READINGS

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IN

MEDICAL SOCIOLOGY

EDITED BY

E. A. OKE
&
B. E. OWUMI

READINGS IN MEDICAL SOCIOLOGY

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ABOUT THE BOOK

The text is a collection of high quality writings from various scholars and practitioners of medical sociology \ anthropology and related disciplines. Although not all written by medical sociologists \ anthropologists, the writings focus on current ideas, concepts and issues in the discipline.

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PREFACE

Reading in Medical Sociology is a collection of group of essays, articles and research findings focusing on current ideas and issues in the discipline. The collection represents the work of medical sociologists and scholars in related discipline. The articles are wide-ranging in terms of coverage, approach and content, they raise a whole host of issues which are of particular interest to the discipline.

The need for the book arises because of lack of adequate and suitable reading materials particularly, local materials, for students specializing in Medical Sociology/Anthropology and also for general readers interested in the area. We have designed the book as a supplementary reading, it is an excellent collection which covers the major sub themes in Medical Sociology/Anthropology.

We are grateful to our students, past and present in the Department of Sociology and Nursing, University of Ibadan; The Federal Centre for Teachers of Health Sciences, University Teaching Hospital (UCH) Ibadan. We have also been "guest" Lecturers at the West African College of Physicians Revision Course for Primary Part One and Part Two, Department of Preventive and Socio Medicine, U.C.H. The ideas and enthusiasm of these students have been very challenging and have provided an impetto for assembling the materials.

We are indebted to Dr. Dele Jegede, Department of Sociology, for arranging for the production and providing technical advice.

We appreciate all the contributions of our colleagues. We also acknowledge the contributions of the Head of the Department of Sociology, Dr. Justin Labinjoh. Finally, we wish to express our profound love and gratitude to our wives Mrs. Lola Oke and Mrs. Angela Owumi for their moral support and encouragement.

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Chapter One

INTRODUCTION

THE EMERGENCE OF MEDICAL SOCIOLOGY

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INTRODUCTION

Medical Sociology is a sub-discipline of sociology. It arose from developments in both Sociology and Medicine. This led to an appreciation and articulation of interests in the discipline in the middle of the 20th century. There were two main antecedents, these are (1) Sociological developments and (2) Developments in Medicine.

SOCIOLOGICAL DEVELOPMENTS

The developments in Sociology could be found with reference to (1) subject matter (2) Theoretical concerns and (3) Research Methods (Twaddle, 1982).

Subject Matter

Initially, the subject matter was mostly demography, specifically the long standing tradition of fertility, mortality an morbidity studies which can be traced back into the 1600s with the work of Graunt in London an Petty in Dublin, to the work of contemporary scholars throughout the world.

Death rates have been analysed as indicators of the health of population as well as being components of population composition and change. Today, considerable sophistication has been

developed with respect to measurement and a high level of refinement and conventionality with respect to definition of key concepts.

Theoretical Developments

A massive theoretical development has created a fertile ground for the development of medical sociology. Twaddle (1982) identified six of them, these are:

Spencer's Organic Tradition: This provided a common conceptual ground with medicine by conceptualizing societies as organisms. Through this idea, Spencer contributed the concept of System in which wholes are seen as more than the sum of their parts and changes in one part are seen as affecting each of the other parts.

The Debunking Tradition: This was articulated by Berger (1963) as inherent in sociology. Research, 1966) as inherent in sociology. Research findings have challenged the traditional beliefs of some segment of the society "as a self conscious motif, this has led to the punturing of the myths generated by and for the most powerful prestigious groups". For instance such groups as physicians and corporations have received special attention.

Durkheim's Study of Suicide: The study gave a centra attention to what later emerged as the discipline of psychiatry. In fact, Durkheim could be regarded as the founder of medical sociology.

The Concept of Cultural Lag Developed by the Chicago School: in most of the associated studies, medical care was used as a case example. Prominent among these studies were the work or sydenstricker's (1930) study of health services to the poor and Moore's (1927) study of the relationship between social change and the development of medical services.

The Lynds' Study of Middletown: The studies were carried out in 1929 and 1937. The were regarded as major empirical studies of social class. The emphasis was on the influence of class on American village life. The studies revealed social class differences in the health practices and the treatment of disease.

Talcot Parson's Theoretical Development of Professions and Clients: This was the most important development. Talcot Parsons (1951) argued that as the businessmen emerged as a dominant figure in the transition to capitalism, the professional was also becoming a dominant occupation.

He further suggested that the professions differed from business in that they took a collective position toward the interaction with clients while the businessmen took a competitive one. This analysis centered attention on the physician as a prototype professional and the patient as a prototype professional and the patient as a prototype client, thus conceptualizing sickness as a form of deviant behaviour which he placed as an important element in the existing sociological study of social control, analyzable in comparison with crime and law.

Methodological Development

The survey was the most important methodological development, notable Lazarsfeld's creation of the panel design, the scaling techniques provided a basis for collaboration between sociology and medicine.

Developments in Medicine

The developments in medicine can be divided into two broad categories, these are: (1) Theoretical crisis associated with the collapse of the explanatory power of the germ theory of disease and (2) The changes in the organisation of medical services.

Theoretical Crisis

The theoretical crisis had been developing slowly for many years. The following are some of the elements:

1. The germ theory as noted by Dubos (1959) is an ideology that makes an implicit claim that all disease is ultimately conquerable. Dubos observed that germs are a necessary, but not sufficient cause of some diseases.

   They do not cause diseases unless other environmental conditions present. The narrowing of focus away from social and environmental concerns would not work and such factors needed to be taken into account.

2. The development of psychiatry within medicine was based on demonstration that some physical cause. Further, psychic factors were implicated in all disease and all disease has psychological component. Coupled with recognition of the importance or social environment for the development of personality system (Erikson, 1959; Parsons, 1964). It became difficult to treat any illness a simple physical problem.

3. Social Epidemiology has demonstrated that disease remains socially patterned. Based on social surveys and vital records, it has been shown that the overall success of medicine in reducing the level of disease is negligible and possibly negative as rates of chronic disease seem to be rising. Further, the high correlation of many causes of death with social characteristics and with each other has led some epidemiologists to abandon the concept of disease as irrelevant (Syme, 1996).

4. Finally, health surveys have not only contributed a technique of research to medical interests, but also they

have repeatedly demonstrated the continuing relevance of social structures for the patterning of disease and the utilization of heath care resources.

At the very least, a multi causal mode of disease seems to be needed. While micro-organic life continues to be relevant, it is clear that a germ theory of disease is not. In the search of alternatives, the social sciences seem to be promising area.

Changes in the Organisation of Services

The development of the modern medical school contributed to a chain reaction including the following:

1. Placing medical schools in universities and requiring a core in the basic sciences improved the level of medical knowledge.

2. As a result of improvements in knowledge, diagnosis and treatment became more intricate, requiring more efforts in each case.

3. Medicine responded to these pressures like any other historical system as follows:-

   (a) It increased the scale of its organisation by moving practice out of the home of the patients into the clinic and hospital. The trend toward bureaucratization was increased by the need to share expensive new techniques developed in part in an attempt to find labour-saving means of coping with demand.

   (b) Physicians began to specialise. From the perspective of the patient, this constitutes fragmentation of

service. The patient is often faced with the need to see several physicians to treat difficult problems. Medicine is less well coordinated and takes more sophistication on the part of the patients.

4. The increase reliance on high technology, the greater labour intensiveness of medicine as a result of bureaucratization and technological elaboration, the increased unit costs of specialised as compared with generally trained physicians, all combined to drive up medical costs. These trends have a number of implications:

   (a) There were pressures to make the system more efficient for clients.

   (b) There was a need for cost controls and better organisational forms to improve coordination.

   (c) There was a need to provide a more humane mode of delivering service.

The central emerging issues facing medicine were those that had long been core concerns of sociology. Issues such as social organisation, interaction and alienation. As we have mentioned, the developments in sociology made the field ripe for developing a focus of medicine. In articulation of these interests, medical sociology emerged in the 1950s and became an established speciality by 1960.

The Three Dimensions of Medical Sociology

The basic premise that led to the development of medical sociology is the assumption that understanding of health problems and the mobilisation of effective response to these problems could

be found through medicine.

This assumption was clearly demonstrated during the period following the second world war. Medicine had firmly established its credentials as an effective source of treatment of disease. As Twaddle put it, "physician - centered scientific healing was where the action was", that was where sociological attention was directed.

We can identify three but inexclusive dimensions of this development, these are:

(1) Sociology in Medicine;

(2) Sociology of Medicine; and

(3) Sociology of Health.

Some scholars particularly Robert Strauss (1957) identified only the first two dimensions which he labelled "The dual focus of Medical Sociology". He saw the third dimension as a new trend in sociology or what Twaddle Sub-categories as "Toward a Sociology of Health". Today, Sociology of Health has emerged as an integral part of medical sociology.

Sociology In Medicine

Sociology in Medicine refers to the applied aspects of medical sociology. In extreme form, it refers to sociological work that provides technical skills for the solution of medical problems or of problems in health care delivery without regard for contribution to sociological theory.

The work of those primarily concerned with the prevention and treatment of disease, the allocation of resources, and similar problems fell into this category. The basic stance of people with this orientation is to treat sociology as an adjunct of medical

practice, a supporting discipline to medicine. The problems defined for investigation tend to come from the concerns of physicians.

The goals of sociology in medicine have been to improve diagnosis and treatment. This has meant getting involved in medical education and in medical settings particularly hospitals. This approach has contributed much to medical education, social epidemiology and our knowledge of utilization and compliance.

Sociology of Medicine

Sociology of Medicine on the other hand refers to the basic research of medical sociology. As with education, religion, the family and the economy, medicine is a social institution worthy of sociological study in its own right. As with other social institutions, the study of medicine generates insights into the properties of social relationships and social organisation.

The goal of this approach is to learn about societies rather than to understand disease processes or otherwise contribute to medical ends. The fundamental stance of the sociology of medicine is hence that medical practice is a social institution that can serve as an avenue for understanding society.

The goals of sociology of medicine therefore are to improve the state of knowledge relative to social structures and processes. Such things as complex organisation, the biological parameters of human behaviours, social norms and identities, status changes, roles, interaction, and deviance. These can be studied in medical setting.

These settings make explicit some of the criteria and assumptions that are left largely implicit in other settings. For example, the evaluation of human beings on non-technical grounds is more explicit among physicians than among school teachers. The unique concerns of medicine and medical settings highlight questions that are generic to the discipline.

Sociology of Health

Modern medical sociologists have directed much effort in the direction of sociology of health. This is a result of some changes in the issues facing health services. Scholars in this direction are now divorcing from the traditional perspective and medico-centric perspective to one that takes medicine as one element associated with the health of both individuals and populations, the relevance and salience of which needs to be empirically established.

While both sociology in health and sociology of health or what may be referred to as traditional medical sociology, were essentially modelled on biological and sociopsychological paradigms, the sociology of health is based on social structure and humanistic paradigms.

The main change of emphasis has been from a positivist emphasis on the organism and physiological foibles, and on the human personality, social roles and deviance towards an emphasis on social structures in which human beings are enmeshed and the problems of coping with these structures.

Traditional medical sociology was centrally concerned with disease, illness and sickness. The sociology of health is taking a broadened perspective on all kinds of events and structures that limit freedom of choice and/or reduce personal effectiveness. In traditional medical sociology, the key healing roles were located within medical institutions. For sociology in medicine for instance, attention was given primarily to the physician and secondarily to the patient, who was seen most often as a passive recipient of services.

Sociology of medicine paid some attention to other health occupations, mostly nursing, but primarily from the perspective of the relationships between physicians and nurses. For the sociology of health however, all of the traditional healing roles have a lower profile. For instance, emphasis is on politician who can legislate

changes with major implications for health; powerful groups in the economy who have interests that may be detrimental to or supportive of health concerns.

Sociology of health is moving toward a different conception of the main means of healing which focuses attention on social change, environmental control, smoking, nutrition and exercise.

The objective is to promote well-being, reduce mortality and morbidity in population. There is also a change in the kinds of organisation - this is central to the field. The shift is away from the hospital, clinic, and self-care centre, which were most important to traditional medical sociology, toward legislation, schools, public recreational settings and more informal settings.

Medical Sociology and Medical/health Profession

Although medical sociology is closely related to other sciences, nevertheless, it has a unique relationship with medical/health profession. It provides an adequate cultural and social context for interpreting and solving health problems (Oke, 1991). Otite (1987) had earlier expressed similar view, he noticed that the phenomenon of health is both a medical and a socio-behavioural concept, just as medicine itself is a natural as well as a socio-behavioural science.

He suggested a comprehensive view of health that combines both physical and socio-cultural dimensions that is capable of providing adequate explanation of health phenomenon.

The relationship between socio-cultural factors and the use or non-use of health services has long been demonstrated by scholars. Otti (1991) emphasized that this depends not only on the presence or absence of disease, or of health care institutions "but also on the feelings of acceptance or rejection of health services offered by professionals. She further observed, "Such acceptance or rejection may arise from the nature of people's perception of the usefulness of the health care delivery, which is essentially a

socio-cultural phenomenon". In short, there is an association of personal characteristics and/or socio-cultural factors with the use of medical services. (Oke, 1982).

The implication is quite obvious, medical sociologists and medical/health professionals alike should recognise the fact that both health and illness are intricately woven together with the way man lives (Otti, 1991). Disease or illness is a manifestation of social and physical context in which an individual lives. This view is well articulated by Otti referred to above. She observes "The individual patient lives in a social environment in which various factors contribute to or even almost entirely on their own product disease conditions".

It is apparent from the above that there is a need to recognise medical sociological knowledge and skills and fully utilise the expertise of the practitioners by the health professionals in our society. Relevant courses in Sociology should be taught to our medical students by Sociologists along side with other students taking such courses, so that by the time they (medical students) become fully qualified and become professionals, they will have an appreciation and understanding of socio-cultural phenomena that have bearing on health and health related practices. For similar reason, medical sociology students should also have some exposure to biomedical science.

In addition, medical sociologists must always remember that medical professionals operate in terms of a sub-culture and are apt to be disturbed as any one else when basic tenets of their sub-culture are challenged (Oke, 1991). The sociologist must maintain his professional posture, but he must be willing to learn and adjust. He must try to keep communication lines open and remember that medical professionals as well as other professionals have specified goals they wish to reach. These can be accommodated in a multi-disciplinary venture, this will promote advancement of science for the betterment of mankind.

In this text, we have brought together a diverse collection of high quality writings from various scholars and practitioners of medical sociology and related disciplines. Although, not all written by medical sociologists, the writings focus on current ideas, concepts and issues in the discipline.

No attempt is made to categorise each chapter or groups of chapters into a distinctive dimension as this will be mere superficial. In reality all the three dimensions identified above are mostly for analytical purposes and can be represented, and is often represented in a single research project especially now that multi-disciplinary approach is the vogue for health and health related projects and programmes.

Nevertheless, the reader will appreciate the orientation of each scholar as reflected in his contribution and thus a better understanding of the readings and an appreciation of the dynamics of medical sociology.

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Chapter Two

ADAPTATION OF ANTHROPOLOGICAL METHODOLOGIES TO THE HEALTH CARE DELIVERY PROGRAMMES

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INTRODUCTION

Application of anthropological data, theories and methods to action programmes had long been recognized and appreciated by health professionals and health workers. The sub-discipline of anthropology, referred to as "Applied Anthropology" has played a remarkable role in this direction. The most important contribution of applied anthropologists to action related programmes is an unusually broad and flexible research methodology based on a holistic view of society and culture (Foster, 1969).

The traditional approaches of anthropology, particularly the "System approach" that is, the concept of whole systems underlies the anthropological method. The anthropologist habitually thinks of data and problems in the context of large units. This may be social, cultural, economic or more likely a combination of this.

The emphasis on systems was not a mere accident, it developed from within the discipline itself, it is an inevitable outgrowth of the early definition of the anthropologist's primary task. Foster (Ibid) puts it vividly.

> The task was to study and record the primitive societies of the world before they vanished. The assignment was total - find out everything there was to be known about the people studied.

The underlying problems were assumed to be historical and the goal was to describe and reconstruct as far as possible the histories of non-literate peoples.

The interests then have been theoretical rather than practical and most time and effort were devoted to university teaching and university based-research.

But as far back as the first part of this century, there was a need to shift attention to solving practical problems, more so, anthropology's claim to status as a social science has now been established as such, applied anthropologists are most concerned with processes of social change and cultural change particularly as they bear upon planned improvements in the fields of agriculture, health and medical services, educational systems, social welfare programmes and community development as a whole.

It is also obvious that the traditional approaches are too expensive and time consuming. Programme planers do not often have the patience or the funds to finance such research. At times, anthologists have been called upon to give quick advice on specific problems based on their years of experience with cultures and programmes. Scrimshaw (1992) however observes:

> Often the practical questions asked by programme planners and health care providers could be answered with information derived from examine the existing anthropological and rural sociological literature and suggesting common sense solutions or by a few days or weeks of exploratory observation and interviewing. This work and the methods used was unlikely to be shared with the originating profession since it did not constitute formal research.

The need then arises for formalizing anthropological methodologies aimed at action programmes, in this case, health

related programmes.

Such methodologies have been well documented and applied to various health programmes or community development projects (Oyejide, Oke, Oladepo, 1988: Oke and Yoder, 1989: Oni, Shumann, Oke, 1991: Oyejide, Oke, Oladepo, 1991: Yoder, Oke, Yanka, 1993: Oke, Oladepo, Oyejide, 1991: Wilson, Shale, Parker, 1992: Iyun, Oke, 1993: etc). The main focus of this chapter is to illustrate with a few recent studies, drawing heavily on African materials, the application of anthropological methodologies to health delivery programmes.

SELECTED STUDIES

The studies selected for discussion here are mostly for easy illustrations. They include:

1. A Longitudinal Observational Study of Diarrhoeal disease Risk Factors in a Rural Nigerian Community, Oluyole Local Government Area (LGA).

2. Maternal Education, Maternal Behaviours and Risk Factors for Diarrhoeal Disease in Children in Urban Nigeria and

3. Rapid Assessment Procedure in the Early Planning for Control of Paediatric Acute Respiratory Infections: Lesotho.

A Longitudinal Observational Study of Diarrhoeal Disease Risk Factors in a Rural Nigerian Community, Oluyole LGA (Oyejide, Oke and Oladepo, 1988).

The study was a multi-disciplinary project. The approach involved a combination of three research methods, these are:

(a) Ethnography

(b) Diarrhoeal surveillance and

(c) Structured observation in homes. It was conducted in rural villages of Oluyole LGA of Oyo State.

The Principal Investigators (PIS) include Dr. C. O. Oyejide, a medical doctor from Department of Preventive and Social Medicine, University of Ibadan, Dr. E. A. Oke, an anthropologist from Department of Sociology, University of Ibadan, and Dr. O. Oladepo, a Health Educator from Department of Preventive and Social Medicine of the same University. Although the PIS worked together as a team throughout all the phases of the study, my main concern here is on the ethnography being a major contribution of anthropology to the project.

The overall objectives of the study were to determine the incidence rates and severity of diarrhoeal disease among under - five children in the community and to identify environmental and behavioural risk factors for diarrhoeal disease with the ultimate aim of utilizing the information for planning an intervention study aimed at reducing diarrheal morbidity in this community.

The primary objective of the ethnographic study was to elicit information on knowledge, attitudes, beliefs and practices (KABP) of mothers about diarrhoeal etiology and method of prevention. The study also aimed to obtain information on a list of common childhood diseases in the community, to identify the symptoms, causes, and treatment options for these diseases. In addition, it was aimed to obtain information about childhood feeding especially during episodes of diarrhoea. This information is indispensable for the preparation and implementation of an anticipated intervention programme.

Research Method

The study was conducted in four villages clusters of Oluyole LGA (Jago, Badeku, Ajia and Ojoku) between June and December, 1988 by the research team including a trained ethnographer with a M.Sc. degree in sociology and M.P.H degree candidate. The ethnographer resided permanently in the community throughout the duration of the study. It should be noted that the ethnographer and the PIS belong to the same ethnic group (Yoruba) of the community.

The study was based on indepth interviews. The main target groups for the interview were the mothers of under-five children and village key informants. This was on the assumption that the mothers (or care-takers) of young children were mostly responsible for taking the initial decisions about diagnosis and treatment of their children although the investigators were also aware of the fact that the men often made the final decisions.

The second target made up of community leaders were the key informants. Their views, utterances and behaviours were considered, to a great extent, a reflection of community ideas, habits, beliefs and values. These individuals are sources of information that have ceased to exist or have been modified by the time the ethnographer arrived on the scene. Thus the information obtained from such key informants is vital.

Community Level Data

The community level data was collected on the following:

1. Geographical conditions
2. Demographic distribution
3. Health services availability and utilization
4. Sources of water supply

5. Methods of human waste disposal
6. Methods of refuse disposal
7. Women's work/child-care practices
8. Religious beliefs
9. Utensils used for cooking and eating and those specified for children.
10. Inventory of utensils used for water storage
11. Animals kept in the house.

Household Level Data

The household level data included:

1. General childhood diseases
2. Childhood diarrhoeal
3. The last diarrhoeal episode
4. Feeding and weaning practices
5. Feeding during diarrhoeal episodes
6. Hand washing practices

The ethnography lasted for about one month in each village cluster. A total of 151 persons participated in the interviews. The preliminary information gathered from the ethnography helped considerably in the formation of questions or guide-lines for both the structured observation and the diarrhoeal surveillance (Ethnography, in this study, is regarded as an integral part of the baseline study. The baseline study as it is then is a combination of a more intensive and extensive ethnographic study, structured observation and diarrhoeal surveillance).

Once the preliminary investigation in the first village chaster was analyzed and the instrument for a more intensive and

extensive ethnographic study, the structure observation and the diarrheal surveillance were prepared, the investigations were conducted simultaneously. The three set of field workers (the ethnographer; the field workers responsible for the diarrheal surveillance and structure observation; and the staff nurse and the nursing sister in charge of the min-clinic) met daily and exchange notes. The information from each component served as complementary, cases were referred to appropriate field worker for thorough investigation or treatment.

Aside from treatment of cases referred to the clinic for instance, the staff nurse and the nursing sister assisted in validating the surveillance data. Day-to-day supervision of the data collection was done by the ethnographer (also designated as the supervisor); and by the PIS during each of the weekly visits. At the end of each day, the supervisor collected the observation forms completed for the day and checked them. Every Friday, there was a meeting of all the field staff with the PIS where activities in the previous week were discussed. Almost all the field workers are indigenes of the community and resided there (including the staff nurse) throughout the period of the study.

The result of the ethnographic study showed that the villagers were familiar with the symptoms of diarrhoeal and were able to distinguish various types. However, they were ignorant about the causes and about preventive measures. This finding is not peculiar to Oluyole LGA alone but is common through most rural areas in Nigeria. The fear of certain diseases such as cholera (Onigbameji) and tetanus (Giri), that is, the fear of mentioning was rampant. It was believed that mere mentioning of the name will cause the disease.

The fact that teething diarrhoeal was not considered to be a disease but a normal apart of growing up is a cause for concern as it was, many of these village children would have frequent episodes of teething diarrhoea which would contribute to malnutrition and the mother would not be aware of the association.

A reorientation needs to be done to make the mothers aware of the potential danger of teething diarrhoea as a potential contributor to malnutrition. For a more comprehensive discussion on the methodology and the findings, interested readers are referred to the source.

Maternal Education, Maternal Behaviours and Risk Factors for Diarrhoeal Disease in children in Urban Nigeria (Oni,Schumann and Oke,1988).

The study was conducted in Ilorin, an urban centre in Nigeria. The P. I. was Dr. Gbolahan Oni of the Department of Epidemiology and Community Health, University of Ilorin, the Co P. I. was Dr. Debra Schumann, Department of Anthropology, Case Western Reserve University, Cleveland, Ohio, U.S.A., Dr. Ezekiel A. Oke of the Department of Sociology, University of Ibadan was the Anthropological Consultant/Advisor in addition to his role as a Co P. I.

The study examined the relationship between maternal education, maternal behaviours and risk factors for diarrhoeal disease in children in an urban Yoruba population in Kwara State. It was suggested that generally, the effect of mother's education on child mortality is far greater than paternal education (Cochrene et, al, 1980) although the investigators were aware that father's education may also be equally important in explaining differentials in child mortality.

RESEARCH METHOD

The research was divided into three stages. The first stage was a household survey carried out between October, 1988 and December, 1988. The primary purpose of the survey was to ascertain family and household composition, maternal and paternal education and occupation as well as household amenities.

A list of mother-child units was developed upon completion of the survey for the following four strata based upon maternal and socio-economic status:

1. No maternal education/low socio-economic status.
2. Maternal primary education/low socio-economic status.
3. No maternal education/medium socio-economic status.
4. Maternal primary education/medium socio-economic status.

The second stage involved a 12 months diarrhoeal disease surveillance among 240 mother-child units stratified by maternal education and socio-economic status. The diarrhoeal disease surveillance was carried out between February, 1989 and January 1990 by 14 trained fieldworkers. Trained surveillance workers visited each child home twice weekly recording the occurrence of diarrhoea and treatment given. The workers arrived at each home as early as 6.30a.m and remained until about 5p.m.

The third stage involved an ethnographic study and structured observation of behaviours associated with diarrhoeal disease. The ethnographic design emphasized an intensive key informant interviewing to provide detailed information and descriptions of childhood management practices at different phases of the disease.

The interviews were conducted by Dr. Oke and a female ethnographer (B.Sc. Sociology, University of Ilorin) and Dr. Sohumann between August 1 and August 15, 1989 in ten study households in Alanamu ward. The preliminary ethnography included community observation (focusing especially on environmental sanitation), household observation and an interview using a study guide with the mother of the index child focusing on:

1. Health services availability and utilization
2. Mother and child daily schedule

3. Child care and family domestic task allocation
4. Water collection storage and use
5. Methods of human waste and refuse disposal
6. Meal preparation
7. Treatment of diarrhoea
8. Feeding and weaning practices (including feeding during diarrhoea).

After the ethnographic study, research instrument for structured observation was developed. This involved mostly observational studies of behavioural risk factors associated with diarrhoeal disease. The objective was to identify diarrhoeal disease transmission behaivours which increase the risk of diarrhoeal disease incidence and which may be helpful in developing an intervention strategy.

As in the previous case, at the end of each day's work, the research team went through the field-notes, cases that needed further investigation/observation were referred to appropriate fieldworker or investigator. Seriously sick children, discovered during the course of the study were referred immediately to Alanamu Basic Health Clinic (Operated through the State Ministry of Health) for prompt treatment.

The preliminary findings from the ethnography reveal that:

(a) Diarrhoea is perceived as a major childhood disease in the community. The informants were knowledgeable of the symptoms but did not recognize causation and prevention,

(b) Teething diarrhoea is perceived as normal and self-regulating. As such, virtually nothing is done in terms of treatment unless the problem persists or is getting worse. Because it is considered to be a normal part of the child's

development, informants perceive that it is not possible to prevent the child from acquiring it.

It is apparent from these findings that health education efforts should specifically target mothers' perception of teething diarrhoea. There is also the necessity for use of oral rehydration solution as well as addressing the causation of diarrhoeal disease. Specific efforts towards improved environmental sanitation, excreta, and refuse are needed in the poorest areas of our urban centres. Diarrhoea should not be viewed in isolation, there is a need to provide a comprehensive health programme to improve the health status of the community. There is also a need to raise the confidence of the community in the effectiveness of modern health care delivery.

(Rapid Assessment Procedures in the Early Planning for Control of Paediatric Acute Respiratory Infections: Lesotho (Wilson, Shale and Parker, 1989).

A two-phase anthropological study was designed to obtain community baseline data on acute respiratory infections (API) in Lesotho. The phase one of the study is of a particular interest to us in this chapter. The PIS included Dr. Ruth Wilson, a medical anthropologist at the Centres for Diseases Control, Atlanta, Georgia, U.S.A. Dr. Mamochaki Shale, Department of Sociology and Anthropology, National University of Lesotho, Rama, Lesotho, and Dr. Kathleen Parker, a Health Education specialist, Centre for Disease Control, Atlanta, Georgia, U.S.A.

The primary purpose of the phase one was to determine if there was a specific comprehension of ARI among village health workers and among care-takers of children under five years of age in Lesotho.

The study also aimed at an assessment of rapid anthropological methods in the collection of social and cultural

data on ARI (Wilson, Shale and Parker, 1992). Rapid Anthropological procedures are generally used to determine local terms, categories and treatment practices associated with a particular illness.

Research Method

Two study sites were selected by he Lesotho Ministry of Health based on accessibility and the presence of an active village worker programme. The plan was to interview 20 - 24 care-takers of small children (10 - 12 per health catchment) and two groups of village health workers (5 - 6 per village).

A preliminary interview guide was designed by the PIS through discussions with the staff from the Ministry of Health, this was pretested in thee field setting, then revised and a final instrument emerged which included the following five categories:

1. Illness terms related to general childhood illness.
2. Categories of severity for elicited illness terms.
3. Illness terms associated with breathing difficulty.
4. Narratives of ARI - related illness explain how Basotho define, diagnose and respond to ARI episodes in young children.
5. Suggestions for appropriate health education interventions.

The research team was made up of three PIS and two interviewers. The interviewers were selected from a list of applicants who had similar field experience and could read and write English and Lesotho languages. When possible, the interviewers were accompanied by a village health worker assigned to the selected village. He assisted by helping the researchers gain entrance to the community and permission to conduct the

interviews through meeting with the village chiefs.

A small purposive sample was selected from identified households. The sample represented different socio-economic groups in the community. In most cases, the village chief or health worker helped in the selection of the information. Data were collected using participant observation, observations and informal and formal interviews with individuals and groups.

Observations of the household surroundings were the basis for deciding socio-economic status. Other variables considered included demographic and distance from a health centre. The selection of small purposive sample requires that researchers who are knowledgeable of the culture make quick decisions after asking a few direct questions from the informants.

The study was completed in three weeks, five days for logistics of the field work, twelve days for data collection in the field, and two days for writing a draft report. A final report was submitted to the Ministry one month later. The study reveals that home treatments, traditional and religions leaders play a part along with over-the-counter medicine, health providers and modern medicines in caring for young children with ARI. These findings would help in the preparation of research instrument for phase two of the study.

CONCLUSION

The above studies are excellent illustrations of conscious efforts by anthropologists either as individuals or in collaboration with other scientists to adapt the traditional approaches in order to provide needed information and solutions to health care related problem(s). In most cases, such information was used for preparing and implementing comprehensive health care programmes.

There are certain prominent features common to all the three studies:

(1) The need to collaborate with medical scientists or health professionals and cooperate with government agencies, non-governmental organizations (NGOs) and other health provider organizations in order to provide a comprehensive health programme without compromising the fundamental tenet of anthropology as a scientific discipline.

(2) The need to make anthropology more relevant to modern human needs, that is, human species as a whole, rather than concentrating on archaic cultures or the so called primitive societies.

(3) A realization that in a modern complex world, there is a need to focus a research project to specific or manageable aspects of human behaviour(s) aimed at providing information/solution to a pressing or anticipated problem(s) rather than all facets of social life.

A common criticism of anthropological studies is that the field-work is too slow, too rigid and takes a long time to complete. Modern anthropologists are conscious of this and have learned that the speed of conducting anthropological research can be enhanced (Wilson, Shale, and Park op cit) by:

(1) Focusing the scope of the research problem.

(2) Cooperating with a multidisciplinary research team that can answer technical questions rapidly,

(3) Working with a country national social scientist with expertise in his or her own culture in the host country who are participating and fully cooperative with the research

activity and

(4) Having the managerial support of a resident project staff member.

For anthropology to remain relevant and sensitive to human needs, to continue to be the science of man, men of all periods and his work, it is apparent that the traditional methodologies must be modified, we must strengthen the capability to collaborate with multidisplinary research teams, cooperate with health care delivery agencies and organizations without undermining the identity of the discipline.

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CHAPTER THREE

COMPARATIVE HEALTH CARE DELIVERY SYSTEM.

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THE GOAL OF HEALTH CARE DELIVERY

The theme of this chapter reminds me of a joke told by one of my lecturers sometime ago. It had to do with a debate organized to mark the independent anniversary of Nigeria in the early seventies. Featuring were three international students on exchange programme. Each participant was given ten minutes to address the issue of health care coverage and funding in his own country.

The first speaker was an American. He described the operation of health care delivery services in his country as a derivative of market focus. He spoke about Laissez-faire arguing that America's health care policy is in line with its principle of liberal democracy. He maintained that health care is a private matter for the most part and that a number of private insurance firms exist to provide coverage. He summed up by saying that his country's health care delivery was the best in the world because it was considerably funded and that the introduction of medicare and medicaid policies by the American congress guaranteed coverage from birth to death.

The second speaker, a Briton, rendered an equally moving account. He acknowledged that his country is a capitalist society and that like the first speaker, they too believe in market forces. However, because his country realizes that a healthy nation is contingent on healthy citizenry, it has devised a plan whereby everybody in the population can be adequately catered for. He called this plan, National health service scheme. He spoke about the organization of this scheme, talked about modes of payment as capitation, and at other times General practitioners whom he

sometimes referred to as Family doctors. He rounded up by claiming that Britain's health care delivery services is the best in the entire universe because it was the most adequately funded and that coverage was from craddle to grave.

The third speaker spoke with equal zeal. He was of Russian origin. He spoke articulately and tried to convince his audience that Socialist Russia's health care delivery system is the best. He disagreed with the first speaker arguing that America's health model engenders the exploitation of man by man. He talked about social classes and key terms like bourgeois, proletariat were used quite freely. He did not believe that British health care can guarantee much, considering that people were still at liberty to shop health care outside the National health service. He concluded by saying that Russia's health model is the best in the entire globe because it is socialized and promises coverage from the rising of the sun to the setting.

A hallmark of the above discussion by these boisterous speakers is that each of them eventually underscored the fact that health care delivery service are closely tied to the policy economy of operating nation and the noble objective of health care delivery services. In its Alma-ata Health Declaration, the World Health Organization (The WHO) (1978), reaffirmed this when it observed that:

> Health which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

As we shall soon find out, the practice of health care delivery by nations is principally concerned with the realization of the WHO's objectives. However, the modalities for achieving this is shaped by a number of actors; among which are the climatic conditions, the amount of funds available for health services and the political idealogy or will of a country. Let us now examine the operations of each of these factors in some details.

DETERMINANTS OF THE NATURE AND SCOPE OF HEALTH CARE DELIVERY SYSTEMS

Climatic Condition: The pattern of medical care or health care delivery of a country can be determined by the types of diseases that are prevalent in such countries. For example, some countries are situated in the temperate regions of the world, while others are located in the tropics. It is known that some diseases that are spread by vectors need warm climate to thrive. Examples of such diseases are cholera, blackwater, lassa fever, yaws, worm infestations, yellow fever, schistosomiasis, trypanosomiasis, malaria and onchocerciasis. Since the vectors which causes these diseases hardly survive in the temperate regions of the world, they are usually not transmitted there. The implication of this for health care delivery systems, is that for effective control, countries that are located in the tropical axis of the world, should ideally develop a health care system which emphasize preventive measures.

Funds: The amount of resources a nation has or is willing to devote to health care, directly influence the pattern of health care delivery of such nation. In the past, all nations were poor and diseases like plague, tuberculosis, cholera, rabies, small pox, measles, leprosy, kwashiorkor and others which have their roots in poverty were quite prevalent. However, as a result of industrial revolution, most Euro-American societies have been able to raise the standards of living of their people and to reduce or virtually

eliminate poverty induced diseases to the part of non-existent (Jolly and King, 1975),

In contrast, most developing nations of today are still very poor. There is shortage of everything needed for effective health care delivery. Aside from shortage of physicians, lack of adequate funds, the hiring and training of all other categories of health workers, there are no drugs, available facilities are breaking down from lack of maintenance and the sites are littered with abandoned projects. Worse still, the people themselves are poor and this further limits access to health care. Health services financing has to compete with other needs of a nation. In the end, aver has to determine exactly how much to spend on health services. Where this amount is small, it invariably follows that not much can be achieved.

Political Ideology/Political Will: This variable finds expression in the operations of health care delivery services. The pertinent questions here are: should health care delivery services be funded by individuals or the state? What category of people should be covered by a particular health programme? Although this may not be a conscious policy, we find that whatever health care system is adopted by a particular country is not completely divorced of its political ideology. As indicated by the American, the United States health policy is highly influenced by laissez-faire. Efforts to socialize medical care is usually blocked by medical practitioners who contend that it will be grossly unfair to adopt such measures in a society which believes so much in market forces.

Arguably, health care organization can be placed on a continuum. At one extreme, are liberal democracies and capitalist societies like America where the sense of individual is so strong. In the United States, health care funding is mostly in the hands of individuals who reserve the right to shop wherever they like. Under such arrangement, the poor is usually at the mercy of the private insurance companies which exist to cover diverse range or

health services as the most sophisticated or quality care is reserved for the highest bidders (Erinosho, 1982).

Liberal democracies like Britain, Sweden and Japan are in at the middle of the continuum. In these countries, the governments even while acknowledging the strong sense of individuals have established national insurance schemes that have gone a long way to ensuring a reasonable health status for their citizenry. Lastly, countries like Russia, China, Cuba and other socialist/communists societies can be located at the end of the continuum. These countries emphasize the state rather than individuals. It is believed that the state is more than the summation of the individuals that make it up. Accordingly, the state owns and directly interferes in the running of health services. Private practice, and private insurance companies are not tolerate. The remaining part of this chapter will be devoted to the organization of orthodox medicine and its operations in selected countries.

The Organization of Orthodox Medicine

Units of Health Care:- It is common to hear people refer to hospital as the corner stone of orthodox medicine. In practice, the units of orthodox medicine can be classified as follows:-

(1) Village aide;

(2) Aid camp;

(3) Dispensary;

(4) Health centre;

(5) Hospital; and

(6) Teaching hospital.

Let us take a closer look at each one.

Village Aide:- This is usually a person who has some knowledge of modern medicine. He resides in the community where he works and usually acts as the local representative of health services at this quasi level. Such a person can be a Traditional birth attendant, who can be given some training in sanitary practices like cutting their nails and washing their hands before delivering a baby. They are also taught the act of sterilizing equipment and can be given a delivery kit containing a pair of scissors, and a few medicaments. Some village aides are part-time workers. As an agent of modern health care, a village aide is regularly visited by mobile teams from the dispensary, health centre or hospital, (depending on the supervisory body) and instructed on how to address health matters in the locality. His basic function is to educate the people on health practices (Jolly and King, 1975).

Aid Post:- This is usually an agreed place of meeting. It could be a market square, village square or town hall. Such places are normally arranged in advance between the health workers and a targets population. An aide can be sent to inform the people either through local chieftain or any medium that a particular health activity - inoculation, public health education, and the like - will take place. At such times, the team arrives and the business of the day is conducted.

Dispensary:- Like the previous two categories, a dispensary is normally located in the rural areas. It is often a small structure and is run by a medical assistant, a nurse and/or a midwife. Treatment at a dispensary is mostly on an out-patient basis. However, there is small provision for in-patients. In addition, dispensary personnel are also expected to spread knowledge of healthy practices in the area where they work.

Health Centre:- The latter can be differentiated from a dispensary by the scope of its activities. A health centre may be headed by a

medical doctor, or a medical assistant. However, which ever one is adopted usually depends on the official policy of a nation and the amount of manpower available. Fendall (1975) classifies the services rendered by a health centre into two, namely: personal and community.

Personal Services

General curative outpatients services

Maternity care

Family planning

The care of under-fives - immunization

The care of school children

Consultative clinics

Clinics for special diseases, eg. Tuberculosis and Malnutrition

Dental care

Mental care

Home visiting

Case work

Limited in-patient

Community Services

Health education

The improvement of excreta disposal

The supervision of housing conditions

The regulation of food-shops and market

Campaigns against communicable diseases

The collection of statistics.

Hospital and Teaching Hospital: Hospitals can be classified based on size, number of beds, admission rate and the number of outpatient cases seen. A more remarkable distinction however, is that based on specialization and technical sophistication. Hospitals are usually manned by physicians, a good number of whom are general practitioners. Together they carry out the functions listed against the health centre. On the other hand, Teaching hospitals are quite sophisticated. They are run by consultants and professors. They are expected to cater for patients who have special cases or ailments which need the attention of specialists.

It is often the case, to restructure these units of care into three tiers. In such arrangement, a village aide, aid post, dispensary and health centre will become the point where a patient makes the first contact with a health care system (Primary health care). Hospitals will represent the second level (Advisory) and Teaching hospitals the third tier (Specialized treatment) (Ency, Britannica, 1990).

The relationship amongst these levels is ideally that of referral. A village aide or work at a rendezvous aid camp is expected to refer cases that cannot be handled to a dispensary or health centres. Similarly, health centres are supposed to refer special cases to hospitals and only cases that will require specialized treatment and/or use of very sophisticated equipment that will be referred to a Teaching hospital.

This means that as one moves from Primary health care (PHC) to the third tier, health workers encountered get more specialized. This is not to say that doctors cannot work in for example, a dispensary, they can in the country can find them, but as with other resources, manpower is scarce and this leads to increase rationalization regarding optimum utilization. In most

developing nations, PHC is usually an area for auxiliary workers. The assumption underlying a referral system is that all units are available in all localities and that patients actually move from one to the other. In practice, one finds that among other things, the amount of money an individual is prepared to commit to health care vis a vis the degree of freedom permitted in health shopping, the politics of resources do ont always make it feasible or even necessary to move from one unit to the other. In places like Nigeria, there is no clear-cut patter of utilization. A patient who began a course of treatment at the Teaching hospital may later be moved to the house of a traditional healer or may decide that to cut down on cost, it will be better to ask an auxiliary health worker in his vicinity to complete the course of treatment.

A PARADIGM FOR CLASSIFYING WORLD'S HEALTH SYSTEMS AND HEALTH CARE DELIVERY SERVICES IN SELECTED CONTEMPORARY SOCIETIES

Field (1973) suggests four 'ideal types' of medical system, namely: (1) The pluralistic health system; (2) The health insurance system; (3) The health service system; and (4) The socialized health system. This section outlines Field's contribution and examines a contemporary medical system 'erected' on such touchstone.

The Pluralistic Health System: In this system, a number of medical systems and/or institutional schemes exist contemporaneously for the provision of health services. A number of systems of ownership of health facilities can be identified in a plural society. The first of these is ownership by the public. This means that the facilities that are provided are owned by the government. Depending on the tier of government in a country, this could be national, regional/state, or municipal/local government. In such organization, the government provides health services and

remunerates all cadre of health workers. A second form of ownership is private proprietary. This means that a member of the society can own a clinic or a hospital and can provide services on a fee-for-service basis to members of the public. A third form of ownership is voluntary organizations. These bodies are usually motivated by humanitarian reasons. They do not exist to make profit. Examples of this will be Missionary owned facilities. A fourth form of ownership under a plural health care system is co-operative or Group practice. An example of this will be where a labour union sets up a hospital to cater for the interest of its members, or where two or more doctors team up to establish and run a health care centre.

Two examples of nations whose health care system can be designated as plural are the United State of America and Nigeria.

HEALTH CARE DELIVERY IN THE UNITED STATES

The provision of health care in the United States is basically in the hands of private enterprises, which exist to provide coverage for a range of health needs. Accordingly, a good number of American doctors are in private practice. Two forms of practice can be distinguished. These are solo and group practice. A Physician in solo practice works alone. He may be a general practitioner or a specialist in one body system. In group practice, a number of physicians come together for the purposes of providing health care. Similarly, it is possible to distinguish three forms of group practice. The first is general practice group, where a number of general practitioners team up, the second is a uni-specialty or single-specialty groups which cater for one body system and multi-specialty groups in which a number of physicians specializing in different areas come together.

Two modes of payment can be identified. The first is called fee-for-service. This is the practice whereby health consumers pay directly for the services they get. In the second form which

involves paying advance (prepaid), patients and/or his agents pay an agreed sum (fix rate) every month for a full range of medical coverage. Prepaid arrangements are also of two types. The first type is called Health maintenance organization (HMO). This type of arrangement combines prepayment with services. Usually, a number of physicians specializing in various aspects of health come together or form a group practice which collects monthly fee from member of the public (subscribers) in advance with the promise that they will be catered for when ill. The second mode of prepayment involves private health insurance coverage. Here, a person pays a specific amount annually (premium) to a health insurance firm for coverage of all or some of the medical expenses that might arise as a result of ill-health. Again, ownership of insurance companies also range from solo, through partnership, limited liability companies to non-profit ones like Blue cross and Blue shield.

About 80 per cent of Americans are covered by one form of insurance or the other. Generally, insurance companies do not pay all medical bills incurred at any particular time. Consequently, individuals still have to find at least a third portion of the money themselves (Ency. Americana, 1990).

By the middle of this century, it became clear that certain categories of people lack health access of any kind, either because they are too old to work or too poor to afford the cost of health care. After series of debate and protests b powerful lobby groups like American Medical Association (AMA), the American congress finally passed a bill providing for a public owned Medicare and Medicaid programmes.

Medicare programme is actually a Federal health-insurance programme which provides coverage for the aged - defined as individuals over 65 years of age and the disabled. Medicaid on the other hand, is a Federal-state sponsored programme designed to help the poor and the medically indigent.

HEALTH CARE DELIVERY SERVICES IN NIGERIA

Nigeria has two medical systems. These are orthodox and traditional medicine. Orthodox medicine or modern medicine as it sometimes called, is the only officially recognized practice. However, due to a multiplicity of factors, traditional healing has continued to remain the people's medicine. Some of these factors have to do with the phenomenon of the definition of disease and the fact that orthodox medicine is simply not available to two thirds of Nigeria's teaming population who reside in the rural areas. Patronage or utilization of healers services are usually at the discretion of patients or his therapy managers (usually kinsmen). Traditional doctors are not allowed to issue excuse duty certificate to their patients. No official policy exists regarding the practice of traditional medicine.

The implication of this is that health care delivery relates only to orthodox medicine. Nigeria's approach follows the three tiers of PHC, Hospitals, and Teaching hospitals. There is no provision for village-aide in Nigeria, but aid camps and other forms of rendezvous are fairly regular, especially in the rural areas. This means that aid camps, dispensaries and health centres are the first point of contact with health services. These facilities are financed by the local governments and are manned by medical assistants and other cadre of paramedical staff. It is possible to see hospitals financed by local governments, but they are few, compared to the number of local government in the country. Hospitals are more the domain of the states. They are usually located in the capital and other cities. Similarly, Teaching hospitals are almost the sole responsibility of Federal government.

There is no specific pattern of utilization, but orthodox medicine is usually thought to be the best form of treatment for natural ailments, while traditional healing is considered most appropriate for prolonged ailments or illnesses which are diagnosed to be of preternatural origins. Oke (1995) finds that such

conception cuts across all segments of the society, while the pattern of dual utilization described by Asuni (1979) adequately captures the illness behaviour. Aside from public health facilities, a lot of physicians are in private practice. It is possible to classify private practices into solo and group practices, but the latter is quite few. No form of prepaid arrangement exists. This means that there is no health insurance of any kind. The closest arrangement to this is found where governments and certain companies cater for their employees, their spouse and a maximum of four children. Physicians in such practice usually send their health care bills on monthly or quarterly basis. Other than these, all forms of practice - both public and private - operate on a fee-for-service basis. As in America, utilization of orthodox services does not take cognizance of tiers of health care. People utilize tier or system depending on the definition of disease. Health care delivery services in Tanzania, Ghana, Kenya and a number of developing nations follow the same basic structure outlined above.

The Health Insurance System- Except for Great Britain, most other countries of Western Europe and Japan practice this system of health care delivery services. Health structures in these parts bears resemblance to those obtainable in pluralistic societies. However, unlike the case in the latter societies, most financial transfers, either to institutions or physicians are made by third party agencies - which could mean the government or private groups. In these countries, the role of insurance companies are limited to that of collecting premium - dues, taxes, contributions - from a population needing coverage and ensuring that such monies are disbursed either directly to those responsible for providing the services or to the patients as part or total reimbursement for their medical care expenses. The health care delivery services of Japan is proto-typical of this model.

HEALTH CARE DELIVERY SERVICES IN JAPAN

In Japan, two major types of health insurance scheme exist. These are the National Health Insurance and Employee Programmes. Japan National health insurance scheme came into force in 1961. This programme covers all Japanese residents who are not in the labour force. The employee health insurance scheme on the other hand, covers everybody working in any establishment or organization that employs an upward of five people.

The government takes direct charge of administering all insurance schemes and sees to it that equity is achieved in terms of coverage and benefits. In a limited cases however, the government nominates or mandates health insurance firms to manage employee schemes. Funding for the latter scheme is sourced by equal contribution from both employers and employees, while the national programme is funded directly from the treasury. As the case with most insurance schemes, the National health insurance does not cover an entire medical or hospital expenses. Patients still have to look elsewhere or subscribe to a private health insurance to make up the shortfall. Health structures in Japan bears close resemblance to the pluralistic system. The three tiers of operations are discernible. Doctors can either work for the Ministry of health or in private practice. They can be in lone practice (solo) or work in group.

The Health Service System

In this category most physicians are either in private practice or work in government hospitals as consultants. Health structures follow the same three tiers discussed earlier. One hallmark of this system, is that almost all health facilities are owned by the state (national government). The maximum number of patients a physician registered with the scheme can see in regulated by the government. Physicians are paid directly from the

state treasury. Such payments usually very, depending on whether or not a physician is in private or public service. The physicians in the latter service are usually paid salaries. Those on contract for the government either get salaries, or they can charge by the times they see a patient (sessional fees. Another way is by capitation. This is a form of block payment which taken cognizance of the number of patients seen rather than number of times seen. The British National Health Service is an archetype of this third model.

HEALTH CARE DELIVERY IN BRITAIN

In Britain, most medical facilities are owned and operated by the state (national government). The National Health Service Act of 1948 provided for everyone in the population. Medical attention is free. Residents are expected to register with the general practitioners (family doctors) of their choice. The ceiling of doctor-patient ratio is pegged. Specialists in this system usually work in the hospitals or a salary.

The National health service programme is funded by the government from taxes. Doctors are paid capitation (fixed rate) based on the number of patients that are registered with them. Physicians can choose to register with The National health service or be independent of it. In reality, almost all physicians register with the scheme. Wealthy citizens or those dissatisfied with the services of their family doctor, are at liberty to see other doctors of their choice. However, they are expected to bear the medical expenses. Again, the structure of health care also follows the three tiers discussed earlier.

The Socialized Health System

In a socialized system, all facilities are owned and managed by the state. As in Britain, the state is responsible for fixing the number of patients a doctor can see. Such patients are usually

selected on a geographic or occupational basis. Physicians and paramedical staff in a socialized system are regarded as state employees and are paid salaries directly from the state's treasury. The health care systems of Eastern Europe and Russia are classical examples of socialized medicine.

HEALTH CARE DELIVERY IN RUSSIA

As typical or socialized medicine, health care delivery in Russia is operated by the government. Physicians and other paramedical staff are paid salaries from the treasury. Health care is comprehensive and free. Again, heath care delivery follows the three tiers mentioned earlier. However, emphasis is placed on preventive care. A lot of polyclinics or outpatient units exists to cater for the health needs of people.

Polyclinics are staffed by teams or physicians, a good number of whom are specialists. Health care in the more remote areas are largely in the hands of auxiliary workers. In large cities, polyclinics are organized for children, adults and for special purposes like looking after one aspect of the body system. In contrast, small towns usually have one multipurpose polyclinic. Unless in extreme cases and that is after due process, patients are not at liberty to change their physicians. Similarly, physicians have no choice over the schedule of duty that is allocated to them.

SUMMARY

This chapter is concerned with comparative health care delivery services. We have pointed out how health care delivery services can be influenced by ideological considerations. We have identified the goal of health planning and suggested that the nature and scope of a health care delivery services is affected by a number of factors, among which are the climatic conditions of a country, the amount of funds available for health services and the

political leaning of nation. Lastly, we examined a number of medical systems using Field's scheme In all, one basic fact stands out: the goal of health planning remains that of equalizing health access and achieving a reasonably high health status for all citizenry.

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Chapter Four

SOCIAL EPIDEMIOLOGY

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INTRODUCTION

The definition of epidemiology as academic discipline has been controversial over the years. Scholars have defined epidemiology in various ways. But the most important thing is that society from the existence of man has been bedeviled by one disease epidemic or the other. Therefore, the word 'epidemic' is not just mere abstraction but it is a social fact which has its root in the Greek words 'epi' meaning 'on' and 'demos' meaning 'people' (Evans 1979). The modern science of epidemiology originated with John Snow's identification of a particular source of drinking water as the cause of the 1849 cholera epidemic in London.

Although epidemiology which is simply being defined as the study of prevalence and dynamics of stages of health in human population (Frerichs and Neutra, 1978) is primarily based on biological theory at the cellular level it is now drawing more on sociological theory. As a result epidemiology has been conceptualized as a social phenomenon thereby reflecting more on social and cultural factors of incidence, prevalence, distribution and determinants of states of health and disease in human group and population. Therefore, social epidemiology is the study of disease process, its occurrence in population groups, those socio-cultural factors that affect their incidence, prevalence, distribution and host responses, as well as their dynamic state, in the understanding of disease prevention and control in human population. This is the

basic goal of social epidemiology as academic discipline. It helps to understand the role of socio-cultural factors in state of health and disease in population groups, and how these can be influenced to provide solutions.

This chapter discusses social epidemiology by looking at various perspectives in social epidemiology such as sources of data collection, approaches and the use of epidemiological data.

PERSPECTIVES IN SOCIAL EPIDEMIOLOGY

Many social science theories have contributed immensely to the understanding of disease. For instance, the theory of roles in disease has been used to designate social science model. Labelling theory has also been used to explain mental illnesses (Becker, 1963). For instance, social science models of health were developed by various scholars like Talcolt Parsons' (1951a and b) work on sick role model, Becker's (1974) theory of Health Belief Model (HEM), Mabogunje's (1974) urbanization theory, Erinoso (1978) Oke's (1982) model of socio-cultural variables, Jegede's (1994) work on the social concept of health and illness analysis, and epidemiology transition model by Omran (1971) etc.

Hipocrates had argued that disease may result from the imbalance of the four humus of the body that is, blue bile, yellow bile, blood and phlegm. He said, for people to be healthy there must be balance between the four bodily humus. This may differ from culture to culture and may also depend on ecological diversities.

After this model came the germ theory of disease. The model states that diseases are caused by certain agents. It explains how people can be infected by bacteria or viruses, the host responses and manifestation on the part of the victim. The model suggests treatment by eliminating the bacteria and viruses by the use of medicines. The theory developed by Pasture in response to health problems of his time dominated medical thought for a long

time and was major break through in biomedical research. After sometime this theory depleted because it became clear that it could not account for wholistic perception of disease causation. As a result multicausal perspective of disease as against monocausal model gained ground. Both social and physical environments are considered necessary for incidence and prevalence of disease (Hollingshead, 1961). For instance, recent survey of Yellow Fever in Delta State of Nigeria show that Yellow Fever is more prevalent in the upland area of the state where there are thick forests and high population density than in the riverine area (Jegede and Onoja, 1994). Also Mozden (1966) has found that there is relationship between environment and incidence of cancer.

Social perspective of epidemiology explains that human activities are relevant to health analysis. Human interaction process, behaviour, attitude, belief and practices contribute to incidence, distribution, prevalence and dynamics of diseases in human population groups. Changes in pattern of social organization like moving from one place to the other as the case is with refugees. They are always exposed to health hazards. For instance, water borne diseases like cholera and diarrhoeal, and infectious diseases are associated with refugee camps. High incidence of cholera was reported from the Oru Camp of the Liberian refuses in Nigeria in 1991. Also, the recent civil war in Ruwanda left many of the citizens dead in the refugee camps in the neighbouring countries. Erinoso (1978) and Oke (1982) studies among the Yoruba people of Nigeria found that the type of food eaten have health implications for the people. For instance, certain food items that are required for certain category of people may be forbidden while some harmful ones may be approved. Also, Odebiyi (1989) noted this nutritional factor in her study of healing processes in Ile-Ife.

Sociologists have used social structure, class, network system, environment, social status, socio-cultural practices, and urbanization to analyse health.

Within a social system a patten of relationship exists between individuals and groups. Such relationship may lead to certain health hazards. For instance, sexually transmitted diseases like gonorrhea and acquired immuno-deficient syndrome (AIDS) have been associated with indiscriminate sexual intercourse. It has been argued that the onset of AIDS has generated interest in sexual behaviour both before and outside marriage in an attempt to identify the quantity and characteristics of men and women at risk of contracting AIDS, especially through heterosexual activity, and to understand differences between the sexual behaviour of different groups (Isiugo-Abanihe 1993, Orubuloye et. al. 1992, 1993). In a recent study, Isiugo-Abanihe (1994) found that about 54 per cent of men and 39 per cent of women have had extra-marital relations. This has implication for incidence, distribution and prevalence of AIDS in Nigeria.

These models tend to explain disease from various perspectives other than the germ theory. This shows that disease diagnosis may not be monocausal rather multicausal. Certain diseases have more than one causes. Even many illnesses may not be as a result of any germ but due to break down of the social process. For instance, stress may be caused by failure in an aspect of life, divorce, bereavement, disappointment, loss of jobs etc. Social epidemiology makes it possible to analyse health in the light of social-cultural factors that may influence illness and profer adequate solution or therapy. To do this we will have to discuss health research in epidemiology.

SOURCES OF DATA COLLECTION IN SOCIAL EPIDEMIOLOGY

Social epidemiology uses various sources of data in its operations. It has been argued that social epidemiology is a discipline involving diverse disciplines of the social sciences like demography, economics, political science, sociology and

geography. All these have tended to employ one type of method or the other to explain epidemiological investigation of particular disease. The sources of data range from census data, ministry or institutional data, vital registration, hospital data, business data, personal data-documents and biographies to international sources.

Census is an enumeration of the entire population at an interval of periods either quininally (every ten years) or more as may be determined by individual country. In census data an attempt is made to gather information on sex, age, occupation, marital status and other varied demographic sources that may inform the knowledge of a researcher. In using this type of data the demographer or the epidemiologist who is involved in the study tend to relate the prevalence of a particular disease to the age categories within the population. It can also be used to determine the ratio of health workers such as nurses and doctors to the entire population. For instance, the on-going development of Preventive Health Care (PHC) in Nigeria is based on the 1963 census data. Odebiyi and Edington (1976) used 1962/63 census to analyse the occurrence of cancer in Ibadan.

Census data as good as it is has its limitations. Census data are primarily collected for administrative purpose and therefore it becomes very limited in use for epidemiological studies because all the information needed in health analysis may not be available. Secondly, it is politically biased since allocation of resources is usually based on population while election is a game of numbers (Odumosu, et. al. 1995). Also in most cases census data are inflated. This was the case with the 1973 census in Nigeria. Because census takes place periodically usually every ten years it becomes difficult to base health analysis on it.

The ministries and research institutions collect data for use in administrative matters. This include patient biodata, drug supply personnel etc. This type of information is useful for epidemiological studies. This particular source of data has some setbacks in its effective utilization. Since ministries send out questionnaires and

information card to collect information from outside, it becomes apparent that most of them are not returned. For instance, the cancer registry unit of the University College Hospital (UCH), Ibadan between 1962 and 1963 sent ut cards to private hospitals as well as public hospitals to gather information on the incidence of cancer in Nigeria, but most of the cards were not returned.

Vital statistics or registration of vital events like births, deaths, marriage etc. is another source of data. In some countries like the U.S.A., Britain and Sweden, it is a law that such events as births, deaths etc. must be registered at a specific centre approved by the government. It could be an administrative unit or on town basis. Usually chiefs and local teachers, assembly pastors and health care centres are used for this type of data gathering in Nigeria though not very effective. Although this is a good method of gathering information, it has the problem of proper implementation. For instance, National Demographic Health Survey (NDHS) for Nigeria revealed that many of the births in Nigeria were delivered by traditional birth attendants (TBAs), friends and relatives, (NDHS, 1990), and therefore, this kind of deliveries may not be registered. This shows that only a negligible proportion of births, for instance, were registered. Secondly, the law guiding registration of vital events are not effectively enforced. The local chiefs and teachers normally used for the assignment in the rural areas where majority of the people (about 65 per cent) reside in Nigeria are weak and could not enforce the law.

Hospitals records. When a patient reports in the hospital it is a routine to collect his/her biodata information usually referred to in medical parlance as 'Clack'. In case of any incidence such as death the doctor takes down certain information concerning the victim or deceased. This information tends to say some things about him/her. Although the physician acting within his professional ethics may not be concerned about such things that the epidemiologist might be interested in. For instance, Odebiyi and Pearce (1976) in their study of congenital malformation found that

the data collected by the doctors in the hospital was not sufficient enough to explain the cause and distribution of the disease.

Business data is another source of epidemiological data. The geographers in collaboration with the town planners may delineate a city for study. The problem with this type of data is that they are primarily collected for specific purposes and not for epidemiological use, per se, but can only be twisted to suit one's purpose.

Personal data or biography can be used for epidemiological analysis. This is useful because it unveils information concerning the owner of the document. But it is not very reliable because it is not kept for epidemiological purpose, one can only make inferences from it. It is also subjective and the definition of concepts may create a barrier for the interpretation of such document.

International source of data like the United Nations Organisation's (UNO's) documents, atlas and so on are very useful in epidemiological analysis. They provide information that are necessary for comparative analysis and cross-cultural studies. Although they are good sources of data they cannot be relied upon because the information provided may not be good enough for epidemiological studies of a particular place at a point in time. This is because they are usually too large to handle.

Although these have been considered as sources of data, epidemiologist must go to the field to collect primary data in order to perform their job effectively. Some of the data from the sources above may not provide the required answers to epidemiological questions. Even where they tend to provide answers such information may not be reliable, even they may be completely obsolete as the case is with the 1963 census data. In order to provide valid and reliable data, epidemiologist use primary data.

APPROACHES OF SOCIAL EPIDEMIOLOGICAL STUDIES

Epidemiological studies involve certain dimensions if they are to be adequately carried out. These are cause; diagnosis, symptom, treatment, prevention and rehabilitation. It also includes the origin, nature and solution of health problem, and nutrition that contribute or can contribute to it. Availability of data is paramount to such research. Since epidemiology deals with incidence, distribution and prevalence of diseases data on custom of the people and health facilities will be very useful. Relocation of facilities and evaluation of their effectiveness in relation to the population will be helpful for the assessment of the adequacy of such facilities. Information on age composition and distribution will help health planners in planning and implementation of health programmes. The number of children will help whether to train more peadiatricians or not. The result of hypothetical test will determine the type of intervention programme needed to solve any particular health problem (Grundy and Reinke, 1973).

Epidemiological hypothesis will normally reflect the cause and effect relationships between two variable. Several other intervening variables may determine whether or not such relationship exist. The first stage is that whether a statistical association exists between the two categories, and also whether there is correlation. For instance, drinking of water from the stream and the incidence of diarrhoea among a certain population group. Epidemiologist will first establish whether there is relationship between water and the disease. Then they will examine the association between the variables. The contribution of epidemiology to the assessment of relationship is the provision of information whether an association exists between cause and effect. Several methods can be used to obtain data and test hypotheses.

Social Epidemiological studies can either be qualitative or quantitative or both. Most epidemiological studies today employ qualitative methods as a short cut to provide rapid assessment

measure for any epidemic. Methods used include focus group discussion (FGD), indepth interview, observation (participant or non-participant), and semi-structured interview. While quantitative methods include structured interview, non-experimental studies, cohort studies, case control study, retrospective study, prospective study, cross-sectional and longitudinal studies and the Cornell medical index method. All these methods attempt to understand the relationship between disease prevalence and causal factors.

Focus Group Discussion: This is a method of interview that involves a group of people with similar socio-demographic characteristics. Participants are usually arranged in a circular form which provides opportunity for participants to sit face to face. Participants range from 6 to 12 per session. There is usually a study guide to which participants respond freely. There is no restriction as to answers because it is an avenue for people to speak up their mind about the theme of discussion. It is usually administered by a facilitator or moderator and recorder or note-taker. Also, responses are recorded on magnetic tapes. A typical FGD is usually conducted under conducive atmosphere while the facilitator makes sure that no participant is dominating the discussion, as well as guide against the problem of digression from the these of discussion. This method is useful for rapid assessments in social epidemiology to gather information for intervention and evaluation programmes during epidemics. A typical FGD lasts between 30 minutes and 1 hour.

Indepth Interview: This is a method used to obtain information from individuals in the society in which the respondent is allowed to talk freely about the topic under discussion. Responses are probed further by the interviewer who normally records the responses. Sometimes the interviewer may seek the consent of the informant to record the interview. There is usually a study guide for the interview. This method is also useful for rapid assessment

in social epidemiology to gather information for intervention and evaluation programmes during epidemics. Questions for this type of interview should not be too long and must be clear.

Observation Method: There are two types of observation. These are: participant observation and non-participant observation. In participant observation researcher gets himself involved in the activities of the group under study. He takes note of his observations and record them at the end of an activity. On the other hand non-participant observer does not take active part in the activity of the group under study. He merely observes as an outsider and records his observations.

Structured Interview: This is a method of interview in which respondents have options of choosing from preceded answers. It is restrictive and usually can be self-administered. It can be mailed to respondents or through telephone, fax or administered by an interviewer especially while dealing with illiterates. This method is usually useful for longitudinal studies because of the time involved in it administration and analysis.

Semi-Structured Interview: This is a combination of both qualitative and quantitative approach. Here some questions may be preceded while some may be left open. This can be self administered for illiterates while the interviewer can administer it to the illiterates. It stands between indepth interview and structured interview. It is also useful for rapid assessment during epidemics.

A social-epidemiologist is not restricted to these methods. Today social epidemiologist use other methods that are explained below.

Experimental Studies: This provides a way of testing cause and effect hypotheses by deliberate application of certain variables or holding them constant. This provides information about occurrence

or lack of occurrence of certain factor as contributing to the disease episode.

Non-Experimental Studies: This is a way of gathering facts to test hypotheses without necessarily performing experiment. The epidemiologist want to identify the natural circumstances that cannot be put into experiment. For instance, human experience is used to test the hypotheses that cigarette smoking causes lung cancer. This is done by categorising study groups into smoking and non-smoking categories and examine the groups with history or causes of lung cancer by quantifying them and find their ratio before drawing conclusion.

Cohort Studies: Here the investigator selects the study population consisting of two categories of people who are exposed to a particular health hazard and those who are not exposed. He will then observe these groups for a specified period of time in order to determine how many of them are exposed to and how many are not exposed to such health hazards. By doing this he will be able to determine the group which is prone to illness. He will have to compare the proportion of cases between groups. This helps to know the rate in each group.

Case Control Study: This is an alternative study method. In an epidemic environment a study population of sick people and healthy people are selected. The investigator will observe the frequency at which people are exposed to causal factors. He will examine the proportion of people wyo are sick and are exposed to the causal factors. He will compare this with those who are not ill but are exposed. Although in an study of this type the study groups are selected from the affected and unaffected categories, they represent unknown proportion of the case study population since the number of controls included is determined by the available number of cases.

Choosing the Research Study: Cohort studies provide the most adequate and easiest method. They are economical when the disease under consideration appears more frequently. It is uneconomical when disease under consideration is not frequent. Very large cohorts are required to obtain firm estimates.

The case control approach is more preferable. A limitation of the case control study is that information on the supposed case must be retained either in the memory of each person or written down until the person can be identified as having disease.

A case study is usually more advantageous in terms of time and resources, it is usually frequently undertaken first to determine the cause and effect and that may explain the occurrence of an association between the two categories. Cohort study can be undertaken later to confirm the degree of the association of occurrence. While retrospective study collect data on past events prospective study collect data to forecast future events or occurrences.

Cross-Sectional and Longitudinal Studies: Epidemiological study can be ascertained where the event relates to two points in time or a point in time. In longitudinal study, the observation will relate to two points in time. Most cohort and case control studies are longitudinal in nature.

In cross-sectional study reference is made to a particular point in time. Although it is more and easier and economical, it is limited to studies that are permanent or relatively permanent of individual so that the relationship of the individual status to the cause has the probability of reflecting his/her status as at the time of disease episode.

The Cornell Medical Index: This is a 'symptom-list' questionnaire. It is used together information about different categories of people or population. It provides crude health-illness profile of a particular group or community. This method has been

criticised for its limitation in cross-cultural studies. According to Oke (1982), it is very difficult to use in non-literate societies for which it is not designed. He argued, for instance, that the index designed for Dade County in Florida, United States, is not suitable for any rural community in Nigeria.

MEASUREMENT APPROACHES IN SOCIAL EPIDEMIOLOGY

In examining the relationship between health and environment there is needs to take certain measurements. For example, in order to describe health problems in communities frequency distribution need so be constructed. That is we count the number of occurrences of each phenomenon, proportion and percentages are used to explain raw data in order to understand the distribution and compare variables and categories. For instance, in two communities with different population sizes say community A with 10,000 people and community B with 20,000 people and reported cases of Tuberculosis of 9,000 and 19,000 respectively. In analysing the two communities one may be tempted to say that community B has more TB problem than community A. It is a problem to conclude from data on the face value. Measurement shows that incidence of TB is almost the same because the proportion or percentages of the population is the same pattern. Therefore, in epidemiological studies percentage and proportion are used because raw data is difficult to comprehend explanation in this case:

$$\frac{9{,}000}{10{,}000}\ (A) \text{ and } \frac{19{,}000}{20{,}000}\ (B)$$

For example Oduntan gives an idea of cases of anaemia in children aged 6-15 admitted to the University College Hospital (UCH) Ibadan in 1965.

ANAEMIA	FREQUENCY	PROPORTION	PERCENTAGE
Sickle Cell (HB.SS)	42	0.575	57.5
Sickle Cell (HB.SS)	8	0.109	11.0
Megaloblastic Anaemia	3	0.041	4.1
Haemolytic Anaemia	2	0.027	2.7
Iron Deficiency Anaemia	1	0.014	1.4
Unspecified Cases	17	0.232	23.2
TOTAL	73	1.00	100

Source: Oduntan, S.O. (1973) Pattern of Disease and Anaemia in Nigeria Children of School Age. The Journal of Tropical Medicine and Hygiene, Vol. 76: No. 2: 28-35. From the table above, the data show that sickle cell is the most frequent type of anaemia with 57.5 per cent and the least is iron deficiency with 1.4 per cent.

For comparison it is important to know the prevalence, proportion and the percentage. We also calculate the rates and ratios in order to compare the incidence of diseases between communities when comparing communities of different sizes than there is the need to calculate the rate A = 50, B = 100. A has different size from B. To be able to understand the distribution there is need to calculate rates and ratios.

According to MacMahon and Pugh (1970) "a rate is the frequency of a disease or characteristic expressed per unit of size and time of the population of group in which it is observed". The population of a group that is being observed is generally referred to as the population at risk. For example in two communities A and B with population of 300,000 and 1,000,000 respectively, there are 500 and 1,000 TB cases respectively.

$$\text{Community A} = \frac{\text{Cases of TB}}{\text{Population}} = \frac{500}{300{,}000}$$

$$\text{Community B} = \frac{\text{Cases of TB}}{\text{Population}} = \frac{1{,}000}{1{,}000{,}000}$$

In the two communities above rate is case divided by population size. This is frequency per unit size and time. Rate is the number of cases in a given community divided by population at risk or population in the community. Therefore the rates for the two communities are as follows:-

A = 1/600 or 0.0016%
B = 1/1000 or 0.0001%

Tuberculosis rate is higher in Community A although the frequency is higher in Community B going by the raw data the problem is in A than B. Therefore, the chance of contracting TB in community A is higher than B.

Ratio: This indicates the number of affected persons as a proportion of the number of unaffected persons in a particular population. For instance, from the example given above, we will subtract the affected cases from the total population and divide the number of cases by the number of unaffected population. That is: in Community A 300,000 - 500 = 299,500 and Community B 1,000,000 - 1,000 = 999,000. The ratios are:

$$A = \frac{500}{299,500} - \frac{\text{Affected population}}{\text{Unaffected Population}}$$

$$= 5/2.995$$

$$B = \frac{1,000}{999,000} - \frac{\text{Affected population}}{\text{Unaffected Population}}$$

$$= 1/999.$$

The social epidemiologist are also interested in the incidence and prevalence of diseases or state of health of the population.

Incidence: The incidence of a disease is the number of new cases which occur within a particular period of time among certain category or population group. The usual period of calculation is one year.

Prevalence: This denotes a total number of cases at any given time. It refers to the existing cases at a given point in time e.g. January to June of a particular year.

Period Prevalence: This is a number of prevalence observed over a period of time usually three months.

USE OF SOCIAL EPIDEMIOLOGICAL DATA

The usefulness of social epidemiology cannot be over-emphasized. Social epidemiological data provides a comprehensive clinical outlook and/or disease history in a social group or population. The data are used for planning health programmes. Erinoso (1982) has argued that no human society can adequately plan for its needs in the field of health unless there are epidemiological data. He also argued that epidemiological data are to the health planners as demographic data are to a nation. It provides information for the development and expansion of health facilities including the training of health workers. Social epidemiology helps to understand the influence of social and cultural factors on the health of the population. As a result, these socio-cultural factors are taking into consideration in prevention and control of diseases as well as health planning and implementation.

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Chapter Five

AGE AND AGING PROCESS IN NIGERIA

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INTRODUCTION

Age has always constituted a very important variable for ensuring order in African, societies, of which Nigeria is a part. However the tendency that this phenomenons will continue to be relevant to the social structure is slim.

This is because 'Europeans', conquest and colonial rule, have fora long time set the agenda for development in Africa. African values have been under pressure not only from Christianity, but also from imported paradigms of development such as Europeanization, Westernization, Modernization, and now democracy'. (J. F. Ade Ajayi, n.d.: 41). Thus recent breeds of African know more of European ways of life than of themselves. They are what someone has referred to as 'White men in black skin'. The few who care about African culture do not seem to know the philosophies informing it.

Interestingly, the Europeans and Americans being emulated now care about age and aging. Though for different reasons. The various publications arising from government concerns on the youth and the elderly were responses from social problems emanating from their social structure. Thus, for instance, the falling birth rate in the American society in the 1960s led to the concern for the aged. It led to a new demographic structure such as that elderly became politically and economically significant. In the words of Lammers (1983: 1):

> The falling birthrate beginning in the early 1960s, coupled with increases in life expectancy, makes this demographic shift inevitable. The number of older persons with the personal resources and political skills needed to participate in the political process is growing, and elected officials are becoming increasingly sensitive to their voting strength. This suggests the likelihood of greater political influence for the aging. (my emphasis).

Consequently, the various political parties' policies have been shifting in emphasis to the aged. The educational institutions have responded by directing attention from the youth to the aged.

In Nigeria, like in most Africa societies, the modernization process is directing attention towards the establishment of European and American social structures. It is not surprising, therefore, that some of these developing nations have started to think of establishing 'Old Peoples Homes'. This is in spite of the fact that the traditional social structures have not completely broken down. There have been enough studies on the youth even though African populations are youthful. Even the aged, now constituting the retirees, in the urban centres and those in the rural areas who constitute about 70 per cent, male and female are not being cared for.

Traditional African Social Structures, as earlier stated, had their own peculiar arrangements such that both the youth and the elderly were taken care of towards the maintenance of social order. We shall now turn to a consideration of some of these.

Age in Traditional Nigeria

The principle of extended family is central to an understanding of the kinship system in Africa. In fact, the concept of extended family was developed from studies of African societies (Aldous, 1965: 109). Central to this principle is age. It is in relation to age that social anthropologists identify the position of different members of the extended family.

The polygynous extended family is commonly practised in West African societies (Oke, 1984). The head of he family is the oldest man in he extended family tree and is treated with awe and reverence. He had the last say in almost all affairs. Due to his age, he is assumed to have a wealth of experience about the environment. Thus he decides and advises his wives and children s the accepted ways of life. He is only one of the many elders in the community all of whom belong to the same age-group and therefore act in the same way.

In almost all African societies, age-group or age-set associations are used to assign duties as well as to control and discipline members. This is possible because age-sets cut across lineages. The age-groups are assigned duties such as maintenance of order in markets; clearing of bushes/roads; defense and so on. Especially in non-centralized societies like the Igbo in Eastern Nigeria, the age-groups was the only formalized group. The questions of war and peace were decided by the senior age grade along with members of titled societies. It is also from this age-grade that personalities to provide leadership, during wars

and other external danger, emerge. Junior age-grade provide social services such as sanitation and related services. There were also lower age-groups responsible for music, play and so on. Members of the society move through these age-grades as an important socialization agent.

Even in centralized societies where sophisticated administrative systems had been established apart from age-grades and lineages, age-grades still helped to facilitate, effective participation of the members in decision-making process. For instance recruiting people into the army and the determination of location in normal formations are done through the age-grades. Among the Egba, the youths often assist as 'scouts' during war to locate enemies. In short:

> age-set associations were an important mechanism for fostering group feeling across lineage loyalties and affinities, and for mobilizing community according to age in the traditional societies in Africa. The age-set associations were thus a major factor making for change in traditional societies (Ade Ajayi Op. cit)

It has ben pointed out that age-grades or age-groups are different from age-sets. Age-grades are, like 'status-positions', 'stages through which a person passes between birth and death'. Age-groups have also been differentiated from age-sets (Huntingford, 1960: 216). The later is seen as a loose unit unlike the former. Age-groups are a corporate entity the members of which are not only conscious of their unit and of their distinctiveness from both older and younger groups ... but they often act as a single body. They recognize common rights and obligations and acknowledge their own selected leader's (Gulliver 1963: 25). The transition is often made through circumcision for boys or through engagement in physical fighting from age 13 - 16 (Nadel, 1960) and clitoridectomy ceremonies for girls as among the Okpe. Physiological development of the breast for women, especially between ages 10 - 14 years, also mark an important transition stage. At about the age of 14, the girl undergoes the clitoridectomy ceremonies as means of initiation (for details see Owumi, 1993) and circumcision for boys. This age grade is for those who undertake the production and the fighting for men as well as 'active' participation in societal affairs by the women (for Okpe society see Otite, 1972). From about the age of 14 years up to 40 or 45 years can be categorized as the working-group. Aside from this age categories the other two major categories, below and after, also contribute significantly to the survival of the system. For instance the elders often constitute members of the secret societies as among the Ogboni in Egba Kingdom (Lloyd, 1962).

The young children often run errands for their parents at home and on the farm. As earlier mentioned, the elders are a repose of knowledge and experience from whom the working or economically active groups depend for

advise concerning not only how to behave but even the work they do. Ade Ajayi (Op. Cit: 41 42). 'The societies looked forward to the ancestors (i.e. the dead and the aged); their interest in looking backward was to protect their heritage in the interest of generations yet unborn, the kind of interest that is now being fostered in the West with the newly found concern for the environment'.

Ironically, the present trend in African societies particular, Nigeria is that of neglect of the future due to the very practice of European values. It is as if these societies want to first get to the crisis stage, as is being witnessed in developed nations. For now however, there is still a hope if only attempt are made to revive relevant values which can assist in maintaining order in the so called developing societies. The present situation from which a recourse needs to be made is what we now turn to.

Age and Aging in Modern Nigeria

According to the United Nations Economic Commission for Africa (1994), the African populations, unlike the developed nations, are youthful. This, it is argued, is a result of recent history of high fertility and decrease in child mortality. The percentages of children aged under 15 years ranged from 41.2 percent in the North African subregion to 47.4 per cent in the East/Southern Africans sub-region in 1989 and above 40 per cent in the countries of West Africa in 1990. Nigeria had 47.4 per cent of its population aged under 15 years in 1990 while Kenya had 50 per cent; Botswana 49.4, Rwanda 49; the United Republic of Tanzania 49.2, Zambia 49.7, and Zimbabwe 44.9 percent. Countries with low fertility rate had lower percentage under age 15 years. Such countries include Egypt 39.4, Morocco 40.5, Tunisia 30.8 Gabon 32.4 per cent. Generally, the member States of Economic Commission for Africa had the weighted percentage of 45 percent in 1990.

The working age group i.e. 15 - 64 percentage are also very high in Africa. The percentages vary from 51 in the West African (Nigeria has 49 per cent) sub-region to 55 in the North African sub-region. This implies that the total dependency ratio is quite high for Africa (99 per cent in 1989) as compared to the developed world (50 per cent also in 1989). This also implies that the percentage population in the 65+ age group is also less for member states of the Economic Commission for Africa as compared to those in the developed world. In other words, the problem of an aged population is not as precarious as in the developed nations. Consequently, more attention needs to be directed to the population below age 65+ in Africa than in the developed world.

In fact, one may hypothesize that increasing wave of violence and even political instability in Africa is a result of the age composition. It would be recalled that such violent tendencies pervaded the economies of the developed world in the eighteenth century as witnessed in what became known as industrial revolution. By he nineteenth and early twentieth centuries in Europe, and America, so many studies were carried out focusing on the youth. By the mid-twentieth century,
attention was being re-directed to the elderly in the developed nation for reasons earlier adumbrated.

It should be pointed out that it was during these revolutionary periods that sociology emerged as a discipline to study the disorder pervading these social structures. So many theories were developed during this period while anthropology was being used to study the seeming orderliness - which was perceived as stable (1) societies - in Africa. It was not until the early twentieth century that sociology was being applied to the study of African societies since changes were being witnessed in its social structure attributed to contact with Europeans. African societies were perceived as having no histories and the sociological theories, earlier developed for Europe was applied to these societies. (Roxborough, 1979). As these theories change in their application to the developed nations, the same was still being lifted wholly to African studies. This is not surprising since the application of 'scientific' methods to the social sciences requires a generalizing frame work. Unfortunately, the histories and experiences of different societies have continued to render the results from empirical researches invalid. In spite of this, the reproduction of foreign values has persisted. Consequently, virtually no relevant solution has been proffered for the instability in Africa. The age structure may be a relevant indices of analysis of this problem.

Ideally, as in the Westernized system being practised in Africa, the concept of milestone is central to the study of age and ageing. Milestone according to Kimmel (1980: p. 5), is 'an event that stand out in a person's memory or future plans as a significant, age-related turning point, or marker, this 'maker' is relevant only to the socio-cultural milieux. Even 'biology' or the physiological changes reflect cultural constructions of societal dictates. For instance the years of puberty which follow birth and childhood is marked by menstruation for women. What follows as societal expectation in traditional societies, including British society even in the early nineteenth century, was marriage. These societies designated women's 'nature' as being characterized by marriage, pregnancy, childbirth, nursing and child care. These were inventions of a cultural time and place. 'They were also ideological control,

whose social functions included the restriction of the social and economic activity of their women. These models of the female life cycle were social stereotypes which defined what was acceptable and unacceptable in terms of gender' (Jalland and Hooper, 1986).

These stereotypes, among others, became well established during the colonial period. Consequently, a child is expected, rather that still being backed by the mother, at the age of three starts a day care/nursery school (often earlier). By the age of six he/she begins elementary school. At about age fourteen, puberty sets in and instead of traditionally celebrated rites of passage marking the end of childhood and initiation into the beginning of adulthood requiring production and fighting activities, the youth is not socially relevant in the modern social structure. This is also the beginning of adolescence during which the child enters into youth culture but which is largely undefined in the modern African setting. In fact, very few attempts are being made to understand the youths of Africa at this stage of development. The general feeling is that a child who partakes in this sub-culture is a deviant - a product of improper up-bringing rather than crucial stage in life during which the effect of peer pressure and influence is far more than parental influence on the youth. In fact, military despotism has become the norm rather than excepting (Vogt, M. 1992). Most parents become intolerant of their adolescents who, in turn, result into identifying more with their peer groups. This is moreso since parental historical experience of societal expectations of children is totally different form the children's. Hence, the 'generation gap' creates a fundamental transformation from the shared experiences affecting the attitudes, values and the world view of parents and children. (Kenniston, 1971); Kimmel, 1980).

The children are torn between two-worlds-that of their parents and that of their peers. The latter has grown in influence since the socialization of the youth is now done by new agencies outside the nuclear/extended family structure. The educational, religious, economic and even the political institutions present values which are often contradictory to that which the family gives. For instance the freedom/independence which the child is exposed at about the age of sixteen in the University is far different from what exists in the family. The 'official' means of communication even in secondary school is, also, often different from that in the home. Most importantly the physiological awareness of the child often leads to social awareness which the parents have not been able to cope with successfully. Since the peer groups associate with themselves more than their parents, the boys often engage in gangsterism while the female would have engaged in sex (Demographic and Health Survey (1992) and now even engage in prostitution (Olutayo, 1994). This is in spite of the fact that

adolescents are categorized as an extended period of moratorium between childhood and adulthood (Kimmel, 1980). Unlike in the traditional societies, the adolescents are treated more as children than adults in modern societies, (Bilton, 1981). Furthermore, the christian tradition of morality also reinforce (d) beliefs among adults about the
discomfort of talking about sexuality with adolescents' (UNECA, 1994).

At the age of 18, the society confers social and legal rights and privileges on the child. Such privileges include voting rights, driver's license and criminal trial as an adult. In Nigeria, and most African countries, most children enter into the University and is often the first time of leaving home and a sudden incase of self-reliance. For some, the age signals, full participation in the adult role of the society. The rate of school drop-out is quite high in Nigeria, for example, of about 71 per cent of female children aged 15 - 19 years in rural areas in 1990, (calculated from Population References Bureau 1992) not less than 60 per cent would have dropped out after primary school, given the fact that only 34 percent of 29 percent in the same age category in urban area had secondary school education. For the very few who enter the University, full participation in adult-role is post-pointed while most of the drop-outs often get married.

After the age of 18 years and/or 21 years, very few significant events occur. What often becomes significant is the decade ages i.e. 30, 40, 50 etc. "Middle age", begins at the age of 40 and lasts till 50. It has also been observed that age of 30s and 40s are decades of having most responsibilities and to accomplish most (Neugarten, Bernice, Moore and Lowe 1965). From age 30 and the middle years of adulthood, events such as marriage, parenthood, occupational advancement, child rearing, launching the children from the home leading to 'empty nest' (Thompson, 1988), and the death of parents occur. It is also during this period that the individuals make most of their contributions to the society. This segment of the population support the children, students, and par of the elderly population.

The most significant events, decades after the adolescent, are menopause and retirement. The former occurs among when during which the production of sex hormones cease. and this is physiologically determined. This often has both negative and positive effects on women. This is because the accompanying physical changes such as weight gains or changes in fat distribution around the waist and hips may make dieting and exercise necessary to maintain the figure. Some may feel useless that they can no longer bear children wholesome may be happy that they no longer bear children wholesome may be happy that they no longer attractive which could, in turn, affect their sex

life. Some may isolate themselves to avoid social contact. Yet still others may be positively disposed such that they may achieve even educational or new career opportunities in business. They may also have a renewed interest in sexuality and better relations with their spouses. Furthermore, since the home is now an 'empty nest' with the children gone, these renewed interests may indeed lead to a grater acceptance of themselves (Thompson, 1998). For women who live in the rural areas, the post-menopausal period may have more negative effects than women in urban areas. While the men in both rural and urban areas may re-marry and urban women may, in their Western orientation, decide to seek out men who are loving and young, the rural women cannot do such. At this period, they are neglected and rejected. Except their married children invite them to assist in taking care of their children, rural women at the age of 50 and above in modern Nigeria would have looked far older than their age. In fact they would encourage their husbands to marry new wives who may also help them to survive their old age.

The second most significant event, i.e. retirement, is a phenomenon that is gradually gathering momentum and is socially determined. It is a non-colonial experience since most of the people employed in European establishments from the colonial period only reached the retirement age after independence. Nonetheless, the pension and gratuity schemes left behind by the colonial government has not experienced any significant change. As at now, the retirement age is generally 60 years or 35 years in service (whichever comes first). After retirement, the retiree is entitled only to pension and gratuity. Unfortunately, apart from probably retired politicians and private employees, retired civil servants are very poor. The chances are that years after retirement will mark declining physical health and economic hardship. Only very few enjoy health, economic security and freedom from traditional occupation and family responsibilities.

Death is the final point in the individual's life. In traditional Nigeria, this position is perceived s meeting with the ancestors i.e. family re-union. This is being gradually eroded with Moslem and Christian religions. This is because religion is now dissociated from the immediate family.

CONCLUSION

In this paper, we have tried to show the importance attached to the process of age and aging in traditional as different from modern Nigeria. What comes out most clearly is the fact that age and aging process in Nigeria, especially in urban areas, is gradually becoming like the process in United States

and Europe in the nineteenth century.

As in all capitalist societies, age is not respected, not even as status position. Bureaucratic organizations recognize the position occupied in the organization rather than (the age of) the person occupying it. Consequently immediately the person occupying a position retires as a result of old age, he/she becomes more or less, irrelevant, in the scheme of things. It is also common for even the government to argue that there is a need to 'pump new blood into the system'. In spite of this however, the young adults now occupying the bureaucratic establishments often still show certain respects to those lower to them in rank. For example, they may, in greeting, bow (as in traditional system) to those older than them but lower in rank. In the same vein, the traditional system of greeting is still very common in urban capitalist establishments. Students tend to prostrate/kneel down to their lecturers and junior lecturers do the same to their senior 'colleagues'.

Furthermore, it is becoming common to see the aged and children roaming the streets begging for money in urban areas. In other words, the aged and children are being neglected and uncared for in the urban areas unlike in rural areas even in present day Nigeria. This is not surprising because of the increasing monetization of the society. The dependency ratio of 100 in Nigeria (UNECA, 1994) has made it difficult for the working age group to be able to care for these age groups (0- 15 and 60+ years). The situation is being further compounded with high unemployment rate among the working age group. Also, there is the increasing difficulty of children to gain admission to school or receive appropriate education. Hence the children on whom parents may want to rely on, for a better future, themselves have no future!

Consequently, and especially for persons in the lower socio-economic classes the aged tend to perceive themselves more negatively less happy, and less self-confident. The aged also have the tendency for increased anxiety. (Kuhlen, 1964). Generally, there is a regressive physical growth and biological decline among the aged. This is in spite of medical break through that have prolonged the years of survival both in the developed and the developing world. In the latter, however, 'life' has not been added to the years of the aged not only are they being retired, their relevance to social and political problems are being jettisoned. In fact, even the treatment of ailments peculiar to the aged is not being given required attention in medicine.

For instance, one of the most common health problems relating to aging is hearing impairment. This medically known as presbyensis. According to Thompson, (1988), it is not medically treatable and is caused by degenerative changes in the inner ear. Hearing improvement among the aged often lead to

unusual behaviour such as irritability, fatigue, withdrawal, depression, anxiety, rudeness, appearing stupid, and so on.

The problem of vision is another area about which little efforts have been made with regards to the aged. As one ages, the ability to see objects clearly decreases and adaption time from light to darkness is increased because the eye share become dryer and depth perception changes. The implication of this is that the aged need to sleep early enough before it becomes dark. Yet, associated with aging, the elderly often have difficulty falling asleep and they may make up more often at right.

Furthermore, the internal excretory organs and even the mental capacity of the elderly also decreases. The bladder becomes inefficient such that the elderly may not themselves before getting to the toilet. Unfortunately, some old people may have become accustomed to bad odour and their sense of perceiving bad odour may have diminished. They may not, therefore, he conscious of the urine odour on them.

For those who live in rural areas of the developing world, their farming life, apart from the above ailments, also affect their physical stature. Most of them have difficulty in standing erect and often need staff (i.e. wooding stick) to support their weight in order to move around. Consequently, their diminished depth perception and inability to see clearly is further compounded.

Aging, indeed, is a social problem that requires urgent attention. The attention required however transcend the establishment of old peoples' home. It entails the need to resuscitate the age-old culture of maintaining family ties with the elderly. African societies are not too far from this position and this, therefore ,should not be too difficult to achieve. Its success however involves de-emphasizing the urge for material wealth. The old ways of life even in the developed world, it has been argued contributes to the development of one's self image and self-worth by providing love, affection, approval and support. It helps to establish a sense of belonging and provides opportunity for sharing information and ideas that are essential for survival and life satisfaction. (Thompson ibid). In short copying with old age is a family affair which in itself, helps to enrich the quality of life of both the youth, middle-aged, and the aged. It entails mutual understanding which can only be easily achieved among members of the immediate family who have known themselves. It is only among this group that tolerance should and is, expected.

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Chapter Six

WOMEN AND THE RISK OF HIV INFECTION IN NIGERIA: IMPLICATIONS FOR PREVENTION AND CONTROL PROGRAMMES.

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INTRODUCTION

Sexual transmitted diseases (STDs) pose a threat to the health and well being of the sexually active population in Nigeria (Asuzu and Idoko 1994: Asuzu, Omotara and Padonu 1992: Mersusmith, Kane, Odebiyi and Adewuyi, 1994). The eommon STDs in the country are gonorrhea, trichomoniasis, chlamydia, candidiasis, syphilis, human papilloma virus, lymphogranuloma venereum, genital warts and chancroid (Brabin et al, 1995: Adekunle and Ladipo, 1992: Ogunbajo 1989). Although there is no national data on the incidence and prevalence of each of these infections, most scientists in Nigeria agree that the incidence of STDs is high and increasing due to inadequately trained health manpower, scarcity of functional laboratories, treatment facilities and change from restriction to a more liberal attitude towards sex especially among teenagers (Adekunle and Ladipo, 1992).

The consequences of STDs are devastating: infants of infected mothers may have ophthalmic infections (which may later lead to blindness) and pneumonia: chronic pelvic inflammatory disease (PID) may complicate STDs, and patients may develop infertility as a result of untreated infections. STDs are also associated with spontaneous abortion, ectopic pregnancy and cervical cancer (Adekunle and Ladipo, 1992; Lande, 1993). Thus, the management of these complications places a heavy toll on the health care delivery in Nigeria.

The advent of HIV/AIDS in Nigeria in 1984 and the increasing number of those infected since then, have compounded the STD problems in that the prevention of HIV and the management of AIDS now place an additional burden on the health care system already overstretched by other preventable health problems.

Heterosexual contact is the main rout of HIV transmission in Nigeria (Federal Ministry of Health and Human Services (FMOHHS), 1992; 1995). This suggests that there is a parity of risk of infection between men and women. However, we argue in this chapter that women in Nigeria are more at risk to HIV infection than men. We have described the biological, cultural and economic conditions which make Nigerian women susceptible to HIV infection and have suggested that intervention strategies that will address them.

THE HIV/AIDS SITUATION IN NIGERIA

The first case of AIDS in Nigeria, involving a sexually active 13 - year old girl, was officially reported in 1984 (FMOHHS, 1992). Since then, the number of persons infected with HIV and those who have developed AIDS has been increasing rapidly. For example, in 1992, 367 new AIDS cases were reported in the country; the number rose to 917 by September to 1993 (WHO, 1993) and 1,490 at the end of 1994 (FMOHHS, 1994). FMOHHS project that between one to three million adult Nigerians will probably be infected with HIV by 1996 (FMOHSS, 1994).

As shown in Table 1, HIV has ben reported among a broad spectrum of the Nigerian Population. These are apparently heathy persons (Mohammed et al, 1988: Olusanya, Lawoke and Blumberg 1990). Blood donors (Shokunbi, Saliu and Essien, 1993) clients of STD clinics, tuberculosis (TB) patients, long distance truck drivers (FMOHSS, 1994) pregnant women attending antenatal clinics (ANC/2) (Nnata, Anyiwo, Obi and Karpas, 1993) commercial sex workers (CSW) (FMOHSS, 1992; Chickwem, Mohammed, and Ola, 1989; Mohammed et al., 1988) and their clients (Williams, Heart and Udoifa, 1989). However, because the CSWs engage in many risk-behaviours they have the highest reported rates of HIV and in addition are responsible for the transmission of others STDs that facilitate HIV transmission (FMOHSS 1994; 1992). Using the HIV prevalence among the ante natal clinic attendants as an index, the FMOHSS has put the national seroprevalence rate of HIV in Nigeria at 3.8 per cent of the sexually active population in the country (FMOHSS, 1995).

The figure is low in comparison to 28 per cent and 30 per cent HIV prevalence reported for a comparable population in Uganda (McGratt et al, 1992) and Kenya (Kiragu, 1995) respectively. However, the Nigerian figure may believe the extent of the problem because AIDS is under reported due to paucity of HIV screening centres (only 16 out of the 30 States in the country have screening centres) inadequacy of laboratory resources for testing and in-complete reporting from some centres (FMOHSS, 1995; Isiugo-Abanihe, 1994). In addition, the fact that AIDS may mimics other common health problems in Nigeria such as tuberculosis, mal-absorption syndrome and malnutrition may mislead Nigerians to think that AIDS is now a new disease, and therefore under-report it. Under reporting and the long latency period of HIV suggest that many HIV infected Nigerians may not be detected for several years during which they can transmit the virus to others.

Both HIV 1 and HIV 2 are common in Nigeria (Olusanya et al, 1990; Shokunbi et al, 1993). These have been reported in virtually all parts of the country, but particularly in urban areas with Plateau, Benue, Delta, Lagos and Enugu States leading (in that order) in the number of reported cases (FMOHSS, 1995). The explanation for this may be the fact that these states have some features which favour the rapid spread of HIV. Plateau, for example, has a cold climate and is therefore, a popular holiday resort with a relatively high number of CSW. Delta and Lagos have major sea ports which attract a large influx of sailors who are likely to engage in causal sex during their stay in these states.

Despite the wide publicity given to AIDS by the local media, the efforts of governmental and non-governmental organizations (NGOs) to educate the public about the threat of AIDS and the report of the increasing number of persons infected with HIV, majority of Nigerians continue to engage in behaviours which place them at risk of HIV. For example, in s survey on sexual networking in five locations in Southern and Northern Nigeria, Uche-Abanihe (1994) found that 54 per cent men and 39 per cent women have had extra-marital relationship, with 18 per cent men and 11 per cent women having done so during the week preceding the survey. Majority of these respondents have not used the condom which is known to offer protection against sexually transmitted HIV (Roper, Peterson and Curran, 1993; Van de Perre, Jacobs and Spencer - Goldbergers, 1987). High levels of unprotected sexual networking has also been reported by other investigators in Nigeria (Ososanya and Brieger, 1994; Ajuwon, Oladepo, Adeniyi and Brieger, 1993/94; Orubuloye, Caldwell and Caldwell, 1990).

The explanation for the problem is that many Nigerians perceive themselves to be at low risk of HIV infection, even though they engaged in high

risk behaviour (Onile, 1993; Osowole, 1992). Some Nigerians believe that because they have not yet knows or seen any AIDS patient AIDS does not exist in Nigeria. Others view the danger posed by AIDS with fatalism, arguing that one will eventually "die of something", and so are not prepared to change their sexual behaviour because of the threat of AIDS (Uche-Abanihe, 1993). In this situation and also considering the pattern of the AIDS epidemic in other sub-saharan African countries, there is likely to be an exponential rise in the incidence of AIDS in Nigeria in the next few years.

CURRENT NATIONAL HIV PREVENTION AND CONTROL EFFORTS

The Federal Government of Nigeria responded to the threat of AIDS in 1986 by setting up the National Expert Advisory Committee on AIDS (NEACA) which was later reconstituted in 1992 and renamed National AIDS and STD Control Programme (NACP). The NACP is located in the Department of Disease Control and International Health of the FMOHSS. Charged with the responsibility of co-ordination AIDS prevention and control activities nationwide, the NACP is divided into five sections: Programme Management, Epidemiology and Surveillance, Information, Education and Communication (IEC); Laboratory; and Clinical Management and Community-based care (FMOHSS, 1992).

The NACP has recorded some achievements since it inception. For example, it had decentralized its operations by appointing one AIDS co-ordinator for each of the thirty states and the new capital city, Abuja, whose charge is to oversee ongoing AIDS prevention and control efforts in their respective states. In addition, the NACP had established HIV screening centres in some states to tract the incidence and prevalence of HIV and design intervention measures to control further spread of the virus in the country. To this end, routine anonymous unlinked method of testing is being used to screen six groups: CS; Clients of STD clinic; TB patients; long distance truck drivers; and women attending ANC (FMOHHS, 1992). With respect to education, the NACP had developed many IEC materials (posters, brochures, pamphlets), trained some health workers and sponsored several educational programmes on the electronic media.

Various individuals, local and international agencies have complemented the efforts of the NACP through production of educational materials, training of health workers, education of CSWs and donation of equipments and HIV Screening resources (FMOHSS, 1993 Webster and Nnabugwu, 1993, Williams, 1994). Despite these achievements, however, a number of problems continue to

undermine the current control efforts in the country.

First, the number of screening centres is grossly inadequate for the 88.5 million population in the country. The centres are concentrated in towns and cities thus creating an urban bias in the sero-prevalence data.Second, as mentioned earlier, there is incomplete reporting in some centres. For example, some centres do not screen the desired sample from the groups (FMOHSS, 1995). In addition, vital information such as the gender of clients of STD clinics, TB patients, and apparently healthy persons were omitted. As a result, we do
not have national data of the gender distribution of HIV infected persons in the country.

Finally, educational efforts have relied heavily on the use of the print and electronic media despite the limitations associated with them. Although the media campaign has raised the level of public awareness about AIDS (Oladepo and Brieger, 1994; Odujinrin and Akinkuade 1993), its impact on behaviour is limited because many Nigerians who have heard about AIDS continue to engage in sexually-risky behaivour (Uche-Abanihe, 1994; Orubuloye et al, 1990).

The cause of the problem is that some of the media messages are too diffused, hence they do not address the socio-cultural and a economic constraints to behaviour change. For example, many educational messages encourage the sue of a condom to prevent HIV infection without suggesting how women can overcome the many difficulties they face in convincing me to use it.Such messages are also unrealistic because the cost of the condom may not be affordable to many rural dwellers. Also, campaign messages request Nigerians to stick to one sexual partner without suggesting how women can overcome the economic problems which cause many of them to resort to risk-taking behaviours to survive. Furthermore, the message about having one partner, may be quite dicey for a woman in polygynous marriage. A faithful woman in such a marriage still runs the risk of contracting HIV if her husband or any of the other women have extra-marital affairs with an infected person. Innovative educational interventions are needed to address these issues. We now turn to the discussion of the conditions which make women susceptible to HIV infection.

STDs AS A GENDER ISSUE

The physical differences between men and women affect their risk of suspectibility to STDs including HIV. Women are three times as likely as men to become infected through sexual intercourse because the vaginal wall is delicate and prone to sores and abrasions, which may create pathways for the

transmission of STDs during sexual intercourse with an infected person (Skelmerud, 1995). Yet, STDs are more difficult to diagnose in women than men (Cates and Stone, 1992).

Since STDs are common asymptomatic in women they are likely to harbour untreated STDs, some of which are known risk factors for HIV transmission (Pallangyo, 1989; Johnson and Pond, 1988; Piot et al, 1988). This makes the long term complications of untreated STDs far more serious in women than men.

In Nigeria, there are some cultural barriers that may prevent infected women from seeking prompt and appropriate treatment for STDs. First, there is the stigma associated with STDs. In Nigeria, it is a serious embarrassment fora women to be publicly seen attending an STD clinic. As a result, many infected women often seek treatment from traditional healers or patent medicine sellers who are likely to provide confidential but inappropriate treatment for their conditions. Secondly, the practice or purdah, (the system of seclusion of women from public places) which is widespread in many Muslim communities in Nigeria, may prevent infected women from seeking prompt and appropriate care, especially in areas where medical units are staffed by male doctors (Adekunle and Ladipo, 1992).

Nigeria is a male dominated society where women are expected to produce a many children as possible, preferably males. The woman is blamed, therefore, for infertility or reproductive failure, consequently many Nigerian women may value pregnancy more than their health and may engage in sexually risky behaviours which would raise their chances of contracting HIV (Adekunle and Ladipo, 1992). Nigerian pregnant women infected with HIV face a serious dilemma. They are likely to develop AIDs sooner than other HIV infected adults if they carry their pregnancy to term, and run the risk of transmitting HIV to their babies (Sabatier, 1988), thus contributing further to the spread of the virus in Nigeria. Yet, many of these women may not accept the option of an abortion given the high premium placed on fertility in Nigeria.

CULTURAL PRACTICES THAT CONTRIBUTE TO THE SUSCEPTIBILITY OF WOMEN TO HIV INFECTION:

Genital Mutilation

In Nigeria, it is unfortunate that women are victims of a range of cultural practices which undermine their health and well being. Of relevant to the issue of risk of HIV infection is genital mutilation of which there are two

types: 'gishiri cut' and 'sunna' circumcision. 'Gishiri cut' is a type of mutilation practiced by the Hausa of Northern Nigeria in which the vagina is cut usually by old women using unhygienic razor blade or knife (Adekunle and Ladipo, 1992). The cut is usually done to treat conditions such as infertility, generalized body pain etc. On the other hand, the 'sunna' involves excision of the clitoris of infants and young girls. The practice has persisted in Nigerian despite concerted efforts to eradicate it (Ajuwon, Brieger, Oladepo and Adeniyi, 1995; Ebomoyi, 198; Oduntan and Onadeko, 1984; Olamijulo, Joiner and Oladeji, 1985).

The 'sunna' mutilation is a violation of the rights of the girl-child, but has always been justified by men on the grounds that it prevents promiscuity. The excision of the clitoris is, therefore, aimed at controlling the libido of the females, thus suggesting that sexual pleasure is the exclusive right of men.

Although there is no research evidence yet that female genitation mutilation is a risk factor for HIV transmission in Nigeria, the fact that mutilation and subsequent scaring could result in vaginal tears during intercourse imply that it carries some risks. Such tears could create a pathway for the transfer of HIV during sexual intercourse with an infected person, thus increasing further, the efficiency of male to female transmission of HIV. HIV may also be transmitted to the girl-child through use of unsterile instrument which could harbour bacteria and HIV (Ajuwon et al, 1995).

Sexual Abstinence, polygyny and divorce

The practice of sexual abstinence by Nigerian women shortly before the several months after delivery has been well documented in he literature (Orubuloye, 1979;Caldwell and Caldwell, 1977; Ajuwon, 1990). Among the Yoruba of Western Nigeria, married couples are expected to abstain from sexual intercourse while the infant is being breastfed, after which they can resume normal sexual intercourse with their husbands. Sexual intercourse is discouraged during breast feeding because of the belief that the semen could have an adverse effect on the growth of the infant. Although the duration of post abstinence after delivery has declined in recent years due to increasing use of modern contraceptives, the practice itself is still common especially in the rural communities
where access to modern contraceptives is limited (Ajuwon, 1990).

Inherent in this practice is a system of double standard of sexual morality between men and women. Although women are expected to abstain from sexual intercourse while the infant is being nursed, men are not affected

by this rule because they have other sexual outlets. For example, polygynous men could easily turn to other wives and monogamous men could have extra-marital sexual relationships while their wives abstain (Ajuwon, 1990). Thus, sexual norms prompt sexual license for men and sexual purity for women. Whereas the wife is expected to be absolutely faithful to her husband, men have the freedom to philander.

This system of double standard in sexual relationship is also reflected in divorce practices. Under Nigerian customary laws, men are normally granted divorce if it is proven that wives have had extra-marital relationships (Ajuwon, 1990). Unfortunately, women married under customary and Islamic laws in Nigeria do not have that same opportunity because these laws permit polygyny (Ekundare, 1969). An adulterous man can therefore easily justify his action by claiming that he plans to marry the other women.

Under an ideal situation, wives of adulterous men could encourage their husbands to use condoms as a means of protection against HIV. However, persuading men to wear the condom may be a difficult if not an impossible task for many women because in Nigeria, a man will consider a woman 'loose' (that is promiscuous) if she request him to use a condom during sexual intercourse. Women may also encounter problems with the use of the female condom, which is now available but not yet used on a large scale in Nigeria because of its prohibitive cost.

This situation places women at a disadvantage in that they lack to ability to control the sexual risky aspects of the behaviour of their spouses and do not have the economic power to take action which would protect them from infection with STDs including HIV. Indeed, many women in Nigeria ar expressing concern that their own fidelity may not be a guarantee for safety from HIV, considering the fact that previous researchers in Nigeria show that a high proportion of women acquired STDs from their spouses (Elemile, 1982).

WOMEN, ECONOMIC CRISIS AND SEXUAL RISK - BEHAVIOURS

The Nigerian economy has been in recession since the early 1980s. To revamp it, the Nigerian government introduced in the last half of the 1980s, the economic structural Adjustment Programme (SAP) which consisted of cuts in public spending, removal of subsidies, trade liberalization, currency devaluation and retrenchment of workers. These measures caused a tragic decline in real income and living standards of majority of the population. For example, following the removal of subsidies, inflation got out of control and cost of living in Nigeria doubled between 1986 and 1987 (Webster and Nnabugwu, 1993;

Alubo, 1990).

Women have been particularly hard hit by the crisis. Faced with minimal economic support from their spouses and the need to care for their children, some married women in Nigeria have been compelled to exchange sex for additional material support for themselves and their children. As one rural married women pointed out during a focus group discussion on the cause of sexual net-working, "sometimes we are unable to leave our poor husbands and marry men who are better off because we do not want to abandon our children. Instead we have 'ale' (non- marital male sexual partner) who can assist us financially" (Ajuwon et al. 1993/94). The incidence of non-commercial exchange of sexual favours is also on the increase among young girls in institutions of learning who accept gift, food or many from other men with whom they established casual sexual relationships.

Furthermore, some out-of-school young girls have responded to the economic crisis by entering occupations in which they are vulnerable to being lured or forced to having sexual risk relationship with men. For example, several incidents of sexual exploitation of the itinerant female hawkers (IFH) in the course of their work have been reported (Orubuloye, Caldwell and Caldwell, 1993; Obot, 1986). Because of their relatively young ages, and the fact that they earn little income, the IFH in Nigeria are easily lured, harassed and sometimes raped by men inside the bus/lorry stations where the IFH sell their wares. As public awareness about AIDS is increasing in Nigeria, the IFH have become sexual favorites of men because of their believe that the IFH are not likely to have HIV, are sexually inexperienced and are not regarded as full time commercial sex workers. Unfortunately, there are no programmes in Nigeria that specifically target the AIDS education need of this group.

Another consequence of the economic crisis in Nigeria maybe the high proportion of Nigerian women who go into full time commercial sex work, as a means of survival. This situation is reflected in the change in the profile of the CSW in Nigeria in recent years. Previous researchers show that CSW were usually old women with limited education who have ben separated or divorced from their husbands (Cohen, 1969; Oleru, 1980). However, recent researchers indicate an increasing number of single, well educated young women and even teenagers involved in full-time sex work (Adedoyin and Adegoke, 1995; Orubuloye, Caldwell and Caldwell, 1994).

Despite the vigorous social marketing campaigns for condom in Nigeria, many CSW still do not use it (Chickwem et al, 1989; Adedoyin and Adegoke, 1995; Orubuloye et al, 1994). This increase their risk of exposure to STDs some of which are known risk factors for HIV transmission (Pallangyo,

1989; Johnson and Pond, 1988; Piot et al, 1987). Another source of risk to CSW in Nigeria is heir practice of receiving injections of antibiotics as prophylactics against STDs from patent medicine dealers who re-use needles and syringes (Chickwem, 1989; Ajuwon et al, 1993/94). Intervention measures that address these problems are required to reduce the risk of infection among CSW. We now discuss strategies that can reduce the susceptibility of women to HIV infection.

IMPLICATIONS FOR AIDS PREVENTION AND CONTROL PROGRAMMES

The following suggestions are made to reduce the risk of women.

1. Assessment of the nature and extent of STDs in Nigeria

Since STDs are risk factors of HIV transmission, their control will have a salutary effect on the prevention of further spread of AIDS in Nigeria. There is currently no national data on the incidence and prevalence of STDs in Nigeria, therefore, there is need to assess the current situation to determine the extent of the problem in the country. In addition to clinic-based collection of STD data, there is need to conduct routine community surveys and develop a surveillance system whereby STD trends can be monitored, interventions implemented to control them and their impact assessed. The NACP, in collaborating with secondary and tertiary health facilities is appropriately positioned to implement this proposal.

2. Development of women specific interventions

Interventions specifically designed and targeted at women in Nigeria are urgently needed. Different intervention measures will be used to address the range of AIDS education needs of the Nigerian women. For women in general, realistic media campaigns and formal and informal associations can be used to sensitize them to the risk AIDS pose to their health and motivate them to take action. Women of privilege who belong to professional associations such as Federation of Women Lawyers (FIDA), Medical Women Association, Association of Lady Pharmacists can be easily reached through these associations. Other less privilege women can be educated through informal associations, which have been found to exert a powerful influence on the behaviour of members. Women in high risk occupations such as CSW, IFH and

long distance traders, and others who engage in risk behaviours including in and out of school adolescents can be reached through peer education approach which has proven to be effective in influencing risk behaviours (Williams, 1994). These intervention approaches should be incorporated into the current structure of the NACP. However, the NACP will require the collaboration of international agencies such as the
society for Women and AIDS in Africa (SWAA) to be able to fully implement the programmes.

3. Improvement of access to medical care .

As a way of improving their well being and protecting them from HIV infection, comprehensive health services including reproductive information and treatment of STDs must be made more accessible to all Nigerian women. One way of reaching this goal is to use women volunteer health workers (WVHW) who will be trained to provide women-friendly health services to their counterparts. This intervention option may be integrated into the existing Primary Health Care Programme in the country and may be particularly appropriate in medically undeserved rural communities. Advocacy can also be done by NACP to mobilize the directors of health facilities in urban centres to provide women-friendly services.

4. Economic empowerment of women

The health and well being of women need to be improved by creating more opportunities for them to be educated. Such education would enable them become economically independent from their male partners. Both formal and adult literacy programmes need to be organized for women with the assistance of local and international agencies interested in improving the well being of women in Nigeria. The ability of women to become economically independent can also be enhanced by improving their access to seed funds which can be used to set up small scale income yielding business. The Ministry of Women Affairs recently created by the Nigerian Government to improve the conditions of women should be responsible for achieving this goal.

5. Enlisting the support of men

The suggestions mentioned above have policy implications, hence the support of men is required because in Nigeria more men than women occupy

important policy making positions. NACP need to sensitize opinion and policy makers, health care providers and media men to the nature of the risk women are exposed to and the need to formulate policies that would address them.

CONCLUSION

The epidemic of HIV/AIDS is growing rapidly in Nigeria and until a cure is found, primary prevention through education is the only realistic means of controlling further spread of AIDS in the country. Women in Nigeria are particularly susceptible to HIV infection, but unfortunately, few of the intervention programmes being implemented in the country have addressed the social and economic conditions which place women at risk to HIV infection. Women in Nigeria constitute a significant proportion of the Nigerian population, therefore, there is need fora change in the direction of AIDS programming in the country. Women specific interventions, planned and implemented with the strong input from the women themselves are required urgently to address the AIDS education needs of this disadvantages segment of the Nigerian population.

	SOURCE	POPULATION SCREENED	LOCATION	NO. TESTED	NO. HIV POSI TIVE	% OF HIV POSI TIVE
1	Mohammed et AL (1987)	Healthy persons and patients	Maiduguri, Potiskum, Calabar, Enugu	5,238	12	0.23 %
2	Chickwem, Mohammed and Ola (1989)	Commercial sex workers (CSW)	Maiduguri	353	18	5.1%
3	Williams, Heart and Udofia (1989)	Clients of CSWs	Ikom, Calabar	133	2	1.5%
4	FMOHSS (1991/92)	CSW, Women attending ante-natal clinics (ANC) clients of STD clinics and TB patients	11 sentinel sites*	11,907	482	4.04 %
5	Olusanya, Lawoke and Biomberg (1993)	Health business employees	Ogun State	385	3	0.77 %
6	Shokunbi Saliu and Essien (1993)	Blood donors, healthy international travellers and patients	Ibadan	6,389	41	0.93 %
7	Nnatu et al (1993)	Pregnant women attending ANC	Lagos	230	2	0.8%
8	FMOHSS (1995)	CSW, women attending ANC, STD and TB patients, long distance truck drivers	16** sentinel sites	22,569	1,490	6.59 %

*The sites are in Benue, Delta, Lagos, Enugu, Cross-Rivers, Kaduna, Kano, Osun, Edo, Oyo and Jigawa States.
** These are in Plateau, Benue, Delta, Lagos, Enugu, Adamawa, Borno, Cross-River, Kaduna, Kwara, Kano, Osun, Anambra, Edo, Sokoto, Oyo and Jigawa States.

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Chapter Seven

WOMEN AND FAMILY PLANNING PRACTICE IN NIGERIA

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INTRODUCTION

Bongaarts has identified four key factors that determine fertility in any population, namely the age at marriage, contraceptive use rates, the number of months of postpartum non-susceptibility or sterility, and the rate of induced abortion. Of these four proximate fertility determinants, contraception, which is usually achieved through family planning programmes, has the strongest effect in reducing fertility inmost developing countries (Bongaarts, 1978), except in sub-Saharan Africa where postpartum non-susceptibility has the most powerful negative effect on fertility (Nongaarts et al., 1984).

Family planning is an organized effort essentially to assure that couples who want to limit their family size or to space their children have access to contraceptive information and services, and are encouraged to use them as needed. Of course, anthropologist, sociologists and medical doctors have known for many years that couples in various parts of Nigeria have consciously and effectively controlled pregnancy and births, hence nowhere in the country does recorded fertility approach the biological maximum. Taboos on intercourse during lactation with intentional long periods of breastfeeding, intentional physical separation of wives from their husbands, permanent and periodic abstinence, herbal medicines and waist bands, incantations, and even abortion, have traditionally been used to regulate family size among Nigerian

cultures and to enhance the health of mothers and their children.

Family planning saves lives. It enables couples to decide for themselves when to have their children as well as how many children to have. By helping women bear their children during healthiest times for both mother and baby, family planning helps to prevent deaths of infants, children and mothers. the use of family planning allows women to avoid unwanted pregnancies dangerous illegal abortions, and childbearing under circumstances that will threaten their infants' lives and their own health. Thus modern family planning is beneficial even though it remains a controversial issue.

The impact of family planning programmes on fertility vis-a-vis economic development has perhaps drawn the most controversy (Davis 1967; Berelson 1975; Isiugo-Abanihe, 1994a). Family planning advocates argue that if birth control information and services are widely available, knowledge and access to services can prompt couples to limit their childbearing, leading to significant fertility declines, even without substantial economic development, essentially a 'supply-side' argument. On the demand side many scholars and policy makers argues that economic development is a necessary precondition for fertility decline (Donaldson and Tsui, 1990). This argument is anchored on the belief that the social and economic transformation brought about by development and rising standards of living force couples to re-evaluate the desirability of large families and motivate them to use family planing. The consensus of opinion, however, suggests that for developing countries a complementarily of organized family planning and development achieve the best result with respect to fertility transition (Maudlin and Berelson, 1978; Lapham and Mualdin, 1987).

Clearly, organized family planning programmes do improve the availability and accessibility of contraceptive services, and the presence of such services may constitute the motivating factor to many couples. At the same time, social and economic development

affects a broad range of variables which are conductive to fertility reduction, among which are increases in the age at marriage, the level and quality of schooling and consequently labour force participation, improvements in infant and child mortality and increased motivation for contraceptive use. Thus, socio-economic change in Nigeria, for instance, has increased female education and employment, has tended to enhance the status of women and conferred a legitimacy for smaller family sizes, thereby providing a fertile ground on which family planning will thrive. Therefore, even in the likely event of a temporary increase in fertility which may accompany the declining prevalence and intensity of breastfeeding, erosion of postpartum abstinence rules, and greater control over diseases which had hitherto impaired fecundity, the overwhelming influence of the forces of social change and the increasing cost of children to parents are sufficient to predispose coupes to family planning. This may take some time to happen; only a beginning has been made.

This chapter provides a brief overview of organized family planning activities in Nigeria, and examines latest national figures on the levels of contraceptive awareness and prevalence. The issue of family planning in Nigeria is the study of women, who as child bearers have been the target of organized family planning activities in the country. But women face a lot of social and cultural barriers which hinder their adoption of family planning. Most important is the male-dominant family and social milieu in which production and reproduction take place. Although this article attempts a justification of the female emphasis of family planning in Nigeria, we also make a case for more male involvement and support for family planning practice not only for their wives but also for they themselves. Lastly, we question the adequacy of family planning as a means of population control in Nigeria.

THE DEVELOPMENT OF FAMILY PLANNING IN NIGERIA

To a large extent, the development of family planning in Nigeria is the history of the Planned Parenthood Federation of Nigeria (PPFN), formerly know as the Family Planning Council of Nigeria (FPCN), which wa a metamorphosis of the Family Planning Committee. The visit to Lagos of Edith Gates of the Pathfinder Fund, first in 1956 and many times subsequently, marked the beginning of family planning awareness and activities in Nigeria (Olusanya, 1989). Her concern for family welfare issues led to the formation of the Lagos Marriage Guidance Council which undertook the responsibility of organizing courses in family welfare and sex education for select groups of women. The Marriage Guidance Council became aware of the problem of unwanted pregnancies following the occurrence of two tragic cases of septic abortions in 1957 (PPFN, 1988). Subsequently, a sub-committee set up to investigate the need for family planning services revealed that illegal abortion was a common practice among married and unmarried women with unwanted pregnancies, and recommended the establishment of a family planning clinic to be run once a week in the domiciliary mid-wifery centre of the Lagos Local Health Department. The clinic was to be named Marital Health Clinic "to forestall any opposition to the concept of birth control or family planning as a new and foreign discipline, and to give expression to the intention to offer advice, information and service on both birth control and infertility" (Olusanya, 1989). The first family planning clinic was thus opened in Lagos by the Marriage Guidance Council in 1958, but due to financial constraints its activities were seriously curtailed.

In 1962 the National Council of Women's Societies (NCWS) founded the Family Planning Committee with the responsibility of providing family planning services and marriage

counselling. The family Planning Committee was in 1964 transformed into the Family Planning Council of Nigeria (FPCN), with the International Planned Parenthood Federation (IPPF) and Pathfinder Fund as the main source of funds (PPFN, 1988; Olusanya, 1989). The FPCN implemented its family planning activities through loosely affiliated clinics that were directly responsible to a hospital, maternity home or other heath agency whose policy and personnel the FPCN did not control. Also during these early years of its existence the government did not openly support or identify with the family planning activities of the FPCN. Up to 1976, the Council did not receive financial aid from the government and when government subvention was eventually granted it was relatively small.

In 1987 the FPCN underwent a drastic re-organization and was re-named Planned Parenthood Federation of Nigeria (PPFN), adopting a federal structure of operations. The need for re-organization was precipitated by organizational, financial, administrative and image problems which greatly undermined the operational effectiveness of FPCN. Significantly, the new name did away with the term 'Family Planning' and in Council's name, thereby placating government and public suspicion or opinions which equated 'family planning' with 'population control'. Also, the term 'Planned Parenthood' in the new name was in consonance with the name of the parent organization, International Planned Parenthood Federation, which remains its main source of funds.

The primary objective of the PPFN is the development of healthy and happy families through family planning, an objective which contributes to, as well as complements, other efforts aimed at improving the quality of family life in Nigeria (PPFN, 1988). This objective also necessitates the development and implementation of birth spacing activities that promote maternal and child health, counselling and treatment of infertility and the delivery of sex and family life education to adolescents and youths. Currently, the PPFN works closely with the government, and also

with international and national non-governmental organizations, and operates clinics in virtually all states of the federation, recording an ever increasing number of clients.

The launching of the national population police in 1988 has greatly enhanced the activities of PPFN, and family planning in the country. For a long time different Nigerian governments had assumed a laissez-faire posture on family planning, and population policy generally (Isiugo-Abanihe, 1979). Rather surprisingly, the first post-independence development plan (1962-68) recognized the country's high rate of population growth as a serious problem (FRN, 1962). However, it offered no solution to the problem; there was no mention of family planning. In the Second National Development Plan (1970-74), government planned to provide family planning services within the framework of the overall health and social welfare programmes of the country (FRN, 1970). However, by the end of that plan period family planning had not been integrated with the health-care delivery system as envisioned, and the government had not supported any family planning efforts. The Third National Development Plan (1975-80), did not differ from the one before it. It declared that "emphasis is being deliberately placed on accelerating the rate of growth of the economy rather than direct action to achieve a drastic or immediate reduction of overall birth rate" (FRN, 1975). While asserting, like the one before it, that the present demographic situation in the country did not call for 'emergency action', it recommended that family planning activities only be integrated into an overall health and social welfare programmes; there was no federal budget on family planning.

The Fourth National Development Plan, 1981-85, gave some indication of a change of government's attitude to population growth and control. The document states inter alia that:

> For meaningful and sustained economic development ... to take place, population growth will have to be more closely monitored and shaped in a way that will make them consistent with our resource potentialities. Consequently, appropriate measures will be introduced to influence vital population variables ... a long directions which enhance the country's growth and development prospects (FRN, 1981).

The plan observed that the forces of social and economic change were already lending to small average family size, especially in urban areas, and expressed government's intention to strengthen these forces during the plan period by encouraging the provision of facilities for family planning in health institutions and educating couples to take advantage of such facilities to regulate the size of their families (Olusanya, 1989). However, government would not do this directly but supporting the activities of private organizations in the country.

A rather dramatic change in government's attitude to population issues happened in 1985, when the military government set in motion plans for the formulation of a comprehensive and explicit population policy aimed at reducing the rate of population growth in the country, with a heavy reliance on family planning. To a large extent, the increasing difficulty of government in implementing programmes and achieving planned targets or goals may have been the predisposing factor. According to Olusanya (1989), part of the explanation for this change was the worsening economic situation in the country (huge external debts, mass unemployment, gross inadequacy of social services, etc.), which made it difficult to implement development projects. The new government posture on population was also influenced by the 1984 Second African Population Conference in Arusha, Tanzania from which emanated the Kilimanjaro Programme of Action which

guided the position of African governments in the 1985 International Population Conference in Mexico City (Isiugo-Abanihe, 1994a). At that conference the then Head of State, General Buhari, declared:

> We in Nigeria now feel that in the face of rapid population growth, a well-articulated population policy is necessary. Such a policy would have as its main focus, guidance in fertility behaviour which will emphasize the health of both mother and child... something has to be done to ensure that the galloping population growth rate and over-urbanization do not eclipse efforts ... to improve the economy and enhance the quality of social services available to the people (Population Institute, 1984).

The Nigerian Population Policy, as adopted in February 1988, is a comprehensive document outlining the population problems facing the country, with their consequences, all of which informed the goals, objectives, targets and strategies of the policy. The goals of the policy include the achievement of lower population growth rates trough reduction of birth rates by voluntary fertility regulating methods ...' (FRN, 1988: 12). Among its seven objectives is one that will 'make family planning means and services to all individuals easily accessible at affordable prices, at the earliest possible time, to enable them to regulate their fertility' (FRN, 1988: 13). Thus the policy gives a new impetus to family planning activities in the country, and although the emphasis remained on women, there was the recognition of the role and responsibility of men in family planning and family size decisions. Consequently, there are new initiatives throughout the country to educate Nigerians on the need to regulate family size, and services are being provided through many outlets, including PPFN outfits, government hospitals and maternities and even

private clinics and NGOs. In spite of all these, the prevalence of family planning in Nigeria remains low.

KNOWLEDGE AND PREVALENCE OF FAMILY PLANNING

Given the relative recency of family planning in Nigeria and the hitherto laissez-faire government attitude toward it, it is hardly surprising that both knowledge and use of family planning are low. Two national surveys, the 1981/82 Nigeria Fertility Survey (NFS) and the 1990 Nigeria Demographic and Health Survey (NDHS), provide us with national and comparable data on knowledge and prevalence of family planning methods in the country, although ad hoc KAP-type surveys, some dating back to the 1960s, abound for different parts of the country.

The NFS shows that knowledge of family planning methods was very low among Nigerian women in 1981/82 (NPB, 1984). Only one out of three women have heard about any method of family planning, including inefficient (traditional) methods; even fewer women, one out of five, knew about modern methods (Table 1). Abstinence was the commonest method known, perhaps in consonance with the traditional practice which is still observed by many women, especially in rural areas. Among modern methods, the pill and injection were known most, even though by slightly more than one in ten women.

The NDHS data show that knowledge of family planning methods witnessed a remarkable improvement between 1981 and 1990 (Table 1). About 46 per cent of all women aged 15-49 knew at least one method of family planning, with about 44 per cent identifying modern methods of which the pill, injection, condom, IUD and female sterilization were the most commonly known. Knowledge of these methods experienced more than 100 per cent increase between 1981 and 1990. This recent improvement in knowledge of modern family planning methods may be related, at

least in part, to the national population policy which has tended to give legitimacy to family planning through widespread discussion and communication in the media, hospitals and clinics and even in civic activities. As a result of the official approval given by the policy, advertisement of family planning has received an unprecedented impetus throughout the country, including the use of drama and music that eulogize the virtues of the small family. AT the same time, the HIV/AIDS pandemic has had a profound impact on condom advertisement on both the radio and television in the past few years.

TABLE I: PERCENTAGE OF ALL NIGERIAN WOMEN AND CURRENTLY MARRIED WOMEN BY KNOWLEDGE OF CONTRACEPTIVE METHODS AND SOURCE OF METHODS. 1981/82 AND 1990

Contraceptive Methods	NFS 1981/82				
	All Women	Currently Married	All Women	Currently Married	Knows a Source
Any method	33.6	32.9	45.7	36.0	34.0
Modern methods	21.1	20.3	43.5	43.6	33.2
Pill	13.4	12.5	35.1	41.2	25.0
I.U.D	4.4	4.4	20.3	33.8	15.9
Douche	3.2	3.1	-	-	-
Condom	5.6	5.1	24.1	21.6	17.7
Injection	10.7	10.1	34.2	33.6	25.2
Foaming tablet	-	-	10.7	9.6	8.1
Diaphragm/ foam/jelly	-	-	7.9	7.3	6.2
Female sterilization	6.9	7.0	20.4	19.4	15.7
Male sterilization	2.1	2.0	7.5	6.7	5.6
Traditional method	12.5	12.6	25.7	23.6	-
Rhythm	9.3	8.7	17.3	14.7	-
Withdrawal	6.3	5.6	14.2	12.7	-
Abstinence	19.4	18.8	-	-	-
Herbs	6.7	6.5	-	-	-
Bands	4.8	5.0	-	-	-
Rings	7.0	6.9	-	-	-
Others	-	-	10.0	10.3	-

Source: For NFS data, National Population Bureau (NPB), 1984, for NDHS data, Federal Office of Statistics (FOS), 1992.

If knowledge of contraceptive methods is low among Nigerian women the practice of contraception is even lower. Only about 15 per cent of all women have ever used any contraceptive method in 1990, and only 9 per cent have ever used a modern method. Among currently married women, the figures are slightly lower: 14 per cent and 8.4 per cent respectively. Compared with the result of the NFS, which indicated that 14.5 per cent of currently married women ever using family planning, the level of ever use of family planning appears to have remained constant between 1981 and 1990.

(Table 2). It should be pointed out, however, that prolonged abstinence formed a large share of the ever-used data reported in NFS, while the NDHS did not include abstinence among family planning methods. That ever use of family planning increased between the two periods is clearly evident from the use of modern methods. Only 2 per cent of currently married women had ever used modern methods in 1981/82 relative to 8 per cent in 1990.

Table 2 also contains data on current use of family planning, that is, the percentage of women who were using any method of family planning at the time of the respective surveys. In 1981/82 6.2 per cent of currently married were using any family planning method: the remaining 93.8 per cent were not contracepting. A closer look at Table 2 reveals that nearly all the contracepting women (5.5 per cent) were using methods that are not considered reliable. The NDHS also gives a contraceptive prevalence rate of 6 per cent among currently married women; however, there are more women (3.5 per cent) using modern methods relative to those using traditional methods (2.5 per cent). While overall use of family planning is low, the analysis of the NDHS shows a wide disparity in contraceptive prevalence among socio-economic groups with urban residence, education above the primary level and residence in the southern part of Nigeria, especially the south-west, having the greatest effect on

contraceptive use (FOS, 1992). Also contraceptive use seems to increase with age and the number of surviving children, suggesting that family planning is being used to space births at low parity, but more so at higher parity as women approach or attain the desired family size. For instance, while only 3.5 per cent of women with one surviving children were currently using family planning, 7, per cent of these with 4 living children were doing the same, as were 9.6 per cent of their sisters with 5 or more children (FOS, 1992). Also as should be expected, older women and those with more surviving children are more likely to be currently using more effective contraceptive methods such as the pill, IUD and injection. For instance, NDHS data show that 2.2 per cent of women with 5 or more surviving children were using the pill, 1.4 were using IUD and 1.5 were using injection. The corresponding figures for women with 2 surviving children are 0.9 per cent, 0.3 per cent and 0.6 per cent respectively.

Table 2: Ever Use and Current Use of Contraceptive Methods among Currently Married Nigerian Women, 1981/82 and 1990

Family Planning Methods	1981/82 NFS			
	Ever Use	Current Use	Ever Use	Current Use
Any method	14.5	6.2	14.0	6.0
Modern methods	2.2	0.7	8.4	3.5
Pill	1.4	0.3	4.8	1.2
I.U.D	0.3	0.1	1.7	0.8
Injection	0.5	0.2	1.9	0.7
Foaming tablets	0.0	0.0	0.5	0.1
Diaphragm	0.0	0.0	0.1	0.0
Condom	0.7	0.0	2.0	0.4
Female sterilization	0.1	0.1	0.3	0.3
Male sterilization	0.0	0.0	0.0	
Any Traditional method	12.4	5.5	8.1	0.0 2.5
Rhythm	3.1	0.4	4.3	1.4
Withdrawal	1.4	0.1	2.8	0.5
Abstinence	11.8	4.9	-	-
Others	0.6	0.0	2.3	0.6

Source: As in Table 1.

Clearly, contraceptive prevalence rate (CPR) is very low in Nigeria. The CPR for Nigeria is low even when compared with her two West African neighbours: Ghana and Togo, where the Demographic and Health Survey (DHS) also took place. The CPR for Ghana and Togo are 13 and 12 per cent respectively (at least twice that of Nigeria). For Africa as a whole DHS data indicate that CPR is highest in Zimbabwe (43 per cent),Botswana (33 per cent) and Kenya (27 per cent) PRB, 1992). Little wonder that these are the same sub-Saharan African countries where fertility has begun a decided decline. Because of the low contraceptive

prevalence in Nigeria, the current pattern of high fertility will persist well beyond the target year 2000 envisioned by the population policy, and achieving the stated goal of four children per woman may remain unrealistic and unattainable well into the next century. Thus, organizing and implementing family planning in Nigeria remains a challenge. The task is made more difficult because of the rapidly growing number of women entering the reproductive age, who are to be served with family planing services, and because those who are least likely to use family planning services are often the hardest to reach, such as rural residents, the poor, uneducated and muslim women.

Yet many Nigerian women who are not practising family planning would like to delay the birth of their next child or cease child-bearing altogether. These women form a large pool of potential family planning users, women whose need for family planning is 'unmet'. The NDHS shows 'unmet need' for family planning among currently married Nigeria women as 20.7 per cent - about 11 per cent of currently married Nigerian women do not want any more children but are not using a contraceptive method, and another 10 per cent expressed interest in birth spacing but also are not using a method to achieve it (PRB, 1992). Reasons for the observed high level of unmet need for family planning in Nigeria, as in other African countries, are many. Foremost, Nigerian women still lack access to high-quality family planning services and would take advantage of such services if they were available. As has happened in Latin America and Asia, easily accessible, well advertised and high quality family planning services will go a long way in reducing the number of unintended births and abortions in the country. Table 1 indicates that many Nigerian women who know about family planning methods do not know where such services could be obtained. We have shown elsewhere that many Nigerian women who seek family planning services are unaware of the range of methods available at the clinics, and there is a general concern about the side-effects of contraceptive

methods (Isiugo-Abanihe, 1992). Still others fail to use family planning because of their husbands' disapproval - real or imagined; unilateral use of family planning by a woman is rife with suspicion, and is a sufficient reason for divorce. These issues can be addressed through information campaigns and education programmes for the general population, but especially for men, to underscore their role and responsibility in fertility and contraceptive decisions.

MALE INVOLVEMENT IN FAMILY PLANNING

Historically, men have provided a major impetus for the practice of birth control. The European demographic transition was achieved not through the use of present day female contraceptives, but mainly through widespread use of coitus interruptus or withdrawal (van de Walle and Knodel, 1980), which is essentially a male method. Apart from withdrawal, many couples relied upon periodic abstinence, and alter condoms, long before modern female methods made their appearance in the 1950s and 1960s. Still, the increasing popularity of male surgical methods or vasectomy in many developed countries suggests that men, not only play a important role in fertility and family planning decisions, but also are willing to take responsibility for contraception (Gallen, 1986).

The spread of family planning followed a different route in the developing countries, guided mainly by the development of modern female contraceptives, which are usually offered in the context of maternal and child welfare programmes. Implicitly, these programmes promote female methods, such as oral contraceptives and intrauterine device (IUD), and ignore male methods, such as condom, since the clients are usually women. In line with this approach, surveys on attitudes of fertility and family planning were typically focused on females as the bearers of children; the opinions of men were considered secondary, even in patriarchal Nigerian societies where male views prevail in the

social, economic and political spheres of life.

Nigerian men are often assumed to have little interest in contraception; they are generally thought to be opposed to family planning because of their tendency to favour a larger family size than their wives. Recently, however, policy makers, scientists (including physicians) and family planning organizations are beginning to recognize the need to actively focus family planning activities on men. This makes a lot of sense in view of the dominance of men in all spheres of family life (Isiugo-Abanihe, 1991). Male dominance in Nigeria is the product of the patriarchal system which, among all ethnic groups, confers on men decision-making roles on matters affecting the family; their authorization is crucial even in trivial matters (Isiugo-Abanihe, 1994b). As the main opinion leaders, therefore, efforts to influence the attitudes of men on population issues, and motivate them toward family planing use, would form the bedrock of a successful family planning programme. Reaching men with messages and methods that encourage the use of family planning will also motivate them to support their wives in family planning decisions.

It is note worthy that the new Nigerian population policy took cognisance of the important role of men in the family and the need to focus educational programmes on them on that account. The document succinctly summarized the position of Nigerian men with respect to family life:

> In our society, men are considered the head of the family and they take far-reaching decisions including the family size, subsistence and social relations ... The average man bears greater paternalistic burden in caring for the family. Special information and enlightenment programmes are necessary to increase awareness of men as to the need of having the appropriate size of family they can foster within their resources (Federal Republic of Nigeria, 1988: 19).

It is equally important to focus attention on men because they have indeed been active in family planning in Nigeria, even if that role has not ben obvious. Our analysis of the NDHS data indicate that about 48 per cent of all women (or 38 per cent of currently married women) who are currently using a method of birth control, use any of three methods that require male participation or cooperation: the condom, rhythm and withdrawal. There is also evidence that men's attitudes toward family planing are changing in Nigeria, with men now favouring family planning for child spacing to enhance the health of mothers and children and to have a family size they can adequately cater for (Isiugo-Abanihe, 1992). Also, most of what has ben tagged men's opposition to family planning could be due to the characteristic lack of communication between husbands and wives. The fact that men's attitudes on family planning have typically ben derived from information supplied by their wives rather than from men themselves, may well have misrepresented men's views on the matter. In all, evidence suggests that programme emphasis of family planning information and services on women alone is not justified by the social reality of the Nigerian family. Indeed, male participation and involvement constitute the bedrock of a successful family planning programme in Nigeria, at least because male values affect female behaviour. In the case in point, a more positive male attitude toward family planning would be expected to enhance female adoption of the innovation.

ON WHY WOMEN SHOULD BE THE TARGET OF FAMILY PLANNING

Although the case has ben made for male involvement in fertility and contraceptive decisions, primarily, women constitute the major target of family planning. Male role is mainly a supportive one. Because women are the ones who bear the brunt and risks of prolific childbearing, which include various

disabilities, deformities and a high level of maternal mortality, they are the ones for whom contraceptive use is more imperative. One of the eight strategies for the implementation of the Nigerian population police is to make family planning easily affordable, safe and culturally acceptable. The policy notes that:

> In recent times, the incidence of unwanted pregnancies, abortions, abandoned babies and child abuse has greatly increased and now constitutes a national social problem. Voluntary fertility regulation and organized family planning have proved to be effective, preventive and low cost measures to control such social problems. Also, family planning reduces maternal and infant morbidity and mortality as well as stems rapid population growth in the shortest possible time ... It is necessary to adopt fertility regulation as a code of ethics (FRN, 1988: 16).

Nigerian women spend the majority of the years between 15 and 50 conceiving, carrying, delivering and suckling babies. The pattern of early and universal marriage means that most women initiates childbearing in the teenage age, during which period they face considerable health risk. Childbearing also continues till the late 40s, where the health risk of childbearing is also high. Thus pregnancy and delivery of babies constitute a special life-threatening hazard for Nigerian women; childbearing is the cause of a large proportion of all deaths of women in the reproductive ages. Hence in many developing countries where the data available, female life expectation in the prime childbearing years is often lower than that of males. Indeed, motherhood is a dangerous preoccupation in countries, like Nigeria, where medical facilities are rudimentary.

Apart from high maternal mortality, Nigerian women suffer severe measures of physical and nutritional stress given the high proportion of their lives spend pregnant, breastfeeding and caring for children. Chid rearing in Nigeria is an exclusive preserve of women, and this takes place a longside other activities, as is evident from the common sight of children straddling the back of working and trading women everywhere in Nigeria. Sometimes, such children suckle their mother's breast from their precarious position, while their older siblings are being dragged along. Clearly, family planning is god for Nigerian women. By helping them bear their children during the healthiest times for both mother and baby, it helps to prevent deaths of mothers, infants and children. Family planning is an effective, inexpensive way to prevent many deaths: it is an investment in human resources that can be a key part of programmes designed to improve material and child health. By focusing on the right of parents to decide the number and spacing of the children they wish to have, or to have babies by choice rather than by change, family planning enables women to avoid unwanted pregnancies, dangerous illegal abortions, and childbearing under circumstances that will threaten their lives. Unwanted pregnancies result not only from none use of contraceptives, but also from the use of ineffective methods or from improper use of contraceptives. Thus the use of effective and culturally acceptable methods, administered in a clean environment, by medically qualified personnel, will be profoundly beneficial to the teeming population of Nigerian women, many of whom are literally dying in ignorance.

Yet such a woman is typically a worker (in the family farm or outside the home), the household cook and caterer, and a wife to a man whose demands and expectations are often tasking. Nigerian women have ben very active in the economy, they work long hours in the farms; clearing the bus, planting, weeding, harvesting, preserving and processing agricultural products, often with the most crude of implements. Also, women generally are the

ones to gather fuel wood, fetch water and market household produce. In all Nigerian cultures, women occupy a subordinate position relative to men, are generally discriminated against in the home and society. Women issues and concerns are often treated with laxity by the patriarchal family. In spite of their relative poverty and powerlessness, strangely many women see prolific childbearing as a mean to status enhancement, at least in future when the children become adult. Conversely, our research indicates that under the weight of physical, maternal and emotional burden they bear, many are compelled to secretly accept family planning, fully aware of the risk of their action to their marriage.

The foregoing justification of family planning for women should not suggest that women unanimously approve of family planning. On the contrary, Nigerian women are generally apprehensive of the side-effects of modern family planning methods, apart from the concern for high social and monetary costs of the device. Thus the perceived availability of contraceptive services, involving knowledge of sources of method, distance to location, cost of services, treatment by service providers, follow-up medical care, etc., should be sufficiently encouraging to women who are motivated to adopt family planning. In time, such satisfied users will constitute effective advertisers of services and important change agents. Clearly, an efficient family planning programme constitutes a profound benefit to Nigerian women and the family at large.

IS FAMILY PLANNING ENOUGH?

Family planning is advocated for women to enable them plan their childbearing given to the prevailing social, economic and health constraints. However, because family planning connotes individualistic planning, it may not necessarily be relied upon to achieve national goals (Davis, 1967). Even couples who use family planning effectively can still plan to have eight or more children,

which is antithetical to the national goal of four children per women. By definition, thus the voluntary nature of family planning renders it ineffective as a means to plan or achieve a national goal or target. It is highly unrealistic to achieve the kind of fertility control envisaged by the Nigeria population police merely by encouraging couples to have the number of children they can 'adequately cater for', given that they 'have the basic right to decide freely and responsibly on the number of spacing of their children' (FRN, 1988: 2). Since it is not a punishable offence for a woman to have more than the stipulated four children, and given the apparent demonstration effect emanating from public figures who have exceeded that number by a wide margin, the policy strategy of 'encouraging couples' is indeed a tough one to sell. Furthermore, as Davis (1967) has observed although family planning enables couples (if they so choose) to restrict the number of children, it offers only those means that are considered 'respectable' or morally acceptable, not necessarily those that are the most effective. Hence, the proponents of abortion as a means of family planning are few, even though it plays a considerable role in the recent fertility transition that took place in Japan and other countries.

Additionally, by suggesting four children as the desirable number per woman, rather than per couple, the policy tended to ignore the role and responsibility of men in family size determination, and doing so despite the fact that Nigerian men generally want more children than their wives (Isiugo-Abanihe, 1991: 1994b). Thus, in the unlikely event that the policy of four children per woman is enforced in future, the incidence of polygyny may be expected to rise as a consequence, since the policy merely encouraged men 'to have limited number of wives and optimum number of children they can foster within their resources' (FRN, 1988: 19).

Nevertheless, that a policy legitimizing family planning is in place in Nigeria, despite decades of passivism on population

issues, is a landmark event in Nigeria's development planning. The rapid population growth being experienced in the country, with its long-term momentum and widespread ramifications, requires the for sighted statesmanship shown in 1984/85 by the government in power, which was the first to recognize the population problem confronting the country. Yet the experience of Ghana, whose population policy was first formulated in 1969, suggests that a policy per se does not necessarily do the magic; a strong government commitment in all aspects of the policy implementation is the only panacea for its effectiveness. This is the major weakness of the Nigerian population policy.

Finally, it hardly needs stressing that the improvement of the position and status of Nigerian women would have a positive feedback on family planning. It is now well-established that improved female education, female participation in the modern work force, and other female empowerment indicators are associated with the adoption of family planning. All these tend to increase the cost of childbearing and work or career aspiration, and invariably redispose women to family planning. In such a situation, fertility comes within the calculus of conscious choice, and reduced fertility is seen as an advantage not only to the woman but also to the couple and the family. Being a modern way of life, it is hardly surprising that only women who have been sufficiently exposed to modern lifestyle embrace family planning as a way of life. From the experience of the developed countries and countries that are recently completing their demographic transition, it is only when family planning is accepted as a way of life that it becomes sufficient in bringing fertility to a low level nationally. This another reason why government development efforts should deliberately target women for status enhancement.

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Chapter Eight

ORGANIZATION AND MANAGEMENT OF HEALTHCARE SERVICES AND FACILITIES

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INTRODUCTION

The World Health Organization's long standing definition of health as "a complete state of physical, social and mental well being, not merely the absence of disease or infirmity" represents an ideal state towards which all human societies strive to achieve for their members. This is borne out of the rather ancient realization that only healthy people can fulfil their various obligations to society and in the process ensure its survival and development. In the pursuit of this goal, each society, or more comprehensively, each culture, no matter its level of development, evolves a healthcare system best suited to its own peculiar circumstances and environment. With this emergent medical system. The society tries to bring about a high status of healthcare for its members.

Thus in all parts of the world, various kinds of healthcare system evolved, these are known in many developing countries as the traditional healthcare system. Pearce (1986) characterized the traditional medical system as found in Nigeria thus:

> It was a decentralized system in which community-based practitioners served clients from their compounds or the patients' homes. Easy access to the healers was one of its main assets. A variety of

practitioners competed for clients including herbalists, diviners, bone setters, psychiatrists, soothsayers and birth attendants.

The point to note here is that this traditional system of healthcare was (and still is) quite adequate and relatively efficient for its millions of patrons for centuries hence its persistence to the present in large parts of the world.

However, although each culture evolved its own concepts of physical health and illness as has been stated above, much of what is now recognized as medicine derives from developments in western society over the past two or three centuries (Giddens, 1989) from where it spread to almost all parts of the world. The consequence of this is that in Nigeria today, as in other sub-saharan African countries. There exists a dualism in the healthcare system, a situation where the traditional medical system exists side by side with the modern medical system, with the modern system however, being relatively dominant.

Perhaps the most important features of this modern healthcare system is that it is highly centralized and organized. It is an understanding of the manner in which the services and facilities of the modern healthcare system are organized and managed which forms the main interest of this chapter.

THE ORGANIZATIONAL IMPERATIVE

One major factor which had a great impact on, among other things, the evolution of modern healthcare, is the emergence of large scale organization within which most of human activities now take place. Although organizations are not in the real sense of it modern intention - for instance, the Pharaohs used them to build the pyramids - it is in contemporary society that they have assumed an al-pervasive nature. As Etzioni (1964) puts it:

> Modern civilization depends largely on organization as the most rational and efficient form of social grouping known. By coordinating a large number of human actions. The organization creates a powerful social tool. It combines its personnel with its resources, weaving together leaders, experts, workers, machines and raw materials. At the same time, it continually evaluates how well it is performing and tries to adjust itself accordingly in order to achieve its goals.

Due to its vital importance to social life in modern society, it is not surprising that organizations have become subject of great interest to scholars. Similarly, attempts at defining what is meant by organization are as numerous just as perspectives of analyzing it are several. Thus Barnard (1938) defines organization as "a system of consciously coordinated activities or forces of two or more persons". Parsons (1960), on the other hand sees it as "a social unit (or human grouping) deliberately constructed and reconstructed to seek specific goals". While these and several other definitions have contributed immensely to our understanding of the workings of organizations, for present purposes Lawrence and Lorsch's (1967) definition is considered as most suitable. According to them, an organization is a system of interrelated behaviours of people who are performing a task that has been emphasis into several distinct sub-systems, each sub-system performing portion of the task, and the efforts of each being emphasis to achieve effective performance of the system. (emphasis added).

Two concepts are crucial to this definition - differentiation and integration. "Differentiation" is defined as "the state of segmentation of the organization system into sub-systems each of which tend to develop particular attributes in relation to the requirements posed by its relevant external environment". On the

other hand, "integration" is seen as "the process of achieving unity in effort among the various sub-systems in the accomplishment of the organization's task"

This definition is particularly useful for present purposes because it enables us to view ar organization, for example, a healthcare facility, as a unit or a whole made up of several units of departments all of which contribute in one way to the other to the achievement of the organization's goals or objectives. In this instance the curing or taking care of sick people. Thus the coordination of the activities of the various units constitutes perhaps the most important management function.

Finally healthcare facilities, just as other types of organizations. Share certain common characteristics, which most importantly distinguished them from other forms of social grouping such as the family or friendship clique. These characteristics include:

(i) division of labour, power and communication responsibilities, divisions which are not random or traditionally patterned, but deliberately planned to enhance the realization of specific goals:

(ii) the presence of one or more power centres which control the concerted efforts of the organization and direct them toward its goals; these power centres also must review continuously the organization's performance and re-pattern its structure, where necessary to increase its efficiency:

(iii) substitution of personnel i.e., unsatisfactory persons can be removed and others assigned their tasks. The organization can also recombine its personnel through transfer and promotion (Etizioni 1964).

Of particular importance for present purposes is the second characteristic eg. the present of one or more power centres from where the various activities of the organization are controlled and coordinated. This characteristics simply points to the fact that each organization must be if it is to attain its goals or objectives. Management is defined here after Kohn (1977) as "a process that consists of planning, organizing, activating and controlling the resources (personnel and capital) of an organization so they are used to the best advantage in achieving the objectives of the organization".

Although a complex activity, management is the important variable which makes the difference between an organization which achieves its objectives and that which does not. Thus a well-managed organization is that which is able to use available resources, both manpower and equipment, to achieve it goals efficiently and effectively. On the contrary, the poorly managed organization is that which no matter the resources available to it, is not able to produce optimally and is thus unable to provide. For instance, adequate services for its clients. In the final analysis therefore, the point being made is that every organization requires an administrative structure to enable it arrange its resources economically and control deviant behaviour.

HEALTHCARE SERVICES AND FACILITIES IN NIGERIA

Having made the point that modern society is an organizational society in which most of human social life, including healthcare, takes place in organizations which possess more or less determinable characteristics or features, it is important at this juncture to examine the various forms which modern healthcare facilities have assumed in Nigeria. This would serve as an important prelude too an understanding of their internal structure and functioning.

Health care facilities, according to Okafor (1987), constitute the most tangible features of healthcare delivery systems and their provision constitutes society's most obvious response and investment in health. In this connection, there can be no doubt that Nigeria has expended a great deal of resources in the establishment of such facilities although the social and economic returned on such investment in terms of efficiency and effectiveness of healthcare services to the citizenry is another matter entirely.

As with other former colonial territories, modern medicine in Nigeria is a colonial legacy first introduced by medical missionaries as early as the 1850s, Pearce (1982) points out the colonial administration later converted this emergent medical system into the colonial medical service, "a centralized system under the authority of British medical officers" she argues further that:

> As with other acquired territories in East and West Africa, the British initially developed the facilities for the europeans serving abroad. Only lager was it extended to indigenous government officials and after 1952 to the general public. From the onset, the new medical system was modelled after what existed in Britain. It was thus organized around the **hospital** which had since the industrial revolution in the West become the specialized medical care institution (emphasis added).

Since colonial times, therefore, the hospital has remained the central pivot of the modern medical system in Nigeria. The concept 'hospital' is used here in a generic sense to refer to several types of establishments, of various sizes, in which both medical practitioners of various types are brought together with modern medical equipment for the sole purpose of attending to ill people.

Thus it is clear that hospitals are not of the same size or of the same sophistication in terms of manpower and equipment. On

the basis of this distinction, Onokerhoraye (1981) suggested that in most parts of Nigeria, four different categories of healthcare facilities may be distinguished.

The first categories comprise dispensaries, health centres, maternity centres and health officers. The second category comprise general hospitals and cottage hospitals. Thirdly, there are the teaching and specialist hospital ... Finally there is the fourth category of health centres which cannot fall within the hierarchy discussed above. This category comprise specialized hospitals such as dental clinics, mental health centres, leprosarium and tuberculosis hospitals.

Okafor (1986) goes further by dividing these healthcare facilities into two broad categories: lower-order and higher-order healthcare facilities based largely on "their size, variety of services offered, their range, threshold or similar considerations". In this hierarchical system, the teaching hospital occupies the top position while dispensaries occupy the bottom. According to him,

> .... lower-order healthcare facilities handle routine and in some cases very simple health problems that do not require hospital care. As such they are cheaper to provide and therefore more numerous than hospitals.

On the other hand,

> .... higher-order facilities offer services of their respective orders as well as the services offered by all lower-order facilities below them. Accordingly, a teaching hospital such as the University College Hospital Ibadan performs the functions of a dispensary, a clinic, a maternity centre, a health centre, a general hospital, a specialist hospital and a teaching hospital.

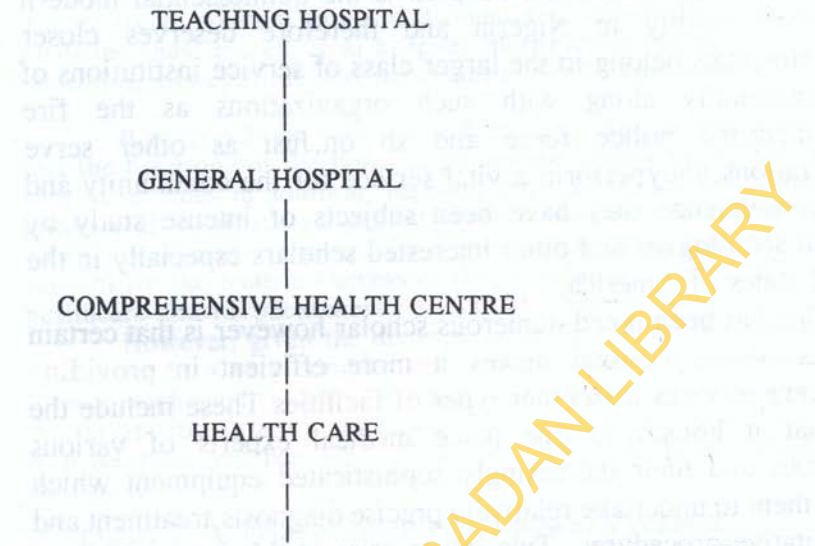
It is evident from the foregoing that there are several types of healthcare facilities in Nigeria offering all kinds of medical services to the population although the point must be emphasized that this medical system from inception to the present revolves around the hospital.

Before going on to examine the internal structure and functioning of a hospital, something needs to be said about the Primary Health Care (PHC) system, which provides additional healthcare services outside of the hospital although very much integrated with it.

The PHC system was launched officially in Nigeria in August 1986 as an entry point to the healthcare services aimed at providing general heath services of preventive, curative, promotive and rehabilitative nature to the population. Its importance lies in its non-specialized nature, its easy accessibility coupled with its resultant acceptability, sustainability, appropriateness and affordability by the mass of the citizenry (FMH, 1988).

Thus the primary healthcare system together with order healthcare facilities form a high centralized system of medical care in Nigeria as Figure 1 below clearly illustrates.

FIGURE 1 **REFERRAL SYSTEM OF THE PHC SERVICE**



Source: Adapted from PHC Unit, Abeokuta South LGA., Ake, Ogun State.

Finally, the question of ownership of the healthcare facilities also has some implications for the analysis being undertaken here. Since privately owned healthcare facilities are still comparatively smaller in number in most parts of the country, much of the existing medical facilities tend to be government owned and this, as will be show later in this chapter, has important implications for the type of management structure that has emerged in these facilities. Furthermore,ownership and management also varies with the size and sophistication of the facility. Thus higher-order facilities are owned and owned and managed by the Federal government; the state governments managed the medium sized facilities, such as the general or cottage hospitals, while the local governments manages the lower-order facilities and the primary healthcare system.

The Hospital

As was state earlier,the hospital is the quintessential modern healthcare facility in Nigeria and therefore deserves closer study.Hospitals belong to the larger class of service institutions of the community along with such organizations as the fire department,the police force and so on.Just as other serve organizations,ttheyperform a vital service for the community and as a consequence they have been subjects of intense study by medical sociologists and other interested scholars especially in the United states of America.

What has been noted numerous scholar however is that certain features of the hospital makes it more efficient in providing healthcare services than other types of facilities.These include the fact that it houses in one place medical experts of various specialties and their increasingly sophisticated equipment which enable them to undertake relatively precise diagnosis,treatment and rehabilitative procedures. Two issues arise at this juncture: first, what are the functions of the hospital, and second, what are the main features of the management structure of the hospital in Nigeria?

On the first issue, there are several functions which have been associated with the hospital. In this regard, Lentz (1968) provides a very adequate characterization of the functions of the hospital, interestingly within a historical framework:

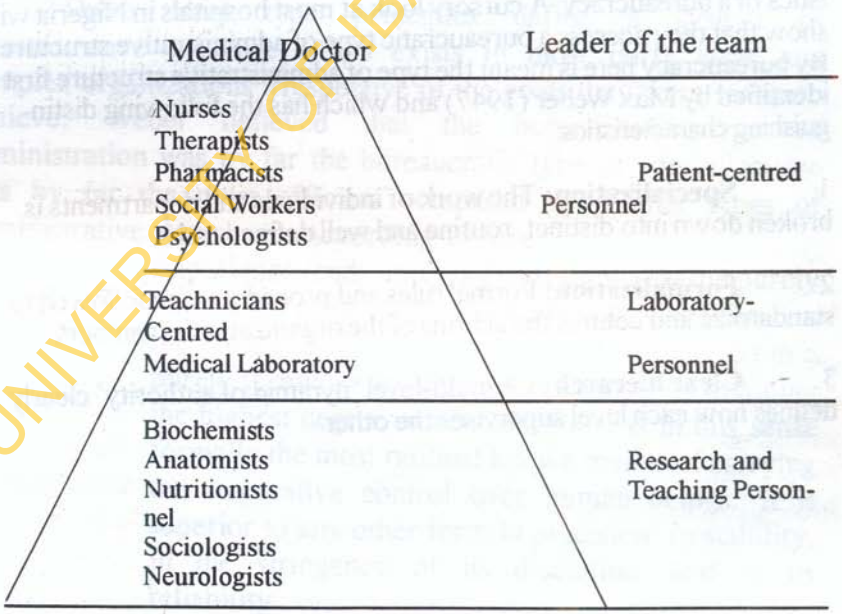
> The original function of the hospital ... was custodial care of the dying poor. Curative care, as contrasted to custodial care, became a second function. Custodial care was relatively easy to provide, but curative care requires highly trained personnel. The education of such personnel became the third function of the hospital. Once doctors were the only recognized therapeutic agents. Today

nurses, dietitians, social workers and a wide variety of technicians are so required, and the hospital has become their school and laboratory. Scientific research into the cause as well as the cure of diseases is still a more recent addition to hospital functions. And finally ... preventive medicine (has) placed upon hospital management the necessity of allocating money, time and personnel to health education.

It is clear from both figure 2 and from the quotation above that the functions of the hospital go beyond simply caring for the sick. It includes in addition, research and educational functions, however all of which are geared towards providing better and more efficient healthcare services. The varied nature of its functions helps account for the relative success of the hospital as a centre of healthcare and its phenomenal growth all over the world.

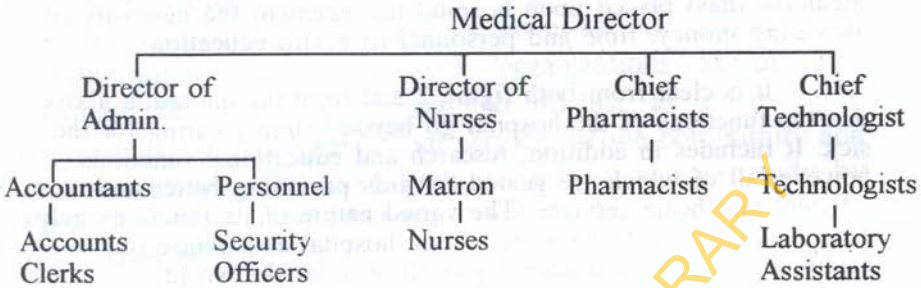
However, given the diversity of its functions, the hospital cannot but be a very complex organization indeed. Its complexity is further heightened in that it combines an administrative structure wit the therapeutic structure and each of these structures possesses its own priorities and personnel. The figure below gives in indication of the configuration of a typical hospital.

Figure 2 **A Typical Health Manpower Pyramid**



Source: Adapted from M. Smith and D. Knapp, Pharmacy, Drugs and Medical Care, Baltimore. The William and Wilkins Co., 1972, p. 209.

FIGURE 3: **ORGANIZATIONAL CHART OF A TYPICAL HOSPITAL**



Thus the first important management feature of the hospital as can be seen from the abbreviated organizational chart shown above in figure 3 is that to a very considerable extent, it possesses the characteristics of a bureaucracy. A cursory look at most hospitals in Nigeria will show that they possess a bureaucratic type of administrative structure. By bureaucracy here is meant the type of administrative structure first identified by Max Weber (1947) and which has the following distinguishing characteristics:

1. **Specialization:** The work of individuals and departments is broken down into distinct, routine and well defined tasks.

2. **Formalization:** Formal rules and procedures are followed to standardize and control the actions of the organization's members.

3. **Clear hierarchy:** A multi-level 'pyramid of authority' clearly defines how each level supervises the other.

4. **Promotion by merit:** The selection and promotion of staff are based on public criteria (e.g. qualification or proven competence) rather than on the unexplained preference of superiors.

5. **Impersonal rewards and sanctions.** Rewards and disciplinary procedures are applied impersonally and by standardized procedures.

6. **Career tenure:** Job holders are assured of a job as long as they commit themselves to the organization.

7. **Separation of careers and private lives:** People are expected to arrange their personal lives so as not to interfere with their activities on behalf of the organization (Handy, 1985).

These ideal type principles define a system of administrative structure which exists in most fairly large and complex organizations irrespective of the goals they were set up to achieve. Weber believed that the bureaucratic type of administration was by far the bureaucratic type of administration was by far the most efficient compared with other types of administrative structures. According to him.

> Experience tends universally to show that the purely bureaucratic type of administrative organization - i.e the monocrotic variety of bureaucracy - is, from a purely technical point of view, capable of attaining the highest degree of efficiency and is in this sense formally the most rational known means of carrying out imperative control over human beings. It is superior to any other form in precision, in stability, in the stringency of its discipline, and in its reliability.

Many scholars have of course disagreed with Weber about bureaucracy being perhaps the most efficient way of achieving organizational goals (see for instance, Merton, 1952: Schaffer, 1967). However, the reality on the ground is that when an organization attains a certain size and complexity, it develops the characteristic of a bureaucracy.

Thus, in the hospital organization, a great deal of division of labour and delegation of authority occurs between the various levels of officials and between the various functional units. The Chief Medical Director of a teaching hospital for instance, is responsible for both the administrative and therapeutic activities of the hospital. However, while he or she exercises leadership in both interdependent areas of responsibilities, it is obvious that he cannot carry out all the duties involves alone. So he/she must delegate power to the Head of Administration to exercise control over such duties as recruitment, staff welfare, remuneration, procurement of materials etc. Similarly, delegation of authority also takes place between the medical director and the Head of Nursing Staff, and so on. In the final analysis the primary duty of the medical director therefore is mainly coordinative, bringing together the various contributions of other people towards achieving the stated goals of the hospital.

On the other hand, for most members of staff, whether medical, para-medical or administrative, their job constitutes a career for which they are paid a fixed salary and ar entitled to pension on retirement. They expect to be promoted at fairly reguiar intervals and expect to obtain some job satisfaction from their jobs based mainly on expected enlightened management practices on the part of the hospital's administration. Finally, they are subject to control via established disciplinary procedures in the performance of their jobs. All these are features of a bureaucratic form of administration and are present in all hospitals in Nigeria to one degree or the other.

Another important feature of the hospital is that the multiplicity of skills and professions represented there has been a source of great conflict. This conflict is perhaps exemplified by that between nurses and doctors, a conflict which often takes the form of a power struggle between these two groups of professionals over control of the work process. The origin of this particular conflict in Nigeria dates to the colonial era when doctors enjoyed a very high status, in fact next in status to the regional governor, according to Alubo (1995). Alubo maintains that during this period, doctors earned higher salaries than other civil servants, 'an advantage they maintained until recently'.

For a large part of the post-independent years, doctors have struggled to maintain their privileges and status vis-a-vis other non-physician medical workers. The struggle has also extended to the maintenance of the dominance of medical practitioners over the political leadership not only of the Federal Ministry of Health but also at the level of the states as well. As the Nigerian Medical Association (NMA) argued on one occasion:

> Since only doctors received training in the art of patient care, the appointment of paramedical professionals, pharmacists included, as head of the health team would amount to enthronement of mediocrity . . . it would be absurd to appoint a person who was not a lawyer as an Attorney General, just as it would be if a professional, other than a medical doctor assumed the secretaryship of the Health Ministry (quoted from Alubo, 1995).

While doctors no doubt deserve very high status and rewards for their relatively rare skills and contributions to the maintenance of the health of the society, modernization and the technology revolution have however led to the professionalization of other health related occupations with the consequence that these

other professionals now increasingly question the preeminence of doctors in the health team. Experience however shows that this conflict is rather needless as any of the professionals can provide effective and efficient leadership in the pursuit of health related goals.

Thus nurses, for instance, who spend the greater amount of time weight the patients and thus bear the greater burden of patient care often resent the greater degree of authority traditionally granted doctors. The conflict, although often muted, is greater where the doctor is younger and thus considered as less experienced by the nurses who have to work with him/her and take orders from him/her. Issues of deferential pay and fringe benefit between doctors and nurses are also sources of conflict and have actually led to strike action in the past.

As Shepard (1961) saw this inter-professional conflict, differences in orientations create points of tension and conflict. Often the tension and conflict remain latent and is expressed largely by isolation and in feelings and expressions of such things as pride and superiority. Sometimes, however, the tension and conflict become manifest and create a barrier to cooperation.

Similarly, but arguing from a broader American perspective, Hall (1951) saw the struggle between the various specialists employed in the hospital as a 'struggle for prestige' which extends beyond the boundaries of the hospital. In his words,

> the various specialists are sensitive regarding the invidious evaluation of their respective specialties. The struggle extends beyond the hospital, in so far as there exists a public which is sensitive to medical prestige and its symbols.

At this societal level, the struggle is waged by the various professional associations who acting as interest groups seek to influence public policy in favour of their own members and

preferable at the expense of other groups. The continuing attempt by the Nigerian Medical Association to exclude other professionals from leadership positions in health institutions and in the sector as a whole has already been alluded to above. Experience shows however that this conflict could be (and sometimes actually is) a serious problem indeed in Nigerian hospitals with each professional group asserting its superiority over other and thus making cooperation in patient care difficult if not impossible.

Finally, having argued that the hospital is a bureaucratic organization, an important question that arises then is, does the bureaucratic structure enhance the efficiency of Nigerian hospitals? The answer is obviously to the negative. The fact of the matter is that over the years, the performance of Nigerian hospitals has deteriorated and a large number of reasons have been advance to explain the prevailing state of affairs, including lack of funds .. absolute equipment. Low morale of staff, etc. What is clear however, is that for more efficient services, the conditions under which the various people work must be improved and adequate and up-to-date equipment provided. Perhaps of greater importance is that the bureaucratic structure will need to be modified to give greater autonomy to the various units and allow greater use of initiative on the part of staff. This will reduce to a very great extent much of the conflict that a present afflict many of the bigger hospitals.

CONCLUSION

This chapter has examined the manner in which healthcare services and facilities are organized and managed in Nigeria. The fundamental basis of the analysis is that health is central to societal well being and has important implications for individual productivity and hence societal social and economic development Various types of healthcare facilities exist in Nigeria, conveniently divided into lower - and higher - order facilitates. What is however

important is that in Nigeria, the modern medical system is hospital based. Such hospitals, owing partly to government ownership of most of them and their sizes, are bureaucratic organizations exhibiting the various features of typical bureaucracies as first articulated by Max Weber.

The evidence on the ground shows that for a number of reasons public establishments, including hospitals, have usually performed below expectation. Perhaps the solution lies in the loosening of the bureaucratic structure in favour of more organic administrative structures which wold allow for more individual and group autonomy in pursuit of organizational goals. In such an administrative structure ... now relatively common in many private sector organizations in Nigeria, centralization and standardization are greatly reduced and more attention is paid to the building of work teams to whom high targets are set. The corollary of course is that the requisite equipment and motivational provisions are made available so that high performance can be achieved and sustained.

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Chapter Nine

PROFESSIONS, HIERARCHY AND MANAGEMENT WITHIN THE HEALTH COMMUNITY: A DOCTOR'S VIEW

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INTRODUCTION:

There has ben more development in the world in the last hundred years alone than in the thousands of years before this time all put together. This development has ben largely in the areas of science and technology. Of necessity, this growth must put stress on the way that society is organized and functions. These stresses are found in virtually every ramification of life - the value systems, the morals, the religion, the family (structure and function), of politics (and of leadership and participation in it), etc. The health services organization and functions cannot be exceptions to this. In order for the health services to continue to function efficiently, it is important for the people involved in leadership at all levels of such an industry to understand the nature of these developments. They also need to understand the direction of the pressures that such developments bring about. In that way,they can work to tandem with such development, allowing true development to take place but without allowing it to do fundamental damage to the system itself, or to the other structures and functions.

The nature and development of medicine and the medical and health industry

In its historical development, medical practice was a very personalized service that its practitioners gave to ill people. At its beginning, there would seem to have been little science to it. It was mostly an art, mixed with religious ministration. Hippocrates was to change all that in the 4th century before Christ. But even until the industrial revolution, the developing scientific medical practice remained an individualized service rendered to people either in the physician's home or at the home of the client. All the nursing care needed by the patient was provided by his family. Even though temples were reportedly used as centres for medical training, and sometimes used as a refuge for the sick and infirm, they did not perform the same function like those of modern hospitals.

Hospitals as the standard place of care of acutely ill people away from their homes developed during the middle ages and for a long time still functioned as a refuge for the sick and homeless, and for the dying poor. Medical practice continued as a service which doctors gave to patients who wilfully subjected themselves to their professional knowledge and skills concerning health and disease. They did for the patients things which were by far outside of the knowledge and skill competence of the patient. Because medicine dealt with grave issues of life and death, the drugs and other interventions that can affect these gravely, even if one were a doctor himself, ethics make it unacceptable for him to practice his medicine on himself, or to people of very close (1st degree) relationship with him. This has continued to be the nature of medicine and medical practice as a profession.

Within just a little over a century of the recent rapid developments, medical knowledge and skills have expanded so greatly that it is no longer possible for anybody to acquire and exercise all the medical skills and knowledge by himself alone.

Fields of the curing practices such as surgery and dentistry (which were not allowed for medical practitioners by the Hippocratic codes) have also become admitted into the expanded professional understanding of medicine and of its practice. This has largely been so because of the reduction of the brutality seemingly involved in these later practices through the science of anesthesiology. Dentistry however, unlike surgery, has managed to maintain a relative distinction from medicine as newly developed: even though ethically and organizationally, it has virtually remained inseparably bound together with medicine. For this reason, persons can enter dentistry as a primary profession from the start, and nota s a post-graduate specialization in medicine.

The rest of the newly expanded medical profession has however developed several specialties for its post-graduate practice, both of broad areas such as medicine, paediatrics and general surgery, as well as of narrower specialties such as ophthalmology or even cardiology, etc. What all these have meant is that the former overwhelming authority that doctors wielded while they had sole charge to treat all of the patients illness in the past, has now to be shared among this growing number of medical care givers. The line of authority over the patients care has become more diffuse in the big or especially specialist hospital settings. This phenomenal growth in medical practice in terms of the diversified areas of knowledge, of technology and of people involved (even in a single patient's care) has resulted in the situation in which medical care is to dy referred to as an industry.

The medically-allied professions; their development, nature and relationships

Just as medicine in its later scientific and technological development has resulted in its incorporation of surgery, the development of many postgraduate specialty areas and the closer

aligning with dentistry, it has also dropped some practices which were earlier thought to be part of medicine as a single profession. Some other professional practice areas have also developed, either independent but aligned to medicine or out of what doctors could naturally incorporate with their practices but usually would not, because of the large areas of knowledge and practices more in the heart of the profession which they would need to stick to. Thus pharmacy developed as a profession of its own out of apothecary, previously considered an inferior aspect of medicine. Nursing developed from the need to takeover the care that the family would normally have provided for the patient were he to have been treated at home. Its science and art ordinarily consist of things that the patient should be otherwise able to do for himself. The laboratory and other diagnostic and therapeutic science practice areas also developed with the application of basic science to those aspects of patient care beyond those strictly applicable at the clinic examination couch for reaching a clinical/medical diagnosis and direct medical or scheduled surgical intervention. These get passed down as ancillary services to be rendered by others. In this later group are physiotherapy, radiotherapy, laboratory sciences and radiography.

Even though many of these disciplines have developed as full professions, physicians in their undergraduate training are required to train in all the basic sciences as applied to all these areas of practice, as well as some degree of the services provided by these service areas. At the postgraduate level, doctors may still specialize in the whole or aspects of these disciplines, except dentistry, pharmacy, physiotherapy and nursing which have remained fully not entered for post-graduate specialization by doctors. Thus doctors may specialize in clinical pharmacology, the laboratory sciences, radio-diagnostics and therapeutics. The common factor in all these disciplines outside of medicine, dentistry and midwifery is that patients usually ethically, do not attend health care primarily to see their practitioners. Their need

is subsequently determined by the doctor or dentist. Midwifery itself (like its related nursing profession, as dentistry is to medicine) concerns the determination of the normalcy of a pregnancy and the monitoring and supervision of same for any serious departures from the normal: so that if it remains normal, a simple natural delivery may be allowed to take place without medical intervention. The aspect of midwifery that implies abnormal pregnancy and interventional manage and delivery has become incorporated into medicine as obstetrics. Hence, even though midwifery has remained a distinct profession form medicine, it would require a functional link with an obstetric health care system to take over any abnormal pregnancy managements identified by it. Nursing however has remained not practicable independently, except in the case of old people with no relatives willing to take adequate care of them; and who may then make use of old peoples/nursing homes.

The impact of the recent developments on integrated medical care

The impact of all the above developments on medical care has been what has been called "the fragmentation of the medical care" by some people. Within the medical profession itself, it has given rise to repeated calls for the development of a coordinating specialty practice area so as to curtail these negative effects. This specialty is to maintain the singly controlled care for individual patients by the medical practitioner as was the case of old. This specialty has been called general medical practice in some countries and primary medical care or family medicine in others. It is reckoned that if individual patients entered the medical services through one such general practitioner, or family physician, the latter will have the responsibility of looking after that patients total care.

He will help him avail any other specialized care which he may stand in need of since he has basic professional knowledge of those. This will avoid the fragmentation of service and physician allegiance of the patient that may otherwise arise in the care if he were to seek it entirely all by himself. In this situation, the patient maintains his health are trust to the family physician while all other care givers literally function as technical experts to provide these needed services.

The basic nature of professions

Professions have been described in management and social science circles to be areas of service involvement characterized by at least three attributes: firstly, a profession has an existing body of knowledge which has developed over the years from established principles. Secondly, professions have definite standards of performance in their job which gives them a unique status in the community and prevents charlatans from finding easy access into such a profession. Such standards of profession performance allows the clients to repose some levels of confidence on such professionals. Finally, professions are governed by a strict code of ethics which protect the professionals and their clients from the abuse of the practice: as well as indeed, the society at large.

Usually, members of given professions bind themselves into guilds or associations which help them to pursue and maintain the professional attributes mentioned above. In addition, professions are able to demarcate practices and privileges which belong to that profession, especially in areas in which they share served relationship with other professions or technical services. The professions differ from what are called the arts and trades in several ways. This includes the fact that the professional associations are not trade unions and do not identify with them as such. Unlike professional associations which concern themselves mainly with the ethics of their profession, the maintenance of high

standards of practice, the regulating and standardization of training, research to improve and further develop the professions knowledge base, trade unions are concerned primarily with the creation of cartels, or bargaining with employers for better pay and conditions of service. The arts and trades in human life really constitute ancillary service enterprises; and in the area of science and technology, the term technicians or technologists have ben applied to people who give those services in relation to the main professional disciplines in such areas of their services - e.g. engineering technologists, legal draughts-men, medical laboratory, technicians and technologist and X-ray technicians.

Medicine and the health services

It is important to draw a line between medicine and medical practice on the one hand and health and the health services on the other. While medicine and its medically aligned disciplines concern primarily the care of sick people, health concerns the whole areas involved in being well maintaining it.

Preventive medicine is the aspect of medicine that delves into the whole domain of heath and well-being principally. Thus, while all the aligned medical disciplines in their preventive practices also can get involved with health, there are more professional and technical services involved in health than the strict medical and allied professions: food and nutrition, education and training, public works and environmental sciences, good societal organization and employment/labour etc.

Hence while the hospital is a medical institution and the medical and medically aligned professions are easily recognized in it, in the area of health, other workers not easily recognized as medical or health workers are very important in it as well. Nobody interested in or properly trained in preventive/community medicine and/or health can really under-rate such people. However, since medicine constitutes the important ingredient in the pursuit of

health, it continues to be the focal point when health is being considered.

Hierarchy and the medical industry

Since medicine grew beyond the point when one man can provide all the services possible to get from it into a complex industry, it has developed a need for a bureaucracy to be able to run its services. professional management skills are needed in order to be able to run the medical or health industry than is needed in the simple/solo medical practices of old. Attempts to develop professional managers in the full sense of the word (other than physicians) to run hospitals and other health services have however not managed to work; for without technical medical knowledge, such so-called managers may only function as administrators, with skills in human and resources management only, but no technical or only limited knowledge, or skills to really be able to function as real managers. Thus, large/public hospitals with corporate management and professional administration but no official medical directors have functioned largely as acephalus organizations. Corporate management may determine the policies, budget, remunerations etc. but the doctor at once takes up the functional headship when it comes to the actual function of the hospital in individual patient management, even if no doctor is officially designated to be responsible for this at the top level of management. The services of the other professionals therein at once become ancillary only. The creating of hospital hierarchy of staff, of course, occurs for each profession in its designated service area as they each contribute to patient care.

Health Management

Health Management has become very important as medical practice developed into an industry. It is recognized that three

areas of knowledge and skills are needed for anybody to perform management functions; namely technical, human management and conceptual skills.

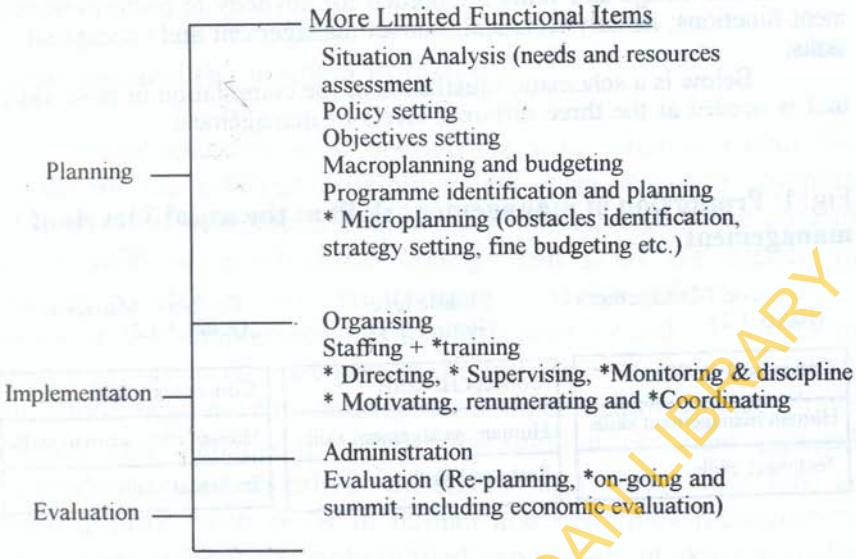
Below is a schematic illustration of the compilation of these skills that is needed at the three different levels of management.

Fig. 1: **Proportion of management skills at the usual 3 levels of management**

First level Management (Ratio: 1:2)	Middle level (Ratio 1.1:1)	Top Level Management (Ratio 3:3:2)
Conceptual skills	Conceptual skills	Conceptual skills
Human management skills	Human management skills	Human management skills
Technical skills	Technical skills	Technical skills

In the health field, more technical skills are needed at top level management than on other fields of endeavour because of the life and death issues involved. Also, concerning the functions actually performed by management (Fig. 2 below), aspects such as training, directing, supervision and coordination in the medical field would need someone who has technical knowledge and skills in all the areas of practice involved, even at the top management level. It is particularly in view of these issues, both in the principles of management and the very nature of medical care and patient expectation and allegiance, that it is not really possible to create the top management of a hospital or any health care system with a doctor playing other than the top level leadership in it; otherwise such non-physician will function not as a true top level manager but merely as an administrator in a largely acephalous institution. This fact in no way denies the importance of everybody in the medical or health team; but only reflects its interest nature.

Fig. 2: **Structure of Management functions**



* Areas that need technical knowledge of the practices involved.

Problems of doctors in the leadership of the health team

From the nature of medical care as a service which patients sought in the hands of doctor, the physicians have always presided ever all that it takes to give those services. With the growth of medical field into a multi-disciplinary industry, doctors remain the only professionals in the field of health care whose profession stipulates that they must be trained in the basic science of all the fields that is required to give medical care. Even in the broader area of health, physicians who enter the post-graduate discipline of public health medicine (preventive and social or community medicine etc: as it may be called in various places), their discipline

stipulates training in all the theoretical and practical areas of the public health endeavour which will not be required of any other public health practitioner. Because of these facts and the three skill areas needed for adequate health management, doctors have always felt that even in public health and large corporate settings in which medical care has become truly an industry, the medical doctor should always be at the leadership of the team to avoid unnecessary friction and blamable inadequacies. Patients have always seen it these way as well. Other health workers have naturally felt similarly until lately, the reason for this being the secular humanist cultural one.

However, because doctors' undergraduate training do not involve detailed training in management, much as doctors may have inherent capacity for conceptualization of the needs in the health field as well as the needed technical skills, they often have no skills in human or resources management. Also because of the social role-modelling inherent in the profession, doctors grow up expecting acceptance of their leadership of the health team without question from the other members of the health team. Modern secular humanist trends which encourage people to assert themselves however they can (and so making human management a more difficult thing) would indicate that doctors should have more training in management at the undergraduate level so that they are better able to give the needed leadership to the health team. One of the important functions of management is motivation of the subordinates, including due recognition of their importance and a balanced effort at improving their remuneration and welfare on the job. Leaders who do not do that will fail to merit leadership and would end up extracting it at great psychosocial cost to the industry. Such problems however do not arise at private medical practices where a medical bureaucracy does not exist.

Because human management is often more of a natural than a learned skill, it is obvious that not all doctors who climb the ladder of their profession in public enterprises can give it.

Professionals in other health fields who reach the top of their professional ladder and have natural human management skills may wonder why they cannot step beyond that profession and manage all of the medical industry since the intellectual needs of all the professions require that they already have enough intelligence for conceptual skills. Because of the social nature of medicine, it would be obvious that they cannot do so unless they go and train in all of that medicine. It would therefore seem to me that apart form expanding the undergraduate medical training in human management, and providing further postgraduate training for doctors who later function in the areas requiring such skills, the problem of discontent by other health workers concerning the permanent leadership of the complete medical team by doctors is something that we will have to live with until better understanding by these workers takes care of it. No doctor would go to head a purely pharmaceutical industry or service centre, a mere maternity centre, a nursing home, an independent medical laboratory or X-ray centre. The professionals in those narrower or less technical disciplines have to do so. If they affiliate their services to a hospital, the doctor functions as a referral person or to visit such places as an external consultant as may be requested. Why would these other professional not leave a doctor to preside over the medical centre/hospital which is his full professional centre? The secular humanist culture that is spreading worldwide and encouraging people not to accept any status-quo no matter the obvious and valid fact or rational for it is the apparent reason for the clamour for anybody to be able to allowed to do anything. However, apart from the already recognized need to train doctors in management at all levels of the profession, the other health professions may also need to train in the sociological realities which make it unreasonable to expert more than such improvement for the god leadership order in the medical and health team.

Such training should encourage these professions to indeed try to develop and define their professions so well that they would

not try to confuse themselves with professional medicine itself, or have medicine interfere in these professions unduly. For example, midwifery as a supremely technical and exacting profession should define itself as such. Even though it would need to have a place to refer obstetrical acute medical cases to, when they arise, a supervisory relationship with such an obstetric until will not be mandatory for its functions as long as health centres do not need a supervisory relationship or even an existing secondary health care centre to exist; nor such secondary centres a tertiary one, even though it will be good to have those. To insist otherwise is impractical. Similarly, while it is a medical decision that a cardiovascular accident patient encountered at OPD or casualty clinic requires hospital admission for their medical care, whether that patient can actually be admitted to particular ward is a nursing decision, based on the nursing staff strength, the equipments and the nature of the other patients already admitted to that ward. These are some of the issues that have not been professionally studied and ethically refined and claimed by the nursing and midwifery professions. Instead, they are busy trying to practice invasive therapeutics of patients that actually should belong to medicine as in the IUD, nor plant and similar contraceptive practices (if ethically admissible even in medicine itself). These are obviously the result of the present secular-humanist-induced moral and ethical weakness in the world and the medical profession. Because pharmacy has refined itself in similar regards, a doctor may determine that a patient should take a given drug for his therapy. But if he writes an underdose or overdose of such a drug, no matter how senior a doctor he may be, even a pupil pharmacist can (should and usually do) refuse to dispense of the drug; call the doctor to review the order, and only administer the drug when appropriately dosed. This is the result of professional refinement. Other health professions aligned medicine need to do likewise.

Even in the individual professions, they should mind the growth of charlatans. If medical laboratory technologists for

example develop themselves into a full profession as medical laboratory scientists, and radiographers as such, they must ensure that in establishing independent medical laboratories or X-ray centres, medical laboratory technicians or X-ray technicians do not go ahead and establish such centres as well, just because they can exercise some of the skills of such professionals. So also with the case with so-called nurse-assistants and pharmacy technicians and patent medicine dealers! These professions obviously have more work to do on their own professions, their refining and leadership, than struggling to become medical doctors by default, the dearth of physicians in some disciplines and geographical areas notwithstanding. The different professions, the patients and the world at large would be better off with these more relevant growths and developments.

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Chapter Ten

PROFESSIONS, HIERARCHY AND MANAGEMENT WITHIN THE HEALTH COMMUNITY A NURSE'S VIEW

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INTRODUCTION

Man has been described as a social being whose life involves a variety of social interactions. Some of these interactions may be intimate, personal and persistent, others may be transient, impersonal and intermittent. As a result of those interactions, man continually manifests characteristics of a social being.

As a social being, man belongs to a number of social groupings such as race, society and community. Race is a biological term which identifies man's physical traits. A society is usually defined by territory and it is made up of people who share habits, ideas and attitudes. A community is a smaller grouping of people within the larger society who carry on among themselves some essential activities.

On the basis of the above definition of community, one may talk of the health community. The health community which has been variably called the health care complex (Aina, 1986) or the medical care complex (APHA, 1965) is made up of three distinct components. Only one of these is the subject of this chapter.

In 1965, Myers talked of a medical care complex consisting of three interrelated components. According to her, it was the interactions and interrelationships among these components that provide the structure of the complex including its form and functions. She went on to state that the boundary, scope and direction of the complex are determined by and large by the varied

goals and expectations of each of the components.

The three identified components are the professional, personal and the social. The professional component consists of those who provide personal health care services. This is the subject of this chapter. Included here are a variety of professional and semi-professional people who provide diverse health care services. This includes but not limited to physicians, dentists, nurse, pharmacists, physiotherapists and medical laboratory personnel.

These varied personnel are trained to render personal health services. It should be noted that these various health care personnel may have diverse and sometimes divergent goals an expectations as a result of their different characteristics, background and practice pattern. The common objective however is to provide adequate health care to all those who need it.

The personal component comprises of people who need health care services. These maybe individuals, families, groups a or communities who at one time or the other will need the services made available at the health care complex. These people will arrive with various needs, values, goals and expectations of which alleviating pain and suffering may be the greatest ones.

The social component is the organized arrangement, which is a combined efforts of those needing health care services and those providing them with the aim of achieving mutual goals. Hospitals, clinics, dispensaries, community health centres and maternity homes are some of the various organizations within the society that perform certain functions designed to make health care services available to people.

The goal of the health care complex is to promote, protect and restore the health of individuals, families and communities and to alleviate pain and suffering. Major functions in the health care complex are organizing delivery of health services, financing health services, regulating health services, developing and allocating resources, planning and coordinating relationships. These functions although performed by the social component, must

involve the other two component because of their interrelatedness. In order to properly harness the resources of the complex, there is a need to understand fully the structure of the complex.

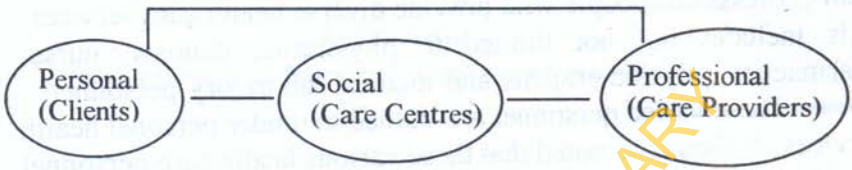

Fig. 1 **Structure of the Health Care Complex**

The interactions among these three components take into consideration specific goals, values and expectations of each of the components. One of the major interactions is between the people who need health care services and those whose duty it is to provide these services.

The Professions

Social Scientists find it very difficult to agree on a common definition of a profession and its characteristics despite the fact that numerous studies have been and many books writing on the subject. This is due to the complexity of the term. What differentiates an occupation from a profession? Originally, there were three professions - Clergy, Law and Medicine but as time went on, other professions emerged.

A profession can be defined as an occupation for which preliminary training is intellectual in nature and which involves accumulation of theoretical knowledge and learning and not mere acquisition of skill. We cannot overemphasize the importance of professions in the health care industry. There is no other industry with such a large number and an array of professionals at different

levels of skills.

Many characteristics have been advanced for differentiating an occupation from a profession. In a 1971 treatise, Palvako identified the following characteristics that a given occupation must satisfy before it can be accorded a professional status. The occupation must:

1. Perform a unique, definite and essential social service.
2. Depend more on intellectual than physical techniques in performing its services.
3. Have long period of specialized training.
4. Possess a broad range of autonomy for individual practitioners and the group.
5. Accept personal responsibility of its members
6. Emphasis public service rather than economic gain.
7. Have a clear and easily understood code of conduct to guide members.
8. Possess a unique body of knowledge exclusive to its members.
9. Have an association to set and monitor standards.

Over the years, these characteristics have been modified and redefined as more and more occupations become professionalize. In recent years definition of a profession in the United States has come from court decisions based on the following four parameters:

1. A long period of training
2. A predominantly intellectual work that also varies in character.
3. Exercise of individual discretion in work performance.
4. The work can neither be standardized nor routinized.

There are several occupations in the health care industry. Milio (1971) identified 125 different occupations with an additional 250 alternative job titles. Health care professionals have diverse

goals and expectations because of their personal characteristics, professional backgrounds and practise patterns.

They require different kinds of skills, have different kinds of relationships with clients and their attitudes and methods are influenced by their practice settings. In order to make sense out of the many professional and occupational groups in health care they can be classified in several ways. We may classify them as professionals, semi-professionals or non-professionals. We may also classify them according to task they perform.

Table 1: **Health Care Team**

	A. PROFESSIONALS	B. SEMI-PROFESSIONALS	C. NON-PROFESSIONAL
1	PHYSICIANS/SURGEONS	PHYSIOTHERAPIST	SOCIAL WORKER
2	DENTISTS	OCCUPATIONAL	ADMINISTRATIO N
3	NURSES	RESPIRATORY	MEDICAL RECORDS
4	PHARMACISTS	DIETICIANS	TECHNICIANS

The above are some of the examples on each of the categories of the health care team. As can be sen, the health care team is multidisciplinary.

Table 2: **Health Care Team According to Tasks**

A. **Those involved in diagnosis and therapeutics**

Physicians (Medicine and Osteopathy

Optometrists and Opticians

Dentists

Pharmacists
Occupational therapists
Physiotherapists

B. Those involved in care of dishabilitated
Nurses and Midwives
Auxiliary Nurses
Nursing Aids, Orderlies and Attendants

C. Those involved in Counselling and Education
Social workers
Psychologists
Dietitians and Nutritionists

D. Those involved in Machine-related technologies
Bio-medical engineers
Laboratory workers (Technologists and Technicians)
X-ray, E. C. G., and E. E. G. technicians

E. Those involved in management and interrelations
Administrators
Medical records
Finance workers (Accountants and Book keepers)
Source: Milio (1975).

The above table categorizes the health care workers according to the tasks performed by each member of a particular group. In the hospital, doctors and nurses are the two largest professional groups. Most of doctors are males while most of the nurses are females. This gender disparity has some influence on

hierarchy and management in the health care complex.

Professional groups should have autonomy which is based on the body of knowledge and a unique service to render to society. This autonomy means that the profession is self-regulating. This implies total control of its functions and practice. Since the body of knowledge is specialized, then only those who possess that knowledge are competent and qualified to decide on its practice.

HIERARCHY AND MANAGEMENT

Hierarchical relationship in the health care complex creates management problems especially when certain groups insist on permanent leadership of the community. The Military-type relationship which operates in most health institutions in Nigeria is not conductive to professional practice.

It is not only inappropriate but also dangerous for those who do not posses any competence in a particular field to make judgement about how the knowledge in that field ought to be used. A profession must have authority to control, manage, and direct the practice of its members.

It is customary for professionals to advise, consult, coordinate and collaborate with their colleagues in the same or similar discipline, but responsibility and accountability for policy and professional decisions and actions must reside with individual members of the profession. Professional judgement requires the use of specialized judgement which no one but members of that profession possess.

Management has been described as a socio-technical (Parsons, 1966) process that users resources, influences human activities and facilitates changes in order to achieve a set goal. The development of modern organizational management is credited to such people as Taylor (Scientific Management), Fayol (Administrative Management), Grant, Mary Parker Follet, Eton Mayo, Carl Max and a host of others who pioneered theory and

model development in the field of Management.

As pointed out earlier, the social component of the health care complex represents the various organized arrangements designed to bring health care to individuals, families and communities. The hospital is the epitome of such an arrangement. The hospital is a system made up of people with needs, goals, expectations and it possesses specialized technology. It has certain characteristics that differentiate it form other organizations (Georgopoulos, 1972).

As an organization, the hospital defines the roles of its members which is constrained only by its own socio-technical limitations places on it by societal demands. Hospitals usually prescribe relationships which are task-relevant, impersonal and authority-oriented and expect members to comply. There are different cadres of workers operating at different levels of skills.

All these people with extremely different skills, diverse backgrounds and different goals and expectations must be brought together to achieve the main objective of the hospital professionals (doctors dentist nurses and pharmacists) have strong demands for personal independence in their work and they usually have an aversion to organizational regimentation.

Although, these professionals seek progressive independence in their work, the hospital cannot function effectively without a good deal of compliance with certain rules and regulations by members of the professional groups. Sometimes, some of these rules and regulations may be opposed to the tenets of a professional calling. While seeking to run an effective organization, the managers of hospitals must not allow the main objective which is patient care to be compromised.

The hospital as a living system should be capable of problem-solving and self-regulating including that of restructuring itself without much loss to its identity and continuity (Emery and Trust, 1960, Buckley, 1968). In order, to be effective, the hospital must pay attention to both human and material resources. Adequate

functioning of the hospital depends upon the proper coordination of the workforce, majority of whom are professionals.

Effective functioning of the hospital depends upon its paying attention to personal goal attainment, meaningful participation in decision-making, getting individual members to identify with the hospital, satisfying individual motives and attainment of psychological rewards. The hospital must also deal with problems of adaptation, allocation, coordination, integration, strain, output and maintenance.

The present situation in the country in which Medicine has assumed preeminence and has tried to keep other professional groups out of management cannot fulfil the above requirements of proper management. The best approach to health care should be that of team management. No particular professional group should delude itself into believing that it has monopoly of knowledge of health care. Each group has its contribution to make to health care.

The health care industry is a system and with all systems, it consists of several components. One property of system is that what affects one apart of affects the whole system. This has been aptly demonstrated each time a section goes on strike or embarked on work to rule, the other parts cannot function properly.

The functions of management are four folds:- Planning, Organizing, Motivation and Controlling. One needs to study management in order to become an effective and efficient manager. The present system whereby one is made the manager of a health institution simply because he belongs to a particular profession has not worked well in this country. It is about time that changes in that system take place.

Management is a serious business. It is on the basis of this, that we suggest that management of our health institutions be undertaken with all seriousness. The peculiarities of health institutions earlier identified put some kind of pressure on managers but with proper understanding and harnessing of all the resources, the well trained and experienced manager can make a

success of the endeavor.

Health care providers should be able to, from time to time, define their goals, structure and functions. Each professional group within the health care industry should be able to manage its own affairs realizing that professional practice connotes a professional relationship between the care providers and the care receiver.

The framework or relationships among members of an organization is known as the structure. It is a logical interplay of management levels and functional areas arranged in such a way that allows the organization attain its objectives in an effective and efficient manner. The structure of management in the health care complex should reflect professional competence.

The head of the complex must have the ability to weave together its various part in order to make them work together in an effective and efficient manner. This individual would likely perform better if he/she does not belong to any of the professional group within the system. He must exercise power and authority in a way that would not jeopardize the professional autonomy of each professional group.

The management board of the health care complex must have membership from all major professional groups within the system and each group must have adequate representation in other areas of management. The ultimate goal is to bring health care to the people, so all must be involved in the planning and execution of health care programmes. It is more likely to be successful if everyone has a say in its plan and implementation.

CONCLUSION:

The health care complex is made up of people who need health care, those who provide it and the organized arrangement for providing it. The chapter has dealt mostly on those who provide health care, and management of health care.

There is need for cooperation and team work among the various groups within the health care system. It is this cooperation that will allow for effective and efficient practice which will lead to achievement of goals.

The goal of the health care complex is to provide health care to those who need it irrespective of sex, age, and national origin.

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Chapter Eleven

BIOCULTURAL ADAPTATION

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INTRODUCTION

Medical Anthropology is an aspect of Human Biology which is an integral part of physical and/or Cultural Anthropology depending on the subject matter. This chapter draws heavily on materials from physical anthropology otherwise referred to as human biology in the widest contest. Human biology more often centres on human as a whole or to human populations than to individuals.

Moreover, the subject of medical anthropology is people, and people are the only culture - bearing animals (Lasker, 1976). Medical anthropology therefore deals substantially with the interaction of socio-cultural and environmental factors with genetic processes in explaining health related behaviours. In other words, medical anthropology is concerned both with cultural and environmental influences on health behaviours and with biological/genetic preconditions.

From the anthropological point of view, there are two quite distinct types of heredity:

(1) **Genetic Heredity:** By which physical traits are passed from one generation to he next and

(2) **Social Heredity:** The process by which one generation teaches its cultural inheritance to the next (Bleibtreu et al, 1971). Genes and culture traits often affect one

another. It has been suggested, for example, that the invention of the spear replacing the club probably set in motion an entirely different conditions for survival to which the genes that control physical structure must adapt. Spear users' physiques would then be selected for the leverage of broad shoulders and long limbs whereas, club users would be better off with ruggedly compact physiques.

The bio-cultural approach emphasizes the evolution of man's biological capacity for culture and the mutual influence of genes and culture traits. Culture as represented by the massive use of tools and symbols constitutes the basic adaptive mechanism of man. Bleibtreu et al summarize this view point as follows:

> But adaptation is an on-going evolutionary process. Although culture proper is unique to Homo Sapiens, it is nevertheless the biologically adaptive technique of this particular animal, built physically and functionally as he is. The use of fire and weapons has certainly affected man's dentition and jaws, eye-brow ridges and skull in general. But even more subtly and drastically, cultural adaptation has altered the basic biology of man (Bleibtreu et al, 1971).

The biocultural approach to the study of human health helps to illuminate what man is and how he behaves as a culture - bearing animal.

In a wider perspective environment is an aspect of both cultural and physical factors. Now, let us look more precisely into variable interaction with the environment. Green et al (1993) had earlier observed certain modifying factors thought to be both genetic and environmental. They argued that even if a

woman has the gene for a disease, there is still a 1 in 5 chance she will not develop the disease.

This implies that most disorders with a genetic component rely on the interaction of genes and environment to bring about a clinical manifestation of disease (Davison, Macintrye and Smith, 1994), about 4000 disorders are identified as being affected by such interactions. Takagi (1991) even suggested that it is difficult to think of many diseases from which this is not the case.

However, in diseases characterized by highly expressive genetic material, environmental influences may be expected to be of little importance as the pathonegic effects of genetic inheritance will be manifest whatever conditions are experienced. Nevertheless, the timing and severity of the onset of such diseases would wholly and partly be determined by the interaction of the individual and the environment. In such cases, genetic components are grea ly been influenced by the environment.

ADAPTIVE PROCESSES

Adaptation implies the series of changes by which organisms surmount the challenges to life. It involves major evolutionary events, the growth of the individual and behavioural and physiological changes which may last only hours or minutes (Lasker, Op. Cit). Adaptation in this sense implies its antithesis, that is, if one way of functioning is adaptive, another is less adaptive or maladaptive under comparable circumstances.

Adaptive selection is the central theme of the Darwinian theory of evolution, the natural selection of better-adapted organisms and the extinction of the less well adapted through earlier death or reduced fertility. In this perspective, we can view adaptation as a modification in structure and/or function

which enables an organism to survive and reproduce. This can apply to a particular organ or the whole individual and the entire population or the whole species. Questions of different adaptation remain among the most pressing and the most practical facing medical anthropology, such questions often arise: Are different populations differentially adapted to the differing environments in which they live? What are the implications of these for example, to national heath care delivery services? Meanwhile, we shall discuss the main channels of human adaptation.

Two main channels of organism-environmental interaction have been identified, these are:

(1) Physiological adaptability and

(2) Biological response (Harnson et al, 1964)

Physiological Adaptability

Physiological adaptability is concerned mostly with biological changes induced in the human body by the stresses or demands of the environment. It may be necessary to distinguish the responses and activities of the individual man, woman and child from those that concern the group as a whole.

Individual responses are physiological, the body can adapt, acclimatize or become immune to a wide variety of external factors such as nutritional, climatic, and pathological by virtue of the general somatic property. Physiological adaptability is a species property, all members of our species, for example, can exhibit this flexibility of response, it is an evolutionary product of the species.

Biological Responses

Biological responses are specific to particular individuals and are determined by particular genotypes. Traits of this type may be peculiar to a few individuals or may confer special advantages on particular populations such as narrowness of nose in cold or excessive dry conditions, dark pigmentation in the tropics.

Homeostasis

The significance of adaptation is the maintenance of biological homeostasis. Homeostasis is defined as the totality of steady states maintained in an organism. It involves two interwoven processes:

(1) Steady balance and

(2) Self regulation.

In the physiological sense, it refers to the preservation of that constancy of internal cellular conditions necessary for the life of the body.

Steady states are attained within the same limits in all races such as body temperature, blood H-ion concentration, sugar content or osmotic pressure though the exact level within the range may be set at values depending on particular factors or activity or environment. Human group by virtue of its genetic constitution displays homeostatic properties. There is a strong tendency to stability in the range of bodily features with a clustering of the majority round a mean value. This distribution arises inevitably from the fact that many adaptive genes are involved.

The mean represents the greatest degree of heterozygosity while the extremes represent a greater degree of

homozygosity. The mean value is on the whole the most favourable, the extremes, the less favourable expression of the phenotypes. Elimination of the less fit, in the interest of group adaptability, does not however, deprive the group of genetic variability since the more favoured heterozygotes continue to supply this. There is thus a genetic homeostasis maintaining both the optimum and the range and providing the material fora shift to the appropriate genotype should circumstances change.

Social and technical factors are also responsible for maintenance of homeostasis. These are social and technical activities which allow the group to come to terms with or to dominate the environment. These include social organization or institutions, division of labour, the arrangements for constructing shelters, the disposal of working energy and the measures for caring for offspring. Although these institutions and customs were not designed to serve biological purposes, nevertheless, they do.

Homeostatic Adjustment-Physiological and Behavioural

The difference between biological adaptation (which covers both functional processes and structures on which they depend) and human biology (which essentially addresses the ways in which organism relates to the circumstances it must meet to live) become blurred upon careful analysis of homeostatic adjustment. Homeothermy implies the ability to maintain constant and congenial temperature particularly under the condition of extreme heat or cold. This is common to all mammals and hence mammals, especially man, are more active all the time and cover wider geographical area.

The concept of Heterodontism/Mastication explains the structure and function of the teeth of mammals. The teeth were shaped differently (structure to perform different functions, that is, the teeth were highly specialized. However, man now has the

most generalized teeth of all animals. This can be explained as a product of human evolution, an interplay between culture and biology.

Reproductive Economy Pre-natal

Reptiles lay eggs and they are programmed to produce in quantity to maintain their number due to wastage. In man and great apes on the other hand, off-spring are usually only single at birth, they are referred to as monotocous creatures. In polytocous creatures, intra-uterine selection would put a premium on the quicker-growing embryo since space and nutrition are limited. Only a few of the promsimians produce single young. Twins are common among the most primitive of the New World Monkeys (particularly the callithis) but in the rest of Anthropoidea, single birth is the rule.

The suppression (by selection) of the multiple conditions in man is evidenced by the fact that it still occurs in low frequency (about 1 in 90). Selection against multiple births proceeds both naturally and artificially. The vigour and life expectancy of twins is somewhat below that of single infants and many primitive societies ruthlessly eliminated twins at birth. Single young can then be considered a re-adaptation for progressively increased maturation time, in this respect, man shows a clear continuity with the great apes.

Another prominent characteristic of mammals is the periodic estrus cycle, this is more pronounced among the prosimian primates. Estrus or heat is an event characterized by bleeding or show and the readiness of the female to receive the male. The human female however undergoes the continuously recurring monthly menstrual cycle. The two types of cycle are physiologically, endocrinologically and morphologically closely related, but the differences between them are sufficient to cause significant differences in the sexual and social behaviour of both

males and females.

Unlike the menstrual cycle of man, that of the great majority of the monkeys and the apes is characterized by changes in the external genitalia and sexual skin. In the menstrual cycle of baboons, chimpanzees and gorillas for instance, there is at ovulation no 'show' but under the influence of estrus, there is swelling and discoloration of the sexual skin round the external genital organs. This is absent in man and has important implication in human sexual behaviour.

Post-natal

The long growing period is characteristic of the anthropoid groups but it is more prominent among human species. It has certain advantages in regard to human social structure. The increased dependence of the young is associated with a strong material instinct particularly in monkeys and chimpanzees. In man, this combined with the sexual bond between the parents provides the enduring linkages for the basic family unit whether polygamous or monogamous.

The delay in attaining full maturity greatly reduces competition between males and their offspring. The father maintains his dominance for the greater part of his reproductive period. The long period of rearing between mother and child ensures protection of the child. Slower growth rate provides enough time to learn and enhances survival of safe environment learning enhances flexibility and better adjustment to the environment. This could be inform of:

(1) Trial and error which is somewhat dangerous

(2) Imitation, which is faster but rather inflexible and

(3) Instruction which involves the use of language and mostly used by modern man.

TECHNIQUES FOR SURVIVAL IN HARSH ENVIRONMENTS

The history of man is full of contrasting examples of the dynamic nature of the relationships between different kinds of living things in a community. These relationships form one of the most important aspects of the environment to which creatures must adapt. Hulse (1971) once observed:

> Life itself is a process and since each organism is born, grows, and dies, the relationships between organisms are constantly changing. Even if the purely physical aspects of the environment remain constant as they may over considerable periods of time, the biotic aspects, those due to the activities of animals and plants cannot be the same even from day to day (Hulse, 1971).

The degree to which most creatures appear to be adapted to their ways of life at any given moment may easily lead one to conclude that each variety was designed to fit its proper place and to fulfil its functions in the living community. We must emphasize however that there is no conflict between heredity and socio-environment, their joint action produces the characteristics of all living things including ourselves. We shall give a few examples of the interactions, that is the coping measures between man and his environments starting from the penman apes or the great ancestors of man to the contemporary primitive peoples.

Pre-man Apes

The pre-man was a successful hunter, utilizing, all the resources of the environment available to him, this resulted in a

fairly satisfactory nutritional intake. Aegytopithecus, our common ancestor, from which modern man and apes descended lived about 30 million years ago. He was a forest dwelling primate and moved on all fours. The Australopithecus Africanus, regarded as the great ancestor of man lived about 5 million years ago. He lived in open-land. He was an hunter and gatherer and used simple stone tools and hand axe.

The HOMO - erectus (Java man) lived between 500,000 and 300,000 years ago. He was wide spread and had about three fourth of modern man cranial capacity (1050 cc). He successfully hunted animals such as bison, horse, rhinoceros, deer, beer, big horned sheep, mammoth, camel, water buffalo, wild boar, hyena etc. His nutrition included vegetables and fruits and he used fire (as evident from Choukoutien cave near Peking in China).

The Neanderthal man lived about 100,000 years ago. He had an average of 1450 cc, just about the same with modern man (1400 cc). This shows some relationships between the volume of brain and the growth of culture and hence capability to manipulate, exploit or control diverse environments. He was wide spread, also known as:

(a) Rhodesian man of central Africa

(b) Solo man of Java

(c) Palestinian mount carmel man and

(d) Sharidan man of Iraq.

The Neanderthal man was able to exploit the varied resources of his habitant. The likely food animals includes horses, pig, otter, bear and chinocerors. It is doubtful whether the extinction of the Neanderthal could be attributed to nutritional causes (such as vitamin D deficiency) considering his wide geographical spread and the food resources available to him.

It must be noted that our early ancestors, during their long period of arboreal life took full advantages of the opportunities of the period, anatomically, physiologically and in social behaviour, they carried with them the marks of a continuous process of selection which persisted through several million generations of arboreal existence. Adaptations for efficient operation in various ecological zones are responsible for many of man's abilities (and stabilities). It was the good fortune of our ancestors to make the sort of adaptations which later proved to have been most adequate as a basis for evolutionary developments in the direction of generalized rather than specialized ability.

Primitive Peoples

Today man lives in a range of settings from desert to arctic tundra to steaming jungle. When we look at him in ecological terms, we see him as one component in complex webs of interrelationship with his physical environment. We are centrally concerned here with culture as mediating man's relations with environment. We will concentrate (illustrating with contemporary primitive peoples) on the way adaptation to an ecosystem shapes a culture and on the way a culture shapes an ecosystem and man's place in it. The four illustrations include:

(a) The Australian Aborigines

(b) The Bushman

(c) The Pygmies and

(d) The Somali

Australian Aborigines

The Australian aborigines live in parched desert in central Australia. They wrestled a living from an unpropitious environment through hunting and through collecting grubs, plants, roots. Material possessions are minimal. Keesing and Keesing (1971) reported that an Australian aborigine may travel with no more than a digging stick, hunting weapon and bundle of sacred objects with no shelter or with crude lean-tos that are abandoned as the band moves on.

Hunting weapons for large animals include bows and arrows, spears, snares, pit traps, blowguns, boomerangs. Fire is produced by friction in various ways. Read reported that the aborigines built up what they regarded as a measure of security through rituals which linked each band to an area and to the possible food to be found there and ensured continuity and preservation through a system of seasonal ceremonies and taboos. She stated further:

> The food quest was a such vital importance to the aboriginal population that all their life was organized around it, and measures of severe social discipline were enforced in the small communities to ensure that on one individual exploited the scarce resources so as to deprive his fellows of the deprive his fellows of the necessary food for keeping alive (Read, 1966).

It is apparent that the technologies of the aborigine are highly limited in terms of the control they give him over the environment and the efficiency with which investments of energy yield a return. Nonetheless, the aborigine is highly ingenious, at this technological level, he has adjusted to an environment, changing his pattern of living to follow the cycles

of an ecosystem. He has a oneness with the world of nature that modern man has lost.

The Bushmen

The Bushmen are about the lowest possible level of subsistence. They perpetually face the danger of death from hunger or thirst. They have to wander continuously seldom staying in one place more than a day or two (Turnbull, 1963). They live in the Kalahari Desert in south West Africa. Although the desert was not their natural homeland, they have adapted to it in a remarkable way.

It is almost impossible for anyone else to live there even with all the equipment and tools of modern civilization, yet, the bushmen survive and refuse to leave. The golden-brown athletic little hunters who are only about five feet tall can hunt down and kill any animal however big or dangerous with their bones.

They know the land well, every rise and fall of it, every clump of scrub, every three has a name. In the whole barren waste, they are never lost, but always know exactly where they are Turnbull further observed:

> And where everyone else would think there was no food or water within a hundred miles or more, a Bushman will walk a few feet to a little patch of scrub and pull out a 'tsama' melon or he will dig down into the sand with a hollow reed that he always carries with him and begin to suck and in time it (water) comes up through the reed, enough not only to slake his thirst, but perhaps enough to fill the shell of an ostrich egg (Turnbull, 1963).

Consideration of his fellow extends right through his whole life. A family is close and intimate, but a Bushman will

not ignore the needs of others merely because they are not his relatives.

The men go off to hunt and the women and children go off to search for whatever growing thing that can be eaten be it fruit or root on daily basis. They often return too exhausted to do anything but sleep. But at times, they gather together and sing and dance. This act of singing and dancing is both a recreation and an expression of their joy. They dance under the open sky and they sing to the stars which they regarded as their fellow hunters, chasing their quarry across the sky. The slim physical feature of the Bushman and rarity of problem of overweight or obesity is attributed in part to his rigorous life style and simple diet.

The Pygmies

The Pygmies (Bambuti) live mostly in the northeast Congo. They live a simple life, hunting and gathering almost daily. They are hunters because they have never, have had the need to be otherwise. There has always been plenty of food all around them and they are perfectly content. Their organization is equally simple, not living in large groups and having plenty of land in which to hunt without a band coming into conflict with another.

The forest shelters the pygmies from the heat of sun, it provides them with fresh drinking water wherever they go and it supplies an abundance of game vegetable foods, sometimes, a hunt will be successful enough to make it possible for the entire band to relax for the following day or two, during this time, they will sing and dance.

The technology is simple, comprises bow, arrow, spear and nets. They live in small bands of about three or four families. In the morning, the men go off together to find fresh animal trial. They climb up into trees and wait for the animals

to pass, sometimes calling them by imitating their cries. While hunting, the women would be gathering mushrooms, the sweet Itaba roots and whatever nuts they can find and these will all be used in cooking the evening meal. The game is divided up so that nobody goes without, and special preference is given to the old people who can no longer hunt for themselves. The Pygmies have an excellent understanding of their physical and social environment and seem to have adapted to it perfectly.

The Somali

The Somali live in the arid region of Northeast Africa. Their life style brings out the rigours of a nomadic life. They depend on their herbs and there is the need to find pasture and water for them. The perpetual search for water governs their migration.

There is always shortage of food, the Somali strongly believe that milk, the chief element in their diet, is the only food that can sustain life by itself. Among the women there is a high fertility rate, but there is also a high rate of infant mortality. In a study of heart disease among Somali tribes men, it was suggested that there was a relationship between the diet, consisting almost entirely of camel's milk and the extreme rarity of artherosclerostic conditions (Read, 1966).

The study concluded that in spite of the simplicity and monotony of the diet, physical development is good and shows a remarkable power of resistance to hard and demanding living conditions. It was also observed that the people live in accordance with country-old custom, and are emotionally balanced and free from nervous tension because their way of living is closely adapted to the surrounding conditions into which they were born and in which they will spend all their lives.

SUMMARY AND CONCLUSION

This chapter emphasizes the notion that biocultural adaptability is a human attribute. Human beings are the most widely distributed species, they have to adapt to altitude, cold, heat, and various kinds of diets. As Keesing and Keesing (Op. Cit) noted, man's uniqueness, in ecological terms likes in this "what a lion does in any environment will be broadly the same. He is not likely to eat berries or fly south for the winter. He can survive in only a limited range of settings. Yet man's culture, particularly his technology, can radically alter what kind of animal he is".

The techniques for survival in harsh and isolated environments are summarized as follows (Read, Op. Cit):

(1) The people learned to adjust their forms of livelihood to the limitations of their surroundings in which their basic needs for food, shelter, and care for their health had to be met.

(2) The people were organized in relatively small groups and so preserved their mobility in search of food and water and

(3) They accepted the rigours of their life and believed in the value of establishing harmony with their environment through rituals and ceremonies.

The need to live in harmony with the natural environment in a give - and - take relation cannot be over emphasized. The relationship between man and nature should not be of opposition but of mutual dependence. The environment is not fixed and immutable, even the environments of individual humans differ with a characteristics of each person. In this

sense, the physical body and the socio-cultural environment are one indivisible entity hence as far back as the time of pre-man-apes, our ancestors have been adapting/modifying their environments in ways that have made them to survive and ensures the continuity of human race, anything contrary have been a total extinction.

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Chapter Twelve

SOCIETY AND HEALTH: SOCIAL PATTERN OF ILLNESS AND MEDICAL CARE

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INTRODUCTION

It is a common belief today particularly in Africa and the developing societies that the perception, conception and management of ill-health is culture bound though the significance which ill-health holds for the population remains the same among all groups of people, In other words, remaining healthy is vital to all people in all societies but the ways and means of evaluating and treating the problems of ill-health varies from one group to the other. This is the more reason why understanding of the subject at hand is crucial to all members of society.

The concepts of society and health are interrelated and mutually in exclusive especially as the latter finds its expression and context within the former. It is in this light that we intend to examine the concept of society and how it informs health beliefs, associated illness pattern and medical care available to the people.

Society and culture

In most discussions of health and its management, the concept of culture features more frequently in the prediction of patterns of health management than the concept of society. That in itself does not imply the meaninglessness of society as a heuristic method in the understanding of health issues in sociology, what is rather significant is the fact that both concepts are not mutually

independent of one another because a society cannot exist without a culture while a culture exists only within a society (Chinoy 1967) and given the fact that most discussions in the health realm focus on the role of culture in the management of ill health, it would be pertinent to discourse culture within the context of a society.

Society:

The conception of society varies from one authority to another and according to the subject under review (Onwuejeogwu 1981). This implies that no single and uniform concept of the term is acceptable among social scientist (Chinoy 1967; Otite and Ogionwo 1981). Given this background and the nature of the subject our emphasis would be directed at presenting a definition which would best illustrate and give meaning to illness pattern and health.

A society is an aggregate network of social relationships of a group or groups of people who may have lived, worked together long enough to get themselves organized and to think of themselves as a social unit and live a common life. The environment thus defined as a society may inhabit one, two or many groups with their distinct norms and values. A rural community may inhabit one group while a modern urban centre may inhabit many groups. In this sense, a society can be classified as folk-urban (Redfield 1947), sacred-secular (Howard Becker and Harry Barners 1952), status - contract (Sir Henryt Mainer 1872), communal - associational (Chinoy 1967), and that which is sustained by mechanical and organical solidarity (Durkheim 1933). In each of these classifications a group or groups with common values obtains in a society with a distinct culture, implying that there could be one culture or more in a society as in the case with the Okpe society in Delta State and the Nigerian society.

Culture:

In the same token, culture connotes different things to different authorities. The word is not only abstract in nature but the range of objects or phenomena it refers to is diverse hence its complexity and empherical nature. this fact probably accounts for the conceptual controversy. The concept in the views of Oke (1984) is borne out of the desire to characterize in an empirical terms the similarity and wide differences between groups of people. In this sense, group or groups of people can be demarcated based on their ways of living. It is that artifact which equips the group to cope with the environment that is referred to as culture. For instance, Taylor (1891) defined culture as the complex whole which includes knowledge, beliefs, arts, morals, laws, customs and any other capabilities and habits acquired by man as a member of a society. These acquisitions enhance man's adaptability and mastering of the environment. The artifact which essentially qualifies to be defined as cultural traits must be acquired by men through learning and are shared by all members of the same group and are transmitted from one generation to another.

The approach and methods of dealing with ill health or discomfort and the maintenance of health is rooted in the culture of the people and therefore a cultural trait. Lambo (1961, 1969) observed that his experience of non-literature societies have demonstrated the influence or importance of cultural factors in the management of mental patients. Similarly, Oke (1994) writing on the influence of culture on health services utilization noted that even some organic diseases have at least indirect cultural origin, he therefore, concluded by alluding to the fact that human behaviour is a manifestation of his culture. His behaviour is culturally conditioned.

Health:

Health according to the World Health Organization(WHO): is a state of complete, physical, mental and social well being and not merely the absence of disease or infirmity. Put differently, being healthy goes beyond not having any diseases or infirmity but compete physical, mental and social well being. Given this definition and considering its complexity it may not be practicable to pursue the subject under examination adequately. In this light it may be convenient and pragmatic to adopt the concepts for understanding the social pattern of illness and medical care in society.

Diseases in the words of Idler (1979) is an abstract biological-medial conception of pathological abnormalities in people's bodies. This is indicated by certain abnormal signs and symptoms which can be observed, measured, recorded, classified and analysized according to clinical standards of normality (Mechanic 1968, Coe Rodney 1970). Viewed from this angle, it is objective and empirical consequently therapy is predicated upon the findings of the investigation.

Scientific as the above conception may appears, its utility in sociological analysis in the management of health is limited by the values and perception of problems which are hinged on the culture. For instance, an Egyptian physician says:

> Peasant people in the villages of rural Egypt believe that illness must be associated with pain and discomfort otherwise it is not illness. He want further to observe that bilharziasis and other parasitic infections are not illness because they do not cause pain and therefore do not require treatment". (Read 1966).

In the same token, chronic ailment may also be responded to different by people of differential social status and age. The

aged might perceive ailment at old age as normal in the same way as mild ill-health is accepted as a normal part of life even when it has biological underpinnings and consequently not induce illness behaviour amongst many groups of people in society.

This fact brings us to the essential subject of illness which is a subjective evaluation of ones state of being (Mechanic 1968). In the same vein Idler (1979) conceives of illness as the human experience of disease which is social. This state is indicated by personal feelings of pain, discomfort etc. which may lead to behavioural changes. These changes may or may not preclude objective disease realty but rooted within a social context. The above contention is aptly contextualized by Low (1982), he observed that illness is given socially recognizable meanings. That is they are made into symptoms and socially significant outcome consequently adequate classification on causation and therapy are designed within the socio-cultural context for its management. Read (1966) for instance observed that in African systems there are three groups of illness. The first are trivial or everyday complaints treated by home remedies. The second are European disease - that is disease that respond to Western scientific therapy while the third categories is of African disease - those not likely to be understood or treated successfully by western medicine. This observation is true of many ethnic groups in Nigeria. Erinosho (1976) and Oke (1995) working among the Yorubas and Owumi (1989) among the Okpe people of Delta State noted that illness etiology could be traced to three basic factors, viz: natural, super-natural and mystical. Thus illness evaluation and management is predicated on the presumed causative agent and thus defines the pathway to health care delivery.

Illness Behaviour:

Illness behaviour as distinct from health behaviour refers to how illness is evaluated perceived and acted upon by people who

experience discomfort and pains. It is the consciousness of the state of health that is the cue to the action taken (illness behaviour). For example, it is likely for an individual to have a disease and yet be unaware or be mindless of its and therefore, take no actin. The effort made to relieve one of the associated discomfort and pains experienced that is referred to as illness behaviour. The utility of this concepts of disease and illness are considered in the light of the social determinants of health services utilization and health status evaluation within a cultural context.

Medical System:

The medical system of a given state, community or nation refers to the available health care facilities in place for the management of the health problems. The existing health care system is defined by the culture and the belief of the members of the community. In the Nigerian context as it is with many other developing nations of the world, a variety of medical systems are available.

First, there is the indigenous health care model which existed and still existing in the community. This system is defined by the cultural values of the people and thus varies from one community to the other (FMOH 1988). In other words, it is community based while practitioners practice their art in a solo manner to their clients (Pearce 1986, Alubo 1995). A variety of practitioners known as either herbalists diviners, bone setters, psychiatrists sooth-sayers and birth attendants all of which fall under the tag of traditional medicine men or practitioners now operate in the urban and mostly rural areas of the developing world and Nigeria in particular. It should be mentioned, however, that the practitioners of traditional medicine in Nigeria have been operating under difficult and hostile environment (Alubo 1995) due partly to government attitude/policy and, the operator of western medicine and the educational status of traditional medicine

practitioners (Mume, 1985) that prevented them from galvanizing their ideas and forming a formidable group.

In addition to the above, western medical services were introduced as a result of missionary activities and the colonization of our society. These services though scientific and modern were alien and unavailable to the generality of the population due partly to our culture and the cost of providing the facilities. Today, this system of health care management is the predominant system in most societies (developed and developing) though not the most patronized in the developing world with special reference to Nigeria (Oyebola 1981, Heggenhougen 1981).

It is also noteworthy to state that syncretic health care services (that is Islamic religious teacher are recognized as healers and priest in churches, Pearce 1986) are also added to the help seeking service sources available in our society. It is therefore, not out of context to say that a plurality of health care services are available from which patients would make choice when the need arises. Given the existence of a variety of health care services the social pattern of illness and medical care choice could be examined within the context of a society.

Social Pattern of Illness and Medical Care Choice

The pattern of illness and medical care discernable in any community is a function of the culture, value and context within which the people operate and conceive the ailments. The patter of illness/disease may be viewed from "epochal" angle where the major diseases are classified according to seasons and ties. That is pattern of disease associated with pre-agriculture age, agricultural societies and modern industrial society. During each of these stages particular forms of diseases are more prevalent as causes of morbidity and death. For instance, diseases of the degenerative types like cancer and cardiovascular diseases are more prevalent in the modern industrial era as causes of death (Fitzpatrick 1984).

Patters of illness may also be conceived from the social perspective where attention is focused on the life conditions, status and environment of the population as determinants of the prevalence and the perception of ailments. It is this fact that essentially determines the nature of medical care (that is whether the care should be preventive, curative or interventionist in approach) and invariably utilization pattern. Fitzpatrick (1984) observed that in many parts of the third world life expectancy at birth is much lower than in Europe or North America. He went further to say that many aspects of the environment in the third world provide much more favourable conditions for the spread of infectious diseases than those that prevailed in historical Europe. The tropical ecology according to him is particularly favourable for such vectors of diseases as malaria (mosquito) and sleeping sickness (tse-tse fly). Beyond the environmental factor, socio-economic status of the people also determines the pattern of diseases and mortality rate. Odebiyi (1980) observed that people of low socio-economic status judged from residence pattern in Ibadan, conceive of disease differently and also have differential access to health care facilities. Beside the question of perception, the low socio-economic status person is most likely to live in the "run-down area" of the society than the high socio-economic status person where the life conditions are generally poor consequently high morbidity and mortality rate largely due to infections and parasitic diseases. In this sense, one can discern a patter of disease prevalent among groups of people in a society. For instance, Guineaworm disease is prevalent among the poor and rural people whose main sources of drinking water are wells, brooks and rivers. The high socio-economic group are most likely not to suffer from these forms of ailments.

The conception of disease by the low and high socio-economic group may also enhance the examination of illness pattern and medical care choice. The low socio-economic group person who is largely illiterate conceive of diseases from the

cultural world view as against the high socio-economic group person (literate) who is more modern and westernized and thus perceive disease from the biomedical angle. The preponderance of any of these groups in society would largely determine the utilization patter of health care services available and invariably health care development approach as earlier argued (Owumi 1994). In other words if the literate group constitute the majority of the population, western health care model would be mainly patronized where the contrary is the case, where the majority are illiterate they will rely on traditional methods of therapy or other alternatives. It should be stated, however, that there is no clear cut line of action as suggested above because the people might be literate (modern) and yet not patronize western services due partly to the cost of availability/accessibility of the services and the existence of the necessary cue to health care actions. Essentially,the path ways to health care is very intricate and it is influenced by a number of factors particularly in a society where alternative health care facilities are available.

CONCLUSION

Generally, men constitute the society and the various ways they have designed to enhance their survival within the environment is what constitute the culture. Health, a system of sound (healthy) is one of such tool to facilitate man's survival consequently the pattern of ailment and illness management technology in existence is patterned by the culture and the society at large.

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Chapter Thirteen

DISEASE DIAGNOSIS AND ETIOLOGY AS A SYSTEM OF THOUGHT

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INTRODUCTION

Explanatory theory of disease has generated a lot of interest among scholars who are curious in ascertaining how disease are caused and diagnosed most especially in non-Western cultures. Scholars like George and Anderson, 1978; Janzen 1978; Turner, 1975, Westerlund, 1989; Yoder, 1981 and others who have conducted some studies on indigenous health and healing systems are of the view that causality concept is a reflection of the system of thought of most traditional societies. It has also been observed that traditional diagnostic methods are equally influenced by cultural and religious beliefs of most indigenous communities, where the concept of two worlds predominates and where human problems are traceable either to heaven which symbolizes the spiritual world, or earth which represents the physical entity. Man's spiritual and physical constituents which correspond to the nature of the universe, have given him to capacity to interact freely with the visible and invisible worlds. God is accepted as the Creator of the universe where events are ordered through the instrument of natural laws. Although the spirits and humans are under God's control, yet they have the capacity to manipulate either the physical or spiritual environment to cause events to happen through supernatural means. Thus, there are events that take place quite naturally without the intervention of either humans or spirits and

there are those which happen through the involvement of living or dead human agents. Traditional medical beliefs therefore provide explanation for diseases that are naturally or supernaturally-caused while diagnostic methods address the issue of natural and supernatural dimensions in causality concept.

The data in this study were based primarily on available ethnographic accounts of some non-Western cultures and the author's interaction with Nigerian healers who share traditional beliefs and attitudes in disease causation and diagnosis. The study revealed that traditional societies have two or three major classes of diseases viz: natural, supernatural and mystical. Since there are overlapping areas in the classification, particularly between supernatural and mystical, the author prefers to refer to diseases that are caused verifiable means as naturalistic while those caused as a result of spirits combined with human activities are referred to as personalistic. Indigenous methods of diagnosis are quite relevant to the two classificatory models.

Etiology

Causality concept is an important aspect of ethno-medicine where health and religion are interrelated. In traditional system of thought, diseases can occur naturally in the course of human interaction with the physical environment. He may contact disease on the farm when harvesting his crops, in the bush while hunting animals or in the river during a fishing exercise. If his source of water is polluted or the environment is in a poor sanitary condition, he is likely to have infection. Naturalistic conception of disease follows the laws of natural which stipulates that as long as human beings comply strictly with naturally-ordered health behaviours, their health is not endangered unnecessarily. But when such behaviours are in opposition with natural laws, disease or death may follow. Among the Yoruba of South-Western Nigeria and other African societies, diseases can occur naturally as a result

of germs or worms believed to be parasites that either reside in the stomach, inside the blood, on the skin or any part of the body. It is also accepted that certain illnesses can pass from parents to their children. Mental disorders, leprosy and sexually-transmitted diseases are in this category. Thus, hereditary diseases constitute naturally-caused diseases that are preventable through a careful investigation of the health background of both parties in marriage before sexual love can take place or the marriage is consummated. Health is also believed to be threatened through unwholesome food or water, over-indulgence in food and sex, bad weather, unrefined alcohol, unripe fruits and strew (Buckley 1985: 1). Diseases in this category include diarrhoea and dysentery, malaria fever, guinea-worm, gonorrhoea, syphilis, cough, barrenness, sorethroat, convulsion, stomachache and mental cases.

Generally, these health problems are common and their causes can be explained or verified by lay or popular knowledge. Like the Yoruba, the Ndembu also recognize natural illnesses as it has been observed:

> Some sickness are so common that the element of the untoward which makes people immediately suspect sorcery or witchcraft is lacking (Turner, 1975: 301).

Naturally-caused diseases are not difficult to manage as they respond to simple medication easily which could be applied by the sufferer, his kin or neighbours. Most patients of naturally-caused diseases are usually not referred to specialist healers or diviners for treatment. But where health is difficult to restore within a short time, and causality cannot be easily determined physically, personalistic factors are believed to be involved. It could be argued therefore that traditional etiology is a multi-causal system in which naturalistic and personalistic illness categories usually overlap. In Janzen's view, when an affliction deteriorates

almost to the level of incurability, there is a suspicion that spirits of human agency may be involved (Janzen 1978: 77). In Western cultures where etiology is not a product of cultural beliefs, personalistic or supernatural classification is not popularly acclaimed.

Personalistic category of diseases are best understood within their religious or social context. Causation is not easily determined by physical examination of the sufferer as signs and symptoms of illnesses are obscure. Self medication is quite irrelevant as specialist healers and diviners are consulted for therapy management.

Diseases in this category are believed to have different causes outside the laws of nature and the assumption has generated a lot of debate among Western scientists. Health problems are often traced to the involvement of neglected gods whose devotees have failed to accord necessary rites.

Witches also have the capacity to cause affliction. They are human beings with inexplicable supernatural power to harm or protect their victims. Sorcerers are also human beings with evil intentions whose pre-occupation is to interfere with the well-being of innocent people by using bad contagious medicine to harm them. In many traditional societies, breach of cultural norms, envy, quarrels or strife within the family, and curses are causes of many health problems. All naturally-causes diseases are in this class when they exhibit strange behaviours that are not readily perceived or comprehended.

They are anxiety-provoking and bring a lot of social, economic and psychological problems to the sufferer and his family. In most cases, patient cannot even explain the nature of his ailment. While examining witchcraft among the Navoho, Clyde Kluckhohn (1970) observes:

> Nothing is more intolerable to human beings than being persistently disturbed without being able to phrase the matter in such a way that relief or

control is potentially available.

In many African societies, fertility concept is almost taken for granted and barrenness not only on natural factors but on either problems with co-wives, quarrel between parents as to the choice of husband and mystical powers of witches and sorcerers. Also, where episodes of headache which is regarded as a common health problem start in the morning and almost become a mental disorder a few hours later calls for causal explanation outside natural laws. An African woman who has a cut on her finger while doing domestic work thinks of the involvement of witchcraft or sorcery when she cannot stop bleeding with application of simple available therapy. These 'strong' health problems are often seriously discussed at family level in order to determine effective therapy. (Yoder, 1981).

Another interesting aspect of traditional classificatory system is the recognition of misfortunes as health problems which are not actually the same as diseases because they lack physiological explanation. They are social problems whose psychological effects often give rise to stress, mental agony, hypertension and even stroke.

When misfortunes give rise to such illness episodes, they are regarded as diseases. They are caused by human agents. A number of socially-sanctioned problems such as poverty, bankruptcy, marital problems, failure in business, politics and administration may cause disequilibrium between body and soul of the afflicted and make him sick. while misfortunes are mere assumptions quite irrelevant to any known medical theory, they are effectively managed by traditional practitioners in most African societies including Nigeria. Misfortunes as health problems can best be understood as just as product of cosmos, emotion and people's psychology in providing a link between social disharmony and human pathology. In sum, study has not shown orthodox doctors prescribing medication for poverty, bad luck, broken home and

failure in business like traditional healers and diviners in many non-Western societies.

Diagnosis

Every culture has some ways of ascertaining causation of illnesses and treating them. Because of cultural diversities, we expect variation in disease diagnosis and treatment in each cultural setting. In orthodox medicine, for example, doctors make use of medical apparatus such as stethoscopes which enable them listen to the beating of the heart and sounds of breathing. They also carry out some laboratory examinations of the patients urine, excreta or blood and make bacteriological and isotemic investigations (Fu Weikang, 1985: 1). Although traditional practitioners do not make use of modern diagnostic equipment in ascertaining causation, there are indigenous methods of knowing people's health or health-related problems and treating them. The methods, which are informed by the people's thought system, have natural and supernatural explanations. It has been observed that traditional diagnostic systems see man within his biological spiritual, and psychological contexts (Janze 1978: 189).

The bio-psycho-social model of diagnosis is based on the naturalistic and personalistic causal factors of illnesses, which he practitioner belief conform with human nature and his environment. Some indigenous methods of investigating diseases include:

(a) Divination
(b) Use of herbal remedies and invocation of supernatural forces.
(c) Water or oil gazing
(d) Visual observation of the patients urine, tongue, palms, faeces and skin.
(e) Feeling the smell of the patients noses and ears.

(f) Palpating the various parts of the body and interpreting patients illness behaviours as related by them or their kin (Osunwole, 1989: 157).

Divination

It has ben argued that since the practitioners in traditional cultures do not have basic knowledge and equipment necessary for modern diagnosis they cannot actually distinguish between diseases and the symptoms they manifest. The assumption therefore, is that the practitioners treat symptoms and not diseases. Truly, the tradition bearers are not pathologists in the modern sense, but it should be realized that indigenous methods of disease investigation, some of which are in conformity with orthodox approach, are quite appropriate in determining disease symptoms and causes. In disease diagnosis, practitioners employ all kinds of divination such as Ifa, sixteen cowries, sand markings and the involvement of some deities who have the ability to predict events and prefer solutions to problems. All divination systems are culture-bound where arts and symbols employed are meaningful within a cultural context. Of all these systems, Ifa divination seems to be the most popular, comprehensive and dependable. The reason for this assumption is that it cannot be faulted easily because Ifa poems have been transmitted in the same manner over many decades and it takes the practitioners many years of training before they are qualified to recite and interprets the verses of the poems. Judging by their training and experience in psycho-therapy, diviners see far beyond the present since they also foresee the future. In effect, they see beyond signs and symptoms as diseases is the target of their investigation.

Because of the intensity of the training and level of competence that is required from diviners, not all Ifa priest can successfully interprets the poems verse by verse and give authentic

predictions. Only the experienced diviners can decode the symbols of Ifa paraphernalia and come out with any useful or reliable information. While examining divination among the Ndembu, Turner (1975: 208) noted:

> The experienced diviner can allocate more meanings to the items of his divining apparatus than the novice diviner, and the latter can interprets them far more fully than the uninitiated villager.

Among the Yoruba, there are other divinatory systems which are less complex and differ from Ifa both in structure and operational techniques. For example, the sixteen cowries system of divination is popular among the women-folks because it is easier to operate. Men who divine with sixteen cowries are those who lack the competence and capacity to compete with Ifa priests. In the system of divination sixteen cowry shells are used for divination and not divination chain as in Ifa divination (Bascom, 1980: 4). Its objects of divination are also put in raffia basket. The sand markings are also used in ascertaining causation of diseases. This system is widely acclaimed and practiced by the muslim practitioners particularly in North and West Africa. In these divination systems, the clients themselves, and sometimes assisted by their kins, play an important role both in the choice of therapy and diagnostic process. Just like a Nigerian healer, an Ndembu practitioner allows the clients to take part in the divinatory process (Ibid). People who want to unravel the mysteries surrounding their afflictions often visit the practitioners in their homes which usually serve as clinics.

In emergency situations, diviners are invited to the homes of high risk patients who may die before getting to the practitioners clinics. Divinatory process starts by asking the patient or his representative to take a cowry shell from the divination tray or raffia basket and relate the problem brought for divination

silently. The patient is asked to rub his/her chest and forehead with the cowry shell. The symbolic transfer of the patients intention to the cowry shell for interpretation and analysis during the actual divination exercise is only meaningful in a magic-religious realm. Nowadays, money is used instead of cowry shell for ritual transfer of intention from the patient. A Yoruba diviner related that the consultation fee originated from Orunmila, the founder of Ifa and as contained in one of the principal poems (Ejiogbe) it is to enhance good predictions. In actual divination, the practitioners chant relevant corpus during which they possess the spiritual power to relate with the super-natural forces for divine direction. The divination instruments are cast and interpreted accordingly. In Simpson's view (Simpson 1980: 73 - 74):

> When the opele is thrown on the ground, one can tell which odu is indicated by the combination of nut segments which fall "up" (inner side up) and which fall "down" (inner side down).

Before giving his prediction, the practitioner asks the patient or his agent a number of questions which will enable him arrive at the root-causes of the affliction. The questions usually touch on the social, economic, political, historical and religious factors that are likely to induce the health problem. Another pertinent aspect of traditional diagnosis is consultation with the gods. The Yorubas god of herbs (Osanyin) like some other local deities are consulted for purposeful direction during an epidemic. It is an African deity that can be likened to a modern pharmacist based on his knowledge of all medicinal plants. It whistles to his priest and communication between them cannot be understood by the uninitiated public. The priest can however give accurate predictions and recommend remedies for all forms of ailments whether natural or supernatural.

There are some practitioners who use a combination of herbal remedies and chars in investigating diseases. Among the Yoruba, pregnancy test is done by the use of a mixture prepared by squeezing some leaves of Boerhavia diffusa (etiponola). Any woman who reports for pregnancy test is usually asked to wash the body with it and if itching of the body follows, there is an established case of pregnancy. Some traditional practitioners also use some medicinal powder to make some specified number of scarification on their lower lips or eyes in order to give accurate predictions and solution to health problems as directed by the supernatural forces.

In fact, there are some Nigerian healers who diagnose their patients just by mere gazing at water or oil. The client says his intention silently to the ritual water put inside a medicinal basin. A virgin girl is asked to gaze at the water and tell the client her experience as reflected in the ritual liquid. Aside from spiritual diagnostic methods, there are other rational approaches which the practitioners adopt in ascertaining causation of afflictions. One of these is by visual observation of the patient's urine, tongue, palms, faeces and skin. The client initiates the process of diagnosis by looking at himself if there is any physical change in his complexion, tongue or eyes. He may ask his neighbours or kin to observe his physical appearance for him where he notices any malfunction of the body. If any obscure features are noticed, he may be advised to consult a healer or diviner. The practitioner whose expertise is essentially based on his experience goes into actin by observing the patient's urine, tongue, palm, faeces and skin. If it is observed that the patient's palm and skin are turning pale or yellow, it is a symptom of yellow fever or jaundice. When the tongue coating becomes white and cloudy, the healer either thinks of yellow fever, sore throat or an infection. A careful observation of the patient's faeces may reveal some worm infection or episodes of pile and dysentery when mucus or blood is noticed. The practitioners know that when someone urinates and the urine

attracts some ants, this is an obvious sing of diabetes. or gonorrhoea infection if it has some blood or white fluid. If a patient complains of general weakness of the body as well as day and night dreams, these are signs of measles or witchcraft poisoning. In diagnosing mental disorders, an African psychiatrist may feel the smell from the client's noses and ears. The case of mental disorder is established if the smell is abominable (Ayodabo, 1993. Personal communication). Another traditional method of diagnosis that seems rational is by palpating the various parts of the patient's body since it is believed that the episodes of any illness whether natural or supernatural, will surely reflect in the physical appearance of the sick. The practitioners use their fingers and palms in feeling the patient's temperature. If it is higher than that of the healer, there is evidence of malaria. Loss of weight is usually diagnosed by asking the patient to jump up at least two or three times and if he staggers at the first or second jump, he must have lost some weight. Moreover, any loss of blood is not only determined by mere perception of the patient's countenance but by what the practitioners refer to as body press. The diagnostic method involves the use of the thumb in pressing any part of the body especially the palm, arm, leg and back. If there is a hollow impression and the skin is unable to shoot up and come back to shape immediately after the press, then the patient has lost some blood.

Other rare forms of diagnosis that are not actually verifiable include the symbolic interpretation of each day of the month and associating it with an event in human life. The belief is strong that each day of the year has a message for everybody concerning his health and general well-being. The practitioners therefore ask their clients to touch any day on the calendar which is symbolically interpreted before predictions are made. Dram interpretation is another popular method of diagnosis. Events in dream are regarded as imagination of the mind about life originating from the supernatural world which may reflect life

situation. There are good and bad dreams depending on their understanding by the practitioners who mostly handle diseases involving human agents. The practitioners are good psycho-therapists who understand the cultural dimensions of illnesses. Also, they are familiar with events, traditions and social life in their cultures and are able to say categorically what health behaviours lead to particular health problems. Good (1987) has observed that in bio-medicine:

> "... few doctors and medical assistants have the theoretical and practical training in cultural analysis and psychology that is crucial to providing an appropriate diagnosis".

CONCLUSION

It is obvious from the foregoing that in traditional cultures, responses to illnesses in terms of causation and diagnosis are informed by indigenous beliefs and practices. In such communities, especially in Africa, therapists are of the view that disease etiology and diagnosis can only be effectively determined through a careful consideration of cultural variables surrounding a particular affliction. Since the cosmos provides explanation for the physical and spiritual worlds and the dual nature of man, naturalistic and personalistic concepts of diseases will continue to be acknowledged. In this regard indigenous diagnostic systems that operate between the religious and psycho-social realms will also continue to be relevant in ascertaining disease determinants.

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Chapter Fourteen

Traditional Practitioners (Healers & Healing Practices)

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INTRODUCTION

The term traditional practitioners brings to the fore the nature and concept of traditional medicine which gives basis for the existence of the professionals practicing the art. It is within this general framework that healers and healing process can be understood. Again, this context is fixed within a larger body which in fact informs the appellation tradition(al), way of doing things. It is essentially the variability of the cultures within society that leads to the variety of terminologies describing the practitioners (such as native doctor healer, traditional practitioner, medicine men, indigenous doctors, witch doctors to mention but a few) and various but differing specialists with different modus operandi which are dictated by the cultures and perception of the people (FMOH 1988).

It is against this background that this chapter attempts to examine the subject using the Okpe people of Delta State as a case study. We would also draw from existing stock of knowledge to enrich our experience of the ethnic group which constitutes our case.

First, let us conceptualize the term traditional medicine before examining the typologies of practitionals available, The range of items and structure which it applies have been descried with differing terminologies by different authorities. Some refer to those as native medicine, indigenous, primitive, folk, black

medicine and in extreme cases Juju (Oke, 1995, Owumi 1989, Macleans 1971; Odebiyi 1976; Oyebola 1981). The reasons for these difference may be due to the various biases of writers and the ways practitioners of the art have professed their art and the variability of culture which invariably gives credence to the existence of the art. These differences in terminologies and practice across ethnic groups have tended to inhibit the growth/development of uniform national traditional health care structure. The national health policy and strategy to achieve health for all Nigeria (FMOH 1988) clearly stated that:

> "Noting that traditional medicine is widely used, that there is no uniform system of traditional medicine in the country but that there are wide variations with each variant being strongly bound to the local culture and beliefs, The local health authorities shall, where applicable seek the collaboration of the traditional practitioners of promoting their health programmes..."

Irrespective of the above fact, it is clear that traditional medicine exists (Owumi 1994), with time, enough data would be generated about the practice from different cultures, on the basis of which a national structure would be put in place. What is, therefore, traditional medicine ?. The World health Organization (WHO) conceive of traditional medicine as the sum total of all knowledge and practices whether explicable or not used in the diagnosis, prevention and elimination of physical, mental imbalance and relying exclusively on practical experience and observation down from generation to generation whether verbally or writing. Germane as the above conception would appear, It is relevant to expatiate further the WHO conception by saying that traditional medicine is an art which is original or originates to/from the group where it obtains. A mechanism designed by the

people from their past experiences. (For instance, early men learnt to avoid poisonous food after eating them) to cope with the environment. In this sense, the practice of traditional medicine goes beyond just maintaining stable health to encompass protection from wild animals, evil spirits, motor accidents, successful harvest, haunting to a host of other human activities that impinges on survival of man in his environment (Sofowora 1984; Owumi 1989). It is against this background of the vast array which it caters for in addition to his indigenous ethos that traditional medicine has continued to appeal to the people inspite of the availability of western (scientific) medicine. It is within this general outlook that the subject is examined.

Belief Systems and Conception in Okpe-Land.

The existence of traditional medicine in our society owes much to the values and perception of the members of the community. It is with this understanding that a belief examination of the belief system of the Okpe people is pertinent as a way of creating an adequate background for the comprehension of the subject under examination. The belief system of the Okpe people is quite embrasive. The belief varies from the ideas of the people about the Almighty God to other divinities and taboos which must be observed for the purpose of ensuring man's survival.

An average Okpe man is highly religious. He seldom does or engages in any activity without praying to the Almighty God for protection (Otite 1973; Owumi 1989). He believe that God (Osolobrugwe) created him and thus should be worshipped. This God is supreme and believed to reside in the sky. There is usually no special place designated for the worship of the supreme God but in some cases a long pole with a folklike top used for holding plantain as food for God exist among the group (Otite 1973, Nabofa 1982). This is usually found at the front of compound. Here prayers can be offered to God for the protection of members

of the family.

In a similar manner, the Okpe people venerate their departed ones. Both males and females are worshipped though with a higher premium being placed on the male ancestors. The worshipping of ancestors among the OKpe people is highly entrenched in the culture of the group. There are three basic level of ancestral worship. First is the central ancestral worship located at Orerokpe the cradle of the Okpe people. Here, all the four sons of Okpe and their descendants worship at Edio annually. Secondly, they worship at the ward level and lastly the family (compound) level where each household would remember their departed ones. These departed loved ones are believed to be the custodian of the living and so when they are not properly attended to could cause misfortunes, in from of ill-health or poor harvest etc. Their spirit could cause or harm living members of the family. So central is this belief that marriages are presumed incompleletely performed until the spirit of ancestors have been involved and offerings and prayers made to "them". (Nabofa 1982). The worshipping items consists of animals like goat, ram, pig, chicken, and some time fish including drinks which are consumed by members of the family. The remains (skull) of the animals are usually displayed at the entrance (door) inside the home. The officiating prist is usually the eldest male or female ancestral worship respectively.

The belief in witch craft is also very rife among the Okpes just as the case with the Ibibio people (Offiong 1983). They believe that a witch can harm his kinsmen or such harm can be done with the knowledge of a member of the family who is also a witch. It is believed that witches can cast spells on their victims spoiling their crops, causing ill health and killing people. Usually, when such spells are discovered early enough, it is believed that only the native doctor can intervene by atoning the witches and wizards (Owumi 1994).

This belief system in addition to others beliefs (Owumi 1989) largely explains the conception of disease among the group.

The Okpes generally believe that ill-health or misfortune could be induced by a number of factors or that it could be traced to many sources. First and foremost, they believe that ill-health or misfortune of any kind can be natural occurrence. In this sense ill-health could be attributed to poor diet, mosquito bite or some natural disasters like earthquakes or death due to famine or an ailment which is hereditary. Though,the Okpes believe in this, some problems that are natural in outlook originally may be defined differently when it persist. It is under this situation that ill-health is believed to be supernaturally or mystically induced. Some ailments are believed to have been induced by some supernatural forces in the environment. It is a common belief among the people that witches and wizards and soarers can kill and cause some forms of misfortune for members of the community. Consequently when difficult problems are encounter such supernatural forces are referred to as the agent of such problem for example the witches are at it again. Why me ?. They want to kill me. In the same way as the Okpe man believes in the evil forces of supernatural beings so also does he believes that the ancestors can also inflict punishment on the members of the family when they are angry. The spirits of ancestors are believed to be around to protect living members who have accorded the their due respects and those have not would be punished. This fact is account for ancestral worship among the group.

Traditional Practitioners and Practices

Traditional medicine practitioners are persons who are endowed with the knowledge and skills to maintain the health needs of the members of the community. They basically rely on the local materials that are available within the community. That in a way suggests that every one who has the local skill to use the local material available for the maintenance of health living is a traditional healer (see Read 1966). That is a person who possesses

some knowledge that can facilitate the management of common/minor household problems. Beyond this group, there are a number of categories of traditional practitioners with specialized skills that transcends the everyday experience, In this light we could discuss the followings as the major practitioners among the Okpe people:-

(1) The general practitioner

(2) Oracle men/women

(3) The Traditional Birth Attendants (TBA)

(4) Psychiatrist

(5) Bone setters

(6) Massagers

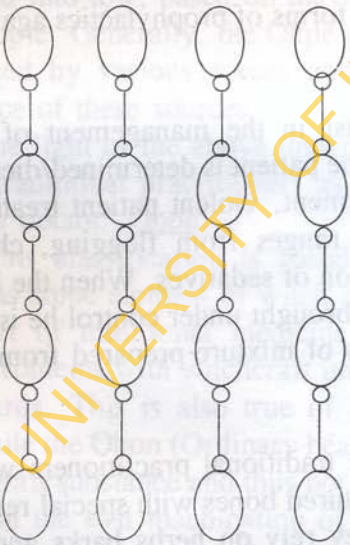
The General Practitioners:- They are persons versed in diverse skills in the management of different forms of problems in the community. That is they perform general services. This group of practitioners combine their knowledge of herbal medicine with their skills in divination. The function of the other categories mentions can be performed by this group of practitioners, It should be noted that inspite of this general skills in all aspect of management, there are special aliment where they are more proficient and so in times of serious problems specialist in those areas are consulted for assistance and special attention. (This point would become clearer when the subject of witch doctor is examined.)

They use a variety of materials which ranges from herbs, backs, animal parts such as the eye, skin of tiger, cat, snakes, cobral and local gin among others. These are made into mixture or powder or pomade which are administered to the patient. Every preparation is made according to the need of the patient regardless of the ailment because the spirit of the patient and the circumstances surrounding the ailment are crucial component in

health management in this realm.

Before the mixture is prepared, the general practitioner would have consulted the oracle for a possible prognosis and course of ill health management.

Oracle men/women :- The oracle are endowed with the special skills of divination. They basically divine the cause of the problem because it is believed among the Okpe people that ailment does not just come on their own and so something must be responsible for its occurrence, beyond this, it is when the cause of the problem is known beyond this, it is when the cause of the problem is known that an effective why of management can emerge. The main instrument of the oracle man in Okpe land is known as 'Evwa. This instrument consist of shells collected from a special tree known as "Agbrogodi". These shells are laced with a string, with each strand consisting of four shells. The total number of strands are normally four, making a total of sixteen shells in the whole paraphernalia. See the sketch below:



A

B

Another instrument used with the evwa is the tusk of a "bush pig" which the oracle-man uses in tapping the four stringed paraphernalia while making some un-intelligible statement which

are regarded as oracular language. The client also makes his inaudible complaint into this instrument. The oracle man holds the stringed instrument in pairs at a time and flings them on the floor. with the aid of the tusk, he taps the shells while speaking the special language during the course of divination. His findings are made known to the client during and at the close of the consultation and he advises accordingly.

Traditional Birth Attendants:- They are mostly women who have the skills in the management of maternity issues and delivery of babies. Their activities cover pre-natal and post-natal services. They have special skills in the management of women during and after birth and childhood diseases which they cure with the use of herbal medicine. Some of these services are administered orally, or through laceration and other forms of prophylactics against evil machination.

Psychiatrist:- He is a specialist in the management of mental problems. The management of the patient is determined/dictated by the nature of the mental derragment, violent patient treated with some level of violence which ranges from flogging, chaining, confinement, to the administration of sedatives. When the level of violence in the patient has been brought under control he is placed on special treatment of a variety of mixture prepared from herbs, barks, Local gin among others.

Bone Setters:- Bone setters are traditional practitioners who are versed in the art of "fixing" fractured bones with special reference to the hand and leg bones. They rely on herbs barks and some other material which they apply to the fractured part of the body in addition to their special skills in setting the fractured bones. The medicine is applied to the fractured part of the body while it is kept in place with the support of sticks woven around the fractured area. This protection is meant to keep the medicine in place and as

well guide the fractured bones and enhance easy recuperation. This approach depends on natural healing process which is a property of the body, some practitioners use some supernatural means as part of the healing process.

Massagers:- These are massagers who possess the special ability to rub the body, and dislocated bones. They also preform services to expectant mothers in order to facilitate easy delivery. They assist to put the foetus in its proper position in the womb.

The above discussion shown the basic category of traditional practitioners in Okpe land. This is not suggest that there is a distinct between the different classification except of course that it tends to highlight the major area of proficiency.

Finally, It must be stated that these taxonomy can be regrouped into tow, based on the values and belief system of the Okpe people. Generally, the Okpe people believe that ailment can be induced by various forces and so management should take cognisance of these sources.

It is in the light of the above understanding that the Okpe further classify traditional practitioners as witch doctors (edjele) and an "ordinary doctor" Oboh.

This classification is based on the belief that the witch doctor has some element of witch craft in addition to his prowess in the art of traditional medicine and is consequently able to resolve problems with witchcraft undertone by stoning the witches and wizards. This is also true of the Ibadan Yorubas (Maclean 1971) while the Obon (Ordinary healers) does not have the element of witchcraft substance and thus not able to handle problems which centres on the evil machination of witches. He only has a wide knowledge of herbal medicine which he uses to treat his clients (Owumi 1989; 1993; 1994).

CONCLUSION

The preceding discussion reveals that the Okpe people have developed a variety of experts entrusted with the management of ill-health and other associated human problems of survival within the environment. These experts and their mode of practicing as discussed above is dictated by the culture and value systems which both practitioners and the/client share.

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Chapter Fifteen

FAITH/SPIRITUAL HEALERS AS ALTERNATIVE THERAPEUTICS: SUCCESSES AND FAILURES.

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INTRODUCTION

Healing is a term which covers a very wide area of human study. It is a term which ranges from the therapeutic activities of the orthodox medical practitioner to the services of the more unorthodox faith cum spiritual healers. While the former healing techniques are based upon scientific investigations and applications, the latter rely on the intuitive insight and faith of both the healer and his patients, which, in most cases, defy empirical and scientific verifications. Between these two therapeutic systems, we have a whole range of "fringe medicines." They include such practices as herbalism, hydrotherapy, massage, cupping or blood-letting, health-therapy, surgery, fasting and faith healing. We are not unmindful of the fact that some faith-healers subject their clients to some of the above tradomedical treatments. Thus they adopt a kind of holistic approach in therapeutics.

The art and science of restoring and preserving health have been closely associated with religion since time immemorial. In the ancient time the sick consulted their priests for health; because therapy has been regarded as "the possession of a Divine Healer who dispensed it through the agency of a priest (Idowu 1967). According to E.B. Idowu, it is the Babylonian belief that Ea "is the great physician of humanity who has under his control all remedies needed to cure diseases inflicted by demons".

In both Ancient Egypt and Rome "men and women slept in the temples of Isis and Serapis.... to recover their health" (Idowu 1967). In many parts of Africa people also sleep in traditional temples and shrines to receive healing. In Nigeria, for example, the Yoruba regard Osanyin and Orunmila as tutelary divinities of healing as the Igbo have Aziza as their tutelary divinity in charge of health and healing activities. Igbo Ubiesha, a traditional monotheistic religion among the Urhoro, has healing as its major ministry. Hence the sick sleep in its shrines to be cleaned of all infirmities. (Nabofa, 1982)

Nowadays many people sleep in some (Christian temples and Islamic centres to receive healing. We subscribe to Bolaji Idowu's opinion that "whatever happened through the agency of the priest, or prist-doctor, in the Temple, the patient believer that healing comes directly from the divine enshrined in such sacred place (Idowu 1967), went further to opine that:-

the origin of hospitals or infirmaries could be traced to such practices. Thus healing ministry has been concomitant with religion from time immemorial. Religion is still playing that role because people have faith in the efficacy of spiritual healing.

The above posture assumed by the religious man has not been left unchallenged. In the 19th century Pasteur and Ehrlich, through their scientific investigations, Came to establish that diseases are caused by microbes, (Biema 1996) and that the only way to cure any illness is to destroy the viruses that bring about ill-health. Since that time medical scientists have regarded belief in faith and spiritual healing as a distraction and should it make claims to medical efficacy, as a possible symptom of a pathology called fraud (Biema 1996).

In view of the above Western medicine has spent the past hundred years trying to rid itself of remnant of mysticism. Since then psychiatrists have become hostile to spirituality. In fact, Sigmund Freud has dismissed religious mysticism as infantile helplessness and regression to primary narcissism. (Wallis 1996).

In the thinking of the African faith healers and their patients, the major causes of diseases are of spiritual origin. These healers believe in the duality of all beings. As man is made up of body and soul likewise every community is made up of physical and spiritual entities. As man has his soul's guardian angel in the same way the community of the living or the quick in the physical society look up to other spiritual beings as the guardians of the physical society. That is every community has a spiritual tribunal; and the well-being of the individual and the physical society depends upon the good will of the spiritual entities or forces that guard either the individual and the community.

The belief also states that for one to enjoy good health and total-well-being one must adhere strictly to the behest of his spiritual counterpart. Any one who behaves contrary to the dictates of his spiritual counterpart would amount to violating some spiritual and natural laws. Sickness could result from act of transgression. It is also believed that human beings are constantly violating these laws in ignorance or willfulness. In fact, the belief is that some people often engage in activities which they know are injurious to their health.

Once such deviance happens the transgressor's spiritual guardians would step aside and any disease may set into the physical part of such a person. In that situation on physical therapeutical system can restore wholeness to such a patient. The psychic part of the matter needs to be addressed first before any cure can be effected.

The other causes of unwholesomeness is the evil machinations of mysterious powers and malevolent spiritual entities. They are among others, witches, wizards, sorcerers, imps, demonic water-spirits and spiritual spouses, estranged human double, family and community divinities that require one to be their priest or votary, and a disgruntled spirit of a departed ancestor. The other sources of sickness are traced to breaking of taboos, heredity and violating the terms of predestination which

one had accepted before one crossed the threshold from the spiritual dimension to the present incarnation.

No orthodox medication can handle, successfully, any malay that may result from the above area. It would require spiritual warfare cum placation (pacification) before the patient can be made whole.

While the orthodox medical sciences approach is to identify and attack and over-power the virus and repair the damaged part, the faith-healer directs most of his therapeutic effects towards the spiritual part of the patient, attacking and placating the spiritual agencies believed to be responsible for the diseases.

As they operate at different levels from which the disease emanated they employ different tools and techniques. The use of inappropriate tools and methods may not yield good results. The orthodox medical doctor may have no tools to diagnose successfully, diseases that normally originate from those malevolent spiritual forces consequently he cannot cure them. But the spiritual healer has the technical know how, due to his call and special endowment, to probe successfully what is happening in the spiritual realm, and bring solace to the invalid. This ia where we can find the relevance of the spiritual healer for present day society and his practices could thus be accorded a place as alternative therapeutics.

The Faith/Spiritual Healer

Faith/Spiritual healers are considered as people who are specially called for the specific duty of divine healing ministry. Thus, no one could just wake up over-night and claim to be a faith-healer. He needs special endowment calling and, in most cases, on the job training. Thus like all other therapists he is expected to have received special training and knowing that will enable him practice and carry out divine vocation successfully.

He deals with the spiritual cause and effects of the disease

which have manifested in the physical body and/or in the patient's aura. Consequently he is believed to receive more of his training, knowledge and information from higher and immoral intelligences. In fact, most spiritual healers claim that they receive their knowledge from the psychic realm, especially while they are in dream state and in an altered state of consciousness. The spiritual healer is believed to be spirit unto which he has been specially espoused. Thus there is always a constant communion and communication between both of them. As his total being has been infused by the divine he has the power of clairvoyance and clairurdience. He can thus see through the veil of obscurity and know the real cause and remedies for any type of illness. Thus noting can be hidden him. His knowledge would thus be unlimited.

Although the traditional African spiritual healer situated in a particular shrine obtains most of his training from the spiritual realm he needs the assistance of some mortals in carrying out his day to day duties. In his daily affairs he needs the guidance of some religious elders. These are the people who direct him in the ethics and some practical aspects of the profession. While he can know the causes and treatments of any ailment the elders are the ones who instruct and direct him on how he should relate to his clients. They also assist him in the area of taboo observances and purificatory rites.

Thus, the traditional African spiritual healer receives his training from two principal realms that is the physical and the spiritual. But the one he receives from the spiritual realm takes precedence over that of the physical. He prefects his knowledge and training through constant practice. That is, through constant atonement with the divine and assistance he receives from elders he has on-the-job training, improves upon his work until he becomes proficient. His fame on the job depends upon how he relates to both his divine and moral instructors as well as how his clients assess his performances.

Elements of Faith-Healing

It is common experience that where-ever one goes to receive faith-healing one is likely to be subjected to almost the same procedure. It has thus been observed that most spiritual therapeutic practices contain the following elements: diagnostic rituals, confession cum mind reading, counselling, atonement, exorcism, fasting, use of symbolic elements such holy oil and water, prayers, dance and drama, giving of testimonies coupled with thanks-giving.

Diagnosis:

Like every other healing system, faith-healing has its diagnostic procedure. The orthodox healer believes that sickness is caused by physical agencies, such as germs, consequently he uses physical laboratory tools such as microscope and stethoscope to investigate the causes and cures of ailments. But the spiritual healer does not rely on those physical elements. He believes that most diseases are caused by spiritual/psychic agencies. Consequently he probes the spiritual realm in seeking solution to the problem. It is here he could demonstrate the power of his intuitive faculties, clairvoyance and ability to se through the veil of obscurity. He may subject his client to serious questioning and rigorous mind-reading exercises. Different forms of divination acknowledged by the spiritual therapeutist are also employed in the diagnostic exercise. We should note that divination is communication between the moral and the divine, and such communication could take any form.

There are different forms of divination. It may be in the form of gazing at the mirror, palms, eyes, aura reading, use of the Bible or any other holy book or items. Diagnosing the problem may be carried on along with the other preliminary therapeutic procedures such as confession, mind-reading and counselling.

Confession:

There are two basic reasons why the person seeking spiritual healing is required to confess his sins. These are religious reasons and psychological outwork. The patient undergoing spiritual healing is a religious man who has faith in the efficacy of divine healing.

Nearly every religion teaches that sin, in its various forms, estranges man from the divine and it also brings about sickness, pain and suffering. It also goes to state that for the patient to be saved from his sickness he should first of all own-up and confess his wrong-doing. It is a strong belief among the Christians that the only way for one to be really saved from the power of satan demons, pain and suffering is for one to confess his sins (Kock, 1972).

They always base their argument on St. James injunction which goes thus:

> Confess your faults one to another that you may be healed (James 5:16).

The position is almost the same among the adherents of Traditional Religion. They believe that breaking of taboos is one of main causes of illness. Consequently, those who are sick or suffering, in one way or the other, are encouraged to search their minds, probe deep into their conscience and confess which-ever sin they must have committed. The idea is that if sins are not confessed before therapeutic adventures the positive effects of any therapeutic measure on the patient could be neutralised by the aggrieved divine being.

This is where the roles of the cult of Ancestor as religious and cohesive factors in traditional Africa are better appreciated. The belief is that if one is in good relationship with his ancestors they (the ancestors) would protect him from all forms of negativity. But if one failed to carry out his finial obligations

faithfully his ancestors would abandon him and he may be exposed to all forms of vicissitudes of life. He has to go to sins before he can become whole again.

On the importance and practice of confession during faith healing in a traditional religious beliefs and practices. Mume (1976) remarked:

> In the practice of religious (sic) Igbeuku, patients are persuaded to confess their sins which torture them, and once this is done such patients feel emotionally relieved after the priest has pronounced them clean and subjected them to rigorous dancing exercise.

There are also psychological explanations for the inclusion of confession in therapeutics. It is common experience that wrong doing imposes a heavy burden on one's heart. When a person becomes conscious of an act or experience which he considered to be sinful he may manage to repress it but at the same time, such will make his heart to become tense. Thought of it makes the heart skip beats. such a heavy burden the heart is bearing may result in an illness which may not be cured unless the person's heart is relieved of its heavy load.

According to Sigmund Freud (James, 1980)

> "Many of the mental events of which a patient is conscious in fact represent other unacceptable past experiences which the individual has managed to repress. The psychoanalyst (confession) attempts to help the patient to remove the disguises of those intolerable past experiences so that the true situation may be seen in perspective and the tension which it created may be released.

James has also observed that if a normal person has a conflict in his mind, or is having difficulty in coping with his

environment, ...it often helps a great deal if he can talk to some other sympathetic but involved individuals. He also opines that while in some cases this listener may be able to make helpful suggestions, the main value of the interview usually comes from the troubled person talking and thinking about his own problem. By so doing he is making a conscious attempt to resolve the conflict and will have feel much better for having done so because he will reduced his own mental tension.

The importance of confession in faith healing has also long been expressed by William James (1975). In his own opinion confession corresponds to a more inward and moral stage of sentiment:

> It is a part of the general system of purgation and cleansing which one feels one's self in need of, in order to be in right relations to one's deity. For him who confess chains are over and realities have begun; he has exteriorized his rottenness. If he has not actually got rid of it, he at least no longer smears it over with a hypocritical show of virtue - he lives at least upon a basis of veracity.

It should however be noted that most of the so-called religious leaders who claim to have healing power may not be pure morally or spiritually nevertheless, the act of confession helps the patient to align himself with the constructive natural healing elements in his body. The act of confession helps him to open up the pent-in abscess to burst and again relief, even though the ear that heard the confession were unworthy (Williams James 1975).

The experienced faith-healer reads the mind of his patient confession his sins which he may feel must have been responsible for his ill-health. When he come out of his close study of the patient's confession and the inner recesses of his mind, he would get a true picture of the patient's problems. He would then be able to guide him aright. The patient will begin to have faith in the

healer's spiritual ability to save him.

One fact which must be noted is that the human mind has great control over every part of his body. Most of what happens to man depends upon his life style from day to day. As it is the belief of the faith-healer that disease is the result of a violation of some taboos, natural laws or sins, the first thing that a faith-healer does to his patient is to find out what (is bothering his mind) and to correct that cause and result of the imbalance. The above should be done instead of treating the disease and allowing the cause to continue at the same time. Very often the cause is deeply rooted in the same time. Very often the cause is deeply rooted in the sub-conscious mind of the patient. Surgery, drugs and were laying on of hands nor any other material method will help such a patient. Here we find the importance of confession, psychoanalysis and counselling. It is after the above that whatever treatment is given to the sick can become effective.

Confession alone does not guarantee automatic release from the negative effects of the wrong deeds. Thus as a continued aspect of faith healing exercise, after confession and counselling the patient is made to atone for his wrongs. The form which the atonement takes varies from one healing house to the other. It also depend upon the nature and gravity of the sin and ailment. It may be payment of some fines, or some kind of self mortification, and providing materials for some sacrifices. In the main, attornment is making reparation for a wrong done or payment for a sin. It is only when such be assuaged. Atonement and sacrifice are, indeed, major factors in spiritual healing and these are wide fields of study(Williams James 1975).

Faith healing procedure can thus be arranged in the following chronological order: Confession, atonement, sacrifice, absolution, purificatory rites and counselling.
They constitute a chain of events and one leads to the other.

The form each of them takes varies from one system to the other. In some cases the acts of atonement, sacrifice, absolution

and purificatory rites are so intertwined that it is not easy to notice where one ends and the other takes off. For example , in some faith healing homes the sacrifice victim or item is used to asked to lay his hands on the victim or hold the item while making his confessions. In some cases it may be used to sweep or touch different strategic parts of his body, especially his head, chest, back, around his solar plexus up to the navel and feet before it is ritually disposed off. Many healing churches use candles, water and oil in preforming such rites. In the cause of emulation the cultic functionary could be pronouncing absolution and forgiveness on the patient. The belief is that while such is going on the impurities in the patient would be exorcised extracted from the body or environment of the patient and transferred into the sacrifice victim or item.

The successful completion of all these acts have much psychological impact on the mind of the patient. They go a long way in relieving the heavy burden in the patient's heart. Much of the healing ritual drama is geared towards arousing, is the patient, some feelings of awe and reverence. These will generate confidence in his mind. While the patient is thus predisposed, his mind will vibrate positively and set in motion constructive and healing natural forces within his body. His mind will become relaxed and the body will begin to heal itself. The success of the above depends much on the personality and expertise of the cultic functionary, and the amount of the aura of awe and reverence he has infused into the healing ritual drama.

In faith healing practices it is believed that the surest way to be really delivered from the power and effects of malaise, especially those caused by demons, is through constant religious devotion or prayer. It is believed that "Medicine does not always do justice to the spiritual side of illness. This is where counselling is strongly emphasized.

Each spiritual healing cult drums it into the ears of its patients that if a patient really wants to be delivered from his

ailments he must commit his life completely to the spiritual power behind the cult or healing system. There has been no thorough deliverance without there having been a thorough counselling session before hand. In most cases this goes with prayers of renunciation in order to have a thorough brake from his erstwhile sinful acts.

Exorcism

Exorcism is a form of therapy for the unbalance mind. This is a therapeutic measure which pre-supposes the common belief that some ailments or unwholesome conditions are caused by the presence of some evil spirit which has pitched its tent in the human body. It infers that with positive respond to any form a patient could be neutralized by the demon indwelt in him. In fact this is the root of exorcism.

Almost every faith-healing system, be it (Christian charismatic group or Islamic system or traditional African belief system, practices exorcism. Such practice can only be possible when the exorcists believe that they are endowed with a power mightier than that of the demons causing the malaise.
It is with this understanding that made Roger Baker (1974) to opine thus:

> "Deliverance through exorcism is common place for charismatic who believe that they have been possessed by the Holy spirit and therefore have the gift of discernment of other spirits,especially demons working in other,troubled, people.

Roger Baker argued further that exorcism is a kind of spiritual equivalent to surgery. Nad also suggested that just as the appendicitis or a cyst can be cut out by a trained surgeon, so a troublesome demon may also be 'cut out' as it were, by an expert on the subjects.

The faith healing exorcist operates mainly by invoking the power of higher force to bind and suppress the demon believed to be the cause of sickness. Such is usually accompanied with the laying on of hand and use of some symbolic items like holy water, salt or oil and herbs.

In most cases exorcism is a highly dramatic ritual; and its effects are quit profound in the mind of the patient. In the word of Roger Baker :(Ibid)

> "With its quasi-magical use if water, salt, perhaps oil, ecclesiastical robes and holy objects, exorcism is, in the words of Pere Joseph de Tonguedec, "an impressive ceremony,capable of acting effectively on a sick man's subconscious. Even, one might add, on his conscious state as well."

There has been a great deal of mental poisoning in the human society. Many people still believe that there are no accidents, consequently they think that nothing happens by chance. Thus, whether an illness has been brought about by socio-cultural pressure or some other natural causes, many individuals still think and believe that some mysterious powers are responsible for its manifestation. Hence exorcism forms parts of most therapeutics that are administered on the psychologically immature and unscientific minded persons who quit often patronise faith-healing homes.

There are as many exorcism symbolic forms and rituals as there are faith-healing system. We shall only mention and describe briefly a few of them. The main idea behind exorcism is to cleanse all impurities from the body and mind of the patient and thus make him whole. It is a spiritual warfare and it is only through exorcism that such battle can be won.

In Nigeria there are both traditional and Christian and Islamic method of exorcism. In the traditional system the people

use herbs and ritualistic items for this purpose. For the example, among the Urhobo, when the need arises for this kind of rituals one of the herbs they use is Oran, or tea-bush. The Yoruba call Efirin.

It has a very strong aroma and its scent is believed to cleanse all impurities and attract good fortune and whole-someness to man.

The purification rites take the following forms. The person performing the rites holds a small branch of this shrub first in his right hand and goes to stand in an open space facing the sun or the main entrance of the compound. while standing thus he does a kind of confession and self-purgation inwardly. After such confession to the self and the ever present and omniscient, he would use the small leafy branch to touch or sweep the different parts of his outer body while enchanting an appropriate supplication which may take the following from:-

It is cleansed
All impurities are cleansed off.
Continuity of life is not cleansed away
Longevity of life is not cleansed away.
Children are not cleansed away.
Money/prosperity is not cleansed away.
Good health is not cleansed away.
Death is cleansed away.
Sickness is swept away.
Poverty is swept away.
Misfortune is swept away.

He does the above four times with his right hand and threes times with his left. At the end of each round he would stretch the hand holding the leafy branch forward, and spits breathily over it. At the completion of the seventh round he would use it to describe three circles round his head and cast it away following it with

contemptuous heavy exploration.

The belief is that once this is done the person would no longer regard himself as ritually impure. It is not only the physical part of the man that has thus been cleansed but also his spiritual counterpart. In fact, in Urohobo belief, such expiatory rituals have more direct effects on the soul personality which has been defiled than the physical body which could be washed clean with soap, sponge and water.

It is a common practice to make magical solution, black soap especially, for bathing. It is believed that such soap can cleanse the sick of all impurities of mind and body and make him whole. There are also specially prepared creams which are capable of exorcising evil out of the sick.

It is not only out of the body that demons or evil spirits are exorcised. They can also be sent out of the sick person's environment. This was the type of exorcism which Simpson (1980) came across in Ibadan and reported thus:

> "A magical fire may be prepared to get rid of an evil spirit that may be persecuting a house-hold. Or one may prepare ese (food and other materials that will injure the tormenting evil spirit if he sees or eats it). Ese is placed where evil spirits are thought to come."

Among the Kumbowel Ijaw people in both Delta and Rivers state of Nigeria, the people use the cracking of iron metals to exorcise evil spirits from the environment of the sick.

Healing through exorcism is also common place among Christians, especially among the charismatic, who claim to have specially endowed with the power of the Holy spirit to overthrow the satan and its kingdom. They use different kinds of oil (especially Olive oil and coconut oil) for this purpose. According to Roger Baker (1974):

"Sometimes the sign of the cross would be traced in oil on the candidate's forehead in order to avert the devil's gaze. On the other occasions the whole body would be anointed, a ritual intended to supply the initiate with a source of strength for the ensuing struggle with the devil. Olive oil was used, also chrism-olive oil blended with a scant, balsam usually."

Roger Baker also has it that the church exorcises negativity from objects and places as well. Objects such as oil, water, and salt, as well as holy objects, where they are to be used in the various rituals of the church, are also cleansed of impurities. Sites for church are also exorcised. The idea behind this practice is to free everything that comes the church from dominion of the devil.

The other formula which some Christian groups use for exorcism and faith-healing are what have generally been referred to as breast-plate prayers. Roger Baker opines that "they are designed to be self-applied for comfort or protection in an emergency. Psalm 23, especially the last verse of it, is the one used mostly by Christians of all denominations. St. patrick's breast-plate or invocation is the best known formula of this kind among the members of Roman Catholic Church. Most faith-healers prescribe special Psalms, or Quranic verses passwords, holy names and incantations for their clients to use, not only for exorcism, but also to attain wholesomeness in both mind, body and estate.

The belief is that a sick person who uses the forms of exorcism faithfully could easily get rid of any evil spirit which may be responsible for his ailment. Dancing, as a therapeutic measure, is common feature in many faith-healing, especially among the charismatic groups.

It is employed by both the traditionalists and Christians. Such dance sessions are well co-ordinated and streamlined to achieve specific purpose: Like to pay homage to the divine, for adoration,

exorcism and healing, just to mention a few.

The mechanism and efficacy of the use of dance in faith-healing enterprise had been succinctly expressed thus: (Nabofa 1990):

> " The vibration coming from the dance and percussive instruments are believed to infuse and cleansed his bring and he soon gets well enough to take part in the vigorous dancing processes which are in themselves health-giving and health-promoting exercises..."

Fasting

Fasting is another main method employed in spiritual/faith therapeutics. Faith-healers urge their clients to fast in accordance with their prescriptions. All methods of orthodox therapeutics have one thing in common, viz, they either give the body something or tamper with it in some fashion.

However, it has been scientifically proved that denying the body something - namely, food-and then not tampering with it in any other way, is a major factor in renewing the body. There are ample scientific evidences to support fasting as an effective means of therapy (Herbert Shelton 1978).

One may want to ask why deny the body food, of all things? Is not nourishment necessary for life and healing ? It has actually been ascertained that in fasting one rids the body of the bad effects of excess food, and gives the digestive system a rest. If one took in only the exact amount of nourishment that he needed, and of the proper kind, than he might never need to fast.

However, in all societies where plenty food is available, most people tend to over eat, and also consume many things that are unsuitable, if not downright harmful to the system.
Fasting helps the body throw off toxins formed by wrong eating habits, along with using up excess fats (Ibid).

From the spiritual angle, fasting humbles one and makes the believer draw closer to his God. It is an important religious duty and sacrifices. Hence many faith-healers, especially the charismatic, include it as one of their religious obligations and therapeutic practices.

It is a pity that for lack of scientific knowledge on the part of most believers, many of them tend to ignore the scientific explanations of benefits derivable from fasting. It has been scientific proved that fasting actually works to rejuvenate the body and bring about good health. It does this through the processes of catabolism and anabolism.

There are two processes taking place continuously in the human body, almost at the same time. There are anabolism, which is the building up; and catabolism, that is, the tearing down. Together they make up metabolism.

When one is fasting a cleansing of the body takes place, thus allowing anabolism rise higher than catabolism. The building-up process of life is accelerated, while the tearing-down process is slowed. In that process all the cells in the body will undergo refinement. Sometimes dramatic changes and improvements take place in the body. The way the heart and bowel function is improved, and the person sleeps more restfully. In that way the body is allowed to heal itself more naturally.

Dr. Herbert Shelton's findings also revealed that there may be increased acuteness in the physical senses of taste and smell, better digestion, stepped up vigour and of course, lose of weight. Many faster subjects/respondents from Shelton's investigation reported increased mental power, more powerful sex drives, a clearing of their complexions, the disappearance of some the finer lines in their faces and improved vision and hearing. (Shelton 1978) Commonly, the eyes become more sparkling, and more youthful bloom become more evident. The faster's blood pressure goes down.

Dr. Herbert Shelton, who experimented and supervised the fasts of over 40,000 people in his clinic in Texas, reported thus: Fasting can bring about a virtual rebirth, a revitalization of the organism. In fact, fasting is also a means of enabling the body to free itself, not only of its accumulated toxic, but also of its burden of accumulated abnormal changes in the tissues. This explains the success of the faith-healing using it as a means of healing and rejuvenation.

Prayers:

Praying fervently is one of the most powerful and effective weapons of the faith therapist. It is the key to success in spiritual healing. This practice is based on the believers strong faith in the efficacy of prayer.

It presupposes a God that is ready to listen and answer prayers of His faithful servants.

Christians quite often make reference to the advice given in The General Epistle of James Chapter 5 verses 14-16:-

> "Is any sick among you? let him call for the elders of the Church and let them pray over him, anointing him with oil in the name of the Lord: And the prayer of the faithful shall raise him up; and if he committed sins, they shall be forgiven him. Confess your faults one to another,and pray one for another, that ye may be healed. The effectual fervent prayer of a righteous man availed much.

The Muslims, the adherents of African Religion, and other religious groups and philosophical/mystical associations, which practice faith-healing, through prayers and meditations also have references from their sacred books to support their belief in the

efficacy of prayer.

But there are some physiological occurrences that take place in the human system during prayer which help in healing. They are worth bring noted here. It has been noticed that prayer relaxes the body because it promotes deep breathing. The person praying may not be aware of this scientific cum psychological effects of prayer.

It is a common experience that our style of breathing effects our body relaxations or tensions. That is, the way we breath and exhale affects our health. In both praying and listening to prayer we seem to adjust our breath to the punctuation, especially pauses by the one uttering the prayers. According to John Palo and Dr. R.S. Woodworth, a directly controllable part of the body can be used to reflex relatively uncontrollable body system. And by controlling our breathing we can control our state of relaxation. Our breathing, offers us a means of self control and adjustment (Cannon 1970).

John Palo and his colleagues also reported that shock-inducing and sudden inhalation raised the pulse rate as well as the blood pressure. He explained further that great excitation with rapid breathing forces the muscles used in breathing to push more blood to lungs for oxygen. At the same time, the heart pumps more blood back to the oxygen-hungry muscles. (Ibid)

In controlled, extended exhalation, as it occurs during prayer sessions, we are actually holding back the blood from reaching the heart. Thus the heart with less blood to pump, pumps more slowly, beating less rapidly.

When one is praying or is being prayed for, he naturally inhales deeply, holding his breath for a while, so as to be able to listen attentively and hear the words of prayer being said by person praying. And in the process of saying the Amen, he exhales slowly. Thus, in that process he would be holding back the blood from reaching the heart.

Consequently, the devotee's heart with less blood to pump, pumps more slowly, beating less rapidly and thus normally.

This is the psychological role that prayers play in faith therapeutic ministry. The process described above occurs in a subtle manner, consequently not everybody is able to notice or aware of it. As it is the breath of God in man that is behind the above functioning, prayer are the most effective drugs that faith-healers administer to their patients.

The efficacy of prayer and meditation in therapeutics has also been confirmed by several scientific researches in recent times. Some of such recent findings are those of Herbert Benson of Harvard University and David Felten, Chairman of the Department of Neurology, at the University of Rochester USA.

According to Herbert Benson (1996) religious faith has some direct influence on physiology and health. In his book, The Relaxation Response. He demonstrated that patients can successfully battle a number of stress-related ills by practicing a simple form of meditation. According to him, the act of focusing the mind on a single sound or image brings about a set of physiological changes that are the opposite of the "fight-or-flight response". He opines that with meditation, heart rate, respiration and brain waves slow down, muscles relax and the effects of epinephrine will diminish. Benson also holds the view that prayers operate along the same biochemical pathways as the relaxation response. That is, praying affects epinephrine and other corticosteroid messengers or "stress hormones" leading to lower blood pressure, more relaxed heart rate and respiration and other benefits.

David Felten's recent research (Time 1996) has also revealed that these stress hormones have a direct impact on the body's immunological defenses against disease. He explains that anything involved with meditation, including prayer, and controlling the state of mind that alters hormone activity has the potential to have an impact on the immune system.

It was on the basic of their above findings that both of them came to draw the conclusion that those who attend religious

services regularly have been found to have lower blood pressures, less heart diseases, lower rates of depression and generally better health than those who do not attend. None church goers have also been found to have a suicide rate four times higher than those who attend church services regularly.

Many other possible explanations have also been advanced for such findings. One of such explanations is that since church goers are more apt than none-attendants to respect religious injunctions against drinking, drug abuse, smoking and other excesses, it is possible that their better health merely reflects these healthier habits. Churchgoing has also been seen as offering social support and such has a salutary effect on the health and general well-being of the religious person (VIDE TIMES 1996).

Cyberphysiology:

A new technique of mind/body communication has been graphted into the realm of faith/spiritual healing enterprise. It is scientifically known as cyberphysiology. It works on the principle that a person's thoughts, attitudes and emotions can make him sick. They can also make one well. This is an old and well known principle; however it is less understood and hardly adhered to by many people.

Cyberphysiology teaches people how to use their mind to make them well and maintain constant health.

According to R.S. Stone, the key to using cyberphysiology is to activate the right hemisphere of the brain. This is done by relaxing and using one's ability to imagine. Stone opines that relaxation is very simple, but we often make it a difficult task. He also explains that the right part of the brain is associated with the creative realm from which we obtain our basic life energy. Activating the right section of the brain through relaxation and imagining connects us to this source of life's energy for healing and communication. (Vide Time 1996).

Secondly, that the usual methods of communication used by one person to contact another is objective or left brain communication. Mind/body communication is subjective or right brain communication. It is accurate and sure, hence it can be successful used handing stress associated diseases.

Cyberphysiology, being mind/body communication is a resource for creative healing used in avoiding the ill-effects of stress and combating negative attitudes and emotions that stress brings on. Practitioners of cyberphysiology believe that affirmation repeated mentally at the relaxed level helps to blunt the causes-and thus- the effects of stress. It is thus recommended that appropriate affirmations should be repeated daily for maximum effect. When the spiritual healer advise his patient recite certain psalms, affirmation and incantations a number of times he is using cyberphysiology principle to help him.

The other cyberphysiology healing procedure Stone advocated is the one he styles support Group-Talking Health to one another. According to him if a person has a healing effect on his body, other bodies can help heal him too. He opines that people who share their experiences with others survive illness longer. People with friends and family live longer than loners. (Time 1996). He also emphasizes the idea that support groups are not people comforting each other in their illness. Rather, they are people comforting each other out of their illness. They do not provide pills to each other. They communicate mind-to-body with each other. People who are seriously ill can magnify positive mind/body communication by part of a support group. This is where people benefit from most when they worship together physically as a group. Stone as well affirms that by helping others you help yourself. He moves a step further by saying that a person also helps himself when he attains (spiritual) unity with something larger than himself or a group of supportive others. He sounded like someone who is deeply religious and psychic when he say: There is a healing supportive universal energy that can and most

be tapped into if you are truly to be in touch with your own self and the needs of your mind and body (Vide Times 1996).

The above situation is what obtains among most religious groups, especially among the Christian, Islamic and Traditional religious pentecostal groups. The same psychical unity is also experienced among some mystical groups such as Eckanker-the Religious of the Light and sounds of God, Christian science, The Rosicrucian Order (AMORC) the Grail Message, Transcendental Meditation, and the Hare Krishna, just to mention a few. It is claimed that most of the mystical exercises that members of these groups perform are meant to raise the level of their psychic consciousness which will enable them achieve a close relationship with the source of life energy. And once such is attained spiritual healing can be easily effected. He also recommended and actually demonstrated how certain vowel sounds and mantras, can be used to effect cure and ensure total wellness in the human body.

Shortcomings of Spiritual Therapeutics

There seems to be some major problems in faith and spiritual healing in many parts of Africa, including Nigeria. They border on narrow-mindedness and selfless on the part of the spiritual healers and their fanatical followers . Many people still believe that only their religion or religious sect can offer spiritual cures. They regard what obtains in other place apart from theirs as works of satan. Their religious leaders have brain-washed them to think and believe so. Consequently they hardly feel free to consult other faith healers outside their own sect.

In Europe and America where spiritual faith healing is being scientifically studied and perfected; People combine methods from different systems in their spiritual healing enterprise (Vide Times 1996). American spiritual healers like Deepak Chopra, who combine medical advice with Indian metaphysics in his faith healing ministry can hardly be whole-heatedly accepted and openly

patronised by both Christian and Muslims in Nigeria. It is such combination of mysticism with religion and orthodox methods that has enabled him to reveal to the Americans the place where spirit and body interact.

Spiritual innovations, who will be free to combine beneficial elements form classical and modern Christian mysticism with sufism oriental and traditional African mysticism in their healing ministry are needed in Africa. And those in need of spiritual healing should be spared of religious and sectal antagonism and free to enlist their services.

The other short-coming of the faith healer, which many have reproved, is that of schism. The motive of commercialization makes people believe that someone who is spiritually gifted and capable of healing people must found a Church or his own ministry. It is also believed that his followers and all those who must have benefitted from him must necessarily remain with him permanently. For fear of schism and for some other selfish reasons they do not train their clients to be independent. They only heal them and solve their problems, but they do not release them. they are required to run to them (the spiritual master) at each time they (the clients) have problem.

Some other more critical views have been expressed against faith-healing practices. It is often argued that majority of faith healers have very little knowledge of human anatomy and what constitute the psycho-chemistry of the human body. Consequently, they do not understand fully causes of most ailments. Hence they attribute every malaise to the evil machination of some negative forces. To this one could respond that while the orthodox medical doctors rely on their brains, reasoning and man-made gadgets in diagnosing cause of ailments, which are limited and could be faulty, the faith-healer claims that his knowledge about ailments and cures comes from the divine, which does not make mistakes, nor deceive his faithful servants. One could also add that not all ailments are caused by virus infections.

The ways the faith-healers wreak confession from their ailments have also been called to question. They force those who patronise them to confess. Those who refused to adhere to their subtle coercion are severely beaten. There have been several reported cases of pastors or some other faith-healers who had tortured some of their clients to death because they failed to confess. In order to avoid being tortured some have made false confession. So the whole of confession exercise has been reduced to a ruse and fake affairs. They thus make a mockery of confession.

Due to false accusations and faked confessions, practice in these healing homes have brought disharmony into many families, especially in polygamous extended families/homes and even in nuclear families. They have broken many homes where there in no loves-lost. They always sow seeds of suspicion among friends, relations and co-workers.

Many faith-healers have sinister power and tricks with which they work on their clients psychically and mesmerise them, to the extent they would be looked upon as semi-gods or super human beings. At such stage they carry out mental poisoning on their clients. they manipulate the unwary with their power of priest craft. They promote ignorance among their clients and make them believe that they have really been chosen by God and whatever problem they are unable to solve no other person can unravel or solve it. They are type of people who promote the idea of a jealous God; and have sown the need of religious intolerance and disturbances in modern Nigerian society.

Some of them have been accused of immorality and exploitation of their members. There are cases of some of them who have seduced other peoples wives who went to them for healing. Many exploit unmarried ladies and have illicit sexual relations with them. Some of these beautiful ladies are mesmerised made/forced to marry them or some of their favourites against their wishes. An affair they would have not gone into if they were

in their right frame of mind.

The way the faith-healers exploit their members is so much that while they, the so-called men of God,grow fatter and fatter, their clients grow thinner and thinner from day to day. They are also accused of not giving their clients a permanent cure. Most faith-healers can easily handle ailments brought about by fear. As they can counsel one to have confidence and thus feel relaxed in both body and mind, likewise they can create fear in the mind of those who believe in them. Such fear can generate a kind of stress that can easily lead to a serious sickness. They thus always tie them to the strings of their aprons so that they can always draw them nearer to themselves for further exploitations.

Some have constituted themselves into public ceremonial magicians. They make public show of their spiritual powers by means of testimonies which some make in their favour. These have been branded as public advertisements which are meant to promote their religious business. They arrogate too much spiritual power to themselves. It has often been alleged that most of these public testimonies and acclaimed healing of the sick, lame, and blind in the public are faked.

Most of them are pre-arranged and well-rehearsed public displays or ritual drama meant to aggrandize the fake-spiritual healers-cum-religious business man.

Most faith-healing enterprises have been commercialized. This is a common features in the Church. There are some genuine spiritually gifted people who can heal. But no sooner than this is realised people will begin to rush to them. Soon they start to build up a large following around themselves. Such a group could become a Church within the main church. Members will soon begin to have divided loyalty between this "holy" man and the Church authorities. If care is not taken the person may break away and form his own ministry. This is one of the major causes of proliferation of Churches in Nigeria.

Faith-healers have no areas of specialization as it happens in the orthodox therapeutics. They claim to have power to heal all manners of sickness. They are jacks of all trades but they are masters of none.

Inspite of the above short comings and handicaps of faith-healings we must not lose sight of their following positive sides and contributions to holistic health-care delivery in the society. There are many of them who are really called to this ministry and are competent healers. As we have chalatants in faith-healing ministry so there are and careless ones in orthodox medicine enterprise.

It is often said that what the drugs (which are mainly chemicals) taken into the body do is to introduce harmonious vibration into the human system and thereby enabled to heal itself. At the same time they produce side effects in thereby body they are supposed to heal. Such side effects may even be worse ailments than the ones they were meant to ameliorate. The harmonious vibrations coming through the faith-healers counselling, prayers, exorcism, fasting, and other healing techniques, into the sick person's body have no negative side effects.

Faith-healers have recorded huge successes and they are still receiving patronage for the following, among others, reasons. The orthodox medicine only looks at the physical aspect of ill-health. While the orthodox medical doctor can repair a broken limb he cannot repair a broken heart and a damaged aura which are the major causes of mental imbalance. In Nigeria many people complain of psychic attacks manifesting through the evil machination of witches, mami-water, spiritual spouses sorcery and born-to-die children syndrome-(Ogbanje or Abiku or Edah). These are manifests of damaged aura or disoriented man's psychic part. These are cases that cannot be successfully handled by the orthodox medicine practitioners. This is the area where the faith-healers have proved their expertise in health-care delivery.

Unlike orthodox medical doctors, faith-healers do not require much capital to set their healing homes. Consequently they are found in every nook and cranny of society. They constitute the grass-root health-care centres. For an orthodox medical practitioner to start operations, he needs a huge sum of money to buy his equipments. His premises also needs to be thoroughly inspected by competent government agencies before he could be given licenses to operate. But the faith-healers does not need such inspection and licenses. The only license required of him is his spiritual call and results of his efficient healing ministry.

As a result of the above their charges are quite minimal. In fact, the patient may not need to pay any consultation fees before he is attended to in faith-healing therapeutics. They thus serve the urgent needs of the lowly people.

Practitioner of faith-healing believe strongly that sin is the author of most ailments that befall man. Hence, they always urge their clients to confess their sins before they can be healed. This doctrine has made many of their clients to be always cautious in whatever they do. They strive to live upright and clean lives. This has helped, to some extent in promoting ethics and good moral behaviour among their clients and the society in general. This could be ascribed to the spiritual healer as great success in nation building health wise.

CONCLUSION

There are many sincere and dedicated therapists in all branches of health-care deliveries, orthodox and unorthodox. Many of them are overworked. As the Master Jesus Christ once said: "The Harvest is great but labourers are Few". We agree with the Atlantean opinion that the stark realistic attitude of the orthodox medical associations of the world contracts with the nebulous approach of many sincere but of times misled members of spiritual healing groups, whose cause is hardly furthered by ignorance of

elementary anatomy and non-acceptance of known biological factors innate in the human physiology (Helis Arcanophus 1977). On the other hand, where the two can join together and work as a complementary group much can be achieved.

It is reported that in Brazil-spiritual and psychic healers are allowed to work freely in hospitals alongside qualified orthodox practitioners and the results are to the satisfaction of all concerned, especially the patient (Ibid). Many patients employ services of all privately.

Faith/spiritual healers are often criticised for inaccurate diagnosis and for poisoning the minds of their patients; and also that they promote ignorance and superstition. But if we consider individual cases of patients, the spiritual healer is probably more successful in his or her initial assessment than the doctor who relies in many cases upon the description of the symptoms relayed to him by his patient. In agreement with the Atlanteans, also, if the symptoms are classic text-book ones diagnosis presents little difficulties, but this in not always the case and patients are obliged to undergo long and tortuous period of observation and exploratory operations in hospitals before the truth of the matter can be reached (Ibid). There are of course, many doctors who are intuitive. Usually these are the more successful physicians.
In fact, an orthodox doctor who is psychic would be the most ideal therapist.

This is one of the explanations for why healing ministry is included among the functions of most African traditional priesthood and in pentecostal cum spiritual idengenous churches. The Africans realise that a combination of doctor/priest encompassed a far wider field of human experience than that afforded by a purely academic background. It could also be argued that there is far less danger for the patient when the faith/spiritual healer makes a wrong diagnosis than when the doctor or surgeon makes the same mistake. We have not heard of a faith healer amputating the wrong leg or sewing up the forcepts inside. It could as well be

argued that an inaccurate spiritual healer can do more damage to the mind of the patient through mental poisoning, but this is debatable.

In Nigeria today most people unofficially combine the services of both orthodox and spiritual therapists in seeking cure and people are looking forward to the time when all the therapeutic systems would be officially combined in hospital.

One of the serious arguments raised, in the Western world, against orthodox treatment by purists is the fact that many of the drugs are tested on animals. The suffering endured by these poor creatures during experiments can only reap an ever heavier Karma for mankind which will doubtless manifest in the very field where it was sown, that of health.

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The text is a collection of high quality writings from various scholars and practitioners of medical sociology/anthropology and related disciplines. Although not all are written by medical sociologists/anthropologists, the writings focus on current ideas, concepts and issues in the discipline.

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