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Hemorrhoids : Treatments and Preventions among Nigeria Police Personnel Oyo State Command

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HEMORRHOIDS: TREATMENTS AND PREVENTIONS AMONG NIGERIA POLICE PERSONNEL OYO STATE COMMAND

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Note: the topic was modified during the defence of the research.

CERTIFICATION

I certify that this research work was carried out by Abolaji AZEEZ (167988) in the Department of Sociology, Faculty of the Social Sciences, University of Ibadan, Nigeria under my supervision

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DEDICATION

To God, daddy, mummy and my fiancée

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Horses are always prepared for days of battle, safety is of the Lord. With profound gratitude, I appreciate God Almighty for all He has done for me. Lord Jesus, You are the author and the finisher of my faith. Thank You for being there at all times.

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ABSTRACT

Hemorrhoid or pile culturally known as *Jedijedi* among people of south-western Nigeria, is an anorectal disease with high prevalence breaking every social status coupled with several misconceptions about its causes, effects and treatments. It is a common cause of distress and its treatment is often unsatisfactory due to its recurrence or complications. The predisposing factors includes any form of straining, poor bowel habit, constipation, standing and sitting for a long time, age among others while its aftermath ranges from anal itching, protrusion, bleeding, feeling of incomplete defecation to inability to stand or sit for long. Policing exposes officers to stress, standing or sitting for long and walking continuously, which increase their likelihood of developing hemorrhoids. Culturally, until it becomes problematic, people may not take necessary action. Therefore, the mainthrust of the study is to understand the social cultural explanation of piles among Nigerian police officers.

An exploratory survey design was utilized to investigate the sociocultural construction of hemorrhoids, causes, prevention, treatments and coping strategies among members of Nigeria Police Force Oyo State Command. For the study, 302 available on-duty and consenting police officers were recruited through multistage sampling technique. In stage one, the Nigeria Police Force Oyo State Command was purposively selected. Secondly, the study area is clustered into four groups according to the four existing area commands. The selection of Divisional Police Headquarters was purposive, based on the size of personnel in each police station. Also, 98 exit interviews were conducted at selected areas. In addition, 5 consenting key informants were selected and interviewed at the study area considering profession and proximity, to represent orthodox and alternative medicine vendors. Data were subjected to chi-square and content analysis.

Results indicated high prevalence rate among respondents. The majority (73.5%) of the respondents had poor awareness of the risk factors stating that sugar intake was responsible for piles which was unfounded scientifically. The belief negatively influenced the treatment adopted, because they had nothing to do with hemorrhoids. Thus, the recurrence of hemorrhoids is inevitable. Piles affected work negatively among the respondents but contrary to popular belief, hemorrhoid was not responsible for poor sexual strength or backache. Also, the use of herbal medicine for pile was as a result of the cost of treatments, fear of hemorrhoidectomy; over 60% of the officers used herbal treatment only coupled with 30% of them opted for both herbal and modern therapies, while the religious affiliation of officers did influence the kind of herbal remedy used. Furthermore, orthodox practitioners and herbal vendors have areas of conflicting interests over the explanation of hemorrhoid and its effects.

The study suggested that sensitization is a potent tool to combat ignorance about hemorrhoids. Lastly, government should provide an environment where herbal vendors and orthodox practitioners can synthesize their efforts to treat hemorrhoid effectively.

Wordcount 460

Key words: *Jedijedi*, Hemorrhoidectomy, Sexual-strength, sugar-intake

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CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Health constitutes a major aspect of human socio-cultural existence. To be healthy in life requires conscious efforts of man in all situations. Individuals therefore, put into consideration their wellbeing in making life choices which are culturally influenced. The state of ill-health is personal and social in nature, considering the individual in question, as regards his/her social status, roles and expectations of others. Illnesses and diseases affect wellbeing negatively. Haemorrhoids, as anorectal disease, obstruct and increase straining during bowel movement (Omole and Adegboye, 2012). They are commonly known as piles (*Jedi-jedi*) especially when they become abnormal and unmanageable. Ordinarily, they are natural and functional in human anatomy. Haemorrhoid manifests internally, externally or both. However, its presentation is dynamic. The symptoms include painful defecation, bleeding, blood stain on stool, feeling of incomplete defecation among others.

Globally, it is difficult to ascertain the incidence and prevalence of haemorrhoids. In Africa, such data do not exist. Specifically, Nigeria is not exempted from the dearth of comprehensive epidemiological data even though haemorrhoid is included in Standard Treatment Guidelines (FMoH, 2008). Nevertheless, haemorrhoids are common in Nigeria. The prevalence is yet to be studied but it is estimated that 50% to 85% of the world's population will be affected by haemorrhoids at some time in their lives (Omole and Adegboye, 2012).

Piles have enjoyed notoriety among the Yoruba cultural group in South-western Nigeria, probably, because of the age group affected, the social cultural effects attributed to haemorrhoids and inability to correctly identify the risk factors. However, the poor knowledge of risk of factors of piles may hinder the adoption of appropriate preventive measures and treatments. Many modern treatments and therapeutic procedures have been developed over time. Traditional knowledge cum herbal medicine has also helped in the treatment of the disease. (Oreagba *et al.*, 2011) in a study of *Herbal Medicine Use among Urban Residents in Lagos, Nigeria* assert that *'Agbo jedi-jedi'* (herbal drink for piles) is the most frequently used herbal medicine preparation. The research indicates that 35% of their respondents used '*Agbo Jedi-Jed'*.

Most times the severity and mortality attached to a disease make the society define the problem as a social phenomenon for which attention will be given to it. This attention ranges from research, media sensitization to adoption of healthier cultural practices. This will necessitate documentation of global, continental and national epidemiological data of such disease in information archives. In the same vein, malaria and HIV/AIDS have undergone incessant medical and social research probably because of their level of susceptibilities, severities, comorbidities and eventual mortalities in human population.

Haemorrhoids are common but not a life-threatening disease except when complications occur during or after treatments (Ohning *et al*., 2009). There is no known comprehensive research to document haemorrhoids prevalence globally. Nonetheless, most of the previous studies used American haemorrhoids statistics to uphold its prevalence and incidence. This confirms the relaxed attention given to piles regardless of the fact that many suffer in silence (Alonso and Castillejo, 2003; Orapin *et al*., *2005*). It is glaringly clear that there is a cultural undertone to its explanation which further confirms that culture and health are intertwined. Culture, defined as a total way of life and a survival mechanism (Tylor, 1871 and Oke, 2009), influences individuals' lifestyles, choices of occupations, practices, health definition and its management. This explains how a disease is perceived and therapies to be used when it occurs.

Life engagement is an important factor that influences individuals' health. The police, as an occupational group, engages personnel who are healthy and fit for the task. The definition of health and fitness includes absence of diseases such as haemorrhoids which may preclude the police officers from standing and sitting for long time where required. However, police officers usually undergo continuous stressful conditions (duties), for example, running, jumping, standing, sitting for long which predispose police officers to haemorrhoids. Ideally, the welfare packages for them should be enough to take care of their situations. The reality in the Nigeria Police Force, however, does not portray the ideal situation. Consequentially, the aftermath of poor welfare on quality of life may affect effective and efficient performance of duties.

1.2 STATEMENT OF THE PROBLEM

In Nigeria, the incidence and the prevalence of haemorrhoids may not be known for now (Omole and Adebgoye, 2012), yet it is a common health challenge, especially among the Yoruba. Piles (*Jedi Jedi*) as a concept has entered into the Yoruba sociolinguistic cultural tradition. For instance, Olateju (2009) in *Jedi O M'Akowe (Haemorrhoid Respects Not Even the Educated Elite): A Sociolinguistic-Stylistic Analysis of the Language of Yoruba Herbal Medicine Practitioners* explains how local herb dealers advertise their herbal products for haemorrhoids. This depicts how rampant haemorrhoids are in their settings which break every social status. Despite this, scholars have drawn attention to the poor management of haemorrhoids in Nigeria (Alatise *et al*., 2009; Omole and Adegboye, 2012). The origin of haemorrhoids is not clear, but the risk factors associated with its emergence have been identified. The causative factors include: chronic constipation; inadequate dietary fibre; prolonged coughing and sneezing; common during pregnancy, prolonged sitting and standing; age etc. (Krause *et al*., 2000; Cho *et al*., 2002; Tuchsen *et al*., 2005; Cleator and Cleator, 2010; Omole and Adegboye, 2012). Nevertheless, there is no known Nigerian study that has paid attention to whether people are aware of these risk factors or not.

There are modern and alternative treatments for haemorrhoids. Modern treatments include over-the-counter drugs (OTC) or prescribed medications, change in dietary and stooling habits, and different surgical interventions (Haemorrhoid Institute of South Texas, 2009). But Alatise *et al*. (2010) pointed out that there are a lot of misconceptions about haemorrhoids and its treatments, thus many patients refuse surgical options due to their reservations about general anaesthesia. While herbal medicine has played a significant role in the management of haemorrhoids, Soladoye *et al*. (2012) reports that some plants are used to treat health problems such as haemorrhoids, cancer and diabetes mellitus. Undeniably, many patients living with haemorrhoids opt for alternative treatments. As noted by Osungunna *et al*. (2010) that haemorrhoids constitute one of the diseases for which herbal medicine has enjoyed unprecedented patronage as therapy in south-western Nigeria. Therefore, there is need to study the factors that influence the type of therapy used.

Interestingly, Kaidar-Person *et al*. (2007) found that many individuals suffer from the condition without seeking medical consultation. Patients are reluctant to seek medical help because of embarrassment or the fear, discomfort, and pain associated with the treatment (Kaidar-Person *et al*., 2007). Based on experience, Cleator and Cleator (2010) confirm that

haemorrhoid is a common cause of distress and its treatments are often unsatisfactory as a result of its recurrence or complications. Consequently, the exact socioeconomic burden of this disease is difficult to estimate. Unfortunately, many scholars have focused attention on various dynamics of haemorrhoids thus etymology of haemorrhoids (Kaidar-Person *et al*., 2007), the quality of herbal drink (Osungunna *et al*., 2010; Oreagba *et al*., 2011), modern therapies and procedures (Ohning *et al*., 2009; Cleator and Cleator, 2010) among others, but they have not considered how patients cope with haemorrhoids. Against this backdrop, there is a need to bridge the lacuna in knowledge as regards the social and economic cost, and management styles developed during haemorrhoidal episode.

The societal worldview is influenced by the cultural values, norms and beliefs. Culturally, the definition given to a specific health challenge is borne out of the cultural worldview which is usually interpretatively relative. For instance, in Traditional Chinese Medical (TCM) theory (pathogenesis), haemorrhoids are caused by imbalance of Yin and Yangand influenced by six climatic conditions in an excess of pathogenic factors such as wind, cold, summer heat, dampness, dryness and fire (Zhong & Lin, 2006). Studies have identified disease causations from Yoruba socio-cultural perspectives which include: natural (biological), preternatural and supernatural causations (Erinosho, 1998 & Gureje *et al*., 2005). By extension, Jegede (2010) added hereditary to the existing causal factors. But the health problem thrives where people have misconceptions about a particular disease as Alatise *et al*. (2010) observed pertaining to haemorrhoidal diseases. Consequently, social construction of haemorrhoids is worth studying, which is the preoccupation of this research.

1.3 RESEARCH QUESTIONS

As it is evident from the foregoing, it is paramount to study the social construction of haemorrhoids, therapy and preventive strategies among the Nigeria Police Force due to cultural diversity and their susceptibility to the risk factors. Therefore, to carefully study this phenomenon the following research questions are raised:

- What is the social construction of haemorrhoids?
- What is the level of awareness about factors responsible for haemorrhoids?
- What are the factors that affect the type of therapy used?

- What are socio-economic costs and management styles developed during haemorrhoidal episode?

1.4 OBJECTIVES OF THE STUDY

The overall aim of the study is to understand the socio-cultural explanation of haemorrhoids based on the perceived causes, treatments and preventions of the disease among the Nigerian Police Force. The specific objectives are to:

- examine knowledge of the risk factors for haemorrhoids.
- Investigate the relationship between socio-cultural perception of haemorrhoids and its prevention.
- identify management styles used by persons with haemorrhoids.
- assess the socio-cultural effects of haemorrhoids.
- identify factors responsible for the choice of treatment.

1.5 JUSTIFICATION FOR THE STUDY

Haemorrhoidal disease becomes cyclical when individuals' life engagements predispose them to the disease. Life engagements include physical activities, hobbies, occupations, etc. The police force, as a high risk occupational group, requires police officers to have the ability to stand, sit, and walk for long, among others physical requirement which haemorrhoids may prevent. These police officers are exposed to the risk factors of haemorrhoids. As noted by Okunola and Ojo (2012) police officers were entangled in stressful conditions of service and poor welfare packages especially in their remuneration. Apparently, the cultural misconception about haemorrhoids increases the prevalence among patients. The misconception exposes gap in cultural knowledge as regards the risk factors and efficacy of the therapies available (Alatise *et al*., 2010). This research is saddled with the responsibility to illuminate the social construction of haemorrhoids and the management style developed among patients overtime.

This research reduces the gap in knowledge of the socio-cultural perception of haemorrhoids. In fact, the study seeks to expose the misconceptions about haemorrhoids and thereby achieve

a comprehensive understanding of haemorrhoids in terms of therapies used during disease experience. Moreover, the exposure unveils dynamics of socio-cultural explanation of haemorrhoids to upcoming researchers thus giving them ample opportunity to carve out niches for further research.

Apart from the fact that it has increased the wealth of knowledge on haemorrhoids generally, it constitutes a point of reference in health management, police welfare policy and occupational health safety. At the micro level, the study equips police officers with adequate knowledge about haemorrhoids. Consequentially, they will adopt effective preventive methods, better management and choose from wide range of available procedures. However, from the macro analysis, the study helps the government formulate better workplace policy which will influence the police working condition and society at large.

Furthermore, this study is useful to academia, consultants and practitioners in the field of medical sociology to understand how socio-cultural construction of haemorrhoids influences its management and choice of therapies.

1.6 SCOPE OF THE STUDY

This work focused on the social construction of haemorrhoids, treatments and preventive strategies among the Nigeria Police Force Oyo State Command by examining the perceptions, knowledge and beliefs of haemorrhoids, different therapies available and awareness among respondents in the study area. This is to understand how these influence their behaviours and responses to the phenomenon. Due to the complexity of the phenomenon, respondents of different age, sex, marital status, educational and socio-economic status, department and religious backgrounds were involved at the level of data collection.

This study also consulted orthodox and alternative practitioners, especially herbal vendors to share their own views based on experience on the field. Considering the risk factors, every member of the force was qualified to participate in the study. However, a representative sample was drawn from the population due to space and time available.

1.7 LIMITATION OF THE STUDY

This study could not cover the officers of the Oyo State Criminal Investigation Division because of the bureaucratic system of the Nigeria Police Force. Similarly, the study could not incorporate officers into the study according to proportion of sex, rank, ethnic group, and department in the Nigeria Police Force Oyo State Command since the information was not disclosed and perceived as threat to security. Also, women are underrepresented in the Nigeria Police Force. Therefore, the study does not have equal number of males and females. This study did not cover children even though the disease is not common among people below the age of 20 years.

The study may encounter difficulty in getting these finding across to people who do not have formal education even though they were part of the study. The researcher proposed to disseminate the outcome of the research to the respondents but it may be difficult to assemble them.

1.8 CONCEPTUALIZATION

1. Sexual problem: This covers the following variables weak erection, reduction in the size of manhood, poor libido, infertility, early ejaculation, impotent tendency. It explains any form of dysfunction in the ability of individual to enjoy sexual relationship regardless of the partners involved or state of health. This is subjective and it is used to cover wide range of sexual challenges.
2. Haemorrhoids: This is interchangeably used with piles and sometimes referred to as '*Jedi-jedi'*. It represents the abnormal state of health and illness condition of inflamed anal vessels which may or may not rupture when strained.
3. Herbal drink: This is the local liquid herbal mixture usually for the treatment of piles. It is locally called *Agbo jedi.* It is important to note that herbal drink consist of herbal drink prepared with water on one hand and the herbal drink prepared with alcohol on the other hand.
4. Herbal powder: It covers all types of medicinal powder remedy to treat piles.
5. Herbal smoke: It is a locally made cigarette-like substance from herbal leaves to curtail protruding haemorrhoids. It is locally called *Jedi.*

6. *Jedi-jedi*: This is a Yoruba word and literarily means *eat-bottom eat-bottom*. It entails all the symptoms of haemorrhoids. It does not have a separate meaning from haemorrhoids or piles.
7. Sociocultural explanation: This is interchangeably used as social construction which means societal knowledge, values and belief system about a particular phenomenon (haemorrhoids) transmitted from one generation to another.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

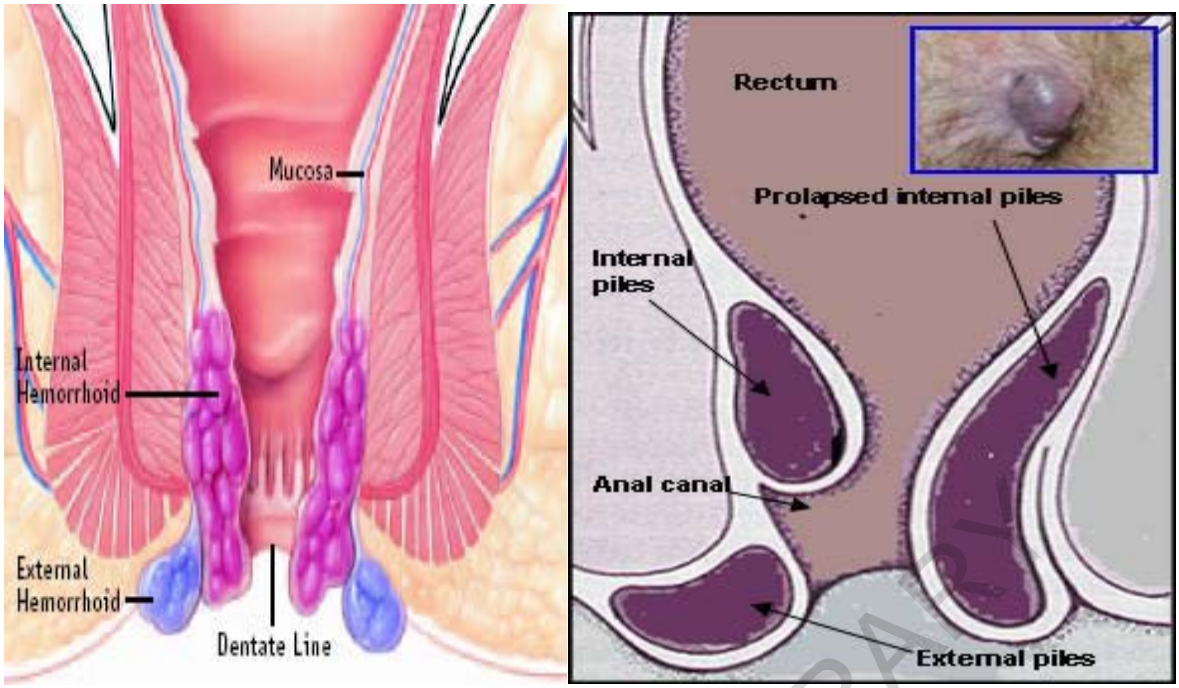
> After all this, the Lord afflicted Jehoram with an incurable disease of the bowels. In the course of time, at the end of the second year, his bowels came out because of the disease, and he died in great pain. His people made no fire in his honor, as they had for his fathers (2 Chron 21:18-19 NIV).

Historically, haemorrhoid was first mentioned in the Bible. During this period, people explained life challenges from metaphysical and supernatural paradigms. The strange illness elicited social definitions and reactions. But as positive society emerges: beliefs and social reactions toward illness are modified. People seek logical explanation of life issues. Scholars have defined empirically that haemorrhoid is a varicose and often inflamed or swollen condition of the veins, inside or just outside the rectum caused by increased pressure in the rectal veins (Chauhan *et al*., 2012). While, Kaidar-Person *et al*. (2007) and Alatise *et al*. (2009) haemorrhoid is most opined as common anorectal disease; it causes distress and its treatments are often unsatisfactory due to recurrence or complications.

Haemorrhoids have a substantially negative impact on the patient's quality of life and social wellbeing (Johannsson, 2005; Abramowitz, 2012). For instance, King Napoleon lost the Battle of Waterloo to an underdog because he was down with haemorrhoids (Wikianswer, 2013). From the macro analysis, Lohsiriwat (2012) affirms that pile is a major medical and socio-economic problem because millions of people suffer from the condition. The illness affects three parts of the anal canal- perianal area, anal canal and lower portion of the rectum (Kaidar-Person *et al*., 2007; Sanchez & Chinn, 2011; Omole and Adegboye, 2012).

Consequently, scholars have done more of exploratory research on haemorrhoids. Based on the general consensus among scholars, two types of haemorrhoids have been identified which are internal and external haemorrhoids (Jani, 2005; Kaidar-Person *et al*., 2007; Imanzadeh *et al*., 2009; HIST, 2009& Chauhan *et al*., 2012). By extension, HIST (2009) added that it can be a comorbidity of internal and external haemorrhoids.

Against this backdrop, haemorrhoids in human beings depict distasteful and unbalanced state of health especially when its severity is at the peak.



www.spread.net.inGami (2011)
Figure 1. The Location of Haemorrhoids

Figure 1 shows the positions of the internal and external haemorrhoids. Internal piles are located in the body before anal canal which may protrude or prolapse after some time especially when precaution is not adopted. External haemorrhoids are located around outer layer of the anus; they cause itching in the anal canal. Sanchez and Chinn (2011) confirm that haemorrhoids are highly vascular submucosal cushions that generally lie along the anal canal in three columns- the left lateral, right anterior, and right posterior positions.

TYPES OF HAEMORRHOIDS

2.1.1 External Haemorrhoids

Typically, the location of haemorrhoids in the around anal cavity determines their classification. Haemorrhoid Institute of South Texas (HIST) empirically asserts that external haemorrhoids occur below the level of nerve endings and patients found piles near the anal opening. Lorenzo-Rivero (2009) opines that the disease may be very painful. But previous finding points out that patients with thrombosed haemorrhoids have acute recurring pain with or without necrosis and bleeding (Federal Ministry of Health, 2008). The recovery from the illness is fast. The pain typically resolves in 2 - 3 days while the swelling may take a few weeks to disappear (Kaidar-Person *et al*., 2007). Consequently, skin tag may remain after healing (FMoH, 2008; Sridhar, 2009; HIST, 2009). This depicts unbalanced and problematic

state in patients. Largely, haemorrhoids may cause hygiene issues by producing irritation of the surrounding skin and thus itchiness around the anus.

2.1.2 Internal Haemorrhoids

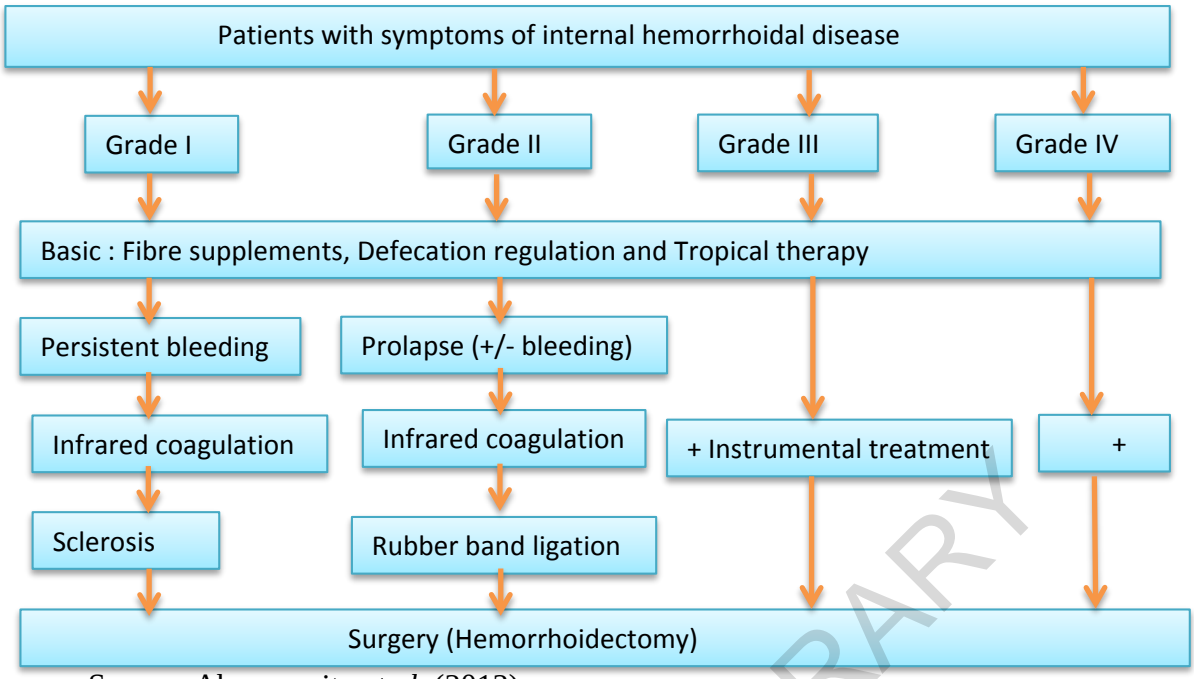
This type is usually found within the anal canal. It does not hurt. It becomes an anal mass only if it prolapses or descends out of the anus during bowel movements. It is relative. Internal haemorrhoids are typically painless but present with bright red rectal bleeding which may become thrombosed and eventually protrude into the anal canal (FMoH, 2008).The degrees of internal haemorrhoid are based on the 1985 Banov's classification.

Table 1. Stages of Internal Haemorrhoids

STAGE	SIGNS	SYMPTOMS
1	•"Bleeding"?? •No prolapse •No pain, itching	Bleeding •No prolapse •No discomfort
2	Bleeding •Usually prolapse •Spontaneous reduction	•Bleeding •Prolapse •Pruritis, mild discomfort
3	Bleeding •Readily prolapse •Manual reduction	•Bleeding •Prolapse •Pruritis, moderate discomfort
4	•Bleeding •Permanent prolapse •Non-reducible	•Bleeding •Prolapse •Pruritis, Pain •Incontinence

Published in 1985; Used by the American Society of Colon and Rectal Surgeons and cited by Winston, (2011)

Generally, scholars consensually agree that there are four stages (Jani, 2005; Ohning, 2009; Su *et al*., 2011; Abramowitz *et al*., 2012). The grades are explained according to their symptoms. These include: Grade 1: It entails bleeding and enlargement of anal veins without anal prolapse; Grade 2: It bleeds with prolapse on defecation that resolves spontaneously after defecation; Grade 3: Prolapse does not reposition without manual digital reduction; and Grade 4: Haemorrhoids remain permanently prolapse and no reduction is possible. These grades also depict the level of severity in patients, although the grades are not clear-cut.



Source: Abramowitz *et al*. (2012)

Figure 2. The Treatment Algorithm for Internal Haemorrhoidal Disease

Figure 2 shows that regardless of the general lifestyle modification to treat piles, the grade of haemorrhoid in a patient determines the specific therapy to be used. Figure 2 explains further the relationships that exist between grades of haemorrhoids and procedures prescribed. However, until all therapies and treatments proved abortive at different grades of haemorrhoids, patient may not consider haemorrhoidectomy.

2.2 CAUSES OF HAEMORRHOIDS

Omole and Adegboye (2012) identifies two types of risk factors which are predisposing factors which include erect position, heredity, occupation, lifestyle and diet while the precipitating factors are constipation, diarrhoea (Alonso and Castillejo, 2003), pregnancy, anal infection, obesity, vomiting, sneezing, physical exertion among others.

2.2.1 Chronic Constipation

There is no consensual agreement on the definition of constipation (Lembo and Michael, 2003), because it is only a symptom not a disease (WGO, 2007). Therefore, symptoms identified by patients are used to conceptualise constipation which includes hard stools, infrequent stools; the need for excessive straining to defecate; a sense of incomplete bowel evacuation, and excessive time spent on the toilet or in unsuccessful defecation (Pare *et al*.,

2001; WGO, 2007). However, the clinical view explains constipation in broader sense. Lembo and Michael (2003) have noted three categories of constipations namely: normal-transit constipation, slow-transit and defecatory disorder. Contrary to oversimplified relationship that exists between constipation and haemorrhoids, Johanson and Sonnenberg, (1990) points out that there is an inverse relationship between the duo after the age of 65years. Remarkably, research indicates that constipation is commoner in patients with larger haemorrhoids than smaller ones and its prevalence among children is higher than adults (Cleator and Cleator, 2010).

Recently, Omole and Adegboye (2012) reinstates that constipation is an important precipitating cause of haemorrhoids. Recurring constipation causes depression in adults and toilet phobia in children (WGO, 2003). Although to a layman, constipation could represent haemorrhoids yet it is a risk factor. For effective treatment, Lembo and Michael (2003) insist that patients should consult physicians. In the management of patients with chronic constipation, physicians should evaluate dietary habit of the patient, consider available medical options and educate the patient. Education of the patient is critical and should encompass explanation of normal physiologic bowel patterns (Jonathan and Jack, 2005). However, most of the experts suggest increase in dietary fibre intake or medicinal bulk agents to be the initial therapeutic option for the treatment of chronic constipation (Jonathan and Jack, 2005). Generally, antidotes to constipation consist of active and healthier lifestyle, increased fibre intake, water therapy, better dietary content, laxatives and drugs.

2.2.2 Prolonged Sitting and Standing

Many scholars submit that prolonged standing is specifically associated with an increase in frequency of lower extremity discomfort, varicose veins, progression of carotid atherosclerosis and complications in pregnancy (Krause *et al*., 2000; Cho *et al*., 2002; Tuchsen *et al*., 2005). Omole and Adegboye (2012) have noted that occupation involving severe muscular stress, prolonged standing and sitting are believed to be increasing susceptibility to haemorrhoids. Measures should be put in place to help employees avoid standing or sitting for a long time. For instance, in Singapore, employers are mandated to inform the Chief Inspector of Factories, whenever employees are to sit or stand for long periods. This is because standing and sitting for long are common sources of discomfort and fatigue (Occupational Safety and Health Division of Ministry of Manpower Singapore, 2007). In developing countries, industrial surveillance may remain largely a difficult task due

to high prevalence rate of unemployment. Cautious efforts to avoid prolonged sitting and standing increases health related quality of life. Messing and Kilbom (2001) therefore suggest that freedom to stand or sit at will while working will go a long way to prevent incidence of piles. Other measures include adjustable seat; comfortable shoes; short breaks from standing or sitting; task variations that demand equal sitting and standing periods etc. Also, sitting for long during bowel movement predisposes individuals to haemorrhoids development.

2.2.3 Obesity

The World Health Organization maintains that obesity is often defined simply as a chronic disease or condition of abnormal or excessive fat accumulation in adipose tissue to the extent that health may be impaired. Overweight is classified into four categories which range from pre-obese to obese class III. This involves evaluation of Body Mass Index (BMI) measurement which is the multiplication of individual's weight (in pounds) by 703, and then divided by the height (in inches) squared (National Heart Lung, Blood Institute, 2000). According to the World Health Organization (2003), about 1 billion adults around the world are overweight, with a body mass index (BMI; in kg/m2) ≥25.Of these, nothing less than 300 million are considered obese (BMI ≥30). Obesity results from an imbalance of energy homeostasis. The true mechanisms underlying this process and effective strategies for prevention and treatment remain unknown .It becomes difficult to maintain a typical body size and weight (Vasanti *et al*., 2006). Thus, at least 2.8 million people die each year as a result of being overweight or obese (WHO, 2011) and common in the developing world (Cecchini *et al*., 2010). Vasanti *et al*. (2006) found a positive association between the consumption of sugar-sweetened beverages and body weight. Interestingly, human beings with obesity are usually more responsible for their health conditions. Onwasigwe correctly asserts that an intake of calories in excess of what is expended during daily activity leads to obesity and may lead to degeneration of weight-bearing body joints. Modernization and industrialization cause lifestyle changes resulting in reduced physical activity, calorie-dense dietary habits etc. These produce escalating rate of obesity (Ramachanran & Snehalatha, 2008). However, there is a global increase in the prevalence of obesity among children and adolescence (Weiss *et al*., 2004). Although, obesity allows comorbidity yet it is modifiable risk factor for haemorrhoids (Bloom *et al*., 2011). The therapies require reduction of caloric intake, readiness to lose weight, pharmacotherapy etc. Most of the studies on obesity focus on its association with chronic non-communicable diseases while some of the studies on haemorrhoids maintained that obesity is a risk factor for haemorrhoids.

2.2.4 Inadequate Dietary Fibre

Dietary fibre sometimes called bulk or roughage and is found in multiple sources particularly from fruits, vegetables and grains (Young, 2000; Encarta, 2009). Dietary fibre consists primarily of cellulose, a component of plant cell walls. Ignorantly, nutritionists disregarded it for many years because fibre cannot be digested (Encarta, 2009). However, studies indicate that dietary fibre constitutes an important and indigestible part of plants consumed as food whether soluble or non-soluble (Young, 2000; Encarta, 2009). Potentially, adequate fibre can improve verticular disease, irritable bowel syndrome, Crohn's disease, constipation and anorectal conditions such as fissure and haemorrhoids (McDonald *et al*., 1983). While low fibre consumption may worsen symptoms in severe cases of inflammatory bowel diseases (Young, 2000). But Fuchs *et al*. (1999) insists that the role of fibre still remains controversial. This could be as a result of the presence of other risk factors to haemorrhoids which individuals may not be conscious of. For instance, Encarta (2009) submits that consumption of fibre without adequate fluid intake increases individuals' susceptibility to constipation and excess consumption of fibre within a short time can result to boating.

Generally, fibre supplements are a good behavioural therapy for all grades of piles (Jani, 2005). However, diet-related items may also predispose individuals to colorectal disorders such as haemorrhoids (Young, 2000; Omole and Adegboye, 2012). Nevertheless, inadequate consumption of fibre probably stems from ignorance or poverty. This could explain the prevalence of haemorrhoids.

2.2.5 Age

The World Gastrological Organization (WGO) has observed that people who are above the age of 50 and exclusively young women under 25 are at risk of constipation (WGO, 2007), which predisposes individuals to haemorrhoids. Also, studies have confirmed that high prevalence of haemorrhoids between 45 and 65 years and the development of haemorrhoids before the age of 20 is unusual, (Johanson and Sonnenberg, 1990; Kaidar-Person *et al*., 2007). This depicts that young adults are prone to the disease. But when haemorrhoid occurs in children, scholars submit that it is commonly caused by portal hypertension (Imanzadeh *et al*., 2009; Omole and Adegboye, 2012). But contrary to the latter assertion, Laosee (2005) argued that symptomatic haemorrhoids are common under the age of 20 in Thailand. Probably, other risk factors of haemorrhoids might be responsible for such exception in Thailand. Hence, haemorrhoidal tendencies decline as age increases above 65years (Johanson and Sonnenberg, 1990). Although, studies on the relationship between age and prevalence of

haemorrhoids paint a vague picture of the duo, majority of the scholars support the view that age is a predisposing factor to haemorrhoids.

2.2.6 Pregnancy

Scholars have pointed out that women are prone to haemorrhoids which are common in young women especially during pregnancy and after child birth (Alonso and Castillejo, 2003; Kaidar-Person *et al*., 2007; WGO, 2007; HIST, 2009; Cleator and Cleator, 2010; Omole and Adegboye, 2012). Medich (1995) and Jani (2005) maintain that pregnancy cause internal and secondary haemorrhoids. The anal pressure increases during the development of foetus in womb. For instance, Omole and Adgboye (2012) found that haemorrhoids developed more often as from 7 months of pregnancy. At birth, the intensification of varicose veins attains its peak thereby producing intense symptoms of haemorrhoid after delivery.

Abramowitz (2012) has rightly suggested that medication during pregnancy should be with caution. Jonathan and Jack (2005) observe that most obstetricians advise women to avoid laxatives during pregnancy and prescribe stool softeners instead. However, stimulant laxatives are reserved for those who do not respond to these initial treatments. Pregnancy in women is a cultural procreation mechanism. Therefore, social expectations placed on women may disallow them to take an exception to pregnancy based on their prior haemorrhoidal episode.

2.2.7 Anal Intercourse

According to World Health Organization (WHO, 2003), the anal canal is defined as the terminal part of the large intestine, beginning at the upper surface of the anorectal ring and passing through the pelvic floor of the anus. The conversion of anus natural use to sexual organ makes its discussion relevant in human sexuality. The attendant health implications and societal reactions cannot be overemphasized. Gestures towards anal sex are relative and it is illegal in some countries. It has been, and in some jurisdictions continues to be a crime carrying severe punishment (Health Discovery, 2010). Anal intercourse is sometimes referred to as sodomy or buggery, and is considered a taboo in a number of legal systems. Also, the anus is often considered a taboo part of the body (Health Discovery, 2010). The anus has a relatively high concentration of nerve endings and is an erogenous zone which can make anal intercourse pleasurable for both the insertive partner and the receptive partner (Wikipedia, 2013). National Diseases Information Clearinghouse (NDIC) (2013) confirms that such

sexual activity increases pressure on anal area. Nevertheless, sexual orientation of an individual indirectly relates with the tendency of haemorrhoids occurrence.

Homosexuality especially among gays, who indulge in anal sex are susceptible to haemorrhoids. A majority of patients with anal dysplasia are referred to colorectal surgeons for the treatment of either genital warts or haemorrhoids (Goldstine & Welton, 2004). Those who engage in anal sex are prone to other infections. For instance, Ven-Pedersen *et al*. (2000) asserted that more than 60% of men without HIV and 90% of men with HIV who have sex with men are infected with Human Papillomavirus (HPV) in their anal canals. Recent evidence suggests that the incidence of anal cancer is between five and ten times greater in gay and bisexual men than cervical cancer is in women (Matterson, 2013). Historically anal cancer is more common in women. However, the incidence of anal cancer in men has been increasing especially among those who practise anal sex with men (João and Leonardo, 2012). Among the risk factors are human papillomavirus (HPV), smoking, immune suppression and anal sex (Uronis & Bendell, 2007). Therefore, anal sex, as human sexual gratification, has negative tendencies on health.

2.2.8 Hereditary

Doctors want to know and keep the family history of patients to determine whether the diseases are hereditary or as a result of the way of life of the patients. Kaidar-Person *et al*. (2007) suggests that a family history of haemorrhoidal disease contributes to the development of the disease although there is no evidence of a hereditary predisposition. Recently, Omole and Adegboye (2012) noted that people with family history of haemorrhoids are highly susceptible to developing symptomatic haemorrhoids. Other scholars did not mention family history as one of the risk factors.

2.3 DIAGNOSIS

Until the symptoms are perceived medical help is not sought. On a general note, closer evaluation of the rectum for haemorrhoids requires physical examination with an anoscope, a hollow, lighted tube useful for viewing internal haemorrhoids, or a proctoscope, useful for more completely examining the entire rectum (Kaidar-Person *et al*., 2007; National Diseases Information Clearinghouse, 2013). The major medical examination is colonoscopy.

2.3.1 Colonoscopy

It is a means of visualising and examining the full lining of the colon and rectum using a long flexible tube-like instrument (Singhealth, 2008). Physicians usually recommend colonoscopy when changes occur in the bowel habit, bleeding, inflammatory bowel disease, blood in faces etc. Before colonoscopy is carried out, good bowel preparation is essential and it lasts for five days (Irabor, 2006). Thus, it is advised that necessary precautions should be observed to avoid post-examination complications (Singhealth, 2008). Arigbabu *et al*. (1985) asserts that when it is carefully performed, it is safe and the results are rewarding. Thomas *et al*. (2002) also stresses that colonoscopy is an accurate method of diagnosing colonic disease but is technically demanding and operator- dependent. Research indicates that over 90% of patients undergoing sigmoidoscopy or colonoscopy are found to have haemorrhoids of varying degrees (Su *et al*., 2011). Unfortunately, Ismaila and Misauno (2011) recently observe that colonoscopy is not a common procedure in Nigeria. This could be as a result of the level of awareness, complexity, duration, cost, anticipated complications and availability of alternative therapy that may not require such extensive procedure.

Based on the medical diagnosis, different grades have been identified; even though there may not be a clear cut characteristic of each grade yet necessary and appropriate medication is prescribed. However, the traditional herbal vendors only rely on complaints from the people with haemorrhoids before the administration of therapies.

2.4 TREATMENT AND THERAPY FOR HAEMORRHOIDS

There are two broad pathways to health. These include biomedical and alternative treatments. Generally, medical treatment of haemorrhoids is aimed initially at relieving symptoms.

2.4.1 Biomedical Therapies

2.4.1.1 Tub or Sitz Baths

The warm sitz bath is the non-invasive hydrotherapy recommended for uncomplicated haemorrhoids but requires a high degree of patient's compliance (Gami, 2011). This measure entails the use of warm water for several times a day in plain for about 10 minutes. The patient is expected to sit on the warm water to ease the pain and allow for prolapse of protruding haemorrhoids. Sitz baths are useful for relieving anal pain and maintaining anal hygiene (Dodi *et al*., 1986; Shafik, 1993). Sitz baths work by improving blood flow and

relaxing the internal anal sphincter (Feldstein & Kay, 2009). Also, treatment could be an application of a haemorrhoidal cream or suppository to the affected area for a limited time (National Diseases Information Clearinghouse, 2013). Feldstein and Kay (2009) refer to this as tropical treatments which are used without prescriptions. These remedies are for external haemorrhoids.

2.4.1.2 Rubber Band Ligation (RBL)

This is an office procedure (Alonso and Castillejo, 2003). Su and colleagues (2011) maintain that rubber band ligation has been used to treat internal haemorrhoids since Blaisdale introduced the device in 1951. Feldstein and Kay (2009) insist that ligation is the most widely used procedure. Rubber band ligation is safe and most commonly recommended for first to third-degree haemorrhoids (Gastroenterology, 2004; El Nakeeb *et al*., 2008; Su *et al*., 2011). A rubber band is placed around the base of the haemorrhoids inside the rectum that precludes blood flow in the region. The band cuts off circulation, and the haemorrhoids wither away within a few days. Cleator and Cleator (2010) uphold the beneficial prospect of rubber band ligation. Single therapy may not be sufficient for haemorrhoidal episode. Feldstein and Kay (2009) observe that many patients report a sense of "tightness" after the procedure which may improve with warm sitz baths. But complications occur when the rubber band falls off, usually two to four days after the procedure. The effects of complication include severe pain, thrombosis of other haemorrhoids, and localized infection or pus formation (abscess). Rubber band ligation rarely causes serious complications but when such occurs rebanding is possible (Jani, 2005; Feldstein & Kay, 2009). El Nakeeb *et al*. (2008) assert that RBL is a simple and effective method for treating symptomatic second and third degree haemorrhoids as an outpatient procedure with significant improvement in quality of life.

2.4.1.3 Sclerotherapy

This is one of the oldest forms of non-operative treatment usually reserved for first and second degree haemorrhoids (Gastroenterology, 2004). It is considered a simple, safe and effective method for treating bleeding haemorrhoids which has success rate close to 100% (Alatise *et al*., 2009). Sclerotherapy requires no anaesthesia and takes only minutes to perform through an anoscope (Walker *et al*., 1990). During sclerotherapy, a chemical solution is injected into haemorrhoidal tissue, causing the tissue to break down or shrink and form a scar. This measure may be less effective than rubber band ligation (Feldstein & Kay, 2009). Even though sclerotherapy is minimally invasive, it can cause complications. Scholars have

noted that complications as a result of injecting sclerotherapy are due to the sclerosing agent used or incorrect placement (Guy & Seow-Cheon, 2003; Davies, 2006). Research indicates that pain reported ranges from 12% to 70% of patients (Walker *et al*., 1990). Other patients complain about impotence, urinary retention, and abscess (Bleday, 1992; Bullock, 1997). In Nigeria, modern medicine has not enjoyed the same patronage as alternate medicine for the treatment of haemorrhoids. Probably, it is because commonly used sclerosants are not available or very expensive in Nigeria (Alatise *et al*., 2009).

2.4.1.4 Infrared Coagulation

This is a special device used to burn haemorrhoidal tissues. It could be laser, infrared, or bipolar coagulation. These methods involve the use of laser or infrared light or heat to destroy internal haemorrhoids. Coagulation may have fewer complications than rubber band ligation. Recently in 2011, Giamundo and colleagues who compare laser procedure technique with rubber band ligation conclude that despite higher cost, laser procedure is more effective than rubber band ligation in reducing post-operative pain and ultimately improving the quality of life. However, Feldstein and Kay (2009) argue that infrared coagulation has higher recurrence rates than rubber band ligation. This disparity may be due to different stages of haemorrhoids.

2.4.1.5 Haemorrhoidectomy

Occasionally, haemorrhoidectomy -a surgical procedure- is engaged to remove extensive or severe internal or external haemorrhoids. It covers the surgically removing excess haemorrhoidal tissues and the anal canal lining. Scholars have classified haemorrhoidectomy into two broad categories which are open and closed surgery (Halverson, 2007; Feldstein & Kay, 2009). These two incorporate the following: Miligan-Morgan haemorrhoidectomy, the Ferguson haemorrhoidectomy, Stapled haemorrhoidopexy, traditional haemorrhoidectomy etc. Li *et al*. (2013) assert that the choice of procedure will depend on different stages of the disease. The preparation for the procedure involves the medical and psychological fitness in which local anaesthesia is important (Alatise *et al*., 2010). Pain is the most common complication of haemorrhoidectomy (Vinson-Bonnet *et al*., 2002; Kim *et al*., 2005 Alatise *et al*., 2010). Other complications include difficulty emptying the bladder or bowels, a bladder infection, rectal bleeding and impotent which is unfounded. Alatise and colleagues (2010) argue that many patients decline haemorrhoidectomy as a result of fear of postoperative complications.

2.4.1.6 Lifestyle Adjustment

It is a conservative procedure (Bussen *et al*., 2012). This has dual functions: both therapeutics and prevention effects. Prescription of healthier behavioural lifestyle is one of the major integral therapies used to combat anal problems. These modifications should be offered to patients with all stages of the haemorrhoidal disease as part of a comprehensive treatment regimen (Kaidar-Person *et al*., 2007). This will embrace increased consumption of fibre and fluids in diet and avoid constipation. Scholars have recommended that increased consumption of varieties soluble fibre daily will help the body system. For instance they prescribe fibre intake of 30-35g for men and 25g for women, and 7-8 glasses of water daily. In addition, doctors may suggest a bulk stool softener or a fibre supplement such as psyllium (Metamucil) or methylcellulose (Citrucel). Cleator and Cleator (2010) found that patients who did not follow soluble fibre prescriptions had haemorrhoids recurrence.

Young (2000) upholds that bowel health is that state where the individual is satisfied with their own frequency and ease of defecation which depends to a large degree on overall healthy dietary lifestyle. Jonathan and Jack (2005) suggest that patients should be encouraged to recognize and respond to the "call to defecate". Cleator and Cleator (2010) advise further that patients should avoid sitting in the toilet beyond minutes for a bowel movement. However, the adoption of western diets and lifestyle has been linked with the prevalence of anorectal diseases in Nigeria (Ani, 1983).

Other treatments include local injection therapy, anal divulsion, cryotherapy, direct application of electrical current (Su *et al*., 2011), which should be handled by experts.

2.4.2 Alternative Therapies

In 2001, WHO estimated that 80% of the world's population used herbal medicine for some aspects of primary healthcare. Africa and indeed Nigeria is not exempted from its usage (Osungunna *et al*., 2010). In 2008, Lawan and colleagues confirmed that the stem bark is traditionally used to relieve pain and discomfort associated with haemorrhoids. Locally, herbal products for piles treatment are common in south western Nigeria. This may be responsible for why herbal medicine has enjoyed unprecedented patronage. But Orapin and colleagues (2005) argue that availability of traditional medicine for haemorrhoids in an area does not necessarily determine its patronage. People are interested in herbal medicine because it represents the indigenous knowledge. Research indicates that patients want procedure that is safe, effective, painless and free from adverse effects- death, sepsis, severe

pain, bleeding, impotence, urinary retention and anal stenosis (Cleator and Cleator, 2010; Alatise *et al*., 2010).

The cost of traditional medicine is believed to be relatively cheaper compare to orthodox therapies. The traditional/modern medicine ratio has increased with decreasing cost. Li *et al*. (2013) recommends its usage based on cost-effectiveness especially in the developing countries. In China, apart from local herbal medicine, traditional haemorrhoidectomy has been developed probably as a result of standardization of herbal therapies and level of technology. However, in Nigeria, traditional medicine has not been fully incorporated in theory and practice, thus making traditional haemorrhoidectomy a mirage.

Africans continue to heavily use herbal medicine (WHO, 2003b). This demands quality control of the content of herbal mixtures. Scientific evidence related to the efficacy of the traditional healing systems in most time is deficient (Prata, 2008). According to Osungunna and colleagues, consumers of *Jedi* drinks were at risk of gastroenteritis which therefore necessitates constant monitoring and quality control of herbal medicinal products manufactured, advertised, sold and used in Nigeria (Osungunna *et al*., 2010). Also considering its patronage, there are other factors that contribute to such level of usage. Some of the users prefer *Jedi* drinks mixed with alcohol. This may connote recurrence of haemorrhoids or alcoholism of its users. However, herbal powder therapies have not enjoyed the same patronage like Jedi drinks. The nexus between the prevalence of haemorrhoids and traditional therapies usage to treat haemorrhoids may not be clear-cut. In recent development, Akande *et al*. (2012) suggests that the combination of modern drugs and traditional herbal remedies is a fast growing practice among many Nigerians as many people believe in their efficacies. Jegede (2010) upholds that patients seek medical care only when the case is advanced. Therefore, it is difficult to rely on traditional medicine for haemorrhoids treatment in all grades.

2.5 PREVENTION

The prevention of haemorrhoids is possible if only individuals are aware of the risk factors and adopt healthier behavioural lifestyle. Many people especially those who have had haemorrhoids before may find it difficult to effectively prevent haemorrhoids. As in case of every disease prevention, is the best common treatment (Gami, 2011). The best treatment is

always prevention (Brisinda, 2000). The latter assertion reinstates the significance of preventive measures available to treat any disease. Culturally, there is no clear cut difference between haemorrhoids prevention and tropical treatment.

Scholars have pointed out that diet plays a significant role in colorectal disorders. The modification of dietary lifestyle is a potent factor to prevent and treat various grades of haemorrhoids (Young, 2000; Gami, 2011). Specifically, dietary supplements can help prevent piles (Ahad *et al*., 2010). Gami (2011) indicates that high fibre diet is an important component to the prevention and treatment of both haemorrhoids and varicose veins.

Generally, the best way to prevent haemorrhoids is to keep stools soft so that they can pass through anus easily, thus decreasing pressure and straining and to empty bowels as soon as possible after the urge occurs (Jonathan and Jack, 2005). Exercise, including walking, swimming etc. are relevant to the preventive methods.

Studies have found that haemorrhoids are troublesome to patients and treatments can lead to a poor outcome or have painful prolonged recovery periods (Orlay, 2003; Cleator and Cleator, 2010). Since many people feel embarrassed when facing the problem, patients with severe symptomatic haemorrhoids are likely to prevent the reoccurrence of the disease (Kaidar-Person *et al*., 2007).

2.6 SOCIOCULTURAL BELIEFS ABOUT HAEMORRHOIDS

Socialization entails a lifelong learning process of cultural mechanism to survive in the human society. The process of socialization influences attitude formation of human beings and their belief systems towards social phenomenon such as health. Individually, patient's construction of the meaning of illness is central and of which is superimposed upon that of biomedical causality and rationality (Langdon and Wiik, 2010). As observed by Jegede (2002) that people tend to hesitate before seeking modern health especially in a society where perceived causes of a disease determine the choice of prevention and treatment. Therefore, the explanation of diseases is social, which emerges from cultural beliefs, norms values, social interactions and social reactions.

Cultural account of a disease may be negative. Stigmatization and discrimination are commonly placed on people with life-threatening diseases especially when such people are

perceived to be responsible for their predicaments. For instance, people living with HIV/AIDS and mental patients are usually victims of labels, prejudices and discriminations (Jegede 2005 & 2010). However, haemorrhoids are not perceived as life-threatening. The illness may reoccur, which calls for consistent treatments.

Culturally, Olateju (2009) reported that herbal vendors believed that symptoms of piles in women include black, smelling, irregular or hindered menstrual flow. This does not depict an objective reality. Medically, the symptoms include blood in the stool, stooling repeatedly; anus becomes burning; pains during or after bowel movement and anus making a kind of ceaseless sounding staccato noise. Haemorrhoids are believed to cut across all demographic qualities - age, sex, social class or status. Herbal vendors portray symptoms of haemorrhoids as inexhaustible. Haemorrhoids are considered multi-symptomatic disease ranging from difficulty in stooling to sexual problems (Olateju, 2009).

Sexual problems put strains on marital relationship and sexual relationship in marriage has a social and emotional value. Zargooshi (2008) observes that one of the reasons tenable for divorce is unconsummated marriage in Nigeria. This is not an exception in Yoruba cultural tradition. People believe that haemorrhoid prevents sexual excitement: it is responsible for poor libido in women and weak erection in men prior or during sexual episode. This could be seen as impotence in men which carries social stigma (Olateju, 2009; Alatise *et al*., 2010). Contrary to this belief, stressful lifestyle precludes libido in human beings (Concordia University Health Services, 2013). Unfortunately, issues relating to sexual problems are discussed covertly among adult victims. The shameful experiences predispose individuals to seek therapies.

Patients' health-seeking behaviours and choice of therapies are largely determined by cultural explanation of the illness. Jegede (2010) points out that people that attribute a disease to supernatural and preternatural are likely to seek alternative medicine while those who attribute their illnesses to natural cause seek medical therapies. Also, culturally people believe in cure rather than management of disease. Therefore, in the search of cure for haemorrhoids, people tend to use all available alternative therapies at their disposal.

2.7 CULTURE AND DISEASE/ SICKNESS

Culture is an important element of social existence. It defines social phenomena which include health, illness, social behaviours, etc. Culture plays a significant role in the

perception of the world, which encompasses materials and non-material things such as artifacts, knowledge, beliefs, norms, values, practices etc. that endure beyond a generation. The perception stems from various beliefs learnt during socialization process. Culture is relative to time, place, circumstance etc. This explains why issue that is regarded as illness and disease in one society may not necessarily be a health challenge in another social grouping.

Society and health are interrelated and mutually exclusive especially as the latter finds its expression and context within the former (Owumi, 1996). This relationship is culturally deterministic (Jegede, 2002). Healthiness is vital to all people in all societies. To explain individual's health status, there is need to know that illnesses and diseases have areas of convergence and divergence. Idler (1979) opines that illness is experience of disease which is socially indicated by personal feelings of pain, discomfort, etc. which may lead to behavioural changes. Pelto and Gretel (1990) differentiate between illness and disease. Culturally, illness is defined as feelings and perceptions of physical and/or mental ailment and disability in the minds of people in specific communities. While on the other hand, disease is the formally taught definition of physical and mental pathology in medical profession. Illness is a subjective evaluation of one's state of being whereas disease is an objective evaluation of individual's wellbeing. Owumi (1996) upholds that the means of evaluating and treating ill-health is group relative. Teshome-Bahiru (2004) observes that patients and researchers mostly find it difficult to make out the dichotomy between illness and disease. Consequentially, the poor state of health is a common denominator of illness and disease, not necessarily the presence of physical injury or pain.

Religion as part of cultural system, contributes immensely to attitude formation in the societies as regards health and illness. This determines the explanation and reaction towards patients and certain ill-health conditions. For instance, religious perspectives such as Buddhist and Confucian doctrines view illness and death as a natural phenomenon perceived as bad luck, misfortune or nemesis (Culture Cue, 2007). Beck (2007) submits that illness and sin are believed to have causal-effect relationship and man's religious life influences states of mind -peace, joyfulness, harmony or disharmony, fear and desperation. Considering this definition, individuals may not seek appropriate medical attention.

Every society has historical antecedence and mythology that influence her social phenomena. In Yoruba worldview, destiny mythology (*ayanmo*) plays a significant role in the explanation

of health conditions (Jegede, 2002). He stresses further that good health signifies a positive destiny (*ayanmo-rere*) and ill health depicts a negative destiny (*ayanmo-buruku*). Thus illness and disease episodes in such societies are believed to be predestined phenomena which individuals cannot alter except supernatural power is consulted. Teshome-Bahiru (2004) has noted that when illnesses are associated with the spirit and divinity, people prefer traditional medicine to orthodox medicine to treat the illness.

In African settings, incest, taboos, negative practices, disrespect for cultural heritage, antisocial behaviour and neglect of ancestral worship could be responsible for ill-health in human body (Nabofa, 1996; Jegede, 2010). Culture prescribes acceptable practices in the society and any deviation may result to psychological traumas and unstable health. However, some of these cultural practices are detrimental to individuals' wellbeing. For instance, Jedege (2010) identifies cultural practices which prevent sound health. The practices include: forced feeding, Female Genital Mutilation (FGM), avoidance of certain diets during pregnancy, etc. among the Yoruba of south-western Nigeria. The latter explanation does not dispute the relevance of culture. As noted by Oke (2006) that culture is a survival mechanism.

Culturally, definition of illness is usually casual. People label illness and disease after their dominant symptoms, anatomical location and causes (Teshome-Bahiru, 2004). Many people, especially the unschooled may not know the word like haemorrhoids. The word, *Jedi-Jedi* (Eat-bottom, Eat-bottom/ piles) in Yoruba conception, literarily identifies the body part affected and damage done by the disease. This label overshadows other medical conceptions of the disease. In linguistic discourse, *Sapir-Whorf Hypothesis* asserts that the structure of a language can strongly influence or determine individuals' worldview. Therefore, health belief system emanates from cultural worldview of individual.

2.8 THE NIGERIA POLICE FORCE: AN OVERVIEW

2.8.1 History and Structure of the Nigeria Police Force

The establishment of the Nigerian Police Force is dated back to 1861 during colonial era, when the consul of Lagos colony established a consular guard of thirty members to watch over the colonial properties (Akuul, 2011; Wikipedia, 2013). Later, this guard grew to 1,200 members and was named as the Hausa constabulary because it was dominated by Northerners (Akuul, 2011). In 1896 the Lagos police was established. A similar force was already formed in Calabar in 1894 known as the Niger Cost Constabulary. In the same vein, the Royal Niger

Company set up Royal Niger Company Constabulary in 1888 (Akuul, 2011; Wikipedia, 2013).

In the early 1900's when the protectorates of Northern and Southern Nigeria were proclaimed, part of the Royal Niger Company constabulary became the Northern Nigeria Police and part of Nigeria Coast Constabulary became the Southern Nigeria Police. Although the South and North were amalgamated in 1914, their police forces were not merged until in 1930, with headquarters in Lagos (Akuul, 2011; Wikipedia, 2013). Akuul (2011) emphasizes that during colonial period most of the police officers were associated with local government (Native authorities). But by 1960's under the first Republic, these forces were regionalised and then nationalised. Consequently, the Inspector General of Police was in control of the general operation and administrative duties. He was supported at the headquarters by a deputy Inspector General and in each state by Police Commissioners.

Plans were announced in mid-1980 to expand the force to 200,000. By 1983, according to the federal budget, the strength of the NPF was almost 152,000, but other sources estimated it to be between 20,000 and 80,000. Reportedly, there were more than 1,300 police stations nationwide (Wikipedia, 2013).

The 1999 constitution also provided for a Police Service Commission that is today responsible for policy, organisation, administration and finance of the Nigerian police force (Akuul, 2011).

The structure of the Nigeria Police Force is provided for in section 214(2a) and 215(2) of 1999 constitution. The Nigeria Police Force has hierarchically distributed offices with the attendant power and authority to allow effective and efficient service to humanity. From pinnacle of the organisation to the least, the Nigeria Police Force operates along the hierarchical structure which includes the Inspector-General of Police; the Deputy Inspector-General of Police; the Assistant Inspector-General of Police; the Commissioner of Police; the Deputy Commissioner of Police; the Assistant Commissioner of Police; the Chief Superintendent of Police; the Superintendent of Police; the Deputy Superintendent of Police; the Assistant Superintendent of Police; the Inspector of Police, Sergeant; Corporal and Constable. Therefore, there are fifteen steps to the peak of Nigeria Police Force as a career.

The NPF is composed of senior officers (ASP II to IGP) and junior official (Constables to Inspectors of Police), with sex distribution of 95% males and 5% female (Wikipedia, 2013).

Considering the systemic relationship that exists between the personnel, the Nigeria Police Force is administratively structured and divided into seven (7) Departments which function together to allow societal continuity and pattern maintenance. The departments range from 'A' to 'G' with each department charged with peculiar duties. The functions according to each department are as follow: A for Administration; B for Operation; C for Logistics and Supply; D for Investigation and Intelligence; E for Training and Command; F for Research, planning, Information management and G for Information Communication Technology (Wikipedia, 2013).

2.8.2 The Roles of Nigerian Police Force

Akuul (2011) points out to that traditionally policing was the responsibility of all adults in a community but the complexity of the modern society demands for professionalism in policing. Thus, the police are saddled to perform the following responsibilities or duties:

i. Prevention of crime.

ii. Protection of lives and properties.

iii. Enforcing law.

iv. Maintenance of peace and public order.

v. Providing a wide range of services to the citizens. By doing this, the police have the right to use coercive means to curtail violence and establish peaceful co-existence (Yecho, 2004).

The Nigeria Police Force is relevant in the scheme of things considering the present insecurity and political insurgencies that are bedevilling the country. Unfortunately, despite the fact that much is expected from the police yet they receive poor welfare packages coupled with stress. These have negative effects on their performance of duties.

2.9 POLICE STRESS

Stress can be simply defined as a response to something in the environment (a stressor) when the environment changes. Stress entails an unpleasant state of emotional and physiological arousal that people experience (anxiety or overwork) in situations that they perceive as dangerous or threatening to their well-being (Auerbach and Gramling, 2009). In the advanced world, necessary social amenities are available to the masses which help to combat stress. In contrast, developing countries are exposed to continuous stress without adequate social securities to assuage the situation. Police officers are expected to maintain psychological and physiological homeostasis during numerous stressful activities. These activities include

standing and sitting for a long period; walking continuously, etc (Department Public Safety Standards and Training, 2011).

Everybody faces stress. Studies have detailed that stress transforms and manifests in different forms (Sutton and Khan, 1984). The forms cover organizational, structural and metabolic factors such as job security, shift work, long work hours, role conflict, physical hazard exposure and interpersonal conflicts with co-workers or supervisors contribute to increase stress levels (Hart, 1999; Omolayo, 2012).

Work-related stress emerges from two perspectives; unavailability of required equipment to perform assigned duties and social relationship involved. In an ideal situation, the police officers should have access to high performance police cruiser, coupled with computer keyboards, cellular telephones, pepper spray, shotguns, handguns, batons, flashlight, notepad, radio, sirens/lights, vests, handcuffs, utility belts, etc. (Hart, 1999). Police work becomes more stressful when important gadgets are not supplied coupled with daily assaults faced in the course of duties. Paradoxically, the required energy to function increases especially when all the equipment is available.

Aluyor (2005) indicates that ineffective policing in Nigeria stems from low funding, poor logistics and poor motivation; lack of modern communication, inadequate training, deplorable barrack accommodation and lack of public support. Often times, policemen at the macro level, complain of broken equipment, excessive overtime, frequent rotating shifts, regular changes duties. From micro analysis, disparities occur in individual's experience as regards family problems, financial problems, health problems and taking a second job to make extra income.

2.10 EFFECTS OF STRESS ON THE POLICE

Many people suffer in silence probably because of their inability to identify their stressor and inability to withdraw from their stressors or they lack counsel (Nyamwamu *et al*., 2012). The effects may not be known because their manifestations are not immediate. As society enters the body, people die gradually without knowing it. Information regarding police officer stress relating to the officers and their families is difficult to access and not all forms of stress could be identified. Gau *et al*. (2012) observe that promotional aspirations motivate officers to go beyond minimum standards. Scholars have pointed out that stress cannot be taken out of

police work. Police officers' stressors include their supervisors, non-conducive overstretched shift-work resulting in the loss of time spent with their families, fellow officers, career advancement and the citizens (asshole factor) at large as well as low pay, irregular sleep schedules, draining restraints and conflict with family and friends (Haines, 2003; Johnson, 2011; Gau *et al*., 2012).

Stress generally, affects police effectiveness (Moss, 1999) which has brought about growing concern of its potential risks (Nyamwamu *et al*., 2012). This predisposes them to haemorrhoids (Omole & Adegboye, 2012). Police officers are engaged in tasking schedules which increase their susceptibility to restless legs syndrome, sleep deprivation and sleep disorders. The need to work frequent overnight shifts and week-long work lead to acute and chronic partial sleep deprivation as well as misalignment of circadian phase. Stress can cause a multitude of problems in the officer's professional and social life. Haines (2003) emphasises that stress could lead to numerous sicknesses, cynical attitude and in family life, estrangement is inevitable. Furthermore, the consequences of stress among the police include divorce (Haines, 2003), alcoholism, depression and suicide (Nyamwamu *et al*., 2012).

Despite the police's predicament, the society expects officers to perform flawlessly whereas sleep deprivation and unrecognized sleep disorders adversely degrade cognition, alertness, reaction time and performance. These affect personal health, increasing the risk of gastrointestinal such as haemorrhoids and heart disease, impairing glucose metabolism and substantially increasing the risk of injury due to motor vehicle crashes (Auerbach and Gramling, 2009).

2.11 HAEMORRHOIDS AND QUALITY OF LIFE

As part of the haemorrhoids symptoms, Li *et al*. (2013) perceive haemorrhoids as a disrupted quality of life. The ubiquitous concept, quality of life (QoL) has different philosophical, political and health related explanations. Scholars have identified two indicators of quality of life. First, subjective indicators that permit comprehensive and meaningful assessments of an individual's quality of life; and secondly, measures of subjective wellbeing - especially overall life satisfaction - are the best available indicators of the degree to which the expectations and needs of the population are met (Anderson *et al*., 2009). Research indicates that material conditions and standard of living are among the key aspects of quality of life

(Anderson *et al*., 2009). On a general note, information gathered from quality of life inquiry is always subjective and important to policymakers.

In line with WHO's definition of health which is a state of complete physical, mental and social wellbeing and not merely absence of disease or infirmity, most people are not fit to consider themselves healthy. Studies have revealed that health- related quality of life is a patient-reported outcome which encompasses physical, functional, social and emotional wellbeing of an individual (Anderson *et al*., 2009; Li *et al*., 2013). This emanates in a bid to understand relative patients' perception about their health statues. Measuring health related quality of life is increasingly essential when evaluating the benefit and harm of new clinical treatments (Riss *et al*., 2012; Bussen *et al*., 2012). Reduced quality of life has adverse effects on health outcomes. For instance, Li *et al*. (2013) asserts that there is significant increase in mortality risk of diabetes as a result of reduced health related quality of life in individuals. Recently, Nordyke and colleagues in their study found that adolescents with unrecognized Celiac diseases experience similar health related quality of life as their peers without such disease except those with severe painful condition (Nordyke *et al*., 2013). This shows that disease and illness can also affect the quality of life of individuals. There are very few studies carried out to investigate the influence of haemorrhoids on the quality of life of those patients (Riss *et al*, 2011).

Haemorrhoidal disease leads to disability and reduces quality of life (Denisenko, 2010). In a 2009 comparative study on quality of life, Mishalov and colleagues asserted that patients with chronic internal haemorrhoids who were treated with infrared photocoagulation had an improved quality of life. In contrast, Riss *et al*. (2011) maintained that haemorrhoids, irrespective of their degree, do not influence quality of life measured by Short form-12 Health Survey. The haemorrhoids degree distribution is not known and there is need to establish the cultural perception of illness of the group. Cultural and socio economic status may determine pain perception. Audu *et al*. (2009) advances that ethno-cultural peculiarity influence pain perception. For instance, the Fulani women are not expected culturally to demonstrate pain felt. In Southern part of Nigeria women perceive labour pain as divine and a source of joy and are averse to complete elimination of labour pain (Faponle and Kuti, 2004). This may affect their perception and influence their expression of health status under stressful and painful condition. Nevertheless, in as much as health related quality of life is subjective personal health evaluation, a distorted reality is inevitable.

2.12 HEALTH CARE AND WELFARE SERVICES

In social planning and administration, welfare constitutes programmes aimed at helping people who are unable to support themselves fully or earn a living. Welfare package is a devised mechanism to sustain people who find it difficult to eke out living. Historically, employee welfare services were meant to reduce absenteeism and time off due to illness (Nyamwamu *et al*., 2012). In recent times, from macro analysis, they include almost all aspects that relate to an employee's wellness and personal development in the work place (Manzini and Gwandure, 2011).

Healthcare and health status of a population are important indicators of welfare provision in a society and socio-economic development (Agba *et al*., 2010). National Health Insurance Scheme (NHIS) established with a lofty vision has not done much since its inception. Metiboba (2011) advocates the need for beneficiary participation in the scheme probably because 3% of the entire population have been covered and less than 25% of its objectives have been achieved. NHIS is hindered as at present by several factors in Nigeria. Some of these include poverty, poor supply of drugs or vaccines, inadequate trained health personnel, dwindling funding of health care etc. (Odeyemi and Nixon 2013).

NHIS in Nigeria survives on the contributions of government and private sectors. Government's aid is undersized contributing 22.9% and 24.1% in the north and the south respectively, while private sector underwrites huge financial backup for NHIS (Olaniyan and Lawanson, 2010). Precisely, apart from funding by government and donors, employees under the scheme contribute 5% of their basic salary while the employers contribute 10% of employees' basic salary to NHIS (Executive Secretary, NHIS, 2009). Olaniyan and Lawanson (2010) have observed that most of the firms are less concerned about the welfare of their workers, considering conditions of service and low contributions to total health expenditure.

In a comparative macro analysis on NHIS, Odeyemi and Nixon (2013) point out that despite the progress is being made in healthcare, Nigeria is still entangled with finance and accessibility problem compared with Ghana. Agba *et al*. (2010) has revealed that the federal civil servants have more access to NHIS in Cross River State than state and local government

staff. This study is limited probably because of the population used. The Nigeria Police Force has continued to suffer in silence. The fear of health insecurity may constitute predicament preventing accountable, loyal, effective and efficient policing. Alemika, (2008) correctly maintains that Nigeria lacks a comprehensive and sustainable welfare policy due to corruption both in the budgeting and expenditure processes. Therefore, the continuous neglect of police welfare services has enduring adverse effects on the performance of their duties.

2.13 THEORETICAL FRAMEWORK

This discourse delves deeply into Health Belief Model (HBM) and Dramaturgical Theory as premises for explaining the societal perception of haemorrhoids; causes, treatments and prevention among the police in Nigeria.

2.13.1 HEALTH BELIEF MODEL

Health Belief Model was developed to explain people's health behaviour and why health intervention programme fail (Rosenstock, 1974). The advocates include Rosenstock, Strecher, and Becker who explained the influence of personal beliefs on health behaviour. They identified four major constructs: perceived severity, perceived susceptibility, perceived benefits and perceived barriers. Other constructs have recently been added which are: cues to action, motivating factors and self-efficacy. The relationships between these constructs give impetus to the acceptance of health and medical recommendations (Janz and Becker, 1984).

According to health belief model constructs, the following relation can be predicted:

a) The higher the perceived severity of disease the higher the likelihood of an individual to take up healthy behaviour.

b) The higher the perceived risk of disease the more an individual is likely to adopt new behaviour.

c) The more the perceived benefits of new behaviour in reducing the risks of disease, the more individual is likely to adopt the behaviour.

d) However, the more the perceived barriers or obstacles to adopt new behaviour the less likely an individual will do.

e) Modifying variables cue to action and self-efficacy could also influence individuals' behaviours. Rosenstock (1974) asserts that the combined levels of susceptibility and severity provide the energy or force to act and the perception of benefits (less barriers) provides a preferred path of action.

Individuals' perceived susceptibilities to a disease vary widely because the dimension of perceived susceptibility now incorporates issues such as resusceptibility, belief in the diagnosis and susceptibility to the illness in general (Becker & Maiman, 1980). This dimension refers to one's subjective perception of the risk of contracting a condition (Janz & Becker, 1984). It is difficult to measure personal feelings about ones' vulnerability to haemorrhoids despite the fact that it has been medically established. Haemorrhoids may not be significant until it becomes symptomatic. Thus, individuals' perceived susceptibility to develop haemorrhoids increases especially when they are prone to the risk factors such as age, pregnancy, standing or sitting for long time, family history, stress, constipation (Alonso & Castillejo, 2003; Kaidar-Person *et al*., 2007; WGO, 2007; HIST, 2009; Cleator and Cleator, 2010; Omole & Adegboye, 2012).

Perceived severity entails feelings and beliefs concerning the seriousness of the effects of contracting an illness (or of leaving it untreated) are also relative to individuals. This involves evaluations of both medical consequences and possible social consequences (Janz, & Becker, 1984). Unlike HIV/AIDS and malaria in Nigeria, haemorrhoids rarely cause mortality (Ohning, 2009). However, complications during or after treatments could lead to impotency in man and severe itching, bleeding in both sexes (HIST, 2009; Li *et al*, 2013). Haemorrhoids affect efficient performance of duties such as in police because of increased duration for defecation, sense of incomplete defecation among others. Furthermore, haemorrhoids put strains on social relations especially conjugal commitment between spouses, because the Yoruba cultural belief maintained that *Jedi-Jedi* (literarily means 'eat bottom'- eat bottom') i.e. piles will preclude men from effective libido and superb sexual energy (Olateju, 2009). People tend to take necessary precaution to avoid piles because of the medical and social outcomes.

Perceived benefit by individuals is opinion- based; individuals adopt the different behaviours. Everybody wants to be healthy but reality proves otherwise (Iyalomhe and Iyahomhe, 2012). Culturally in the Yoruba oral traditions, health is tantamount to wealth (*ilera lo ro*). Therefore, healthy state avails one the opportunity to make wealth. As regards haemorrhoids,

many people use herbal medicine (*agbo jedi-jedi*) even before the emergence of illness. About 20 percent of those who consume herbal medicine (*agbo*) use it for no specific reason (Oreagba *et al.*, 2011). This perhaps culturally constitutes a preventive measure. Individuals assess the positive consequences of adopting the behaviour. This explains why people adopt a dietary change, consuming more fibre content- fruits, whole grains- drink more water, taking breaks at work etc. to avoid haemorrhoids and stay healthy. Ultimately, people only adopt such behaviours when they are more susceptible to the disease (Rosenstock, 1974; Wikipedia, 2013).

Perceived barrier is one of the major constructs. This is a potential negative perception or condition acting as impediments to undertaking the recommended health behaviour. A kind of cost/benefit analysis is thought to occur wherein the individual weighs the action's effectiveness against perceptions that it may be expensive, dangerous (side effects, iatrogenic outcomes), unpleasant (painful, difficult, upsetting), inconvenient, time-consuming, and so forth (Janz, & Becker, 1984). Many people eat below the prescribed level of calories and fibre per day in Nigeria as a result of poverty and literacy level. Single-handedly, poverty may not be the sole factor responsible for poor dietary habit but also ignorance is another major problem. Consequently, situational dilemma becomes inevitable. People working under strenuous and inhuman conditions are incapacitated to resign from the work considering poverty rate and rate of unemployment in the country (Haines, 2003).

Moreover, the barriers may include: inability to change personal habit -sedentary lifestyle; tendency to lose the job if they complain about job condition; reduced income, more expenses on diet; quantity of liquid substance to be consumed; exact time and duration of break; ability to use the break for health-promoting exercise; effects of prescribed therapies such as cost, pain and severity; and inability to perform the appropriate physical exercise.

Cues to action involve internal and external influences promoting the desired behaviour. Personal experience during haemorrhoidal episode, information sought or provided by significant others will go a long way in determining the adoption of desired behaviour. Culturally, people follow procedure used by others or stick to their own experiences.

Perceived control influences the tendency of adopting a behavioural pattern which emanates from the belief about the level of self-efficacy. Jegede (2010) observed that health problems perceived as less serious are treated at home while serious ones are treated at traditional therapies. Also, those considered to be very serious are taken to the orthodox healthcare.

From the forgoing, there is need to explain the symbolic interaction that is responsible for management of haemorrhoids in Nigeria. Therefore, dramaturgical theory is used to illuminate the scenario.

2.13.2 DRAMATURGICAL THEORY

Erving Goffman in *the Presentation of Self in Everyday Life* in 1959 developed the concept of dramaturgical explanation. It is argued that human actions are dependent upon time, place, and audience. Thus, social interaction is analysed in terms of how people live their lives like actors performing on a stage (Macionis & Gerber, 2011). Dramaturgical model perceives the self not as a possession of the actor but rather as product of dramatic interaction between actor and the audience (Ritzer, 2012). Goffman assumes that when individuals interact, they want to present a certain sense of self that audience will accept, perceive and act toward them as they wanted. The process refers to impression management. This involves the techniques actors use to maintain certain impression in the face of problems they are likely to encounter and methods they use to cope with these problems (Ritzer, 2012). He identifies the front (setting and personal), back stage and outside which interrelate through mystification (social distance).

Everybody wants to remain healthy (Iyalomhe and Iyahomhe, 2012). They tend to cover up their health status especially when they are diagnosed of diseases. But present themselves as healthy to the audience. People with haemorrhoids avoid the exposure of their health status to people around them. The unmanageable severity of haemorrhoids propels patients' visit to the hospital and physicians

The workplace constitutes the front stage for haemorrhoids patients. People tend to present themselves as healthy to employers, clients and colleagues at work. For instance, in many countries of the world, prospective candidates living with haemorrhoids may be disqualified from joining the police. This preconceived notion from the inception of their employment will encourage them to have back stage where individuals can manage their health. The police officers usually present themselves as agile at different duty posts even under stressful situations.

Across-the-counter drugs or available herbal products are used as cover up at the back stage from the audience. Police officers seek medical help behind the audience to manage their health.

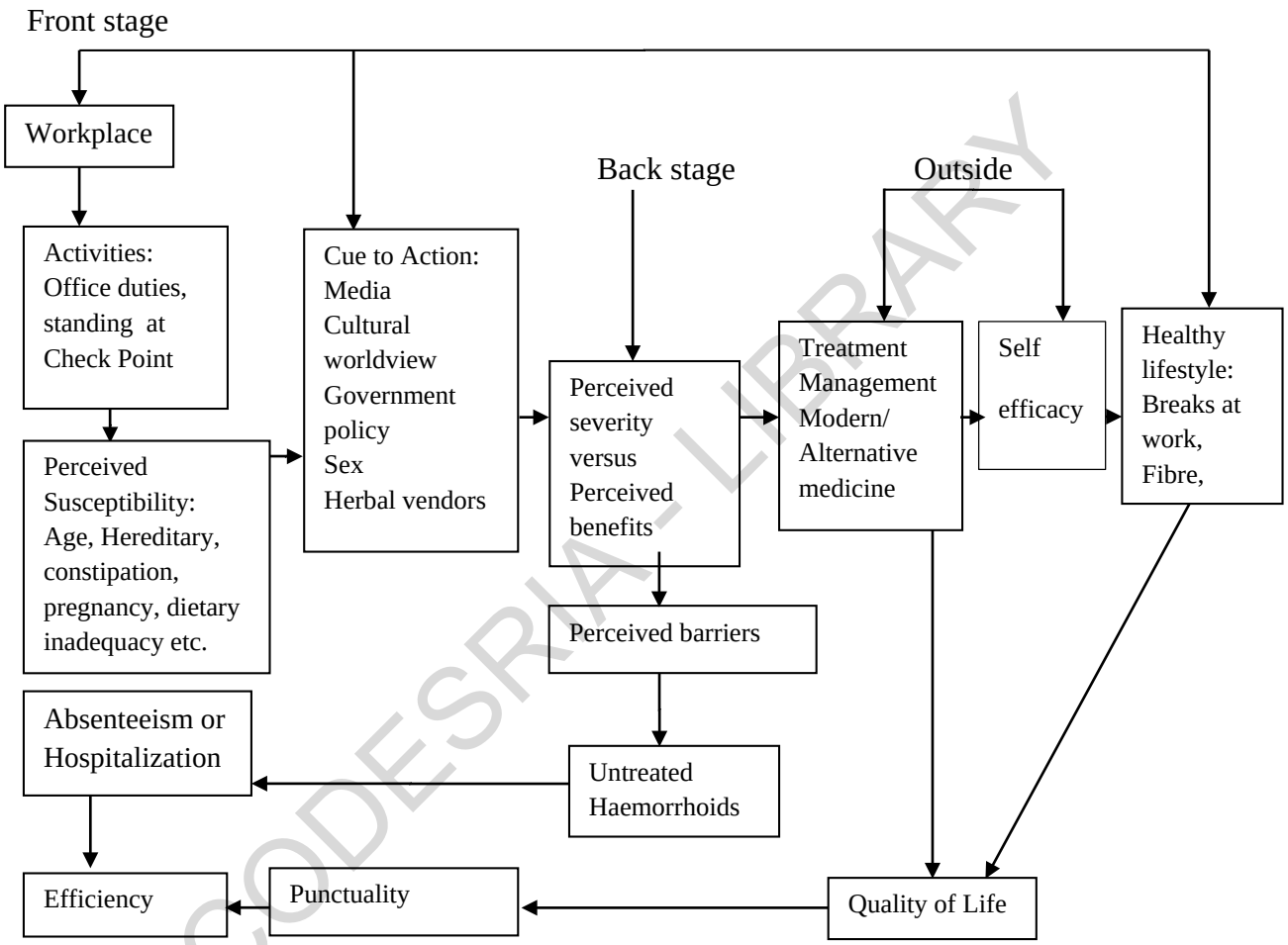


Figure 3. Abstract Sphere of Health Seeking-Behaviour of people with haemorrhoids

Health maintenance of individuals demands continuous interaction between different variables usually influenced by many factors- perceived risk, perceived severity, perceived benefits and perceived barriers. These interactions take place at different imaginary locations such as front stage, back stage and the outside.

Front stage: The workplace, cues to action and healthy lifestyle constitute the front stage which involves the audience and activities such as boss, colleagues, friends, significant others and official duties. For instance, police officers present themselves as healthy during official

duties in the public include sitting in the office, standing at the check points, running, kneeling etc. The police officers via cues to action- mass media, herbal vendors, cultural worldview, etc.- are abreast of the effects of continuous daily routine work. These constitute perceived susceptibility, especially when the police officers are exposed to the risk factors.

Back Stage: individuals move from the front stage after his/her awareness of the tendency to develop haemorrhoids. The back stage entails the interplay between perceived severity and perceived benefits, as a result of the cues to action they retrieve from front stage i.e. media, herbal vendors among others. Officers begin to cogitate at the back stage about the perceived benefits of working without haemorrhoids and perceived severity. The perceived barriers- poverty, inability to avoid sedentary life style, inability to avoid consistent stressful work shift etc., influence decision at the back stage. The cognitive discourse of individual officers determine behavioural tendency, either to seek treatment for haemorrhoids or leave the disease untreated. Health status of officers may degenerate depending on the stage of the piles while quality of life is enhanced when treated. The two major pathways to piles treatment include modern and alternative medicine. Also, officers consider their abilities to act or use the treatment appropriately before adopting healthy behaviour that could prevent haemorrhoids.

Outside: from the back stage, officers move to public sphere- which could eventually lead to front stage when piles are not treated or outside where no social definition is attached to individual health behaviour. These are perceptions and attendant behaviours which emerge from rational analysis at the back stage to maintain health. The modified lifestyles, many a time are not adopted necessarily because of the audience. Consequentially, the adoption of treatment and healthier life style will result into better quality of life, punctuality and ultimately lead to efficiency at the front stage.

The nexus between the health beliefs constructs and the stages have reinforcing effects on the health outcomes. All pathways in the framework lead to efficiency because most of the time the public sphere (front stage) influences both the private sphere and outside. Even when haemorrhoids escalate, officers assume sick role and therefore seek necessary medical assistance at the front stage.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

This study adopted exploratory cross-sectional survey design. A survey is a research method in which a population, or a portion of it, is questioned in order to reveal specific facts about it (Okunola & Ojo, 2012). This design is appropriate because haemorrhoid has gained notoriety among in the Yoruba people in Western Nigeria. Babbie (2010) asserts that exploratory studies are appropriate for more persistent phenomena. To achieve this, both qualitative and quantitative methods were used in data collection, analysis and interpretation which are to aid better understanding of the phenomenon under investigation.

3.1.1 STUDY AREA

Oyo State is located in South west Nigeria. Oyo State is cosmopolitan and comprises Oyo, Ibadan, Ibarapa, Ogbomosho and Okeogun, all belonging to the Yoruba-speaking area of Nigeria. Ibadan, the capital city of Oyo state, with an estimated population of about 6.6 million inhabitants is reputed among Nigerian states (Wikipedia, 2013b). There are three senatorial districts and thirty-three local government areas in Oyo State. This study cuts across the three senatorial districts namely, Oyo North, Oyo Central and Oyo South. The State is divided into four Area Police Commands consisting of Agodi, Iyaganku, Oyo and Ogbomosho Area Commands police stations. The Area Commands have subdivision stations within their constituencies.

3.1.2 STUDY POPULATION

Population simply refers to the totality of items in a given investigation (Atoyebi and Gbadegeshin, 2005). Babbie (2010) maintains that study population is the aggregation of

elements from which the sample is actually selected. Nigeria Police Force (NPF) Oyo State Command is under Zone 2 headquartered in Lagos, with two Commands which are Lagos and Ogun Commands. The NPF perform conventional police functions and is responsible for internal security generally, for supporting the prison, immigration, and customs services; and for performing military duties within or outside Nigeria as directed. Police officers are not usually armed but are issued weapons when required for specific missions or circumstances.

The study population comprised three categories of respondents: the Nigerian Police Force, service providers- traditional healers or herbal vendors, and medical practitioners in the study areas- and people who patronise herbal vendors to treat piles. These categories of respondents allow for better understanding of the issues under study.

3.1.3 SAMPLE SIZE

Atoyebi and Gbadegeshin (2005) assert that a sample is a portion of the population selected using a prescribed technique for the purpose of obtaining useful information about the population. Also, the importance of quantitative methods is their ability to use smaller groups of people to make inferences about larger groups that would be prohibitively expensive to study. However, the larger the sample size, the less the sampling error. Therefore, the lower the sampling error, the more the sample is representative of the population (Atoyebi and Gbadegeshin, 2005).

For the quantitative category, the sample size will be drawn from the population of police officers using Kish sample size formula:

$$n = \frac{Z^2 P (1-P)}{d^2}$$

Where: n = the sample size;

Z= Z statistics for level of confidence at two-sided test is 1.96;

P= expected prevalence or proportion for pile which is 0.67 (Omole and Adegboye, 2012);

d= precision is 0.05

$$n = \frac{(1.96)^2(0.67)(0.33)}{0.05^2}$$

n= 340,

Non-response rate is 10% for this study; therefore 34 questionnaires will be added to 340 making the total number of respondents to be 374.

Three hundred and seventy-four respondents were selected for the police. Hence, the sample was selected from the Divisional Police Headquarters. The selection criteria for the police officers at divisional headquarters include officers who were on-duty and were willing to participate in the study.

Using accidental sampling technique, ninety-eight respondents were interviewed who purchased and consumed herbal therapies for haemorrhoids because of time constrain and absence of sample frame.

3.1.4 SAMPLING TECHNIQUE

This study adopted a multi-stage sampling procedure. In stage one, the Nigeria Police Force Oyo State Command was purposively selected. Secondly, the study area is clustered into four groups according to the four existing area commands. The selection of Divisional Police Headquarters was purposive, based on the size of personnel in each police station. Available on-duty and consenting police officers were recruited into the study.

Five consenting key informants were selected at the study area considering profession and proximity. The five personnel included two medical personnel for orthodox medicine and three herbal vendors for alternative medicine. Also, exit interview was conducted for those who purchased herbal medicine to treat piles.

3.1.5 METHODS OF DATA COLLECTION

For the respondents in the police, permission to conduct the study was sought from the management of the Oyo State Police Command. The four area commanders of Nigeria Police Force Oyo State Command were visited before the permission was given to go to any divisional headquarters selected to conduct the research. At divisional level, selected police stations in Iyaganku and Agodi area commands were visited. However, in Oyo and Ogbomoso area commands, questionnaires were enveloped and mailed to various divisional headquarters through their administrative offices because the stations are widely dispersed.

The administration and collection of the questionnaires were achieved through the help of the Divisional Police Officers (DPOs) and the Station Officers (SOs) who were responsible for the administration of questionnaires which were delivered by hand to the participants. Also, the freedom not to participate and confidentiality of all the information so received were

guaranteed because names of participants were not required. These encouraged the participants to return filled questionnaires to their respective DPOs or SOs as the case may be. The administration of the questionnaires and collection of data took an average of ten weeks. Only data from 302 respondents were used for the analysis. The other questionnaires were either unfilled or incompletely filled.

For the participants in the exit interview, the researcher got permission from herbal vendors who sell *jedi* drinks on a large scale to people to conduct interviews for their customers. Apart from that, the researcher solicited for the customers' consents and interviewed qualified customers at the purchasing points. In order to incorporate all eligible customers, the researcher read the questionnaires to them and filled in their responses especially for customers who had no formal education. The administration and collection of the questionnaires took four weekends. Data from 98 respondents were used for analysis in this category.

Also, five key informants were interviewed including three herbal vendors were interviewed, each from Ibadan, Ogbomosho and Oyo town. The interviews were conducted in Yoruba language, after herbal vendors gave their consents for the exercise. Also, two physicians from the Nigeria Police Force Medical Centre Oyo State Command were interviewed. One of them was from Ibadan medical centre and the other one was from Ogbomosho Centre. Finally, all activities involved in data collection took ten weeks because the activities were carried out concurrently.

3.1.6 RESEARCH INSTRUMENTS

In this study, both quantitative and qualitative instruments were used in the collection of the data. For quantitative instruments, two reworded structured questionnaires were used for the survey. First version of the questionnaires was administered to the members of the Nigeria Police Force and the other version was used in the exit interview. The questions were open and closed ended to retrieve necessary and relevant information for the study. Also, interview guides were developed for key informant interviews.

3.2 ETHICAL CONSIDERATIONS

This research involves human subjects, therefore principles that herald world best practices were adopted. The four cardinal principles, according to *the International Mandate* of 1974 which include, respect for persons, beneficence, non-maleficence and justice were adopted.

The consent of Nigeria Police Force Oyo State Command was sought before the study commenced. Respondents participated out of their free will.

For clearer understanding, English and Yoruba languages were used to conduct the In-depth Interviews and Exit Interviews as situations demanded.

3.3 PROBLEMS ENCOUNTERED IN DATA COLLECTION

This study faced different challenges in the course of data collection. First, it was a tedious exercise to secure the permission to conduct the study among the Nigeria Police Force Oyo State Command. This was as a result of bureaucratic procedures and nonchalant disposition of some officers. Thus the researcher visited their State Headquarters several times before the permission was finally granted. Secondly, at the Area Command level, one administrative officer especially in one of the Area Commands, overtly displayed his reservation about the work and was unwilling to mail the questionnaires to the widely dispersed divisional headquarters under their jurisdiction. After much persuasion from the researcher, the officer sent the questionnaires to very few divisional headquarters. The retrieval of those questionnaires was possible not until several phone calls and visitations were made. In another area command, the administrative officer could not recall some divisional headquarters where he mailed some of the questionnaires. These disallowed proper follow-up of the questionnaire and eventually delayed the work. More expenses were incurred in travelling and reprinting of questionnaires. Thus, these reduce response rate of the questionnaires to 89%.

Thirdly, exit interviews were conducted at the point of purchase of herbal drink to treat haemorrhoids, where many of the customers smoke. This exposed the researcher to smoke-filled environment which could be detrimental to health. Also, there was high demand for incentives which the researcher could not afford; however, some willingly responded to the questionnaires without any expectation of reward.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 INTRODUCTION

A total number of 600 well-structured questionnaires were distributed to the respondents. The questionnaires were directly administered and mailed to members of Divisional Headquarters of Nigeria Police Force in Oyo State, Nigeria. Since some of the questionnaires were mailed, 359 questionnaires were retrieved, out of which three hundred and two (302) questionnaires were properly filled. These questionnaires were used for the analysis in this category.

Furthermore, ninety-eight exit interviews (EIs) were conducted for those who patronised herbal vendor, coupled with five key informant interviews (KIIs) conducted among experienced medical practitioners and herbal vendors. The inclusion of EIs and KIIs was primarily based on the respondents' willingness to share their perceptions about haemorrhoids.

Quantitative data were edited and cleaned to eliminate inconsistencies that could undermine validity. Therefore, 302 structured questionnaires and 98 exit interviews were coded differently and finally analysed with Statistical Package for the Social Science (SPSS) version 21. Qualitative data were analysed using a computer software -Alas ti 6.2. The process began with transcription and translation of computer recordings from the key informant interviews. The next stage involved coding of response relevant to the objective of the study. The software helped in quick retrieval of quotes relevant to the study.

This chapter presents the result of the study and juxtaposes the findings with the previous studies. Both qualitative and quantitative results were jointly presented. The presentation

includes the following: descriptive statistics of frequency counts and percentages were computed for demographic variables and two of the research questions; the inferential statistics of association and difference were used to analyse other two research questions at 0.05 alpha level of confidence. The demographic results and the summary of the observations were presented in tables. Interpretation and discussion were done alongside of each table for easy understanding under the following sections:

- Section A is for socio-demographic data presentation.
- Section B is for the perception on haemorrhoids.
- Section C is for hypotheses testing and interpretations.
- Section D is for discussion of findings on the objectives of the study.

4.1 SECTION A: SOCIO-DEMOGRAPHIC DATA PRESENTATION

Table 4.1 shows the sex distribution of the respondent. About 67% of the respondents were male, while 33% were female. The predominance of male officers in the sample is borne out by the fact that more men than female are engaged in the Nigeria Police Force. Therefore, male officers constitute the majority of the respondents in this work.

Table 4.1 Percentage Distribution of Respondents According to Sex

Sex	Frequency	Percentage
Male	203	67.2
Female	99	32.8
Total	302	100

The religious affiliation of the respondents is presented in Table 4.2. The Christian police respondents constituted 74.8 percent, 23.5% were Moslems while the traditional worshippers among them recorded less than 2% of the total police respondents. The Christian officers recorded highest percentage in the study.

Table 4.2 Percentage Distribution of Respondents According to Religion

Religion	Frequency	Percentage

Christianity	226	74.8
Moslem	71	23.5
Traditional Religion	5	1.7
Total	302	100

The percentage distribution of the respondents with respect to marital status is presented in Table 4.3. More than 78% of the respondents were married while slightly above 20% were still unmarried. About 0.3% of the respondents cohabited and 0.7% were divorced. The majority of the respondents have conjugal partners. This depicts that larger proportion of the respondents were adults.

Table 4.3 Percentage Distribution of Respondents According to Marital Status

Marital Status	**Frequency**	**Percentage**
Cohabit	1	0.3
Divorced	2	0.7
Married	236	78.1
Single	63	20.9
Total	302	100

Table 4.4 displays the ethnic composition of the respondents. As expected, a large majority of the respondents were of Yoruba extraction representing about 82% of the sample population, considering that Oyo State is predominantly inhabited by the Yoruba. The Igbo and the Hausa were 11% and 6% of the respondents respectively.

Table 4.4 Percentage Distribution of Respondents According to Ethnic Group

Ethnic Group	**Frequency**	**Percentage**
Hausa	20	6.6
Igbo	35	11.6
Yoruba	247	81.8
Total	302	100

The educational attainment of the respondents is given in Table 4.5. It indicates that the majority (46.7%) of the police respondents had either Nigeria Certificate in Education (NCE) or Ordinary National Diploma (OND) and 28 percent obtained Senior School Certificates. Nearly 23 percent of the respondents were graduates, while 1.7 percent had postgraduate degrees. Only 1 percent of the total respondents have attended only primary school. In other words, there are more graduates among Nigeria Police officers than before now.

Table 4.5 Percentage Distribution of Respondents According to Educational level

Educational Level	Frequency	Percentage
Primary	3	1.0
Secondary	84	27.8
NCE/OND	141	46.7
HND/Degree	69	22.8
Masters/Ph.D	5	1.7
Total	302	100

With respect to age of the respondents, Figure 4.1 reveals that more than 44% of the respondents were between 30-39 years and 29.5% were around 20-29 years. Police respondents whose ages are between 40-49 years were 18.9 percent, while 6.6% were aged 50-59 years. Less than 1 percent of the respondents represent were elderly who are sixty years and above. The mean age is 34 years. Thus the age of the majority of the respondents ranges from 20-39 years.

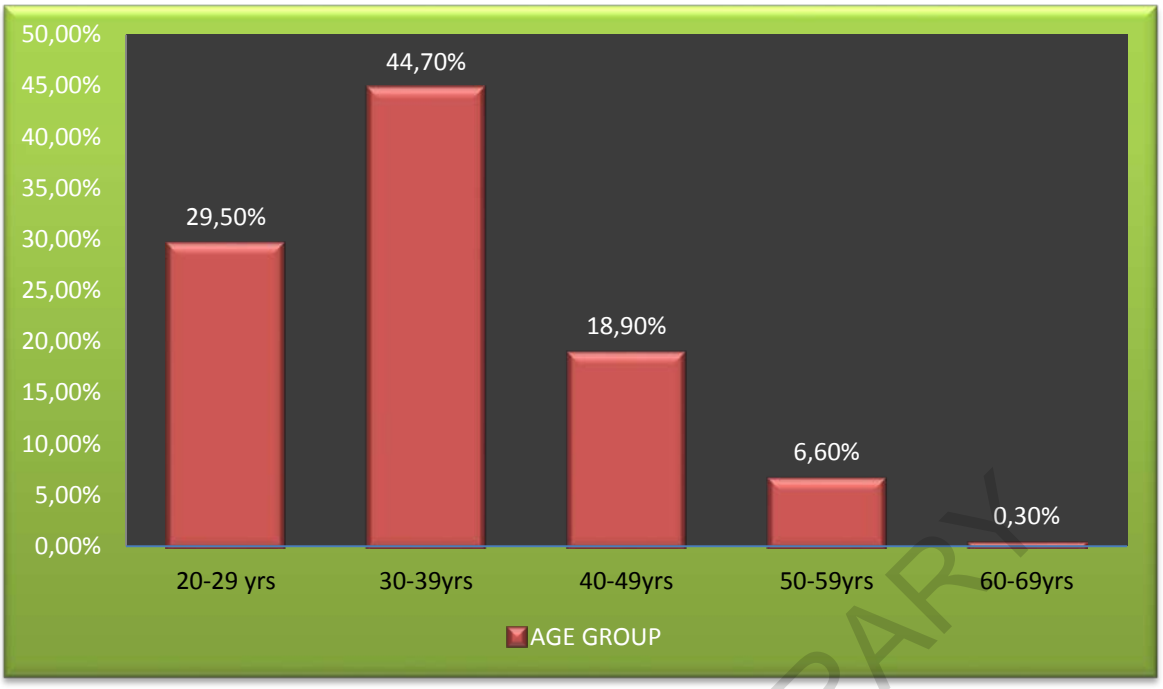


Figure 4.1 Percentage Distribution of Respondents According to Age

Table 4.6 displays the departmental profile of the respondents. The majority (75.5%) of the respondents are from General Duty Department. About 7.3 percent of the respondents worked in the Administrative Department, while Patrol and Guard; Logistic and Supply, and Juvenile Welfare Centre accounted for less than 1percent each for the study. Only 2 percent of the respondents did not disclose their department. This shows that the majority of police officers are usually engaged in duty posts as circumstance may require.

Table 4.6 Percentage Distribution of Respondents According to Department

Department	Frequency	Percentage
Administration	22	7.3
Detective Crime Bureau	16	5.3
Divisional Traffic Officer	7	2.3
General Duties	228	75.5
Juvenile Welfare Centre	1	0.3
Logistic and Supply	1	0.3
Motor Traffic Detective	8	2.6
Operation	4	1.3
Patrol and Guard	2	0.7
State Investigation Bureau	7	2.3

No response	6	2.0
Total	302	100

Table 4.7 details the rank of the police personnel interviewed in the study. The police officers, whose rank is corporal constituted 41.4 percent of the respondents, while 21 percent were constables. Number of officers in the position of Inspectors and sergeants are close to each other which were 13.2 percent and 13.8 percent respectively. Only few officers represented senior cadre of the Nigeria Police Force in the study. As expected, this depicts pyramidal rank distribution of the police.

Table 4.7 Percentage Distribution of Respondents According to Rank

Rank	Frequency	Percentage
Chief Superintendent of Police	2	0.7
Superintendent of Police	6	2.0
Deputy Superintendent of Police	5	1.7
Assistant Superintendent of Police	12	4.2
Inspector	40	13.2
Sergeant	42	13.8
Corporal	125	41.4
Constable	64	21.0
Undisclosed	6	2.0
Total	302	100

4.2 SECTION B: PERCEPTIONS ON HAEMORRHOIDS

The general awareness of piles among police officers is presented in Table 4.8. As expected, the majority (98%) of the respondents have heard about piles. Only 6 of the respondents heard about piles for the first time during this study. This suggests that the disease is common.

Table 4.8 Percentage Distribution of Respondents by whether or not Police Officers Have Heard about Haemorrhoids

Have you heard about piles?	**Frequency**	**Percentage**
Yes	296	98
No	6	2
Total	302	100

With respect to respondents' illness experience, Table 4.9 presents the dichotomy between respondents who have suffered piles and those who have not. About 73.5% of police respondents have had haemorrhoids before while less than 27% have not. Also, in the exit interviews which cut across all walks of life, 71 percent of the respondents had piles as at the time of the interview while 29 percent did not. This depicts high prevalence of haemorrhoids in the society. Considering the trend of responses from the respondents, it confirms that the majority of people across the society have had haemorrhoids and some people go for herbal medicine for piles without necessarily suffering from the condition.

Table 4.9 Percentage Distribution of Respondents According to Whether They Have Suffered from Pile

Have You Ever Suffered from Pile?	**Frequency**	**Percentage**
Yes	222	73.5
No	80	26.5
Total	302	100

The results for the prevalence of haemorrhoids according to sex are presented in Table 4.10. About 71 percent of the male respondents have had pile before relative to 76.8 percent of the female. Regardless of the fact that female police officers constituted 32.8 percent of the

study, at least 76 percent of them have had pile. This depicts that it somewhat affects more women than men. On the contrary, the results in the exit interview indicate that a majority (97%) of the respondents who affirmed they had pile are male as against 3% of female.

Table 4.10 Percentage Distribution of Respondents by Sex and Whether They Have Pile Before

SEX		Have Had Pile Before		Total
		Yes	No	
Male	Count	146	57	203
	% within Sex	71.9%	28.1%	100.0%
Female	Count	76	23	99
	% within Sex	76.8%	23.2%	100.0%
Total	Count	222	80	302

One of the KII respondents confirmed the prevalence of haemorrhoids among the police with clarification. He said:

> …it so common among all groups but what we notice here in Ogbomosho police hospital… we have more male than female in the system. Therefore before we have 5 females we must have got 20-40 males, thus more male report in this setting. (KIIa, Medical Personnel, Ogbomoso).

This finding points out that it is more common among female folk than male group. Since the prevalence of pile is high among women, there is a need to know how women treat themselves during pile episode, because majority (96%) of those who used herbal medicine for it are male.

Table 4.11 presents the choice of therapies during haemorrhoidal episode. The table indicates that 61% of the police respondents who had piles used only herbal therapy to treat the illness, whereas 30.2% used both herbal and modern treatment when they had piles. Only 1% of the respondents did not use any treatments while 7.7 percent used only modern treatment for piles. It is therefore evident that the majority of the respondents patronise local herbs for the treatment of piles.

Table 4.11 Percentage Distribution of Respondents According to Treatment Used During Haemorrhoidal Episode

Treatments	Frequency	Percentage
Herbal Treatment	135	60.8
Modern Treatment	17	7.7
Both Treatments	67	30.2
None	3	1.0
Total	222	100

Also, both medical practitioners and herbal vendors agreed that there is high patronage for herbal treatment for piles. Their views are as follow:

> …you see we have to be sincere to ourselves, because as soon as we encounter one patient like this, the condition would have escalated and you ask why they were just coming to the hospital. Because by now you were supposed to have noticed it for some time, they would try to cover-up but we got to know that they have visited one local practitioner (KIIa, Male, Medical Personnel, Ogbomoso).

One of the herbal vendors said:

> People consume herbal medicine more than the modern medicine. If one says he has gone to buy metronidazote, it does not really work. What I know metronidazote for is when one is stooling and wants to stop it. If one is having difficulty to defecate, they cannot give any drug from the chemist but we can give them herbal drink or powder which will aid defecation (KII.c, Female, Herbal Vendor, Agbowo).

Indeed, such affirmations depict that the majority of people with haemorrhoids culturally use herbal treatment for pile and this suggests that herbal medicine effectiveness in the treatment of piles.

Figure 4.2 displays respondents' perception of the causes of piles. At least 80 percent of the police respondents believed that substances such as sugar, starch, oil, meat, beverages and sex are responsible for piles. Only 4% correctly reported that the causes of piles are constipation, sitting and standing for long, sedentary lifestyle and low fibre intake. About 9% of the police respondents agreed with both the correct and wrong causes of piles at the same time while 7 percent did not know the causes of haemorrhoids.

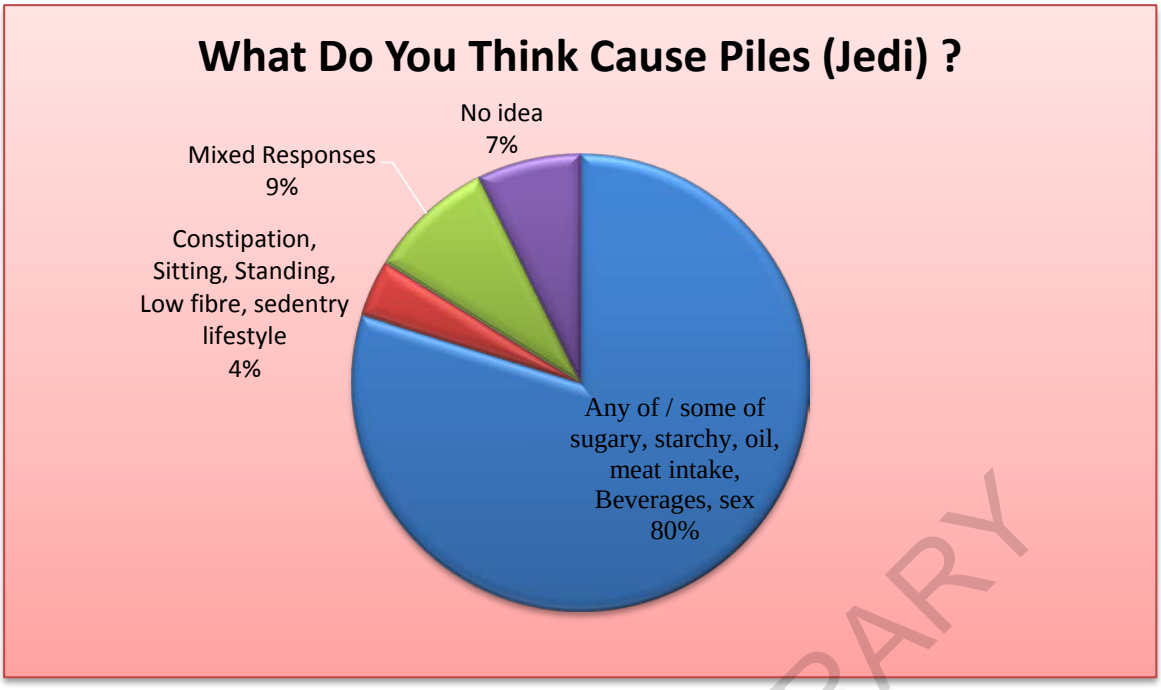


Figure 4.2 Level of Awareness of the Causes of Piles

Accordingly, the results suggest that there is widespread misconception about the risk factors of piles because the majority of the respondents popularly believe that sugary and starchy intake predispose individual to piles.

Exit interview reveals that 97% of the respondents were aware of risk factors for piles. But they exhibited the same general misconception about the causes of piles. The misconception corroborates the views of all herbal vendors interviewed as vividly captured by one of them:

> Many things cause pile; all foods especially solid ones, high carbohydrate concentration. In our place when people want to take pap they add sugar and pap itself contain a lot of carbohydrate, even when some people cook yam they add sugar to it…The love and continuous consumption of red meat and rich tea are good for body but cause piles. (KII.d, Female, Herbal Vendor, Agbowo).

However, the medical doctors in the KIIs had contrary opinion about the risk factors as different from popularly held misconception. One of them noted:

> The risk factors of haemorrhoids are very many especially during pregnancy, nutritional factor, low fibre diet can predispose individuals to haemorrhoid. So also those who are used to straining, straining when passing stool, urine, this also can be a risk factor. People that have cough for a long-time (chronic) which is beyond two weeks can lead to haemorrhoid. Obesity is another factor; people that are obese are prone to

> it. People who sit for a long-time or sedentary lifestyle can lead to haemorrhoids (KII.a, Male, Medical practitioner, Eleyele).

Undoubtedly, the majority of the respondents believe that sugary intake is one major variable that predisposes individuals to piles. This confirms that many people do not usually consult medical doctors during the illness, because if they do, they would be aware of haemorrhoids' risk factors.

Figure 4.3 reveals cultural perception of haemorrhoids by the respondents. More respondents (82.7%) disagreed with the notion that God is responsible for haemorrhoids, relative to 10.6 percent who upheld such notion. Similarly, the majority (85.5%) of the respondents disagreed that sin could cause piles compare to 5.9 percent that agreed. Data on preternatural force as a cause of piles indicate that 82.8 percent of the respondents resisted the view, while 9.2 percent agreed. The results show that few respondents believed that supernatural and preternatural forces cause haemorrhoids, which influence their health-seeking behaviours.

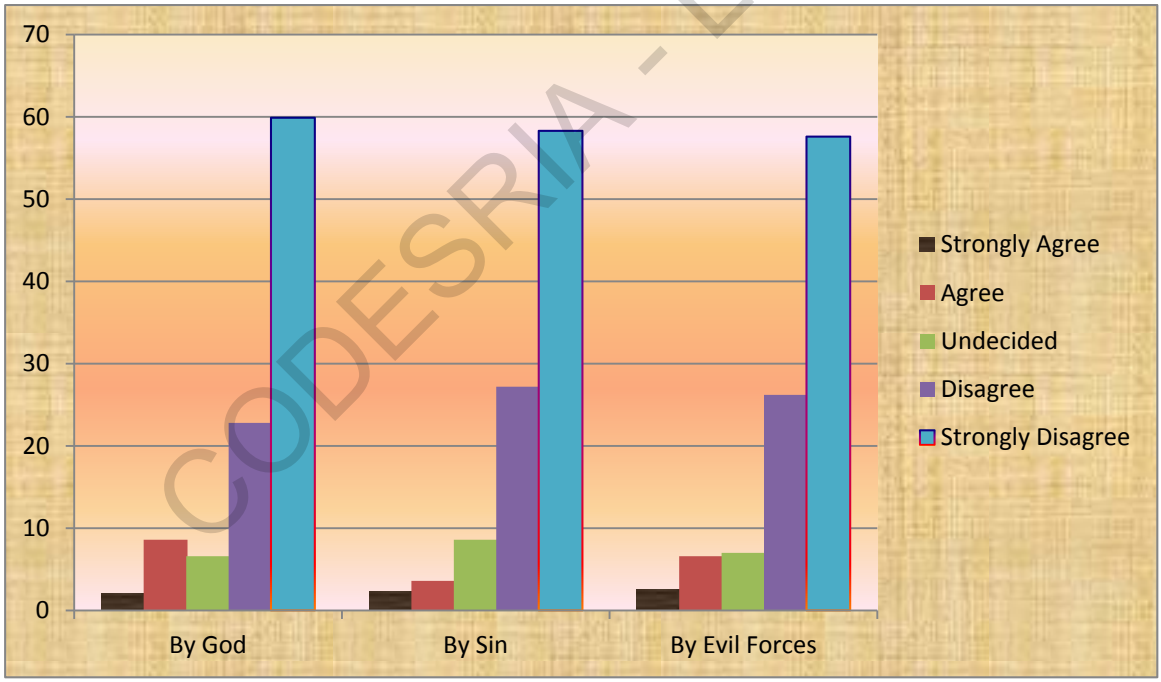


Figure 4.3 The Preternatural and Supernatural Construction of Haemorrhoids

Furthermore, medical practitioners and herbal vendors agree that preternatural and supernatural forces are not responsible for the illness. One of the herbal vendors posits:

> It is not from God although it is part of our body system. It is not caused by supernatural force. No, it's what we eat. For instance, my body system

> dislikes too much oil. If I take it before dusk I will be stooling with stomach pain or upset. There are some things that will not affect one's body. Not caused by sin. But if one goes to party and take beer, rice and meat; piles may occur. (KII.c, Female, Herbal Vendor, Agbowo).

Such statement gives an insight that the majority of the respondents do not believe that metaphysical forces are responsible for their health especially in a disease like haemorrhoids.

The social perception of haemorrhoids by the respondents is revealed in Table 4.12. The results indicate that scores of police respondents (85.1%) agree that haemorrhoid was common while 69.4 percent of the respondents believed that it was common in men compare with 41.9 percent of them who agreed that it was common in women. However, 19.6 and 38.5 percent of the police respondents denied high prevalence among men and women respectively. The majority (73.5%) of the police respondents considered haemorrhoids as a serious disease. The perceived seriousness of pile could be as a result of its effects.

Assessing the effects according to the respondents, 85.7 percent of the police respondents agreed that piles cause backache, while more than 84 percent believed that piles hamper individuals' ability to stand or sit for long, as against 6 percent who believed otherwise. More than 82 percent of the respondents linked poor sexual strength to pile, while at least 79.5 percent opined that piles are in stages. The effects are vividly described by one of the KIIs in the study. She said:

> …it is common among young men because pile can negatively affect their manhood... Some women expecting menstruation may complain of backache then such woman should take *Jedi* drink. It is also good for women who complained of menstrual abdominal pain or backache…especially married man, who used to have many rounds of sexual escalation and could not do that again, would have known that pile has come. Or he gets to a woman and cannot perform. He would have known that the pile is around. In female folks, piles can seize their menstrual cycle, make them unable to sit…Pile can prevent work, if one gets to workplace but cannot sit or stand and remain uncomfortable (KII.e Female, Herbal vendor, Oyo).

In the exit interview, about 38 percent of the respondents asserted that piles caused backache while 28 percent of respondents asserted that pile affected sexual strength of individuals. These statements confirm that a large majority of the respondents erroneously believed that piles affect their sexual strength and backache. Similarly, about 38 percent of the respondents asserted that piles prevented work greatly.

Table 4.12 further indicates that about 69.8 percent of the respondents agreed that haemorrhoidal patients should see a doctor, while 19.2 percent of them disagreed. The latter position allows misconceptions about haemorrhoids to thrive among respondents. Although a large majority (88.1%) of the respondents agreed that haemorrhoids were curable, yet 81 percent of the police respondents indicated that piles reoccur.

Table 4.12 The Percentage Distribution of Respondent According to Social Perception of Haemorrhoids

Are haemorrhoids	SA	A	UND	D	SD	TOTAL
Common	31.1	54.0	3.6	7.9	3.3	100%
Common in men	20.6	48.8	11.0	12.0	7.6	100%
Common in women	8.3	33.6	14.6	28.2	15.3	100%
A Serious Disease	21.5	52.0	5.6	12.6	8.3	100%
Caused by backache	43.5	42.2	7.0	2.7	4.7	100%
An impediment to standing or sitting	34.3	53.0	6.7	1.0	5.0	100%
Affect sexual strength	40.2	42.2	8.0	4.0	5.6	100%
Different stages	32.8	46.7	9.3	5.3	5.6	100%
Patients should see doctor	18.5	51.3	10.9	12.6	6.6	100%
Curable	44.7	43.4	4.0	5.6	2.3	100%
Reoccur	23.9	57.1	18.9	9.0	4.0	100%

Key: **SA** = Strongly Agree; **A** = Agree; **UND** = Undecided; **D** = Disagree; **SD** = Strongly Disagree

Orthodox practitioners in KII had a contrary opinion concerning the variables mentioned. One of them suggested:

> Some people believe it affects their sexual life although it is a wrong notion yet it could affect work causing inability to sit or stand (KII.a Male, Medical practitioner, Eleyele).

In another similar but comprehensive view, he said:

> …directly, it has nothing to do with sexual relationship except when it is not treated. It occurs around the genital area if treated there won't be any problem. But if not treated, you know condition like this, when you add one plus one it gives two and when you add two plus two it gives four that is the way all these conditions work. When single condition sets in, use your vehicle as an example, when your car develops a minor fault that you need to take to the mechanic but you decide not to go to the mechanic, then procrastinate. After that, another fault occurs. However, when you finally take to the mechanic you don't expect to meet the two faults but more faults if you differ it for one year then one should expect many things. This analogy is applicable to haemorrhoids. If the condition starts one week which you are supposed to treat but you do not treat it. There will be comorbidity. If haemorrhoid is not treated it can then affect the sexual life (KII.b Male, Medical practitioner, Ogbomoso).

In sum, respondents agreed that piles affect work and prevent one from standing and sitting for long. But views regarding relationship between pile and poor sexual strength remained a controversial issue between the respondents and herbal vendors on one side, and medical practitioners on the other side.

The shortcoming of social construction of haemorrhoids is its failure to meet scientific definition of haemorrhoid. Thus it reoccurs.

The result of preventive actions adopted by the respondents is displayed in Table 4.13. A high percentage (76.5%) of the police respondents used herbal medicine while less than 24 percent refused to use it. At least 21 percent of the respondents consciously chewed their food. However, the majority (79%) of the respondents did not consider it important to chew their food. About 68 percent of the respondents ate fibre to prevent piles, while 31.8% did

not eat enough fibre. These activities and habitual actions increase respondents' tendencies to develop hemorrhoids.

Table 4.13 The Preventive Measure against Haemorrhoids adopted of the Respondents

Preventive Actions	**Yes**	**No**	**Total**
I use Herbal Medicine always	76.5	23.5	100%
I chew my food	21	79	100%
I eat fibre	68.2	31.8	100%

Figure 4.4 displays how respondents managed haemorrhoids during haemorrhoidal episode. About 34 percent of the police respondents adopted the reduction of sugar, carbohydrate, starchy intake and beverages as the way-out during haemorrhoidal episode. This is followed by 24 percent of the respondents who did nothing when they had piles. Some of the respondents used home treatment. About 15 percent of the respondents opted for herbs (*scent leaves*) and 11 percent used drugs, medical advice and check-up. Few respondents (2%) adopted both types of home treatments. Equally, 2 percent of the respondents endured and engaged in prayer during piles episodes.

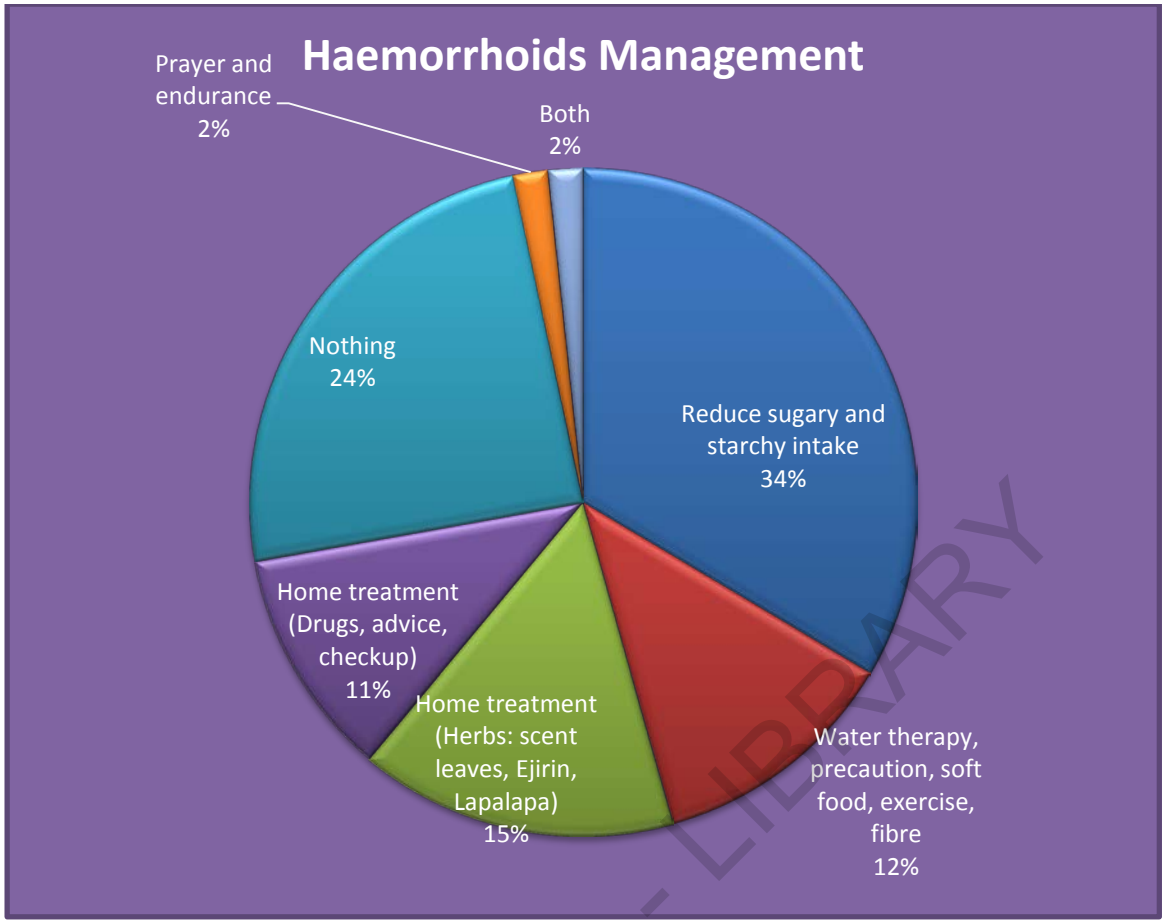


Figure 4.4 Management Used During Haemorrhoidal Episode

Furthermore, the exit interview points out that 82.1 percent of the respondents who patronised herbal vendors did one thing or the other whenever they had haemorrhoids, while 17.9 percent maintained they did nothing during haemorrhoidal episode.

In same vein, one of the medical practitioners said:

> This is based on what we have heard from them. What is so much common in this region, everybody must have tried one thing at home which is not exclusive to haemorrhoids alone, 'home remedies', self-medication' maybe this thing will work, let me take this'. Based on the report we heard from them some have consulted the herbal vendors for remedies that will tell them the herbs to get such as scent leaves etc. squeeze it, extract liquid and drink it. Some expose their anus to hot flames or liquid as a way of controlling because it starts gradually. Some are encouraged to observe personal hygiene because of the itching around anus. Some keep trying until it becomes unbearable (KII.b Male, Medical practitioner, Ogbomoso).

Above all, the majority of the respondents would have developed and adopted at least one management style. However, few of the respondents did not use any therapy before visiting either herbal vendors or medical practitioners.

Table 4.14 examines the influence of religion on the usage of herbal medicine among police respondents. The table indicates that a large majority (92%) of the Christian police respondents and more than 97 percent of Moslem police respondents used herbal treatment for pile. As expected, 100% of police respondents who practised traditional religion used herbal medicine. Results from exit interview on religious influence and the use of herbal medicine for pile among respondents corroborated the result in the Table 4.14. Consequentially, the associational test (p-value> 0.05) confirmed that there is no significant relationship between religion of the officers and the use of herbal therapy. Therefore, this suggests that religion does not influence the use of herbal medicine among patients.

Table 4.14 The Influence of Religion on the Use of Traditional Therapy for Haemorrhoids among Police Officers

Religion	Do you use herbal medicine for jedijedi		Total
	Yes	No	
Christianity	207	18	225
	92.0%	8.0%	100.0%
Moslem	67	2	69
	97.1%	2.9%	100.0%
Traditional religion	5	0	5
	100.0%	0.0%	100.0%
Total	279	20	299

Pearson Chi-Square (df) 2.566 (2)
Significant Level 0.277

Table 4.15 presents the preference of different types of herbal treatments among officers according to their religions. About 69.1% of the Christian officers preferred herbal drink for piles, compared with 67.2% of Moslem officers who indicated their preference for herbal drink to treat piles. The result indicates that the majority of the respondents preferred herbal drink for pile to herbal powder for pile regardless of their religious affiliations. This connotes that there is no significant relationship (P-value>0.05) between the type of herbal therapy used by officers and their religion.

Table 4.15 The Religious Influence on the Type of Herbal Treatments Preferred by the Police Respondents

Religion	Preference in Types of Herbal Treatments			Total
	Herbal Powder (Agunmu)	Herbal drinks (Agbo-jedi)	both	
Christianity	48	143	16	207
	23.2%	69.1%	7.7%	100.0%
Moslem	20	45	2	67
	29.9%	67.2%	3.0%	100.0%
Traditional religion	1	3	1	5
	20.0%	60.0%	20.0%	100.0%
Total	69	191	19	279
Pearson Chi-Square (df)	4.009 (4)			
Significant Level	0.405			

Table 4.16 displays the religious influence on the usage of *jedi* drinks with alcohol among officers. More than 67 percent of the Christian police respondents and about 76.6 percent of the Moslem police respondents opted for *Jedi* drinks without alcohol while about 75 percent of the police respondents who practised traditional religion used both *jedi* drinks.

Table 4.16 The Religious Influence on the Types of Herbal Drink Preferred among the Police Respondents

Religion	If Agbo-jedi, which one do you prefer?			Total
	Agbo-jedi with water alone	Agbo-jedi with alcohol	Both	
Christianity	107	24	28	159
	67.3%	15.1%	17.6%	100.0%
Moslem	36	4	7	47
	76.6%	8.5%	14.9%	100.0%
Traditional religion	1	0	3	4
	25.0%	0.0%	75.0%	100.0%
Total	144	28	38	210
Pearson Chi-Square (df)	16.677 (4)			
Significant Level	0.029			

The associational test reveals that there is a significant relationship (P-value<0.05) between religious affiliation of the officers and the type of herbal drink preferred for the treatment of

pile. This depicts that the majority of the respondents adhere to religious injunctions about alcoholism.

In the key informant interviews, one of the herbal vendors said:

> They like both of them. We have the herbal drink prepared with water because of customers who do not take alcohol. Some of them will not even use the same cup we used to serve *jedi* drinks with alcohol. Everybody buys what he/she likes. People who take beer before will not refuse *jedi* drinks prepared with alcohol.

The statement suggests that herbal vendor use alcohol to prepare herbal drinks for piles in order to sustain the patronage of those who like alcohol. Therefore, religious adherence of the respondents may not necessarily be the only factor responsible for the type of herbal drinks patients would use during illness episode.

Table 4.17 shows the implications of haemorrhoids on respondents' work. The table indicates that at least 69.9% of the respondents opined that haemorrhoids affected work negatively while 20.9 percent claimed otherwise. Also, about half of the police respondents (45%) believed that they could continue with their daily duties at work even if when they had piles. More than 43% of the respondents could not continue to carry out their duties if they had pile, while 11.6% could not decide their position if such ailment would affect them.

Table 4.17 The Perception of Effects of Haemorrhoids on Work by the Respondents

Haemorrhoids	SA %	A %	UND %	D %	SD %
Affect work negatively	19.2	50.7	9.9	11.3	8.9
But I can continue my work	7.3	37.7	11.6	24.2	19.2

Key: **SA** = Strongly Agree; **A** = Agree; **UND** = Undecided; **D** = Disagree; **SD** = Strongly Disagree

From one of the KIIs, an interviewee stated:

> It will not only disturb your work but many things. For instance, if individual with severe pile is coming your way, it will be difficult for you to allow such individual to sit with you. It can be embarrassing! It will definitely affect many things. That person will not be able to carry out some daily activities (KII.b, Male Medical practitioner, Ogbomoso).

Despite the fact that the majority of the respondents asserted that haemorrhoids affected work and disturbed other social activities, many of them also submitted that they would continue their work. This suggests that they regarded piles as serious enough to hinder their work.

4.3 SECTION C: TEST OF HYPOTHESES AND INTERPRETATION

This section presents the test of association using Chi-square and the test of difference using T-test. In all, five hypotheses were tested, four of which tested association while one tested difference among groups based on location.

HYPOTHESIS 1

H_1: The sex of police officers is more likely to influence their perception about the negative effects of haemorrhoids on their work.

H_O: There is no significant relationship between officers' sex and the perception that piles will affect work negatively.

INTERPRETATION AND HYPOTHETICAL DECISION

The outcome of the test of association between the sex of officers and their perception about the effect of pile on their work is presented in Table 4.18.The Chi-square result is 10.832 whereas P-value is 0.029 at 0.05 significant level and the degree of freedom is 4. This associational test reveals that there is a significant relationship between sex of officers and their perception about the adverse effect of piles on work. Consequently, the alternative hypothesis (H_1) is accepted. The table further reveals that majority (74.9) of police respondents submitted that piles affected work adversely compare to 59.6 percent of their female counterparts. This depicts that haemorrhoids hinder more male police respondents than female group from discharging their duties. Invariably, this explains why more men than women sought herbal treatment in the public sphere.

Table 4.18 Test of Association between the Assertion that Piles Affect Work Negatively and Sex Distribution

Sex	Piles affect work negatively					Total
	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	
Male	17	21	13	109	43	203
	8.4%	10.3%	6.4%	53.7%	21.2%	100%
Female	10	13	17	44	15	99
	10.1%	13.1%	17.2%	44.4%	15.2%	100%
Total	27	34	30	153	58	302

Pearson Chi-Square (df) 10.832 (4)
Significant Value 0.029

HYPOTHESIS 2

H_1: Police officers who believe they cannot afford modern treatment are more likely to use traditional treatment to treat piles

H_O: There is no a significant association between the officers' belief in ability to afford a treatment and its usage.

INTERPRETATION AND HYPOTHETICAL DECISION

Table 4.19 displays the result of the test of association between the type of treatment officers could afford and use of herbal treatment among them. The Chi-square result is 43.489 while P-value is 0.000 at 0.05 significant level and the degree of freedom is 2. The associational test depicts that there is a significant relationship between affordability of a treatment and use of herbal treatment for piles among police officers. Consequentially, the null hypothesis (H_O) is rejected and the alternative hypothesis (H_1) is accepted. This shows the intrigues of choice of treatment for piles. Therefore, the affordability of a treatment is one of the major factors that determine choice of therapy.

Table 4.19 Test of Association between Ability to Afford a Treatment and its Usage

Do you use herbal medicine for jedijedi	Which of the treatments for piles can you afford			Total
	Modern Treatments	Traditional Treatments	both	
Yes	44	217	14	275
	16.0%	78.9%	5.1%	100.0%
No	15	3	2	20
	75.0%	15.0%	10.0%	100.0%
Total	59	220	16	295
Pearson Chi-Square (df)	43.489 (2)			
Significant level	0.000			

HYPOTHESIS 3

H_1: The sex of officers is more likely to influence their perception of whether piles influence sexual relation or not.

H_O: There is no significant relationship between sex of officers and the perception that pile affects sexual relation

INTERPRETATION AND HYPOTHETICAL DECISION

Table 4.20 examines the relationship between officers' sex and their perception about the effects of piles on sexual relation. The sexual relation connotes ability to perform effectively during sexual activities. The table indicates that majority (91.6%) of the male police respondents believed that piles affected sexual relation, compared to 76.7 percent of female respondents who agreed with such view. It is evident that men place much emphasis on their sexual ability than women do. Consequentially, the Chi-square result is 16.402 while P-value < 0.05 and the significant level is 0.05 while the degree of freedom is 4. The associational test suggests that there is a significant relationship between officers' sex and their perception as regards effects of piles on sexual relation. Accordingly, hypothetical decision is to accept alternative hypothesis (H_1) and reject the null hypothesis (H_O).

Table 4.20 Test of Association between Sex group and the Perception about Effects of Haemorrhoids on Sexual Relation

Sex	Piles Affect Sexual Relation					Total
	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	
Male	7	3	7	94	92	203
	3.4%	1.5%	3.4%	46.3%	45.3%	100.0%
Female	5	7	11	32	44	99
	5.1%	7.1%	11.1%	32.3%	44.4%	100.0%
Total	12	10	18	126	136	302
Pearson Chi-Square (df)	16.402 (4)					
Significant level	0.003					

HYPOTHESIS 4

H_1: The police officers who perceived surgery for piles as a barrier to the adoption of modern treatment are more likely to use herbal treatment for piles.

H_O: The police officers who perceived surgery for piles as a barrier to the adoption of modern treatment are not likely to use herbal treatment for piles.

INTERPRETATION AND HYPOTHETICAL DECISION

Table 4.21 reveals the result of the relationship between the reservation for surgery to remove piles and the adoption of herbal medicine to treat pile. The Chi-square result is 10.638 while P-value < 0.05 at 95% confident level and the degree of freedom is 1.The associational test depicts that there is a significant relationship between the fear of surgery to remove pile and usage of herbal treatment for piles among police officers. Consequently, the null hypothesis (H_O) is rejected and the alternative hypothesis (H_1) is accepted. This shows that the barriers in treatment of haemorrhoids influenced the choice of treatment for piles. Therefore, treatments with little or no barrier are more likely to be adopted than treatments with many barriers.

Table 4.21 Test of Association between Perception about Surgery for Pile and the Adoption of Herbal Treatment

Do you use herbal medicine for jedijedi	Are you afraid of surgery to remove piles		Total
	Yes	No	
Yes	239	36	275
	86.9%	13.1%	100.0%
No	12	8	20
	60.0%	40.0%	100.0%
Total	251	44	295
Pearson Chi-Square (df)	10.638 (1)		
Significant level	0.001		

4.3.1 DISCUSSION OF FINDINGS

The main objective of this study was to examine socio-cultural explanations of haemorrhoids among the police and to identify cultural misconceptions about haemorrhoids. The working assumption was that the information that an individual has about haemorrhoids will affect his/her health seeking behaviour, preventive measures, and the treatments used during haemorrhoidal episode. Haemorrhoid is a common disease, which emanates from pressure on anal vessels. Various factors are responsible for haemorrhoids. This study found that there was high prevalence of haemorrhoids among the populace especially among female police officers. The study further indicates that more than 76 percent of female officers compared to 71.9 percent of male officers have had piles. Similarly, other studies have found that haemorrhoid is common in women especially during pregnancy (Alonso & Castillejo, 2003; Kaidar-Person *et al*., 2007). However, the exit interview revealed that very few women (4%) sought herbal treatment in the public sphere. There are two tenable explanations for that observation. First, females are afraid to seek herbal vendors publicly because the environment is usually dominated by male. Alternatively, as suggested by Cleator and Cleator (2010), it connotes that females tolerate pile without treatments more than males.

Scholars have found that many factors can predispose individuals to pile, which include constipation, anal sex, obesity among others and there are misconceptions about haemorrhoids. This study has identified the misconceptions about the factors responsible for piles, as the majority of the respondents opined that sugary and starchy intakes, meat,

beverages etc. cause haemorrhoids (see figure 4.2).The study observed that more than 80% of the police respondents upheld that misconception about the risk factors for haemorrhoids compared to 4% that are fully aware of the actual risk factors. This level of misconception may be as a result of indigenous knowledge which influences the cultural definition of piles handled down from one generation to the other. As noted in the study, the herbal vendors interviewed, upheld the same misconception about piles. In previous studies, Pelto and Gretel (1990) and Jegede (2002) found that illness is culturally defined. As a result, people tend to evaluate their health status and explain their present health challenges based on the accumulated cultural knowledge. This implies that a large majority may continue to suffer from the recurrence of piles.

From the available literature, no study has established or clarified the relationship that exists between sugar and piles. Olateju (2009) only explained how herbal vendors stylishly cajole their unsuspecting customers but he did not draw a relationship between sugar intake and piles. The medical doctors interviewed, asserted that sugary intake has no scientific backing to support it as a risk factor for haemorrhoids but that it can only aggravate bleeding by disallowing the healing process because bacteria thrive on sugary surface. As noted in the study, herbal vendors opined that physicians only treat symptoms of haemorrhoids but herbal medicine goes to the source of haemorrhoids. The latter opinion may suggest that there are inadequacies in the orthodox treatments and procedures for pile. This corroborates the finding of Cleator and Cleator in 2010, when they concluded that the treatment of haemorrhoid is often unsatisfactory due to recurrence or complication.

Studies have indicated that symptoms of haemorrhoids include painful defecation, bleeding, blood stain on stool and feeling of incomplete defecation and piles allow for comorbidity of symptoms (Pare *et al*., 2001; WGO, 2007; HIST, 2009). In this study, the respondents identified multiple symptoms for piles which include sexual problem (including weak erection, early ejaculation during sex, reduction in the size of manhood and impotent tendency); backache, waist pain, stooling, difficulty in stooling; blood-stained stool, inability to sit or stand for long time; stomach upset and pain; painful menstruation and poor libido in women. Therefore, the opinions of the respondents about the symptoms of the illness cover the symptoms of other diseases, thus some of the respondents were suffering from some other diseases which they did not know. As noted in the study, this lack of awareness cuts across all demographic characteristics of the respondents, since the majority of respondents gave

multiple symptoms to describe piles. This probably explains further other dimensions of misconception about haemorrhoids.

In addition, the study observes that misconceptions about the causes and effects of pile influence treatment sought by the respondents. The majority of the respondents who believed in a causal-effect relationship between sugary intake and haemorrhoids usually avoided sugary substances as a first precaution during haemorrhoidal disease; and they opted for bitter substances such as bitter leaves before they sought any medical help or herbal medicine. In the same vein, respondents who believed that piles affected their sexual strength tended to avoid sugar; and preferred mixed herbal drink which would contain sex enhancing content (*Ale and Afato*), antimalarial content (*Iba*) and *jedi* content in order to aid sexual strength and treat piles. It is suggested, therefore that since there are misconceptions about the factors that are responsible for haemorrhoids; it would be very difficult to prevent piles. The survey reveals that 29 percent of the respondents who use *jedi* herbal medicine did not notice any symptom of haemorrhoids in their bodies. This observation corroborates a study by Oreagba *et al*. (2011), who found that 20 percent of those who consume herbal medicine (*agbo*) use it for no specific reason.

With respect to the effects of piles, the study found that most of the respondents complained that haemorrhoid affected their sexual life and the associational test indicated that there was a significant relationship between officers' sex and their perception as regards effects of piles on sexual relation. About 91 percent of male respondents and 76.7 percent of female stated that piles preclude their sexual relation. This suggests that the society places much emphasis on the sexual ability of men and probably men are usually exposed to more strenuous work than women. Also, the respondents stated that pile was responsible for backache and negatively affected work. This study shows that 86.1 percent of male and 84.9 percent of female respondents believed that piles cause backache which eventually affected work. The associational test reveals that there was a significant relationship between sex of officers and their perception about the adverse effect of piles on work. Straining is one major risk factor for piles. Strenuous work dovetails with stress condition. The findings suggest that there was a tripodal relationship between stressful work, backache and sexual life. Research has shown that backache affects the self-esteem of males, especially during sexual intercourse (Concordia University Health Services, 2013). The majority of the respondents did not know that the same risk factors that cause piles are also responsible for backache and sexual weakness. For example, people may not understand that standing and sitting for long are

usually stressful which will affect the spinal cord and put pressure on the anal cushion. Therefore, people with haemorrhoids tend to notice the backache, sexual weakness and pile at the same time, and then they tend to assume piles cause backache and sexual problems.

Considering the economic and health burdens of haemorrhoids on the patients, the study notes that at least 70% of the police respondents disclosed that pile affected their work negatively and 55% perceived that it would prevent them from working. This explains that official responsibilities are sometimes inimical to health condition of the employee. Specifically, about 42% of male and 56% of female respondents would continue with their work, whereas 72% of male and 66% of female respondents advised that patient suffering from pile should consult a doctor. However, the study further reveals that 82% of male and 70% of female police respondents who have had pile preferred traditional treatments. Their decision is in line with the treatment they can afford. For instance 77% of male and 70% of female police respondents could only afford traditional therapies. Previous studies established that there is high level of patronage for herbal medicine and recommended herbal medicine for patient as a result of its cost effectiveness (WHOb, 2003; Li *et al*., 2013). Consequently, this finding points out that preference for traditional medicine to treat piles is borne out of their ability to afford it.

From the key informant interview, there is disparity in social construction of piles between medical doctors and herbal vendors as regards its effects on sexual relation. In the conception of medical practitioners, pile does not have anything to do with sexual strength. On the contrary, there was a consensus among all the herbal vendors that pile is a bane to sexual escalades coupled with impotence. Also, the study notes that the majority of respondents perceived that it is impossible to prevent haemorrhoid in as much as individuals cannot do without food. This conclusion emerges from the cultural misconception about the risk factors for haemorrhoid. Since culture is relevant in health definition, the conception of piles by the respondents is identical with herbal vendors' view about piles. Hence, the respondents perceived that only the herbal vendors understand their explanation of haemorrhoids which make them believe that herbal therapy is cultural and natural.

From the study, there are different treatments and procedures for pile but only very few respondents know more than the conventional medicine (across-the-counter drugs and haemorrhoidectomy) and herbal treatments (herbal drinks and powder). Previous studies on modern treatments for haemorrhoid have identified and brought to notice the therapies at the

disposal of haemorrhoidal patients (Halverson 2007; Feldstein & Kay, 2009; Alatise *et al*., 2009; Giamundo, 2011). Similarly, there are other herbal therapies which generally remain unknown. The exit interviews reveal that there is a cigarette for haemorrhoids although its efficacy is still questionable. Also, all of the herbal vendors stated that there is a special powder which patients with protruding internal haemorrhoid can apply on stool after defecation for it to relapse. This suggests that many of the respondents do not make necessary enquiry about the other available therapies and procedure probably the respondents have not received objective information about pile management because the associational test depicts that there is a significant relationship between the fear of surgery to remove pile and unprecedented patronage for *jedi* herbal treatment among police officers.

The study indicates that respondents used herbal medicine for pile regardless of their religious affinities. In the study, 92 percent of Christian respondents and 97 percent of Moslem respondents used herbal medicine during haemorrhoidal episode. However, none of the respondents who practise traditional religion used modern procedure for piles. Erinosho (1998), Gureje *et al*. (2005) and Jegede (2010) have identified social cultural perceptive to illness, which are natural, preternatural, supernatural and hereditary. The study found that the majority of the respondents did not believe in preternatural and supernatural causes of haemorrhoids but they stated that haemorrhoid is a natural disease. Contrary to previous studies by Teshome-Bahiru (2004) and Jegede (2010), the study found that despite the fact that the majority of the respondents perceive piles as natural disease, they patronize herbal vendors during illness episodes. The finding suggests that conglomeration of factors might have influenced their choice of therapy.

The study found that there are two kinds of herbal drinks for piles which depend on whether it is prepared with water or alcohol (hot drink). At least 28 percent of the respondents preferred herbal drink with alcohol while about 36 percent of the respondents used herbal drinks with water. Considering the influence of religious affiliation on the consumption of alcohol among the respondents, the associational test reveals that the relationship was not significant. Thus the respondents have different reasons for the use of particular type of *jedi* herbal drinks. The reasons include: effectiveness, pace of reaction, to be psychologically high, or sexually active.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 SUMMARY

The research work focused on the issues relating to social explanation of haemorrhoid, its causes, its prevention and management developed over time among the Nigeria Police Force Oyo State Command. Pile is a common and recurring illness regardless of sex, driven by misconceptions depicting socio-cultural explanation of haemorrhoid. Haemorrhoid occurrence cuts across cultural enclaves. However, as a result of its high prevalence everybody has individual perception which culminates into divergent social definitions of haemorrhoid.

The study population was the members of the Nigeria Police Force from the four area Commands in Oyo state to include Iyaganku, Agodi, Oyo and Ogbomoso as well as those who patronised herbal vendors to treat haemorrhoids. Also, medical practitioners and herbal vendors were part of the study population. Data collected were carefully analysed in descriptive presentation which included tables and charts; and inferential explanation of social construction of piles.

The findings from the field work revealed that the prevalence of haemorrhoids is higher in Nigeria Police Force compared to the combination of people from all walks of life who sought herbal treatment. The prevalence rate is 73.5 percent among members of the police force while the rate among other group is 71 percent. The prevalence rate does not exempt any form of demographic dimension such as sex, rank, marital status, religion and location. Some of the people believed it is natural while majority confirmed that everybody has them.

Also, the level of awareness of the risk factors is very low. Less than 4 percent of respondents mentioned at least one of the correct risk factors of haemorrhoids. The risk factors identified by the population of the study are quite different from the medically accepted risk factors. Sugar intake was perceived to be responsible for piles but no known article or research work has established a relationship between sugar and piles. The outcome of such misconception includes: wrong management developed; allowance of disease comorbidity; wrong treatment; health impairment and ultimately the cost of time and resources committed to treatment. Nevertheless, the social and economic cost of this misconception cannot be overemphasized.

People developed management of the disease that has nothing to do with haemorrhoids which would not yield any positive result. For instance, anytime the respondents perceived haemorrhoids the first aid would be avoidance or reduction of sugar intake. In the study about 34 percent of the respondents who reduced sugar intake during haemorrhoidal episodes were somewhat better than those who did not act during illness. The improvement in their health could be as a result of other social activities they practised during illness episode which they might not be conscious of. This suggests that when patients do not know the risk factors of an illness, the prevention of such illness remains an impossible task. The position is evident in the study because few respondents that understood the risk factors did not perceive haemorrhoids as an inevitable disease.

Effects of piles are controversial; the effects of pile by the respondents are more encompassing than the actual side effects of haemorrhoid according to literature. The effects of piles mentioned by respondents included farts, sexual problems, backache; and inability to sit or stand for a long time, stained stool, stooling, difficulty in stooling etc. However, some of those symptoms occurred as a result of the presence of risk factors for haemorrhoids. People are not aware that the risk factors for piles such as long standing and sitting and straining may lead to backache. This suggests that patients with multiple symptoms of haemorrhoid should go for comprehensive medical check-up.

With respect to treatment of pile, there were many factors that determined the preference and choice of treatment. The respondents considered various factors before choice of treatment was made. The factors include cost of treatment, proximity, ease of usage; the belief that a treatment is cultural and natural or foreign and synthesized; and fear of haemorrhoidectomy not necessarily as a result of personal experience but antecedence and anticipated complications. However, religious affiliation of respondents did not influence their preference and choice of treatment. Thus people tend to seek healthcare from practitioners who have the same perception of the illness. As noted in the study, large majority of the respondents most times chose healthcare systems in which they were not fully aware of all procedures and treatments available in such system. In traditional healthcare, for instance, there are two therapies- herbal powder and pile smoke- which remained largely unknown to the majority of respondents. Similarly, the majority of respondents were only aware of some of the across-the-counter drugs and haemorrhoidectomy but they did not know other therapies and procedures for haemorrhoids. These therapies and procedures are not exhaustive but include infrared coagulation, sclerosis, rubber band ligation, tropical therapy among others.

This indicates that patients with haemorrhoids have not fully utilized the medical options available for pile treatment.

The social construction of haemorrhoids influenced the respondents' perception about preventive measures for pile. Culturally, some of the respondents believed it is impossible to prevent haemorrhoids in as much as the risk factors are unavoidable in their daily living. The majority of respondents opined that pile is as a result of food consumption and these foods are limited. Therefore they believed that individuals cannot effectively prevent pile. This position stands as justification for the recurrence of haemorrhoid in its victims.

As expected the herbal practitioners uphold the social construction of pile both in its conception and effects. They identified sugar as a major cause of pile and opined that sexual and menstrual problems are a result of pile. However, the medical practitioners have a contrary opinion about haemorrhoid; they explained the interplay among factors that lead to haemorrhoid. It is evident that medical education for herbal vendors is necessary in order to enlighten the herbal vendor about pile and other diseases.

5.2 IMPLICATION

Based on the findings, the poor knowledge about haemorrhoids is pervasive among the police officers and the general populace. This level of awareness necessitates the need for comprehensive and objective understanding of piles and its causes, effects and available therapies, because until people understand its risk factors and effects, the available therapies and the management may be of no effect. This depicts that individuals with inadequate knowledge of haemorrhoid will have challenges in identifying some of the symptoms and to act appropriately.

Furthermore, patients living with haemorrhoids are likely to have aggravated and recurring illness episodes because of their low level of awareness about piles. Considering the level of knowledge about haemorrhoids, and actions taken to alleviate the illness condition are like to be futile.

From the study, the respondents did not pay much attention to stress in the workplace and other strenuous activities encountered in their life course. The negligence predisposes the respondents to continuous stress with attendant effects. Similarly, research has posited that

people who are continuously engaged in strenuous activities, put their health at stake (Haines, 2003). This will eventually lead to haemorrhoids. By implication, if people will not adhere to better lifestyle which includes exercise, fibre intake, etc. individuals may not be able to prevent haemorrhoids.

The study notes that there are rivalries between medical practitioners and herbal vendors. They have areas of conflicting interests over haemorrhoids. Medical practitioners could not fathom the traditional explanation of haemorrhoids whereas herbal vendors believe that orthodox medicine only treats symptoms of piles which allows for the recurrence of haemorrhoid. This suggests that patients are usually confused of which of the therapies is effective to treat pile especially when it becomes problematic. Also, patients cannot make the maximum use of the available therapies for pile when these therapies are not known. From the study, the healthcare systems offer different remedies for pile, but many of these therapies remain unknown to the general populace.

Ultimately, the extent to which haemorrhoids affect work may be difficult to ascertain in a situation where most people covertly manage the health challenges based on the limited knowledge about haemorrhoids. Thus, effects of haemorrhoids will automatically prevent officers' optimum output and efficiency at the workplace. This implies that both patients and work will suffer from the consequence of the illness.

5.3 CONCLUSION

Many people are not likely to be correct at all times in the explanation of their health because human body is complex and its normal functionality depends on systemic interdependent relationship that exists between various organs in the body.

Drawing from research findings, haemorrhoid as a common disease with low mortality tendency is culturally defined. The cultural conception of piles precludes comprehensive understanding of the illness. As a result, there are misconceptions about haemorrhoids. The misconceptions are evident in associated causes, symptoms and perceived effects which are embedded in the socio-cultural explanation of haemorrhoids.

The socio-cultural construction of haemorrhoids has not really helped in the perception of the causes, treatments, management styles developed over times. With respect to perceived

causes of pile, the majority of the respondents have misconception about the cause. They believe that sugar, carbohydrates, meat, tea, oil, beverages and sex are risk factors for piles. On the other hand, few of the respondents have correct knowledge about the causes of piles. They stated that constipation, standing and sitting for long; low fibre intake and sedentary lifestyle are responsible for pile. This explains why pile reoccurs in patients.

Furthermore, the management styles developed by the majority of the respondents during illness were not necessary. For instance, majority of the respondents abstained from or reduced the consumption of sugar, carbohydrates, meat, tea, oil, sex etc. and increased their consumption of bitter substances. This shows that the misconception about the cause of an illness will affect the management styles individuals will develop during illness.

Also, the respondents have poor knowledge about different options in the management of haemorrhoids. Majority of the respondents are not aware of all the therapies and procedures available for the treatment of piles. Despite the fact that the respondents have poor knowledge about the management of haemorrhoids, they have developed both positive and negative beliefs about the few treatments and procedures they know. These beliefs are one of the factors that influence their choice of treatment.

The preference and adoption of any treatment are usually influenced by many factors. In the study, it is concluded that the ability to pay for a treatment will determine preference of therapy and its usage. The findings showed that majority of the respondents who could not afford modern treatment, preferred and opted for herbal medicine. Therefore, if cost of healthcare is expensive, deferment of treatment or usage of substandard therapy is inevitable. Also, people are afraid of surgery. Specifically, the respondents in the study are reserved when it comes to haemorrhoidectomy. The reservation for haemorrhoidectomy is as a result of a belief that it could lead to impotence and death. But such outcomes are rare.

Generally, haemorrhoids affect ability to stand or sit and ultimately preclude work or human activities. The study has drawn a relationship between the sex of police officers and the perception that piles affect work negatively. Haemorrhoids affect men's work and activities more than it does for women. In the same vein, health belief model posited that the more individuals perceive the severity of a disease the more the likelihood such individuals adopt healthier behaviour. This explains why men constitute absolute majority of those who sought herbal medicine for piles in the exit interview. Also, people believe that haemorrhoid affects their sexual strength. The study confirmed that respondents perceived pile as a cause of

sexual problem which includes impotence, poor ejaculation and reduction in the size of manhood. Even though such belief exists among people, it has no scientific support. However, haemorrhoidectomy with complications could be a risk factor for ineffective sexual life.

5.4 RECOMMENDATION

Haemorrhoid is a common disease because everybody has it. Haemorrhoids therefore, constitute a health issue since the study has established that the misconceptions about haemorrhoids influence the health-seeking behaviour among the respondents. In order to utilise the findings and achieve the purpose of the study, the following recommendations are suggested:

To reduce the prevalence rate of haemorrhoids, the mass media such as newspapers, television stations, radio stations etc. should be used to sensitize the general public about the misconceptions about haemorrhoids. The sensitization should entail better preventive measures and effective management of piles. Also, awareness of the available treatments and procedures for pile and the adoption of better preventive and management among the police officers and the general public should be enhanced. This can be achieved through police symposia and public lectures.

The general public should be encouraged to desist from sedentary lifestyle, anal sex, prolonged sitting and standing; and adopt healthier behaviour that will enhance their health. The behaviour includes consumption of fruits and vegetables, whole grains; avoidance of straining; taking break in-between prolonged sitting and standing, and avoidance of continuous stress. This will help prevent haemorrhoids.

Government should maximize human capital resources at her disposal. This will meet some health demands of the populace. Therefore, a heuristic platform should be set for both medical practitioners and herbal practitioners to discuss issues relating to haemorrhoids. This gives herbal vendors a leverage to discuss their findings over the years of experience. The discussion will correct the misconceptions about haemorrhoids and build up a synergy to treat piles among the populace.

Also, occupational safety policy should be reviewed especially job aspects that predispose individuals to straining and stress. This review should extend to Nigeria Police Force in order to reduce their tendency to develop symptomatic haemorrhoids. Thus improvement of their welfare services will enhance effectiveness and efficiency.

At organizational level, the authorities in the workplaces are to review the condition of work. The review should cover sitting position and standing for long, shifting duration, demands of the work which may require straining etc. The organizations should get better seat, allow employees to take break during a prolong standing, and reduce the shift duration.

It is recommended that further studies be carried out on how women manage piles in as much very few of the respondents in exit interview are women and haemorrhoids in other socio-cultural enclaves in Nigeria should be studied. This will elucidate the prevalence of haemorrhoids among the three major ethnic groups in Nigeria and explain their perceptions about piles.

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Apendix1 Questionnaire

Department of Sociology,
Faculty of Social Sciences,
University of Ibadan, Ibadan.
Oyo State.

Dear respondent,

RESEARCH QUESTIONNIARE

Good day. My name is Azeez Abolaji, a research student of University of Ibadan. I am conducting a research on Sociocultural Explanation of Hemorrhoids (*Jedi Jedi*): Causes, Treatments and Preventions among Nigeria Police Force. This research work is part of the requirements for the Msc degree in Sociology.

You have been selected for this study through a scientific procedure, and I will appreciate your participation by responding to the questionnaire. The information collected will be used purely for academic purpose. Your answers will be strictly confidential, and no names will be used in reporting the findings.

Thanks for agreeing to participate.

Yours faithfully,
Azeez, Abolaji

Section A: Demographic data

Please encircle your response and fill in the answers where necessary.

(1) Age, ……

(2) Rank:……..

(3) Department ……

(4) Sex: (1) Male (2) Female

(5) Marital status: (1)Single (2) Married (3) Cohabit (4) Divorced (5) Widowed

(6) Religion: (1) Christianity (2) Moslem (3) Traditional religion (4) Others specify ……

(7) Ethnic group: (1) Yoruba (2) Hausa (3) Igbo (4) Others specify……

(8) What is your educational level? (1)Primary, (2) Secondary, (3) NCE/OND, (4) HND/Degree,
(5)Masters/Phd

(9) How many years have you spent in service……

Section B: the level of awareness about factors responsible for hemorrhoids.

1) Have you heard about pile (jedijedi) before? (1) Yes (2) No
2) Has it affected you before? (1) Yes (2) No

3) If yes? what do you use to treat it……...
4) What do you think cause piles (*Jedi*)? ....., ……., ……..,……,……
……
……
5) Have piles affected your colleague before or now? (1) Yes (2) No
6) If yes, what did he/she say were the causes of *jedijedi*
……
……
……
7) What treatments were used? (1) herbal only, (2) modern medicine only (3) modern medicine and herbal medicine (4) None (5) others specify……..
8) Do piles reoccur? (1)Yes (2) No
9) Name all the treatments and cures for you know:
……
……

Section C: Relationship between Sociocultural Perception of Hemorrhoids and its Prevention.

10) How do you know you or your colleagues have piles (*jedi*)?
……
……
……
11) I can continue with my work even with piles (1)Strongly Disagree (2)Disagree (3)undecided (4) Agree (5) Strongly Agree
12) Pile is from the body (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
13) Piles are from the parents (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
14) I visit doctors whenever I have piles (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
15) I use herbal medicine always to prevent jedijedi (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree

16) Herbal drinks with dry gin for Piles (*Agbo jedi*) are more effective than herbal powder for piles. (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
17) Piles affect work (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
18) Piles affect sexual relation (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
19) I eat enough fibre (e.g fruits and vegetable) (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
20) I do not drink water while eating (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
21) I don't have the time to chew my food when eating (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
22) I cannot afford good food (1) Strongly Agree (2) Agree (3) Undecided (4) Strongly Disagree (5) Disagree

Section D: Differences in Cultural Explanation of Hemorrhoids

23) Piles are serious disease (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
24) Pile is not serious therefore I treat myself whenever I have piles (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
25) Piles can be cured (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
26) Piles are common disease? (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
27) Piles are caused by God? (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
28) Piles are caused by evil power? (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
29) Piles are curable (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree
30) Piles reoccur in the body several times (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree

Section E: Management Styles Used By Persons With Hemorrhoids.

31) What do you do to cope with piles before you seek herbal medicine or modern medicine?

……
……

32) What do people to prevent piles

……

33) Do you take necessary precaution to avoid hemorrhoids (1) Yes (2) No

34) If yes, mention them

……
……
……

Section F: Sociocultural Effects of Hemorrhoids

35) Treatments for piles are costly? (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree

36) Piles affect sexual strength? (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree

37) Piles affect people ability to stand or sit for long? (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree

38) Piles cause backache? (1) Strongly Agree (2) Agree (3) Undecided (4) Disagree (5) Strongly Disagree

39) How do piles affect you?

……
.....
.....
.....

Section G: Factors Responsible for the Choice of Treatment

40) Can you afford all treatments for piles? (1) Yes (2) No

41) Do you use herbal medicine for jedijedi? (1) Yes (2) No

If yes, which of herbal treatments do you prefer? (1) herbal powder (*Agunmu*) (2) Herbal drinks (*Agbo jedi)*

If *Agbo jedi*, which one do you prefer? (1) Agbo jedi with water alone (2) Agbo jedi with alcohol (3) both

Why?.....

.....

.....

42) Are you afraid of surgery to remove piles? (1) Yes (2) No

43) Which treatment do you prefer for piles? (1) Modern medicine (2) Traditional medicine

44) Why do you prefer the one you choose?

.....

.....

45) Mention all treatments of piles (Jedijedi) you know:

……

……..

Appendix 2 Interview Guide for Herbal Vendor and Medical Personnel

Objective 1: The level of awareness about factors responsible for hemorrhoids.

What do people believe cause hemorrhoids?..... Probe God, diabolical, objective cause?

What are the causes of piles? Common in police?

Objective 2: Relationship between sociocultural perception of hemorrhoids and its prevention.

Do you think people prefer herbal medicine to modern medicine?

Why?

Do you think people have preventive measures for piles?

Please describe?

How can individuals prevent hemorrhoids?

Who are those buying your treatments? Male or Female; Educated or non-educated; Rich or Poor, age

Objective 3: Management styles used by persons with hemorrhoids

How do people view/ perceive piles?

Are there misconceptions about piles?

What are the societal misconceptions about piles? : Treatments, causes, effects ?

Objective 4: Management styles

What are the things people with hemorrhoids do before they seek herbal medicine?

How do people keep piles before they seek herbal vendors?

Objective 5: Sociocultural effects of hemorrhoids

What do you think will happen to individuals with hemorrhoids when not treated?

What complains do people with hemorrhoids give?

Is there any societal reaction to people with piles?

Please describe the reaction: marital, work, roles and expectations

Objective 6: Factors responsible for the choice of treatment

What are the factors responsible for the choice of treatment people with piles make?

NB Probe the factors

Apart from *agbo jedijedi* (liquid herb) and *agun mu* (herbal powder) is/are there any other treatment.

Or apart from across-the-counter drugs and surgery is there any treatment

Why do you think people prefer a particular therapy to the other?

Do people prefer multiple or mixed therapies?

Types of herbal medicine e.g. agunmu (herbal powder), agbo jedi with water, or with dry gin.

Which one was the most preferred? Why

Appendix 3 **Questionnaire for Exit Interview:**

Demographic data serial no ( ) location (……)
(A) Sex ? (1) Male (2) Female (B) What is your age? …….
C) Marital status? (1) Single (2) Cohabit (3) Married (4) Divorced/Separated (5) Widowed

(D) Religion? (1) Christianity (2) Moslem (3) Traditional religion (4) Others specify……..

(E) Ethnic group? (1) Yoruba (2) Hausa (3) Igbo (4) Others specify……..

(F) What is your occupation? …….
(G) Educational level? (1) Primary, (2) Secondary, (3) NCE/OND, (4)HND/Degree, (5)Masters/Phd (6) others……..
Obj 1 (H) Do you have piles? (1) Yes (2) No (I) Do you know the causes of piles? (1) Yes (2) No
(J) If yes, what do you believe cause(s) piles? ……..
……
……
(K) Is it caused by God? (1) Yes (2) No (L) Is it caused by evil power? (1) Yes (2) No (L1)Sin? (1) Yes (2) No
Obj 2: (M) How do people perceive piles?……

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(O) Why are you buying *agbo jedi-jedi* or *agunmu?*
….....
(N) What do people used to treat jedi?
…….
Why?.....
……..
(P) Do you prefer herbal medicine to modern? (1) Yes (2) No
If yes, why?
.....
..... (Q) Do you prevent piles? (1) Yes (2) No (q) How?..... (R) Do you drink much water while eating? (1) Yes (2) No (R1) Do you eat fruits and vegetables? (1)Yes (2)No
Obj 3: (S) What does society think about piles?
……
……
(T) What is your view/perception about piles?
.....
.....

Objective 4: (U) Did you do anything to help your health when you have piles? (1) Yes (2) No

(u) If yes, what were the things you did before you sought for herbal medicine?.....

……..……
……

Objective 5: (V) Is there any side effect, if you do not treat piles? (1) Yes (2) No

(v)If yes, what do you think would happen?.....

.....

……..……
……

(W) What do you notice before you came for the herbal medicine?

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.....

Objective 6: Factors responsible for the choice of treatment

(X) Which of the therapies do you prefer? (1) Modern medicine (2) Herbal medicine (3) Both

(x) Why?

……
…….

(Y) Which of the treatment centre(s) is closer to you? (1) Modern medicine (2) Herbal medicine (3) Both

(Z) Which of the treatments do you think is easy-to-use and painless (1) Modern medicine (2) Herbal medicine (3) Both

(ZA)Apart from *Agbo Jedijedi* (liquid herb), *Agumu Jedijedi* (herbal powder), across-the-counter drugs and surgery, is there any other treatment you know? (1)Yes (2) No

(za) If yes, mention them 1……..

2…… 3……

4……. Etc

(ZB) Do you use herbal medicine for jedijedi? (1) Yes (2) No

If yes, which of herbal treatments do you prefer? (1) Herbal powder (*Agunmu*) (2) Herbal drinks (*Agbo jedi)*

If agbo jedi, which one do you prefer? (1) Agbo jedi with water alone (2) Agbo jedi with alcohol (3) both

Why?.....
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