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Accessing and utilizing services by rural borderland communities in South-Western Nigeria

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Abstract: Borderland communities hold a strategic position in many countries. However, in spite of this, many of these communities, specifically in Nigeria, are still characterized by neglect and underdevelopment. Based on the above fact, this study explores the service deprivation and coping strategies of rural borderland communities in South-Western Nigeria. The study revealed that the majority of inhabitants of rural borderland (64.0%) get their water supply straight from streams and are bound to cover distances of 500 meters or longer to collect water. Similarly, the majority of them defecate in bush reserves around their houses. Also, the study showed that people can travel across the national border to neighboring countries on a regular basis to access basic services, like healthcare facilities. Likewise, medical personnel or attendants from neighboring countries or towns are called during critical or serious illness to render services which the Nigerian Government does not provide. The development of Nigeria's frontier areas is therefore of paramount importance and really pending, and must be made priority in urgent and major developmental actions taken in the country.

Keywords: access to services, rural communities, borderland communities, deprivation, South-Western Nigeria

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1. Introduction

Accessing and utilizing services in rural communities constitute major challenges in Nigeria and this is worse in communities inhabiting rural borderland. However significant, these challenges are sparingly presented and addressed in both research and policies. The strategic

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position which the borderlands of the country hold has been recognized by many authors (Bonchuk, 2011; Weber, 2012; Tandia, 2010; Afolayan, 2010; Adepoju, 2005; Adejuyigbe, 1989). This was part of what prompted Nigeria and all the countries that border on it to meet in Lagos on the 10th of August 1989 for Nigeria's first National Planning Conference for the Development of Border Regions. The conference was a showcase of Nigeria's policy of developing and maintaining its borderland areas through cross-border cooperation with its neighbors. This cross-border cooperation is one of the basic principles embedded in the country's foreign principle which includes the sovereign equality of all African states and the functional cooperation as a means of promoting African unity (Folarin et al., 2014). Part of the major highlights of the Conference was the need for data collection on which planning in the region will be based and the development of the borderland communities as the basis for secure borders.

Despite the 1989 National Planning Conference and the country's awareness of the strategic position the border areas hold in the country, most borderland communities are still neglected and underdeveloped, especially regarding the provision of infrastructural facilities and are worse off compared to many other rural communities. For instance, most of these borderland communities have a limited access to opportunities, information, facilities and amenities, like healthcare facilities, educational facilities, transportation facilities, portable water and electricity needed to live a good quality life. They are also totally neglected and are still not excluded from major developments in the country compared to other rural communities. Specifically in Nigeria, most of the inhabitants of borderlands have strategized ways of accessing and utilizing services.

There is no empirical information about access to services in border communities of Africa, especially in Nigeria, where borderland studies like this are very important and really urgent, the more so when one considers the recent atrocities of the Boko Haram sect, being a typical example of the implication of neglect of the general situation found in the borderlands in Nigeria. However, while Boko Haram are operating in the North-East of Nigeria, other communities on the borders with Benin, Cameroon, Niger, Chad and Equatorial Guinea also experience their own problems. For example, Nigeria-Republic of Benin borderland area is characterized by smuggling activities and functionaries who enforce legislation beyond their areas of jurisdiction; the Nigeria-Cameroon borderland area faces the problem of boundary dispute - the Barkassi-Peninsular land dispute; Nigeria-Chad area is characterized by a dispute over water (Lake Chad) which is speculated to be behind the Boko Haram insurgence; Nigeria-Niger has the most cordial relationship but there have been incursions of Nigerien

destitute into the country and have turned the Northern highways into killing zones; and Nigeria-Equatorial Guinea area is ranked the second most dangerous in the world, with the operation of armed pirates in the Gulf of Guinea having about 3000 creeks in Nigeria territorial waters alone (Folarin et al., 2014).

These problems will not be overcome until the Nigerian government, rich with oil wealth, redistributes some of that wealth to address the deprivation and difficulties of these communities. Until then, such communities may easily align themselves with communities and services from Nigeria's neighbors. Therefore, this study is necessary to provide information that could inform policy makers of the direction to which policy initiatives should be tailored to manage access to services, particularly in rural borderland communities in Nigeria.

The questions addressed in this paper are as follows: 1) Are borderland communities worse off than other rural communities? 2) In the context of a lack of services, how do borderland communities manage?

2. Methodology

The research made use of primary data which were obtained through interviews and structured questionnaires administered in selected rural borderland communities of South-Western Nigeria (SWN), using a multistage sampling technique. The household head representing an individual household selected for the purpose served as the respondent to the administered questionnaire. A total of two hundred and thirty-five (235) questionnaires were administered, of which two hundred and twenty-eight (228) were retrieved for the final analysis. Focus Group Discussions (FGDs) were also organised for five (5) selected households in each community. At the first stage, the Border States in SWN were identified. Two Border States were randomly selected from those located in SWN. The states are – Oyo and Ogun in the South-West. At the second stage, two local government areas were purposively selected from each of the Border States on the basis of their closeness to the border. The third stage involved selection of four remote rural borderland settlements from each of the local government areas through a simple random selection process. The fourth stage consisted in selecting every third house in the respective settlements after the first houses were randomly selected.

3. Conceptual issues

3.1 Rural service deprivation and border service deprivation

Deprivation is a disadvantageous situation, one whereby people lack in basic necessities while others may live a good life. Akinola (2007) explained that in rural areas of Nigeria, many people are deprived of basic needs, such as clothing, housing, healthcare, education, transport facilities. These areas also lack in recreation facilities, neighborhood amenities, credit facilities and opportunities for self-development and, moreover, are characterized by stagnation, poverty and retrogression of economic life. This rural condition, according to Kolawole and Torimiro (2006) and Akinola (2007), is attributed to the type of administrative and governance arrangements, as well as the inappropriate and ineffective development policy which the post-colonial independence leaders adopted. These policies emphasize development in the urban centers at the expense of the rural areas with the belief that this will trickle down to the rural areas. This work particularly focuses on service deprivation, which is equally related to the type of administrative and governance failings.

3.2 Service deprivation and access in rural borderland communities

This sub-section draws on the empirical study discussed in the methodology. Service accessibility is determined in terms of distance, cost, time, availability (provisions), quality, (Chakraborty et al., 2003; Manzoor et al., 2009; Onah et al., 2009). These determinants affect people differently across the socio-economic hierarchy of the population. However, while this study made use of those determinants, it did not analyze them by socio-economic characteristics.

4. Results and discussion

4.1 Deprivation based on water access

Previous studies show that rural areas have poorer access to water than urban ones (Dada, 2009; WHO and UNICEF 2010). Joint Monitoring Report on global progress on water and sanitation 2014 noted that the gap between the urban and rural access to improved water supply is decreasing. This assertion was based on the report produced by the World Health Organization (WHO) and the UN Children's Fund (UNICEF) 2014, which explained that in 1990, 95% of people in urban areas could drink improved water compared with 62% of people in rural ones, but by 2012, 96% of people living in towns and 82% of those in rural areas had access to improved water. Also in Nigeria, the National Demographic and Health

Survey 2008 reported that access to safe water in the rural communities of Nigeria was 43.8%. Safe water, according to Ishaku *et al* (2011), includes treated surface water, as well as untreated but uncontaminated water from sources such as natural springs and sanitary wells and protected boreholes. This shows a considerable increase in the accessibility to improved water supply, especially in rural areas.

However despite this major progress in rural communities of Nigeria, rural borderland communities in Nigeria are worse off, totally neglected and deprived of improved water supply. For example, Table 1 reveals that the majority of households (64.0%) get their water supply from a stream, another 24.9% get their water from a well. However most of these streams/ponds contain stagnated water with green algae, which is shared with animals. They will normally dry up during the dry season as shown in Figure 1. Wells too are not covered and are muddy or unavailable during the dry season. In the study areas, only 10.5% of the households can avail themselves of water from boreholes, which are covered and therefore might be classed as 'safe'.

Also the majority of household members (65%) cover the distance of 500 meters or more to collect water. Likewise, more than 32% of the households spend over 60 minutes on collecting water, while only 25% spend 30 minutes or less. According to Sphere project (2011) and WHO, the maximum distance from any household to the nearest water point must be within **500 meters** and the collection time should not exceed **30 minutes**. This water situation in the rural borderland communities presented above is worse than the figures obtained in the 2008 National Demographic and Health Survey (NDHS). The NDHS survey showed that 71.9 % of Nigerians residing in rural communities were able to access water within 30 minutes.

Figure 1. Water supply from a stream

Source: authors' fieldwork (2015)

Table 1. Households' water access in rural borderland communities

Source of water supply	**Frequency**	**Percent**	**Cumulative percent**
Stream	146	64.0	64.0
Rain	7	3.1	67.1
Well	51	22.4	89.5
Borehole	24	10.5	100.0
Total	228	100.0	
Distance to source of water supply	**Frequency**	**Percent**	**Cumulative percent**
less than 250 m.	38	16.7	16.7
btw 250mtrs and 500 m.	42	18.4	35.1
btw 500mtrs and 750 m.	66	28.9	64.0
750 m. and above	82	36.0	100.0
Total	228	100.0	
Time spent to collect water	**Frequency**	**Percent**	**Cumulative percent**
<=15 min	19	8.3	8.3
16-30 min	38	16.7	25.0
31-45 min	46	20.2	45.2
46-60 min	53	23.2	68.4
61min and above	72	31.6	100.0
Total	228	100.0	

Source: authors' field survey

4.2 Deprivation based on access to healthcare facilities

A review of literature shows no greater or lesser deprivation in relation to access to healthcare services between rural non-borderland and borderland communities. However, the latter are clearly still largely lacking in health services. The UN Committee on Economic, Social and Cultural Rights, adopted a General Comment on the Right to Health in 2000. It stated that the right to health contains four elements which are: **Availability** of functional healthcare facilities and programs; **Acceptability** of all healthcare facilities, goods and services; **Quality** of healthcare facilities, goods and services; and **Accessibility** of healthcare facilities, goods and services by everyone. Accessibility of healthcare facilities has four dimensions, they are as follows: non-discrimination; physical accessibility (distance); economical accessibility (affordability) and information accessibility.

The studied households showed that 76% of them practice self-medication, 13.2% patronize traditional herbs sellers, 7.9% use local chemist stores, while only 2.6% go to

hospitals (private clinic/state-run hospitals). In communities where there are healthcare facilities, 32.5% of the respondents complained of long distances to reach them, 17.5% mentioned the poor state of hospitals/clinics (as seen in Figure 2 showing the condition of health center in the area), while 9.0% talked about the high service charge. People had to travel long distances to get to healthcare services providers. For instance, 20.2% of the households spent more than 90 minutes to get to a healthcare center, another 42% spent 31-60 minutes. During this period, some of the patients died. Others were a little closer to services; nevertheless, 32.5% of the households spent 30 minutes or less to get to a healthcare center, 42% spent 31-60 minutes, while 20.2% of the households spent more than 90 minutes to reach their healthcare centers. This situation (as shown in Table 2) proves that rural borderland households are deprived in their access to healthcare facilities. This is against the WHO/UNICEF primary healthcare declaration of 1978.

Figure 2. Condition of healthcare centre in the study area

Source: authors' fieldwork (2015)

Table 2. Households' access to water in rural borderland communities

Choice of healthcare of the respondents	Frequency	Percent	Cumulative percent
Traditional herbs seller	30	13.2	13.2
Self-medication	174	76.3	89.5
Local chemist store	18	7.9	97.4
Private clinic	1	.4	97.8
State-run hospital	5	2.2	100.0
Total	228	100.0	
Reasons for not patronising hospitals	**Frequency**	**Percent**	**Cumulative percent**
Long distance to a healthcare facility	74	32.5	32.5
High service charge	21	9.2	41.7

Unavailability of healthcare centres and provider	93	40.8	82.5
Poor state of hospitals/clinics	40	17.5	100.0
Total	228	100.0	
Time spent to reach healthcare facilities	**Frequency**	**Percent**	**Cumulative percent**
<=30 min	74	32.5	32.5
31-60 min	96	42.1	74.6
61-90 min	12	5.3	79.8
91 min+	46	20.2	100.0
Total	228	100.0	

Source: authors' field survey

4.3 Deprivation based on access to educational facilities

The Universal Basic Education (UBE) Act 2004 is one of the Government's approach to make basic education free and accessible to all children in Nigeria. In line with this, according to the Nigeria 2013 Millennium Development Goal (MDGs) Report, one of the targets is to ensure that by 2015, children everywhere should be able to complete a full course of primary schooling. Also, the country's program document for Nigeria 2014-2017 (2013) showed that World Bank, in collaboration with UNICEF, supported rural education in Nigeria by giving scholarships to encourage teachers to work in remote rural areas so that the teachers would be available in country schools.

However this is a mirage and the situation is quite different in rural borderland communities of Nigeria because resources needed for the programs are hardly available. Teachers are very few and are not always available because the few ones posted in individual areas cannot stay there on a permanent basis and thus stay away or come once in a while. Also, the available primary schools are very few and very far away while the secondary schools are not available at all. Most of the pupils have to trek long distances. Table 3 reveals that more than 88.7% of the households complained of their children travelling between half a kilometre and above 5 km to school daily. Another (63.1%) complained about their children spending between 45 minutes and more than one hour getting to school. Moreover, once children did manage to walk to school, the quality of school facilities was very poor as shown in Figure 3. This discouraged school attendance and completion of primary education.

Figure 3. Classroom with a thatched roof

Source: authors' fieldwork (2015)

Table 3. Households' educational access in rural borderland communities

Distance from home to school	Frequency	Percent	Time spent getting to school from home	Frequency	Percent
Less than half a km	26	11.4	less than 15 min	8	3.5
btw half a km and 1 km	59	25.8	btw 15 min &30 min	25	10.9
btw 1 km and 5 km	87	38.0	Btw30 min & 45 min	51	22.3
5 km and longer	57	24.9	Btw 45 min & 1 hr	60	26.2
			1 hr & more	85	37.1
Total	229	100.0	Total	229	100.0

Source: authors' field survey (2015)

This is however not the case in many non-border rural areas. The Nigeria MDGs Report 2013 on education showed that the primary completion rate in rural areas in 2012 stood at 90.50% as compared to 81.50% for urban areas. Also the unavailability of secondary schools in the borderland communities discourage many of the students from pursuing their education.

4.4 Deprivation based on access to sanitation facilities

WHO defined "sanitation" as provision of facilities and services for a safe disposal of human urine and faeces. Also WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, 2004, explained that a household qualifies as one having an improved toilet if the toilet is not shared with other households and the facility used by the household separates the waste from human contact. The Millennium Development Goal (MDG) for sanitation was to halve the proportion of people without sustainable access to basic sanitation by 2015.

However, in 2008, the population of Nigerians with access to sanitation facilities was put at 32%. This situation is really far from the MDG Target of 63% for 2015 (NDHS, 2008). Also, the National Rural Water Supply and Sanitation Strategic Framework (2004) showed that Nigeria's minimum standard for household excreta disposal is a safe, hygienic and conveniently-located facility.

However, in Nigeria, Water and Sanitation Monitoring Platform (*WSMP*) NIGERIA-Country Summary Sheet, 2008, noted that the proportion of the population in rural areas with access to improved sanitation increased by 3% from 22% in 1990 to 25% in 2006. The summary sheet noted that this represents some progress, but it is still very slow. For instance, Abogan (2014) did an appraisal of the existing sanitation technology in Nigeria. His study revealed that 25% of the households in rural areas use an improved toilet facility compared to 31% in urban areas. It further explained that among the rural households with improved toilet facilities, 4% use flush toilets (pipe sewer system, septic tank, or pit latrine), while 14% use ventilated improved pit (VIP) latrines and are more common in schools and 6% use pit latrine with slabs.

However, this is not the case in the rural borderland communities of South West Nigeria, where there are no toilet facilities in all the houses or few available schools and health centres. All the residents in the borderland communities in the study area practice open defecations. Most of the houses have reserved bush around them for defecating as shown in Figure 4. The implication of this is that bad sanitary practices cause air, food and water pollution which impacts health by causing diseases like diarrhoea, typhoid, cholera, amongst others. Another implication of open defecation, especially for women, girls and people with disabilities is that it leaves them with a sense of shame (Gnanakan et al., 2004). Also the lack of accessible sanitation facilities can be hazardous, especially in communities where women defecate at night.

Figure 4. Reserved bush around a house for defecating

Source: authors' fieldwork (2015)

4.5 Coping strategies for service deprivation in rural borderland communities

It has been shown above that borderland areas are the most deprived, even more so than communities inhabiting other rural areas. Nevertheless, members of the rural borderland communities of South-Western Nigeria, despite their lack of access to services, have managed to adapt to the situation. They have developed coping strategies to overcome unfavorable community problems. These strategies are discussed below.

4.5.1 Coping strategies for water accessibility

In many of the communities, most of the households get drinkable water from streams. 64.1% of the households explained that when they get their water from a stream, they just allow it to settle and filter it before drinking or using for other purposes; 31.9% boil theirs, while 3.9% put Allum before drinking or using water. Villagers believe that stream water is good for drinking. For instance, a man from one of the villages declared: *I don't drink from any other source than this stream because am used to it, I prefer it, and it is quite medicinal.* On the other hand, some households feel the water from streams is not drinkable and therefore they get their water from areas with wells and boreholes, which are usually very far away. For instance, a man that was interviewed lamented: *The same water we drink is where the Fulani herds men bring their cattle to drink water. To get drinkable water we go to communities with wells, we go very, very, early in the morning before the water becomes muddy.*

4.5.2 Coping strategies for healthcare accessibility

In areas where there are no healthcare centers or where the healthcare facilities are not in good condition, some of the households cross the border to the neighboring countries to access the healthcare facilities there. In the case of a critical or serious illness medical personnel or attendants from a neighboring country or a neighboring town (which usually lies very far away from a neighboring country) can be asked to treat the patient since the

community has no medical personnel at their disposal. In most cases, therefore, they will get drugs or medicaments from those that hawk around and, at some other times, will rely on herbs. For example, a woman who was cooking was interviewed, and it was noticed that she was boiling Mango, Guava and Orange leaves popularly called "Ewe Tii" in the Yoruba language. She explained: *The drink would be used with either Paracetamol or Novalgin for effectiveness and it is used in treating malaria or pile.* She was asked about the quantity to be used and she responded: *Half of a tea cup would be okay with just a cube of sugar!* This is problematic as there are no professionals in the village and there is no one to caution or query this approach.

4.5.3 Coping strategies for educational accessibility

In almost all the communities, there are no secondary schools and very few primary schools. In some of the communities, it is parents who contribute money to build classrooms for the primary schools which have already gone run-down. It is also parents who provide wells and employ more teachers since those provided by the government are not sufficient or are not available at all. The parents often complain: *There are no secondary schools in our communities! After our children finish their primary education, they go to a secondary school across the border or they go to distant towns and stay with relatives or friends for secondary education. Many of our children don't go further with their secondary education. We really wish we could have a secondary school in our village!*

4.5.4 Coping strategies for sanitation facilities

The majority of households reserve bush around their houses for defecation. Also the few available schools and healthcare centers in the communities do not have toilet facilities. The people go to nearby bushes to pass waste. Many of them have to wash their clothes in streams. The majority do their cooking outside in the open on cooking sticks. Their kitchens are located outside their homes.

5.0 CONCLUSION

This paper explored the service deprivation and coping strategies of rural borderland communities in South-Western Nigeria. In addressing the aim, the study examined how rural borderland communities are worse off than other non-borderland rural communities in terms of their access to services and also how the former cope with the lack of services.

Drawing on a study of communities along the border, it was discovered that rural borderland communities are evidently worse off in comparison with other rural communities. In other words, rural communities along Nigeria's national borders face greater service deprivation than other non-borderland rural communities. For instance, the majority of rural borderland inhabitants get their water from streams and walk 500 metres or more to collect water, defecate in the bush compared to many rural communities which are better off as regards accessing such amenities. The implication of this is that poor water supply and bad sanitary practices impact on health by causing water borne diseases like diarrhoea, typhoid, and cholera, amongst others. Bad sanitary practices also cause food, air and water pollution.

Also members of such communities often have to travel across the national border, even on a regular basis, to access basic needs. However, despite the lack of access to services, inhabitants of borderland have managed to adapt to the existing situation by developing coping strategies. For instance, water collected from a stream is made usable by boiling it or putting alum in it. Such water can also be left to settle or is filtered before it is drunk or used for other purposes. Also, inhabitants cross the border to the neighboring countries to access healthcare facilities or medical personnel residing there are called to render medical services during critical or serious illnesses, since they are not available in their own local areas. At some other times, members of borderland communities resort to using herbs or getting their medications from those that hawk around.

Development of the borderland areas in Nigeria is therefore very important and really urgent, especially in the light of neglect and the general under-development situation of these regions in the country. Geographic targeting in government-run developmental programmes and service delivery must be made a priority in necessary intervention. This implies that Nigeria's borderland areas must be made priority areas for urgent development and must be taken into account in major developments and service delivery plans in the country. The government, CBOs and NGOs should join forces to provide more facilities like public toilets, pipeborne water, healthcare facilities, and educational facilities in order to improve the quality of life. The government can also give incentives to educational and medical personnel to stay and work within rural borderland communities. Sensitization programmes, civic education, and shaping awareness of implications of bad sanitary practices should also be organized for the people and lastly, there should be enforcement of sanitation laws.

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Dostępność oraz korzystanie z usług przez wiejskie społeczności przygraniczne w południowo-zachodniej Nigerii

Streszczenie

Społeczności przygraniczne odgrywają strategiczną rolę w wielu krajach. Jednakże, pomimo tego faktu, wciąż aktualną, charakterystyczną cechą wielu z takich społeczności, szczególnie w Nigerii, jest zaniedbanie i niedorozwój. W oparciu o powyższy fakt zbadano poziom niedoboru usług i strategie radzenia sobie z nim przez społeczności przygraniczne w południowo-zachodniej Nigerii. Badanie wykazało, że większość mieszkańców obszarów wiejskich pogranicza (64,0%) zaopatruje się w wodę prosto ze strumieni i jest zmuszona do pokonania odległości 500 metrów lub więcej w celu zebrania wody. Podobnie większość z nich nie korzysta z toalet, lecz krzewów wokół swoich domów. Badanie pokazało również, że ludzie mogą regularnie przekraczać granice sąsiednich krajów, aby uzyskać dostęp do podstawowych usług, takich jak placówki opieki zdrowotnej. Jednocześnie, personel medyczny lub stażyści z sąsiednich krajów lub miast są wzywani w sytuacjach krytycznych lub poważnej chorobie, aby świadczyć usługi, których nie zapewnia rząd Nigerii. Rozwój obszarów przygranicznych Nigerii ma zatem ogromne znaczenie i musi stać się priorytetem w działaniach rozwojowych podjętych w tym kraju.