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FUNDAMENTAL CAUSES OF HEALTH ISSUES AND CONSEQUENCES OF MARGINALISATION OF SEVERAL COMMUNITIES IN SOUTHEAST, NIGERIA

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ABSTRACT

This study investigates the root causes of health issues and the consequences of marginalisation of several communities in Southeast, Nigeria. It analyzes the socio-economic determinants, cultural beliefs, and institutional inequalities that lead to health disparities in several communities. Qualitative ethnographic research design was applied, involving semi-structured interviews and observation of rural and urban dwellers of several communities in southeast, Nigeria. It aimed to capture variable lived experiences and health practices within the community. Findings revealed that several communities are significantly affected by socio-economic disadvantages and various forms of marginalisation. These resulted in high rates of child and maternal death, as well as widespread of infectious diseases such as malaria and tuberculosis. The health infrastructure in these societies is very weak with poor access to medical facilities, professional treatment, and availability of essential drugs. Therefore, most tend to postpone preventive actions until cases become serious. The study highlights the deep-rooted health inequalities faced by a majority of the population in these communities due to socio-economic and systemic factors. It presents a rich insight into how the population copes with healthcare difficulty and shows that their coping strategy is guided by their structural and environmental realities. Targeted policy interventions and investment in culturally tailored healthcare institutions are needed to address these inequalities.

KEYWORDS: Health Issues, Marginalisation, Socio-economic, Southeast, Nigeria.

1. INTRODUCTION

Nigeria, with a population of over 200 million people, is still afflicted by profound health issues rooted in underdevelopment and structural inequality. Nigeria, as much as it is the most populous nation in Africa, remains to this day a country with poor health performance. The people in these communities possess a rich cultural heritage that is marked by a strong emphasis on traditional norms and beliefs. There are three levels of healthcare in Nigeria: primary, secondary and tertiary.

In rural areas, primary health care is the foundation of the health care system but is underfinanced and inadequately resourced (Nwokoro et.al., 2022). Women have been said to play significant roles in contributing to determinants of availability and quality of prenatal care services within their localities (Ozumba et al., 2018). Mothers in urban areas have greater access and education also plays a role in access to improved antenatal care services (Ozumba et al., 2018). Nigeria carries an enormous health burden, with high maternal and infant mortality, repeated infectious disease outbreaks and rising rates of non-communicable diseases (Ezeanolue et al., 2018). The nation is also facing a high rate of mother-to-child HIV transmission. Many of the population are below the poverty line, with an income of less than \$400 per year (Ezeanolue et al., 2018). Southeast, Nigeria, has long faced marginalisation on various reasons that involve political marginalisation and economic disparity. The history of the Biafran War in the area and the resulting neglect have fueled the sense of marginalisation and limited access to resources, hence enriching health inequalities within the population.

The marginalization is also evident in the unequal access to healthcare, education and economic empowerment among both men and women in the area. Fixing these enduring problems requires commitment towards equality, regarding health equity as a global human right, and actively opposing structural violence and institutional discrimination driving the inequalities (Qoseem et al., 2024). Discriminatory access to public services aggravates the underlying issue (Uzochukwu et al., 2020). These all cumulatively provide a unique vulnerability in terms of health. Environmental and socio-cultural interaction plays a big role in the adoption process of children in several communities in Southeast, where adopted children struggle to get full acceptance in some parts of society in the Southeast due to traditional customs, cultural beliefs

as well as values (Nwoga, 2013). The situation could have long-term effects on the overall health and well-being of adopted children. Underdevelopment and marginalization together create a range of health risks. One of the most important indicators of underdevelopment and poverty severely limits access to food, clean water and health care (Iwundu, 2017). The higher rates of non-employment and underemployment aggravate this condition, as they greatly impact the use of health insurance and the overall cost of health care services. These economic determinants selectively impact disadvantageous groups and thus aggravate already existing health inequalities. Severe poverty, rates of high illiteracy, economic dependency, and low technical innovation define Nigeria's situation (Awofeso and Odeyemi, 2014). Undeniably, the sociocultural aspects have a great impact. Traditional beliefs, gender inequality and biased practices have a great impact on health-seeking behavior and treatment access. Occupational gender inequality limits women's contribution to overall well-being and advancement (Okafor et al., 2007). This is often prevalent among women who experience marginalization and segregation, and limitations that deter them from engagement and achievement in power dynamics (Taiwo, 2019). Health outcomes are significantly compromised by the unequal distribution of resources, discrimination in public services and widespread corruption. Corrupt politicians lead to the misallocation of public funds meant for economic development in important sectors such as health and education (Awofeso and Odeyemi, 2014). Medical underdevelopment is a phenomenon closely related to the larger background of economic underdevelopment (Alubo, 1985). The marginalisation related to mental health problems aggravates the situation; people with mental diseases may not seek help because of fears about social isolation or prejudice (Adesuwa et al., 2015). This marginalisation promotes cycles of untreated disease and results in a lack of understanding of the mental health options available in societies. People also run across difficulties obtaining medical records, inadequate emergency service responses, and segregation inside healthcare institutions and during delivery (Schaaf, 2010).

Moreover, individuals living in rural areas are often excluded from basic healthcare services, making it difficult for them to access quality medical care. This leads to an overreliance on emergency services, which in turn compromises their overall health and well-being (Bobakova et al., 2015). Health challenges in Southeast, Nigeria are largely driven by environmental factors. Rapid urban growth has

increased pollution from poorly regulated industrial activities (Yemi et al., 2018), while inadequate waste management has raised the risk of diseases like malaria and cholera. According to research by (Ogonna et al., 2022), just twenty percent of rural healthcare institutions are functioning and appropriately staffed. Lack of trained healthcare experts, declining infrastructure, and inadequate financial resources given to the healthcare system aggravate the present situation. The imposition of user fees, often paid out-of-pocket, creates a significant barrier to accessing essential services (Onwujekwe et al., 2011). Nonetheless, we seek to explore the ramifications for informants' perspectives and actions in addressing health issues. Expanding upon this foundation, we delve deeper into the outcome of marginalisation within the health domain on behaviours and decision-making related to health issues, posing the question: What strategies do informants employ in response to enduring health care disadvantages? In what ways does ongoing marginalisation influence the formulation of both adaptive and maladaptive plans among informants? What elements determine the degree to which these strategies are characterised as proactive or passive, and in what ways do these strategies differ across contexts with varying degrees of marginalisation? Considering the preceding discussion, we propose the following hypothesis: The ongoing marginalisation of ethnic groups fosters the emergence of a range of coping strategies, both adaptive and maladaptive in nature. Our objective is to comprehend the ways in which the community in Southeast, Nigeria engages with these experiences and to illuminate their strategies for coping amidst marginalisation. This understanding has the potential to enhance access to dignified and fair health care services for the population in Southeast, Nigeria. The analysis further explores marginalisation and its associated health consequences, framing it as an overarching concept that encompasses discrimination and racism (Hatzenbuehler et al., 2013).

1.1 Marginalisation and how it affects the Health of Several Communities in Southeast

Marginalisation, shaped by the complex interplay of social, economic, and political factors, has a profound impact on the health and well-being of individuals within a society (Nsoedo, 2019, Uzochukwu et al., 2020). Southeast Nigeria, despite its rich cultural legacy, faces marginalisation rooted in a complex historical narrative, resulting in significant health inequalities across region (Baah et

al., 2018). The term "marginalisation" refers to the social, economic and political exclusion faced by the people in these communities, which exacerbates their vulnerabilities and limits their access to essential resources, including healthcare (Nurmatoy et al., 2014). Understanding the fundamental origins of health challenges and their implications for marginalisation is crucial for developing effective interventions and policies that promote health equity and improve the well-being of the population in these communities (Marrone, 2007). It is important to have a thorough plan that considers the unique social, economic, and cultural elements causing health differences in underdeveloped areas like the southeast (Rice, et al., 2018). This exclusion typically results from unequal power relations in social groups, therefore impeding access to basic resources and opportunities required for health and well-being (Baah et al., 2018, Sevelius et al., 2020). Conditions that marginalise people rather than their innate traits cause the establishment and continuation of inequality; this results in an asymmetrical burden of social dissatisfaction and ill health (Browne et al., 2012).

In several communities in southeast, a range of factors, including gender inequality, financial differences and cultural traditions, greatly affect the marginalisation of communities. Their health-seeking behaviours, access to treatment and general health outcomes all suffer greatly from this marginalisation. Like many other areas of Nigeria, southeast Nigeria faces significant health issues, including a high incidence of infectious illnesses, a load of chronic diseases, and high rates of mother and newborn mortality (Ezeanolue et al., 2018). But these difficulties are not equally distributed across the population, as poor groups suffer a disproportionate quantity of diseases and a lower quality of life (Thresia et al., 2020). Unequal access to healthcare facilities and resources often aggravates health inequalities in southeast Nigeria, leading to differences in health status and determinants among several demographic groups (Qoseem et al., 2024). The complex issue of health inequalities in various civilisations and countries calls for thorough awareness of the local causes of these variations and the development of remedies to properly address them. Health inequalities in southeast Nigeria are clear in several spheres, including socioeconomic level, and rural and urban populations, as well as in terms of particularly disadvantaged populations regularly find it difficult to get first-rate treatment (Banaag et al., 2019). Just a small fraction of the population has health insurance; most of the overall

health expenditure is paid out of pocket (Fayehun et al., 2022). The prevalent cultural ideas on the origins of diseases and their inclination for traditional healers greatly affect the ways people seek conventional medical treatment prenatal care and delivery (Fayehun et al., 2022). Historical and modern disparities that provide major obstacles to healthcare access help maintain health inequalities (Jindal et al., 2023). Postnatal care and services help aggravate the health differences in Southeast Nigeria (Usman et al., 2013).

1.2 Root Causes and Consequences of Health Issue in Several Communities in Southeast, Nigeria

To adequately oppose the health challenges stemming from marginalisation in Southeast, Nigeria, it is essential to discern and address the fundamental causes of these inequities. This entails advocating for inclusive governance, guaranteeing fair distribution of resources, and addressing discriminatory practices across all societal levels. Investing in public health infrastructure, job creation and education in marginalised communities is crucial to mitigate the negative consequences of neglect and to improve overall health outcomes (Reed and Mberu, 2014). Also, promoting health literacy, improving access to healthcare and addressing social determinants of health interventions are essential for reducing health disparities in marginalised communities. Nwaka (2015) in his article states that while promoting inclusive urban environments by reassessing discriminatory legislation and regulations that hinder access to affordable land, healthcare, and housing is the main policy challenge that involves effectively engaging impoverished populations and reducing disparities in healthcare access. Supportive environments through the implementation of inclusive programs, policies and equitable strategies should be provided by government. This involves prioritising initiatives and improving financial investments to address equity gaps (Temitope et al., 2024). To reduce barriers to healthcare access, particularly in remote rural areas, it requires dialogue with communities and the development of policies. To ensure genuine access to health services (Bernal et al., 2024), it is essential to develop strategies that prevent the marginalisation of communities and alleviate poverty (Nyarko and Tahiru, 2018). To promote a more equitable and healthier society for all, particularly for marginalised groups like the people in these communities in Nigeria, it is important to implement a

comprehensive strategy addressing root causes of marginalization (Chelak and Chakole, 2023, Mapping disparities in education across low- and middle-income countries, 2019, Oluduro and Durojaye, 2013). The negative effect of marginalisation on health issues in communities in the Southeast, Nigeria require a comprehensive and detailed approach, necessitating political commitment, resource allocation, and community engagement. Developing strategic plans action to enhance healthcare accessibility in rural areas (Mangundu et al., 2023) is very important in involvement of professional nurses, healthcare users, national health directors, and members of parliament.

1.3 Fundamental Cause Theory and Health

Fundamental cause theory (FCT), introduced by (Phelan and Link, 1995) in medical sociology, emphasises the significance of social determinants in health access. FCT has predominantly been utilised within the U.S. context, where discrimination targets the black demographic. We recognise the distinctions and the infeasibility of establishing direct comparisons between marginalised groups in the USA and people in these communities in Nigeria. Nonetheless, we assert that the application of FCT is feasible to a certain degree in the analysis of significant aspects from a marginalised group in Nigeria. Socioeconomic status (SES) significantly influences health outcomes. Individuals with lower socioeconomic status typically encounter inferior health outcomes and reduced life expectancy (Hatzenbuehler et al., 2013, Phelan and Link, 2013). Elevated socioeconomic status correlates with an array of advantages beyond mere financial assets, encompassing education, influence, prestige, and social connections. Increased resources enable individuals to make superior decisions, including selecting their residence, acquiring nutritious food, participating in preventive practices through schooling, and steering clear detrimental substances. The theory asserts a stable and persistent correlation between socioeconomic status and health (Phelan and Link, 2013). The idea posits that socioeconomic status is a primary determinant affecting diverse health outcomes. The principal notion, Fundamental Cause, is characterised by a collection of adaptable resources that various social groups possess to varying extents. The adaptability of resources is shown in their ability to yield varied outputs in diverse contexts and through distinct interrelations. Historically, differences among social groups were more evident due to the proliferation of infectious

diseases stemming from substandard living circumstances, unsanitary environments, insufficient sanitation, and inadequate nutrition.

However, improved living conditions and medical care have resulted in the elimination or significant decline of certain illnesses, including typhoid fever, cholera, Tuberculosis (TB), and mumps. Phelan and Link (2013) contend that this did not improve overall health or universal access to quality healthcare. Presently, access to healthcare differs significantly between countries, leading to disparities in health outcomes across socioeconomic classes. Freese and Luftey (2010) investigate four fundamental frameworks that influence health. The first is Means, referring to the economic resources that individuals utilize to deliberately improve their health. The second is Spillovers, denoting the advantageous effects arising from social networks and the impact of an individual's health. For instance, if members of an individual's social network invest their money in health improvements, it can positively affect the individual without necessitating direct involvement. The third is Habit, denoting the norms, attitudes, or lifestyles that vary among people of different socioeconomic statuses (SES). Unlike Means, habits are unintentionally formed by individuals. Nevertheless, it influences their choices, leading to potential health benefits. The fourth framework relates to actions taking place within institutions. It includes healthcare institutions and other organizations that cater to people with varying socioeconomic backgrounds in different ways. In several communities in Southeast, providing these means plays a significant role in clan support networks. For example, extended family members can assist financially to help cover expenses of medical facilities or healthcare access services. Also, sharing knowledge about health care within the community can lead to improved health practices. Traditional knowledge shared by elders about nutrition and prevention of diseases can significantly improve community health. In communities in the Southeast, the health-related knowledge or the benefit derived from one person's healthcare access often extends beyond the individual to their family and broader community. For instance, when a sick person receives effective treatment for a chronic illness due to financial assistance from relatives, this support can inspire others within the community to seek similar care.

Furthermore, communal events like traditional gathering platforms can facilitate the sharing of health management experiences and information. Such activities will encourage collective learning on

health preventive measures and treatment within the community. Notwithstanding alterations in circumstances (political, historical, or medical advancements), numerous inequalities endure since some underlying causes remain intact despite these changes. Eradicating socioeconomic status disparities may not eradicate health inequalities, as certain determinants of health disadvantage are anchored in issues outside socioeconomic status. This understanding emphasises the significant effect of marginalisation on health and stresses the necessity of directly tackling marginalisation to attain equitable health outcomes.

2. METHOD

The ethnographical data for this survey was gathered throughout the dry season of 2024, supplemented by further information from the previous years. The selection of the site was significantly influenced by earlier research phases conducted by the first author within the communities in Southeast, Nigeria. Having consistently frequented the informants' residences since 2022, when she initiated her early research in the area, she had cultivated a sense of trust among them throughout this period. Prior to that point, the informants had grown accustomed to interactions with individuals, from the majority occurring only in essential circumstances, with such visits predominantly restricted to the activities of field social workers representing the local authority. However, ultimately, none of the informants expressed any reluctance in engaging openly with the researcher regarding the pertinent subject or in extending an invitation to her residence. Consequently, additional interviews were conducted in the informants' residences and within their natural surroundings. Moreover, while the informants initially perceived the first author, particularly during the first phases of the research, as a potential source of assistance, anticipating that her position as a member of the majority could facilitate improvements in their circumstances through engagement with pertinent institutions and local government officials. The informants regarded the initial author's contributions to the community favourably, valuing the sincere interest demonstrated in their lives and local culture. The subjects of the study were residents of a segregated community located in a smaller district town in Southeast, Nigeria. The settlement constitutes one of the officially recognised concentrations, with certain residents residing interspersed among the predominant population within the town.

The researcher concentrated on a distinct rural area in Southeast Nigeria, comprising 500 residents. The selected segregated locality was primarily favoured due to its enhanced accessibility for residents, who are more densely populated compared to other regions within the urban centre, where individuals reside separately in distinct apartments among the larger population. This observation proved to be especially advantageous during the initial stages of the investigation. The opportunity to conduct the initial interviews in an impartial setting facilitated the essential process of establishing trust with the residents. Consequently, the initial invitations and visits to the informants' residences occurred subsequently. In the year 2024, the sample comprised 200 informants, ranging in age from 18 to 70, with a distribution of 80 males and 120 females were selected from the total population of 500 residents using purposive sampling. Nevertheless, due to the first author's enduring engagement within the community, the quantity of individuals with whom she has engaged, both formally and informally, is markedly greater. The sample encompassed individuals who had temporarily departed from the locality to pursue employment opportunities abroad yet subsequently returning to the area after a certain duration. Observing the viewpoints of this group of informants was beneficial to our research, both for the increased diversity of the sample and for the final findings drawn. This data offered substantial insights into the influence of the environment on the informants' habitation. The researcher, additionally, engaged with a selected group of individuals who have departed from the area and now reside within the predominant community of the town.

A multitude of adverse experiences, some

culminating in tragic outcomes, remained too vivid for many individuals to recount, thereby preventing them from emotionally re-experiencing those distressing moments. The researcher was cautious to disclose these challenging experiences, mindful of the potential distress it might cause the informants. It is acknowledged that this method of sampling presents certain constraints. The foundation comprised a limited group of informants, specifically those engaged in semi-structured ethnographic interviews. Several informal interviews were carried out and were not documented. Through consistent presence in the locality over an extended period, the first author engaged in numerous spontaneous interactions with informants. Her long-standing presence in the community and deep understanding of the residents' challenges, extending beyond health concerns, supports the view that the citations used in the text effectively reflect the insights of both unnamed informants and other community members. The ethnographic data comprised of interviews, a field diary, and assorted field notes, facilitating the development of the conclusions shown below. Interviews with informants were carried out in individual families, sometimes in the company of other family members and usually within two-generation family structures. Although each informant was the central subject of their interview, the narratives were enhanced by contributions from other relatives who offered more insights and explanations. The study comprised interviews with twenty healthcare professionals, including a 32-year-old emergency care worker from the local clinic, a 55-year-old hospital care worker, a specialist from the Ear, Nose and Throat (ENT) clinic, and personnel from a nearby hospital.

Table 1. Informants from Several Communities in Southeast.

Gender	Men	80
	Women	120
Age	18–46	110 Informants
	46–70	90 Informants
Area	All informants originated from a singular, excluded segregated community, although some lived in a different part of the city or briefly worked overseas throughout the research time.	
Education	Primary School Level	100 Informants

	Secondary School Level	70 Informants
	Higher Education	30 Informants
Personal practical knowledge with hospitalisation at a local medical facility	20 Informants	
Personal practical knowledge of marginalisation in healthcare	16 Informants	
Population with long-term health conditions and/or chronic illnesses	12 Informants	
Frequency of informants consulting specialist physicians	7 Informants	
Health Professionals (who encounter patients from these communities with varying levels)		
Sex	Male	11
	Female	9
Age	35-60	
Place of employment	Regional medical facility	6 Informants
	Emergency medical personnel from the fast response unit	9 Informants
Duration of work experience	First-contact rescue doctors	5 Informants

In terms of infrastructure, the area is not equipped with all essential utilities. Nevertheless, certain residents encountered challenges regarding their access to drinking water and electricity, attributable to persistent unresolved liabilities. The informants were categorised into three distinct groups according to their educational levels. The older respondents successfully concluded their elementary education throughout the study, whereas the youthful respondents had recently attained completion of their secondary and higher education. Consequently, the findings presented here may not comprehensively reflect the circumstances of households in other marginalised community settlements in the Southeast, which may possess distinct social conditions and infrastructure. The assessments were conducted in the local language. Semi-structured interviews and participant observation were implemented as qualitative ethnographic methodologies. The interviews were documented in audio format and subsequently transcribed into a final written document. The lead author did not observe any active healthcare delivery, medicine, or assessment intervention during the stay that would support any hindrance experienced by most health workers.

Nevertheless, she found herself in numerous contexts where the informants engaged in spontaneous discussions regarding health matters, navigated decisions concerning treatment, and confronted various dilemmas that ultimately led to choices such as opting against receiving treatment, among others. During the preliminary phases of the investigation, the lead author undertook exploratory research to discern the factors that shaped informants' choices regarding the utilisation of healthcare services, drawing from their past experiences. The central inquiry of the research examined the extent to which individuals' encounters with illnesses shaped their choices regarding the pursuit of healthcare services. Furthermore, the research examined how the experiences of others within the community influenced the informants' perceptions. The study further explored possible variations in decision-making across various age demographics and other pertinent factors. The research enquiries were specifically designed to focus on health issues due to marginalisation that the informants had personally encountered or referenced in their narratives, rather than enquiring about their relationship with all existing ailments. The objective was to undertake a

comprehensive retrospective analysis of the complete course of the illness, irrespective of its acuteness or classification. The focus was on delineating knowledge and encapsulating the localised viewpoint of those knowledges, rather than collecting broad attitudes. Participants were requested to articulate their responses when confronted with health issues, the efficacy of those responses, the rationale behind any shortcomings in effectiveness, and the individuals they sought for assistance. The cohort of informants engaged in semi-structured interviews is of moderate size, and the participant observations were specifically directed towards the interactions occurring between the population in these communities and healthcare practitioners. Consequently, this serves as a delineation of the health care practical knowledge as perceived by the people in these communities.

Conversely, the consistent engagement with the local regions and the diverse circumstances in which the primary author was actively involved contribute to a deeper comprehension of their health-related choices, often surpassing the insights gained from direct narratives. The analysis of the data was conducted through thematic exploration employing a multilevel coding methodology. At the outset, thematic categories were established and subjected to iterative comparisons with one another. The examination subsequently advanced to discerning connections among these classifications and formulating a cohesive narrative elucidating the categories that had been previously delineated. The subsequent phase entailed a comparative analysis of the data gathered from interviews alongside the records of participant observation. Conclusions that emerged from this process were articulated. Variations from the conceptual supposition observed were explained by examining the context of data collection. This examination enabled the evaluation of the research objectives and assessed the effectiveness of the addressed research questions.

2.1 Experience of the Communities in Southeast and Healthcare Services

The residents of communities in the Southeast in various localities encounter numerous circumstances in which, from their perspective, they perceive a lack of sufficient health care provision. Their assertions indicate a recognition of the numerous marginalising stereotypes linked to their geographical context. This association frequently presented itself as a denial of medical rights, which, according to the informants, were specifically denied based on their geographical location. In this context, the notion exists that a

significant portion of the populace typically does not confront the challenges that they face. The emergency care providers' identification of the place was considered a clear signal and marker of the caller's identity, indicating ethnicity, since only the people in these communities live in the region. Health practitioners explained the missing medical visits among the community in the Southeast by recalling past unpleasant experiences with interventions they felt were unnecessary and not immediately life-threatening. The experiences of the population in these communities with healthcare services are intricate, influenced by a diverse array of socioeconomic conditions, infrastructural challenges, and cultural subtleties. A significant portion of the population faces economic constraints that impede access to quality healthcare, illustrating a broader issue in Nigeria, where a considerable percentage of citizens live below the poverty line (Freese and Luftey, 2010). This economic instability often compels individuals to prioritise their basic needs over healthcare, resulting in delayed treatment and, consequently, poorer health outcomes. The healthcare framework in Southeast Nigeria, while attempting to meet community needs, faces challenges such as inadequate personnel, limited access to essential medications, and outdated equipment. The uneven distribution of healthcare resources exacerbates the inadequacies in infrastructure, often leaving rural areas with fewer services than urban centres. Consequently, individuals residing in isolated communities encounter significant challenges in accessing timely and appropriate medical care, potentially leading to preventable complications and fatalities. The accessibility of healthcare services is greatly affected by the substantial distances between villages and health facilities, as well as the high costs associated with transportation. This circumstance drives certain individuals to seek help from traditional healers (Freese and Luftey, 2010).

In different rural areas in Southeast Nigeria, traditional healers and spiritualists often serve as the primary source of support for many individuals, particularly due to limited access to modern medical attention. The preference for traditional medicine stems from a combination of factors, including cultural beliefs, perceived cost-effectiveness, and the assumed effectiveness of conventional treatments for health concerns. This reliance on conventional medicine may sometimes delay or discourage individuals from seeking timely medical attention from qualified healthcare professionals, potentially leading to adverse health outcomes. A significant

portion of the population in Southeast Nigeria relies on direct payments for healthcare needs, indicating a low uptake of health insurance programs in the region (Ogben and Ilesanmi, 2018). The dependence on out-of-pocket expenditure generates a considerable financial burden for many households, particularly those with restricted incomes, which may discourage them from seeking necessary medical care (Sirag and Mohamed, 2021). More than 70% of total health expenditures are directly incurred by individuals, with only one in twenty having health insurance (Fayehun *et al.*, 2022). The intersection of poverty, inadequate public health systems, and high costs of private healthcare has prompted a considerable portion of urban and especially rural populations to turn to traditional medicine (Mbah *et al.*, 2019). Telemedicine has been proposed as a solution to healthcare disparities; however, these initiatives have achieved only limited success (Adewale, 2004). Telemedicine offers a substantial opportunity to improve healthcare accessibility in remote areas. However, its implementation in Southeast, Nigeria faces challenges such as inadequate internet connectivity, a lack of digital literacy among the population, and the need for extensive training for healthcare providers in the use of telemedicine technologies. The way elderly individuals in Nigeria seek medical attention is influenced by financial limitations and educational attainment, which points to the need for targeted interventions to improve their access to care (Atchessi *et al.*, 2018). Efforts to improve healthcare accessibility in Southeast, Nigeria should consider the essential socioeconomic factors that contribute to health disparities (Audu *et al.*, 2014). It was noted that the residents of Igbos in that area would deliberately postpone seeking emergency medical assistance until after the standard office hours of physicians had concluded, asserting that their health issues had arisen abruptly. An emergency care worker recounted that, throughout his nine years of service, merely 15% of the calls received in the locality were truly warranted.

He observed that informants often overlooked chronic health issues for a span of 25 to 35 years, resorting to emergency measures only at the eleventh hour. This postponement frequently led to a deterioration in their standard of living, which could

not be entirely reverted to their previous condition. Professional health workers elucidated that the inclination of the population in these communities towards consulting a chemist instead of a conventional medical practitioner was shaped by a multitude of factors. The factors encompassed financial constraints, mindset, convenience, and the absence of alternative options. The individuals highlighted that the communities in the Southeast in the vicinity frequently lacked the financial means for taxi transportation, also, did not have an emergency response conveniently located within walking distance, rendering the procurement of medications from the chemist a more accessible alternative for them. Following numerous instances where medical services failed to respond to the locality despite persistent appeals, the residents devised a proactive approach by independently visiting the nearby traditional healer to advocate for sufficient medical care in this manner. Our research provides an illustrative instance in which an informant's family sought medical assistance for a suspected stroke. After the medical practitioner failed to arrive even after the fourth request, the family opted to consult a traditional healer. Within this framework, the participants underscored the inadequate treatment afforded to all patients universally. Their observations revealed no disparities in access related to ethnicity; rather, they highlighted the indifferent conduct of the hospital personnel, the previously mentioned substandard quality of treatment, and the insufficient qualifications and expertise of the medical practitioners. In this regard, numerous communities in Southeast, Nigeria, as observed in our investigation, rationalised their subsequent decisions to support a reversal and stop hospitalisation at their own risk. The transmission of representations across generations significantly impacts the perspectives of other informants, potentially leading to considerable discouragement regarding the use of local hospital services, even among those who have neither encountered such experiences nor faced any adverse situations there. The prevailing sense of insecurity among residents, coupled with pervasive malaise within the community, has inevitably manifested in the ongoing challenges faced by health professionals dedicated to serving marginalised Igbo populations.

Table 2. Review of Communities in Southeast: Practical Knowledge and Locality Strategies.

Determinants of Marginalisation	Manifestation of Marginalization in application	Consequences
Locality	Refused access to hospital facilities	Attending the emergency room independently

Ethnicity	Spatial segregation within distinct wards in a local hospital	Strengthening marginalisation
Health professionals' general impressions, attitudes, and stereotypes about patients from these communities	Negative remarks from paramedics, coupled with a condescending and authoritative demeanour exhibited by paramedics and physicians at the local hospital.	The informants exhibit a sceptical attitude regarding the utilisation of health care services.
The absence of support from the majority	Protecting informants by withholding certain types of information from community residents in good faith.	Decline in engagement with information that may reinforce feelings of marginalisation
		Avoiding the consideration regarding the effects on the self-image and impression of oneself of the residents
	The stress associated with job loss or income reduction due to health issues during employment.	Types of risk behaviour Impact on the degree of health awareness and participation in medical assessments

Factors Relevant to the Justification for Informants' Health Behaviour	Coping Mechanisms
Generation after generation perpetuates perceptions about the local hospital's poor quality of care, further undermining its already negative reputation.	Personal risk is associated with premature discharge from hospital. Investigating alternative treatment methods.
The segregated location's distance from the town and the absence of health facilities within walking distance are structural barriers.	Seeking treatment from a traditional healer rather than a hospital.
	Home-based supportive care, primarily aimed at symptom management and medication, is often utilised in less severe cases, delaying medical consultations or favouring self-care exclusively within the home setting.
	Reduction in the desire to use medical treatments provided by institutions.
Inadequate funds to cover the cost of medical services or hospitalisation in another city. One important determinant is the person's aptitude for life circumstances management and adaptation.	Examining different forms of therapy
	The availability of resources and the potential for their utilisation, as well as the influence of the environment.

2.2 Profile of Several Communities in Southeast, Nigeria

The Igbos constitute a group primarily situated in the Southeast, Nigeria. They further encompass areas within the Southern regions of Nigeria. The current

inhabitants of Abia, Anambra, Ebonyi, Enugu, Imo State, as well as a segment of Delta State known as Anioma -West Igbo and a portion of Ikwerre and Etchie in River State are the populace in these communities. The region is situated between 5 to 6 degrees north latitude and 6.1 to 8.5 degrees east longitude, encompassing an area of roughly 16,000 square miles. The region experiences a humid climate characterized by an annual average temperature of approximately 80°F, with an annual fluctuation ranging between 5 and 10 degrees. The rainy and the dry season are the two primary seasonal variations. April marks the commencement of the preceding period, extending until October, when the dry season begins and persists until March. The annual precipitation is around 70 inches on average, with the quantity decreasing as one progress farther northward from the Southern parts. Ijaw people are located to the South, Efik and Ibibio people are located to the Southeast, Ogoja people are located to the East, Edo and Urhobo people are located to the west, and the Igala people of Kogi State and the Idoma people of Benue State are located to the north. The region is North of the Delta swampland, east of the Niger River, and West of the Cross River. Two distinct groups of Igbo people, known as the Western Igbo and the Eastern Igbo, were separated by the mysterious River Niger, which bisected their country. It is important to note that the Eastern group constitute most of the population, whereas the Western group only account for one-tenth of the total population. To this day, members of the people in these communities may be found all over the world. It is believed that there are thirty million people in these communities living in Nigeria, making them one of the three most prominent ethnic groups in the country.

On the African continent, Southeast Nigeria is widely acknowledged as the region with the highest population density, second only to the Nile Valley. An airborne study undertaken in 1989 (Okechukwu and Ugochukwu, 2024) reveals that Imo State has a population density of 700 individuals per square kilometre, whereas Niger and Borno States have densities of 276 and 59 inhabitants per square kilometre, respectively. The community in Southeast communicates in the local language, which exhibits a range of dialectical variations. The English language emerged as the official medium of governance in Nigeria after colonialism, considering the country's diverse societal composition. The people in these communities exhibit a stature that can be described as average, characterized by a predominantly dark complexion, a robust physique, broad nasal features,

curly black hair, and lips of moderate thickness. They are individuals of considerable dynamism, embracing democratic principles, valuing freedom, and oriented toward achievement. They exhibit a receptiveness to innovative concepts and initiatives, demonstrating adaptability, hospitality, and commitment to egalitarian principles. They detest injustice and consistently harbour an aspiration for excellence, striving to achieve or surpass it in commendable pursuits, all without the intention of diminishing others.

3. DISCUSSION

This study investigates how ongoing marginalisation influences the formulation of healthcare-related strategies and their implications. We expected that these strategies might include both adaptive and maladaptive approaches. However, we posited that ongoing marginalisation would result in the emergence of increasingly maladaptive strategies. Inhabitants of this region endure a degradation of their community, marked by pervasive stereotypes such as unhealthy habits, stagnation, inadequate sanitation, low literacy rates, excessive alcohol use, and a tendency towards conflict and hostility. Residents' living conditions have a substantial impact on their mental and physical health. The implications of marginalisation for the population's health are significant and multifaceted. Marginalised people often have limited access to educational resources, job opportunities, and political participation, which in turn affects health outcomes. Our findings align with the conclusions drawn by other researchers like (Ezeanolue *et al.*, 2018) in their research that the health status of the people these communities in Nigeria presents a multifaceted array of challenges which extend beyond fundamental medical concerns, like many communities in low- and middle-income countries. The problems include high rates of mothers and children dying, regular outbreaks of infectious diseases, and many ongoing infections, all of which create a serious public health issue. This situation's complexity stems from the interplay of socioeconomic factors, cultural practices, environmental conditions, and disparities in healthcare access, which collectively perpetuate adverse health outcomes and marginalization (Jacinta and Harris, 2023). Financial limitations constitute a major obstacle to accessing healthcare in Southeast, Nigeria, where a sizable section of the populace lives below the poverty line and encounters difficulties in affording healthcare services (Fayehun *et al.*, 2022, Nyarko and Tahiru, 2018). The scarcity of

healthcare professionals, particularly in rural areas, intensifies the problem of delayed or inadequate medical attention, creating substantial barriers for individuals seeking timely and appropriate medical care (Eze and Chukwuma, 2024). Infrastructure deficiencies, marked by inadequate road networks and limited access to electricity and clean water, exacerbate these challenges, hindering healthcare service delivery and increasing vulnerability to waterborne diseases (Kirigia and Barry, 2008).

The behaviours related to accessing health services are notably influenced by the community's educational attainment and health literacy, which are critical determinants of the acceptance and use of modern healthcare services (Ogben and Ilesanmi, 2018). Marginalised groups face systemic barriers in accessing public services, including healthcare, which further isolates them from mainstream society (Tune et al., 2020). This situation creates a harmful cycle of poverty, poor health, and marginalisation that is difficult to dismantle without targeted interventions and policies that address the root causes of these inequalities (Feinberg et al., 2021). Addressing the root causes of health challenges and mitigating the effects of marginalisation in Southeast, Nigeria requires the implementation of a comprehensive strategy. The strategy should include the improvement of healthcare systems, the progress of socioeconomic development, and the removal of cultural and structural barriers. Increased investment in healthcare infrastructure, including the development and equipping of medical facilities and the training and hiring of healthcare professionals, is essential for improving access to high-quality healthcare services (Aboderin et al., 2017). State governments in Southeast, Nigeria should develop training programs mainly on healthcare and specialized fields essential to local needs. Also, improving healthcare by ensuring supportable development through community involvement and partnerships. Initiatives designed to improve socioeconomic conditions, such as educational advancement, job creation, and the implementation of social safety nets, can reduce poverty and enhance overall health outcomes. Public health interventions must evolve to tackle the fundamental causes of health disparities, including socioeconomic inequities, restricted access to healthcare, and insufficient health education (Luo et al., 2024). Addressing cultural and structural barriers necessitates the improvement of health literacy, the examination of harmful traditional practices, and the promotion of policies that advance equity and inclusion. It is crucial to prioritise culturally

competent healthcare services to ensure that healthcare workers are equipped to address the specific health requests of marginalised communities. Community-based interventions that involve local leaders, traditional healers, and community members can effectively improve health outcomes and address cultural beliefs and practices that may negatively impact health. Government policies designed to address social disadvantages may reduce health inequalities (Chelak and Chakole, 2023). The incorporation of localised understanding and the preparedness of communities into approaches aimed at addressing disparities in social determinants of health can yield improved results (Baker et al., 2005). It is essential to emphasise that these locations are not exclusively characterised by the presence of individuals from lower socioeconomic backgrounds. Their marginalisation arises from the presence of the population in these communities, and the challenges faced by the community in the Southeast are not because of their status but rather their cultural identity.

In the context of marginalisation related to healthcare access, our findings are consistent with those articulated by several researchers (Feinberg et al., 2021, Aboderin et al., 2017, Tune et al., 2020). Within this framework of understanding, the accessibility of health care, along with a compassionate and impartial approach to problem-solving, holds significant importance. Adverse encounters with healthcare systems, whether experienced personally or observed indirectly, can yield enduring effects on one's health. The interplay of these experiences, along with the impact of influential figures, may result in sensations of powerlessness and a disregard for preventive healthcare measures. Moreover, the availability of healthcare services is frequently constrained in the smaller villages in Nigeria, particularly within the Southeast settlements. Maintaining one's health and prioritising prevention can prove challenging, even for those outside these communities in smaller regions, owing to the lack of specialised professionals. The limited availability of specialised clinics can result in extended wait periods for patients. This issue becomes increasingly evident when intertwined with prejudiced perspectives. As a result, individuals often engage in maladaptive behaviors such as self-medication and evading visits to healthcare facilities. This implies that individuals with mental health issues usually involve themselves with substances such as illicit drugs or alcohol, which can lead to substance dependence and worsen underlying mental health conditions. Also, they can

avoid seeking medical help due to previous negative experiences. These can deteriorate their health conditions, which could have been managed effectively if addressed early on. Maladaptive health-seeking behaviors among several communities in the Southeast stem from systemic discrimination, not inherent cultural traits. Our investigation, grounded in qualitative research, uncovers subtleties in attitudes and behaviours that warrant further exploration. Perspectives that might initially seem uninformed or careless are often grounded in (frequently valid) apprehensions and concerns regarding the escalation of marginalisation. This is exemplified in the perspectives of mothers in these communities who decline additional diagnoses when there are suspicions of mental disorders in their children. An approach characterised by paternalism, intended to safeguard the residents of the settlements, may not be the most appropriate course of action, as it could similarly foster isolation and a sense of powerlessness among the inhabitants. The experiences shared by the informants are not singular; rather, they are recorded across various locations within Southeast, Nigeria. Nevertheless, this does not undermine their importance, as they can exert a considerable influence. Conversely, anthropological inquiry can illuminate subtleties in perspectives that may result in misunderstandings if not considered within their contextual framework. In this context, a clearer comprehension of various strategies that adversely affect the individual emerges. These findings may be further utilised for practical research endeavours.

4. LIMITATIONS

This study presents a few limitations. The investigation within the context was primarily grounded in routine exchanges. It was feasible to conduct semi-structured interviews, albeit to a restricted degree. The experiences of informants are influenced not only by the marginalisation of their community but also by the overall limitations in access to healthcare within the locality. The subjects of the research primarily comprise permanent residents of these communities. To advance research, it is essential to methodically concentrate on individuals who have undergone the experiences of emigration and subsequent return to their locality, while also delineating their strategies. The sample skews toward rural dwellers; perspectives from urban areas in the Southeast are underrepresented. It is essential to conduct a more thorough examination of the sustainability of the proclaimed health care and to elucidate the mechanisms that contribute

positively to its efficacy

5. CONCLUSION

The foundation of our research lies in the ethnographic fieldwork conducted by the first author, who has engaged directly with the community over an extended period. This enduring engagement has enabled us to grasp the intricate and dynamic experiences of individuals in these communities, offering a level of comprehension that is frequently absent in more fleeting research endeavours. We offered a nuanced examination of the challenges faced by several communities in the Southeast in their health care experiences across various localities, elucidating the diverse strategies individuals adopt and the ways in which these strategies are influenced by their specific circumstances and situations. Informants demonstrate an impressive ability to be receptive and adaptable to external stimuli, choosing their health care practices as a direct reaction to these influences. This fact may be viewed as both a drawback and a benefit, depending on its careful and thoughtful application in interactions with these communities or in the development of social policies. This research articulates the essential health experiences of the population in these communities in the region. Furthermore, health issues are deeply intertwined with numerous other facets of life. Health issues, in their totality, encompass a social dimension as well. We propose that understanding the components of exclusion and their consequences at the local level can be advantageous in addressing challenges at the macro level. They can illuminate aspects that might otherwise go unnoticed when viewed from a broader perspective. The diverse essentialist notions and viewpoints concerning the people in these communities lead to the attribution of their adopted strategies to a distinct mentality or lifestyle that is characteristic of their identity.

However, what may be interpreted as an unwillingness to adopt the dominant values and to adapt could arise from a profound sense of trepidation and helplessness. Recent investigations into resilience suggest that it transcends being a mere characteristic derived from personal psychological factors; rather, it is significantly shaped by the social and cultural environments in which individuals are situated (Kirmayer *et al.*, 2009). Social resilience denotes the capacity of communities to adeptly confront social and ecological challenges. It encapsulates the capacity of the environment from which a person emerges to provide access to health-enhancing resources and activities in a way that

resonates with cultural relevance (Ungar, 2008). For vulnerable communities, the development of these capacities cannot solely rely on internal efforts; rather, it necessitates robust external support. However, such investments ought not to manifest as

intervention programs within marginalised communities but rather should be accompanied by a broader awareness-raising effort directed at the external environment.

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