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## **AN OVERVIEW OF HEALTH AND OCCUPATIONAL HAZARDS OF RURAL WOMEN IN NIGERIA**

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### ABSTRACT

In Nigeria, few research studies have been documented on the health and occupational hazards of rural women with its implication on rural productivity. Women are often incapacitated by occupational hazards that interact with other causes of illness to produce a wide range of adverse outcomes. The increasing morbidity common among women has greatly impaired rural potential for optimum production. Hence, this review seeks to analyze health problems and occupational hazards of rural women resulting from their income generating activities. It also examined access and use of health care services. Primary data analyzed revealed reduced access to health care services, poverty, low level of agricultural mechanization, long work days, inadequate information and lack of extension contact and poor health status of women. Hence, dissemination of health related information is a panacea for dealing with rural occupational hazards. Extension workers must also educate women on necessary precautions during production activities.

Women all over the world have been acknowledged for their major and complementary roles in providing livelihoods for their families. They have also won an enviable reputation for their economic contribution through food production, processing and trading (FAO 1995; Fapohunda 2012; IFPRI 2012). Processing of agricultural produce is a major traditional responsibility of women and they are regarded as architect of food processing technology. It is in this area that women, particularly in Nigeria are mostly distinguished (Adejare 2001). Synder (1990) and IFAD (2012) described women as the principal, if not sole economic support for themselves and for their children. Their involvement in agricultural production and nutrition lies in their participation in activities at each stage of production of the food chain that determines the quantity and quality of food available. This implies that they are responsible for food security and nutritional well-being of their families (Omonona and Agoi 2007; World Bank 2008).

They provide up to 60 to 80 percent of domestic food production (Ajani 2008). Women unpaid work in the field crop production and other agricultural activities is increasingly an important labor force. Despite this, the impact of women's labor and their long work hours is ignored. In addition, they perform intensive labor on their own farms. Aside agricultural activities, on average, rural women spend

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almost an hour each day gathering fuel and carrying water to prepare meals. In some communities, these activities may take up to four hours a day. Often, dangerous back breaking and unrelenting drudgery are inevitable for them. The consequences of energy consuming tasks and multiple roles played by women can be disastrous to their health and family.

According to the International Labor Organization (ILO) definition, women are half the world's population, who receives one tenth of the world's income, account for two-third of the world's working hours and own only one hundred of the world's prosperity. Women in Nigeria constitute 49.12 percent of the national population and most of them live in the rural areas where they explore the resources of nature (NPC 2006). They are usually unskilled and obligated to accept whatever work they can find. Besides, they occupy the lowest rung of the societal ladder and are the least educated thereby usually employed at the lower grades (Annan-Yao et al. 2004).

Yet, a significant proportion of women do not enjoy a level of health that will enable them to achieve socially and economically productive lives. The most vulnerable of these women are those in the rural areas, who are often incapacitated by illness, disability and occupational hazards to mention a few. This reduces their efficiency for both agricultural and non-agricultural activities. High prevalence of epidemic and endemic diseases in most rural areas further aggravates poor health and misery (ILO 2000).

However, the right to health is the most basic of all human rights. The constitution of World Health Organization (WHO) asserts that: the enjoyment of the highest attainable standard of health is a fundamental right of every human being without distinction of race, sex, religion, and political belief, economic or social condition. This means that every human being has the right to live in an environment with minimum health risk, have access to health services that can prevent or alleviate their suffering, treat diseases and help maintain and promote good health throughout the individual's life (WHO 2004).

Hence, this review therefore seeks to consider the causes of health problems, occupational health hazards and effect of health and occupational hazards on implications for rural women in a bid to come up with suggestions to improve their health condition and living standard.

#### CAUSES OF HEALTH PROBLEMS

Although the major causes of health problems vary by age group, certain health problems affect Nigerians at every age. Perinatal infectious and parasitic diseases

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are common among children while hormonal deficiencies, circulatory diseases, injuries and others are notably evident as causes of health problems in adult. Oyebola (1980) in his study of concepts of disease causation, identified natural, pre natural and mystical as three major causes of diseases prominent among the “Yoruba’s” one of the three major tribes in Nigeria. The natural factor falls within the scientific explanation of disease causation while the second and the third falls within the nonscientific explanation attributing diseases and ill-health to the interferences of supernatural or cosmic forces, witchcraft or evil machination of the enemies. It is generally believed that the victims are afflicted by an offended god or spirit. However, such diseases are incurable, but those linked to the factors such as poor nutrition, insect bites, bad odor, filthy or unsanitary conditions, lack of exercise, emotional, mental, respiratory disorders and contagious diseases, such as venereal diseases and leprosy are hereditary. All of them fall within the first category and they are curable.

*Overview of Health Concerns*

*Malaria.* Malaria is Africa’s most persistent disease problem. In areas where malaria is endemic, 30 to 40 percent of women may be incapacitated by it at any time during the year. It prevents women from working due to the long period of fever, headaches and pains. Absenteeism from farm work due to malaria reduces their productivity and causes economic burdens which makes them poorer. Hence, there exists a relationship between health and physical efficiency regarding increased productivity (Adejare 2001).

*Nutritional Stress.* Generally, improved nutrition contributes to better health that in turn adds to economic well-being as healthy population are more productive and spend fewer resources on medicine (IITA 2004). The consequences of inadequate body reserves and deficient dietary intake result in low pregnancy weight gain for birth outcome and birth weight that are well-known problems of maternal depletion. Nutritional deficiencies among pregnant rural women also make them to suffer from anemia that creates complications during childbirth and increase the risk of maternal mortality.

*AIDS/HIV.* AIDS and HIV have also been discovered to be changing the demography of agricultural labor. The impact is greatest in rural areas since infected urbanites migrate to their villages to be cared for and add to the number of local cases there. Therefore, it affects the availability of labor because those who are healthy are preoccupied with caring for the sick or undertaking additional tasks that were previously done by others. Time-consuming work like weeding,

mulching, planting and harvesting are either left undone or not carried out properly. Failure to carry out essential agricultural practices promptly decline fertility of the soil and increase pest and disease infestation that inevitably reduce output significantly (World Bank 2004).

#### OCCUPATIONAL HEALTH HAZARDS

Majority of the rural women are exposed to occupational hazards. UNFPA (1998) in its recommendation had advocated the need for more research to be carried out on hazards posed to health by occupational activities in rural settings with the synergistic effects of heavy household work, malnutrition, multiple pregnancies as they affect poor women in developing countries. In spite of this advocacy, few research works have been documented. Over the years, it was observed that modern technology has done little to improve the welfare of women (Annan-Yao et al. 2004).

For instance, pounding and cooking stages in the preparation of “fufu”—a cassava product—is most tasking and energy sapping and women used up their body strength for desired taste and texture. Modern processing techniques have not been introduced to women who are still engaged in using the traditional method of processing cassava. In addition, back ache, itching/scratching, cuts, skin irritation, dermatitis, pigmentation and fungal infection on skin, pains, tiredness, headache, cough and swelling of the eyes due to smoke characterizes occupational hazards of women cassava processors in rural communities (Adejare 2001).

Adejare (2001) also found that processing of cassava into “gaari” causes exposure to cyanide, heat and burns. The prolonged exposure to cyanide fumes, fire and smoke during processing were considered responsible for respiratory diseases, migraine and heat exhaustion. According to Wallace (1991), during processing of food and cooking in smoke filled rooms, women inhale up to 40 times the volume of suspended particles safe by the WHO. They also inhale air during bush burning and fuel used in cooking. In a study of women farmers in Edo state, Egharevba (1992) discovered that the most common occupational hazards of women engaged in crop production and other activities were heat related sicknesses such as heat exhaustion and heat stroke. Besides, it was noted that carrying of heavy loads of firewood and raw farm produce can cause serious muscle and skeletal disorder such as chronic back pain, chest pain and miscarriages.

Others occupational hazards of rural women are muscular fatigue, sunburn, migraines, and respiratory diseases and in a few cases still birth. Increased exposure to air pollution, organic dust from food processing, job overload and chemical

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hazards are also major risk factors in developing countries. According to the ILO (2000), exposure to poor working conditions has serious repercussions on pregnancy. The risk of miscarriage, premature delivery and spontaneous abortion has been related to exposure to pesticides. The WHO (2004) asserts that the Nigeria mortality rate is the second largest in the world caused by complications of pregnancy

Sims (1994) also listed health problems of women in pesticide exposure with adverse effect on pregnancy outcomes. Pesticides are absorbed into the body through three routes: inhalation (lungs), ingestion (stomach), dermal absorption (through the skin, eyes and mucous membrane of the respiratory tracts). The symptoms vary from headaches to cancer. Other notable symptoms of pesticide poisoning are abdominal pain, vomiting, headache, dizziness, mucous spasm, delirium, watery or bloody diarrhea and sometimes convulsions that reflect direct injury to the central nervous system plus extra cellular electrolyte disturbances and shock showing chemical poisoning. Because of heavy reliance on chemical pesticides, large quantities of toxic materials remaining in the environment cause irreparable human health hazards. Pesticide poisoning is toxic in small absorbed doses while others have harmful effects only when very large amounts are consumed or absorbed. Yet, rural women resort to injudicious and excessive use of pesticides due to illiteracy (Sims 1994).

Moreover, since most of the rural women engage in farming, injuries and accidents are sustained from implements that may cause disability, cut or abrasion. Experiencing different forms of bites (snake, insects and so on) is also common. Others are in the form of biological hazards; some women do contract zoonotic diseases and infection too. The victim's general symptoms are headache, nausea, vomiting, abdominal pain, watery diarrhea, violent muscular spasm, convulsion, dizziness, weakness, unconsciousness, shocks, fever, profuse sweating, and difficulty in breathing, speaking, swallowing and movement.

The persistent health problems of women adversely affect agricultural activities resulting into increased morbidity and mortality, which has greatly impaired their potential for optimum rural production. Undoubtedly, several indicators suggest that health could emerge as a serious constraint to agricultural production in years to come.

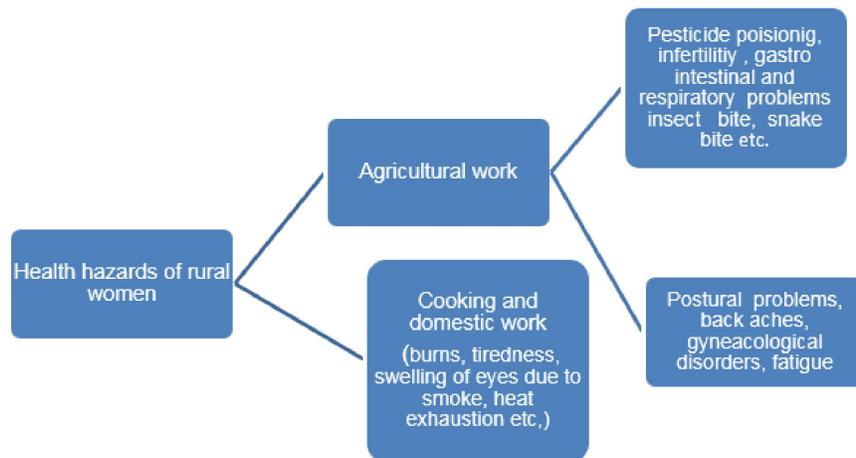


FIGURE 1. SCHEMATIC REPRESENTATION OF THE OCCUPATIONAL HEALTH HAZARDS OF RURAL WOMEN

#### EFFECTS OF HEALTH AND OCCUPATIONAL HAZARDS ON RURAL PRODUCTIVITY OF WOMEN

Health condition affects individual hours of work and its importance as a determinant of labor supply has been documented in several studies. The World Bank (2007) affirmed that capacity and ability for productive agricultural and non-agricultural rural activities are endangered by poor health. Illness and death from HIV/AIDS, malaria and other diseases reduce productivity of rural women. The negative effect of poor health on economic activity is enormous as women lost days of work and cost of treating illness may be significant in per capita GDP. Processing hazards often lead to reduction in quantity of product processed and hours of work of women. At times, it causes poor quality of the product (Adejare 2001). Besides, if it were found that lack of adequate information on cassava processing deleteriously affected the processors' health and output because many were not aware of any innovation in cassava processing and had no contact with the extension agent.

Until now, rural women constitute a large percentage of the poor in the society, who are relatively powerless to improve their health and quality of life. Tragically, more women throughout Nigeria rural communities do not want to spend on health because of conflicting demands on their little unstable and seasonal returns. At such times when there is no work and money, women probably cannot afford health services. Feachem (2000) had opined that poor health is a common consequence of poverty. Only healthy people can work more and easily earn an income and

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contribute to increased economic growth. Hence, there exists a chain relationship between poverty, health and rural labor because the study of one leads to the other.

The negative effect of poor health on rural productivity makes it very important to improve rural social services. The ILO (2000) declared that the delivery of occupational health to rural population should be integrated into the primary health care structure that includes, among others; environmental protective measures, improved statistics on occupational accidents, injuries and diseases, health promotion and well-being measures and sustainable approach to agricultural safety in the use of Agrochemicals. Occupational health needs to be addressed with a well-defined strategy and must be integrated into a rural development policy.

*Poor Health Status of Women*

Health status largely depends on behavioral factor and health care system variable. Posited by Iyun et al (1995), it is a dependent variable that varies as a function of lifestyle factors, demographic and socioeconomic characteristics such as age, sex, income, social, physical and medical environment. Health status is not only determined by the physical make up but also by socioeconomic status. Adejare (2001) used self rated health status, frequency of seeking treatment and frequency of inability to work were used to compute the health status rating scale of rural women. Similarly, the burden of diseases can be measured in terms of disability adjusted life years (DALYs), physical quality of life index (PQLI) and gender related development (GDI) to determine the overall level of physical well-being.

Rural women have extremely limited access to services such as health centers. Their ability to take full advantage of health care programs is related to their economic status. Adejare (2001) and Ukeje (2004) found that access to health care varies from one community to another and less than half the population under the study utilizes these facilities. Although other issues determine accessibility and utilization of health care services for women, distance from the woman's home is a factor. To make a life changing difference for women, equitable distribution of health facilities is necessary and provision of social amenities such as electricity, good roads, and portable water to make their life more comfortable for rural dwellers. Chinai (2005) suggested that getting health care to these vulnerable groups who are in the rural communities whose access to treatment and care is minimal is inevitable. Though life expectancy of rural women is increasing, however, the numbers of years free from disability is stagnating. This phenomenon of living longer, but not necessarily enjoying a good quality of life has implication for health services and family care.

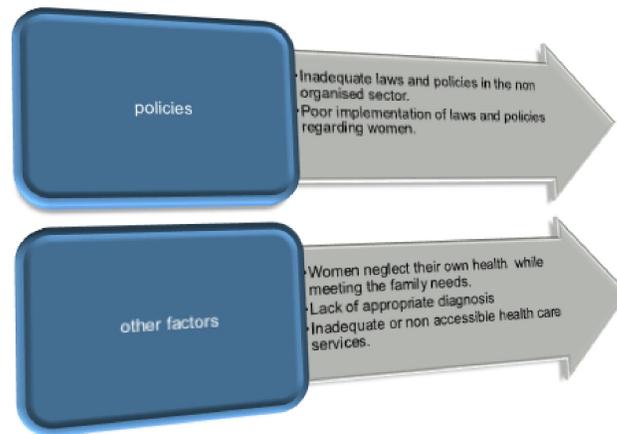


FIGURE 2. SCHEMATIC REPRESENTATION OF CAUSES OF LOW PRODUCTIVITY OF RURAL WOMEN

## CONCLUSIONS

Achieving better health of women in Nigerian rural areas must be given priority. There is need to create an enabling environment and educate rural women through regular information and communication on improved health related practices that will enhance their well-being and productivity. Health information is a panacea for dealing with health problems, hence, information must be organized and presented so that it will motivate and encourage the rural women to use them. Community education for preventing locally endemic diseases and in particular for the improvement of the welfare of women is essential too. In addition, agricultural extension workers must train women on environmental crop protection in modern pest management practices.

Operationally relevant national policy must be formulated quickly to meet rural health needs. Although this will require many interrelated actions, ranging from identifying the disadvantaged groups whose health needs must be clearly defined and improving the quality of primary health care services in the rural area by expanding system of well-functioning health centers and referral hospitals for increasing productivity of women in the rural areas. Increasing rural productivity will be achieved by improving access to health services.

Since the end of rural development is bound up with promoting the welfare of the people, providing labor-saving devices is important, but there is need to consider gender issues when designing such technologies. The machines must be suitable, convenient and must be with minimum risk. Hence, if women occupy a

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crucial role in agricultural development and they have persistent health problems unattended to, outcome of their most viable labor force will decline, leading to an overall decline in productivity.

AUTHOR BIOGRAPHY

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