DISABILITY: A SOCIAL DISADVANTAGE AND ITS IMPACT ON HEALTH OUTCOMES IN NIGERIA

Ugochukwu A Eze[1,2]

[1]Department of Ophthalmology, Federal Medical Centre, Asaba Nigeria
[2]Department of Public Health, University of Suffolk, Ipswich, United Kingdom

Correspondence to: Ugochukwu A. Eze. Department of Ophthalmology, Federal Medical Centre, Asaba Nigeria. Email: ugorexeze@gmail.com, ugochukwu.eze@npmcn.edu.ng

Abstract

A global and national overview of the burden of disability as a source of social exclusion has been done. It is a diverse and complex entity that has a two-way causal relationship with poverty and negatively affects health outcomes. A wide gap in the knowledge of the health needs of people with disability was uncovered with recommendations made for better inclusion. In conclusion, the need for an intentional approach towards changing the disability narrative in our society is reiterated.

Introduction

The World Health Organization (WHO) defines disability as an interaction between a persons' health condition, his (her) personal and environmental factors.[1] It is a social disadvantage and acts as a barrier to equity in access to quality health care across the globe, and this has an undesirable impact on the health outcomes of people with disability (PWD) and that of their dependents. It is estimated that one billion people live with one form of disability or the other, and this accounts for about 15% of the world's population.[1] With the increasing number of the aging population and chronic diseases, it is expected that the number of PWD in addition to other health needs is on the rise too. Being an extremely diverse group of conditions, PWD have a particular group of health challenges unique to their respective conditions, they also have the same health care needs as everyone else. Their disability may also put them at an increased need for health care need as the general population. The diverse nature of disability is also seen in the fact that some conditions can lead to poor health outcomes and extensive health care needs while others do not. Also, the relationship between poverty and disability as social disadvantages and sources of social exclusion has an untoward combined effect in that either of them independently predisposes to the other and can also coexist leading to unacceptable health outcomes.

The WHO International Classification Functioning, Diseases and Health (ICF) categorized disability into three broad dimensions which are:[2]

1. Impairment – absence or significant difference in a person's body structure and function (including mental) such as loss of vision, memory, or limb and also chronic pain.
2. Activity limitation – related to performing tasks such as seeing, hearing, walking, and cognitive difficulty
3. Participation Restrictions – includes normal activities of daily living such as recreating, daily routine, seeking health care, and preventive services.

The disability may also be related to birth defects (which affect vision, cognition, mobility, hearing, and behaviour), Developmental defects (autism spectrum disorder, attention deficit hyperactivity disorder), Injury related (such as traumatic brain or spinal cord injury), and from chronic and

progressive conditions (such as diabetes that may lead to loss of vision, limb or nerve damage).[3] Visual impairment is considered to be the most common form of disability.[4]

Like every other individual, citizens living with disabilities have the rights to access quality and affordable health care. This is the spirit behind the concept of Universal Health Coverage (UHC). Article 25 of the United Nations Convention on the Rights of People with Disability (CRPD) summarizes the responsibility of the state and the health system to people living with disabilities:[5]

1. Provision of quality affordable health care as provided for the general population, especially as it affects sexual and reproductive health and other health programs.
2. Provision of those services is needed by PWD because early detection, and appropriate intervention, tends to contain the effects, especially among children and the elderly.
3. Make these services available and close to the communities of those in need.
4. Ensure availability of skilled health professionals to render quality and affordable health care for this group as with other members of the society.
5. Ensure equity in access of insurance to all without discrimination based on disability as stipulated by the law of the land.
6. Prohibit any form of discrimination or denial of any kind, be it health care or other essential services, food or fluid on account of disability.
7. This article aims at reviewing disability as a social disadvantage, source of social exclusion, and its impacts on health outcomes in Nigeria and make possible policy recommendations that will benefit people with disability (PWD) in Nigeria.

Discussion

According to the International Labour Organization (ILO), PWD are at constant risk of various discriminations which constitute barriers to participation in different community activities. These may be economic, social, political, cultural, and most disheartening, health inequity. Over half a billion people were then estimated to be living with disability and over 70% of this population are of working age but are more likely to earn less or even be unemployed compared to their non-disabled counterparts. This is even more among women.[6] The disabled are likely to be less skilled or less educated and work in an unprotected informal working environments. The effect of this exclusion from the labour force costs the economy and leads to a gross domestic product (GDP) loss to the tune of 3– 7% of the GDP.[7] As a result, the ILO recommends equal opportunity and mainstream inclusion for people living with a disability. (ILO, 2012)

A qualitative study in Brazil by Olivera et al,[8] suggested that about 20% of PWD are of low socioeconomic status. According to statistics from the American Center for Disease Control, 40% of people 65 years and above have some form of disability and live and live among social disadvantaged American Indian communities.[3] Also, adults with disabilities tend to be obese, smoke, have diabetes, and have heart disease in the proportion of 38.2%, 28.2%, 16.3%, and 11.5% respectively. Furthermore, this report showed that about 30% of adults with disabilities aged 18–44 years do not have a usual health care provider and have an unmet health care need in the past one year due to cost, while 25% of the same population did not have routine health check-up in the last one year.[3]

A 2018 WHO publication reported that the population of Nigerians living with a form of disability or the other stood at about 29 million which represents about 15% of the country's population.[9] Another data from a demographic health survey showed that 7% of household members' 5years or more and 9% of those 60years or greater have some degree of difficulty in a functional domain.[10] This rapid assessment survey also found that PWD lacked access to basic health

needs. The prevalence rates were found to be roughly the same among male and female participants. A large population-based study in central Nigeria detailed the socio-demographic profile of PWD and causes of disability among participants living in Niger and Kogi states.[11] About 30% of the population were less than 21yearsold and had no form of occupation, while 16.3% and 13.6% were involved in begging and students respectively. Other types of gainful employment include farming (10.7%), trading (10.7%), civil service (6.5%), full-time housewife (4.6%), skilled artisan (tailors, carpenter, labourers, mechanics, and blacksmiths), and unspecified respectively accounted for 3.5% and 3.3% of the study population.[11] The essence of this detailed breakdown of these occupations was to highlight that majority of PWD are willing and able to engage in gainful economic ventures as seen in 55% of this population in central Nigeria. With over half of the population gainfully engaged in a sub-optimal setting, when provided with an environment that guarantees full social inclusion, this group of citizens will perform almost at par with the general population and meaningfully contribute to national development and world economy. This collaborates with the ILO publication.[6] Other important social-demographic characteristics of this population were the average monthly income and priority needs. This showed that despite their economic activities, a majority still live in poverty. Though health and rehabilitation ranked low among their priority need, other highly ranked priorities such as food, clothing, accommodation, and education had a direct impact on their health outcomes.

In Nigeria, access to health care remains an issue due to her inability to attain universal health coverage due to a poorly developed health financing system. This naturally excludes PWD due to its various inherent disadvantages. The effect of this is a worsening health outcome among this group of people.

Evidence exists that people with disability are at higher risk of ill health and long term morbidities than the general population.[12,13]

Unique health needs of PWD may be categorized as those as a result of a causal link with the primary disability such as the increased risk of respiratory and urinary tract infections and bedsores in people with spinal injury or stroke. Coexistence of blindness from retinopathy and renal disease in poorly controlled diabetes.[14]

1. Comorbidity – PWD are prone to psychosocial morbidities by 2-3 folds. This predisposes them to poor self-care and adherence. The latter can be either due to the behavioural issue or frank physical inability to comply due to the existing condition. Examples of such include the inability to exercise due to physical mobility restrictions, or forgetfulness from dementia especially in the elderly. As a result, early mortality from manageable conditions like obesity with its attendant respiratory and cardiovascular risk.[15]

2. Those that occur due to non-compliant environments – for PWD, a lot depends on the environmental configuration.[16] The absence of a staircase well adapted to suit their need or road furniture can lead to psychological trauma. Inability to withdraw funds from an automated teller machine by the visually disabled person due to the lack of Braille characters can cause untold emotional trauma especially when it has to do with funds needed to meet a pressing need. Another example is the sense of exclusion felt by a deaf conference participant if the organizers fail to make plans for an interpreter for the hearing impaired.

Some studies suggest that PWD still have unmet needs irrespective of documented gains made in ensuring equity in access to health services. Sanmatrin et al[17] confirmed that despite the obvious improvements, about 50% of persons still fail to receive routine care due to certain unmet access domains such as:

1. Long waiting time due to human resource shortage from non-availability or lopsided distribution.

2. Configuration of stirs, doorways, examination tables, and equipment to suit their needs.
3. Attitude of personnel
4. The dearth of expertise on natural course and special considerations associated with certain disabilities.
5. Insurance-related unmet needs such as dysfunctional social insurance packages, restriction of coverage for certain conditions, and need for co-payments.[18-20] Whereas unmet need has been estimated at 3% in the general populations, it is up to 30–40% in certain groups like children with special needs, people with mental conditions, and the elderly.[18,21-23] These needs and burdens when unmet can have a negative impact on the quality of life in addition to the trauma of adapting to the disability-adjusted life years (DALY) lost.

The online literature search and reviews conducted exposed a huge knowledge gap on issues related to the health care needs of disabled members of Nigerian society. From this, one can extrapolate that disability-related issues in Nigeria appear not to be encouraging. Having a basic knowledge of the burden of a problem is the first committed step for any reasonable planning and efforts targeted at solving this problem. The unmet need of people in Canada earlier highlighted is a reflection a society that made tangible efforts towards improving the lots of their disabled citizens from the policy end. Though we appear not to have data, it is only expected that the met needs will be infinitesimal compared to unmet.

In Nigeria, efforts aimed at enhancing the level of social protection for people with the recent accent of the Discrimination against People with Disability Prohibition Act, and some entrepreneurial skill training for PWD, the narrative needs to be taken beyond the usual rhetoric. This law is yet to reduce the various forms of exclusion against these special citizens nor has it provided real protection for them.[24]

Going forward, this work will make a few policy recommendations expected to put Nigeria on a better pedestal towards creating a disability-friendly society.

Recommendation/Implications

The United Nations Sustainable Development Goal 10 aims at reducing inequality, improving social inclusiveness while Goal 11 aims at creating a conducive and sustainable environment for PWD. Also, Goals 4 and 8 center on education and empowerment for vulnerable groups.[25]

1. There is an urgent need for those involved in the care of PWD to plan and conduct a widespread situation analysis on the health needs of people with disabilities in Nigeria. This is the only way we can appreciate the enormous amount of work that lies ahead if we are to make any meaningful gain in improving the health outcome of this group of people in our society. This should include a comprehensive profile of PWD, with periodic updates.
2. In these days of interest in Universal Health Coverage, issues of vulnerable members of society should be at the forefront. There should be intense advocacy that PWD will benefit from the non-contributory schemes especially for those who cannot afford to make contributions. This is why profiling is important. Judicious utilization of donor funds and special tax intervention will find a place here.
3. We need to be intentional at promoting disability rights in our society. This should be a purposeful departure from the usual political and conference rhetoric. They should have representations at these pressure groups, and the advocacies should center on involving them in issues that concern them and encouraging them holistically to come out and get involved in decision making.
4. The need for global partnerships cannot be over-emphasized. However, for this to succeed, individual governments do what is required of them by creating a conducive platform upon which some of the partnerships can function. Some degree of local investments need to be on the ground before

considering invitations or soliciting help from other nations and donor agencies.

5. The orientation and perception of Nigerians need to change on issues of disability. There is a need for more empathy as regards disability. This will go a long way in reducing discrimination and improving protection for PWD.
6. Training of health manpower should include making provisions for requisite skills that will meet the needs of our PWD. Health workers need to become interested in certain communication skills such as sign language and a host of others.
7. Nigeria as a member of the United Nations is party to several treaties targeted at achieving disability-related SDGs, and as such should live up to her billing in this area.
8. From the policy aspect, Nigeria needs to ensure proper implementation of provisions of extant laws such as the disability-related aspect of the 2014 National Health Act and Discrimination against People with Disability Prohibition Act 2018.[26,27]
9. In town planning, public places and utilities should be furnished with disability-friendly amenities to enhance the interaction of PWD with the environment and even protect them from avoidable injuries.
10. The role of professional and civil society groups in achieving the above recommendations through purposeful advocacies cannot be over-emphasized, and this will go a long way in alleviating the plight of PWD.

In conclusion, this review has reiterated the diverse and common nature of the disability and its negative effect on health-related quality of life of PWDs. Issues of inequity and poor access have complicated the plight of PWD. Also, there is a wide gap in knowledge of the health needs of PWD in Nigeria, and this translates to a high burden of unmet health needs. Finally, all stakeholders should be intentional in their efforts aimed at improving the quality of life of PWD.

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