

HEM 603

DISEASE ILLNESS, AND SOCIETY



NATIONAL OPEN UNIVERSITY OF NIGERIA

HEM 603: DISEASE ILLNESS AND SOCIETY

COURSE GUIDE



NATIONAL OPEN UNIVERSITY OF NIGERIA

CONTENTS

3 BASIC CONCEPTS

- 3.1 Definition of Disease
- 3.2 Definition of Illness
- 3.3 Definition of Health

4 HEALTH INDICATORS

- 4.1 Antenatal Care
- 4.2 Birthplace and Assistance during Childbirth
- 4.3 Prevalence and Responses to Childhood Disease
- 4.4
- 4.5 Infant and Childhood Deaths

5 ILLNESS AND TREATMENT

- 5.1 Nature and Length of Illness
- 5.2 Place of Treatment
- 5.3 Treatment Decisions and paying for it
- 5.4 Cost of Treatment

6 CHOICE OF HEALTH CARE PROVIDERS

- 6.1 Government Health Facilities
- 6.2 Private Health Facilities
- 6.3 Traditional Health Care Facilities
- 6.4 Faith and Spiritual healing

7 EXPERIENCE WITH HEALTH CARE PROVIDERS

- 7.1 Encounters with Care Providers
- 7.2 Duration of Encounters
- 7.3 Supply of Medicine
- 7.4 Cost of medicine
- 7.5 Treatment Outcome

8 DETERMINANTS OF DISEASE, ILLNESS AND HEALTH

- 8.1 Age, Sex, Disease, Illness and Health
- 8.2 Environment, Disease, Illness and Health
- 8.3 Social class, Disease, Illness and Health

9 MEDICAL BELIEFS AND PRACTICES OF TRADITIONAL MEDICINE

- 9.1 Approach to Traditional Medicine
- 9.2 The Philosophy of Traditional Medicine
- 9.3 Forms of Traditional Medicine

10 MEDICAL BELIEFS AND PRACTICES OF TRADITIONAL MEDICINE

- 10.1 Development of Modern Medicine in Europe
- 10.2 The Philosophy of Modern Medicine
- 10.3 Modern Medicine in Nigeria

11 STRUCTURE OF A MODERN HOSPITAL

- 11.1 Goals of a Modern Hospital
- 11.2 Features of a Modern Hospital

12 RESPONSE TO DISEASE AND ILLNESS

- 12.1 Perception of Disease and Illness
- 12.2 The Sick-roll
- 12.3 Variations in Response to Disease and Illness
- 12.4 Stages of Illness Behavior

13 PATIENT-DOCTOR RELATIONSHIPS

- 13.1 Relationships of the Expert and the Layman
- 13.2 Guidance-Cooperation
- 13.3 Mutual Participation
- 13.4 Privilege Access
- 13.5 Handling of Recognized Uncertainty

14 COST AND FINANCING HEALTH CARE IN NIGERIA

- 14.1 Health policy and Responsibilities
- 14.2 Quality Versus Adequacy
- 14.3 Approaches to Health Care Financing

INTRODUCTION

HEM603 Disease, Illness and Society is a first semester, two credit unit course. It will be available to all students of the diploma in HIV Education and Management

and to all students who are willing to take the advantage of the programme to update their knowledge on the HIV/AIDS epidemic.

The course, which is broken down into 12 units, will introduce the students to the basic concepts of disease, illness and health and determinants of disease. It will also explain beliefs and practices of traditional and modern medicine and the social structure of a modern hospital. It will also focus on the understanding of response to disease, illness and health-seeking behavior, doctor-patient relationship and the cost and financing health. At the end of the course student should be able to understand, explain and be adequately equipped to deal with the issue of diseases, illness and health not only among themselves but also in their individual families, the community and the society in general.

The course guide tells you briefly what the course on Disease, Illness and Society is all about. The kind of course materials you will be using and how to work through the materials. It suggests some general guidelines for the amount of time students are likely to spend on each unit so as to complete the course timely and successfully. The course guide also contains information to guide student's tutor-marked assignments.

There are regular tutorial classes linked to this course, and students are advised to attend all the tutorial sessions.

WHAT YOU WILL LEARN IN THIS COURSE:

The basic aim of HEM603, Disease, Illness and Society is to enable students learn and understand the basic concepts of disease, illness and health, the determinants, belief and practices of medicine, institutional arrangements for dealing with disease and illness in the society, response to illness and the relationship between the care-giver and the sick person.

Students will also learn about appropriate and delay in health-seeking behavior for themselves and their families. The consequences for the community and the larger society will also be understood.

The knowledge that students will gain in the study of disease, illness and health is relevant for the understanding of how they affect the foundation of human groups. The knowledge will enable students to appreciate the impact of disease such as HIV/AIDS has on the individual, community and the society, and the importance of HIV Education and Management.

COURSE AIMS:

The aim of this course can be summarized as follows:

- 5.0 To raise the level of understanding of the concepts of disease, illness, and health and the determinants.
- 6.0 To discuss the systems of medical beliefs and practices and the development of modern medicine.
- 7.0 To explain the mechanisms for dealing with diseases, illness, individual and community responses to diseases and illnesses.

Given the above, students should be able to understand the concepts of disease, illness and health and the factors determining their occurrences in the society. Students should also understand why people react to the event of disease and illness in a particular way.

Students should also understand the development of traditional and modern medicine and the institutional arrangements for dealing with diseases in the society.

COURSE OBJECTIVES:

To achieve the aims set out above, the course sets the overall objective. In addition, each unit has specific objectives stated at the beginning of a unit. Students should read them carefully before going through the unit. You will have to refer to them during the course of your study to monitor your progress. Students should always refer to the Unit objectives after completing a Unit. This is the way you can be certain that you have done what was required of you in the unit.

The wider objectives of the course are set below. By meeting these objectives you should have achieved the aims of the course as a whole.

On successful completion of the course, you should be able to do the following:

- 1.0 Explain the meaning of the concepts, disease, illness and health
- 2.0 Identify indicators of health
- 3.0 Describe nature of illness and treatment
- 4.0 Discuss choice and experience with health care providers

- 5.0 List factors determining disease, illness and health
- 6.0 Outline systems of medical beliefs and practices
- 7.0 Describe the social structure of modern hospital
- 8.0 Outline responses to disease and illness
- 9.0 Discuss patient-doctor relationship
- 10.0 Identify the cost of financing health care

WORKING THROUGH THE COURSE

To complete this course successfully you are required to read the study units, read the recommended books and other materials provided by the National Open University of Nigeria {NOUN}. Each Unit contains self-Assessment exercises. At certain points in the course you are required to submit assignments for assessment. At the end of the course there is a final examination. The course should take you not more than 13 weeks to complete. All the components of the course, what you have to do and how you should allocate your time to each unit in order to complete the course successfully on time listed below.

COURSE MATERIALS:

The major components of the course are as follows:

- 3 Course Guide
- 4 Study Units
- 5 References
- 6 Presentation Schedule

STUDY UNITS

- Unit 1: Basic Concepts
- Unit 2: Health Indicators
- Unit 3: Illness and Treatment
- Unit 4: Choice of Health Care Providers
- Unit 5: Experience with Health Care Providers
- Unit 6: Determinants of Disease, Illness and Health
- Unit 7: Medical Beliefs and Practices of Traditional Medicine

- Unit 8: Medical Beliefs and Practices of Modern Medicine
- Unit 9: Structure of a Modern Hospital
- Unit 10: Responses to Disease and Illness
- Unit 11: Patient-Doctor Relationships
- Unit 12: Cost and Financing Health Care in Nigeria

The first unit concentrates on the definition of concepts of disease, illness and health. The next five Units examine health indicators, illness and treatment, choice of and experience with health care providers, and determinants of disease, illness and health. The next two units discuss the systems of medical beliefs and practices of traditional modern medicine. The next examines the social structure of a modern hospital. The next discusses response to disease and illness. The next examines patient-doctor relationship, while the last unit looks at the issue of cost and finance of health care.

Each study unit consists of introduction, objectives, reading materials, conclusion, summary, exercise and further readings. The unit directs you to work on exercises related to the required readings. In general, these exercises examine on the materials you covered in the unit or require you to apply it in some way and help you to assess your progress and reinforce your understanding of the material. These exercises will assist you in achieving the stated learning objectives of the individual units and of the course.

ASSIGNMENT FILE

There are 12 assignment files in this course. The assignment files will cover the following:

- 5.0 Basic Concepts of Disease, Illness and Health {Course Guide Unit 1}
- 6.0 Indicators of Health {Course Guide Unit 2}
- 7.0 Illness and Treatment {Course Guide Unit 3}
- 8.0 Choice of Health Care Providers {Course Guide Unit 4}
- 9.0 Experience with Health Care Providers {Course Guide Unit 5}
- 10.0 Determinants of Disease, Illness and Health {Course Guide Unit 6}
- 11.0 Medical Beliefs and Practices of Traditional Medicine {Course Guide Unit 7}

- 12.0 Medical Beliefs and Practices of Modern Medicine {Course Guide Unit 8}
- 13.0 Structure of a Modern hospital {Course Guide Unit 9}
- 14.0 Response to Disease and Illness {Course Guide Unit 10}
- 15.0 Patient- Doctor Relationships {Course Guide Unit 11}
- 16.0 Cost and Financing Health Care in Nigeria {Course Guide Unit 12}

PRESENTATION SCHEDULE

The presentation schedule included in your course materials gives you the important dates for this year for the completion of tutor-marked assignments by the submission date. You should guard against falling behind in your assignments.

ASSESSMENTS

There are two aspects to the assessment of the course. First, there are tutor-marked assignments. Second there is a written examination.

In tackling the assignments, you are expected to apply information. Knowledge and strategies gathered during the course. The assignments must be turned in to your tutor for formal assessment in accordance with the dead lines stated in the presentation Schedule and the Assignment File. The works you submit to you tutor for assessment will count for 50% of your total course work.

At the end of the course you will need to sit for a final written examination of three hours' duration. This examination will also count for 50% of your total course mark.

TUTOR-MARKED ASSIGNMENT {TMAS}

There are 12 tutor-marked assignments in the course. You only need to submit 10 of the 12 assignments. You are encouraged, however, to submit all the 12 assignments, in which case the highest of the 10 marks will count towards your total course mark. Assignment questions for the units in this course are contained in the Assignment file. You will be able to complete your assignments from the information and materials contained in your reading and study units. It is desirable to show that you have read beyond the required minimum. Reference to other materials will enhance your understanding and enrich your knowledge on the subject.

When you have completed each assignment send it together with your tutor-marked assignment to your tutor as soon as possible. Make sure that your assignment reaches your tutor on or before the deadline given in the Presentation Schedule and Assignment File. If for any reason you are not able to complete your work on schedule, contact your tutor before the assignment is due to discuss the possibility of

an extension. Extensions will not be granted after the due date except on exceptional cases.

EXAMINATION AND GRADING FINAL

The final examination for HEM603 will be for duration of three hours and will be 50% of the total course grade. The examination will consist of questions which reflect the types of self-testing, practice exercises and tutor-marked problems that you have previously encountered in the course. All areas of the course will be examined.

Use the time between finishing the last unit and the examination to revise. The final examination covers information from all parts of the course.

COURSE MARKING SCHEME

The following table lays out the actual course marking is broken down

ASSIGNMENT	MARKS
Assignment 1 – 12	Assignments best marks of the count @ 10% each =50% of course mark
Final Examination	50% of overall course mark
Total	100% of course mark

This table brings together the units, the number of weeks you should take to complete them and the assignments.

UNIT	TITLE OF WORK	WEEK'S ACTIVITY	ASSIGNMENT
1	Basic concepts of disease,		Assignment 1

	illness and health	Two Weeks	
2	Indicators of Health	One Week	Assignment 2
3	Illness and Treatment	One Week	Assignment 3
4	Choice of Health Care Providers	One Week	Assignment 4
5	Experience with Health Care Providers	One Week	Assignment 5
6	Determinants of disease, illness and health	One Week	Assignment 6
7	Medical beliefs and practices of traditional medicine	One Week	Assignment 7
8	Medical beliefs and practices of modern medicine	One Week	Assignment 8
9	Structure of a modern hospital	One Week	Assignment 9
10	Response to disease and illness	One Week	Assignment 10
11	Patient-doctor relationships	One Week	Assignment 11
12	Cost and financing health care in Nigeria	One Week	Assignment 12

HOW TO GET THE MOST OUT OF THE COURSE

In distance learning, the study units replace the university lecture. This is one of the greatest advantages of distance learning. You can read and work through specially designed study materials at your own pace and at time and place that suit you best. Think of it as reading the lecture notes instead of listening to a lecturer. In the same way that a lecturer might set you some reading to do, the study units tell you when to read your other material. Just as a lecturer might give you an in-class exercise, your study units provide exercise for you to do at appropriate points.

Each of the study units follows a common format. The first item is an introduction to the subject matter of the unit and how a particular unit is integrated with the other units and the course as a whole. Next is a set of learning objectives. These objectives let you know what you should be able to do by the time you have completed the unit. You should use these objectives to guide your study. When you have finished the unit you must go back and check whether you have achieved the objectives. If you are in the habit of doing this you will improve your chances of passing the course in flying colours. The main body of the unit guides you through the required reading from other sources. This will usually be either from a Reading section or some other sources.

Self-test are interpersonal throughout the units and answers are given at the end of units. Working through these tests will help you to achieve the objectives of the unit and prepare you for assignments and the examination. You should do each self-test as you come to it in the study unit. There will also be many examples given in the study units. Work through these examples when come across them.

The following is a practical strategy for working through the course. If you run into any trouble feel free to contact your tutor. Remember that your tutor's job is to help you when you need help, do not hesitate to call and ask for help.

1. Read this course Guide thoroughly
2. Organize a study schedule. Refer to the course overview for details. Note the time you are expected to spend on each unit and how the assignments relate to the units. Important information e.g. details of your tutorials and the date of the first day of the semester is available. You need to gather together all this information in one place such as your diary, a wall chart calendar or an organizer. Whatever method you choose, you should decide on and write in your own dates for working on each unit.
3. Once you have created your own study schedule, do everything you can to stick to it. The major reason that students fail is that they get behind with their course work. If you get into difficulties with your schedule, please let your tutor know before is too late for help.
4. Turn to unit 1 and read the introduction and the objectives for the unit.
7. Assemble the study materials. Information about what you need for a unit is given in the table of contents at the beginning of each unit. You will almost always need both the study unit you are working on and one of the materials for further reading on your desk at the same time.
8. Work through the unit. The content of the unit itself has been arranged to provide a sequence for you to follow. As you work through the unit you will be instructed to read sections from other sources. Use the unit to guide your readings.
9. Keep in mind that you will learn a lot by doing all your assignments carefully. They have been designed to help you meet the objectives of the course and will help you pass the examination. Submit all assignments as at when due.

- 10 Review the objectives for each study unit to confirm that you have achieved them. If you are not certain about any of the objectives, review the study material or consult your tutor.
- 11 When you are confident that you have achieved a unit's objectives, you should then start on the next unit. Proceed unit by unit through the course and try to pace study so that you keep yourself on schedule.
- 12 When you have submitted an assignment to your tutor for marking, do not wait for its return before starting on the next unit. Keep to your schedule. When the assignment is returned, pay particular attention to your tutor's comments, both on the tutor's-marked assignment form and also comments written on the assignment. Consult your tutor as soon as possible if you have any questions or problems.
- 13 After completing the last unit, review the course and prepare yourself for the final examination. Check that you have achieved the unit objectives listed at the beginning of each unit and the course objectives listed in the Course Guide.

TUTORS AND TUTORIAL

There are 17 hours of tutorials provided in support of this course. You will be notified of the dates, times and location of these tutorials, together with the name and phone number of your tutor as soon as you are allocated a tutorial group.

Your tutor will mark and comment on your assignment. Keep a close watch on your progress and on any difficulties you might encounter and provide assistance to you during the course. You must mail your tutor-marked assignments to your tutor well before the due date. At least two working days are required for this purpose. They will be marked by your tutor and returned to you as soon as possible.

Do not hesitate to contact your tutor by telephone, e-mail or discussion board if you need help. The following might be circumstances in which you would find help necessary, contact your tutor if:

- 5.0 You do not understand any part of the study units or the assigned readings.
- 6.0 You have difficulty with the self-tests or exercises.
- 7.0 You have questions or problems with an assignment, with your tutor's comments on an assignment or with the grading of an assignment.

You should try your best to attend the tutorials. This is the only chance to have face to face contact with your tutor and to ask questions, which are answered instantly. You can raise any problem encountered in the course of your study. To gain maximum benefit from course tutorials. Prepare a question list before attending them. You will learn a lot from participating in discussions actively.

SUMMARY

HEM 603 intends to introduce disease, illness and society to you. Upon completing this course, you will be equipped with the basic knowledge of disease, illness and health, its determinants and responses to disease and illness. You will be able to answer the following questions.

What do we understand by the concepts of disease, illness and health?
What are the indicators of health, nature of illness and treatment?

How can we explain choice of and encounter with health care providers?

What are the determinants of disease and illness?

How can we explain systems of medical beliefs and practices?

What are the approaches to the development of modern and traditional medicines, their philosophies and forms?

What do we understand about the social structure and the features of a modern hospital?

How can we explain individual, community and societal response to disease, illness and health?

What are the various stages in health-seeking and illness behavior?

How does patient-doctor relationship affects recovery and restoration of ill health?

What are the problems of the cost and financing of health care in Nigeria?

HEM 603: DISEASE, ILLNESS AND SOCIETY

COURSE DEVELOPMENT

Course Developer
Professor I. O. Orubuloye

Course Writer
Professor I. O. Orubuloye

Programme Leader
Dr. M. Oki
School of Science
National Open University of Nigeria, Lagos

Course Coordinator
K. S. Olubiyi



NATIONAL OPEN UNIVERSITY OF NIGERIA

Unit 1

Disease, Illness and Society: Basic Concepts

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Definition of Disease and Illness
3.2	Definition of Illness
3.3	Definition of health
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

1.0 INTRODUCTION

After reading through the course guide, you will have a general understanding of what this unit is all about and how it fits into the structure of this course. This is a Foundation unit in the programme, Diploma in HIV/AIDS Education and Management. The Unit focuses on the definition of disease, illness and health.

2.0 OBJECTIVES

At the end of this unit, learners should be able to do the following:

- Explain the concepts of disease, illness and health.
- Define disease, illness and health
- Discuss the similarities and differences between disease, illness and health

3.1 DEFINITION OF DISEASE

According to Rodney M. Cole, disease are specific kinds of biological reactions to some kind of injury or change affecting the internal environment

of the body when a person is sick, he feels that something is wrong with him as an individual, and his or her sickness affects everything that he or she does and the ways he or she thinks about himself or herself.

Disease alters the normal functioning of the body, and creates a lot of anxieties for the sick person. Diagnosis of a disease is often made by correcting the observable signs or symptoms of disease with knowledge about the functioning of the human organism.

Disease is a universal phenomenon, and it affects all people everywhere but not always to the same degree or in the same way. Diseases are not uniform or random in their occurrence in the population.

Disease constitutes a threat to group unity and survival and disrupt the social and economic life of the people, and reduce the ability of group members to carry out their social roles and tasks. Diseases can also alter the ways in which group members perceive and respond to one another, whether as a family or a larger group.

3.2 DEFINITION OF ILLNESS

Illness is a phenomenon in which individuals perceive themselves as not feeling well and therefore may tend to modify their normal behaviour by not attending to their day to day duties or act in ways which are different from those which might normally be expected of them.

When a person is ill his or her primary concern is to get well quickly. Therefore he or she tries to seek help from someone who can understand and deal with whatever disease is making him or her to feel ill.

The basic difference between disease and illness is that disease is an objective phenomenon characterized by altered functioning of the body as a biological organism; illness is a subjective phenomenon in which individuals perceive themselves as not feeling well. Disease may be objectively observed or measured with some degree of certainty. Knowledge of illness tells very little about type of disease that causes illness or about the state of the illness.

3.3 DEFINITION OF HEALTH

According to the World Health Organization {WHO} health is a complete physical, mental, social and spiritual well being not merely absence of disease or infirmity.

Two concepts are important in the understanding of health. They are individual or family health and public or health or community health.

An individual is a member of a community. His or her needs including health needs are part and parcel of the needs of the larger community, which he or she belongs.

A community is a group of people with common identity and who are living together within a define territory. Quite often, they share the same goals and aspirations. Such goals most often include good health for all members of the community.

The community has a direct responsibility for the health of the individual in the community. A sick person is a community's liability, and it is the responsibility of the community to provide certain minimum of both preventive and curative health services to all members of the community at an affordable price, and to assist members in the processes of treatment, recovery and rehabilitation.

4.0 CONCLUSION

The understanding of basic concepts of diseases, illness and health is important for the understanding of the pattern and distribution of disease in the society. It is also important for the how the community reacts to disease and assist the individual in the process of treatment, recovery and rehabilitation.

17.0 SUMMARY

In this unit you have learned about the basic concepts of diseases, illnesses and health. You should have learnt about the differences between diseases, illnesses and health. The Units also attempts to describe the importance of how the community reacts to diseases in the process of treatment, recovery and rehabilitation.

18.0 EXERCISE

1. Define the concepts of disease, illness and health?
2. Described the relationship between disease, illness and health?

19.0 FURTHER READINGS AND OTHER RESOURCES

Cole, Rodney M. *Sociology of Medicine*. New York. McGraw-Hill Book Company, 1970

Orubuloye, I. O. *Health Treatment in Nigeria*. Ado-Ekiti, Centre for. population and health research, 1999

Robinson, D. *Patients, Practitioners and Medical Care: Aspects of medical Sociology*, London, William Heinemann Medical Books Ltd. 1973
Sociology, London, William Heinemann Medical Books Ltd. 1973

UNIT 2

DISEASE, ILLNESS AND SOCIETY: INDICATORS OF HEALTH

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.1	Antenatal Care
3.2	Place of Delivery
3.3	Assistance during Delivery
3.4	Prevalence and Responses to Childhood Diseases Infant, Child and under-five Deaths
3.5	Conclusion
4.0	Summary
5.0	Exercise
6.0	Further Readings and Other sources
7.0	

1.0 INTRODUCTION

This unit is a follow-up to Unit 1, which focused on the definition of the concepts of disease, illness and health. The Unit will discuss the indicators of health, there rural-urban and educational differentials. It will focus on antenatal care, place of delivery, assistance received during childbirth, prevalence and responses to child illness and diseases, and infant, child and under-five mortality.

2.0 OBJECTIVES

At the end of this unit, learners should be able to do the following:

- Explain the major indicators of health

- Discuss the variations between rural and urban area, and between educational groups.
- Apply the knowledge to their immediate environment

3.1 ANTENATAL CARE

Antenatal care during pregnancy is an important aspect of primary health care and a good indicator of health. In 1999, 64 percent of Nigerian Women received antenatal care from a trained doctor, trained nurse or a midwife. The proportion of Women in urban area was 83 percent, compared 56 percent in the rural area. Among women with more than secondary education, the proportion was 95 percent compared with only 39 percent among women with no formal education. The distributions are presented below.

Percentage distribution of births according to antenatal care during pregnancy

Characteristics	Doctor	Nurse/Midwife	TBA	None	others
Urban	40.1	43.4	3.0	10.3	3.2
Rural	18.8	37.1	4.2	37.2	2.7
No Education	7.9	30.7	3.6	54.4	3.3
Primary	29.7	51.9	5.4	10.6	2.5
Secondary	47.3	43.9	3.3	3.4	2.1
Higher	66.5	27.7	0.6	0.8	4.5
All	24.7	38.9	3.9	29.7	2.9

Source: National Population Commission, Nigeria Demographic and Health Survey, 1999. Lagos Nigeria, 2000. P. 106.

3.2 PLACE OF BIRTH

The place of birth or delivery is an important indicator of health care delivery. In 1999, only 37 percent of births occurred in modern health facility compared to 58 percent that occurred at home. There were rural-urban and educational differentials. More than one-half of births in the urban area occurred in health facilities compared to about one-third in the rural areas where two-thirds of births occurred at home. Among the educated women, more than four-fifths births occurred at health facilities compared to about one-ninth among women with no education among whom more than four-fifths of births occurred at home.

The Distributions Of Births According To Place Of Births

Characteristics	Health Facility	At home	Others
Urban	52.5	42.2	5.4
Rural	31.5	64.5	4.0
No Education	13.4	82.9	3.7
Primary	48.0	47.1	5.0
Secondary	67.9	27.0	5.1
Higher	83.9	11.4	4.7
All	37.3	58.3	4.4

Source: National Population Commission, Nigeria Demographic and Health Survey, 1999. Lagos Nigeria, 2000. P. 109

3.3 ASSISTANCE DURING CHILDBIRTH

Another important indicator of health is assistance during childbirth. Less than one-tenth of all births in Nigeria was attended to by medically qualified doctors in 1999, one-third by nurses/midwives and one-fifth by traditional birth attendants. A significant proportion did not receive any kind assistance at all. Again there were rural-urban as well as educational differentials. Slightly more than 10 percent of women with more than secondary education did not receive help from medically qualified personnel compared to more than one-half of those with no formal secondary.

Percentage Distribution Of Births According To Assistance During Delivery

Characteristics	Doctor	Nurse/ Midwife	TBA	Relative /others	None/Don't Know
Urban	14.0	43.9	15.5	14.2	12.4
Rural	5.5	29.8	22.7	27.3	14.7
No Education	2.1	12.8	29.6	33.3	22.2
Primary	8.4	47.3	14.8	20.8	8.6
Secondary	15.0	59.2	11.1	9.8	4.8
Higher	33.4	54.7	4.4	5.2	2.4
All	7.6	33.7	20.7	23.7	14.0

3.4 PREVALENCE AND RESPONSES TO CHILDHOOD DISEASES

In Nigeria, like in most developing countries, children suffer from a range of diseases which are preventable. The major ones are acute respiratory infections {pneumonia and cough}, fever {mostly malaria} and diarrhea. These are major causes of childhood illnesses and child mortality. The

percentage of women who received treatment for their children during the last illness episode is shown below. Slightly more than one-third received treatment from health facility for acute respiratory infections, about one-third for fever and one-quarter for diarrhea. There were variations between urban and rural areas and between women with no formal education and those who had been to school. More urban and educated women used the health facilities than rural and no education women.

Percentage Of Women Who Received Treatment In Health Facility For Childhood Diseases

Characteristics	Acute respiratory infection	Fever {malaria}	Diarrhoea
Urban	64.8	64.8	50.9
Rural	44.5	44.5	32.8
No Education	39.5	39.5	29.4
Primary	56.0	56.0	45.0
Secondary	58.5	58.5	47.3
Higher	78.2	78.2	70.0
All Children	49.7	49.7	37.4

Sources: National Population Commission, Nigeria Demographic and health Survey, 1999, Lagos Nigeria, 2000. P. 117

3.5 INFANT AND CHILDHOOD DEATHS

Infant and childhood deaths are high in Nigeria and in nearly all the developing countries, and they vary by certain characteristics. There are urban and rural differentials and by the socio-economic status of the parents, especially the mothers. The distribution of infant, child and under-five deaths shown below indicates that the incidence of these deaths are lower in the urban than rural areas and among women who have been to health school. The differences can be explained by the certain factors. The urban area enjoy better health facilities than the area, while educated mother are far more likely and use modern health facilities than the uneducated ones.

Infant, Child Deaths And Under-Five Deaths Per 1000

Characteristics	Infants Deaths	Child Deaths	Under-five Deaths
Urban	59.3	51.6	107.8
Rural	75.0	73.4	142.9
No Education	76.9	86.6	156.8
Primary	71.2	54.5	121.8
Secondary	59.0	39.3	95.9
Higher	40.5	13.0	53.0
Total	70.8	67.4	133.4

Source: National Population Commission, Nigeria Demographic and Health Survey, 1999, Lagos. Nigeria, 2000. P.101.

4.0 CONCLUSION

An understanding of the indicators of health is important for the assessment of the quality of health care delivery services in a community. It is also an important indicator of health-seeking behaviour in the society. It is also important for the understanding of how different the communities and different educational groups employ various health facilities.

5.0 SUMMARY

In this Unit you have learned about the indicators of health. You should have learnt about the pattern of utilization of health facilities. The Units also attempts to describe the importance of how the different communities and educational groups employ the various health facilities for child health.

6.0 EXERCISE

1. Define the indicators of health
2. Discuss the urban and rural differentials and differences in indicators of health between educational groups
3. Asses the infant, childhood and under-five deaths.
4. Identify and discuss the major childhood diseases common in your community.
5. How do people in your communities react to the event of these diseases.

7.0 FURTHER READINGS AND OTHER RESOURCES

National Population Commission, Nigeria Demographic and Health Survey.

Orubuloye, I. O. Health Treatment in Nigeria. Ado-Ekiti. Centre for
Population and health Research, 1999.

UNIT 3

DISEASE, ILLNESS AND SOCIETY: ILLNESS AND TREATMENT

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Nature and Length of Illness
3.2	Place of Treatment
3.3	Decisions and Treatment and Paying for Treatment Cost of Treatment
3.4	Conclusion
4.0	Summary
5.0	Exercise
6.0	Further Readings and Other Resources

8.0 Introduction

This unit is a follow-up to Unit 2, which focused on health indicators. This Unit will discuss nature or types of common illnesses experienced in the communities length of illness, place where treatment are received, the person or persons who decide on treatment, the cost and the person meeting the cost.

9.0 OBJECTIVES

At the end of this Unit, learners should be able to do the following:

- Explain the nature and length of illness.
- Discuss the place where treatments are normally received.
- Identify the person or persons who often made treatment decisions and paid for it.
- Understand the cost of treatment.

3.1 NATURE AND LENGTH OF ILLNESS

Health-seekers usually refer to complaints by mentioning symptoms rather than naming a specific type of illness. Children's illnesses are often accompanied by a multiplicity of symptoms. Adults may have accurate knowledge of some of the common diseases, while the majority of mothers often have some knowledge of some of the major childhood diseases such as diarrhoea respiratory infections and fever.

In Nigeria and much of the developing countries, most illness episodes involve fever and are believed to be malaria which accounts for about 2 millions deaths in Africa per annum. In recent years, there has been increase in reported cases of typhoid fever. Other infectious diseases such as measles, chicken pox, whooping cough and tuberculosis now account for the majority of illness episodes and deaths in Nigeria. Often there are differences in the types and intensity of the common illnesses between rural and urban areas and between one socio-economic group and the other. Nevertheless, when illness struck, majority of mothers often responds promptly to seek treatment especially in the event of their child illnesses.

3.2 PLACE OF TREATMENT

Health-seekers often have numerous treatment options when they are ill and in need of health care. In Nigeria, there is an array of health care providers both indigenous and modern. Health care is often sought among providers concurrently or sequentially depending on the perceived nature and cause of illness.

In the past, the approach to health care was usually two-fold. For most illnesses, health care was usually first sought within the household from older members of the family who have through experience the knowledge of treatment for such illness. If the illness persisted, traditional specialists were consulted. Today, the situation has changed significantly. A large proportion health-seekers now consult modern health care providers both private and government facilities at the onset of illness. Home remedies, chemist, medicine stores and faith/spiritual healing are frequently being used. Purchase of drugs from peddlers who are found in large numbers in Nigeria are frequently used especially in the rural areas and among the poor whose access to other sources is limited. The medicine sold by the peddlers range from painkillers to malaria suppressants and antibiotics of various types and composition.

3.3 DECISIONS ON TREATMENT AND PAYING FOR TREATMENT

In the Africa context, diseases and illness fall into two categories: Natural and Supernatural. Decisions on treatment therefore, involve many factors such as the nature of illness, the cost and the person paying for it. Diseases though to be due to natural factors are often treated by either traditional or modern therapies. Those thought to be supernatural are treated by spiritual means. Whether the therapy is traditional, modern or spiritual, the person taking the decision is important because that person invariably also meets the cost.

In much of sub-Saharan Africa, women are central to maintaining the health and well-being of their households. They manage health as care-givers and when members of the family are sick is the women who look after them. When the women themselves or their children are sick and receiving treatment they are often called upon to meet part of the treatment cost. In Nigeria, the father or the husband, generally makes most of the treatment decisions and almost invariably pay for it. Family members and relatives often assist in meeting part of treatment costs.

4.0 CONCLUSION

Health-seekers in the developing countries tend to seek health care currently or sequentially depending on the nature the illness and the resources at the disposal of the family. Place of treatment is a function of cost and accessibility as well as the perception of those who require treatment and the person or persons making treatment decisions and paying for it. When the cost of treatment is high the father in the case of child health or the husband in respect wife's treatment often meets the cost. The woman in respect of her children's health and her own health often meets the low order costs. Family members have traditionally assisted in assistance of family members to an extent that health-seekers no longer count on such helps.

5.0 SUMMARY

In this Unit you have learnt about the nature and length of illness, place where treatment was received at the onset of illness, the person or persons who decided on treatment and paid for it, and the cost of treatment. These indicators are important aspect of management of illness and approach to good health.

6.0 EXERCISE

1. Assess the nature and length of illness.
2. Discuss the various places of treatment and the extent to which they are complimentary.
3. How are treatment decisions made in your communities?
4. Examine the cost of treatment in the area you live. How are the costs met?

7.0 FURTHER READINGS AND OTHER RESOURCES

Orubuloye, I. O. Health Treatment in Nigeria. Ado - Ekiti. Centre for Population and health Research, 1999.

DISEASE, ILLNESS AND SOCIETY:
CHOICE OF HEALTH CARE PROVIDERS

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Government Health Care Facilities
3.2	Private Health Care Providers
3.3	Traditional Health Facilities
3.4	Faith and Spiritual Healing
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

   INTRODUCTION

This Unit is a follow-up to Unit 3, which focused on illness and treatment. The Unit discussed the nature and length of illness, place of treatment, the person or persons making treatment decisions and paying for it and the cost of treatment. This unit will focus on the choice of health providers. In Africa, there is multiplicity of health care providers. Health-seekers tend to seek health care concurrently or sequentially, depending on the perceived nature of the illness and the resources at the disposal of the family.

   OBJECTIVES

At the end of this Unit, learners should be able to do the following:

- Explain the major determinants of choice of health care providers
- Discuss the differences between the various health care providers
- Identify the type of health care providers in their immediate environment.

3.1 GOVERNMENT HEALTH CARE FACILITIES

In sub-Saharan Africa, there are several systems of health care and uneven distribution of modern health care facilities between communities. Several of these distinct health care systems are often adopted either concurrently or sequentially in the course of illness episodes. The most common one is the modern scientific health care now provided by the government and private medical practitioners. Others are the traditional health care and faith spiritual healing.

In Nigeria, health is on the concurrent legislative list. Therefore the arms of government: the Federal, State and Local Government are responsible for health care matters. The Federal government is responsible for tertiary health services while the State and Local government are responsible for secondary and primary health care services respectively.

The adoption by Nigeria of the 1978 Alma-Ata Declaration on primary health care has accelerated the provision of health care facilities by the various tiers of government. Today, nearly all the major towns have at least one health centre and each local government headquarters with a small hospital. Between 1970 and 1983, a physician per capita increases more than fourfold and nurses nearly sevenfold as new hospitals and health facilities were built. Provision of health facilities slowed down from the mid-eighties because of the downturn in the economy. Similarly, use of government health care facilities dwindled during the period because of the deterioration in the quality of health services and the introduction of user fees in the health sector.

A good number of users have lost confidence in government health facilities because of poor services, and lack of drugs and equipment. Attempts are now being made to improve on the bad image of government health services.

3.2 PRIVATE HEALTH CARE PROVIDERS

Independent private medical practice has traditionally been an important part of the Nigerian health care system. The Christian medical missions and private individuals are the major operators of private medical practice in Nigeria. Private medical practice now accounts for between one-quarter and one-third of health care services in Nigeria. The Christian Health Association of Nigeria alone now operates about 4,000 health facilities across Nigeria, including hospitals, maternity centres, mobile clinics and leproseries.

Health-seekers use private health facilities because the services are better and closer to the users. Although private health services are more expensive than the government ones, the providers are always available, equipment are often better and above a good number now offer flexible pricing system which allows their constant and reliable customers, especially those of their religious faith to pay on agreed terms. Flexible pricing system has traditionally been aspect of the Christian missions' health care philosophy. The poor have been provided in the scheme of things

The proliferation of private hospitals and clinics posed serious dangers to the health care system. All kinds of hospitals and clinics are now being ruined by medically qualified and unqualified personnel. Many of such individual private hospitals and clinics are mere consulting clinics, and taking sick persons to them is similar to passing a death sentence.

3.3 TRADITIONAL HEALTH FACILITIES

Traditional health care is undoubtedly the oldest form of health care system in nearly all societies. It is widely used by a large proportion of the people in the rural areas and among the poor who have no access to other forms of health care facilities. The practice is in various forms, depending on the perceived cause and nature of illness. Most of the treatments are usually the application of herbal therapies of various forms and dosage. It is generally believed that there are certain types of diseases, which can only be treated with traditional means.

Traditional health care providers are closer to their clients, they offer cheap services, and they offer flexible pricing policy that conforms to the ability of the family to pay. Despite the acceptance of traditional health care practice, most people perceived it as unreliable, unhygienic and lack standardization.

The Nigeria Association of Traditional Medical Practitioners is currently addressing these problems. The plan to integrate traditional health care into the main stream of the National Health Care System may enhance the status and reduce bias against it.

3.4 FAITH AND SPIRITUAL HEALING

The advent of the African syncretic churches led to the emergence of faith-healing Christian churches. This group now accounts for a significant proportion Christians in Nigeria. There are many different sects within the syncretic churches and the kind and form of faith healing provided for their members varies accordingly. The emergence of electronic media, especially

television, has increased the effect of faith healing churches on the general population.

The services provided by the practitioners cut across the whole spectrum of the members of the faith, both poor and rich. Faith healing is growing in importance in the Nigerian health care system. Many syncretic churches now have maternity homes as part of their establishments where their members who have medical training provide health care for needy members almost free of charge. A small but increasing number of modern medical personnel now combine faith healing with modern medicine in line with the practice of the early Christian missionaries.

4.0 CONCLUSION

There are overlapping in the choice of health care providers in Nigeria. The government, federal, state and local is the largest provider of health facilities in Nigeria. A significant proportion of the population has lost confidence in government health care facilities because of the services provided.

Private health practitioners have attempted to fill the vacuum by providing better services. But such services are often beyond the reach of the poor and those in the rural areas that form the majority of the population.

Traditional health care practice continues to be an important aspect health care in Nigeria despite the poor perception of the practice by the elite.

5.0 SUMMARY

In this unit you have learnt about the kind of choice of health providers which health-seekers make in the course of illness episodes. You should have learnt about how health-seekers make perceive the various types of health care providers open to them when making their choices. Health-seekers choose government health facilities because they are highly subsidized but the deterioration in the quality of services provided has driven many health-seekers to other health care providers some of which offer poor services. Private health care providers occupied an important place in the health care system of the country. Their services are judged to be better but more expensive.

In the unit you also learnt about the place of traditional health care providers and Faith/spiritual healing in the health in the health care systems. The positions of these providers have been jeopardized because of proliferation and unfulfilled promises.

6.0 EXERCISE

1. Identify the various types of health care providers in your community
2. Discuss their contributions to the health care delivery of your country.
3. Identify the problems that are currently facing government health care providers in your country.

7.0 FURTHER READINGS AND OTHER RESOURCES

Orubuloye, I. O. Health Treatment in Nigeria. Ado-Ekiti. Centre for Population and health Research, 1999.

UNIT 5

DISEASE ILLNESS AND SOCIETY
EXPERIENCE WITH HEALTH A CARE PROVIDERS

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Encounter with Health Care Providers
3.2	Duration of Encounters
3.3	Supply of Medicine
3.4	Cost of Medicine
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

1.0 INTRODUCTION

This Unit is a follow-up to Unit 4, which focused on choice of health care providers. This Unit will discuss encounters of health-seekers with health care providers, duration of encounters, supply of medicine, cost of medicine and treatment outcome.

2.0 OBJECTIVES

At the end of this unit, learners should be able to do the following:

- Explain the encounters which health-seekers have with health care providers
- Discuss the duration of encounters.
- Examine the supply and cost of medicine.

- Understand treatment outcome.

3.1 ENCOUNTER WITH CARE PROVIDERS

Previous experience of persons seeking health treatment from the health care providers may influence the decision to delay treatment, and use or not use particular health personnel at the onset of another illness episode. Because of the inadequacy of modern health facilities in many of the developing countries and in Nigeria in particular, health seekers are usually not given enough time to talk to health care providers. A typical encounter between a patient and a modern health care provider may last less than two minutes. Descriptions of symptoms may be limited to a single sentence and physical or laboratory examination may be cursory or even non-existent.

In Nigeria, there are variations according to certain socio-economic factors in the pattern of encounter with modern health care providers. Students have shown that generally more people in the urban area have encounters with government health care providers than those in the rural areas. This is understandable because there are better educated, more conscious of their health problems and are far more likely to take prompt actions. Biological children of parents are far more likely to be taken to modern health care providers on the onset of illness than fostered children.

3.2 DURATION OF ENCOUNTERS

The duration which health seekers have with health care providers especially in government health facilities is an important factor in treatment behaviour. Experience had shown that health-seekers do not always have enough time to discuss their health problems with the health care providers because of the large number of people, which consult with daily. Generally, the length of an encounter is often less than ten minutes with more educated tended to spend less time compared with less educated people. Less educated are far less likely to be precise or give accurate descriptions of symptoms of illness and more time may be needed by health care providers to elicit such information from them.. Instructions are often given in the language which the health-seekers understand rather than that of the health providers. Interpreters may be requires thus increasing the time a health seeker needs to stay with a provider.

3.3 SUPPLY OF MEDICINE

Supply of genuine medicine is an important aspect of health care. Since the mid-1980s, there has been a shortage of drugs in nearly all government health

facilities in Nigeria. Most government health facilities were until recently reduced to mere consulting clinics. Those that were able to supply medicines gave drugs that at best offered temporary relief to patients. Patients were advised to purchase their drugs from privately operated pharmacies and patient medicine stores abound in Nigeria. These medicine stores sell expensive drugs, which are often beyond the reach of the average Nigerian family. A large number of health-seekers go to peddlers or medicine stores that sell cheap drugs, which are of little value.

3.4 COST OF MEDICINE

The cost of medicine is an important component of treatment cost. This has gone up significantly since 1987 in Nigeria. The cost of medicine when added to that of consultation, medical accessories which health-seekers now have to provide transportation and feeding is substantial and often difficult to find within the disposable income of the family. Before the floating of the Naira in 1987, the cost of treatment in attack of malaria was less than one hundred naira or one US dollar. Today, the average cost has increased tenfold, while the income of many families has increased only marginally or in most cases stagnant or decreased.

4.0 CONCLUSION

Experience of persons seeking health from health care providers often influences the decision to use or not to use a particular health facility at the onset of illness. In Nigeria, there is an acute shortage of health personnel and facilities, encounters with health care providers are usually short, description of symptoms limited, physical examinations seldom carried out and laboratory examinations often absent. Medicines are rarely given out to patients, while a significant purchase their drugs from chemists or medicine stores or peddlers.

5.0 SUMMARY

In this Unit, students have learnt about the experience which health-seekers often have with health care providers when they are sick and looking for help. They have learnt about encounters with healthcare providers, the duration of encounters, supply and cost of medicine. This information is important for the understanding and assessment of the health care system and whether health-seekers will use or not use a particular health care facility.

6.0 EXERCISE

- Discuss the type and duration of encounters which health-seekers often have with health care providers.
- Explain the supply and cost of medicine in your community.

7.0 FURTHER READINGS AND OTHER RESOURCES

Orubuloye, I. O. Health Treatment in Nigeria. Ado-Ekiti. Centre for Population and health Research, 1999.

UNIT 6

DISEASE, ILLNESS AND SOCIETY: DETERMINANTS OF DISEASE, ILLNESS AND HEALTH

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Age, Sex, Disease, Illness and Health
3.2	Environment, Disease, Illness and Health Social Class,
3.3	Disease, Illness and Health
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

1.0 INTRODUCTION

This Unit is a follow-up to Unit 5, which focused on the experience with health care providers. The Unit will discuss determinants of disease, illness and health in human population.. It will focus on age, sex, the environment and social class as major determinants of disease, illness and health.

2.0 OBJECTIVES

At the end of this Unit, learners should be able to do the following:

- Explain the major determinants of disease, illness and health.
- Discuss the variations from one society to another.
- Apply the knowledge to their immediate environment.

3.1 AGE, SEX, DISEASE, ILLNESS AND HEALTH

It is a common knowledge that patterns of disease; illness and health vary with age and sex of the population. However, it is absolutely clear how the pattern varies or the extent to which it varies.

Data on disease, illness and health by the characteristics of the populations are, very difficult to come by in Nigeria. In developed societies with long history of data collection and utilization, there have been consistent patterns which can be applied to our situation in Africa, and in deed Nigeria.

The general pattern all over the world is that infants and old people are known to have the highest incidence of illnesses and hospitalization than the adult population. Therefore, they constitute a very significant proportion of the total health services needs. For example, young people are more prone to infections parasitic diseases and respiratory conditions than adult members of the society. On the contrary the rates of chronic conditions, such as heart disease, cancer, diabetes and arthritis, increase with age.

Although, there has been a higher rate of illness from chronic diseases among older persons because chronic diseases are primarily due to the degeneration of body tissue and the inability of organs to function normally, older persons may be more immune to communicable diseases because they have had greater exposure. Among infants whose systems have not built up strong defense mechanisms, a higher rate of diseases and acute illness is often experienced.

Socio-cultural factors also often have implication for disease and rate of differenced in illness and resources to hospitalization. There is a different attitude of family and the public toward the general wellbeing and care of children that toward care of the aged. In certain parts of Africa, mostly now rural areas, children are still subjected to all kinds of discrimination in terms of feeding and nutrition. This has implications for the building of strong dences to ware off the attack of communicable and parasitic diseases that are prevalent among this group.

It has been generally observed that males experienced higher morbidity and mortality rates, and lower life expectancy at birth than females. The explanation of the sex differential in rate of illnesses and deaths between male and female is partly biological and socio-cultural. In a given year, among any human population, more males than females are born. At any

given stage of the lifecycle, children, adult and old age, there is always more females than males.

There are several explanations for this phenomenon. Females are believed to be physiologically stronger than males. In African culture, females are assumed to be the weaker sex, hence, the culture prescribed certain roles and activities for males which expose them to hazards than the females. For example, in our society, men climb palm trees but women are prevented from doing so not because they are physiologically incapable of doing so but because the society ascribed that role to males. Females by their nature take more precautionary measures to protect their health, while males often take their health for granted.

However, women in their reproductive years, 15-49 years old, tend to have a high rate of illness and hospitalization than men of the same age group. Most of the illnesses and hospitalization are as a result of the problems arising from complications of pregnancies and childbirth.

In communities where there are civil strife and wars certain age groups may experience some depletion in their numbers. The groups that are mostly affected are males between 15-35 years of age. This age range is likely to take part in physical combat, which may result in loss of lives. Children and women are likely to suffer some kind of deprivation, which may increase the potential to acquire diseases that may increase their level of morbidity.

3.2 ENVIRONMENT AND DISEASE

The importance of environmental factors on disease has been a major focus in the study of diseases in human groups. Climate, location, soil, water and other natural features are closely linked to disease and illness causation. Certain environmental conditions enable some disease-causing agent to flourish and others to die. The natural habitats of the anopheles mosquito that causes malaria are the tropical regions of the world. This species of mosquito survives better because of the wet and humid conditions.

The advent of advanced technology has enabled man to change his environment and protect himself from certain diseases and illnesses. Technological advancement has created a scenario whereby the level of health is related to the stage of technological and economical development of the country. The countries that have progressed technologically and economically tend to have the lowest disadvantage and tend to have the highest level of morbidity and illnesses.

Rural population suffers more from illnesses and experience higher rate of hospitalization than their counterparts who live in urban areas. Rural populations are often deprived of social amenities that could improve their health status compared to those who live in the urban area. Rural populations are less educated, have low incomes and limited access to health services. Hence they are more vulnerable to attack diseases and illnesses.

3.3 SOCIAL CLASS DISEASE AND ILLNESS

Diseases are usually observed to be more or less common among various social groups. Differential social groups in the society do not often suffer from the same kind of disease or illness and recourse to health care services.

Studies have shown that the rate of diseases and illnesses from the highest to the lowest social class. Communicable infectious and parasitic diseases associated with poverty are major phenomenal among the lower class. On the other hand, degenerative diseases such as cancer and heart diseases are known to be more common among the wealthy and high class.

Explanations have been provided for the differences between the low and high class. The differences in the patterns of disease and illnesses can be ascribed to the relatively healthy and extremely poor environment in the wealthy and the poor live respectively. The lower social class lives under conditions of poverty, filth, overcrowding, and poor health conditions. The high social class on the other hand lives in a healthier environment and has access to better health facilities and is willing and able to take advantage of modern technology to combat diseases and the occurrence of illnesses among their family members.

In populations where there is a major divide by race, differential incidence of diseases and illness tend to occur along racial groups. Blacks and coloured people in the United States of America and South Africa are known to experience lower life expectancy at birth than the white populations. The black and coloured populations suffer more deprivations in terms of access to education, employment and health facilities than the white population. The apparent deprivation of certain groups tends to widen the gap between races and thus creating the class of the poor and the rich.

4.0 CONCLUSION

The study of the determinants of diseases, illnesses and health are important for the understanding of the pattern and distribution of disease in the society. It is also important for the how diseases can be managed between the various

age groups, male and female, and between social groups and within the different environment which they live.

5.0 SUMMARY

In this Unit you have learned about the determinants of diseases, illnesses and health. You should have learnt about the factors responsible for difference in diseases, illnesses and health according to age and sex. It also discussed the relationship between the environment, incidence and prevalence of diseases and illness in the population. Social class and diseases are also discussed in the Unit. Attention was paid to the differences in the pattern and distribution of diseases between the poor and the rich. Emphasis was on how and why the differences in the environment produce differences in the potential of disease.

6.0 EXERCISE

- Identify and discuss the major determinants of disease, illness and health in the community where you live?
- Explain the factors that are responsible for the differences in the incidence, prevalence and pattern of disease between the various social classes in your society?
- Discuss the impact of the environment on the pattern of disease, illness and health?

7.0 FURTHER READINGS AND OTHER RESOURCES

Cole, Rodney M. *Sociology of Medicine*. New York, McGraw-Hill Book Company, 1970.

Orubuloye, I. O. *Health Treatment in Nigeria*. Ado Ekiti, Centre for Population and Health Research, 1999.

Robinson, D. *Patients, Practitioners and Medical Care: Aspects of Medical Sociology*, London, William Heinemann Medical Books Ltd. 1973.

UNIT 7

DISEASE, ILLNESS AND SOCIETY: MEDICAL BELIEFS AND PRACTICE OF TRADITIONAL MEDICINE

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Approach to Traditional Medicine
3.2	The Philosophy of Traditional Medicine
3.3	Forms of Traditional Medicine
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

5.0 INTRODUCTION

In Unit 6 you have learned about the determinants of diseases, illnesses and health and the factors responsible for difference in diseases, illnesses and health. This Unit discusses the institutional arrangements put in place in traditional societies in dealing with the occurrence of disease and illness.

6.0 OBJECTIVES

At the end of this Unit, learners should be able to do the following:

- Understand the approach to traditional medicine
- Explain the philosophy of traditional medicine

- Identify and explain the various forms of traditional medicine in Nigeria.

13.1 APPROACH TO TRADITIONAL MEDICINE

In Unit 1, you learnt about the definition of disease, illness and how they pose major threats to individual and group survival. Different cultures have developed mechanisms for this challenge, the attitudes and beliefs they hold and the means they employ. These processes evolved as the society moves from one stage of development to another.

Traditional medicine therefore, is an important part of the history of Nigeria, and the history pre-dates the advent of Western medicine.

People from other cultures have called traditional medicine several names. The first white man who stepped his foot on the Nigeria soil equated traditional medicine with witchcraft and sorcery. Others that came after him called the practice native medicine, magic, fortune telling, herbalism and juju. Such names and appellations are essentially meant to show the extent to which traditional medicine is inferior to western orthodox and to depict the supposedly lack of scientific validity and explanation behind the practice and approach to traditional medicine.

In Nigeria, traditional medical practitioners include the Wombi of the Hausa armies, a form of military Red Cross; Barber-surgeons or Gozan of the Nupe people; the Adahunse or Onisegun of the Yoruba and the Dibia of the Igbos.

Much of the traditional practitioner's claims and positions have been damaged as a result of its perceived association with witchcraft and sorcery and the general assessment as lacking scientific and empirical validity. Despite the low ratings of an unfavorable attitude to traditional medicine and its practitioners, traditional medicine has continued to occupy important position in the Nigerian Health Care Delivery System. The poor and under privileged members of the society see traditional medicine as the hope of the common man.

13.2 THE PHILOSOPHY OF TRADITIONAL MEDICINE

In its philosophy and practice, there are apparent distinctions between traditional medicine and witchcraft. Witchcraft is generally used for destruction, while traditional medicine stands for prevention and care.

Witchcraft is believed to be the cause of some deadly diseases commonly referred to as wizard-caused diseases. Most traditional medical practitioners are also equipped with the knowledge of preventing and curing wizard-

caused diseases. The practitioners need not be wizards themselves but they have the ability to cure such diseases effectively.

Traditional medicine follows definite natural laws of restoration, maintenance and correction of body disorder. The cause of disease is not attributed to germs but to the transgression of violation of natural laws and failure to keep the natural laws and expected behaviours sanctioned by the society. For example adultery and sexual abuse are seen as violation of natural laws and violation of expected behaviour in the society.

The philosophy of traditional medicine guides the orientation of the practitioners. Prevention and cure therefore must follow the law of nature using the numerous natural agencies available in the environment. It is the general believe that only nature heals and cures the practitioners merely acts as agents who interpret nature's laws for the patients and lends intelligent assistance, persuading their patients to confess their sins which the practitioners of traditional medicine believe are causative factors of most diseases and illnesses.

If a disease is a wizard-caused disease, the traditional medical practitioner begins the process of treatment and restoration first by attaching and getting rid of the underlying wizard-cast spells. The base of the disease is first attacked. The next stage is the application and administration of herbal therapies. The herbal therapies are meant to assist the natural forces in the human body.

In the process of treatment, the patient may be taken in as out- or in-patient depending on the severity of the disease and illness. An out-patient comes to the practitioner on a daily basis or as may be determined by the practitioner, while an in-patient resides with the practitioner for the entire duration of the treatment. The involvement of members of the family of the sick person during treatment is important for quick recovery and restoration. Most of the time family members as nursing aids, especially in cases of chronic illness or illnesses that require long period of treatment. An example is mental illness.

One distinct characteristics of traditional medical care, which undoubtedly fundamental to its philosophy, is the issue of payment for the services rendered. Traditional medicine and its practitioners in the form operate flexible pricing policy whereby payments for services were usually free, and when charges were involved they were often in kind and sometimes in cash. Both kind and cash payments could also be on installment basis. The position has changed since the monetization of the entire economy. Today, treatment costs are met mostly on cash and carry basis.

Other aspects of traditional medicine is that it was the onset open to both male and female and the knowledge handed down from generation to generation. This has remained the major source of knowledge of the practice.

13.3 FORMS OF TRADITIONAL MEDICINE

Forms of traditional medicine include the following:

- Divination
- Herbal therapy
- Massage
- Heat therapy
- Hydro therapy
- Faith-healing

13.3.1 Divination

Divination is not a healing method. It is an approach towards unveiling the causes of diseases or misfortunes. It is the first step in dealing with the spells of diseases and illnesses that are inflicted on people. It involves magical and mystical manipulations, and communication with the spiritual world.

Divination is central to traditional medicine. It affords the traditional medical practitioners to understand the underlying causes of diseases as well as the kind of treatment required for dealing with them. This stage is synonymous with the stage of investigation and laboratory tests in modern medical practice.

13.3.2 Herbal therapy

Application of herbal therapy is the section stage in the management of diseases and illnesses in traditional medical care practice. It is the system of restoring health through the administration of herbs.

It relies on the use of roots, leaves back of trees, flowers and juices. Occasional use of parts of animals in the preparation of therapies has also been reported. Application of herbal therapy is the first healing method known to man. The earliest man had no option but to rely on plants and vegetation in his immediate environment for sustenance and medicine.

The use of herbal therapy is gaining more recognition more than ever before not only in the poor countries where the cost of health care is outside the rich of a large segment of the population but also in the countries that have

advanced technologically in modern medicine. Herbal therapy is widely used in Nigeria, the health care system and people can benefit more if the mechanism for large-scale scientific production and application of herbs is put in place.

13.3.3 Massage

Massage is a method of healing whereby the soft tissues of the body are carefully manipulated to achieve the desired curative objectives. Massage is an ancient form of restoration of health.

In China, acupuncture is a system of restoration of health that is similar to massage. Acupuncture is the oldest form of medicine ever practiced by man in China. The method has gained worldwide acceptance. Massage has now been highly modernized in several parts of the world including Nigeria.

13.3.4 Heat therapy

Heat generated from fire is believed to have mysterious curative agents. It is believed that heat exercise powerful action when it penetrates the body, stimulates the organs of the body, improves the circulation of blood and hastens digestion. It also stimulates the skin through which the impurities in the body are removed.

Heat therapy is often used to calm nerves and induces muscular contractions, which often aid recovery and restoration of health. Heat therapy is sometimes combined with herbal therapy in health care management.

13.3.5 Hydro Therapy

Hydro therapy is the treatment of diseases through the use of water of various forms and temperature. It may take the form of cold bath, steam vapour bath, and hot bath. Each of the processes may contain herbal preparation depending on the nature of the disease. Heat therapy is handled in the treatment of rheumatism, asthma, catarrh, fever and general body pains.

13.3.6 Faith-Healing

Faith healing is based on faith and the patients are persuaded to first confess their sins after which they are cured through prayers, incantations and rigorous dancing exercise.

The practice varies from one group to another. In some group prayers are offered into water for the sick person to drink. In others prayers are offered

into ointments for the sick person to rub the body or in soap to wash the body at a specific time of the day or location. Patients are discouraged from taking other medication including herbal therapy. Some times faith healing is combine with fasting, which has now been seen as an acceptable means of overcoming social and health problems by many religious groups in Nigeria. Faith healing has been found to be effective in solving emotional and psychological problems and it is a fast growing method of curing diseases and ailments not only in Nigeria but in several parts of the world.

The statistics of those who patronize faith healers are not readily available. As at 1975, there were about 7,000 faith healers registered with government in Britain alone. The therapy is reported to have won the respect of the medical establishment in Britain, and many doctors are said to be training to develop their own faith healing powers. Many in Nigeria now combine faith healing with orthodox medical practice.

The advent of electronic evangelism, especially through the television, has aided the new generation of faith healing churches and spiritual homes in Nigeria. Many of which are giving people false hope and unguided zeal. Nevertheless, many people go to them because they believe in the efficacy the practice, and the practitioners continue to occupy noticeable position in the health care delivery system.

4.0 CONCLUSION

Traditional medicine and medical practice are major aspects of the health care systems of the pre-literate societies. Traditional medicine follows definite natural, spiritual, mental chemical and biological laws for the restoration of health. It is a distinct system of healing based upon its own philosophy of health and disease.

Although modern health care system has made in-roads into the health care systems of much of the developing countries, traditional medicine has largely remained the hope of the poor and under privilege members of these societies.

5.0 SUMMARY

This Unit focused on traditional beliefs and practices, its philosophy and forms. It discusses how the philosophy guides the orientation of the practitioners and the patients. The forms are aimed primarily at the recovery and restoration of health.

6.0 EXERCISE

- Identify and discuss the approaches to the understanding of traditional medicine?
- Explain the philosophy of traditional medicine and its practitioners?
- Enumerate the forms of traditional medical care in your community?

7.0 FURTHER READINGS AND OTHER RESOURCES

UNIT 8

DISEASE, ILLNESS AND SOCIETY:
MEDICAL BELIEFS AND PRACTICE OF MODERN MEDICINE

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Development of Modern Medicine in Europe
3.2	The Philosophy of Modern Medicine
3.3	Modern Medicine in Nigeria
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

1.0 INTRODUCTION

This is a follow-up to Unit 7, which focused on development of traditional medicine, its philosophy and forms. In this unit you will learn about the development of modern medicine in Europe, its philosophy and modern medicine in Nigeria.

2.0 OBJECTIVES

At the end of this unit, learners should be able to the following:

- Understand the development of modern medicine in Europe
- Explain the philosophy of modern medicine
- Discuss the development of modern medicine in Nigeria

3.1 DEVELOPMENT OF MODERN MEDICINE

The history of modern medicine dates back to the age of the classical Greeks. Prior to this period, there was a commonly held belief that illness was caused by evil spirits, which entered the human body. Remedies were largely magic-religious in nature, consisting of magic spells, incantations and charms.

In Ancient Greece, during the 5th and 6th centuries B.C. a school of medicine developed, where emphasis shifted from magico-religious explanation to a more or scientific view point. Hippocrates, the most famous physicians of his time lived during this time. His writings laid the foundation for modern medicine. Greek medical practice was organized in many ways much, like contemporary Western medical practice. There were private practitioners and public doctors. The private physicians catered mostly to the Greek Aristocratic social classes, usually on out patient basis but sometimes on an in-patient basis in physician's clinic. Public doctors were found in almost every large town and were retained by the town partly for prestige and partly for serving those whom were in need of medical care. Both private and public doctors tended to concentrate their services on the wealthy, the poor and the slaves seldom received high quality medical care. Where medical care was provided for the poor, the quality was generally low.

The four major achievements were recorded during the Classical Greeks period are:

- Medical practice was put on a scientific basis utilizing observations of patients as data.
- Several theories to account for the presence of diseases were developed
- A system of ethics governing the practice of medicine was established
- The period also produced codified medical knowledge, organisation of hospital and certain elementary public health practices.

The collapse of the Roman Empire also led to the erosion of other sciences and gave way to dogmatic religious scholasticism. There was conflict between philosophical and empirical approaches to knowledge. Much of the population was reduced to a subsistence level of economy and the practice of folk medicine flourished again. Medicine lost much of the scientific nature developed by the Greeks.

The impact of religious dogmatism hindered further scientific advances by prohibiting dissection of the human body, denying free inquiry,

experimentation and observation. Acceptable knowledge was confined to ancient texts approved by the church.

The existing public sanitation measures developed in Rome were neglected, and seeking secular medical aid was viewed as showing a lack of faith in God. Epidemics were strife, diseases and illnesses were considered punishment for sins. For many Christians disease was not merely a natural phenomenon, but something, which had to be interpreted in supernatural terms.

The influence of the church had an impact on the practice of medicine as well as its organisation. Medieval medicine was taught for the first time in the university setting beginning in Italy in the 10th century. Medicine thus became the only science, which the Church allowed the Clergy to practice, disallowed to practice surgery because they could not shed blood. The influence of the Church was tremendous, and at the fall of the Roman Empire all the hospitals under Government control were taken over by the Church.

Widespread epidemic contributed to the advancement of medicine. The Bubonic Plague or the Black Death, which reduced the population of Europe by one-third between 1340-1360, was one of such epidemic. Scientists began to examine certain past events in the life of the victims by paying attention to case histories. There was also the realization that Bubonic Plague was contagious, and for the first time quarantine was used as a preventive measure to break the chains of transmission of the disease.

The re-birth of classical learning otherwise known as Renaissance paved way for the development of medicine in the 17th century. The scholastic grip of the Church was broken, and dogmatism gave way to observations and experiments, faith to logic and reasoning. There was invention of tools and equipment. New data collected and analyzed by scientific methods were added to medical knowledge, and there were advances in dealing with chronic diseases.

The 17th century witnessed series of scientific discoveries in the field of medicine. The description of circulation of blood was done by William Harvey in 1628 and the microscope which lead to further advances in anatomy and physiology was invented in 1673 by Anton Leeuwenhoek.

The Royal College of Physicians was founded in 1660, an organisation designed to promote the development of the field of medicine. There was also the establishment of medical journals as a vehicle for exchanging information of new developments.

During the 18th and 19th centuries, there were significant advances in medical knowledge manifested in series of inventions and discoveries. The discovery of smallpox vaccine was by Edward Jenner in 1797, cholera bacillus by Robert Koch in 1883, x-ray by Wilhelm in 1895 and cause of malaria by Ronald Ross in 1895. It was not until 1900 that Walter Reed discovered cause of yellow fever.

The germ theory of disease was formulated and the search for specific disease Agents became acceptable, and a significant development in the organisation of medical practice emerges during the 19th century. It was an era of great progress in the area of preventive medicine and surgery. Causes of many infectious diseases were discovered, remedies prepared and prevention found.

3.2 THE PHILOSOPHY OF MODERN MEDICINE

Medical culture patterns are integral part of a complex network of beliefs and values of the culture of any society. In western societies, where modern scientific medicine began, disease and illness are most often seen as natural phenomena, and hence subject to investigations and study by scientific methods. Answers to questions about causes of diseases and illnesses are sought in the laboratory where extensive investigations are carried out.

In Western societies, treatment of illness and preventive measures follows logical beliefs about causation. For example, it is generally believed and accepted that drinking of impure water can cause cholera, mosquitoes cause malaria, immunization prevents communicable diseases and drinking and driving can cause accidents.

A common philosophy of modern medical practice is the high degree of specialization and the chain of referral system. That is the extreme division of labour and the sequence of actions and interaction that take place in the process of looking after the sick person. In modern medicine the various stages in medical care are clearly spelt out in the chain of referral system, and duties and responsibilities attached. This is discussed in details in Unit 9, where the social structure of a modern hospital is discussed.

3.3 MODERN MEDICINE IN NIGERIA

Modern scientific medicine dates back to about 500 years in Nigeria, with the advent of the Portuguese traders from Southern Europe. Previous contacts with North Africa also brought some knowledge of Arabic medicine.

The voyages of discovery and inspired by Prince Henry the Navigator opened up trade with the Portuguese. The articles of trade were slaves and pepper, and the outbreak of yellow fever and malaria brought some hardship on both the slaves and the Portuguese. The Portuguese doctors were called in to look after traders and to examine whether slaves were fit to travel across the Atlantic to Europe.

The first doctors that came to Nigeria were meant to care for the Portuguese traders and the slaves to ensure no loss of profit. It was in rare occasions that they took on humanitarian tasks of looking after the health of the native people suffering among them. By 1789, it became mandatory for all ships carrying slaves to have on board a licensed surgeon to examine the physical and mental fitness of the slaves.

The advent of the missionaries and the establishment of colonial government marked the beginning of modern scientific medicine in Nigeria. Thus Western scientific medicine came as an alternative to indigenous systems of health care. The indigenous systems of health care otherwise known as traditional medicine have been discussed in Unit 7.

As soon as the Missionaries establish their administration, they extended serious medical work as well. The Catholics took the lead, followed by the Church Missionary Society. Out of the 12 expatriates medically qualified, whom the Protestants first sent to West Africa, five were deployed to Nigeria.

In 1886, the Catholic Nuns sent a crew of sisters to Nigeria, and were stationed in Abeokuta. Thus extending health care to Nigerian community outside Lagos for the first time. By 1928, the activities of the Missionaries had spread to parts of Eastern Nigeria, and between 1893-1914, medical stations had been established in Jos, Kano, Maiduguri and Nguru.

The early Missionaries experienced a very severe mortality, largely due to malaria and yellow fever. The high mortality rate slowed down the advancement of the Missionaries in Nigeria.

Progress towards medical education was slow. The first medical training institution was the Yaba Medical Training College, which was established in 1930 but became fully operational in 1940. The institution was at its inception meant for the training of medical assistants. Subsequently, the

College of Medicine of the University College Ibadan {since 1962 University of Ibadan} and the University College Hospital were established.

The health care philosophies of the colonial era were the subject of serious attacks during the struggle for independence. They were regarded as elitist and as ignoring the problems of the poor and underprivileged. In keeping with the promises made to the general population during the struggle for independence, modern health facilities were expanded shortly after independence. Treatment at public health facilities was free for government workers and families, and highly subsidized for the rest of the population. Modern health services were gradually extended to the rural areas and other places where none previously existed.

The adoption by Nigeria of the 1978 Alma-Ata Declaration of Primary Health Care further accelerated the provision of health care facilities. Most rural areas were provided with at least one trained doctor, a small hospital in each local government headquarters, with at least one trained doctor, nurses and a community health officer. Nearly all the major towns have at least one general hospital supported by grant from the state governments, and all the university towns now have teaching hospitals or medical centre wholly funded by the federal government.

Despite the concerned efforts of post-independent national governments to extend health care to the vast majority of the population, equitable distribution of health services has been the bane of the Nigeria health care system. The transition from poor to good health has largely remained an illusion.

4.0 CONCLUSION

The writings of Hippocrates laid the foundation for modern medicine in Europe. Greek medical practice was organized in many ways similar to contemporary western medical practice. The collapse of the Roman Empire, led to the erosion of other sciences and medicine lost much of the nature developed by the Greek. The inevitable consequences were the spread of epidemic. The 17th and 18th centuries, however, witnessed a rapid development of modern medicine, and scientific discoveries were at its highest level.

The philosophy of modern medicine was a reflection of scientific thoughts that dominated Europe during the 17th and 18th centuries. Disease and illness were most often seen as natural phenomena and hence subject to investigation and study by scientific methods. Answers to questions about

causes of diseases and illnesses were sought in the laboratory where extensive investigations were carried out.

The advent of modern medicine in Nigeria was a byproduct of contact with the Portuguese traders and the Missionaries. The first Portuguese doctors that came to Nigeria did so to care for the slave traders and the slaves, while the Missionary doctors were the men and women were the first to bring health care to the poor and the under privilege members of the population. Subsequent efforts were made to extend health care to the vast majority of the population by post-independent national governments.

5.0 SUMMARY

In this Unit, we focused on the development of modern medicine in Europe, its philosophy and the development of modern medicine and medical education in Nigeria. The development of modern medicine in Europe was a product of exploration and scientific discovery. In Nigeria, the advent of modern medicine corresponds with slavery, missionary activities and colonialism.

6.0 EXERCISE

- Discuss the development of modern scientific medicine in Europe?
- Explain the role of the Portuguese traders and the Missionaries in the development of modern medicine in Nigeria?

7.0 FURTHER READINGS AND OTHER RESOURCES

Cole, Rodney M. *Sociology of Medicine*. New York McGraw-Hill Book Company, 1970.

Orubuloye, I. O. *Health Treatment in Nigeria*, Ado Ekiti, Centre for Population and Health Research, 1999.

Robinson, D. *Patients, Practitioners and Medical Care: Aspects of Medical Sociology*. London, William Heinemann medical Books Ltd. 1973.

Schram, R. *History of Medical Care Services in Nigeria*. Ibadan, Ibadan University Press, 1971.

UNIT 9

ILLNESS AND SOCIETY: STRUCTURE OF MODERN HOSPITAL

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Goals of Modern Hospital
3.2	Features of Modern Hospital
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

1.0 INTRODUCTION

This is a follow-up to Unit 4, which focused on development of modern medicine in Europe, its philosophy and the development of modern medicine in Nigeria. In this unit you will learn about the social structure of a modern hospital, its goals lines of authority and division of labour.

2.0 OBJECTIVES

At the end of this unit, learners should be to do the following:

- Understand the general goals of modern hospital
- Explain the features of a modern hospital

3.1 GOALS OF MODERN HOSPITAL

The hospital has a set of goals, like many large-scale organizations. The hospital has been described as the prototype of the multipurpose organization. It is a hostel, a school, laboratory and a stage for treatment. The multiple goals of the hospital are subsumed under medical care services, education, training and research.

Most hospitals are designed to provide medical care services to their patients only, while a few provide medical services and at the same time, provide a training ground for physicians, nurses and other paramedical personnel. Others may socialize in research and devote a considerable amount of their resources to it.

It is often difficult to ascribe a particular goal to any hospital organisation. The primary goal of a Teaching Hospitals for example its research. For it to achieve this goal, other such as providing health care is subsumed under the primary goal of training and research. Nevertheless, both the specialists and the laymen generally accept that the most important goal of any modern hospital is to provide health care to the people.

In the pursuance of its primary goals, the hospital acquires certain lower-level goals. One of which is that of economic stability, that is keeping cost down without compromising standards. The goal of keeping cost down is generally ascribed to the administrators as part of the general objective of providing medical care services. The medical staff on the hand sees their goal as providing high quality medical care at all cost. It is the responsibility of the administration to coordinate these goals. Quite often this related but independent goal is a major source of conflict between the administrators and the medical staff. This will be dealt with in the latter part of this lecture.

Because of the peculiar structure of a modern hospital, there is proliferation of sub-goals mostly to various occupational groups found among hospital personnel. A bureaucratic organization is put in place for the hospital for the attainment of its group objectives.

The organizational chart of a typical modern hospital reveals clearly its hierarchical arrangements, but differs from that of organization such as factories or any government establishment. The hospital by the nature of its primary goal has a more pronounced horizontal structure than a vertical one. For example, the line of authority of the hospital director or the hospital administrator or the hospital manager as the case may be extend only to the heads of departments, particularly those who are not professional or whose activities are less directly related to patient care. This is marked contrast to other types of formal organizations in which the lines of authorities reach from the administrator or manager through heads of department down to the level of workers.

In the administrative hierarchy, the Board of Trustees of Board of Governors as it is the case in Nigeria, is at the top of the policy-making body of the hospital made up of representatives of the government, the community and

other interest groups. The translation of policy decisions of the board into action is the job of the hospital administrator who is also a member of the board. By delegation of authority from the board, the hospital administrator is responsible for the day-to-day operation of the hospital. He forms a major link between the community and the hospital on one hand and between the hospital and the proprietor on the other. His duty goes beyond normal administration but sometimes extended to resolution of crises within the hospital organization. In short, he is the chief public relation officer of the hospital.

3.2 FEATURES OF MODERN HOSPITAL

One of the features of a modern hospital is the presence of authority consisting the collegial organization of the medical staff and the bureaucratic arrangement of offices which make up the administrative arm of the hospital. This peculiar organizational arrangement presents the hospital with a different kind of line-staff relations and problems.

In the traditional single authority found in businesses of hotels, decision-making powers rest in the office of the Chief Executive Officer of the Managing Director who directs the activities of line personnel or workers. In the hospital setting, the situation is different, medical officer usually directs the line in its activities while the management's authority is often restricted to matters relating to implementation of policies and provision of the means for achieving the goals of the hospital.

The second feature of a modern hospital is extreme division of labour among the medical staff as well as among the administrative staff. This is a reflection of the specialized training which the staff acquired, the increased number of specialized services which the hospital now offered, technological advancement and increased size of the hospital.

In the hospital, the division of labour in the collegial organization may range from that of the Medical to that of the Nurse Aid, where in the administrative line it is from the Administrative Manager to the Store man. They are all specialists in their own right.

The third feature of a modern hospital is its authoritarian nature. In the hospital setting responsibilities are clearly marked out and rules provided to cover many different situations well spelt out. By the nature of the hospital, the type of activities carry out require quick action without having to depend upon formal rule which are often slow and not amenable for emergency in nature, the hospital is always prepared for such cases. In the large hospitals an emergency department is always prepared for such cases. In the large

hospitals an emergency department is always available to deal with emergency cases.

By the nature of the training and the activities of the physicians, they possess charismatic authority and tend to be dictatorial. The physician is in charge and has privilege of access and information. He dictates the direction and pace at which treatment will take. He is the Commander-in-Chief, and most of the time his words are the final.

The characteristics and the features of the hospital often lead to conflict between individuals and groups within and outside hospital setting. Sometimes the extreme division of labour tends to reduce the flow of information between the administrative, medical and technical staff. This in turn may affect staff morale, the quality of patient care and the hospital relationships with the community. The division within the hospital organization may lead to conflict of goals particularly between the efforts of the medical staff to promise patient care on the individual basis and that of the administration to seek ways to promote patient care in most cost effective way.

4.0 CONCLUSION

Like any large-scale organizations the modern hospital has a set of goals. It is a prototype of a multipurpose organization. In an attempt to achieve these goals a hierarchical administrative structure peculiar to the hospital is put in place. Because of its nature, the hospital presents two lines of authority, extreme division of labour and authoritarianism necessary for the attainment of its goals.

8.0 SUMMARY

In this Unit, we discussed the structure and features of a modern hospital. From our discussion, students should be able to understand and explain the hierarchical nature of a modern hospital and the difference between it and other large-scale organization. Students should be able to describe features of the hospital social structure and developed some understanding of the hospital as a functioning social institution.

9.0 EXERCISE

- Explain the structure of a modern hospital

- Identify and Discuss the main features of a modern hospital
- Construct the organization chart of a General hospital in your or nearest to your community.

10.0 FURTHER READINGS AND OTHER RESOURCES

Cole, Rodney M. *Sociology of Medicine*. New York, McGraw-Hill Book Company, 1970.

UNIT 10

DISEASE, ILLNESS AND SOCIETY:
RESPONSE TO DISEASE AND ILLNESS

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Perceptions of Disease and Illness
3.2	The Sick-Role
3.3	Variations in Response to Disease and Illness
3.4	Stages of Illness Behaviour
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

11.0 INTRODUCTION

This unit is a follow-up to Unit 9, which focused on the social structure and features of a modern hospital. This unit discusses perception of disease and illness, the sick role, variations in response to disease and illnesses and stages of illness behaviour.

12.0 OBJECTIVES

- At the end of this unit, learners should be able to do the following:
- Understand the perceptions of diseases and illness
- Explain the sick-role
- Determine variations in response to disease and illness
- Identify and explain the stages of illness behaviour.

3.1 PERCEPTIONS OF DISEASE AND ILLNESS

The definition of concepts of disease and illness has been done in Unit 1. This Unit will therefore deal with how the person who has a disease, who is ill and the person who provide care respond to disease and illness.

When an individual is afflicted with a disease and eventually becomes ill, he or she feels that something is wrong with him or her. His or her condition tends to affect everything he or she does and the way he or she perceive himself or herself. The illness also affects members of the family, the community and the society when they are aware of this condition.

In Africa, when a person has a disease and becomes ill, there are several options open to him or her to seek medical help. The options depend on the nature, severity and the perception of the illness by the affected individual, the family, the community and the society in general. Several of the options are often adopted either concurrently or sequentially in the course of illness episode. A wide range of social, cultural, economic and behavioural factors also influences the choice of a particular treatment system.

In traditional societies, response to care is usually twofold. When a member of the household is ill, health care is usually first sought within the household from older members of the family who are perceived to have through experience the knowledge of the correct treatment for such illness. At this stage, treatment is usually herbal therapies. If this fails, help is then sought from traditional specialist whose diagnosis is by divination and treatment offered on the basis of the diviner's perception of the illness.

In modern times, and with advent of modern scientific medicine, when a person is sick he or she is far more likely to consult a western trained health care provider. In the process of consultation, diagnosis of a disease is made by correlating the observable signs or symptoms of a disease with knowledge about the functioning of the human organs.

There are differences between the person who is ill and seeking care and the person offering care in the perception of disease and illness and their approaches to health care.

The person, who is ill, often referred to as the layman and the person giving care, the specialists, have widely divergent understandings about the events of illness. The layman may assume certain level of scientific knowledge of the nature of the disease causing his or her illness, that knowledge may be scientifically inadequate from the point of management and cure of the disease.

The person who has a disease and who is ill understands his or her situation differently from the perspective of the specialist. He or she is emotionally involved in a way other people around him or her can never be. While the specialist exercises objectively in his assessment of the condition of the patient, the latter is subjective. This is understandable because he or she is the one who feels the pain and whose life is being threatened by disease and illness.

The specialist perceives a case of disease in terms of knowledge he already acquired to deal with it. Quite the specialists learn from their patients and further broadened their knowledge of a particular disease.

The specialist's basis for deciding what action to take in respect of a disease is often different from that of the patient. The specialist is more knowledgeable about the disease progression and the conditions of the patients than the patient. He has professional standards against which to evaluate his ability and effectiveness in diagnosis and treatment.

3.2 THE SICK-ROLE

When a person is ill, there are certain roles or obligations which the social system which he or she belongs imposed on him or her. These roles and obligations are discussed in this section.

According to Talcott Parsons, there are four main aspects of the sick role.

- The sick person is exempted from certain normal social responsibilities.
- He or she cannot be expected to take care of himself or herself or get rid of his or her illness by will power.
- A sick person should want to get well.
- A sick person should seek medical advice and co-operate with medical experts.

3.2.1 Exemption from Normal Social Responsibilities:

It is generally assumed that the sick person is not at fault for his or her condition therefore one of the rights accorded him or her is to be excused

from normal duties. The patient is not expected to carry on as normal but to adapt his usual way of life by shedding some or all his normal duties. Such duties may be occupational, domestic or recreational.

Alternative arrangements are made for carrying out necessary tasks in the event of an illness of a group member. This new role arrangement is important for continuity. For example, if the person who carries out the household chores is ill somebody must be around to perform that function during the period. Similarly, if the doctor who looks after some patients or the driver of the school bus took ill, someone must be available to carry out such duties for the continuity of the system.

However, exemption from normal duties is not solely a right to be had on demand, especially in occupational duties. A bus driver who is not able to perform his normal duties on account of illness may be required to produce a sick note from a doctor to legitimize the right to stay away from duty.

3.2.2 Getting Rid of Illness by Willpower:

A patient cannot be blamed of his or her condition or get rid of the illness by willpower. He or she must be taken care of, and the condition must be changed. One of the ways to change the condition is to provide the opportunity to receive medical care from the specialist. This is a social responsibility of the group to the sick.

3.2.3 The Desire to Get Well:

Being well means illness is undesirable, and, therefore, a sick person would want to get well as quickly as possible. It is the social responsibility of the sick person to seek help from an expert and cooperate in the process of getting well.

Although it is always the desire of the sick person to get well as quickly as possible, and to resume normal responsibility, certain types of disease are not amenable to this condition. In the case of long-term, chronic or permanent illness conditions, the desire of the people in such conditions to get well as quickly as possible are often far fetched.

3.2.4 Seeking Help:

It is a social responsibility on the part of the sick person and the group he or she belongs to seek help from the expert. It is also obligatory for the sick

person and the group to cooperate with the expert as far as possible to facilitate the consultation, treatment, recovery and recuperation processes.

3.3 VARIATIONS IN RESPONSE TO DISEASE AND ILLNESS

Illness behaviour is the way an illness is perceived, evaluated and acted upon by those who have the feelings of pain and discomfort. By implication there are variations in the way individuals and groups respond to disease and illness.

According to Mechanic and Volkart, two persons having much the same symptoms, clinically considered, may behave quite differently; one may become concerned and immediately seek medical aid while the other may ignore the symptoms and not consider seeking treatment at all.

Factors that may influence illness behaviour include effects of group structure, general cultural prescriptions, the concern for financial cost of care and fear of the possible outcome of the disease.

A sick person's peers, family, community and associates may exert pressure on him or her to seek immediate treatment. Quite often these groups may individually or collectively arrange and even meet part or whole cost treatment for the sick person. Cultural beliefs about causes of diseases and illness may motivate the sick person to seek treatment or not.

In Nigeria, studies of illness and health seeking behaviour have clearly indicated that health attitudes, treatment systems, the degree of access to health facilities and the cultural, social and cultural factors are the determination of individual and community response to illness and treatment behaviour.

The degree of fear or anxiety of the possible outcome of an illness may determine treatment behaviour. If a sick person perceived the outcome of a disease may lead to a major disability or prolonged suffering he or she may seek immediate treatment. On the contrary he or she may do nothing if the perception is that the illness will eventually lead to death. The latter attitude is often manifest in respect of chronic diseases and may well be extended to HIV/AIDS because of the general lack of known cure.

3.4 STAGES OF ILLNESS BEHAVIOUR

Each episode of illness involves a series of stages or phases. Suchman identified five stages of illness behaviour. They are symptom experience

stage, assumption or the sick role stage, medical care contact stage, dependent-patient role stage and recovery and rehabilitation stage. The various stages are discussed below in details.

3.4.1 Symptom Experience Stage:

This stage begins when an individual feels that something is wrong with him or her. This perception may include awareness of physical and emotional change, such as pain and restlessness. At this stage, the affected person may decide to keep the problem to himself or herself. During this stage, the person may attempt self-treatment by a variety of means to achieve relief from the symptoms. The person then awaits further development of the symptoms before taking the next step. If the symptoms persist, he or she then assumes the sick role.

3.4.2 Assumption of the Sick Role:

At this stage, the affected person may have the courage to discuss his or her symptoms with people regarded as trustworthy such as friends, spouse and family members. Help from experts may be sought at this stage or self-medication may continue. Such self-medication may include the use of herbal preparations, purchase of drugs from hawkers of medicine and patient medicine stores. Studies have shown that a large number of people, particularly in rural areas of Africa rely heavily on these sources of health care.

A period of self-medication often leads to a significant delay in seeking expert advice. During this stage, the illness may deteriorate and may result to death. However, those who survive this stage proceed to the third stage of medical contact stage.

3.4.3 Medical Contact Stage:

At this stage the sick person makes his or her first contact with someone who has professional training in medicine. The sick person may decide to seek help from a low order medical person such as the chemists or the pharmacists or a nurse in the neighbourhood.

At this stage prescriptions are made based on symptoms given by the sick person without diagnosis or laboratory tests. Quite often the sick person may have temporary relief from the symptoms. If the symptoms persist, he or she moves to a higher order of health care where the experts would make a scientific assessment of the case. The sick person hereby assumes the sick role and move to the next stage of dependent-patient role.

3.4.4 Dependent-patient Role:

At this stage the person becomes a patient. The patient then assumes the role of a sick person and people around him recognize his or her social role as a patient. The patient is expected to subject himself or herself to the doctor and obey all the instructions to facilitate the road to recovery and rehabilitation.

3.4.5 Recovery and Rehabilitation:

This is the final stage of illness experience. In certain cases recovery process may be rapid or prolonged depending on the severity of the illness, the competence and cooperation of the sick person. Nevertheless, the process of recovery and rehabilitation is without problems. The patient might be denied certain rights and privileges, which the expert considers to be vital for the recovery process. For example, a diabetic patient may have to forgo his or her traditional pattern of eating for a completely new eating regime which the experts consider necessary for the recovery process. In addition, medication has to be undertaken at times not convenient for the patient. Once the recovery and rehabilitation process is completed successfully, the patient joins the ranks of the well and can now assume his or roles and responsibilities in the family, the community and the larger society.

In certain cases of chronic illness, recovery may not take place, and death may become the ultimate. The family, the community and the society share the grief of their loved ones, and a new process of group adjustment begins.

4.0 CONCLUSION

Differences in illness behaviour are important for the understanding of how the individual, the community and the society respond to disease and illness. The part played by the sick person in the various stages of illness experience is important for the recovery and rehabilitation process and the assumption of his or roles in the family, the community and the larger society.

5.0 SUMMARY

This Unit has focused on why sick people react to disease and the onset of illness and discussed variations in their responses. It discusses the social role of the sick, variations in response to illness and stages of illness behaviour.

6.0 TUTOR-MARKED ASSIGNMENTS

- ❖ Identify and discuss the social roles of the sick person in the social system.
- ❖ Discuss individual and community variations in response to disease and illness.
- ❖ Enumerate and discuss stages of illness experience. Illustrate with examples in your locality.

7.0 FURTHER READINGS AND OTHER RESOURCES

Cole, Rodney M. *Sociology of Medicine*. New York, McGraw-Hill Book , . Company, 1970

Orubuloye, I. O. *Health Treatment in Nigeria*. Ado-Ekiti, Centre for Population and Health Research, 1999.

Robinson, D. *Patients, Practitioners and Medical Care Aspects of Medical Sociology*. London, William Heinemann Medical Books Ltd. 1973.

UNIT 11

DISEASE, ILLNESS AND SOCIETY:
PATIENTS-DOCTOR RELATIONSHIP

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Relationship of the Expert and the Layman
3.2	Guidance-Cooperation
3.3	Mutual Participation
3.4	Privileged Access
3.5	Handling of Recognized Uncertainty
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

1.0 INTRODUCTION

This Unit is a follow-up to Unit 10, which focused response to disease and illness, the sick role, variations in response to illness and stages of illness behaviour. This unit discusses the main features of the patient-doctor relationship and how it affects the recovery and rehabilitation processes.

2.0 OBJECTIVES

At the end of this unit, learners should be able to do the following:

- Understand the main features of the patient-Doctor relationship
- Explain the context in which the relationship takes place
- Assess the impact on response health-seeking behaviour, recovery and rehabilitation.

14.4 Relationship of the Expert and the Layman

The relationship between the sick person often referred to as the patient and the care-giver known as the doctor or the physician can only be understood in

the context within which the relationship is set. The patient and the doctor occupy certain social positions and there are roles and responsibilities attached to the positions. Patients and doctors may and often hold different conceptions of illness. This has been discussed in Unit 6 above.

One of the fundamental roles of the patient is to get well, as soon as possible, while the primary responsibility of the doctor to his patient is to facilitate the recovery and rehabilitation of the patient to the best of his ability. In meeting this obligation, the doctor assumes the role of an expert. This is so because of the specialized training acquired to deal with the morbid condition of the sick. The sick therefore assumes the social position of the layman in the relationship. By implication, the layman is dependent upon the expert's specialized knowledge acquired during training in dealing with his illness.

In the course of treatment, the patient (the layman) is wholly submissive to the activity of the doctor (the expert). This social position is more apparent in the case of complicated treatment that requires surgery, during the process the patient is immobilized and passive in the relationship. Certain forms of restraint are employed to enforce total submission of the layman to wills of the expert.

The patient has his own feelings and aspirations but because of his illness, the need for help and desire to get well, sometimes at all costs, he is ready and willing to cooperate with the expert, who is in advantage position of power. The interaction between the layman and the expert is expected to follow what has been described a model guidance cooperation. Most of the time the doctor initiates more of the interaction than the patient, and the later is mandated to do what he is instructed to do by the expert.

14.5 Mutual Participation

The second feature of patient-doctor relationship is that of mutual participation. By mutual participation, the patient is able or required to take care of himself. This type of relationship is more appropriate in the case of chronic illness or during the process of recovery and rehabilitation. This type of interaction is also manifest when the doctor does not know exactly what is wrong with his patients.

In certain cases of chronic illness such as diabetics and HIV/AIDS the period of treatment is often long and painful, patients are required to do more of the care than the doctor. Treatments and care for diabetics and AIDS patients are mostly done outside the hospital environment and the family and the individual assumes greater responsibility of care than the doctor. Chronic illness demands that medicines have to be taken at specific periods of times,

which can better be managed by the patient or his family members. Hence the concept of home-based care has been widely accepted in HIV/AIDS management and care.

👤👨🏻‍🔬👤 Privileged Access

The third feature of patient-doctor relationship is that of privileged access. Because of the desire of the doctor to assist his patients for quick recovery, the doctor has unlimited access to the patients. The patient's body is exposed, touched, sometimes mutilated and its biochemical functioning altered.

It is not a usual occurrence to see a person nakedness or to touch and manipulate the body. This is privilege which the doctor or the care-giver must justify. In health care practice, the doctor is granted this privilege because of the roles and responsibility bestowed on him by virtue of his training and occupation. The doctor has access to the body of his patient in order to perform his function as someone doing everything possible for the well being of the patient, whether in terms of prevention, diagnosis or treatment. Outside the patient-doctor relationship, most of the doctor's actions may be regarded as criminal, immoral and scandalous, and may be subject of litigation.

The privilege of access may cause conflict, tension and even upset the patient because of his preconception of the body as a sacred entity that must not be touched anyhow by anybody. Quite often patients adjust to the inevitable circumstance because the need for help and the desire to get well quickly.

The privilege of access may go beyond touching, manipulation and mutilation to obtaining vital information about the life of the patient, if such information will aid the process of healing. For example, a doctor may want to know the family history of a diabetic patient or asthmatic patient to determine whether the diseases are hereditary or as a result of the way of life of the patients. This information is vital for dealing with them.

There are examples of doctors who have abused the privilege of access to their patients. Where this happened and the cases reported to the appropriate authority they have dealt with within the context of rules and regulation of the medical profession or within the confine of the law.

People are conscious of the conflict, tension and upset that the privilege of access may pose to the patients to an extent which certain defensive mechanisms are put in place to minimize abuse. In some societies, male

doctors are not allowed to treat female patients at all in orders, a male doctor can only treat a female patient only in the presence of another female person.

3.4 Handling of Recognized Uncertainty

It is not always that a doctor will be able to prevent, diagnose and treat all diseases. When a doctor investigates an illness to find out the cause but has positive findings, the onus is on him to choose between further assessment and evaluation or call off the diagnostic process or seek a second opinion from colleagues. This may be a very difficult choice to make, but it is one of the ethics of the medical profession.

The risks associated with further assessment and evaluation may be high in terms of time and resources. The social, emotional and economic risks to the patient's health by continuing the diagnostic procedures may be enormous and economically undesirable for the society. On the part of the doctor, failure to continue may result in a failure to detect a potentially serious condition, which requires early evaluation, prevention or treatment. It may pose a serious danger to the society, if the illness is contagious or can lead to serious epidemic.

4.0 CONCLUSION

The person who is sick and care-giver, whether in traditional and orthodox health care delivery system, perceive illness differently, and the perception has serious implications for their relationships. The patient sees the doctor as a person he can entrust himself to the doctor for his care, undergo the procedures the doctor felt were necessary for treatment, recovery and rehabilitation. In attempt to achieve the desired goals the patient therefore surrenders himself totally to the doctor's orders. He makes himself available for all kinds of experiment, takes the medication that has been prescribed for him to follow the doctor's orders and takes the role of a passive observer in the relationship.

5.0 SUMMARY

This Unit focused on the relationships between the patient and the doctor. Emphasis was on the understanding a relationship of that of a layman and an expert, where although there is no equal chance of participation but there is room for mutual cooperation. The Unit also discussed the issue of privilege of access and recognized uncertainty, the two factors that are generally considered to be the main features of patient-doctor relationship.

6.0 EXERCISE

- ✓ Discuss patient-doctor relationships
- ✓ In your understanding, how does patient-doctor relationship affects the treatment, recovery and rehabilitation of a sick person?

7.0 FURTHER READING AND OTHER RESOURCES

Cole, Rodney M. *Sociology of Medicine*. New York, McGraw-Hill Book Company, 1970

Robinson, D. *Patients, Practitioners and Medical Care: Aspects of Medical Sociology*, London, William Heinemann Medical Books Ltd. 1973.

UNIT 12

**DISEASE, ILLNESS AND SOCIETY:
COST AND FINANCIAL HEALTH CARE IN NIGERIA**

TABLE OF CONTENTS	
1.0	Introduction
2.0	Objectives
3.0	Main Content
3.1	Health Policy and Responsibilities
3.2	Quality Versus Adequacy
3.3	Approaches to Health Care Financing
4.0	Conclusion
5.0	Summary
6.0	Exercise
7.0	Further Readings and Other Resources

1.0 INTRODUCTION

The Unit focuses on cost and financing of health care in Nigeria. It discusses health care policy and levels of health responsibilities, quality versus adequacy, factors responsible for increase cost and the approaches to health care financing in Nigeria.

2.0 OBJECTIVES

At the end of this Unit, students should be able to do the following:

- Understand health policy and administration in Nigeria
- Determine the quality and adequacy of health care services
- Understand the factors responsible for increase costs
- Explain the approaches to health care financing.

3.1 Health Policy and Responsibilities

Health care financing in sub-Saharan Africa, and in deed in Nigeria, has attracted more attention in recent years than before. There have been controversies on how the nation's health care should be founded. The controversies is partly because of the dwindling economic resources and the uncoordinated health policies and programmes arising from political instability of the last two decades.

Before the advent of modern medicine, the approach to health care was usually twofold. For most ailments, health care was usually sought within

the household from older members of the family. At this stage, treatment was usually herbal therapies. If this failed, help was then sought from traditional specialists in the neighbourhood. Individual health was seen as part of the family health. The costs were small and usually borne by the family members mostly in kind. The head of the family was the health administrator and the first point of contact in the chain of the prevailing referral system. This was the health care policy for the high and low, the poor and the rich members of the family.

The advent of the Christian Missionaries and colonial government marked the beginning of modern scientific medicine into Nigeria and distinct health administration policy from what existed before. At the inception, the government, the Christian medical missions, and a small proportion of independent medical practice provided most modern health care. Most government hospitals during this period provided special facilities generally free of charge for civil servants and their families, while the Christian medical missions operated a flexible pricing policy of hospital and community care services for the members of their faith, and sometimes for those suffering around them.

During this period, both medical care and curative services were unevenly distributed, with heavy concentration in the capital cities and large urban centres and a few less efficient health care services in selected rural areas. Those who had no access to these facilities continued to patronize less efficient health care facilities.

The health policy and philosophies of the colonial era was the subject of serious attacks during the struggle for independence. They were regarded as elitist and ignoring the health problems of the poor and the underprivileged. In reaction to the criticism, National Health Development Plans since 1946 had centred around the provision of adequate treated water, improvement in environmental hygiene, expansion of hospitals, maternity, child welfare, dispensary services and campaigns of preventive medicine.

Modern health services were expanded shortly after independence and in keeping with the promises made to the general population during the struggle for independence. Three levels of health responsibilities were put in place in line with the political structure of the nation. The Federal Government was and still responsible for tertiary health services, the states for secondary health services, and the local government for primary health services.

Although provision of health facilities has never been uniform across the nation, treatment at public health facilities has generally been free for government workers and their families, and highly subsidized for the rest of

the population. Modern health services have also been gradually extended to the rural areas and other places where none previously existed.

The adoption by Nigeria of the 1978 Alma-Mata Declaration on Primary Health Care further accelerated the provision of health care facilities. In the spirit of the Alma-Mata Declaration, Nigeria declared Primary Health Care as the cornerstone of the health care system. This resulted into the formal launching of the Primary Health Care Programme in 1987 and the subsequent inauguration of the National Health Policy of 1988. The strategies for the implementation of the Policy are as follows:

- The promotion of community participation in planning, management, monitoring and evaluation of the local government health system.
- The involvement of health-related sectors in the planning and management of Primary Health Care.
- Strengthening of functional integration at all levels of the health system.
- Strengthening of the management process for health development at these levels.

The National Health Policy in 1988 also identified the Local Government Area, as the seat for Primary Health Care (PHC) implementation.

The oil boom of the late 1970s and the early 1980s facilitated the development of the Primary Health Care Programme. During this period, health facilities were expanded, new ones were provided, and physicians per capital increased more than fourfold and nurse per capita nearly sevenfold, as new hospitals and medical facilities were built.

By 1984, the situation has changed because of the collapse of the economy and large-scale corruption in the economy. Consequently, structural adjustment programme was introduced in 1986 and the Nigerian currency the Naira devalued in 1987 as measures to address the problems of the economy.

Government allocation of resources to the health sector declined and the burden of health care transferred to the individual households. There were shortages of drugs in government health facilities, and health care providers often issue prescriptions and advise health seekers to buy their drugs in private pharmacies and medicine stores. Government health facilities were reduced to mere consulting clinics. Where drugs were available in government health facilities, clients paid the market price. This was the situation before May 1999 when a new democratic government was put in place. The problems of the health sector are being addressed. There are

improvements in the health sector but the HIV/AIDS problem is gradually compounding the already bad situation.

3.2 Quality versus Adequacy

Advances in medical science and changes in the organization of medical practice have enabled most of the developed countries to provide the highest quality of health care to their people. Although medical science and practice have generally improved in Nigeria, access to high quality health care has remained largely an illusion to the vast majority of the population.

The poor funding of health services has led to deterioration of the quality of health services in Nigeria. The statistics of funding of health care across the nation is hard to come by. Federal actual recurrent and capital expenditure from 1983 – 1993, a period eleven years shows not only the inadequacy but also the inconsistency in funding of health care by the federal government, the major share holder in the health sector.

Federal Government Actual Recurrent and Capital Health Expenditure, 1983-1993

Year	Health Recurrent Expenditure (₦)	As % of Total Expenditure	Health Capital Expenditure (₦)	As % Total Expenditure
1983	153,197,387	1.7	116,639,850	2.0
1984	168,107,249	2.1	42,808,121	1.0
1985	177,181,081	2.5	45,359,637	0.34
1986	245,769,150	1.6	131,456,527	1.4
1987	229,136,431	2.5	125,557,292	0.8
1988	379,587,918	1.4	117,251,805	1.2
1989	381,783,926	1.5	119,958,232	4.5
1990	485,143,029	1.0	419,745,813	3.1
1991	675,606,844	5.8	412,325,578	0.65
1992	854,071,450	2.8	192,068,820	1.2
1993	2,331,605,150	2.5	351,270,000	1.7

The inadequate funding of the health sector according to O.A. Odukunle led to the following problems:

- Dilapidated structures
- Poor supply of drug and vaccines
- Inadequate manpower programme
- Lack of medicinal equipment and materials
- Poor access to health of rural dwellers, low wage earners and the poor
- Ineffective management system
- Poor health management information system.

In addition, there was the problem of brain drain in the medical and allied professions to mostly developed countries in Europe and America and to the Gulf Oil rich countries. This has led to acute shortage health personnel in all the various aspect of the health sector.

Government's poor funding of the health sector, which manifested in poor quality services drove away patient from government health facilities, and led to the proliferation of private health services of varying degree of quality. All kinds of hospitals and clinics were set up and run by both medically qualified and unqualified personnel. Fake and adulterated drugs were and still common place. Faith and spiritual healers emerged in several thousands, most of whom offered fake promises and unguided skills

The statistics of health indicators shown below indicate that all is not well with the health sector.

Year	1990	1991	1992	1993	1994	1995
Population per physician	4300	4023	3967	3117	3701	3707
Population per nursing staff	666	640	626	618	615	608
Population per hospital bed	1140	1000	1130	1277	1304	1477
Life Expectancy at birth (years)	54.0	51.0	52.0	52.0	52.0	47.6
Child Immunization (overall)	80.0	81.1	83.5	46.0	25.0	17.0
Daily calories per capita	200	2200	2200	--	--	2000
Crude Birth Rate	48.0	49.0	49.0	49.0	49.0	49.0
Crude Death Rate (per '000)	16.0	16.0	14.0	14.0	1 4.0	14.0

Source: UNDP, Human Development Report, 1996

The National Health Plan of 1996 – 2000 identified major weaknesses in the past and recent health policies. The weaknesses are not new, most of them were recognized by the 1946 Health Plan and the subsequent Second and Third National Development Plans of 1970-74 and 1975-80 respectively.

3.3 Approaches to Health Care Financing

Expenditure for health and medical has increased significantly in recent years. Two factors are responsible for the increase in the cost, the increase in

the demand for health care services and the increase in the cost of services and labour. The increase in demand for health care services is a direct result in the increase in population. In Nigeria, fertility is high, the crude birth rate is to close to 50 per 1,000 population, completed family size is about 6 children per woman and the crude death rate is about 14 per 1,000 population. The net effect of this demographic scenario is rapid increase in population and increase demand for health care services.

Since devaluation of the Nigeria currency in 1987, there has been increase in health care services arising from increase in the price of equipment and cost of labour. Government policy of cost recovery meant that additional source of financing health care will be needed to boost health facilities for the teeming population.

In Nigeria, the traditional sources of health care funding are government, private sector, the community, Christian medical missions, external funding, and in recent years user charges. The arguments often used in favour of charging fees for modern health services are that raising user fees has been a longstanding practice in private non-profit organizations such as the Christian mission hospitals; and that people of sub-Saharan Africa are accustomed to paying traditional healers for their services either in cash or kind. Community participation has been an essential aspect of a good health system in Nigeria. Before the oil boom, the maternity centres and the dispensaries were built and managed by the local communities. Similarly, the Christian missions owned and managed their hospitals and clinics. These facilities were at one point taken over by the government thus compounding the funding and management of the health care system.

In 1997, a decree setting up a National Insurance Scheme, as an alternative way of funding the health care system, was promulgated on October 15 1977. the programme has remained on the drawing board until March 2002 when the wife of the President finally launched it.

Certainly, there are obstacles to the effective operation of a centralized system of health insurances scheme especially in a country like Nigeria high level of poverty and small number of wages earners. The people are apathetic to government programmes because of poor leadership and corruption.

Health is a right, and the government has a moral obligation to provide a functional health care system for the people. Community participation and involvement in health care financing is a panacea for the restoration of the Nigerian ailing health care system.

4.0 CONCLUSION

5.0 SUMMARY

6.0 EXERCISE

7.0 FURTHER READINGS AND OTHER RESOURCES

TUTOR MARKED ASSIGNMENTS

Q1. Define the basic concepts of disease, illness and health and identify the similarities and differences

- Q2. What do you understand as health indicators? Discuss the major health indicators in your community.
- Q3. Discuss the nature of illness, place, decision on and cost of treatment in your community.
- Q4. Identify the major types of health care providers in your community and state the factors responsible for choice of health care provider people make.
- Q5. Enumerate the encounters of health-seekers with health care providers, the duration of encounters, supply and cost of medicine.
- Q6. Discuss the major determinants of disease, illness and health.
- Q7. What do you understand as the philosophy and practice of traditional medicine? Enumerate and discuss the major types of traditional medicine practiced in your community.
- Q8. Discuss the development and philosophy of modern medicine.
- Q9. The structure of a modern hospital is like a modern factory, Discuss.
- Q10. Discuss the ways individual respond to disease and illness.
- Q11. Identify and discuss the major aspects of patient-doctor relationship.
- Q12. Discuss the major sources of health care financing in Nigeria.