Household Size and Health Status of Rural Dwellers: Evidence From The Federal Capital Territory, Nigeria.

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Abstract

Household size is one of the determinants of socio-economic development of any country. It is the total number of people living in a house, sharing certain things in common and may contain more than a family. Household size varies in size in space for diverse reasons with its attendant impact on the health status. Health status is the range of manifestation of disease in a given society. In the light of this, the present study is conceived, in order to establish the relationship between household size and health status of rural areas of Federal Capital Territory, Nigeria. The study involved 400 rural households across the six area councils of the study area. Combination of multi-stage, Probability Proportional to Size (PPS) and purposive sampling techniques were adopted to obtain all the relevant data. In all, in-depth- interviews (IDI), Focus Group Discussions (FGDs) were conducted and questionnaires were also administered in the purposively selected settlements of the six area councils on the subject matter. The data were subjected to correlation analysis. The results show that there is a strong relationship between household sizes and life expectancy as the p-value of .007 < 0.05 level of significance at a correlation level of 0.529 at 22 df.; there is weak relationship between household size and infant mortality with correlation co-efficient is 0.349 and in the relationship between household size and level of diseases there is weak relationship as correlation co-efficient is .356 in the study area. In the face of this finding, the study recommends manageable household size as one of the conditions for healthy living upon which economic growth can evolve. This can be achieved through adequate family education.

Keywords: Household Size; Health Status, Rural areas

Introduction

Household size is central to the planning of socio-economic sector of any country, as policies relating to housing, health, education and other aspects of governance are planned with data from households. Household according to NPC/ICF (2014) is a person or group of persons, related or unrelated who usually live together in the same dwelling unit, have common cooking and eating arrangement. Similarly, Havilland (2003) also defined household, as a situation where one or more people live in the same dwelling and also share at meals or living accommodation, and may consist of a single family or some other grouping people.

Without prejudice to the definition, household is relevant for many purposes; Anyanwu (2013) opined that, household as an important aspect of life, matters in

determining poverty in a country. This may be in relation to accessibility to sources of water, sanitation facilities, and persons per sleeping room, because it is made up of smaller units of human settlement. Additionally, Bradbury, Peterson and Liu (2014) submitted that, household is the unit for energy-related consumption, human impact on environment and thus sustainable development. Household assists in having understanding of family size, household headship, needed in formulating population based policies (NPC/ICF, 2014).

Hurtubia, Gallay and Bierlaie (2010), submitted that, a household size is determined by age, ethnic group (culture), sex, education, marital status among others. This explains its geographical variation in space; in some places, there is marked high proportion in the number of households, and while reverse is the case in others (Mohammed et al, 2010) and these households are either headed by male or female. But in many African societies, male headed households are in majority (World Bank, 2015).

It is estimated that, Nigeria has a mean household size of 4.5 persons (World Data Atlas, 2012); this may be linked to African societies where family ties (which enables a temporal continuity of identifiable family connections over generations) and practice of polygamy are common cultural practices. The above scenario has also been aided by dependency ratio of population in Nigeria, which has been estimated to 78.8% (Countrymeter, 2016); this too has added to the level of poverty level and a major challenge in widening the gap between medical facilities and rural masses.

In Nigeria, National Bureau of Statistics (2012) in a survey carried out in the period 2006-2010, submitted that, male-headed households constituted 84.8%, while female headed were 15.2%; this trend has not changed. Gender headship of the family is one of the determinants of the social system in relation to accessibility to health facilities, food, houses, and means of transportation among others. However, inspite of the

relevance of household in the stability of the social system, Rogan (2014) opined that, there exists a larger poverty gap between female and male headed households and the gap has been linked to lower education, small ownership of the land and limitation to utilization of women in female headed households.

On the other hand, health status is the individual's relative wellness and illness, taking into accounts, the presence of biological or physiological dysfunction, symptoms, and functional impairment (American Thoracic Society, 2007). Thus, the health status of a person is determined by his/her mental, physical and function of biological system. It varies from one region to another and even from an individual to another, depending on income level, education, employment status, gender and ethnicity (WHO, 2010). Health status of a country is measured through life expectancy, mortality and burden of diseases (Australian Institute of Health and Welfare (AIHW, 2016).

Individual's relative wellness and illness are determinants of how productive a society is; they determine death rate, how long one stays alive and prevalence of diseases. Studies have confirmed the links between household size and health status among human society (Cools, Markussen and Strom, 2014; Lundborg, Ralsmark and Dan-Olof (date not cited) and Anyanwu, 2013). Large household size has impoverished the rural areas, because of the pressure on poor economic base that is manifested in diseases and poor economic activities, and has further aggravated the economic status of the rural people (Ki-moon, 2011; WHO, 2014 and Olawuyi and Adetunji, 2015). Akanbi (2014) submitted that, in the rural areas of Nigeria, there is inadequate health facilities required to meet the medical needs of the public. Nigeria operates pluralistic health delivery system, encompassing three tiers of primary, secondary and tertiary, with each tier drawing its finances and management from Local, State and Federal Government respectively. In all, there are 30,345 primary health care centers, 3,993 secondary health facilities and

85 tertiary health institutions (Olusesan et al, 2014). Of these, Federal Capital Territory has 559 primary health care, 90 secondary health care facilities and 7 tertiary health facilities. Suffice to add that, majority of the primary care facilities are located in the rural areas, characterized by ill equipped facilities and inadequate personnel. This trend according to Adefolalu (2011) has resulted to an estimated 80% of Nigerians particularly those living in the rural area preferring to solve their health problems consulting traditional healers. This may not be unconnected with low disposable income among other reasons (Srvastava, 2011). Globally, poverty in the rural areas still stands above the urban areas (IFAD, 2016); this is not without its challenges.

It is in the light of this that this work is conceived and therefore, the aim of this study is to examine the relationship between household size and health status of rural dwellers in Federal Capital Territory, Nigeria. This aim is achieved through the following objectives: evaluate the household size and examine the relationship between household size and health status of rural dwellers in Federal Capital Territory, Nigeria.

Hypothesis
Null Hypothesis

H_o: There is no significant relationship between household size and health status: (Life expectancy, Infant Mortality rate and Disease) of rural dwellers in FCT, Nigeria.

The Study Area

The Federal Capital of Nigeria is located in the northern part of confluence of Rivers Niger and Benue. It is bordered in the West and North by Niger State; bordered in North-East by Kaduna State; Nasarawa State in the East and Kogi State in the South-West. Federal Capital Territory occupies a land area of about 7,315 Km^2. It is located between latitude 8^0 30' and $9^000'$ North of the equator

and longitudes $7^000'$ and $7^030'$ East of Greenwich Meriden. United Nations Fund for Population Activities-UNFPA (2015) estimated that by 2015, FCT is to have a population of 3,324,000 people. Federal Capital Territory has dual settlement types of rural and urban, with majority dwelling in the rural areas.

Methods and Materials

The data used in this study were obtained from primary and secondary sources. The primary data sources include Focus Group Discussions (FGDs), questionnaire administration and in-depth-interview (IDI). The secondary source included population statistics from National Population Commission (NPC) publications and maps of FCT.

The study adopted the combination of multi-stage sampling, Purposive and Probability Proportional to Size (PPS) techniques. The first stage in the sampling process is the identification of rural wards from each of the local area council (See Table 1). It also involved selection of 10% of all the settlements in each area council constituting the sampled settlements, by conforming to principle of Probability Proportional to Size (PPS). While purposive sampling method was adopted because of uniqueness of sample sites. Probability Proportional to Size was also adopted because of noticeable high family size in the selected rural settlements and because it permits the use of uniform sample size, particularly in a situation where there is variation in the number of settlements per ward, in order to ensure proportional coverage of the study area (Turner, 2003) (Table 2). The 10% sample size adopted for this study is also to avoid large data which may ensure, if a larger sample size is involved, which according to Schrijver (2013) can lead to waste of precious resources such as time and energy.
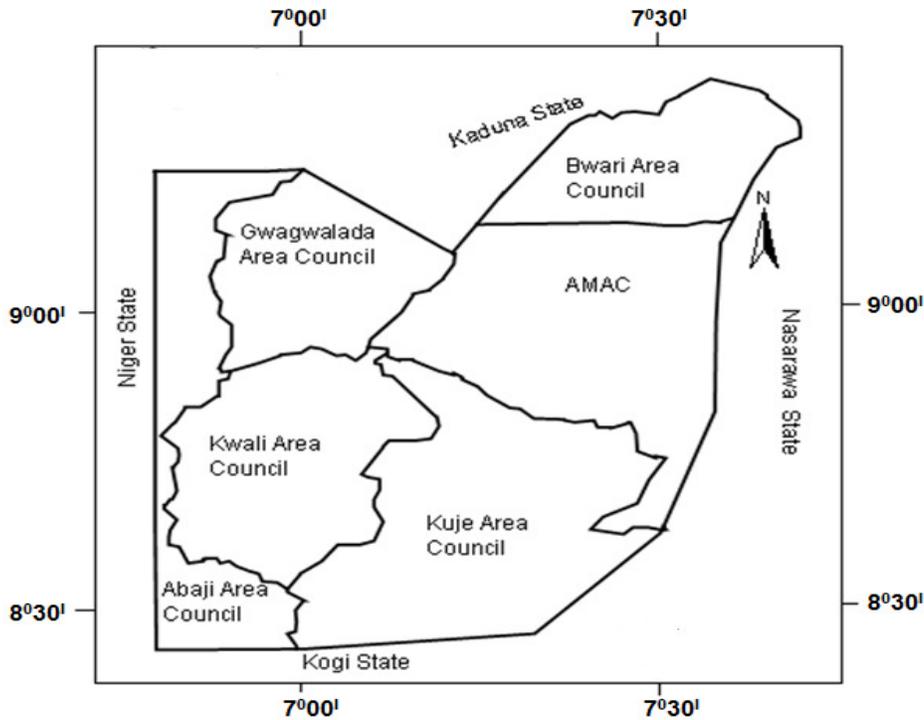
Figure 1: Map of Federal Capital Territory.
Source: Retrieved from GIS Lab, University of Abuja, 2015

The second stage is the selection of sample size (households) purposively in the settlements that make up the study area. Although, household size in the study area ranges from 2 to 19 persons, the study relied on official mean household size of 4.5 (NBS, 2012). In all, a total of four hundred (400) respondents were sampled, six participants were selected for each FGD in the sampled sites to generate robust discussion on the subject matter; a discussion was held in each of the wards, under the supervision of a moderator, who is versed in the subject matter. In all, 363 participants were purposively selected for FGDs. A total of 59 participants were selected each from Abaji, Gwagwalada, Kuje, Kwali and Bwari Council Areas. While 68 participants were selected from Abuja Municipal Area Council. This is, because of variation in number of rural areas (See Table 2). Similarly, resource persons who are mostly from the study sites were interviewed on the relationship between household size and health status of people of the study area. The health status indicators used in the study are life expectancy, infant mortality and disease level.

At least six persons were interviewed across the study area and none of the persons interviewed had less than secondary school education. Thus, they are expected to contribute positively to the discussion on the subject matter.

Correlation analysis was also used to determine the relationship between household size and health status (Life expectancy, Mortality rate and Disease) of rural dwellers of FCT, Nigeria. Correlation analysis is of the form:

$$r = \frac{n\sum xy \; \sum x \sum y}{\sqrt{(n\sum x^2 - (\sum x)^2 (n\sum y^2 - (\sum y)^2)}}$$

Decision rule: we reject Ho when the P value < level of significance (0.05).

Table 1: Local Area Councils and Wards in Federal Capital Territory.

Local Area Council	No	Wards	Local Area Council	No	Wards
Kuje	1	Kuje Central	Bwari	31	Shere
	2	Chibiri		32	Igu
	3	Gaube		33	Kawu
	4	Kabivi.		34	Ushafa
	5	Kwaku		35	Usuma
	6	Rubochi		36	Kubwa
	7	Gwargwada		37	Byazhi
	8	Gudun Karya		38	Bwari Central
	9	Kujekwe		39	.Kuduru
	10	Yenche		40	Dutse
Abaji	11	Agyana/Padangi	Gwagwalada	41	Paiko-Kore
	12	Gawu		42	Ibwa
	13	Rimba/Ebagi		43	Dobi
	14	Nukun/sabongari		44	Ikwa
	15	Alu/Mawopi		45	Tunga-Maje
	16	Yaba		46	Gwako
	17	Gurdi		47	Quarters(Phasei,ii&iii)
	18	Abaji Central		48	Kutunku
	19	Abaji North-East		49	Zuba
	20	Abaji South-East		50	Dagiri
Kwali	21	Pai	AMAC	51	City Center
	22	Kilankwa		52	Garki
	23	Kundu		53	Wuse
	24	Kwali Central		54	Kabusa
	25	Wako		55	Kuyi
	26	Yabu		56	Gwarinpa
	27	Dafpa		57	Karu
	28	Yangoji		58	Orozo
	29	Ashara		59	Nyanya
	30	Gunbwo		60	Gwagwa
				61	Jiwa
				62	Karsi

Source: Field Survey, February, 2016.

Table 2: Sampled households and Distribution of Questionnaire in the Study Area.

Local Area Council	No. of Settlements	No. of Sampled Settlements	Estimated Household = (SS × Mean HH (4.5*)	Number of Questionnaire
Kuje	60	6	27	59
Kwali	60	6	27	59
Gwagwalada	54	6	27	59
Bwari	108	11	50	109
AMAC	40	4	16	35
Abaji	82	8	36	79
TOTAL	404	41	183	400

Sources: National Population Commission (1991).Modified by the Author, 2016.

Results

Socio-Economic Characteristics of Respondents

The result in Table 3 shows the socio-economic characteristics of the respondents in relation to sex, marital status, occupation, educational attainment, religion and income.

The profile of respondents in Table 3 shows that, 85.0% are male, while the remaining 15.0% are female. Higher proportion of male in the sample can be attributed to the fact that in African societies, discussions of important family issues lies with household heads, who are mostly men. This was supported by the view of a community leader, who succinctly summarizes the role of women in family matters thus:

> *"Women's roles in family matters are limited; for instance women are not supposed to divulge family matter in the areas of number of children, family income and management of family property. Their roles are defined by their husbands" (IDI, Yangoji, Yangoji Ward, Kwali Area Council, 2016).*

Marriage was universal among the respondents as high as 95.0% of them are married, while 5.0% are spinsters. Majority of the respondents are farmers. Farmers and artisans constitute 52.5% and 15.0 % of the respondents respectively, while professionals and traders are 13.5% and 11.5% in that order and the unemployed is 7.5% (Table 3). Higher proportion farmers impact the respondents' socio economic status. According to Burgard et al (2003) "occupation is highly related to the people's social economic status as it determines people earning potentials and accessibility to essential of life such as health facilities, potable water, decent accommodation, and relevant education among others".

In addition, 17.5 % of the respondents have no formal education, and 30.0 % have primary education. Similarly, 20% and 10 % of respondents have secondary and tertiary education respectively. Respondents without formal education constitute 22.5%. Education is the background for the development of any human society. Popescu and Diaconu (2009) opined that, there is a strong link between education and development of a country.

Table 3: Distribution of Respondents by Socio-Economic Characteristics

Variables	Cases	Frequency	Percentage
Sex	Male	340	85
	Female	60	15
Marital Status	Married	380	95
	Spinster	20	5
Occupation	Farming	210	52.5
	Artisan	60	15
	Professionals	54	13.5
	Trading	46	11.5
	Civil Service	30	7.5
Education	Non-formal	70	17.5
	Primary	120	30
	Secondary	80	20
	Tertiary	40	10
	No Education	90	22.5
Religion	Christianity	120	30
	Muslim	110	27.5
	ATR Believers	170	42.5
Income	Less N5,000	184	45.9
	N5,000-N10,000	91	22.7
	N11,000-N16,000	51	12.8
	N17,000-N22,000	44	11.1
	N23,000-N28,000	16	4.1
	N 28,000- N 32,000	7	1.7
	More than N 32,000	7	1.7

Source: Field Survey, 2016.
Note: ATR = African Traditional Religion

The analysis indicates a low literacy level among the sampled communities, which means that dissemination of information regarding the effects of large family size may not be adequately understood nor taken seriously by the rural dwellers. In an interview, a resource person agreed that:

> *"Level of literacy is a major determinant of family size; the level of literacy in my ward is low. Consequently, many inhabitants in my area are reluctant at adopting modern means of family planning and it associated benefits".*
(IDI, *Kabusa, Kabusa Ward, AMAC, 2016).*

In terms of religion, Christians and Muslims constitute 30% and 27.5% respectively, while African Traditional Religion believers accounted for 42.5% of the respondents. According Olomola (2006) a society where African Traditional Religion believers are in majority, such society is vulnerable to poverty and chronic under-nutrition.

Similarly, Table 3 reveals that, 45.8% of respondents earn less than ₦5, 000 per month, while 22.5% earns between ₦5, 000 and ₦10, 000. About 12.5% of respondents earn between ₦ 11,000 and ₦ 16,000 and 11.0% earns between ₦ 17,000 and ₦ 22,000 monthly. Suffice to add that 4.4% and 1.8% earn between ₦ 22,000 and ₦ 28,000 and ₦ 28, 000 and ₦32, 000 above respectively. Lastly, 2.0% of the respondents earn more than ₦32, 000. This implies that majority of the respondents in the study area live on less

than 2 USD per day. Beside the fact that this is not good for the health of the people and by extension socio-economic development, it is far below acceptable international standard and may be a major contributing factor to poverty level among the respondents.

Household Size and its Implications for Health Status

The number of persons that constitute human society is central to measurement of socio-economic status of a people. Among the African rural populace, cultural practices such as polygamy and family/kinship tie systems are high and common. In this regard, Macfarlane (1986) submitted that, polygamy is an antidote for labour supply, acquisition of position of leadership among others. Table 4 reveals that, 6.3% have household size of between 2 and 5 persons, while 7.5%, have between 6 and 10 household sizes. Similarly, 25.4% have between 11 and 16 household size and 27.5% have between 17 and 18 household members. Lastly, and 33.3% of respondents, have the largest household size of over 19 members. The household size in Table 4 affirms the submission of World Family Map (2013) that, kinship ties which allow children to live with relatives other than their parents is stronger in low income regions of the world. In Nigeria, 59.0% of children lived with adults, besides their parents who may be grandparents, uncles and cousins. In an FGD discussion, it was averred that:

> *"In our localities, like other African societies, family/kinship ties are considered strong and this usually reflected in living together of relatives from extended. Kinship enables the continuous linkage of generations. Aside, it is a uniting weapon against poverty (FGD, Paiko-kore, Gwagwalada Area Council, 2016).*

There is controversy as to what is an ideal household size. For instance, NPC/ICF (2014) in a survey of Nigeria estimated that 49.5% of the respondents agreed that more than six (6) children are ideal for a household. However, National Bureau of Statistics (2012) submitted that the mean household size of Federal Capital Territory was 4.5. Without prejudice to volume of household size in the study area, the pattern of size of household is determined by occupational and cultural factors. All of which are considered relevant in the explanations on education, food and health status. In an interview, a retired nurse is of the opinion that:

> *"Too many dependants (including our children) have added to the already existing poverty with its negative effects and by extension inaccessibility to health facilities on the system. Experience has shown that, when there are too many dependants, poverty will ensue".* (IDI, Rimfa Ward, Abaji Area Council, 2016).

The bulk of respondents who believe in large household size are abound in the rural areas: this is informed by the nature of occupation and cultural reasons. A community based farmer head, observed that:

> *"My experience in the study area reveals that, high proportion of rural households in FCT is determined by nature of our occupation and cultural practice. We cherish our culture and this achieved through living together".* (IDI, Battalion 1&2, Dutse Ward, Bwari Area Council, 2016).

Central to all these submissions is that, household size in the study area is a major social issue that has effects on health of the rural areas.

Table 4: Distribution of Household Size in Rural Areas of FCT, Nigeria.

Size of Household	Frequency	Percent
2-5	25	6.3
6-10	30	7.5
11 -16	102	25.4
17 – 18	110	27.5
19 and Above	133	33.3
Total	400	100.0

Source: Field Survey, 2016.

Health Indicators of the Study Area

In medical geography studies, health status of people is measured in relation to life expectancy, disease level and mortality rate among others (World Health Thinker, 2015).

Bearing in mind the relationship between diseases and infant mortality rate, The World Health Organization (2014) describe diseases as top killers during the last decade. The health of a people is a determinant of the holistic wellbeing of such society, as it determines their economic and social status. Table 5 shows that, there are 50 diseases and potential causes of human deaths in Nigeria; influenza and pneumonia accounts for the highest of 15.0%, while Alzheimer and dementia constitutes the lowest of 0.12% (World Health Tinker, 2015). For instance, WHO (2015a) affirmed that, in 2015, 80% of malaria cases in 15 African Sub-Saharan countries resulted in 78% deaths.

In the Federal Capital Territory, the most common diseases are malaria, typhoid, cholera, abdominal pain, dysentery, chicken pox, diarrhea and diabetes (FCT, MDG *posted on 2015*). This too may be linked to low life expectancy of 53 years and 56 years for male and female respectively in Nigeria (WHO, 2015b). In a submission by a retired medical practitioner who has traversed the study area in an interview:

"The health status of the people in this area is very low, as manifested in the prevalence of some diseases ravaging the area, resulting in high mortality and low economic development. Most cases go unreported, partly because of apathy of people towards medical records and majorly because of inadequacy in health facilities." (IDI, Gwarigwada Area Council, 2016).

Reliable data has been a bane of many developing countries and where available, Marthers and Boerma (2009) posited that such data are limited, incomplete and uncertain. However, The World Bank (2016) estimated that, the general mortality ratio for Nigeria stood at 69.40 per live births of 1,000 in 2015.

Figure 2 shows that, 38% of the respondents are of the view that, infant mortality is a common health problem in the study area. This may be as a result of poor socio-economic bases of the study area. In an interview, a retired health superintendent submitted that:

"The number of deaths among the children is so enormous, that many have decided to relocate to other neighbouring states. Others have resulted to self medication and alternative medical solutions" (IDI, Orozo, AMAC, 2016).

Table 5: Distribution of Health Status Indicators in the Study Area.

Indicator	Nigeria (Frequency)	FCT, Nigeria (Frequency)
Types of Disease	50 diseases	7 *
Infant Mortality Rate	69.40 Per1,000 Live Births (Infant)	69.40 Per1,000 Live Births (Infant) **
Life Expectancy	Male-53years Female 56years	Male-53years Female 56years

Sources: *****World Health Tinker, 2015. MDG (FCT), 2015. ** World Bank (2016).**
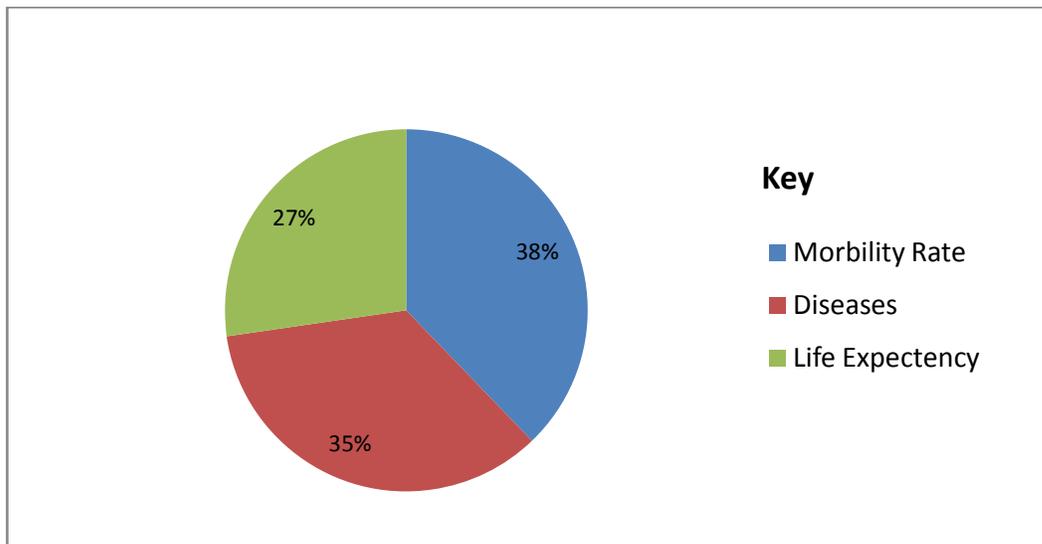

Figure 2: Perceived Distribution of Respondents on Basic Health Status Indicators of the
         Study Area.
Source: Field Survey, 2016.

Furthermore, 35% share the belief that, disease has constituted a major health problem with its attendant problems. Papageorgiou, et al (2005) opined that diseased can be a precursor to mortality in the human society. The number of diseases in the rural areas of FCT, Nigeria is matter of estimate, as many cases are unreported. Health facilities are not adequate to cater for the teaming rural populace, but the health status is easily visible in them through the physical outlook and the nature of the houses they live in (Akanbi, 2014). In addition, 27% of the respondents are of the view that, rural dwellers have short life expectancy. Such levels of life expectancy according to Preston (2007) are associated with the level of economic development.

The majorities of rural dwellers of FCT, Nigeria are peasant agrarians and are confronted with myriads of challenges, impeding agricultural production (Millennium Development Goal, 2015). In Focus Group Discussion, it was agreed that:

> *"High household size is a bane of development of the study area and this is manifested in poor health and by extension inaccessibility to essentials of life (FGD, Kabi-Mangoro Kuje Area Council, 2016).*

Family Size and Health Status in the Study Area.

Health status of human society is of importance because of its role in the stabilization of social system. It determines the productivity, wellbeing as well as continuous existence of the populace. Table 6 shows that, 15.6 % of the respondents share the opinion that, large family size can lead to unhealthy society. This finding is in agreement with the view of Desai (1992). In an interview, a resource person affirmed that:

> *"With 21 children in my house, I have not been able to take my full responsibility as father in relation to provision of essentials of life. My children do not have standard education, when compared to some of my friends with small household size". (*IDI, Chukuku Village, Chibiri Ward, Kuje LAC, 2016*).*

Similarly, 16.1% of the respondents agreed that large family size can lead to inadequate food supply. Even though majority of the respondents are farmers, they practice peasant farming using crude tools with low outputs. The implication of this is that, children are exposed to malnutrition, more especially during this era of privatization when government is reducing its expenses on food, health care. Table 6 also reveals that, 13.2% of the respondents opined that, large household size can retard educational development of the children. In the study area, 30.0% have primary education while 22.5% of the respondents do not have any form of

education (see Table 3).

About 12.9% of the respondent averred that household size can lead to unproductively. Lastly, 13.7% of the respondents agreed that, current household size can lead low income respectively. Large household system, with their noticeable effects, is a common practice in low income parts of the world. Income varies from one household to another, thus Anyanwu (2013) agreed that there is close relationship between household size and level of poverty (which is determined by the level of income among other reasons).

World Bank (2014) concluded that, poverty is a major cause of ill health and a barrier to accessing health care when needed. Low incomes earners are susceptible to diseases and by extension poor health. This is the scenario in the rural areas of the study area. The indirect effects of this, is that there will continue to be economic stagnation and by extension, inaccessibility to essentials of life including health facilities. A resource person submitted in an interview

> *"Large household size has led to low education, through which we can have access to better job and income, and we can access essentials of life" (IDI, Ashara , Kwali Area Council, 2016).*

Testing of Hypotheses

The correlation co-efficient shown in Table 7 revealed that there is a strong relationship between Household size and three health status variables. Life Expectancy (r = 0.53, p<0.05); Mortality rate (r = 0.35, p<0.05) and Disease (r = 0.35, p<0.05).

Consequently, the null hypothesis which states that: "there is no significant relationship between household size and health status (Life Expectancy) (r = 0.53, p<0.05) in the rural areas of FCT, Nigeria" is rejected. This is in line with Johns Hopkins (2016) view which explained that "children born into smaller families in the developing world's

poorest nations will live an unexpected three years longer than those born into larger families".

Similarly, the other two null hypotheses that states that (i) there is no significant relationship between household size and Mortality rate (r = 0.35, p<0.05); (ii) there is no significant relationship between household

size and Disease (r = 0.35, p<0.05) in FCT, Nigeria are rejected respectively. Laskowski et al (2011) submitted that, in non-crowded setting with relatively low average persons per- household, the pre existing immunity of young individuals remain a determining factor. This result is also in conformity with Akanbi (2015) findings on the high level of diseases in the rural area of Nigeria.

Table 6: Effects of Household on Health Status in FCT, Nigeria.

Items	Frequency	Percentage
Unhealthy society	62	15.6
Inadequate food supply	64	16.1
Untimely Deaths	62	15.6
Disease Prevalence	52	12.9
Low Education/Drop Out From school	53	13.2
Low Income	55	13.7
Unproductively	52	12.9
Total	400	100

Source: Field Survey, 2016.

Table 7: The Result of Correlation Analysis on household size and Health Status variables (Life Expectancy, Mortality rate and Types of disease)

Variables	Household size	Sig
Life Expectancy.	0.529	0.007**
Mortality rate	0.349	0.002**
Types of disease	0.356	0.004**

**. Correlation is significant at the 0.01 level (2- tailed)

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Conclusion and Recommendation

From the foregoing, there is significant relationship between household size and health status of rural areas of study area. This trend has been linked to a number of factors such as social, cultural and economic. Rural areas are characterized by peasant and by

extension low disposable incomes; the study area is known for peasant farming from where the majority (45.9%) of the respondents earn less than ₦5, 000 per month, while 1.7% of the respondents earn between ₦ 28,000 and ₦ 32,000 per month. It is also known for the cultural practices of family ties (which enables a temporal continuity of identifiable family

connections over generations) and polygamy. These dual factors have limiting influence on heath facilities and other essentials of life; they can be explained as determinants of poverty level of the study area.

Just like other rural areas, the study area is noted for household sizes that vary from 2-19 persons per household. However, factors of social, cultural and economic differences may be adduced for this. Socio-culturally, many children are added to the population, without any positive increment in the economic base of this rural area, the higher the household size, the higher the poverty.

Economically, larger percentages of the rural dwellers are peasant farmers, characterized by small scale farm, agriculture for food, low women status, and traditional way of life. This exacts pressure on prevailing poor economic base and by extension prevalence of diseases, short life expectancy, and Infant Mortality rate.

In the light of the above, the study recommends that, affordable household size is ideal, for sustainable development. This can be achieved with the aid of adequate family planning education. An effective anti- poverty programmes should be implemented in order to arrest rising trend in poverty in rural areas and it associated adverse health implications .

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