take kunun kanwa.

Kunun kanwa a local diet has been found to be responsible for major heart problem and Anemia suffered by women in the community. Kunun kanwa as posited by Dr. Mamman Ibrahim (Medical Officer, General Hospital DanMusa) has a very small amount of nutrients to give the body good health. Hence most cases recorded in their hospital are cases of Anemia resulting from lack of nutrients especially by the women.

Table 6: Distribution of respondents based on their knowledge that kunun kanwa causes heart diseases

Aware of the dangers	*Frequency*	*percentage*
Yes	0	0.0
No	112	100.0
Total	112	100.0

It is so obvious from the above table that one major social problem facing this group of people is lack of awareness [Education] concerning health related issues. All the respondents so far are unaware that kunun kanwa is having a co-relation with heart diseases and Anemia. Hence, their continual ingestion and consumption of the meal.

Table 7: Distribution of respondents based on their practice of traditional hot bath

Practice traditional hot bath	*frequency*	*Percentage*
Yes	101	90.2
No	06	5.4
Not always	05	4.5
Total	112	100.0

A vast majority of the respondents (90.2%) reported that they have been engaging in the practice of traditional hot bath. Few of them said not always (4.5%), while only a small fragment of them don't engaged at all in the traditional practice. The traditional bath is a practice that is common to the local Hausa people. It is done when a woman is delivered of a baby. They heat water and use a specific traditional leave to sprinkler the very hot water on the woman's body. From personal research, it was discovered that this practice is also harmful to health in the sense that it cause kidney and heart related complications. Like table VI, respondents here when asked further on whether they know the dangers involve in traditional hot bath stated that they are unaware, few said they were aware because the doctor told them when they visited the hospital for heart related

illness, but still continue with such practice for fear of their husbands and tradition.

Table 8: Distribution of respondents based on their assessment of cleanliness of their environment

Environment Assessment	*Frequency*	*Percentage*
Very clean	38	33.9
Clean	67	59.8
Not Clean	07	6.3
Total	112	100.0

Though from the respondents response, majority of them about 69(59:8%) and 38 (33.9%) stated that they have clean and very clean environment respectively even after the interpreter of the questionnaires made it clear to them of what constitute a clean environment. Only a few of them 7(6.3%) were willing to accept that they don't have clean environment when they knew what constituted clean environment. However, from personal observation it could be deduced that the respondents don't live in such clean environment as they claimed to be living.

Furthermore, respondents claimed that they have specific refuse dump. When asked where they said a place inside their houses which they later bury in their farms for manure and dispose the useless ones around the farm. On the other hand, some stated that they don't have a specific place of throwing dirt's. They just keep it at a corner and later dispose of it later any where they feel like dumping it. From these responses, it could be deduced most skin diseases like ring worm are caused by these unwholesome environmental practice of keeping dirt's inside the house and disposing of it round the environment.

Table 9: Distribution of respondents based on the sterility nature of objects used for the circumcision f their male children.

Sterilized object	*Frequency*	*Percentage*
No	7	6.3
Yes	30	26.8
Some of them only	23	20.5
Don't know	52	46.4
Total	112	100.0

Most respondents 52(46.4%) stated that they don't know if the objects used in sterilizing their male children are satirized or not. Asking the reason for this they said they are often not present where the sterilization is done and in most cases where they are suppose to be present, they are sent out of the room. Hence, they cannot tell what use is and how the circumcision is carried out. Whereas about 30(26.8%) respondents stated that the instruments used during circumcision are sterilized but with traditional medicines and leaves. 23(20.5%) who also said they sometimes sterilize the instruments for circumcision also said that, it is still traditional method of sterilization they adopt. Nevertheless, it was only a minor percentage (6.3%) of our respondents who said they don't sterilize the instruments used for circumcision of their male children. It is obvious that from this unhealthy behavior of circumcision using traditional method of sterilization and not even sterilizing at all in some cases, the community can easily fall prey to any epidemic introduced externally such as HIV/AIDS, as a whole household might be sharing same sharp object during circumcision period. Some might even borrow these instruments from a next door neighbor.

Similar response was gotten when respondents were asked if they sterilized the objects they used for making tribal marks.

Table 10: Distribution of respondents based on their source of water supply

Source of water supply	*Frequency*	*Percentage*
Tap	18	16.1
Mono pump	53	47.3
Well	39	43.8
Others	2	1.8
Total	112	100.0

The table above indicates that their major sources of water supply are from mono pump (53/47.3%) and well (39/34.8%). And as it is, these sources of water supply are not safe for drinking, as sand particles could be seen in these water sources including the brown nature of the water. As for the well, there are living aquatic animals such as: Frogs and Fishes. These make the water so unsafe for drinking. Despite the presence of tap that were supposed to be a good source of water supply, only the tap in the local government secretariat is in good condition, and it is just few respondents (18/16.1%) who said they get their drinking source from there. Other respondents consisting of just 1.8% states that their source of water supply include; rain water, artificial streams and rivers etc .

Other findings from the research showed that majority of the people don't have cover their meals properly allowing flies to patch on it and introduce disease causing gems. Moreso, access to medical personnel and facilities seems to be very difficult and this discourages most of the villagers from patronizing modern health facilities. Still, the total assessment of the health habits of the people could be generally rated as poor. And hence they need lots of assistant from both local, state, federal government non-governmental bodies to aid their current predicament.

5. Conclusion and Recommendation

This research work has so far identified some socio-cultural factors and attitudes that serve a breeding ground for ill-health in rural societies using DanMusa as a case study. Whereas some might be controlled by the people if they are willing, others due to poverty and lack of education and inaccessibility to basic infrastructural medical facilities and personnel require external intervention.

Based on the findings in order to improve the health status of the rural dwellers, the following recommendations have been made. Firstly, there is an urgent need for rural basic infrastructural and personnel development in form of more medical health centers and personnel, adequate water supply, good roads to make good accessibility to health personnel and facilities easy and to reduce the incidence of water born diseases such as the chronic typhoid fever which was also common in the area of study.

Secondly, health education and re-orientation should be given to the people by professional groups such as: NGO's like MDG's UNICEF and medical practitioners/ health

workers. As it was seen, most persons engage in some of the practices is due to ignorance and lack of information about better ways of doing things.

Again there should be an increase in education, particular Female education. As it was observed, the whole DanMusa local government has just four secondary schools of which the number of girls in each is just between 10-20 percents. Female education will help refuse harmful socio-cultural practices such traditional hot bath and tribal marks. She can also keep home better and help propagate same to the upcoming children. Education is so important that Ityvayar cited in [12], pointed out that, an uneducated society can never be a healthy society even if they have health centres in every house.

Furthermore, it is expedient that indigene syndrome of discriminating in employing health practitioners who are not from the state be discouraged, and an embracing hand extended to help reduce the concentration of health practitioners in one state. In addition, there should be new programmes that will help reduce the negative impact of poverty since existing and previous programmes have not been able to achieve this aim. The effort to reduce poverty must have a mass character; they must deal with the roots of poverty such as unequal distribution of economic and resources across social groups.

Still the housing pattern of rural societies should be property built to repel mosquitoes and other diseases. Houses should be well ventilated while practice of dumping feaces and dirt indiscriminately should be discontinued, and also, mosquito nets should be used and changed when due. Also, researches should be made to enthrone cultural practices that might enhance the health status of rural dwellers and discourage harmful socio-cultural practices.

Again, community participation in health care should be encouraged as previous researches had shown the benefit associated with this, which is; communities influence the direction and execution of development projects rather than merely receiving a share or benefits. Importantly, there is a need to create awareness for rural dwellers to appreciate the necessity of maintaining a clean environment, good food /eating habits as well as the need for recreation.

Concussively government at all levels should make the primary health care scheme work by properly funding the programme and rising beyond lip service, because it is only when 80% of Nigeria's population is developed, can Nigeria claim to be a developed country. And unless this is done, rural dwellers will increasingly abandon modern health care system with all its benefit and will be at the mercy of quacks or at best alternative medicine which has not fully developed to handle such illness like those requiring surgery [12].

6. Future Implications of the Study

Reviewed conclusions from the study should be able to help people make well-informed decisions about engaging in these harmful practices and attitudes that affect their health status in the future. However, there is the need to conduct future researches on the factors that makes these attitudes and practices to persist in the area of study. More so, alternative local practices or modern practices that can replace their current practices and attitudes should also be surveyed.

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