Dissertation

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Utilization of health facilities in the rural areas of Nigeria : a case study of Akinyele local government area of Oyo State

JANUARY : 1989

UTILIZATION OF HEALTH FACILITIES IN THE RURAL AREAS OF NIGERIA: A CASE STUDY OF AKINYELE LOCAL GOVERNMENT AREA OF OYO STATE

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IN
PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE MASTER PHILOSOPHY DEGREE (M.Phil) SOCIOLOGY OF THE UNIVERSITY OF IBADAN, IBADAN NIGERIA

JANUARY, 1989

D E D I C A T I O N

To My Parents: Mr. Rauf Atanda
Mrs. Asmau Abeni

To My Wife: 'Toun, and

To My Sons: 'Tope and 'Tayo

They are a living and concrete memento of yesterday, today and tomorrow.

A C K N O W L E D G E M E N T S

I am very grateful to my indefatigable supervisor Dr. E. A. Oke for spending his precious time and sacrificing his convenience in reading several drafts of this work and straightening it out with several useful suggestions. I am also grateful to Dr. Olu. Akinkoye who believed in my ability. He read a draft of this work and lifted my spirit through kind words at every turn.

I should also thank Chief (Dr.) V. A. Omigbehin for reading a draft of this work.

I also want to acknowledge the financial assistance given by Council for Development of Economic and Social Research in Africa (CODESRIA) which enabled me to carry out (among others) a successful field work.

I want to acknowledge with big thanks, the moral support given me by my senior colleagues Professors Otite and Imoagene and Dr. Jimi Adesina.

It is also appropriate to thank the villagers who, during my field-work, gave me the information - rawmaterials for this study.

I also want to thank my bosom friend 'Dele Olaleye for his excellent secretarial assistance.

Finally, my unfeigned gratitude is registered to the living God of heaven. It is true he allowed a few difficulties to cross my path while doing this work. These perhaps were

designed to humble me and regulate my 'arrival' so that I may arrive just in time for more excellent gifts. At any rate, a more comoforting thing is that he has availed me the courage to be and good health to weather the storm. Glory be to his name.

S. A. Adewuyi
January, 1989

C E R T I F I C A T I O N

I certify that this work was carried out by Mr. Samuel Adetunji Adewuyi in the Department of Socioloy, University of Ibadan, Ibadan.

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ABSTRACT

Most of the existing studies on utilization of health services merely examined patronage in its relationship to a broad spectrum of illnesses. Thus, not many efforts have been made to find out the pattern of utilization of health services for specific groups of morbidities. The present study was conceived to examine utilization of health services in relationship to respiratory diseases in sixty-seven households selected randomly from fifteen villages in Akinyele Local Government Area of Oyo State of Nigeria.

This study reveals that respiratory diseases constitute a major health problem in the rural areas. It is also revealed that the occurrence of the respiratory diseases could have been due to poor and insanitary living conditions and consumption of commodities of pleasure such as alcohol and tobacco products.

The most outstanding sources of therapy are Self-Medication, Home-made Therapy and Modern Hospital, while the least are the Traditional Healers, the 'Health Workers' and Aladura Churches. An important feature of utilization of services was found to be that the Modern Hospitals, Self-Medication and to a slightly lesser extent, Home-Remedies appeared to

serve as primary sources of health-care. On the other hand, Traditional Healers and 'Health-Workers' were patronized as referral health-care services.

Furthermore, it was revealed that only Self-Medication and Home-Remedies were patronized across all ages and sexes as primary health-cares; the Modern Hospital was patronized overwhelmingly by the very young children while Traditional Healers, the "Health Workers" and Healing Churches were patronized overwhelmingly by older fellows. It seems therefore that theoretically, while the people's belief in the contiguity and efficacy of the available health services remained constant, their perceived relevance of the services in curing diseases in different age-groups remained controversial. It means then that rather than physical barriers per se, it was psychological barriers that determined pathways to respiratory health for the rural dwellers.

It could be suggested for policy actions that more primary health centres be established and equipped in the rural areas. There should also be mass education programme to diseminate right health values and discourage wrong ones. In this regard, it would be possible to reduce geographical and psychological distance as well as the delivery costs of

health services.

It is also suggested that a closer look be taken at Self-Medication since a substantial number of rural dwellers use it successfully, the government should legalize its use subject to the rules and regulations governing sale and administration of patent medicine.

It will also be recommended that Home-Made remedies, Traditional Healers' techniques and Aladura Healing procedures be studied more closely with a view to determining their potency and hygiene.

Lastly, the health hazards constituted by quack medicine sellers should be halted through ensuring that only licensed and 'experienced' medicine sellers are allowed to sell medicines in the rural areas. Again concerted efforts should be made to ensure that expired drugs are not sold.

This study however reveals that there is a great possibility of chemical reaction as a result of the practice of combined administration of several different therapies in the same illness episode. An interdisciplinary research should be conducted with a view to determining the nature and pattern of chemical reactions. It is also necessary to conduct seperate studies to determine the dynamics of patronage of health services in relationship

to other groups of diseases such as dysentary, malaria, malnutrition etc. This will provide a basis for comparative health behaviour.

Finally, a study on utilization of health services with relationship to respiratory diseases should be conducted in an urban area of Nigeria. This will provide a basis for comparison with the present study.

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CHAPTER ONE

1.1.0 INTRODUCTION

This study is an attempt to investigate utilization of health services by persons experiencing episodes of respiratory diseases in sixty-seven households in Akinyele Local Government Area of Oyo State. Many studies related to utilization of health services in various Nigerian settings have been conducted. However, these works are of a general type. They are general first of all because they focussed on utilization of health services by persons suffering a broad spectrum of illnesses. Secondly they are general because they examined utilization of health services and medical care providers as the two main variables within medical practices.

Notable in this respect are Oyebola (1980a, 1980b); Boston (1981); Ezeabasili (1981) and Oke (1982) who exhaustively studied traditional medical practices, practitioners and patronages in various Nigerian cultural milieux. Both Lambo (1963) and Ademuwagun (1969, 1976) also reviewed the strength and weaknesses of therapeutic

regimens within the general scheme of Nigeria's multi-health-delivery system. Similarly, Iyun (1979, 1982) attempted to build a descriptive model of stages of health-seeking in a rural area of Nigeria. He succeeded in building a model against which a broad-range of health-seeking practices could be compared.

Other studies examined continuity problems in utilization of health services (Van, 1972; King 1973; Adejuyigbe 1980; Iyun, 1980). A major empirical reference in these works is the effect of spatial distribution of health services vis-a-vis the dispersal of the people, on their health-seeking behaviour. A major outcome of the studies is that utilization of services varies inversely with the distance between the source of supply of health services and location of health-consumers. Finally, other studies examined the effect of religion, race and cost of treatment on utilization of health services (Morrill 1970).

Looking through the sociological literature, it appears that in general, there is little research emphasis on utilization of health services for specific groups of morbidities. These 'blanket' studies do not allow for discrimination in the perception and possibly attitude of health consumers to occurrence and treatment of specific

morbidities. For instance, instead of determining utilization of health services in general, it should be possible to determine what pattern utilization of health services will take when people experienced episodes of respiratory diseases, dysentary, malaria and other groups of diseases. Our focus in this study is to concentrate attention on episodes of respiratory diseases with a view to discovering the health-services utilized and pattern of this utilization.

1.2.0 Literature Review

Respiratory diseases are caused by organic and viral factors. The causative viruses are pathogenic micro-organisms and are spread successively through breathing and contact. Reliable morbidity data on respiratory diseases in Nigeria are scanty. But it appears that respiratory diseases rank, and in many cases collaborate, with malnutrition and water-borne diseases as the greatest cause of death in the Third World Countries. A couple of studies that have recently been concluded suggested that a child below five years of age in an urban area has an average of about six episodes of respiratory diseases per year (Osuhor et al 1980, Pio et al 1984). Mortality data collected on some 1.2 million people in some 88 WHO-member countries in the '70s indicated that

one person out of about 2,000 dies (and by extension about two million people of the world die) of respiratory diseases yearly (WHO 1981).

On a comparative note, two other researches indicated that deaths arising from respiratory diseases are about 18-75 times higher in the Third World Countries than in the developed countries of the world (Berma et al 1978, Bulla et al 1978). Data on utilization of health services indicate that respiratory diseases constitute health hazards and exert abnormally high pressure on the very meagre health facilities in the developing countries (Adeyokunnu et al 1980). Many socio-economic indices have been identified to be associated with the occurrence and persistence of respiratory diseases. Some of these are the quantity and quality of feeding; environmental influences particularly living conditions and demographic variables.

1.2.1 Feeding and Respiratory Diseases

Several studies have indicated that the deleterious effects of smoking are among the many factors associated with diseases of the respiratory system (Lambert et al 1970, Dean et al 1978 , Hawthorne et al 1978). Those who smoke habitually were found to report most symptoms and episodes of respiratory diseases; ex-smokers ranked second and passive smokers third. The most healthy persons were those who have never smoked and are living in non-smoking

households.

Another set of studies indicated that people who smoke habitually show greater symptoms of respiratory diseases such as cough, phlegm production, cold and shortness of breath, compared with non-smokers (Holland et al 1968, Bewley et al 1973, Rawbone et al 1978). Those studies further indicated that smokers who have given up for five years or more had the same number of such symptoms as those who have never smoked but pipe and cigar smokers have fewer symptoms of respiratory diseases than cigarette smokers.

The contribution of breast-feeding to prevention of respiratory diseases has been hotly contested. On the one hand Gordon et al (1982) found that breast-feeding has no curative effects on respiratory diseases. On the other hand, researches by Saarinen et al (1979) and Kaufman et al (1981) defended the view that children of mothers who breast-feed at all or for a longer time show fewer symptoms of respiratory diseases than those of mothers who either do not breast-feed or do so for a short period. The more realistic also logically possible position is that feeding is directly related to disease-causation. Manning (1975), Linto Snaith et al (1981) and Kitzinger (1984) who are accomplished researchers

on childrearing practices also found out that breast-fed children do not easily fall sick as do bottle-fed children and that sick children fed on balanced diet or breast-milk recover more quickly than those bottle - or ill-fed. Even in many parts of traditional Yoruba-land, the curative effect of breast-feeding and wholesome feeding in general is very well recognized. It is believed in these areas that breast-milk per se can cure earache and eye-troubles. Drops of breast-milk are therefore inserted into the eyes and ear-holes when there are episodes of eye and ear diseases.

1.2.2 Living conditions and Respiratory Diseases

Respiratory diseases also appear to be associated with overcrowding and absence of social amenities. Benjamin (1965) and Morgan et al (1983) found a major association between type of dwelling and respiratory diseases. Similarly, Dean et al (1978) and Gibson (1981) found that people whose places of work were located in unhealthy environments had greater episodes of respiratory diseases. It seems then that people who live in the poorest houses will tend to have more episodes of respiratory diseases because they tend to live in the poorest houses, take up the most unhealthy employment, live in the worst environments and consume poorest diets.

1.2.3 Demographic Variables and Respiratory Diseases

Eight indices of respiratory diseases - cough, phlegm, breathlessness, wheezing, bronchitis, throat inflamation, chest cold and severe chest pain have been studied in a sample of 12,736 adults. The prevalence of each of these symptoms/diseases was independently associated with increasing age, lower social class and exposure to dust or fumes. Prevalence of the diseases was also increased in those that were separated, divorced and widowed (Holland et al 1968; Bewley et al 1973).

Many other studies indicated that respiratory diseases are more common among males than females (Graham et al 1967). In their household survey, Mitchell et al (1973) found that children with severe attacks tend to come from large families. A more definitive study by Ferguson et al (1981) indicated that up to 40 percent of children from large families show symptoms of respiratory diseases such as cough and wheezing during their first year of life.

1.2.4 Respiratory Diseases and Treatment Plans

In the area of treatment, it has been argued that vaccination could improve certain symptoms of respiratory diseases. But other studies have found that social and demographic variables are dominant factors in the decline

of morbidity associated with respiratory diseases (MRC 1951, 1959 Basili et al 1976); and that vaccines carry risks which outweigh their benefits (Stewart 1977, Jenkinson 1978). People have also been found to depend on the use of drugs but a study by Anderson and his colleagues (1983) showed evidence of substantive under-use of drugs by respiratory patients, but that their desire to use them rose with the level of severity (Anderson et al 1980).

1.3.0 Factors Determining Utilization of Health Services

People's desire to utilize health services does not appear to come as an automatic response to feelings of pain and disability. Instead, their predispostion to choose between and utilize services is a function of several factors which are socio-cultural, interpersonal, socio-economic, demographic and spatial distribution of health services. We shall, in the discussions that follow, take a brief look at each of these factors.

1.3.1 Socio-Cultural Factors

The first major factor determining utilization of health services is the socio-cultural milieu within which people live. The historical connection between and recent movement towards convergence of social and medical sciences

are predicated on the socio-cultural aspects of health services. Social and cultural behaviours are important factors not only in the causation and distribution of diseases, but also in the perception, explanation and treatment of symptoms of such diseases.

As many as 80.0% of persons in Africa are still fighting in varying degrees, like the legendary Tantalus, for survival in isolated rural settings (Oyebola 1982). The fact that they have survived for a long time and are still surviving indicates that they have evolved a system of self-preservation through proper understanding of, and adaptation to their respective cultures.

Crosscultural studies reveal that because the Somalians have lived according to centuries-old customs, they are free from artherosclerotic conditions as well as nervous and emotional problems (WHO 1963). Similarly, a positive health behaviour among the Samburi of Kenya is to keep the digestive system clear through the use of purgatives (Brotchmacher, 1955). Tanner (1959) reported that the Sukuma of Tanzania have an enormous pharmacopoenia of some thousands of plants and that their knowledge of medicine is not confined to the specialist class of practitioners.

We can see that from the sociological point of view, health-related behaviour is a socio-cultural activity. Both health providers and consumers should, in their respective positions, fulfill their roles which are socially determined, in culturally determined ways. The success of any medical practice will depend on a profound knowledge of the culture within which it is practised as well as the knowledge of the 'materia medica' of the local people. A medical practice that operates with the awareness that people have alternative sources of health care is likely to be more sympathetic with the peoples way of life. It is also likely to be more successful than if it were to work under the illusion that the people were bereft of ideas.

1.3.2 Interpersonal Factors

Attempts are sometimes made to find solution to the nature, pattern and degree of service utilization by assessing the contribution of inter-personal factors in doctor-patient relationships. Viewed within a framework of social roles and attitudes, the type of relationship that exists between the physician and the patient should, ideally, be mutual. A physician's training, experience and talent are useful variables which can bring success

to the therapeutic milieu. Therapy will be successful as long as closeness and understanding, on the one hand and objectivity and detachment on the other, are discretely conflated. Where the relationship is distant and overly detached, mutual understanding will be lost; where it is intimate, the professional will be more emotionally involved and lose his objectivity.

Patients are characterised by both medical and non-medical needs. The medical needs are associated with the curative aspects of their health. These needs depend on patients' perception of the efficacy of medicaments. Many studies indicated that belief in the efficacy of doctor's prescriptions predicts regular administration of drugs and keeping of clinic appointments (Alpert 1964, Gabrielson 1967, Diamond 1968, Becker 1974). Donabedian (1964) reported that doubts about the recommended procedures explain why elderly patients do not follow the physician's instructions.

The non-medical needs of the patient are associated with the various latent functions of the medical institution. These are more important determinants of success at doctor-patient encounter. The constituents of these needs are patient-patient interaction, patients' interaction with their own relations, patients' general evaluation

of the hospital environment and most importantly, doctor-patient interaction.

If the doctor emphasizes the status-gap between him and his patients, or if he appears to lack tolerance, patience and self-respect, the patients may despise him and ignore his prescription (Shuval et al 1967). To be successful, it is necessary that the doctor's professional competence be accompanied with a genial behaviour that will reduce the patients' anxieties.

Patients do not have the professional and technical yardstick to judge the doctor's professional competence. Thus, patients are not aware of how physicians' technical competence contributes to the achievement of their desire to get well. The criteria that patients use are those that relate to the degree of emotional support which the physicians accord them.

The effect of doctor-patient relationship has been studied. For example, Becker (1974) reported that the traditional belief that "people should do what the doctor tells them" is associated with compliance. This study fails however, to indicate the measure of belief that will be adequate to result in compliance. If the belief is strong, it may be difficult to assess the relative effect of the interaction process between the doctor and the patient.

Davis (1968) reported that patterns of communication which deviate from the normative doctor-patient relationship will be associated with patients' failure to comply with doctor's advice. He enumerated those conditions as circumstances where tension in the interaction is not released and where the physician is formal, rejecting, controlling, disagrees completely with the patient or interviews the patient at length without subsequent feedback.

In their different studies, Alpert (1964) Sapolsky (1965), Diamond et al (1968), Korsh et al (1968) and Francis et al (1969) reported that compliance with prescription is better when the patient is satisfied with the initial contact, perceives the doctor as friendly and feels that the doctor understood the complaint. Similarly, Gouldner (1960); Wilson (1973) and Stimson (1974) reported that the extent to which patient's expectations from the medical visit were left unmet, lack of warmth in the doctor-patient relationship and failure to receive an explanation of diagnosis and cause of illness were key factors in non-compliance.

This interpersonal variable may have a far-reaching influence on patronage in Nigeria's type of multi-delivery system with its peculiar features. For instance, modern

medicine, as opposed to traditional medicine, has a short history of existence as well as acceptance especially in the rural sector of Nigeria. One important factor that accentuates this unpopularity is that entrants into modern medical profession are often youngsters who are in their early twenties. At graduation from the Medical school, they often lack experience and maturity which can bring success to their practice. They are also mostly recruited from the more affluent section of the society with the consequence that they find it more convenient to relate to affluent patients than to poor patients who are incidentally, more vulnerable to diseases.

1.3.3 Socio-economic Factors

Another major variable in doctor-patient interaction is the status gap between the physician and the patient. Modern physicians often come from high social background and this influences their world view. They have the propensity to practise where life is more comfortable and associate with patients of their own social class. Consequently, they give a grudging attention to lower class or poor patients (Chilivumbo 1976); and feel reluctant to practise in the rural areas. Alpert et al (1970) suggested that if socio-economic barriers could be removed, the poor too could improve in their health care patronage.

Rosenstock (1974) in another study, reported that even when immunizations are free, higher income families show a much better rate of protection than do poorer families. He also found that while ambulatory services generally show a lower rate of utilization by lower income households, poor people are over-represented among hospital patients, their hospitalization rates are higher than those of upper income groups and their length of stay longer on the average.

1.3.4 Demographic Factors

The distinction between illness as a sociological state and illness as a socially defined state is particularly evident in studies of demographic differences in relation to symptom response. Women tend to have higher rates of morbidity than men (Nathanson, 1975, 1980; Lewis and Lewis 1977; and Marcus et al 1981). Women tend to show a greater willingness to use health services. But available data suggest that on the balance, women are in better health than men (Verbrugge, 1976).

Two hypotheses explain sex differences in utilization of health services. The first is based on the assumption that the traditional female role is more compatible with the sick role than is the traditional male role. Men at an early age are socialized into instrumental roles. The

notion that women should be dependent is germane with expressive roles (Mechanic 1964). Such value differences in early socialization might suppress sick role behaviour among men while facilitating it among women.

Phillips (1964) showed that women are rejected less strongly for exhibiting certain emotional symptoms than men. Similarly, Kessel et al (1981) reported that women are more likely than men to define specific feelings of distress as resulting from emotional problems. They report that the sex differences in problem recognition explains between 10% and 28% of the excess morbidity reported by women.

The second hypothesis is that sexes differ in their fixed role obligations and in the compatibility of these obligations with illness or sick role behaviour. Suchman (1965) found that certain role obligations can influence adoption of the sick role, since such adoption involves suspension of normal obligations and activities. Individuals with less flexible role obligations will be expected to find the sick role less assessible. Inability to relinquish work or social responsibilities will therefore lead to delay in seeking medical assistance.

Kessel (1965) also reported that one excuse people always give for failure to seek medical advice was being

too busy to see a doctor. More recently, Nathanson (1975, 1980) has shown that women with more fixed role obligations e.g. paid employment and children to look after at home are less likely to report illness and to exhibit sick role behaviour than women with fewer such obligations.

Studies of cost-sharing health programmes also support the fixed role hypothesis. Data from such studies suggest that consumers of health services respond to the monetary costs of obtaining health services as well as to the price paid in time lost from other activities. Among the low income groups, Chassin (1978) found that reductions in the monetary costs led to increase in utilization of services. For the upper and middle classes however, time tends to be more important, and rates of physician visits often decrease in response to a lowering of the monetary price.

1.3.5 Spatial Location of Health Services and Population Distribution

Perhaps, the factor that most directly relates to utilization of health services is the location of the services vis-a-vis the distribution of the users. Health services are point-located services. Therefore, they are established near the users. This factor is most important in a predominantly rural country like Nigeria where most health services are located for centrality and commercial

purposes in big towns (Ayoade 1982); where majority of the rural dwellers are so poor that they cannot feed well, where the rural dwellers are most susceptible to diseases and where transportation is not appreciably developed.

Many studies of utilization of health services in Nigeria, found that utilization is in part closely bound to the location of services. The farther health services are located to the people, the higher the delivery cost and the lower the utilization rate of such services (Adejuyigbe 1980; Iyun 1980, Okafor 1982).

1.4.0 Theoretical Framework

This study attempts to explain empirical observations within the context of health belief models. A model in this context is a system of interrelated variables which describe a phenomenon. Two popular models are basically avaialble and often drawn upon in theoretical discussions of health-seeking behaviour. These are the models of the stages in health seeking and decision theoretic models.

There are several variants of the decision theoretic model. Each of them is premised on different assumptions about the nature of man, the nature of human culture and consequently, the nature and pattern of health behaviour which is made possible and imperative within that culture.

One of the most popular decision theoretic models is the Health Belief Model (HBM). The HBM holds that in order for an individual to be motivated to seek treatment, he needs to believe that he is personally susceptible to the disease; that the occurrence of the disease would be severe; that taking a particular action would reduce its severity and that he would be able to overcome the barriers preventing him from obtaining effective treatment. We shall re-consider these beliefs in turn.

Firstly, the model postulates that for an individual to seek a physician, he will need to believe that he can contact the disease. This means that the individual concerned need feel a certain degree of susceptibility. According to Rosenstock (1974) high susceptibility is a situation where a person expresses a feeling that he is in real danger of contracting a disease. Medium susceptibility is where he admits that, although he is not imune to the disease, but that, at that particular moment, he is not likely to be adversely tormented. Low susceptibility happens where an individual completely denies any possibility of his contracting a disease. It needs to be argued, however, that individuals vary in their perception of a given problem. They also vary in their acceptance of personal susceptibility.

Secondly, the model postulates that even if there is a very high susceptibility and even if the seeker's response-potential is enormous, the individual would still probably not take action unless he believes that becoming ill would bring serious organic or social impairment (Marshall 1974). This is saying that symptom-experiencing individuals would be concerned with the consequences which the disease is capable of leaving in its trails - consequences like reduction of socio-physical functioning, limitation of mental activity, permanent disablement or outright death.

Empirical cases show, however, that depending on the culture or socio-economic background of the potential health seeker, there may not be a unilinear and direct variation between perceived severity and response to an illness episode. In a study, for instance, Zola (1964) found that some people whose condition demanded a rationally positive action refused to take such action even when their lives were seriously threatened. Zola concluded that:

> there is something about these people or in their backgrounds which has disturbed their rationality, otherwise, they would naturally seek aid.

Thirdly, this model postulates that susceptibility and severity variables even when considered collectively,

cannot adequately predict the direction or swiftness of action. To a large extent, beliefs regarding the relative effectiveness of available therapies will also contribute to determination of the individuals' course of action. People have varying beliefs regarding availability and effectiveness of various therapies. These beliefs, (not just the objective facts about the effectiveness of the action), determine the course of action that people will take.

Studies by Blackwell (1963) and Green et al (1974) on why people delay in seeking cure, reflect a conflict between a strong feeling of susceptibility to a disease and a feeling that there are not efficacious methods of controlling the disease.

Fourthly, even if a person feels highly susceptible that the disease is severe and accepts that effective cure exists, he may still be inacapacitated by a set of inhibiting factors. An individual may believe, for instance, that a given action will be effective in reducing the threat of a disease, but at the same time may see the action itself as being inconvenient, expensive, unpleasant, painful or or upsetting. These negative aspects of health seeking are socio-psychological barriers and arouse conflicting patronage-avoidance motives.

Several resolutions of this conflict are possible. Firstly, if the readiness to act is high and the negative aspects are relatively weak, the action is likely to be taken. Secondly, if the readiness to act is low while the potential negative aspects are strong, the negative aspects are likely to function as barriers to prevent action. Thirdly, where readiness to act is great and barriers to action are also great, the conflict is likely to be difficult to resolve.

Finally, for the afflicted persons to take action, the Health Belief Model postulates further that there should be cues. The combined levels of susceptibility and severity provide the energy or force to act, and the perception of benefits provides a preferred path of action. The combination of these could reach quite considerable levels of intensity without resulting in overt action unless some instigating event occurs to set the process in motion. The required intensity of a cue that is deemed sufficient to trigger health behaviour varies with differences in the levels of susceptibility and severity. If people accept that they are least susceptible to or least threatened by a disease, they will need rather intensive stimuli to respond to health services. On the other hand, if a person perceives that he is in great danger of being harmed by a

disease, a slight stimuli may be adequate.

In consequence, even when deliberate attempts are made to create cues through the mass media to urge a population to obtain particular health services, behaviour so emitted varies with the intensity of the messages received. High fear messages are found to be positively related to beliefs about severity and preventability than do low fear messages (Hochbaum 1958; Leventhal, 1965; Guskin, 1965; Kegeles 1965; Kirscht et al, 1970; Becker et al 1974).

The nature of the HMB is such that it exhibits a phenomenologic orientation regarding an individual's health behaviours. That is, the world of the perceiver is held to be ultimate and determinate of what he will do and not the socio-physical environment, except, of course, as the socio-environmental variables come to be vaguely represented in the mind of the perceiver. The model sees man as composed of four analytically distinguishable but mutually reinforcing systems. The first is the biological system which comprises man's being, emotions, affects, stature etc. The second is the interactional system which includes man's relation to his culture and other men. It forms the basis for companionship, cooperation, corporateness,

affection, solidarity etc.

The third perhaps most important system is phenomenologic and enables man to perceive the inter-working of the different parts of his body. It enables man to define and monitor behaviour of his health as well as recognize deviations in what he has come to regard as the normal functioning of his body or any of its parts. Fourthly, the model sees man as possessing experiential capacity. Man is unique in that he can store up his experiences for future encounters.

Fifthly, the model assumes that man operates within a socio-physical life space. Man's life space is seen to be composed of regions. Some of these regions are positively valued, some negatively valued and others relatively neutral. Disease is negatively valued and occupies a region of negative valence because it brings displeasure. The model holds that the individual being rational, will evaluate an instance of illness against the background of some economistic or utility considerations and reach a decision regarding the best or optimal action which will eliminate the illness.

Much as this model is very useful in explaining people's health-related behaviour, it could be criticized

mainly for not fitting into a multi-delivery system like Nigeria's. However, Kirscht (1970) and Fabrega (1973) deposed that there is no reason why the model cannot explain the choices or sequence of choices among an array of therapies. Let us now turn to the other model.

The models of stages in health-seeking explore the pathways of health-seeking with particular reference to decision-making points. One of the protagonists of these models is Freidson (1960). He postulated three decision-making points in pathways to health. These decision-points are recognition and decision that there has set in organic malfunction and application of first aids; discussion of symptom with friends and relations (the lay-referral system); and medical-care contact stage. Another proponent of these models (Kadushin 1959) writing with reference to mental health, developed a five stage decision model as follows. Recognition of an emotional problem, discussion of grief with the lay-referral group, decision to seek medical-care, selection of one of several professional areas, selection of one among several health-care suppliers.

Perhaps, the most inclusive and systematically developed decision model was that developed by Suchman (1965). He proposed five stages namely: symptom experience stage;

assumption of the sick-role stage, the medical care contact; the dependent patient role and the recovery stage. These could be explained as follows:

Firstly, the decision that one is sick often comes as a result of discovery of disjunction or divergence from what one has come to regard as the normal functioning of his body. Such disjunction is heralded by symptoms like fever, cold, convulsion, pain, headache and so forth. This experience is followed by interpretation of the observed symptoms. The interpretation itself is guided by experience acquired through participation in the socio-cultural milieu within which the sick person is having his experience. In addition, the experience of symptom will be followed by an emotional response of fear or anxiety. This emotional response will depend upon the kind of interpretation that the sick person or the lay-referral system gives to the symptoms; and it will depend on the degree of severity or threat that the symptoms are interpreted to be capable of inflicting.

Secondly, having spotted the crisis of ill-health and having calculated that an immediate action will be needed for the illness not to cause an irreparable catastrophe in his life, the sick person will embark on symptom

removing/reducing strategies. At this stage, the sick individual will need the solidarity of his lay referral structure. He needs their sympathy, he needs to be comforted, to be assured, and he needs to be informed about therapeutic regimens that have been tried with success for similar episodes. The individual also needs their approval to withdraw temporarily from his normal social and economic roles. In Africa, solidarity is readily given to the sick member of the family because health and illness seem to be regarded as assets and liabilities which the whole range of kin group shares without limit. This solidarity is not only expressed verbally or through complimentary cards. Relatives come together to cares the patient, feel his pulse, watch his demeanour and listen to his complaints.

Thirdly, the sick person and/or the lay referral system determines that the patient should see a physician. It is at this point that a professional/official sanctioning is given to the patient to relinquish his normal social roles. The decision regarding the type of medical care and the specific practitioner that will be consulted is jointly reached by the lay referral system.

Fourthly, the stage at which the epithet 'patient' can rightly be stuck on the sick individual is when he assumes the dependent patient role. The patient should

ideally submit to the professional advice of the physician and his healthcare team. But the degree to which patients perform this dependent patient role varies from one patient to another.

Finally, the last stage in illness and medical contact stage is the decision and approval to relinquish dependent patient role. The length of time for which the sick individual performed the role of a dependent patient will affect the ease of his adjustment to life as a healthy individual.

Reviewing the models of stages in health-seeking, it is seen that the greater and more complex the lay referral system is, the greater will be the delay or disinclination to patronize qualified physicians. Although by emphasizing the importance of lay-referral system, these models draw attention to an important link in the process of health seeking, the models fail to take into consideration the issues which the therapy-managing-group takes into consideration when taking decisions.

Another defect of these models is that they are unnecessarily unilinear. They describe only the final decision point in utilization of health services. They do not, like the HBM, appear to accommodate the patients'

movement from one therapy to another. This problem is more crucial in a developing country like Nigeria where there are inter-and intra-therapy movement by patients.

The models developed above cannot, therefore, adequately explain utilization of health services in the place studied. We attempted to construct an eclectic model from those described above. This model emphasized only the medical-care contact aspects of the decision theoretic models.

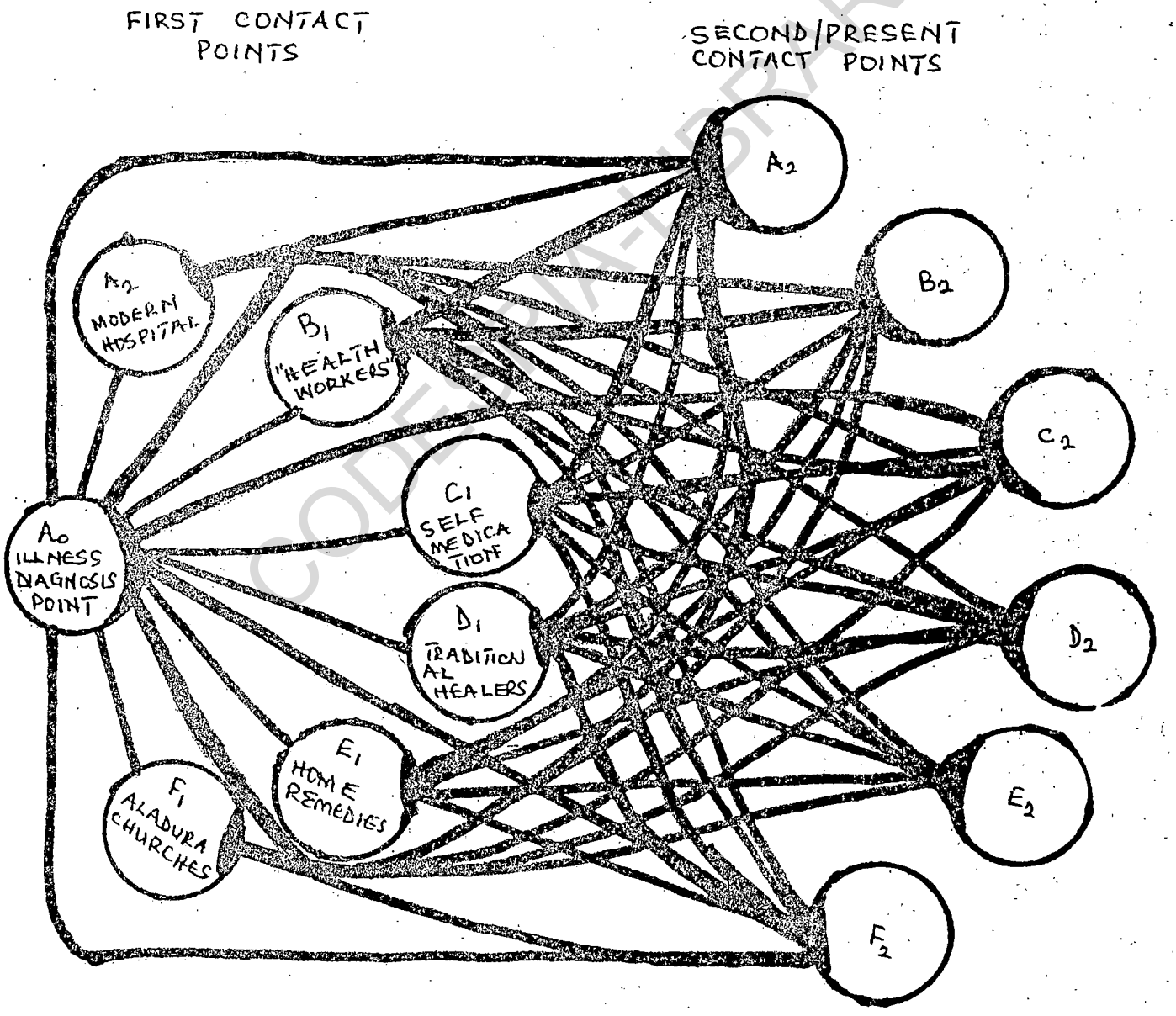
In developing this model, we made the following assumptions:

1) that people hate to get sick and that they will quickly look for cure when and if they fall sick
2) that people possess linguistic categories by which illnesses are labelled
3) that illness is both personal and social responsibility
4) that the perception of need for medical intervention is subjective and not objective
5) that patients use certain subjective criteria to assess the efficacy of the physician and
6) that the patients are rational, being able to weigh alternative courses of action against their economic resources.

Now given that there are 6 health services A, B, C, D, E, and F, and that there are 2 decision points i.e. (movement

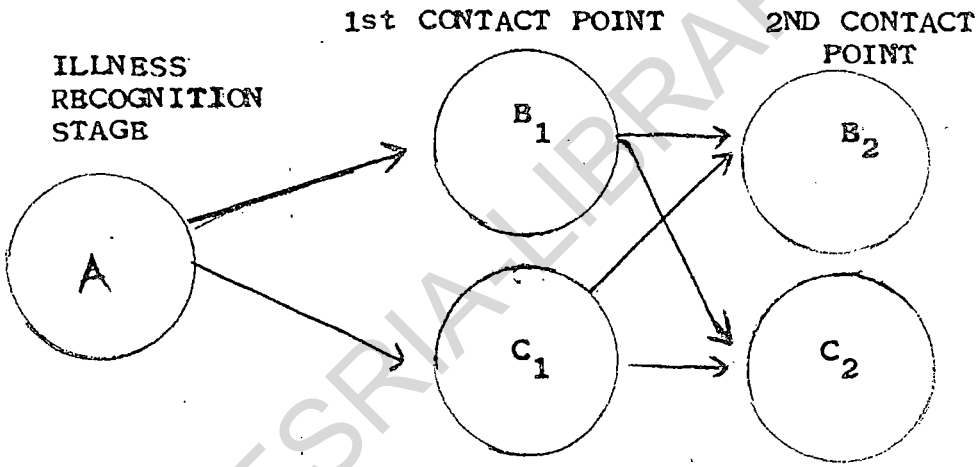
from illness recognition to the first treatment and from the first treatment to the second treatment). Then figure 1.1 will represent a two-point medical-care contact model.

FIGURE 1.1 TWO-POINT MEDICAL-CARE CONTACT MODEL



Taking a brief look at figure 1.1, it is noticed that theoretically, a demander starting from point A_o can make 42 decisions. We shall explain this model with the following simplified 2-point medical-care contact model below.

FIGURE 1.2: A 2-POINT MEDICAL-CARE CONTACT MODEL



Given a 2 therapeutic plans B and C situation, demander P suffering from episodes of respiratory diseases XYZ might make 6 hypothetical decisions which could be any of the following sets depending on the therapeutic services first patronized - AB_1; AB_1B_2; AB_1C_2; AC_1; AC_1B_2; AC_1C_2.

This means that if P started with treatment plan B_1 he could move to treatment plan B_2 and later to treatment plan C_2. If he started with treatment plan C_1, he could move to

treatment plan B_2 and later to treatment plan C_2. It then means that a health seeker can theoretically make 6 treatment contacts.

This model can be used to explain as many medical-care contacts as are theoretically possible. The beauty of it is that it has explanatory capacity for the movement of demanders of health services from health from health services to health services. It therefore ameliorates some of the defects of the models reviewed above.

1.5.0 Objectives

The general objective of this study is to identify the pattern of rural dwellers' utilization of health services and the social and cultural factors that engender and reinforce this pattern.

1.5.1 Specific Objectives

(i) To collect data on incidence and distribution of respiratory diseases in the selected villages

(ii) To understand people's perception of the seriousness of respiratory diseases

(iii) To examine the pattern of rural people's utilization of health care services when suffering respiratory diseases.

CHAPTER TWO

2.1.0 RESEARCH DESIGN AND METHODOLOGY

This study was conducted in Moniya district of Akinyele Local Government Area of Oyo State. The Headquarters of the Local Government Area in Moniya which is a semi-urban town about 15 milometres on the Northern exit of Ibadan city. The population of Akinyele Local Government Area was 185,991 in 1963 and it now has about 377,300[1] persons. Twenty-four settlements are officially classified as towns and 1,682 as villages. Table 2.1 below shows the distribution of the districts and villages.

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1. The 1963 population figure was projected with 3.0% natural rate of increase.

Table 2.1 Districts and Villages in Akinyele Local Government Area

District Head-quarters	Villages	District Head-quarters	Villages
Ajibade	41	Ikereku	140
Akinyele	35	Iroko	126
Akufo	199	Kankun	85
Alabata	44	Moniya	85
Alako-Ladimeji	63	Oganla-Lasokun	67
Apete-Oriare	33	Ojoo	53
Ararо	56	Olode	13
Arulogun	72	Olorisaoko	249
Blekuru	55	Omi-Adio	255
Iddo	142	Onidundu	11
Igbo-Oloyin	69	Owe	66
Ijaye	70	Sasa	30

Total: Towns = 24; Villages = 1,682

Source: Information Manual about Akinyele Local Government Area. Compiled by Akinyele Local Government Council, Moniya.

Each of these 'towns' is regarded as a district Headquarters under which there are a number of villages.

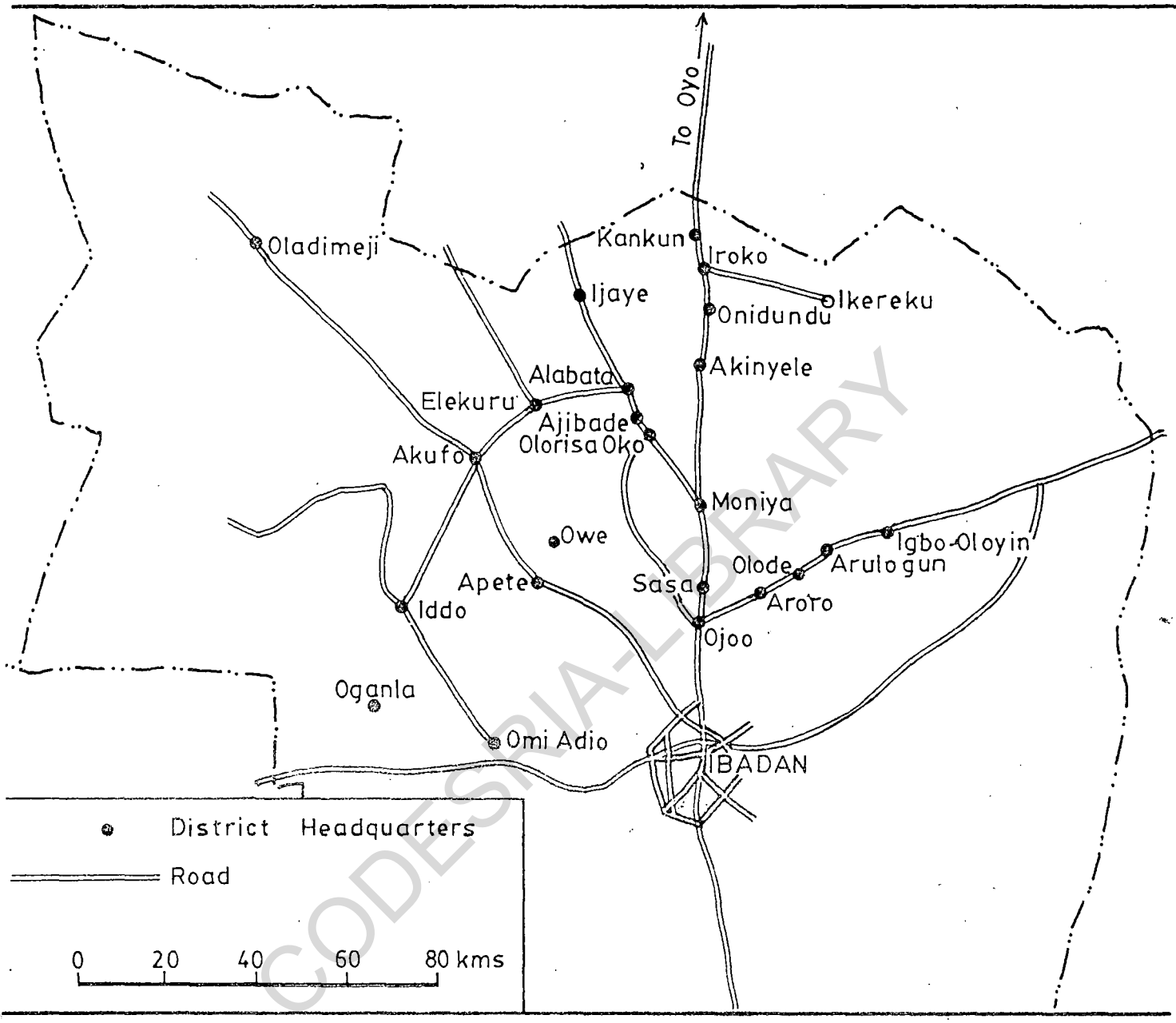

Fig. 2.1: Districts in Akinyele Local Government Area

It would be noticed that the number of villages classified under each district Headquarters varies between eight as in the case of Kankun and two hundred and twenty-five as in the case of Omi-Adio. This shows that the classification is rather arbitrary. The main criterion for the classification is contiguity of settlements rather than to facilitate local government administration per se; as, the bulk of Local Government administration is carried out from the Headquarters. Figure 2.1 above shows the geographical location of the districts studied.

2.2.0 Sample Selection

Characteristically, a sampling procedure must possess properties of appropriateness, representativeness and adequacy of the elements. A sample will be appropriate when the elements can supply the right type of needed responses; it will be representative, if it reflects appreciably, the heterogeneity of the total population from which the sampling frame was constructed; and it will be adequate when it is so big (relative to the total population), that the sampling error is very small (Goode et al 1952). In order to ensure these properties, a sample of 67 households was taken through a multi-stage sampling procedure.

2.2.1 Multi-stage Sampling

In multi-stage sampling, different types of sampling unit were considered at different sampling stages. In this case, our units are the district, the villages, the households and the respondents. The selection procedure was as follows.

2.2.2 Stage-One: Selection of the District

Moniya district is the focus of this study. The preference for this district out of a sampling frame of twenty-four districts was deliberate and arose from our concern for methodological accuracy and appropriateness of our sample.

Firstly, Moniya district with eighty-five villages is statistically a medium district compared with Omi-Adio, Akufo, Iddo and Ikereku on the one hand and Kanukun, Onidundu and Olode on the other hand (See Table 2.1).

Secondly, it is perhaps an ideal district for the study. It is the only district with the largest concentration of modern health care services like hospitals and medicine stores. Naturally therefore, it appears to be the only district where people can more freely choose between traditional and modern therapies. More importantly, from our scientific point of view, it is the only district where direction of therapeutic choice, the reason for that choice

and rhythm of that choice, can be meaningfully ascertained. Finally, there is likely to be greater awareness on the part of the citizens of this district. This is owing largely to the fact that the district 'houses' the Headquarters and is therefore the nucleus of government influence.

It is important to remark here that Akinyele Local Government Area is one of the UNICEF centres for planning an Acute Respiratory Infection (ARI) control programmes in Nigeria. Moniya as the Headquaters of Akinyele Local Government Area is the administrative seat of UNICEF at this level and it is from Moniya that information and action are mediated to all the districts in the Local Government Area.

2.2.3 Stage two: Selection of the Villages

There are eighty-five villages in Moniya District (See Appendix 2). Fourteen villages excluding Moniya were selected randomly with the aid of the Table of Random integers[2]. These fourteen villages together with Moniya constitute 17.4% of the settlements in the district. This selection was painfully constrained by shortage of human and material resources. But the constriction was made for,

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2. The RandCorporation (1955), A Million Random Digits FP Glencoe Illinois.

by including and interviewing about three quarters of the households identified in the settlements.

2.2.4 Stage three: Selection of Households

A household for the purpose of this study includes a man, his wife or wives his children and such other relatives as are residing with him. This is not to imply that only men were interviewed or that the presence of a husband was made a prerequisite for every household interview. Where the male head of the household was alive and available we persuaded him to be interviewed. But we were fully aware, and this research benefitted from the fact, that 'mothers' were equally prominent and in many cases more sensitive and more active than men in recognizing and seeking therapies for the health problems of any members of their family.

To ensure that the households were randomly selected, we first of all divided the villages into clusters of houses using certain arbitrary criteria (e.g all houses near the village mosque, all the houses at the centre of the village, those around the 'odan' tree, those near the entrance of the village etc.). Depending on the size of each cluster, we selected, by lottery method, one or two houses (three in the case of Moniya) for interview. Twelve of the households selected for the interview could not be interviewed

Table 2.2: Distribution of the Respondents by Village and Household

Selected Villages	Number of houses Selected	Number of Households Selected	Number of persons in the hosehold
Moniya	8 (14.0)	9 (13.4)	70 (14.8)
Abedo	2 (3.5)	3 (4.5)	25 (5.3)
Akinsola	2 (3.5)	4 (6.0)	31 (6.6)
Alade	3 (5.3)	3 (4.5)	21 (4.5)
Alase	2 (3.5)	5 (7.5)	27 (5.7)
Apapa	4 (7.0)	5 (7.5)	25 (5.3)
Aponmade	3 (5.3)	3 (4.5)	19 (4.0)
Dabiri	6 (10.6)	6 (9.0)	34 (7.2)
Idiose	5 (8.8)	6 (9.0)	51 (10.8)
Labinkulu	3 (5.3)	4 (6.0)	36((7.6)
Oboda	4 (7.0)	4 (6.0)	34 (7.2)
Ojoemo	4 (7.0)	4 (6.0)	31 (6.6)
Orieni	3 (5.3)	3 (4.5)	23 (4.9)
Otun Agbakin	4 (7.0)	4 (6.0)	17 (3.6)
Solalu	4 (7.0)	4 (6.0)	28 (5.9)
Total	57 (100.0)	67 (100.0)	472 (100.0)

for reasons ranging from refusal to unsuitability. We replaced them with those that were not initiall selected. In the end, sixty-seven households were selected and interviewed. This was 75.3% of all the households in the villages (See Table 2.2).

2.3.0 Socio-demographic Characteristics of the Households

Sixty-seven households were sampled. A statistical analysis of the households shows that there were nine mongamous marriages and fifty-eight polygynous marriages A monogamous marriage simple defined is a socially approved cohabitation of one man and one woman. A polygynous marriage on the other hand, is a socially approved cohabitation[3] of one man and two or more women (Bottomore 1972, Mair, 1975). Three of these households comprised only fathers, their children and their relatives. Seven households comprised only mothers, their children and relatives. Each of the remaining fifty-seven households comprised of the father,

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3. Ideally, cohabitation is usually stressed in sociological literature. We use this concept loosely however. Marriages in which the husband has ever married and got children from more than one woman whether only one or more or none of the women was living with him at the time of the study, were regarded as polygamous. And of course, the converse was true for monogamous marriages Any one-man-one-woman marriage, whether or not one of spouses was still alive, was regarded as monogamous marriage; for the purpose of this study.

Table 2.3: Distribution of the Households by socio-demographic factors

Type of Household	The Parent Head		The Children Members		The Relative Members		Total
	Male	Female	Male	Female	Male	Female	
Monogamous Households	10(14.1)	6(7.1)	2(17.2)	27(21.8)	2(9.5)	4(10.5)	72(15.3)
Polygynous Households	61(85.9)	78(92.9)	111(82.8)	97(78.2)	19(91.5)	34(89.5)	400(84.8)
Total	71(100.0)	84(100.0)	134(100.0)	124(100.0)	21(100.0)	38(100.0)	472(100.0)

his wife or wives and their relatives. Table 2.3 above shows this distribution.

There were between four and fifteen persons in each household. The monogamous marriages appear to be different in many respects. Both or one of the spouses were younger (ages between 15 and 53), their dependants i.e. children and relatives were younger and they appear to bear on the average, greater dependency burden - 4.6 as against 2.9 being borne by the ploygynous household[4].

As is also shown in Table 2.3, women are about 4.2% greater than men in this sample. This female predominance could be explained in five ways. Firstly, Akinyele Local Government Area being part of Oyo State is a predominantly Yoruba and muslim community (See Table 2.4A). Like any traditional Yoruba and/or Muslim community, polygamy is the more common pattern of marriage, hence a man is married to several women at the same time without loss of social standing. Secondly, and by the same token, there is the practice of widow inheritance by which a man inherits the widow of this relation. Thirdly, one demographic hypothesis holds that women have longer life-expectancy than their men counterparts. In fact there are more widows in the sample than are widowers.

Fourthly, it appears that women more easily lose their jobs or less easily get employed than their men counterparts during economic crisis, the type Nigeria is presently experiencing. Generally, among the Ibadan Yoruba, jobless

4. The couples in each type of family/household were divided into their total dependent relatives to determine the dependency ratio.

wives and their children are asked to go and live temporarily with their husbands' parents or in rare cases with the wife's parents in the village. Finally, another demographic hypothesis states that migration in general and rural-urban migration in particular, is selective of the young and the male persons in most populations. The young boys were said to have moved out of the villages in pursuit of secondary and higher education, to learn a trade or to search for unskilled jobs in Moniya, Ojoo, Ibadan city and other big setttlements in the country.

2.3.1 Social and Demographic Characteristics of the Sample

Four hundred and seventy-two (472) persons constitute the sample of this study. This number corresponds broadly with the number of persons living in the households at the time of the study. From Table 2.4B, we can see that not many of the persons living in the households had an appreciably high level of education. Besides the fact that as many as 42.0% is completely illiterate and only 38.6% had various levels of primary education, 87 Or 94.6% of the 92 persons who claimed to have secondary school education did not attempt the school certificate examination.

Table 2.4: Distribution of Subjects by Religion and Educational Status

A			B		
Religion	Number	Percentage	Educational Status	No.	%
Muslims	340	(72.0)	Non-literate	198	(42.0)
Christians	90	(19.0)	Primary School	182	(38.6)
Traditional	42	(9.0)	Secondary School	92	(19.4)
Total	472	(100.0)	Total	472	(100.0)

The age-sex distribution of the sample is presented in Table 2.5 below. It appears that the distribution is heavy at the bottom (Ages 40 to 64) heavier at the top (Ages 0-19) and contracts comparatively in the middle (Ages 20-39). We have already remarked that women are greater than men in ratio 52: 48. We only need to say that the sex distribution by age does not differ significantly from the trend shown in age distribution.

Table 2.5: Distribution of subjects by Age-Sex Variables

Age	Sex		Total
	Male	Female	
0 - 4	30 (13.2)	36 (14.6)	66 (14.0)
5 - 9	26 (14.5)	27 (10.2)	53 (11.2)
10 - 14	22 (9.7)	24 (9.8)	48 (10.2)
15 - 19	14 (6.2)	13 (5.3)	28 (5.9)
20 - 24	13 (5.7)	14 (5.7)	26 (5.5)
25 - 29	12 (5.3)	15 (6.1)	25 (5.3)
30 - 34	11 (4.9)	12 (4.9)	23 (4.9)
35 - 39	13 (5.7)	13 (5.3)	26 (5.5)
40 - 44	16 (7.0)	17 (6.9)	33 (7.0)
45 - 49	13 (5.7)	15 (6.1)	28 (5.9)
50 - 54	15 (6.6)	16 (6.5)	31 (6.6)
55 - 59	16 (7.0)	17 (6.9)	32 (6.8)
60 - 64	13 (5.7)	13 (5.3)	26 (5.5)
65+	12 (5.3)	14 (5.7)	27 (5.7)
Total	227 (102.5)	246 (99.3)	472 (100.0)

While it is expected that younger persons dominate any Nigerian and for that matter, any African population, we do not expect ages 20 - 39 to fall below ages 40 and

above in magnitude. This seeming abnormal distribution could be explained with one or both of the following reasonings. Firstly, it could be that rural urban migration has been selective of ages 19 and 39 while urban-rural migration has been selective of older persons. This is likely to be true judging from our experience in the villages during the interview. There were quite a number of retired civil servants, teachers and erstwhile traders whose stalls were demolished in big towns who came to settle in the villages as farmers.

Secondly, the irregular or inconsistent age distribution could also have been due to lack of official records of vital statistics. Recall was hampered by loss of or fading memory; therefore accurate ages were difficult to obtain in most cases. We relied on national and regional events to determine approximate ages.

2.4.0 Procedure for Data Collection

The ethnographic survey method was used in collecting the data. The ethnographic method is a combination of interview and observation methods. According to Mair (1975) "Ethnography refers to the process of collecting data by direct inquiry and observation, whatever the theoretical purposes of the inquiry in which the emphasis is on the description of the society studied rather than on general

theoretical problems". Thus data for this study were gathered through direct interview and through direct observation. Each of these procedures is explained below.

2.4.1 Direct Interview

A field-guide[5] was constructed to 'standardize' the questions that were asked. A field-guide is the ethnographer's equivalent of a sociologist's questionnaire instrument. The major differences between them being that in the field guide, respondents are asked questions and their answers recorded. Many of the questions are open-ended; and, opportunity is created whereby the subjects would be closely observed.

The field-guide is divided into sections. Section one contains questions on socio-economic characteristics of the sample. These are age, sex, occupation, annual income, religion, marital status, number of children etc. The essence of questions on social, economic and demographic characteristics is that they shed light on responses about patterns of utilization of health services. By examining the relationship between these social, economic and demographic variables and pattern of utilization of health services, we were able to analyze the data very meaningfully.

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5. For detailed appraisal of the field guide, see appendix 1.

The second section contained questions relating to the specific objectives of the study. Questions were asked on:

(a) incidence and distribution of respiratory diseases;

(b) perception of seriousness of respiratory diseases;

(c) treatment plans patronized and the sequence of such patronage.

To facilitate questioning, symptoms of respiratory diseases had been defined and arranged accordingly (See Table 2.6). The respiratory diseases and/or their symptoms were read out o one by one to the respondents. The respondents then indicated whether any member or members of the households had any of the diseases/symptoms. They were asked to describe the diseases/symptoms according to the peculiar features of the diseases/symptoms; they were asked their perception of the seriousness of the diseases/symptoms. They were also asked to indicate and assess the sources, sequences and consequences of the treatment facilities which they were patronizing.

2.4.2 Direct Observation

In observing the subjects, issues relating to risk factors that were not included in interview questions as

well as those relating to utilization of health services were borne in mind. These included firstly, environmental factors i.e. living conditions, level of personal and environmental hygiene, protection of foods from flies, prevention from mosquito bites, attitude to water from doubtful source; nature and volume of cross ventilation etc. Secondly we observed nutritional status of the householders i.e. volume and quality of food they ate[6], smoking, consumption of alcohol etc. Thirdly, we observed generally, the status of their respiratory health i.e. we were vigilant to recognize and point attention to observable symptoms of respiratory diseases. Finally, we tried to observe their pattern of utilization of the health facilities especially their utilization of such facilities that were not far-fetched (See Appendix 3).

6a. Accurate volume and quality of their food-intake was not possible to determine. But we were able to determine

(a) that emphasis was on three large and solid meals much of which was largely cabohydrate.

(b) Fruits like orange, guava, mango, pawpaw kolanut, etc. that are grown locally were not regarded as food as such. In fact, children alone were fed such foods as refreshments.

(c) Children were denied too much meat in their meals. They were also discouraged from eating between meals.

2.5.0 Pre-test of the Field-Guide

In a pre-test of the field-guide, six households drawn from two villages in the adjacent Ijaye district were studied. These villages are Ogundana and Alaho. They were used for this pre-test because they seem to possess similar features with the villages studied in Moniya district. For example, they both have continguity advantage to Moniya. Inhabitants are subject to similar socio-environmental constraints e.g. poor roads and inadequate transportation facilities. In addition, age-sex structure as well as health habits appear to be identical in both communities.

We undertook the pre-testing for two reasons. Firstly, we wanted to ascertain the extent to which the research questions, how they were worded and how they were put across to the respondents, would be capable of eliciting desired responses. Secondly, the pre-test was intended to find out the reaction of the respondents to the length of each interview. The pre-test exercise was on the whole fruitful because, the original field-guide was expanded for more questions.

2.6.0 Interviewing

All interviews were held within a three-month period, March to May 1987. We choose this period for two reasons. Firstly, it is a period when many farmers would have comparatively less work to do in their farms. Between May and December people would be busy harvesting crops and clearing bush for the next planting. Between December and March, they would be busy planting new crops. Apart from the fact that they do less work in the farm between March and May, frequent heavy rains also prevent them from working long hours outside the village. The second reason is that we wanted the field work to cover parts of both wet and dry seasons. This, it was envisaged, would give a near-accurate picture of occurrence and treatment of respiratory diseases.

The questions were asked and answers were recorded systematically. Additional questions were asked depending on the peculiarity of each interview. An interview lasted an average of two hours. The result is that sometimes, the investigator did not conduct more than one interview per day. All interviews were conducted in Yoruba but answers were recorded in English Language.

2.6.1 Other Sources of Information

We have already referred to the ethnographic approach of this study as one which puts methodological and procedural emphasis on interview and observation. It also emphasizes the description of the society being studied. In other words, ethnography puts premium on the holistic rather than atomistic properties of the society.

In this regard, we collected additional information from traditional healers, the hospitals and the medicine sellers in the community. The information collected from these sources will be presented in chapter four.

2.7.0 Definition of Concepts

In this section we shall describe how, for heuristic purposes, we determined and employed the concepts of respiratory system and respiratory diseases during the field work.

2.7.1 The Respiratory System

The respiratory system consists of organs subserving the functions of respiration and those of air-breathing vertebrates consisting typically of the lungs and their nervous and circulatory supply, the channels by which they are continuous with the outer air, the nervous, supportive and protective structures and usually, the muscles and

skeletal structures concerned with emptying and filling the lungs (See Appendix 4)

2.7.2 Respiratory Diseases and Symptoms of Respiratory Diseases

Respiratory diseases are two types - infectious and non-infectious diseases (Macdonald, 1977; Gritchley, 1978; Werner, 1981). Infectious respiratory diseases are caused by viruses and spread successively. Non-infectious respiratory diseases are due to deeper organic causes and are not spread through contact. All respiratory diseases affect one or more of the organs of respiration and occasion malfunctioning of the organ or organs concerned. Symptoms in general, are the subjective manifestations of diseases. Symptoms can take the form of pains, cough, iregular breathing, head-ache etc. This study is concerned with people's pattern of utilization of health services when they had one or more symptoms or episodes of respiratory diseases. We tried to elucidate the concepts of symptoms of, and respiratory diseades as contained in Table 2.6 below.

Table 2.6: Respiratory Diseases and Symptoms

Respiratory Diseases	Symptoms/Description
Asthma	Breathing difficulty, expiratory wheezing coughing up sticky mucus, attack may be triggered by allergens viz. air-borne dusts, hair of animals, flour, pollens of grasses etc. Attack may go on for days with little intermission.
Bronchitis	Symptoms of common cold viz. catarrhal, head-ache and fever. The sufferer may cough up blood-streaked sputum; Rapid breathing and laboured breathing are also common.
Catarrh	Increase in secretion of mucus, sneezing fits, pains in the fore-head, redness of the eyes etc.
Common-cold	Fever, headache, catarrh , throat infection etc.
Diptheria	Cold, fever, head-ache, sore throat breathing difficulty etc.
Emphysema	Painful breathing, especially after exercise, chest looks like a barrel in the advanced stage.
Flu	Running nose, cough, sore throat, fever, headache etc. The sufferer may breathe fast, complain of chest pain, or cough up much phlegm etc.
Mumps	Begins with fever, the sufferer may experience a jabbing pain on opening the mouth or eating. Incubation period is two to three weeks. In two days after incubation a soft swelling appears below the ears at the angle of the jaw. Mumps sometimes cause difficult breathing.

Table 2.6: (Contd.)

Respiratory Diseases	Symptoms/Description
Pneumonia	Pneumonia has insidious onset with malaise, shivering, head-ache and muscular pains. These are followed by moderate fever and an irritating cough. Its onset is with a rigour in adults and convulsions or vomiting in children. The sufferer's temperature rises rapidly and remains at a high level with slight remissions for several days. There is a stabbing pain in the side. There is short, dry cough with a grunt. There is rusty sticky, yellowish, greenish or blood-streaked sputum. There is rapid breathing.
Sore-Throat	Sore throat may come with common cold. In this case, there will be fever, cough, head-ache etc. The throat may be red and hurt when something is swallowed. There may be high fever.
Tuberculosis	There is Chronic cough, especially after waking up. There is mild fever in the afternoon and sweating at night. There may be pain in the upper back and there is chronic loss of weight and increasing weakness.
Whooping Cough	Starts like a cold with fever, running nose and cough. Later, the person coughs rapidly without taking a breath, until he coughs up a plug of sucky mucus and air rushes back into his lungs with a loud whoop.

From the above table, we would summarize here-below the symptoms of respiratory diseases which were investigated in the households.

1. Breathing with 'excessive' movement of the clavicle
2. Catarrh
3. Common cold
4. Coughing up of sticky mucus
5. Coughing up of blood-streaked/yellowish/greenish mucus
6. Coughing with a whoop
7. Difficult breathing
8. Mumps
9. Painful breathing
10. Rapid/Fast breathing
11. Stabbing pain at the side as breath is taken
12. Wheezing with or without cough
13. Smoker's cough
14. Sore throat.

Some of the symptoms listed above are pictorially illustrated in figure 2.4 appendix 5.

The nature of symptoms in general is such that they are not exclusively associated to a particular disease or a group

of diseases. For instance, measle, influenza, worms, diarrhoea, dysentary etc. sometimes have symptoms that are similar to those of upper and lower respiratory tract diseases such as common cold, pneumonia, asthma , bronchitis, diptheria, emphysema etc. In using the above symptom list to collect our data, we endeavoured to understand the nature of a particular symptom before we decided whether it could be symptom of respiratory disease or not.

CHAPTER THREE

3.1.0 THE COMMUNITY SETTING

As already indicated, the study population is located at Akinyele local government area of Oyo State. The administrative headquarters of this local government is Moniya which is situated about fifteen kilometres north of Ibadan city. Moniya is located along the Ibadan end of the Oyo-Ibadan highway. This highway links the south-western part of the country to its northern parts. Moniya is fast developing from the status of a rural village into a semi-urban town with a high promise for commercial activities. It benefits very immensely from its location near Ibadan city and along the major south/north high way.

One of such benefits is the development of a daily market in which many types of merchandize are sold. The business activities carried out in Moniya, are medicine selling, supermarkets, food-stuffs-selling, canteens, an abattoir, carpentry, furniture and cabinet-making, vehicle maintenance, gold-smithing, black-smithing, hair-dressing, barbing, hotel businesses, general goods, plank selling,

motor spare parts selling, welding and joinery works, banking activities, and selling of agricultural produce. Many long-distance and short-distance commuters stop over to relax in the hotels and canteens. Many traders who commute their goods from the northern parts of the country also sell their wares in the town.

Various classes of workers employed at the local government secretariat reside in the town. Other category of immigrant settlers include bank employees, construction workers, self-employed workers who work in the town as well as those who work in Ibadan, but choose to live in the town for social and economic reasons.

The other big settlements in the local government area are Ojoo, Orogun, Idiose, Sasa, Akinyele, Onidundu, Iroko, Arulogun, Ikereku, Aroro, Akufo, Iddo, and Ijaye. However, except Ojoo, Orogun and Sasa which also have a fair distribution of variables of development deriving essentially from their nearness to Ibadan city and the south/north trunk road, none of the other settlements is as heterogeneous and busy as Moniya. A critical look at the relatively big settlements will reveal that the nearer they are to Ibadan, and/or the south/north road, the more heterogeneous and busier they are. For instance, Iroko, Onidundu, and Akinyele appear to be

more heterogeneous and more commercially busy thank Akufo, Iddo and Arulogun which are more distant to the road. But Moniya, Sasa, Ojoo and Orogun are most developed because they are nearest to Ibadan and are located on the south/north highway. There are 1682 small villages in the local government area. The location of these villages has certain features. Firstly, villages are located in clusters such that certain villages are situated within walking distance (about 5 kilometres). Secondly it appears that the farther the villages are from Ibadan town, the more they are shut off from modern and/or development influences and the less the exchange of visits that is possible between the villagers and their relations in Ibadan city and other surrounding bigger settlements.

3.1.1 Major Occupation

The major occupation in Akinyele Local Government Area is farming. Farming is still a subsistence activity in that the farmers hardly produce more than enough for their immediate families and relations, who live in big towns. Their produce includes food crops such as cassava, cocoyam, yam, corn, maize and beans. They also produce cash crops like cocoa, coffee, kolanut and palm produce. Farmers go to their farms in the morning and evening. Some

very energetic ones among them go game-hunting in the evening and sometimes in the night. The games killed are sold to traders who re-sell in the markets and on major road sides.

Apart from helping their husbands to work on the family farm, women also have personal farms. They go to the farm early in the morning after doing the early morning household chores like cooking, cleaning the house or compound, fetching of water, and taking care of the children. They come back in the afternoon to settle down again to house-related activities like crushing of palm kernel, cooking and so forth.

The women who also trade mostly in farm produce, return from the farm only to begin to purchase and/or sell their wares. Usually, they hawk their wares from village to village. These wares include palm produce, cassava produce, dry fish, dry meat, salt, groceries, processed foods and so forth. Some of the women produce local soap (ose abuwe), palm oil, palm kernel oil (adi) soup ingredients e.g. locust beans ('Ogiri and 'iru') and many other goods that are locally sourced and consumed.

Despite the fact that farming is the main occupation in these areas, not much of the farm produce is sold in the market. Farmers still depend on the low-yielding old trees for their cash crops and on traditional farming implements

such as cutlasses and hoes. The result is that at a certain period of the year when they have exhausted their produce, they buy food stuff from the local traders who get their supplies from the bigger neighbouring settlements. At all times of the year, the villagers, through the village traders, buy their meat, fish, soft-drinks, beer, hardware, clothes and modern drugs from the larger neighbouring towns.

3.1.2 Infrstructural Facilities

There are no modern facilities in most of the areas studied. In fact, the impact of the modern government has not been felt appreciably in these areas. The roads linking the villages together are not tarred. Most of the roads are not motorable. In many cases, only footpaths link certain villages with the others. It therefore requires great efforts to move and to transport farm produce from one village to the other.

Coupled with the problem of poor roads, is the lack of transportation facility. The roads are too bad and the motor vehicles that ply them are too few and too old to give room and convenience to as many passengers as are willing to move around. Commercial vehicles get to some of these villages periodically either once in a week or a fortnight.

The villagers wishing to travel assemble at the sides of the major roads for the vehicles. Most of the times, the available vehicles are overloaded with goods and passengers. For these reasons, the cost of transportation is high and volume of movement low, compared to transportation costs and mobility in the bigger towns.

There is no potable water of any kind. The local government authorities dug wells in Moniya and a few other bigger settlements. One was also dug in Apapa village. Most of the remaining villages do not have wells. People in such villages depend on water from streams and ponds. These same sources are used for washing and drinking. In the dry season when most streams and ponds dry up, villagers trek to distant places for water. During the period of this field work, there were reports of cases of water-borne diseases like guineaworm, dysentary and diarrhoea.

There is no electricity supply in the villages. Thus all the modern household electrical appliances such as electric pressing iron, cooker, tape recorder, television, fridge, cooker and so forth, are not available. Although a few village elites own transistor radios, the radios are tuned only for major news in the morning and in the evening to save or economize batteries whose cost is probibitive.

The outcome of this is that information dissemination through mass communication has been effectively hampered and life is generally dull. It becomes very unclear whether the benefits of modern government have come to these villages in the extent that will be capable of transforming their material existence thereby improving their quality of life.

3.2.0 The Health Belief System of the Villagers

The health belief system of the villagers could be discussed broadly within the general context of the health belief system in most parts of Yoruba land. In fact, age-long beliefs thrive longer in the villages where life is more peaceful and people are insulated from externally generated disturbances. The villagers believe that illness can be caused by natural, preternatural and mystical forces. These beliefs will be explained in turn.

3.2.1 Natural Factors

The villagers realize that exposure to certain harsh conditions can bring health hazards into their lives. Thus exposure to heat as in a person working in the sun and exposure to cold as in somebody not wearing proper clothes in the rainy season, can cause head-ache, fever cough and other diseases. Similarly, these diseases are quite often believed to be caused by eating and drinking

poorly cooked food. Someone that eats fresh corn can catch cold; someone that eats an unripe fruit can have an upset stomach and someone that eats in quick succession may have stomach ache or constipation.

3.2.2 Preternatural Factors

The people also believe that preternatural factors especially witches and wizards can cause certain illnesses. This is more so if the illness starts in mysterious circumstances or proves too stubborn for treatment. Virtually, all sicknesses are attributable to preternatural forces. And these forces can have various reasons for attacking a victim. Therefore, people try to avoid disputes and provocative utterances. Children are warned not to show disrespect to elders. People watch what food they eat for fear they could be poisoned. Successful individuals are warned not to display their wealth through opulent living so that they may not court the envy of the less fortunate relations or friends. These moral proscriptions and prescriptions are expected to be observed so that preternatural being would not be given occasion to harm them.

It is believed that sorcery is practised by medicine men; and sorcerers are said to attack their victims by using medicine on them. Witchcraft is believed to be

practised by women. Witches on the other hand are believed not to harm their victims with visible substances but believed to operate in the spirit realm. Compared to sorcery, the effects of witchcraft are difficult to prove for two reasons. Firstly, sorcerers are believed to attack their victims by using physical means e.g. poisoning the food of the victim or his personal effects but witches are believed to harm through invisible means, their victims. Secondly, sourcerers, in most cases professional medicine-men, are believed to harm only persons from outside their kin group. But witches are believed to come from the kingroup and may even harm or kill their closest kin. A witch may not necessarily be an old woman. Young girls are also believed to be capable of possessing witchcraft. A young girl could be initiated into witchcarft without her consent. Initiation could be done by infesting the girl's food with witchcraft. On eating this food, the girl automatically becomes a witch.

Quarrels over seduction of women and ownership of property or succession do lead to allegation of witchcraft within the kin group. But in the absence of a quarrel, a woman can still use her witchcraft to retard another person's progress or kill him altogether. When diagnosing mysterious illnesses or circumstances, the old members of

the kin group primarily rely on their knowledge of diseases. But once the sickness that they diagnose has become resilient to treatment, they will shift emphasis to the Ifa oracle. This means that the traditional method of diagnoising disease appears to be un-reliable. For instance, victims who suffer status eclipse or serious illnesses might approach a diviner for explanation. The Ifa oracle investigates and indicates the general cause of the attack. The oracle may for instance, indicate that the sickness or eclipse has a remote connection to a dispute. The patient will then be expected to confess whom he had wronged or had dispute with. If the patient indicates that he has problem with somebody, the diviner could say that an ancestral spirit had been troubled by the dispute. Then the ancestral spirit will be appeased. If after this appeasement the problem is not solved the oracle might indicate that witchcraft was also involved.

3.2.3 Mystical Causes

The people generally believe that ancestral spirits and gods can also cause an 'erring' members of the kin group to be sick. Thus certain diseases are attributed to the gods or the ancestral spirits. The ancestral spirits punish their successors with illnesses if they

were neglected and not given occasional sacrifices. Persistent headache, intermittent fever, continued stomach disorder, rickets and other wasting diseases among children, are attributed to supernatural forces. Similarly, menstrual troubles, miscarriages, smallpox cholera, mental illness and plague are always attributed to the wrath of various godesses. Worship and sacrifice are regarded as the main remedy.

The patients are treated with traditional medicine. They are taken to traditional healers because the illnesses are regarded as supernaturally determined and hence outside the province of modern hospitals. Standard rites of curative and preventive significance are performed in public ceremonies. In such a ceremony, a deity is regularly honoured so that he will give his worshippers good-will and not misfortunes.

The gods and godesses worshipped regularly are 'sanponna' (godess of small-pox), 'osun' and 'oya' (godesses of fertility) 'ogun' and 'oke' (gods of safety and prosperity respectively) and 'Osogiyan' (godess of plentiousness). These deities are worshipped at various times in the year. At the beginning of the dry season a ritual ceremony in honour of the godess of smallpox is performed in the villages.

This is the time when the godess is fed, honoured and ceremonially "led away" from the vicinity of the village. People who die through small pox are buried in the bush. It is believed that if the corpse is buried in the village, small pox will spread to other persons. It is a good health habit, therefore, to maintain good relationship with the supernatural forces.

3.3.0 The Role of Kinship Network in Illness

The saying that 'health is wealth' is underscored by the role which the kin group performs when a relation is sick. The first action taken by the kinsfolks when a member of the kin group is sick is to accept the sickness as a problem confronting the whole family unit. They then proceed to take care of an comfort the sick person. They give him the assurance that they solidly stand by him and vicarisouly share in his distress.

After this, home remedies consisting of concoctions, powder, incision, cupping, extraction, and prayers are administered to the sick person. Most sicknesses are presumed to be naturally caused. Whether perception and explanation of the cause of disease will shift from natural causation will depend on the circumstances and course of the illness. The probability that an illness will be

perceived to have been caused by supernatural forces becomes very high

(a) if the sickness occurs dramatically or begins in a mysterious circumstance or after a quarrel;

(b) if it becomes resistant to home remedies or prolonged professional treatment;

(c) or if many kinsmen and women have been involved in the process of treatment.

When a person falls sick, he may still give instructions as to how he would be treated if he is fit enough. If he cannot, or the initial treatment efforts fail, the oldest persons in the village will be informed for necessary action. If their actions also fail, then one or two herbalists will be called as a last resort. The case may also be referred to a modern hospital. At this stage, several relatives would have gathered to express solidarity with the sick person and to suggest treatment plans. The range of kinship network that is involved will be a function of the seriousness and circumstances of the illness.

As this circle of interested persons broadens, the probability that one or two persons will give a causal explanation based on supernatural factors becomes very great.

A mystical attack is often believed to be rooted in social circumstances like quarrels between relatives, disrespect to elders, a neighbour's envy or unfulfilled ritual obligations. Sickness is not explained only in terms of the individual's experience but also in terms of the group's experience and in terms of the role of the patient within the group. When trying to understand the cause of a sickness, it becomes very essential to review the patient's relations with others in the community.

In diagnosing illnesses and suggesting treatment plans, the knowledge and experience of older relations are very important. They direct the treatment in the light of their own knowledge or medicines and symptoms, combining with this practical therapy, their deep knowledge of mystical forces and the social causes that bring these forces into play. Treatment proceeds on two levels - the level of practical therapy and the level of mystical counteraction in which the mystical consequences of the patient's previous social behaviour are fully explored.

3.4.0 Traditional Health Services

For analytical reasons, traditional medicine will be discussed in three parts. Firstly, there is the use of prayer or Faith Healing. Many Aladura Churches operate healing sessions during which prayers are offered for healing

the sick. Secondly, there is self-medication in traditional medicine. The knowledge and practice of medicinal use of prayer and herbs is very widely spread in the villages studied. It is not confined to specialists like prophets and herbalists. The third type of traditional medicine is the medical care dispensed by professional Traditional Healers. The Professional Healers are believed to have a wide knowledge about the use of herbs and magicoreligious regimens. In the treatment plans, traditional specialists often come in as a last resort when general-knowledge-medicine has presumably failed.
Traditional medicine appears to be easier and cheaper to come by. It also appears to be relevant to the experience of the users.

3.4.1 Modern Health Services

The modern medicine used in the villages could also be analyzed in three ways. The first is Self-Medication in modern medicine. The villagers use pain-relievers, anti-malaria tablets, cough syrups, liniments and so on, at the initial stage of an illness episode. Secondly, the villagers patronize the "Health Workers" who visit the villages regularly. These "Health Workers" "diagnose" sicknesses and make prescriptions which they in turn sell

to the patients. The third type of modern medicine is Hospital-based.

In practice, the villagers or the therapy managing groups patronize more than one of these services in the course of an episode. There are three elements in their utilization of health services. These are shopping, fragmentation of care and self-medication. They shop for medicaments in that they seek many types of medicine at the same time.

Sometimes, relations provide or recommend various traditional and modern medicines. They insist that the sick persons should use these medicines claiming that they are effective. In this circumstance, it becomes very difficult for the therapy managing group to wait long enough to assess the therapeutic effect of one treatment before administering another.. Thus there is fragmentation of care in the pattern of their utilization of health services. Then there is self-medication. It appears that self-medication is the hallmark of treatment in the rural areas. Both modern and traditional medicines are freely used in the villages studied. This appears to be the only alternative in an environment where movement is hampered by lack of transport-ation facilities.

CHAPTER FOUR

4.1.0 A PROFILE OF HEALTH SERVICES AVAILABLE AND COMMON DISEASES IN THE DISTRICT STUDIED

The focus of this chapter is to highlight certain background information which relate to this study. Firstly, we shall present information on the health services that are available in the district. Secondly, we shall give information on certain diseases that are commonly experienced in the district.

There are six therapeutic sources in the villages. These are Traditional Healers, Aladura Churches, Home-made Remedies, Orthodox Hospitals, "Health Workers" and Patent Medicine Sellers. We shall explain these in turn.

4.2.0 Traditional Healing Techniques

There are over forty professional traditional healers in the district studied. There are at least three broad variations in traditional medical practice. Firstly, there is great variation in the level of the organization of their practice. For instance while a few of their healing milieux are established like modern hospitals with various categories of full-time permanent and apprentice health

care personnel, majority of them are manned by only one man - the traditional healer - and possibly one or two members of his family who give him part-time/casual assistance. Secondly traditional practitioners vary according to their area of professional specialization. In one important sense, all traditional healers are supposed to be general practitioners. But we learnt from our field work that some of the healers were more competent in psychiatric medicine than in physical medicine and that within each specialization, there were levels of competence. The third variation is that whilst majority of the traditional healers practise medicine as part-timers, only a few practise it as a full-time occupation. In the next section we shall discuss in some detail more features of traditional medical practice.

4.2.1 Treatment Facilities

The treatment facilities used by traditional healers vary but certain features appear to be common to all of them. A few of them are enumerated here below.

Consultation Space: There is a consultation space or an 'office'. It is sometimes separate from, but sometimes the same as, the healer's living room. It also serves as the divination and waiting room.

4.2.2 Diagnostic and Treatment Paraphenalia

These include sand board, crystal water, calabashes, gourds, horse-whips, Ifa rosary, calabashes, buckets, pots, mortars, pestles, beads, hand-cuffs, grinding stones, broken pots, knives etc.

Many and different seemingly old objects are hung everywhere. All this increases a visitors awareness that the healer's environment is different from the ordinary person's. Some of the healers said that the objects are hung about so that they may come in handy when needed. But many of them said that the practice of hanging medicinal objects in conspicuous places is a time-tested tradition among Traditional Healers, the practice for which there is no better alternative.

4.2.3 Treatment Regimens

The treatment regimens prepared by traditional healers vary very widely in form, colour, taste, durability, preparation and use.

There are powdered substances of different colours. There are liquids such as concoction which are prescribed hot or cold and there are medicaments to be chewed like chewing sticks. Some traditional medicines are used with incantations and some are special medicinal soup or stew (aseje). Some

of the traditional medicines are worn on the body e.g. rings (oruka aloju, oruka giri etc.) medicinal bangles necklaces or belts. There are incisions (gbere) hot or cold compresses, snuff, soap and liniments, to mention a few.

Traditional medicines are prepared from a broad range of natural and supernatural substances. Some are made from trees (e.g. leaves, roots, barks of trees etc.) animals (e.g. animal urine, gall bladder etc.) insects (e.g. ants, bees etc.) human parts (e.g. human hair, finger nail, and parts of human corpses). Medicines are also prepared with mysterious materials e.g. burial shrouds, soil from grave-sides, suicide ropes, and placenta. Dirt from ear-holes, sea-water, tears from human eyes, human faeces, saliva, urine, breast milk, thunder-stones, ant-hills, wasp-nests etc. were also said to contain medicinal ingredients. It appears that virtually every object conceivable has medicinal value in traditional medicine.

4.2.4 Methods of Preparing Traditional Medicine

The methods of preparing traditional medicines also vary according to the illness episodes requiring their use. Medicinal ingredients may need to be collected at certain periods of the day; for instance, at night or at the mid-day.

In some cases, the ingredients may need to be collected from certain directions - East, West, North or South. Furthermore, some of the ingredients may need to be invoked before being collected. All this is believed to increase the potency of these ingredients.

Some of the traditional medicines are bitter to taste, some are salty, some are peppery, some are tasteless and some need to be mellowed with sugar or salt. Some of the medicines have strong smells, some have none while others have sweet smells. Most of the medicines are prepared fresh but some are prepared stale. The stale medicines are hung at the fire-side.

Other things that catch a visitor's attention in a traditional healer's 'office' are the many sooth-gathering materials viz. bottles, gourds, herbs and wrapped substances which are hung up the fire-side. These stale medicines are prepared for emergencies like snake-bite, acute stomach-ache, injury etc.

Traditional medicines are prepared either in a single stage or in several stages. Some are prepared with one herbal substance or several of them. Medical preparations classified as simple preparations consist of one stage or one or two ingredients. An example of simple preparation is where a patient wrings out liquid/juice from leaves of

mango tree for example, and drinks it to cure a disease such as fever or stomach-ache. Another example is where a leaf is ground and/or soaked in water or local gin (ogogoro) and drunk afterwards. Such simple preparations are learnt and dispensed with minimum effort. In fact, knowledge of such simple preparations is most widespread and cuts across sex and to some extent, age. On the other hand, medicines whose preparation is complex go through several stages and/or requires two or several ingredients. Knowledge of complex preparations is the hallmark of professional practice by Traditional Healers.
Complex preparations go through three to four or more stages. They may require intensive invocation. They may require long fermentation and several different ingredients. Whether simple or complex, preparations generally take the following forms among several others.

Firstly, medicinal ingredients may be reduced through grinding or 'burning' into powder form. Secondly, they may be boiled or fermented in cold water or other liquids like vegetable oil, palm oil, human or animal urine, palm-wine or local gin etc. Thirdly, preparations may require some self-inflicted ascetic practices e.g. abstention from sexual intercourse, certain types of food or drink, fasting or using of perfume.

4.2.5 Directions for Using Traditional Medicine

On the part of the user, certain prescriptions and proscriptions may need to be observed for the medicament to be efficacious. For example, strictly speaking whilst some medicines need to be swallowed, some need to be chewed, some need to be drunk, some need to be inhaled and some need to be massaged into the skin only at particular periods of the day. Many of traditional medicines need not get into contact with the circulatory system to be efficacious. For example, some of the traditional medicines merely need to be worn on the neck, hand, waist, wrist, finger, or ankle. Some medicicines are to be carried in the pocket, some hung at the lintel of the house, some buried under one's pillow, some buried under the floor of the house etc.

Some of the traditional medicines are to be used when the user is alone and/or naked, and some of them are to be used in the afternoon or in dead of the night. In some cases, the use of traditional medicines should begin with incantation and end with incantation. It appears from the foregoing that professional practice of traditional medicine, characterized by complex medical preparations, is shrouded more in magicoreligious observances than it emphasizes pharmacologically-active ingredients. By

contrast, it would seem that general knowledge and practice of traditional medicine, characterized by simple preparations, rely on pharmacologically-active ingredients more than on magico-religious observances.

4.2.6 Doctor-Patient Relationship

It is instructive to note that there is a high level of rapport between the traditional physician and the patients. There is also a considerable congruence in the perception of both parties about causation and treatment of diseases. One area in which rapport between traditional physicians and their patients is very prominent is the determination of the reward for treating a patient. Cost of treatment is determined by the type of treatment. For most of the diseases, a lump sum of money and materials are required. Part of this will be paid in advance and the other part will be paid as treatment progresses. There is the possibility that the whole cost will be paid if treatment is successful.

There is no fixed consultation/divination fee in most of the healing centres. The amount that will be paid as consultation/divination fee depends on the health-seeker. But fees that will be paid for treatment depends on the type of sickness. Mental illness and chronic or acute illness attract higher fees. Most traditional healers

interviewed indicated that they sometimes allow their patients, on humanitarian grounds, to pay up their fees after their discharge. However, they said that if the patient refused to settle his medical bills after his discharge, the disease would be caused to relapse. Finally, sometimes, the traditional healters treat their patients free of charge. In such cases, however, the patients or their relations in return, send gifts in cash or kind to demonstrate their appreciation. This practice of free treatment partly explains why most traditional healers are financially poor.

4.3.0 The Aladura Churches

Nine churches are located in the district studied. These are a Baptish Church, a Christ Apostolic Church and Aladura Church at Idiose village. One Anglican Church is in Otun-Agbakin village. There are a Baptist Church and three Aladura Churches at Moniya. Finally, there is one Aladura church at Apapa village. Five of these i.e. the Aladura churches regularly held meetings where healing was ministered to worshippers as part of revival services.

Items used along with prayer are water, candle and olive oil. Patients are often instructed to fast for certain number of days. The spiritual heads weild a lot of influence

and take a lot of initiative in matters relating to healing. They diagnose illness, prescribe the number of days that the sick person will spend in fasting, what form the fasting will take and prescribe the items that will be brought to the church in connection with healing rituals. One of the leader-prophetesses said that what will be prescribed to a sick person depends on divine inspiration. According to her, some persons may be asked to go on absolute fasting (no food no water) for three to seven or more days whereas some others will be asked to go on partial fasting (breaking the fasting every evening).

Seven persons were receiving treatment as 'in-patients' in the churches during the study period. Five out of these were cases of mental illness while the remaining two were complaints about physical illnesses. The prophets and prophetesses in charge had no records of how many patients have been healed through their prayers, but they said that treated cases were many.

4.4.0 Home-Made Medicines

Just as there is functional difference between patent medicine sellers and medical doctors on the one hand and 'Health Workers' on the other, we need also to stress that Home-made traditional medicines are different from traditional

medicines sought from Traditional Healers. We have already pointed out that Traditional Healers possessed greater technical competence that sets them apart from the lay health-care providers.

All grown-up persons interviewed indicated that they were able to prescribe Home-made medicines for two or more ailments. It is in this sense that Traditional medicine is said to be relied upon by most people in the developing countries. One important feature of self-medication is as follows. The villagers and relatives visit any sick individual in turn to express their solidarity. The diagnose the disease episode in the light of their individual or collective experience. They then give or suggest treatment which they claim has been used successfully before. The result is that the sick individual is overwhelmed by many alternative treatment plans. This swift response could be explained in two ways. Firstly, face-to-face interaction dictates that there should be collective responsibility for healing the sick member. Secondly, most of the ingredients of traditional self-medication are available locally.

4.5.0 Modern Hospitals

Four modern health facilities are located at the Head-quarters of the Local Government Area. These are also

the only ones which are closest to the villages studied. They are the 15-bed Olagunju Memorial Hospital at Moniya, the 5-bed Health Clinic and the ten-bed Maternity Hospital at Moniya and the 5-bed Abedo Primary Health Centre.

Table 4.2 Facilities in Modern Hospitals at Moniya District

Health Facilities	Medical Doctors	Nurses	Hospital maids	Number of Beds
Olagunju Memorial Hospital	1(50.0)	3(25.0)	6(15.8)	15(42.9)
L.G. Maternity	1(50.0)	5(41.7)	14(36.8)	10(28.6)
L.G. Health Clinic	-	2(16.7)	7(18.4)	5(14.3)
Abedo Primary Health Centre	-	2(16.7)	11(29.0)	5(14.3)
Total	2(100.0)	12(100.0)	38(100.0)	35(100.0)

The first of these is privately owned while the remaining three are public establishments. It could be seen from Table 4.2 that the hospitals are not staffed by many medical doctors and nurses. We also knew through investigations that there were no laboratories, x-ray

diagnostic equipment or facilities for emergencies in the hospitals. Essentially therefore, serious cases might need to be referred to specialist or general hospitals in Ibadan city.

4.6.0 The "Health Workers"

Five "Health Workers" were interviewed in the district studied. These were the most regular of the eight "Health Workers" who reportedly visit the villages. Discussions with them showed that the "Health Workers" come from Ibadan city. It does not seem that they had any formal training as Health Dispensers although long practice could have conferred on them some experience. It appears that they possessed government licence to sell patent medicine. But, in practice, they did not comport themselves strictly as mere medicine sellers. They listen to their patients' complaints, examine them, 'test' them with a thermometer, and then "diagnose" the disease. In the end they prescribe and sell medicines to their patients. In very rare cases, they give intra-muscular injection. The villagers at Akinsola - one of the villages studied, recalled an incident which happened in 1981. A patient was reported to slump dead after receiving such an injection.

There is need to emphasize the functional difference

between a "Health Worker" and a Medicine Seller or a patent medicine store with which it can be easily confused. From the brief discussion on the "Health Workers", we shall see that the so-called "Health-Workers" actually usurp the function of a medical doctor while the medicine seller only sells prescribed or requested medicines. More importantly, the villagers studied perceived the "Health Workers" as providers who, at least, have more technical knowledge than the ordinary medicine seller. We were told that the "Health Workers" have been dispensing medicine in the villages for more than twenty years although their number had increased only recently. The fact that they were perceived as being capable of treating certain diseases perhaps accounted for their continued acceptance in the villages.

4.7.0 Medicine Stores

Sixty-six "Medicine Stores" were located in the villages studied. What we regard as a medicine store in this study is any stall where modern medicines were sold at all, not necessarily where they were sold as the main items in trading. Many of the "Medicine Stores" identified during the field-work were small scale, in many cases petty, trading concerns. Medicine was not sold in most of them as major items on the shelves. The sellers include grocers, petty traders and hawkers.

Majority of the available "Medicine Stores" are located in Moniya Township. Medicines that are found in them include pain relievers, cough syrups or mixtures, anti-malaria medicines, eye and ear drops, liniments, diarrhoea mixtures, etc.

4.8.0 The Most Common Diseases in Moniya District

In this section, we would present the background information on the diseases that people commonly experience in the district. We would, also, explore their perception of the causes of the diseases.

4.8.1 Common Diseases

As could be seen in Table 4.3, the total number of diseases mentioned is fifty-three[7]. Each of the diseases was mentioned in at least forty-nine or 73.1% of the households. Those mentioned by the smallest proportion of the households are ulcer (ogbe-inu); epilepsy, elephantiasis, gonorrhoea, 'magun' leprosy, goitre, 'ipa', mental illness, cancer (jejere) Rheumatism (Aromoleegun) and Whitlow (Akandun).

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7. The nomenclature of diseases contained in the table is based on the painfully restricted description of symptoms by the respondents. The nature of symptoms is, however, such that they indicate many and different diseases at the same time. This should be added to the fact that in the field survey, there was the problem of giving inaccurate description of symptoms. The nomenclature is therefore more or less an approximate phenomenon.

The diseases mentioned most frequently in almost all of the households are all types of fever, malaria, weakness of the body, all forms of cough, all forms of running stool, vomitting, whitlow, thrush, mumps, stomach disorder, worm infections, measles, cholera, eye troubles, ear troubles, cold and skin diseases diseases. Since the respondents need to make a lot of recall, responses could have been hampered by loss of, or fading memory. The diseases which were easier to recall are those still being experienced or those that were treated not long ago before the interview. Those that were mentioned reluctantly or with some measure of reservation are the disease regarded as social such as gonorrhea, 'magun' psychiatric illness, elephantiasis and goitre.

Table 4.3: The most common Diseases in Moniya District

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Iba	Malaria	High Temperature, headache, golden urine complaint that food is b bitter	Mosquito bites over-work, eating too much, cooking oil, eating a type of yam	Concoction of herbs/ modern medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Iba* kojupon	Jaundice/ Yellow fever	Paleness of the skin, eyes, finger nails and food being bitter	Heredity eating of yellow yam, eating too much cooking oil	Concoction, powdered medicine/ modern medicine
Ara gbigbona	High Fever	High temperature weakness of the joints, back ache	Overwork or over-exertion of the body in sexual activities	Rest, malaria concoction and tablets
Iwora	Weakness of the body	Weakness of the joints and back ache	Overwork, over-exert- in sexual activities	Rest, malaria concoction and tablets
Efori	Headache	Headache	Exposure to sun or heat	Modern medicine
Efori tuulu	Migraine	Severe headache that sometimes affect a part of the head	Bushy, unk unkempt hair or exposure to heat	Modern medicine, traditional medicine
Bebi	Vomitting	Nausea feeling/ vomitting	Eating of bad food, drunkeness, cough	Salt water, eating of kolanut, eating of good and warm food

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Igbe Gbuuru	dysentary	Frequent stool accompanied with abdominal discomfort	Food poisoning, eating of bad food, drinking bad water	Concoction of herbs/ modern medicine
Igbe Orin	Diarrhoea	Watery stool; looks like rice water, patient is weak and sickly	Eating of bad food, drinking of bad water	Concoction and modern medicine
Atawo/ Akandun	Whitlow	Pain in, or swelling of the finger/ toe Blister and painful sore in the affected parts	Contact with an insect or its excrement	Traditional medicine/ modern medicine
Akokoro/ Owoenu	Infection of the gum/ teeth	Painful teeth/ gum difficulty in eating meat, kolanut etc.	Heredity	Traditional medicine or modern medicine
Yoro/ Owo-enu	Thrush/ infection of the gum	Blister in the lips mouth sore or teeth infection	Lack of care of the mouth	Modern medicine/ traditional medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Segede	Mumps	Swelling at the lower part of the jaw. Fever, head-ache, pain and difficulty to eat	Supernatural e.g. Bleeting like/with a sheep/goat, barking like/ with a dog or making a shrill noise like/with a cat. It is believed that little children are more vulnerable to mump	Traditional medicine made from the mound of an insect/ incision
Inu-rirun	Stomach ache	Feeling of intensive discomfort at the lower abdomen	Supernatural causes, unripe fruits or diarrhoea	Modern and traditional medicine
Ikun	Catarrh/ running nose	Incessant nasal discharge	Natural i.e heredity	-
Iko ife	Whooping cough	Rapid coughings with a small pause between coughs. A sticky mucus is coughed up and air rushes back into the lungs with a loud whoop	Heredity, supernatural causes	Modern medicine/ traditional medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Aran-aya	Worms passing through the lungs	Worms enter into the chest hook on to the lungs and disturbs normal breathing. This causes cough. The worms sometimes come out of the mouth.	Eating of tough meet or any food that is difficult to digest	Traditional medicine/ modern medicine i.e piperazine, ketrax, wormer, wormicide
Ile tutu/ Okele	Diptheria	A diseases of the lungs that spreads to the abdomen, produces strains on the sides of the belly. Pain rarely subsides; leads to cough accompanied by swollen limbs and cheeks. Sufferer turns pale, sluggish and sickly.	Heredity i.e. travels through the blood; super-natural causes	Traditional medicine
Iko eyin	Teething cough	Coughs that affect little children when growing the teeth. Such coughs stop as soon as teeth appear.	Causes depend on the parents Some children only have diarrhoea	Traditional medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Osin/ Ofinkin	Sneezing catarrh	Catarrh with violent sneezing and nasal discharge	natural factors	Traditional medicine/ modern medicine
Ogbele*	Measles	High fever, leanness, dry cough, paleness and sluggishness rashes appear on the skin. Lips and eyes turn reddish with sore	Heat/high temperature supernatural	Traditional medicines modern medicine
Onigbameji	Cholera	Sufferer vomits and passes watery stool. Suffer er is dehydrated.	Supernatural/ contact with a sufferer	Traditional medicine/ Modern medicine
Asunkun*	Urinary Disease	Swelling of the abdomen, severe pain, paleness of the skin, inability to eat	Supernatural	Traditional medicine
Ogunoru	Loss of consciousness	Violent Convulsion, loss of consciousness	Supernatural	Traditional medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment
Warapa*	Epilepsy	Loss of consciousness, violent convulsion foamy mouth	Supernatural	Traditional medicine
Giri*	Convulsion	Violent convulsion high fever, malaria or any other sickness	Natural/ supernatural	Traditional medicine
Ipa tabi Yinrun-yinrun*	Tetanus	Violent convulsion with stiff jaw of neck	Supernatural	Traditional medicine
Ako Giri	Meningitis	Follows fever, headache, stiff neck and vomitting violent vonvulsion	Supernatural	Traditional medicine
Jewojewo	Abdominal colid	Discomfort of the belly	Bad milk from a diseased breast	Traditional concoction/ extraction
Jakute	Elephant-iasis	Swelling of the feet/foot and leg	Supernatural	Traditional medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Oka-ori*	Sunken Fontannel	Paleness of the eyes, hair turns pale, vein and blood vessles of the head stand out, the fontannel sinks downs or puffs up	Heredity/ supernatural	Traditional medicine
Tapa	Pile*	Difficulty in passing stool. The faeces passed is scanty or nill sometimes. Ass hole/ anus protrudes sometimes	Food not well cooked. Eating the food to which one is not accustomed	Traditional medicine/ Modern medicine
Olobutu*	Arthritis	Mild/severe pain at the affected joint. The joint may swell up and become painful. The joint may become stiff permanently	Supernatural causes	Traditional medicine
Narun	Eye trouble	Double vision, inability to see clearly at night, sometimes blindness	Natural-eating certain foods okro, ground-nut sometimes supernatural	Modern medicine/ traditipna medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Atosi	Gonorrhea	Veneral disease, difficult urination, affects genitals, painful genitals	Sexually transmitted/ supernatural	Traditional medicine/ modern medicine
Awoka	-	Pains weakness in the different of the body	Natural caused by worms in the body	Traditional medicine
Eti-didun	Earache Ear discharge	Painful ear, swelling around the ear, discharge of pus	Supernatural Natural- heredity, or accident	Traditional medicine/ Modern medicine
Amurun	Nose bleeding	Hermorrhoids of the nose	Natural/ supernatural	Traditional medicine
Roparose*	Paralysis	Paralysis of the limbs	Supernatural	Traditional medicine
Magun*	-	Most serious sexually transmitted disease. There are types depending on symptoms. One symptoms is such that the victim loses weight steadily another is when the victim gains weight steadily.	Supernaturally transmitted through sexual relation as a veneral disease. Affects only men.	Traditional medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
		The third is when the sufferer feels no symptom until he eats certain food mutton and/or okro. Bach of these leads to death inevitably.		
Ipa*	Scrotal hernia	Swelling of the scrotum and scrotal bag	Supernatural	Traditional medicine
Belubelu*	Tonsilitis	Throat infection occasioned by 'overgrown' tonsil. Cuases difficulty in eating	Supernatural	Traditional medicine
Ese*	-	Swelling of the neck near the clavicle. There is an outgrowth which bursts.	Supernatural	Traditional medicine
Ete*	Leprosy	Thickening of the finger, toes, ears and nose	Natural/ Supernatural	Traditional medicine
Iwere*	Mental Illness	Mental Illness	Supernatural	Traditional medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Oro-eyin*	Poisonous	Snake, dog, pig eat, human bite, scorpion, bees, wasp sting. Pains, fever, tiredness or restlessness, death in many cases	Natural/ Supernatural	Traditional medicine
Aran-Oju	Eye	Pains and swelling of the eyes. There could be itchings and movement sensations	Eating too much of okro, groud-nut products etc.	Traditional medicine and/or modern medicine
Otutu	Common	Violent shiver, Sneezing, fits, headache, cough	Natural/ super-natural	Traditional medicine/ modern medicine
Otutu aya	Pneumonia	Feelings of cold in the chest, rapid shallow breath	Natural causation/ super-natural causation	Traditional/ traditional medicine
Gege	Goitre	Swelling on the fontral part of the neck. No pain no dis-comfort. But it is a nuisance	Supernatural	Modern/ traditional medicine
Kuruna	Skin disease/ pellagra	Skin disease chracterised by blisters pains and discomfort as distinct from pinples, eczema and boil	Natural causation but some-times supernatural	Modern traditional medicine

Table 4.3 (Contd.)

Yoruba Taxonomy of Diseases	English Equivalent	Description of Symptoms	Perceived Causes	Treatment Plans
Iko Egbe	Chronic cough	Dry, painful cough accompanied by bloody phlegm	Natural/ Supernatural	Traditional medicine/ modern medicine
Iko-jedo-jedo	Chronic cough	Serious cough characterised by coughing up of blood and the victim getting lean	Natural/ Supernatural	Traditional medicine/ Modern medicine

*The respondents were sceptical about the efficacy of modern medicine in healing these diseases.

4.8.2 Perception

Most of the diseases were perceived to be rooted in either natural or supernatural causation. It is more revealing therefore that the specific cause that is initially perceived is, at best, a temporary cause. It owes its ultimate validity to the course and/or consequence of the sickness in question. This is saying that a disease initially held to have been caused by natural factors (ordinary cold for instance) were potentially attributable to supernatural factors if they resisted several treatment plans. Similarly since ease of treatment is regarded in most cases as indicative of causation,

supernatural explanation is likely to be de-emphasized even in mental illness which is a disease that is mostly attributed to supernatural causation, if it was cured speedily.

Another major revelation is in regards to the households' perception of the nature of relationship between respiratory diseases in general and other diseases which are clearly different from respiratory diseases. Eight or about 12% of the sampled households said that there was no relationship between non-respiratory diseases and respiratory diseases. Some of their reasons for taking this position are that "each disease has its symptoms and course"; "some people who say that the same symptoms can indicate different diseases say so because they have limited knowledge about diseases and symptoms".

Forty-eight or about 72% of the sample indicated that all diseases are related and hence are expressed through similar symptoms. Some of their explanations and reasons for holding this view are as follows. "A child may have fever in the night, before the following dawn he may begin to cough and sneeze". "If any part of the body is sick, all parts of the body will be affected". "Sometimes, even when you are very hungry, you can develop severe head-ache".

"When somebody has measles or chicken-pox, he develops cough and breathing difficulty"; "Malaria also causes cough".

It is important to note further that living conditions, viz. environmental sanitation and nutritional status are not perceived to be appreciably related to disease causation. It was argued in 18 or 26.9% of the households that if the above-enumerated factors were responsible, then all persons who were subject to those living conditions would experience the same disease. A few literal responses given by the households are as follows. "I have lived in this house and in this environment for over 30 years, I have always been hale and hearty". "All diseases travel in the blood, they are caused by food". "New generation human beings do not have strong body constitution, that is why they fall sick when bitten by mosquito".

Even in the 29 or 43.3% of the households where it was responded that diseases were positively associated with poor living conditions, it does not appear that the particular respondents regarded their own material conditions of life as capable of generating or reinforcing diseases. We hold this view because we observed that their housing conditions, nutritional status, and level of sanitation were "below reasonable standard", their responses notwithstanding.

CHAPTER FIVE

5.1.0 PATTERNS OF UTILIZATION OF RESPIRATORY DISEASES' TREATMENT FACILITIES

In the preceding chapter, we provided a profile of the diseases and gave a background information on the health services which are available in the villages studied. We would present in the present chapter, data on prevalence and perceived seriosness of respiratory diseases on the one hand and utilization of health services on the other.

5.1.1 Prevalence of Respiratory Diseases

One hundred and eighty-two (182) persons or 38.6% of the sample indicated that they were not experiencing any episode of respiratory disease (See Table 5.2 below). But over 61% of the 472 persons sampled were suffering at least one episode of respiratory disease. Persons experiencing only one episode were two-thirds of the 290 persons who were sick.

Table 5.2: Distribution of Respondents by Prevalence of Respiratory Diseases

Prevalence of Disease	Number of Sufferers	Percentage of sufferers
No Episode of Respiratory Disease	182	38.6
One Episode of Respiratory Disease	200	42.4
Two or more Episodes of Respiratory Disease	90	19.1
TOTAL	472	100

Conversely, about niney (90) persons who constitute 31.0% of all the sufferers were experiencing more than one episode of respiratory disease. On the aggregate, persons who were experiencing more than one episode were ninety (90) or 19.1% of the total sample. With nearly two-thirds of the sample experiencing at least one episode of respiratory disease, the respiratory health status in the households could be said to be considerably low.

Seventy-six or 26.1% of the patients experiencing at least one episode had cough. Seventeen or 22.4% of the cough-episodes were very serious and due perhaps to more serious lower tract respiratory diseases.

Another very common set of respiratory diseases are common cold, wheezing with or without cough, smoker's cough, catarrh and sore throat. They constitute 27% of all the episodes recorded.

The diseases reported least are mumps, shortness of breath, whooping cough and breathing with 'excessive' movement of the clavicle. Patients suffering these were between 8% and 13% of those suffering respiratory diseases.

That cough is largest single disease/symptom is probably due to the fact that the biological act of coughing is the most convenient defensive reflex by which the lower respiratory

tract is cleared of foreign materials. It could also be partly due to the fact that the respondents had very little knowledge of symptoms and very narrow range of taxonomy of diseases. Thus the different types and various degrees of cough reported could be expressions of deeper respiratory difficulties, irritable sensations and malfunctions of the lower respiratory tract.

Relating these 76 cough-sufferers to the total sample, we notice that about 16.0% of the total sample had one type of cough or another, and one household had an average of 1.1 persons exhibiting a cough-episode or symptom. Running nose was another, most frequently exhbited symptom of respiratory diseases. But the status of running and stuffy nose as perceived by the respondents, is very ambiguous. Medically, incessant running/stuffy nose could be attributable to poor feeding especially overconsumption of carbohydrates and/or organic malfunctioning of the respiratory system. Running nose (whatever is cause/s) assumes the status of a respiratory disease for at least two reasons. First, it is primarily and technically an affair of the respiratory canal. Second, in very many cases, it leads to sneezing and limitation and/or outright blockage of breathing.

Running/stuffy nose was very common especially among the

small children in the villages studied. It is an episode which appeared to be regarded as normal[8]. This very low respiratory status appears to be related to the living conditions in the villages studied. Observation showed that the level of environmental hygiene and nutritional status was somewhat low. The water being used was got either from rain or stream/pond. Not much water was used, therefore. The water was not treated. The water-containers were not properly washed. Leaves (without soap) were used to wash household utensils. Food was not properly covered. The food left over in the night was not properly preserved for the second day. This was eaten cold or slightly warm the second morning. Much of the food eaten was cabohydrate. Personal cleanliness was also poor. Daily bath was not practised by the majority of the villagers. Only very young babies were bathed daily. School-age children were bathed about 2 times in the week. Old persons bathed 2 to 3 times per month. Clothes worn looked dirty. There was no sewage or refuse disposal device. Stools were passed and refuse dumped in the open spaces near the house.

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8. Running nose was regarded as normal not because the householders thought that it was good, but because all children invariably had it.

House flies and mosquitoes were not shut out of the house. There was no proper cross-ventilation in the houses especially in the night. The very small windows and doors were shut in the night for security reasons. There was over-crowding. All of this could affect their respiratory health adversely. Now, two factors, age and sex, appear to relate somewhat to prevalence of respiratory diseases. These factors will be examined in the next section.

5.1.2 Age and Episodes of Respiratory Diseases

Examining Table 5.3, it is noticed that episodes of respiratory disease is slightly un-evenly distributed across age groups. Generally, more younger individuals were experiencing only one episode of respiratory disease whereas older persons appear to suffer more than one episode of respiratory disease. It also appears that no-episode-experience is more widely reported by the younger persons. For example, the number experiencing one episode of respiratory disease falls from 17.0% at age (0-4) years to 10.9% at age (10-14) years. Thereafter, the number of persons experiencing no episode falls more steeply and steadily to reach as relatively small a percentage as 4.5 at age 60 and above. Those experiencing two or more episodes of respiratory disease are, on the other hand, more numerous at the higher age group.

Table 5.3 Distribution of Respondents by Episodes of Respiratory Diseases

Age	No Episode of Respiratory Disease	One Episode of Respiratory Disease	Two or more Episodes of Respiratory Disease	Total of C and D	Total of B,C & D
A	B	C	D	E	F
0-4	26 (14.3)	34 (17.0)	7 (7.8)	41 (14.1)	67(14.2)
5-9	22 (12.1)	26 (13.0)	6 (6.7)	32 (11.0)	54(11.4)
10-14	20 (11.0)	23 (10.9)	6 (6.7)	29 (10.0)	49(10.4)
15-19	11 (6.0)	13 (6.5)	3 (3.3)	16 (5.5)	27(5.8)
20-24	11 (6.0)	11 (5.5)	3 (3.3)	14 (4.8)	25(5.3)
25-29	11 (6.0)	10 (5.0)	3 (3.3)	13 (4.5)	24(5.1)
30-34	11 (6.0)	10 (5.0)	2 (2.2)	12 (4.1)	23(4.9)
35-39	9((5.0)	10 (5.0)	7 (7.8)	17 (5.9)	26(5.5)
40-44	11 (6.0)	12 (6.0)	10 (11.1)	22 (7.6)	33(7.0)
45-49	8 (4.4)	11 (5.5)	9 (10.0)	20 (6.9)	28(5.9)
50-54	9 (5.0)	12 (6.0)	10 (11.1)	22 (7.6)	31(6.6)
55-59	12 (6.6)	10 (5.0)	10 (11.1)	20 (6.9)	32(6.8)
60-64	10 (5.5)	9 (4.5)	7 (7.8)	16 (5.5)	26(5.5)
65+	11 (6.0)	9 (4.5)	7 (7.8)	16 (5.5)	27(5.8)
Total	182 (99.9)	200 (100.0)	90 (99.9)	472 (100.0)	472(100.2)

The data contained in Table 5.3 however, are not sufficiently strong to prove, a prima vista, that adults suffered absolutely more episodes of respiratory diseases

than the younger persons. Our experience in the field convinced us that episodes of respiratory disease affecting children under five could have possibly been under-reported. Most of the very small children lacked ability to give detailed account of their diseases. Indeed, disease experiences of the very little infants especially, were not adequately taken care of. The episodes of respiratory diseases recorded against them were based on their mothers'/guardians' conjecture about what sensations they though their children/wards could be feeling; and their interpretation of these sensations. For instance, a mother could diagnose cough in her infant, but she might not know whether the cough was occasioned or accompanied by chest pains or difficult breathing and she might not know the extent to which this was the case. In this regard, the margin of diagnostic error could be very wide.

The converse is equally valid. Older persons could have over-reported the episodes of their respiratory diseases as, in the field, we observed that the very older persons embraced our interview with remarkable enthusiasm. Our presence and the object of the investigation were so captivating that the whole exercise could have, therefore,

increased their awareness and salience of certain sensations that they probably took, or could have taken, for granted, were there no such interview. They probably even exaggerated some of their disease - experiences hoping to receive sympathy.

Table 5.4 Distribution of Respondents by Sex and Episodes of Respiratory Diseases Experienced

Episodes of Respiratory Diseases	Gender		
	Male	Female	Total
No Episode of Respiratory Disease	88(38.3)	94(38.8)	182(38.6)
One Episode of Respiratory Disease	99(43.0)	101(41.7)	200(42.4)
Two or More Episodes of Respiratory Diseases	43(18.6)	47(19.4)	90(19.1)
	230(99.9)	242(99.9)	472(100.1)

$X^2 = 0.5671$ P = 5.991 at 5% df = 2.

5.1.3 Sex and Respiratory Diseases

One cursory look at Table 5.4 indicates that women reported greater episodes of respiratory diseases than men. Statistical test reveals, however, that there is no significant difference in the overall distribution of respiratory diseases by gender.

Certain additional revelation is carried in Tables 5.5 A and B. The tables contain information on the relationship between age and episodes of respiratory disease experienced by each of the sexxs. For both sexes, it appears that more persons at the lower age-group indicated that they were experiencing no episodes of respiratory disease. But while those who were suffering one episode of respiratory disease each are more numerous among younger males, those who were experiencing one episode of respiratory disease each are spread more evenly across female age groups. Similarly, while older men were experiencing two or more episodes of respiratory diseases more than younger men, those who reported suffering more than one episode each are distributed evenly across female age groups.

Table 5.5 A and B Distribution of Respondents by Age, Sex and Episodes of Respiratory Disease

	(A) Male				(B) Female			
Age	No Episode of Respiratory Disease	Two or more Episode of Respiratory	One Episode of Respiratory Disease	Total Episodes of Respiratory Disease	No Episode of Respiratory Disease	Two or more Episodes of Respiratory Disease	One Episode of Respiratory Disease	Total
0-4	16(18.2)	8(18.6)	6(6.1)	30(13.0)	22(23.4)	4(8.0)	6(5.8)	37(13.2)
5-9	12(13.6)	7(16.3)	5(5.1)	24(10.4)	13(14.1)	5(10.0)	8(8.1)	26(10.7)
10-14	9(10.2)	6(14.0)	7(7.1)	22(9.6)	10(11.2)	4(8.0)	9(8.1)	23(9.5)
15-19	6(6.8)	2(4.7)	6(6.1)	14(6.1)	3(2.8)	3(8.0)	7(7.0)	13(5.4)
20-24	5(5.7)	3(7.0)	5(5.1)	13(5.7)	3(2.8)	4(8.0)	8(8.1)	15(6.2)
25-29	5(5.1)	2(4.7)	6(6.1)	13(5.7)	7(7.8)	2(4.0)	6(5.8)	15(6.2)
30-34	5(5.7)	2(4.7)	5(5.1)	12(5.2)	4(3.7)	2(4.0)	7(7.0)	13(5.4)
35-39	5(5.7)	2(4.7)	7(7.1)	14(6.1)	4(4.7)	3(6.0)	6(5.8)	13(5.4)
40-44	7(8.0)	2(4.7)	7(7.1)	16(7.0)	6(6.5)	3(8.0)	7(7.0)	16(6.6)
45-49	2(2.3)	2(4.7)	10(10.1)	14(6.1)	4(3.7)	5(10.0)	7(7.0)	16(6.6)
50-54	5(5.7)	2(4.7)	8(8.1)	15(6.5)	4(4.7)	4(8.0)	8(8.1)	16(6.6)
55-59	6(6.8)	1(2.3)	9(9.1)	16(7.0)	6(6.5)	3(6.0)	8(8.1)	17(7.0)
60-64	2(2.3)	2(4.7)	10(10.1)	14(6.1)	4(3.7)	2(6.0)	7(7.0)	13(5.4)
65+	3(3.4)	2(4.7)	8(8.1)	13(5.7)	4(4.7)	3(6.0)	7(7.0)	14(5.8)
Total	88(100.1)	43(100.5)	99(100.1)	230(100.1)	94(100.3)	47(100.0)	100(99.9)	242(100.3)

In general therefore, while there is no evidence to suggest that women experience more episodes of respiratory disease than men, there appears to be some indication that episodes of respiratory disease are reported more at certain age-groups than others among males whereas they are more evenly distributed across female's age-groups.

The social organization of the villages do not appear to give clue to the differential pattern in which episodes of respiratory diseases are distributed in the different sexes. The social organization of each of the villages on the one hand and that of each household on the other hand are severally and jointly closely knit. There is a high level of social interaction within and between sexes. On a typical day, a man and his wife or wives and their older children go to the farm together or separately. Their very little infants are carried along to the farm by the mothers. The not too old or not too small ones are left in the care of the older men and women (in most cases grand-mothers) who are left behind in the villages, for care. The team comes back in the afternoon after a hard day's work only to interact once more in their house and/or in the open space outside the house. The children with their mothers on the one hand and with their peers on the other partake in the

most intimate interaction in the villages.

From the above explanation, we see that differences in the distribution of respiratory diseases cannot be attributed to differential association by sexes. Even if it can, such an explanation is, at best, an explanation of how respiratory diseases are spread and not how they are caused. The only possible explanation of differential experience of respiratory diseases are the people's differential consumption of commodities of pleasure such as cigarette, tobacco, snuff, alcohol etc. and the generally poor environment/living conditions of the villagers.

We found, for instance, that while 46.7% of the males smoke tobacco, pipe or cigarette or snuff, only 7% of the women smoke tobacco pipe or licked tobacco snuff[9]. It was also found that whilst none of the women interviewed drank alcohol, as many as 118 or 51.5% of the men interviewed drank alcohol[10] (See Tables 5.6 A & B)

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9. Snuff is made of ground tobacco and certain chemicals. Women lick this powder but men inhale it through the nose.

10. Drinks referred to as alcohols are palm-wine, local gin (ogogoro), beer and other locally brewed drinks like 'burukutu and Sekete'

Table 5.6 A Distribution of Respondents by Consumption of Tobacco Products

	Tobacco Products				
	Smoke Cigarette	Smoke Pipe	Use Snuff	Non Users	Total
Men	69(30.1)	9(3.9)	29(12.7)	122(53.2)	229(99.9)
Women	-	12(4.9)	5(2.1)	226(9.3)	243(100.0)
Total	69(14.6)	21(4.5)	34(7.2)	348(73.7)	472(100.0)

Table 5.6 B Distribution of Respondents by Consumption of Alcoholic Products

	Alcoholic Products				
	Drink Ogogoro	Drink palm wine	Drink Beer	Non Drinkers	Total
Men	14(6.1)	81(35.4)	23(10.0)	111(48.5)	229(100.0)
Women	-	-	-	243(100.0)	243(100.0)
Total	14(3.0)	81(17.2)	23(4.9)	354(75.0)	472(100.0)

This explanation of possible causes of respiratory diseases can admittedly explain why more adult males reported more episodes of respiratory disease, the same fact cannot explain why little male-children also reported a large number of episodes of respiratory diseases.

5.2.0 Perceived Seriousness of Respiratory Diseases

Since perception determines attitude to and consequent line of action on health matters, we tried to understand perception of the respondent about seriousness of the respiratory diseases which they were experiencing. Their perception was found to be based on four factors.

Firstly, the respondents' perception of seriousness of respiratory diseases were found to depend on the degree of discomfort which they were experiencing. A few representative responses of those who perceived their episodes as very serious are given below.

> My child was groaning in pains all the night
> The cough prevented him from sleeping soundly
> My neck swelled and I couldn't eat anything
> He was breathing in with considerable difficulty
> He broke his voice with too much painful cough
> His breath was terribly fast and hot.

But those who perceived their episodes as not very serious complained, among others, as follows:

It was a minor catarrh. He managed to go to school. He normally experiences this disease during the rainy season. It was a minor cough. It was due to the harvesting of new corn.

Secondly, certain diseases whose episodes have been experienced and treated for many years but have not reduced the physical functioning of the respondents were not regarded as very serious. This shows that the longer a disease has persisted or the more determinable the rhythm of its relapse, the more concerted the attempts made to treat it, the less will be anxiety exhibited about it. We came across three cases that have been treated unsuccessfully over a long period. We shall explain them here below as cases one, two and three.

Case 1

The man had the following symptoms. He coughed out a sticky plug of sputum. His breathing had been hampered adversely as he breathed noisily and with great efforts. The cough produced rattling noise. He looked sickly and tired. He could be suffering from acute bronchitis judging from the symptoms described above.

The man was one of the practising traditional healers in the district. Ironically, the man did not perceive the disease that he was experiencing as indicating any serious threat to

his life. He boasted that if the investigator had known

> Me when my problem was very severe, you could have wept for me. At that time, I was groaning in discomfort; I coughed as if my internal organs would all gush out. I took all medicines I knew but I was not cured. Then, in despair, I stopped using any medicaments. I was expecting death.
>
> One day, one of the tenants[11] of my father came to our village. He saw my plight. He was moved to compassion. He taught me a traditional medicine. He assured me that I would be cured if I used it. I tried it and I was cured. That incident made me to decide to become a traditional healer since 1962. That means I have been cured of this disease for twent-five years. I am not sick. I smoke more than twenty-five cigarettes daily; I drink local gin (ogogoro); I eat yam and been-bread (akara); I work on the farm everyday and trek about seven kilometres everyday. If I were sick, I would not be able to do all this.

By the time the interview with him was completed (about two hours), he had coughed about seveteen times in three different fits spewing heavy chunks of sputum.

Case 2

This respondent had sneezing fits which he has at an average of four times yearly. According to him,

> It has worried my wives and relations. They always expect it. It is not an ordinary catarrh. It is always out of proportion with catarrh that everybody has.

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11. Tenants occupying a portion of his father's land not occupying his house.

Concluding however, he did not appear to perceive the disease as very serious because

> To me, it is not indicating a serious disease otherwise I would have died since over twenty years that I have been experiencing it.

Case 3

This man had asthma. He had breathing difficulty. His nose spread as he struggled for breath. His father had asthma before he died about four years ago. Since none of his own five children and none of his nephews/nieces has asthma, he could not say that asthma was hereditary in the family. He did not know the cause of the asthma. He had treated it first with traditional medicine. Later he attended Adeoyo State Hospital to treat it in the orthodox way. Both treatment plans did not heal him.

> Now I have stopped to seek treatment. What I do is try to avoid the things (allergens) that can aggravate asthmatic symptoms. For instance, I don't stay where food is being fried, I don't use perfumes and I don't drink or smoke.

In the three cases listed and explained, it appears that severity of diseases has ceased to be a motivation to seeking health services. In fact, it appears that rather than seeking cure or expressing anxiety over the diseases the people prefer to live by their diseases with the notion

that cure was far fetched or probably non-existent.

The third factor affecting the respondents' perception of seriousness of their respiratory diseases was the question of normality or currency of certain diseases. Running nose and stuffy nose are a good example. Bio-medical sciences appear to attribute running nose or stuffy nose to organic inflamation of the mucuous membrane or deffective feedings. Whichever it is, running nose is a respiratory disease and its perception as a disease should ideally produce in the perceiver the desire to deal with the root of the problem. In the villages studied however, constant running nose was common among little children. It was regarded as a normal occurrence.

> It is normal. There is no problem. Children have always had running nose from time immemorial. There is nothing we can do about that.

These are some of the views of the respondents about running nose or catarrh.

The final determinant of perception of seriousness of respiratory diseases depended on the age of the patient. The younger the person suffering a disease, the greater appeared to be the respondents' perception that the disease was serious. Some of the respondents expresed their sadness

as follows:

> When I saw that he couldn't breathe properly, I tried to suck out (with my mouth) the mucus from his noserils. He coughed incenssantly throughout the night, I pitied him, at a certain time I wept. He could not explain what was troubling him, he was coughing and crying. I thought the pain was too much for him. I felt like transfering the pains to myself. I thought he would die before morning. If you are slow to treat the disease being experienced by a small child, there will develop more serious diseases.

The anxiety that a mother exhibits over a disease troubling her child is very understandable. The rural area is characterized by little influence of bio-medical sciences and low life-expectancy arising from preventable diseases. The uncertainty imposed by the harsh conditions of life is an abnegation of the high prize that is put on having "as many children as God cares to give". This necessitates that mothers leave no stone un-turned to reverse their children's symptomatic or disease experiences as early as possible. This attitude towards children's diseases appears to contrast with attitude towards adults' diseases as demonstrated in the three cases just listed and explained.

Table 5.7 Distribution of Respondents by Perceived Seriousness of Diseases

Status of Diseases	Sex		Total
	Male	Female	
Very Serious	53(23.1)	57(23.5)	110(23.3)
Not very serious	88(38.4)	92(37.9)	180(38.1)
No Respiratory Disease	88(38.4)	94(38.7)	182(38.6)
Total	229(100.0)	243(100.0)	472(100.0)

Out of the 290 persons who were experiencing episodes of respiratory diseases, 103 or 35.5% classified the episodes they were experiencing as very serious and 167 or 57.6% said that they were not very serious. A cursory look at Table 5.7 shows that more women reported "very serious" episodes than men but men reported more not very serious episodes more than women. Statistical test again, does not, however, show a significant different in this distribution.

5.2.1 Respiratory Diseases and Utilization of Health Services

Looking through the static distribution of patronage of Health services shown in Table 5.8, it appears that about the same number of persons at the time of the study

were self-medicating and using Home Remedies as treatment plans for respiratory diseases as persons patronising other services combined.

Table 5.8 Distribution of Respondents by Utilization of Health Services

Health Services	Sex		Total
	Male	Female	
Hospital	18(7.9)	22(9.1)	40 (8.5)
"Health Workers"	7(3.1)	8(3.3)	15 (3.2)
Self-medication	43(18.8)	34(14.0)	77 (16.6)
Traditional Healers	14(6.1)	12(4.9)	26 (5.5)
Home Remedies	32(14.2)	33(13.6)	65 (13.8)
Healing Churches	4(1.8)	7(2.9)	11 (2.3)
Combination	23(10.1)	33(13.6)	56 (11.9)
No Respiratory Disease	88(38.4)	94(38.7)	182 (38.6)
Total	229(100.0)	243(100.1)	472(100.1)

For instance one hundred and forty-two (142) persons who constitute 30.1% of the total sample or 48.9% of all the persons who were experiencing respiratory diseases were self-medicating and using Home Remedies. The remaining sick persons are distributed as follows. About 8.0% of the

sample was patronizing the Hospital, 5.5% the Tradtional Healers, 3.2% the "Health Workers" and 2.3% the Healing Churches. About one-tenth (12.0%) of the disease-experiencing respondents were using various combinations of these treatment plans. We shall explain these distributions in turn as follows.

5.2.2. Self-Medication

Seventy-seven or 16.6% of the respondents who were experiencing episodes of respiratory diseases were self-medicating. Fifty-two (52) or 67.5% of these persons had a good idea of the names and/or descriptions of the modern medicines that they were self-medicating although their pronounciation or description of these medicines was not good enough. In many cases, the respodents showed the medicines or their containers at the interview. The medicines they were self-medicating are capsules some of which are tetracycline capsules, ampicillin capsules; cough mixtures some of which are syrups, cofta syrups, benyline syrups, phenergan syrups, septrin syrups; and tablets some of which are codeine, ephedrine, phenobarbital, phenegan, septrin, panadol, phensic, cafenol pengo, potassium iodide, contac and penetrol lozenges.

Thirty-eight percent of the respondents did not know the names of the medicines which they were administering. They obtained such medicines from benevolent co-villagers or from the 'medicine store' or from the 'Health Worker' or from the hospital. It is not unlikely that some of these medicines were expired or could be used wrongly being not properly labelled.

The following statements are a few of their responses to the question why they used modern drugs without doctor's approval. The responses are arranged in descending order of frequency.

Majority of the responses suggested that they found modern medicine easy to obtain.

> When I had catarrh, I simply sent a child for tablets. It is very easy to obtain.

Another substantial group of the responses indicated that people regarded self-medication as effective.

> Tablets are effective especially if it agrees with one's "body constitution" or "blood"

The respondents believed that the same medicine may have differential healing effects on people suffering the same disease. The belief is that people belong to different groups and that different blood groups have different aiding or hindering effects on efficacy of therapy. Thus

the medicine that cured Mr X of chronic asthma may fail to cure Mr Y the same type of disease if they belonged to different blood groups.

Some of the responses indicated love or admiration for the flavouring of modern medicine.

> My children hate bitter medicines. They like flavoured or sugar-coated modern medicines.

Some of the responses indicated currency of self-medication.

> I use it like every-one else.

Some of the respondents were using modern medicine because somebody gave them gratuitously.

> When I complained that I was experiencing the respiratory symptom, many people were giving and recommending to me the medicine that they have used successfully when they experienced similar symptoms.

Some of the respondents appeared to be using self-medication because it was convenient and neat.

> I do not like to use any traditional medicine because I do not like things that look dirty and taste bitter.

Some of the respondents were self-medicating because they did not have knowledge of any traditional medicine that they could use in the circumstance.

> I do not know what else he could use when the episode started.

Some people were using it because they felt that the hospital was too far or that the hospital would have given them the same medicine.

> The hospital staff will give me the same medicine, You don't rush to the hospital every time you are sick.

Some of the respondents felt that the disease that they were experiencing was not serious to warrant their going to the hospital but have got stuck to self-medication because of long use.

> I thought that when I used the medicine, the disease would vanish. I have ended up using one modern medicine after the other since I tried the first one.

Some of the respondents appeared to be using modern medicine because they thought that they would waste their time if they went to the hospital.

> I have not time to go and waste in the hospital.

Finally, some of the respondents were self-medicating because their relations in the towns always send supplies of medicine to them.

> My child always sends the medicine to me from Lagos.

The factors that account most for the popularity of self-medication appear to be its storability, its effectiveness, and the convenience of obtaining it. For several reasons,

monetary costs did not serve as deterrence to obtaining them.

Firstly, it was interesting to note that modern medicines could be and were purchased in small units. For instance 2 tablets of paracetalmol were sold for 15k, 2 terramycine/ tetracycline capsules were sold for 45k and syrups especially cough mixtures and liquid multi-vitamins were sold in units of 50k and one naira (₦1) at the time of the field-work. Secondly, medicine could also be bought on credit. Thus, even if certain medicines could not be sold piece-meal for whatever reasons, the households were still not deterred from buying and using them. Finally, for the same social solidarity reasons that medicine-sellers sold on credit, villagers lent helping hands by donating their various medicines to the sick person free of charge. They also lent money to one another to meet urgent health-care expenses especially when they needed to buy 'cash down' in any of the big settlements around.

5.2.3 Home-made Medicines

Sixty-five or 13.8% of all the respondents were using home-made medicines. This figure is 22.4% of all the respondents that were experiencing episodes of respiratory diseases. This

means that more than a fifth of the sick persons were using home-made medicines at the time of the field work. Home-made medicines were administered to all sick persons irrespective of age and sex. The reasons given for their using home-made remedies are similar to those given.for self-medicating modern medicine. These reasons are given below by types of response and in descending order of occurrence.

The greatest proportion of the respondents indicated that they needed to explore all the treatment avenues at their disposal before looking further away.

> You have to try everything at your disposal before you visit the doctor.

The second greatest proportion probably felt that the home-made remedies worked more efficiently.

> I have always used home-made medicines. They work more efficiently in my body. I know what is troubling my body and I know that the home-made medicine that I am using is helping to reduce my suffering.

Another substantial numbder said that they have always used the Home-Made medicines that they were using for a very long time.

> The medicine prepared for me has been used successfully to treat similar diseases. I have always used the home-made medicine any time I had an episode of the disease.

The smallest number said that they have just learnt how to prepare the new medicine and that they needed to try it.

> It is a new treatment plan, I need to test it. It appears that this new formular will be effective to cure the disease episode from which he is suffering.

From this brief analysis, it seems that continguity and, to a lesser extent, efficacy factors are the greatest compelling reasons for continued utilization of home-made remedies.

5.2.4 Modern Hospital

Forty of the respondents were patronizing the hospital at the time of the field work. The figure is 13.8% of all the individuals that were suffering at least one episode of respiratory disease. One of these persons was receiving treatment at Adeoyo State Hospital in Ibadan. He was suffering from asthma. The remaining persons were receving treatment in the maternity centre and clinics at Moniya. Three or 7.5% of these respondents were admitted for various respiratory diseases at the initial stage.

About two-thirds (60.0%) of those who were patronizing hospital were below twenty years of age. Six of the patients were referred (or sent) to the hospitals by their classroom teachers. These teachers probably felt concerned that the diseases were dangerous or severe or that the diseases could spread to other pupils in the school. Sixteen of the patients

were being taken to the hospitals on regular appointments by their mothers and two by their fathers. The respondents had varying reasons for patronizing the hospital. The greatest number were patronizing the hospital because other treatment plans did not cure them and because their health was failing.

> The disease was growing worse. We did not know the nature of the sickness. He was coughing and vomitting. He also had running stool. He refused food, he was so lean. I didn't like using home-made remedies so, I decided to go to the hospital.

The second most current response was that if a child as opposed to an adult was sick, the best place to treat him was the hospital.

> I was delivered of the baby in the hospital and was warned to always bring him whenever he was sick. The use of traditional medicine was discouraged by the nurses.

A small number were patronizing the hospital because they did not understand what the sickness was.

> He is too small to describe his feelings.

The least proportion of the respondents said that the hospital is near their house and some said that nurses in the hospitals always warned them to bring the children for treatment in the hospital instead of self-medicating or using home-made

medicines. It will seem that modern hospitals, while not dscriminatory about age of patients, is selective of younger persons and are patronized by only adults who probably have used one or two other treatment plans.

4.2.5 Traditional Healers

Twenty-six persons (26) or 5.5% of the sample were patronizing traditional healers at the time of the study. This figure constitutes 9.0% of the persons who were suffering at least one episode of respiratory disease. The diseases being treated by the traditional healers appear to be severe, have defied several and long treatments and were associated with older perons. None of the respondents being treated by the traditional healers was an in-patient. The patients (in 7 cases, the relations of the sick persons) went to collect their prescriptions from the traditional healers. During such periods, patients give progress reports of their health-status. Medical decisions on further treatment are made on the basis of such reports. The traditional healers also pay visits to their patients from time to time.

When the respondents were asked why they patronized traditional healers rather than the modern hospitals or other sources; the greatest volume of their responses were related to their high regard for the experience of the traditional

healer.

> The healer is an expert, he has cured similar diseases before.

The next substantial volume of responses appears to be related to long association between the healer and the respondents.

> I have always seen him on any health problem of the family. His charges are small. He does not charge anything for his sevices.

Some of the reasons are related to the effectiveness of tradtional medicine vis-a-vis the nature of the sickness being experienced.

> Tradtional medicine is very effective. We have treated it unsuccessfully with modern medicine.

Some of the reasons are related to warm relationship between the Traditional Healer and the patient as well as related to their cultural unity.

> I feel comfortable with the Tradtional Healer. The Tradtional Healer offered to heal him. If she was sick and we did not inform the traditional healer, he would be angry with us.

5.2.6 The 'Health Workers'

Fifteen of the respondents were being treated by the "Health Workers" at the time of the study. This figure is 3.2% of the total sample or 5.2% of the persons that at least an episode of respiratory disease. These persons were

receiving attention weekly and some forthnightly depending on the rhythm of the visit of the 'Health Worker'. Most of the persons that were patronizing "Health Workers" were older and female persons. Only three or 20.0% of them were (10-14) years of age. The remaining persons patronizing "Health Workers" were (35-39) years 26.7% (50-54) years 40.0% and 60 years and above 26.6%. They seemed to be suffering from relatively chronic respiratory diseases. One of the persons being treated by a "Health Worker" said that the diseases have been treated for two years and that shortly after each treatment, "the chest pains always relapsed".

Two-thirds (66.6%) of the persons being treated by the "Health Workers" have been so treated for one to three months. The remaining six persons who constitute a third of those patronising "Health Workers" have been treated for two to three years. One of them has however been inconsistently treated because she was away for some time from the village. When this class of demanders were asked their reasons for choosing to be treated by "Health Workers", instead of qualified medical personnel, or other sources, some of the responses showed that they were getting satisfactory relief.

His medicine agrees with my "body constitution".

The next substantial response indicated that the patients admired the preliminary 'diagnositc test' performed by the "Health Worker"

> I patronize him because he will fist test you and discover what is wrong before giving you medicine. The services he gives you are not different from what you get from Hospital.

The least reasons are that the 'Health Workers' are most accessible and less impersonal.

> I know the time that he will come and I always make usre I am around. In some cases he himself will wait a little if I am not arround.

5.2.7 Healing Churches

Eleven out of the 472 persons sampled were receiving treatment from Healing Churches[12]. This number is 2.3% of the sample or 3.8% of the sick individuals. The healing procedure emphasized hydro-therapy and group-therapy two practices whereby (a) prayer is offered in water and is drunk

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12. There was no evidence to suggest that persons using faith-healing deliberately attended the churches solely to receive healing. For instance, there was no non-Christia person among them. It appears that they appropriated fai healing as part of church doctrine and process of daily worship. In fact, one of the respondents expressed her disappointment that people who are not familiar with church practices always hold the errorneous belief that the church is filled up by sick persons. She argued that the practice in her own church is that when people ordinarily come for worship and fellowship, they receive healing in the process. She however agreed that there could be emergency cases whereby sick persons are rushed to the church. She quickly added that such cases are extremely very rare in her own church.

by the respondents and (b) whereby worshippers clap and dance. The respondents gave many reaons for using faith healing. Many of these reasons relate to cost of treatment.

> It does not cost you anything. You can pray it off on your own.

Some of the reasons relate to their faith and the rituals attached to it.

> Relying on prayer and fasting strengthens your faith as a Christian. Fasting is good Christian habit.

But the least of the reasons relate to efficacy of faith-healing.

> Prayer and fasting can cure any disease

One of the respondents who were using faith-healing indicated that he decided on his own on when to fast and when to pray and that his decision was independent of church injuction.

> Nobody forces it on me. I have come to rely on fasting and prayer over the years. It is very effective. It can cure any form of disease. This is not saying that I hate or do not use other medicines. I use whatever can cure me of diseases. But I rely on fasting and prayer more than other therapies. I decide for myself when to fast and when to pray. I get cured each time.

The persons using faith-healing appear to be somewhat different in their attitude to this treatment plan in that, they did not appear to be looking for healing desperately. Rather, it seemed they were satisfied with getting just some form of psychological relief which appeared to be forthcoming during church services. Majority indicated that they were getting healed 'by faith' - a statement which indicates ambivalence. At any rate, it does not appear that the respiratory diseases they were suffering from were the serious or chronic type, nor did they attend the church for the sole purpose of healing.

5.2.8 Combination of Therapies

Twelve percent of the sample or a fifth of the disease-experiencing respondents were using many and different therapies at the time of the study. The therapies that were most commonly combined for most episodes of respiratoriy diseases are self-medication and Home-made medicines. This combination was made in several ways. The most common practice was that some of the respondents were using both therapies alternately i.e. using self-medicating in the morning and using Home-made remedies later in the day; some of them were taking capsules and tablets with concoctions;

finally, in some cases, the respondents were adding modern medicines to their home-made remedies. The likely effect of administering combined medicine-therapies is a critical factor in this regard. The possibility of a chemical reaction which is a major health hazard cannot be ruled out.

5.3.0 Dynamics of Utilization of Health Services

In the last section above, we explained the static position of the treatment plans being used at the time of the study. The more critical aspects of the description of utilization of health services however, are the interactions between and dynamics of health services as these are occasioned by decision-making demanders of health services. In other words, the crucial issues, to which we now turn, are the history and processes of the career of diseases ie..how the consumers of health services 'shop'[13] for therapeutic plans or behave through decision-making points.

Out of the 290 persons who were experiencing episodes of respiratory diseases, ninety-four (94) or 32.4% have so far used one source of treatment since the diseases began. The

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13. Shop/shopping refers to the practice of moving from one therapy to another especially without waiting long enough to assess the effect of previous therapies.

breakdown is as follows:

Thirty-eight patients (13.1%) have patronized only Hospitals; 25 patients or (8.6%) only Self-Medication; 27 patients or (9.3%) only Home-Made remedies and 2 patients or (07%) each patronized Traditional Healers and Churches since their sicknesses began. This means that only 5.3% of the 40 patients who were patronizing the Hospitals had used medical care sources other than Hospital care since their sicknesses began. Similarly 67.5% of the 77 patients using Self-Medication had used sources other than Self-Medication since their sickness began; and 63.1% of the 65 patients using Home-Remedy had used sources other than Home-Remedy since their sicknesses began.

Virtually all the 52 patients patronizing Traditional Healers, Healing Churches and 'Health Workers' had patronized other sources of health-care apart from the ones being patronized.

Stated more technically, it appears that most of the patients patronizing Modern Hospitals did so as their primary source of care. About a third (32.5%) of those Self-Medicating and about 37% of those using Home-Remedies were using the respective sources as primary sources of care. As comparatively few as 18.0% of the patients patronizing Faith-Healing, 7.7% of those patronizing Traditional Healers and none of those

patronizing the 'Health Workers' were using them as primary sources of treatment rather than referrals.

The above distribution tends to indicate that Hospitals are patronized mostly as primary sources of health care and that Home-Made therapy and Self-Medication enjoy medium patronage as a primary source and that Faith-Healing, Traditional Healing and 'Health Workers' are patronized least as primary health care sources. The distribution also indicates that patients patronizing Modern Hospitals are most brand-loyal[14] and/or that those patronizing Home-Made therapy and Self Medication on the one hand, and those patronizing Traditional Healers and 'Health Workers' on the other hand, are, respectively, moderately and least brand-loyal. There seems to be a marked difference on two grounds. Firstly, there appears to be a difference between patronage of hospital services and patronage of other services. This difference could be as a result of differences in the nature of episodes of respiratory diseases being taken to the hospitals, age of patients who were patronizing hospitals, length of treatment of the episodes and the performance of the modern hospitals operating in the district. It has already been pointed out that over 60.0% of hospital patients are children who probably were being taken to paediatric appointments in the hospitals.

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14. Brand-loyalty is a markeering expression that indicates that a buyer insisist on a particular brand of a commodity even when there are perfect alternatives of the product. For instance, a buyer may insist on Bournvita at whatever price even though Ovaltine is available and perhaps, cheaper. Band-loyalty in this case could be result of perceceived efficacy of the therapy or age of the users or duration of the illness or a combination of these reasons.

In this respect, the episodes of respiratory diseases being treated were relatively new. In addition, since modern hospitals are generally well organized, they perform education functions in the rural areas. The hospital staff encourage, sternly instruct and sometimes closely monitor their patients so that the latter may keep hospital appointments and desist from practising plurality of therapy. The second difference which is between Self-Medication and Home-made therapy on the one hand and hospital treatment on the other is that, whereas the former are widely patronized across all ages and sexes probably because of certain relative advantages, the latter is selective of age.

A further inspection of the data matrix on dynamics of patronages revels the most profound relationships between different health-care contacts.

In general, over 73.5% of the therapeutic contacts which did not end up in the modern hospitals shuttled between Self-Medication and Home-made remedies and from these two therapies to the other health-care sources. On a specific note, 28.8% of the second treatment contacts which did not reach the hospitals moved, (in the course of treating the same episode of respiratory diseases), from Self-Medication to Home-Remedy;

21.3% from Home-Remedy to Self-Medication; 11.8% from Self-Medication to Faith-Healing and 11.7% from Home-Remedies to Faith-Healing. About 84.7% of the therapeutic contacts which ended up in the Traditional Healers; The Aladura Churches and 'Health Workers' were third or subsequent contacts made for the treatment of the same episode of respiratory diseases. We can surmise from the above, that hospitals served as a primary and perhaps also terminal sources of respiratory health care for the younger persons who mostly patronize it; that Self-Medication and Home-made therapy are both sources of primary and secondary respiratory health care for the greater proportion of the patients; and that Tradtional Healers and 'Health Workers' strictly serve as secondary sources of respiratory health care, whenever they were patronized. The Aladura Churches did not seem to be a serious treatment source for respiratory disease.

CHAPTER SIX

6.1.0 SUMMARY, CONCLUSION AND IMPLICATIONS OF THE STUDY

This study was conceived to investigate the pattern of utilization of health services by people experiencing respiratory diseases. Available literature shows that a lot of work has been done on utilization of health services in various Nigerian settings. These works are of a general type not only because they focussed attention on utilization of health services for all illnesses in general, but also because they studied patronage of health services along with medical care suppliers and within the broad scheme of medical practices. The result is that not many efforts have been made to isolate specific illnesses with a view to determining the health seeking behaviour which they engender.

The present study attempted to investigate patronage of health services by the rural people experiencing respiratory diseases. The objectives of the study are to determine the distribution of episodes of respiratory diseases; to determine the rural dwellers' perception of respiratory diseases and to investigate

their pattern of utilization of available health services.

Available literature revealed that respiratory diseases along with malnutrition and water-borne diseases constitute the greatest causes of death among children in developing countries. Respiratory diseases are associated with feeding and consumption of certain commodities of pleasure such as cigarette and alcohol. Those who smoke habitually report many symptoms and episodes of respiratory diseases; ex-smokers rank second and passive smokers third. The healthiest persons seem to be those who have never smoked and are living in non-smoking households.

Studies have indicated that persons who consume the poorest foods are apt to report more symptoms and episodes of respiratory diseases. Similarly, studies have indicated that children bottle-fed as opposed to those breast-fed are more likely to exhibit symptoms of respiratory diseases. Finally studies indicate that episodes of respiratory diseases are directly related to poverty, over-crowding, lack of social amenities and inhalation of dust and fumes.

Among the factors which determine utilization are socio-cultural factors, i.e. the beliefs of the demanders about the causes of diseases and knowledge of therapy; inter-personal relationship i.e. the demanders' subjective

evaluation of the human relations dimension of the physician's conduct; socio-economic factors i.e. social class gradients of the demanders vis-a-vis those of the suppliers and of course the demanders' ability to pay for the services enjoyed; demographic factors i.e. sex-variation in experience and reportage of symptom as well as sex-variation in the seeking of therapy and finally, spatial distribution of health services and their consumers.

Theoretically, decisions to utilize health services are motivated by personal susceptibility to a disease, belief about the severity of the disease, belief that taking a particular action will reduce the severity of the disease and ease of overcoming the physical and psychological barriers which hinder patronage of health services. Having decided to take action, the patient moves through several decision points in the process of seeking health. These stages are symptom experience stage, assumption of the sick role stage, the medical care contact stage, the dependent patient role and the recovery stage.

A major limitation of the above models of health-seeking is that they assume that any pathway to health invariably leads to recovery. In other words, the above models do not take referrals into consideration. Therefore they cannot

explain how consumers shuttle from one therapy to another. Another limitation is that the models assume a perfect situation in which there is only one therapy, particularly orthodox medicine. The models therefore fail to explain consumers' behaviour under multiplicity of therapies. An eclectic model which attempts to rectify these shortcomings was developed to explain 'shopping' from therapy to therapy.

6.1.1 The study community

The community studied consists of fifteeen rural villages in Akinyele Local Government Area of Oyo State. Apart from Moniya - the administrative Headquarters of the Local Government which is fast developing into a semi-urban town and which has infrastructural facilities such as electricity and potable water, the remaining fourteen villages are rural villages which enjoy no government influence in the form of good access roads, potable water and electricity. The villagers are not only socially stagnated through constrictions imposed by dull social existence, they are also restricted in their economic endeavours by lack of cheap and efficient transportation system.

The villagers are primarily farmers but they hardly produce enough for their families for the whole year as, they

always find it necessary to buy more food stuffs from urban markets around. Some of the food crops produced are cassava, yam, cocoyam, and grains. Their cash crops include cocoa, kolanut and coffee, Most of the cash crop trees are old and have become low-yielding. An outcome of shortages and scarcities that have become part of rural existence is that villagers have to depend very indispensably on their relations especially children living in Ibadan city for supplementary foods, drugs, drinks and money.

6.1.2 The sample

The fifteen villages were carefully chosen by random sampling method from a frame of eighty-five villages located in Moniya district. A total of sixty-seven households were selected also by simple random sampling method for the study. In order to ensure that the sample was representative, it was chosen through a multi-stage sampling procedure. First of all, Moniya district was chosen for this study because it is a comparatively medium-size district and because it has many and diverse health services from which its inhabitants can choose.

In the second place, the fifteen villages studied were carefully selected through the use of cluster sampling procedure, from a frame of eighty-five villages located in

Moniya District. In the third place, sixty-seven households were selected through the use of the lottery sampling method. Twelve of the households selected for the study could not be interviewed for reasons ranging from refusal to unsuitability of the elements.

Fourthly, a total of sixty-seven households were selected also by simple random sampling method for the study. A total of four hundred and seventy-two (472) persons were living in the selected households.

6.1.3 Socio-economic characteristics of the sample

The households comprised of nine mongamous marriages and fifty-eight polygynous marriages. Three of the households comprised only fathers, their children and their relatives. Seven households comprised only mothers, their children and relatives. The remaining fifty-seven households comprised fathers, mothers, their children and their relatives. There are slightly more women in the sample. This could be due in part to the fact that the people practice polygyny and widom inheritance. It could also be due to the fact that women have longer life expectancy and the fact that rural-urban migration could have been selective of more male rural dwellers. It could be due however to all or various combinations of these factors.

There appears to be more muslims than christians and adherents of other faiths put together. The sample also appears not to be appreciably literate. The age distribution is heaviest at the bottom of the age group but is thinnest at the middle of the age. The two probable explanations of this are:

(a) that rural-urban migration could have been selective of more young and able-bodied individuals than it is of younger and older persons; and

(b) that there was no official record of birth and other nuptiality variables from which exact age could be computed.

6.1.4. Data Collection

The approach of ethnography was used to collect the data. This is a combination of direct interview, direct observation and description of the society being studied. A field-guide or ethnographic questionnaire was constructed to 'standardize' the questions that were asked in the interview.

The field-guide was pre-tested in two neighbouring villages Alaho and Ogundana. These villages possessed similar characteristics as those that were actually studied. The

pretest was done in order to ascertain the extent to which the research-questions how they were worded and how they were asked, would be capable of eliciting desired responses. Secondly, the pretest was intended to find out the reaction of the respondents to the length of each interview. The pre-test exercise was fruitful because it contributed to the perfection of the field-guide.

The interviews were held within three months March, April and May 1987. We choose this period because it is a period when many farmers would have comparatively less work to do in their farms. The questions were asked in Yoruba and answers were recorded systematically in English language. Additional research - information was collected from Traditional Healers, the Orthodox Hospital, medicine sellers and "Health Workers" in the community.

6.1.6 Knowledge of Diseases

The respondents appear to possess a limited knowledge of the range of diseases which they indicate that they are familiar with in the villages. There are two possible reasons for this limitation. Firstly, the sample is largely illiterate, because respondents possessed a very little knowledge of bio-medical sciences, they seemed to possess little ability to distinguish between and describe symptoms

and associate specific symptoms to their right disease-causes.

A very good example is migraine and head-ache and another is dysentary and diarrhoea. These pairs of diseases have similar symptoms and can be easily confused. Majority of the rural dwellers do not know the symptoms details of these diseases. They merely classify diseases broadly, 'head-ache' and 'running stool' in the examples cited above. The second possible reason why their knowledge of diseases appears to be narrow is that they could have forgotten many of the diseases in the process of recalling.

Most of the diseases are perceived to be rooted in natural causation. But a more interesting revelation is, perhaps, that the cause that is initially perceived is a temporary one. If it proves resilient and defies treatment, it could be re-perceived to have been due to other causes. Perhaps it is more revealing that diseases are perceived to be systemically related. In this regard, it was thought that respiratory symptoms could indicate presence of diseases which are not respiratory diseases.

There are six therapeutic services in the villages studied. These are the Modern Hospital, the "Health Workers", the Patent Medicine Stores, the Traditional Healer, the Home Remedies and Healing Churches. This study tries to stress the functional difference between and functional importance

of these services.

6.1.7 Prevalence of Respiratory Diseases

More than half of the sample was experiencing one episode of respiratory disease or another. About a fifth of the sample was experiencing more than one episode of respiratory disease. The most commonly reported and/or exhibited symptoms/diseases are cough, cold and difficult or painful breathing. The least are mumps, shortness of breath, whooping cough, chest cold and breathing with 'excessive' movement of the clavicle.

The younger persons seem to be experiencing more single-episode respiratory disease than older persons. It also appears that more of younger persons indicated that they were suffering an episode. It was however, not proved that adults experienced absolutely more episodes of respiratory diseases than the younger persons because while adults were able to express and possibly exaggerate the episodes/ symptoms, the very young persons were not able to explain their symptoms/episodes adequately.

There was no evidence to show that disease-distribution varied by sex but our data revealed that while episodes of respiratory diseases were evenly distributed among women, younger and very older males experienced more symptoms of

respiratory diseases than the able-bodied males.

Social organization and social interaction did not give a due to the differential prevalence of respiratory diseases by sex although they explain transference of the diseases. A possible causal factor is the consumption of commodities of pleasure viz. cigarette, tobacco pipe, snuff and alcohol which appears to be consumed by men more than by women.

Perceived seriousness of a diseases appears to be a function of four factors. Firstly, it depends on the degree of discomfort which a patient reports to be feeling. Secondly, diseases that have defied many treatment attempts but have not reduced social or physical functioning of the sufferer are not regarded as very serious.
Thirdly, diseases that appear to be very common are not regarded as very serious. Finally, diseases affecting the very young persons as contrasted with those affecting the very old persons are regarded as very serious perhaps because children express their griefs largely through crying and restlessness the conditions over which parents exhibit anxiety.

About two-thirds of the respondents indicated that their diseases were not very serious. But more females as opposed to males said that the diseases they were experiencing were

very serious.

6.1.8 Utilization of Health Services

Most sick respondents were self-medicating and using home remedies at the time of the study. Another substantial proportion was combining many health services in treatment of their diseases. The proportion attending modern hospitals is the third substantial figure. It appears that persons who are under twenty years patronize hospitals more than older persons. Age of patients therefore, appears to be one of the dominant considerations in the choice of hospitals as their health service. Traditional Healers, "Health-Workers" and Healing Churches in that order, appear to be patronized by comparatively few and very old persons.

Virtually all the patients patronizing Hospitals had not patronized any other medical services. In other words, Hospitals served, for those who were using it, as a primary source of care rather than a referral source. About a third of those self-medicating and using home remedies used self-medication and home remedy as a primary source of care but the remaining two thirds were using these sources as referral sources. Traditional Healers, and Healing Churches were being patronized as referral sources rather than primary sources of health care.

6.2.0 Conclusion

6.2.1 The Major Findings

The Major findings of this study are discussed below. About half of the rural dwellers was experiencing one episode of respiratory disease or another. But more than half of them were experiencing mild symptoms of respiratory diseases. It appears that the causes of the diseases are related to poor and insanitary living conditions and consumption of commodities of pleasure such as alcohol and tobacco-smoking. The diseases could have been spread through over-crowding and close-knitted social interaction and could have been reinforced by poverty, poor working environment and inadequate health-care facilities.

There does not seem that either of the sexes suffers greater or lesser episodes of respiratory diseases but it appears that while diseases are more or less evenly distributed among the females, they are concentrated at the extreme ends of men's age structure.

The most oustanding sources of therapy are self-medication, Home-made therapy and Modern Hospital; while the least are the Traditional Healers, the "Health Workers" and the Aladura Churches.

Another oustanding feature of utilization of services is that Modern Hospital, self-medication and to a slightly lesser extent, Home-remedies, appear to serve as primary sources of health-care. On the other hand, Traditional Healers, and "Health-Workers" were patronized as referral health-care. Similarly, health services patronized as primary health-care sources as contrasted with those used as referral health-care sources were utilized for non-chronic episodes of respiratory diseases.

6.3.0 Implications

6.3.1 Implications for Theory

Susceptibility and severity factors seemed to motivate perfectly, health-seeking behaviour of the persons studied. But the belief about relative efficacy and relative contiguity of the health services did not independently appear to decide appreciably, the variations observed in utilization of health services. Rather, the variations observable in utilization of health services appear to have been brought about by the interplay of the belief components and certain socio-demographic variables of the patients.

For instance, only self-medication and Home-remedies were used across all the ages and sexes as primary sources of health-care. The Modern Hospital was patronized over-whelmingly by the very young children while Traditional

Healers, the "Health Workers" and Healing Churches were patronized overwhelmingly by older fellows. It appears therefore, that while the belief in the contiguity and efficacy of these services remains constant, the perceive relevance of these health services in curing the different age groups remained controversial. Perhaps a most reasonable outcome of this study is that, rather than physical barriers, it was psychological barriers that were available to users to surmount in their pathways to respiratory health.

Secondly, the course of episodes of respiratory diseases does not follow the hard and fast line drawn by Freidman, Suchman and Kadushin in their Health Belief Models. The rural health-seekers tried only two distinctive stages i.e. symptom-experience stage and the medical-care contact stage. All the other stages are subsumed in these two stages. This appears to have resulted from two factors. Firstly, most of the episodes of respiratory diseases being treated were not very serious. Secondly and arising from the first reason, the episodes did not lead to reduction in social and physical functioning of the patients. Therefore there was no assumption of the sick-role behaviour. Herein lies the usefulness of the

eclectic model formulated to explain not the whole vista of health-seeking behaviour, but just the decision-making points in medical-care contact stage.

6.3.2 Implication for Policy Making

The policies of the three tiers of Government in Nigeria should be directed towards achieving a higher respiratory health status in the rural areas. This need should be seen to be dictated by the fact that high health status is a sine qua non for achieving high productivity and rural transformation.

What the governments have done so far ostensibly to achieve greater health and social status is to allocate money to the rural sector without monitoring how the money is used in developing the rural producers. The result is that the majority of Nigerians who are rural dwellers have been reduced through time to "other Nigerians". Even in matters of social welfare and social amenities which city-dwellers take forgranted and regard as their rights, the rural dwellers are consistently being snubbed. Yet they are theoretically being regarded as the corner-stone for economic take-off and often called upon to give their best in terms of productive activities. Until and unless rural dwellers are for practical purposes, seen as

important link in the Nation's productivity chain, regarded as the yardstick per excellence by which the level of the country's development status is measured and the utmost is done to improve their health, the quest for national development may remain a wild-goose chase.

In order to achieve a high measure of respiratory health, certain reformation need to be effected on health services as they are presently being patronized. Firstly, more primary health centres should be established in many parts of the rural districts. It has been revealed in this study that many of the rural dwellers are not averse to Modern Hospital services. But since Hospital is a point-located service its establishment should be made in a way that will ensure nearness to its patronage.

Secondly, the existing Modern Hospitals, should be further activated or strengthened. More qualified personnel should be attracted to them and more drugs supplied. In addition, more auxilliary services e.g. x-ray services, blood transfusion services and public education and monitoring services should be provided and strenuous efforts made to keep them functioning.

Thirdly, perhaps the governments should formulate a policy on drug administration and a special emphasis laid on self-medication with a view to encouraging and/or supporting it. It appears that self-medication is relied upon by a substantial proportion of the rural populace in treatment of respiratory diseases. It then seems that rather than discouraging the use of self-medication, its use could be regarded as a reasonable short-cut to achieving health for all in the year 2,000 in our rural areas where there are yet to develop solid physical infrstructures and other indices of modern health-care services.

The health policy being advocated should be able to spell out, however, the modality for ensuring that expired drugs are not sold by unscrupulous urban drug-pedlers to the unsuspecting and vulnerable rural dwellers. It should also aim at educating the masses about the danger of administering expired drugs and about preventive and curative use of medicine. It should educate the masses about the use of referral system and it should educate the rural people about diagnosis and explanation of diseases.

Fourthly, the separate, better still, combined influence of the mass media, the public enlightenment units

of the rural Hospitals, those of the State Ministry of Health, those of Mass Mobilization for Social and Economic Recovery (MAMSER) those of Agency for Literacy and Adult Education and more relevant, those of the Directorate for Food, Road and Rural Infrastructure (DFRRI) should be geared towards reorientating the rural masses' perception explanation and treatment of respiratory diseases.

Fifthly, the quacks parading themselves as "Health Workers" should be identified and flushed out of drug business as part of Nigeria's contribution to preventing and stamping out of drug abuse which has taken a global dimension. The rural dwellers themselves should be educated thoroughly on the need to receognize and shun the quacks. The task of reorientating the rural masses' perception is very crucial since perception determines attitude and attitude determines practice.

On the other hand, the qualified, certificated and itinerant medicine-sellers should be allowed and encouraged to sell medicines in the rural areas. They should, however, be closely monitored so that they may not be tempted to spread their activities or administer drugs beyond what their certificates or licences of practice permit.

Occasionally, induction courses should be organized for this class of rural workers so as to up-date and broaden their knowledge, improve as well as augment their skill. They may be used as contact persons by government administrators in the rural areas. This is saying that administrators can use the medicine sellers as liason officers through whom rural health-behaviour will be monitored and influenced.

There could, eventually emerge, a permanent forum where, through regular seminars, symposia, workshops and even conferences, medicine-sellers and policy-makers would discuss issues, exchange and cross-fertilize ideas. In such a form, discussion will centre on the status of respiratory health of the rural persons, stability and change in the utilization of health services and modality for improving the respiratory and general health of the rural dwellers.

Finally, the use of Home-made remedies, Traditional Healers and Aladura Churches should, also, be examined with a view to determining their potency and organizing them into an enviable pedestal. They have the potentiality to complement efforts by the governments in bringing better life to the rural people and achieving health for all by the year 2,000.

Implications for Further Research

Another interdisciplinary research should be conducted to determine the nature of chemical reactions that are possible when modern and traditional medicines are administered in the same episode of respiratory disease.

It is also necessary to conduct separate studies to determine the dynamics of patronage of health services by patients suffering such other diseases as dysentary, malaria, diarrhoea, malnutrition etc. Such separate studies would have moved away from the existing studies which merely examined health behaviour in general. They will provide a basis for studies on comparative health behaviour.

Finally, urban-rural health behaviour should be compared with a view to determining utilization of health services across sectoral divides.

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APPENDIX 1A

THE ETHNOGRAPHIC GUIDE

1. General Information

Name of Village: ----------

Number of Household: ----------

Age: ----------

Sex: ----------

Marital Status: ----------

Single: ----------

Married: ----------

Separated: ----------

Divorced: ----------

Widowed: ----------

Religion: ----------

Number and ages of Wives: ----------

Number, sexes and ages of children: ----------

Number, sexes and ages of Relations: ----------

Occupation: ----------

Income p.a: ----------

Type and distance of Water Source: ----------

Level of Education: ----------

Items of Food Consumed: ----------

Distance from nearest modern health clinic: ---------

Episodes he has taken to the clinic: ----------

How many people sell modern tablets in the community?-----

Distance from nearest traditional healer: ----------

What sorts of traditional healer i.e. prophet, alfa, babalawo, etc.

Episodes he had taken to traditional healer:----------

What home remedies for respiratory diseases does he know? ----------

APPENDIX 1B

1. RESPIRATORY DISEASE CENSUS CARD

Name of Village: ----------

Number of household: ----------

What home remedies for Air-borne diseases does he know? ----------

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Members of the household who have had Air-borne diseases

Sex	Age	Type of problem	Description of symptom	Number of attacks this year	Period of suffering	Perceive cause of episode

APPENDIX 1C

TREATMENT CARD FOR RESPIRATORY DISEASES

1. HISTORY OF TREATMENT

Name of village: ----------

Number of household: --------

Sex of sufferer: ----------

Age of sufferer: ----------

Case: ----------

Name of episode: ----------

Cause of episode: ----------

a) a. Home-made remedy: ----------

b. Length of use: ----------

c. Reasons for use: ----------

d. Name of regimen: ----------

e. Effects/assessment of treatment: ----------

f. Fatality of episode: ----------

b) a. Traditional Healer: ----------

b. Length of patronage: ----------

c. Reason for use: ----------

d. Cause of episode: ----------

e. Fatality of episode: ----------

f. Effects/assessment of treatment: ----------

f. Name/type of regimen e.g. concoction, powder:----

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c) a. Aladura churches: ----------

b. Length of patronage: ----------

c. Reason for use: ----------

d. Fatality of episode: ----------

e. Effects/assessment of therapy: ----------

f. Cause of episode: ----------

d) a. Self-medication: ----------

b. Length of use: ----------

c. Name of regimen: ----------

d. Fatality of episode: ----------

e. Reason for use: ----------

f. Cause of Episode: ----------

g. Effects/assessment of therapy: ----------

e) a. Went to Hospital: ----------

b. Length of use: ----------

c. Nature of treatment;----------

d. Fatality of episode: ----------

e. Reason for going to Hospital: ----------

f. Cause of episode: ----------

f) a. "Health Workers":----------

b. Length of use: ----------

c. Fatality of treatment: ----------

d. Kind of regimen: ----------

e. Reason for patronage: ----------

f. Cause of episode: ----------

g. Effects/assessment of therapy: ----------

APPENDIX 2

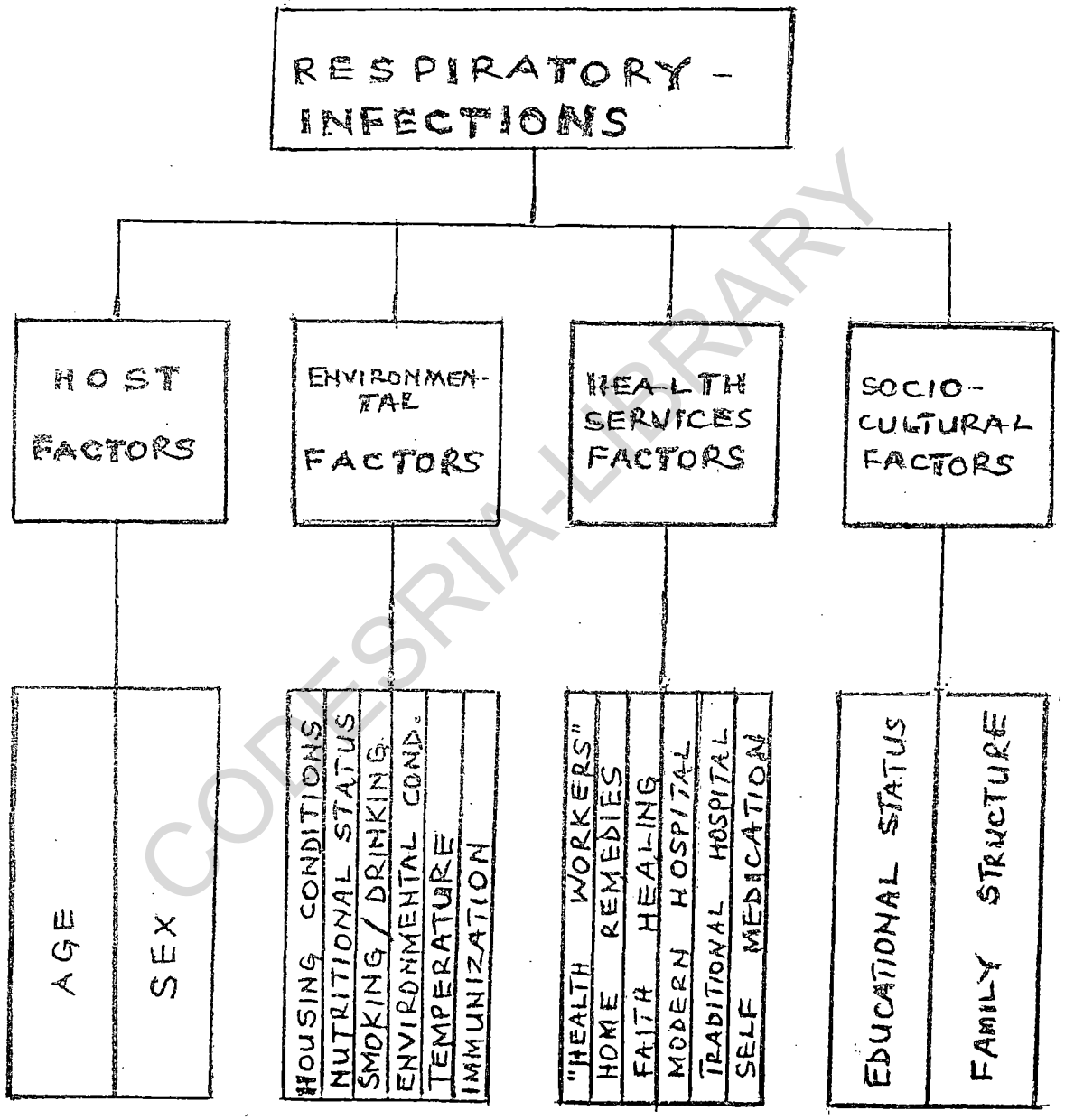
APPENDIX 2: VILLAGES IN MONIYA DISTRICT

Aba-Odo	OY/AK/MO/001		Ido	OY/AK/MO/044	
Abedo	"	002	Igbagbo	"	045
Adekola	"	003	Ijefan	"	046
Adeogba	"	004	Isabiyi	"	047
Agbamu	"	005	Isafunmi	"	048
Agbeka	"	006	Isagunna	"	049
Age	"	007	Isale-Apata	"	050
Agedengbe	"	008	Isale-Osun	"	051
Ayerokun	"	009	Iyana	"	052
Ajoja	"	010	Jooye	"	053
Ajigbagun	"	011	Ketepe	"	054
Ajojurin	"	012	Kitibi	"	055
Akabiako	"	013	Labinkulu	"	056
Akarabata	"	014	Lagbeja	"	057
Akinboro	"	015	Lagunja	"	058
Akingbile	"	016	Lamini	"	059
Akinode	"	017	Lapite	"	060
Alade	"	018	Longbo	"	061
Alagbede	"	019	Oboda	"	062
Alapata	"	020	Oguntilewa	"	063
Alase	"	021	Oje	"	064

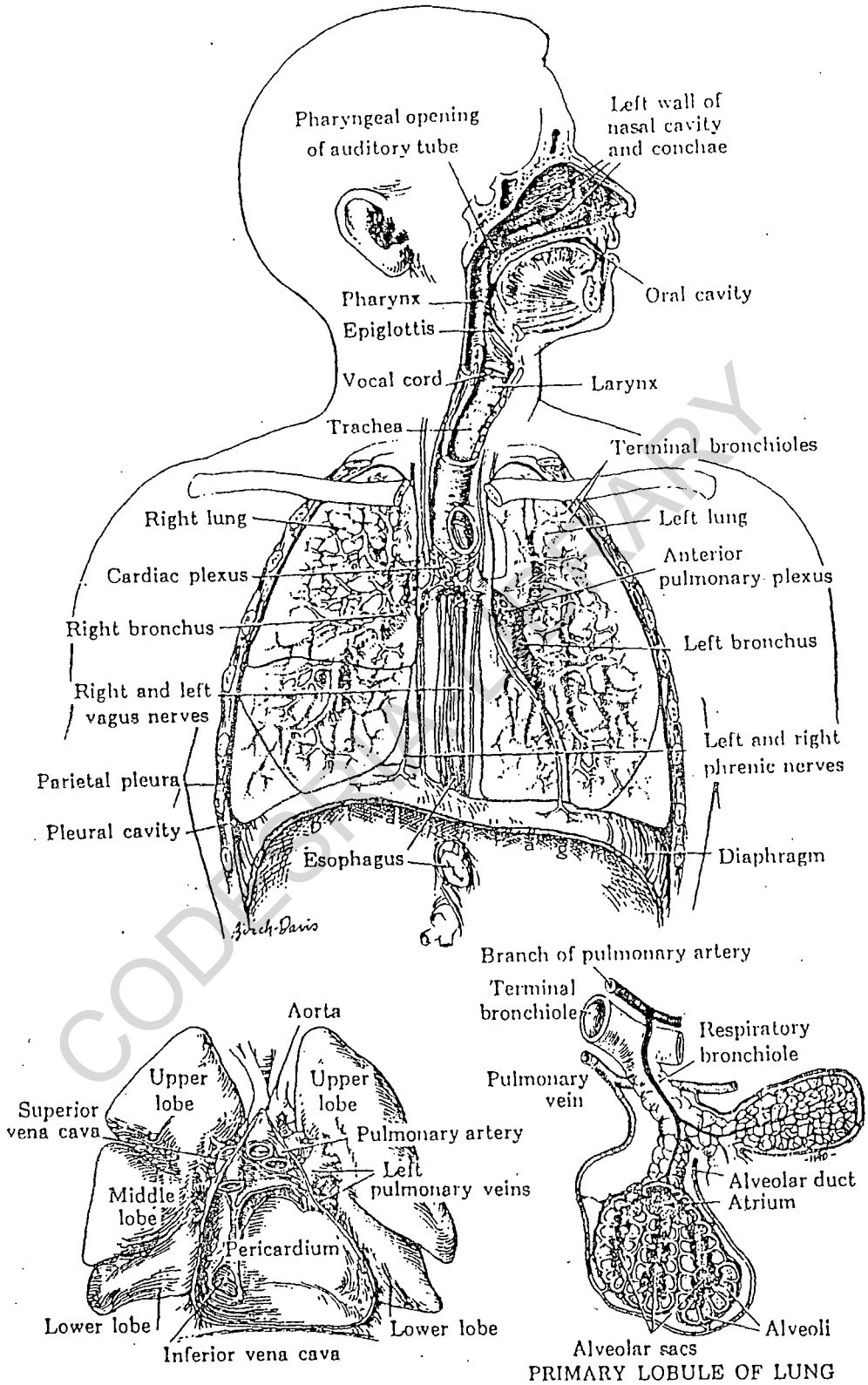
A awusa	OY/AK/MO/	022	Mogaji	OY/AK/MO/	065
Ajonmade	"	023	Molarere	"	066
Alegbe	"	024	Ojopode	"	067
Aleonibon	"	025	Okusinde	"	068
Asanmajana	"	026	Olode	"	069
Awero	"	027	Olodo	"	070
Balogun I	"	028	Otosun	"	071
Balogun II	"	029	Olokunmade	"	072
Bintu	"	030	Orieni	"	073
Dabiri	"	031	Ojoenmo	"	074
Elelu I	"	032	Apapa	"	075
Elelu II	"	033	Orisunbare	"	076
Elelu III	"	034	Otun-agbakin	"	077
Fatokun	"	035	Sagbe	"	078
Fijabi	"	036	Sogunro	"	079
Foranbi	"	037	Talontan	"	080
Aba-Ado	"	038	Tolani	"	081
Solalu	"	039	Tokode	"	082
Akinsola	"	040	Tokun	"	083
Idiose	"	041	Tunda	"	084
Idiorogbo	"	042	Yewande I	"	085
Idiika	"	043			

APPENDIX 3

RISK FACTORS ASSOCIATED WITH RESPIRATORY DISEASES



APPENDIX 4

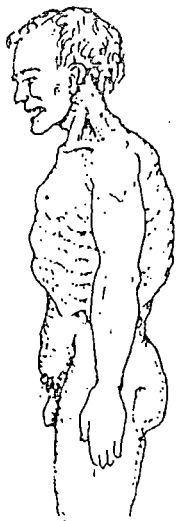


ORGANS OF THE RESPIRATORY SYSTEM

APPENDIX 5

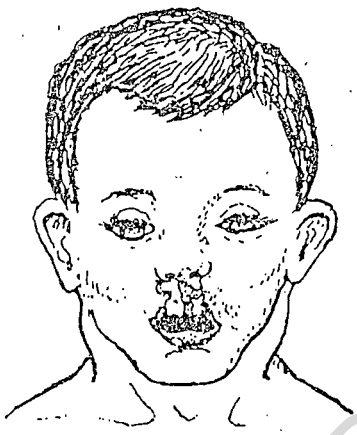
PICTORIAL DESCRIPTION OF RESPIRATORY SYMPTOMS

CHRONIC-BRONCHITIS



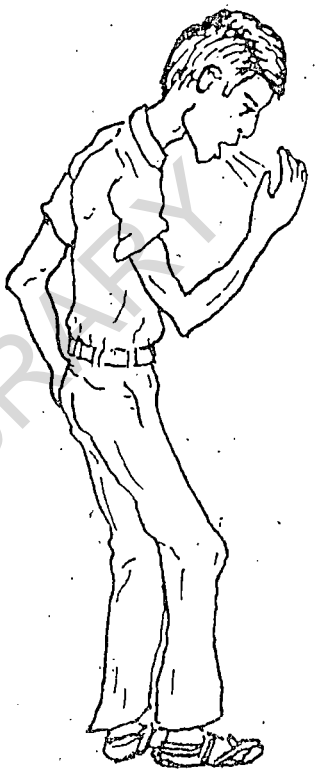
Emphysema can result from chronic asthma

DIPHTHERIA



COUGH

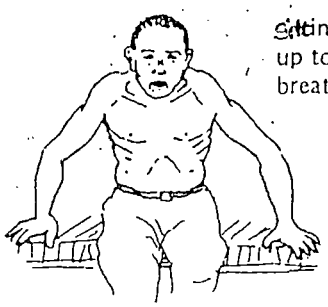
TUBERCULOSIS



MUMPS

WHOOPING-COUGH

ASTHMA



Sitting up to breathe

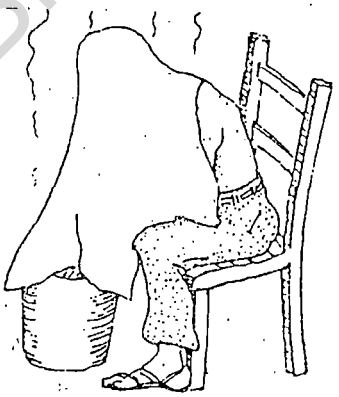
Culled from David Werner: Where there is no Doctor op cit.

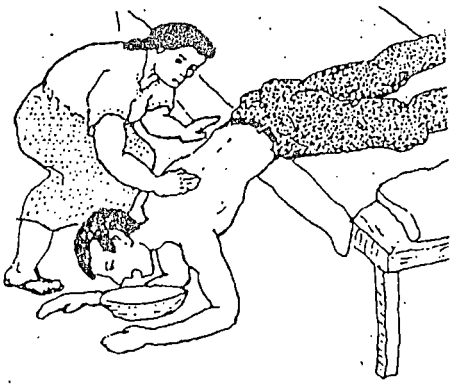
APPENDIX 5

PICTORIAL DESCRIPTION OF RESPIRATORY SYMPTOMS

COLDS AND THE FLU

HOW TO DRAIN MUCUS FROM THE LUNGS (POSTURAL DRAINAGE)





Culled from David Werner: Where there is no Doctor Op cit.