

OUTLOOK

CULTURAL FACTORS BLOCKING THE UTILIZATION OF ORTHODOX MEDICINE: A CASE STUDY OF WARRI AREA IN DELTA STATE OF NIGERIA

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Abstract: This study is aimed at determining the cultural factors (beliefs, traditional religious practices, and customs) blocking the utilization of orthodox medicine among peoples of Nigeria represented in this research by natives of Warri area of Delta State in the Niger-Delta region of Nigeria. With the use of multi-stage cluster sampling technique 190 natives sampled, participated in this study. A structured interview schedule containing a 13-item question translated in pidgin English (the lingua franca in the region) was used by ten research assistants who hail from the selected communities to elicit information from both literate and illiterate natives. The chi-square statistic result ($\chi^2 (8) = 26.83, P < .05$) shows that some ethnic beliefs, customs and traditions are very significant cultural factors blocking the use of orthodox medicine. It was recommended that governments at all levels should put in place information, education and communication (IEC) activities in order to encourage appropriate choice of medical care amongst Nigerians.

Keywords: Culture, education, orthodox medicine

INTRODUCTION

The study is aimed at determining the cultural factors (beliefs, religious practices, habits, customs and traditions) blocking the utilization of orthodox medicine among the people of the Warri district in the Niger-Delta region of Nigeria. According to Ademuwagun (1998) there is a Yoruba adage “*Ara Lile L’ Ogun Oro*”, (which means good health is the right prescription for wealth). The sociological concept of health related behaviour is defined as what people do individually and collectively in order to maintain or remain in good health; what specific steps are taken, some time called pattern of resort and why? (Owumi 1994; Badru 2001; Igun 2003; Ewhrudjakpor 2007).

The implication of this is that the steps taken by any person in the utilization of health services follow a particular pattern. In Nigeria, particularly in Warri area the steps taken by an individual toward utilization of health care services depend mainly on the culture of the people.

Culture or civilization, taken in its broadest ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, traditions, custom, and any other capabilities and habits acquired by man and transmitted from generation to generation among the members of society. Culture and health behaviour are very important segments in society. (WHO 1998).

Three decades ago, World Health Organization (WHO) expert committee shed light on the meaning of traditional (unorthodox) medicine. This committee defines orthodox medicine as:

the sum of all knowledge and practices whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying extensively on experience and observation handed down from generation to generation, whether verbally or in writing, (WHO 1978).

In fact, the committee meant further to describe a traditional or unorthodox healer as:

(that) person who is recognized by the community in which he lives as competent to provide health care using vegetable, animal and mineral substances and certain methods based on the social, cultural and religious backgrounds as well as knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well being and the causation of disease and disability. (WHO 1978).

In contrast to the (WHO 1978) expert committee, modern scientist medicine referred to as orthodox medicine here is defined as a professional discipline that relies on a body of knowledge, and requires specialized knowledge, scientific training and skills aimed at diagnosing, prevention, treatment and rehabilitation of the physically and mentally sick. (Tella 1992; Badru 2001; Ewhrudjakpor 2007; Okujagu 2007). This definition encapsulates such disciplines as internal medicine, psychiatry, pediatrics, surgery, obstetrics and gynaecology, pharmacology among others. The definition differs from a layman's instance, administering drug like paracetamol to relieve pain (Sallah 2007).

The evolution of medical practices does not mean that the past unorthodox medical practice can affect the present orthodox health systems. The cultural variables of the unorthodox past inhibiting the contemporary health concerns is of tremendous interest to researchers of medical sociology, particularly in a developing society like Nigeria. This is because of the generally acknowledged fact that "health is wealth". The negative economic, social and educational impact of illnesses like fever, human immuno virus, acquired immune deficiency syndrome (HIV/AIDS), tuberculosis, reproductive health problems, cancer, mental illness, and leprosy, imposed inadvertently on people of the Niger-Delta of Nigeria is enormous. This blockade must be investigated and then those cultural factors systematically eliminated.

THEORETICAL OVERVIEW

From the theoretical literature on the subject, one may make a selection starting from Fabrega (1973), Palmer (1999), Grossman (1999) through Ichoku (2000) and ending with Igun (2003). Igun used the nested logit technic of Ichoku to model health care decisions in Nigeria. According to Ichoku the health care decision in a sequential choice model allows the analysis of how households make their particular health care decisions as shown in Figure 1.

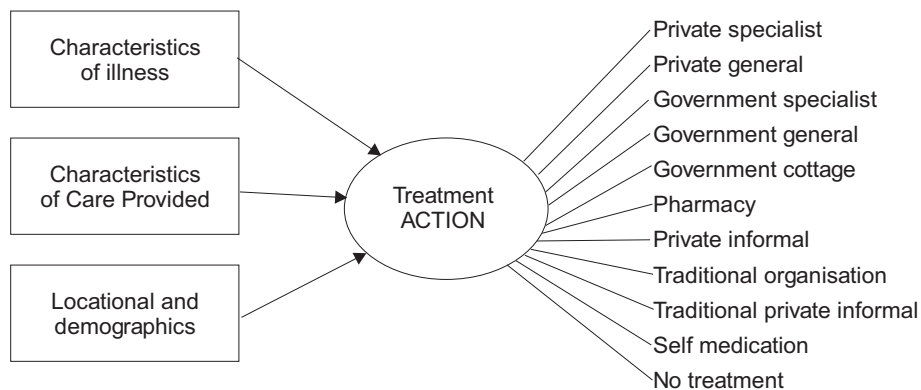


Figure 1. A Nested Logit Model of Health Care in Nigeria
Source: Ichoku 2000: 23.

The theoretical assumption here (Igun 2003) is that the rational individual will choose that form of care which maximizes his or her utility when this is reduced here to an empirical model for use, the model assumes that the choice of health care is a function of three broad groups of variables.

- Characteristics of the illness.
- Characteristics of the care received
- Characteristics of the patient's demographics and location.

From (Ichoku 2000) presentations the following theory of 'characteristics treatment –action choices' was derived (Igun 2003).

THEORY OF CHARACTERISTICS TREATMENT – ACTION CHOICES

Treatment action choices during illness episodes are a function of the characteristics of the illness, the demographic characteristics of the ill person and the characteristics of the available health care.

The treatment action(s) which persons take in relation to any illness episode are determined by the characteristics of the illness; the demographic characteristics of the ill persons; and the characteristics of the health care available.

This theory shall be used to discuss the findings of this study. This is because choices of health care by individuals who are ill are in the area of econometrics of health which is meant for a specialized readership which is the focus of this research.

STATEMENT OF PROBLEM

Eighty per cent of Nigerians utilize unorthodox medicine, (Owumi 1994; Atemie and Okaba 1997; Ewhrudjakpor 2007). This positive attitude has been perceived to be rooted in the culture of the people (Fabrega 1973; Igun 1977; Ohaeri et al. 1992; Owumi 1994; Erinosh 1998; Ademuwagun 1998; Badru 2001; Igun 2003). Thus, it would not be out of place to examine the cultural factors affecting the utilization of modern health services by providing answers to the following questions. Does traditional healing hold greater appeal to the patients than hospital services? Is treatment success contingent on patients' beliefs? What role does traditions and religions of patients' family and kin-group play on healing processes? These and other cultural issues are what this present writer shall address in this study.

In Nigeria, it is a well known fact that traditional medical practices had been in existence long before the arrival of orthodox health services. Traditional healers can be divided into categories. Those who are skilled in the use of home remedies, those who learned the art through inheritance or apprenticeship, those who have the knowledge of herbs, roots and barks; those who perform their healing through rituals or sacrifice, those that specialize in divination because of their ability to consult the oracle, and most recently, those who use religion (the Bible or Quran) to heal ailments.

Tella (1992) writing on the role of traditional healers emphasizes that the medicine men are the greatest gift and the most useful source of help. They are accessible to everybody almost all time; they give personal attention to the patient, which enables him to penetrate deep into the psychological state of the patient. Up to now, there is dearth of orthodox hospitals and qualified manpower in most of the rural areas in Nigeria, (Ewhrudjakpor and Ojie 2005). Natives are therefore encouraged to use unorthodox medical facilities due to their availability, accessibility and affordability.

Erinosh (1989), Aina (1996), and Badru (2001) in their studies among the Yoruba people found that the conception of illness is based on etiological factors, the preternatural, supernatural and natural. The preternatural means that illness is caused by witchcraft or sorcery. Supernatural causation is disease attributed to the wrath of ancestors and supernatural forces. The natural causation includes other variables such as nutrition, insect bites, worms, and infections. Their perception about illness is that people do not just fall sick but as a result of punishment or caused by an offence of the gods or by an enemy through witchcraft power or other evil devices. They believe that such illness could only be treated through their traditional healing method which is usually carried out by a herbalist or a native doctor who then consults the oracle to inquire about the beginning of the illness and the necessary solutions to such an illness (Ewhrudjakpor and Ojie 2005). Although a few believe in modern health care to some extent but do not usually utilize such services due to its non-availability or exorbitant cost.

Igun (1977) observed that all cultures evolve methods of dealing with ill health, discomfort and maintenance of health. Mbiti (1987) noted that his experience of non-literate societies has demonstrated the influence of cultural factors in the management of disease. According to Mbiti (1987) it is the culture which determines the acceptability, the success or failure of a given therapeutic orientation. Tella (1992) summed the above up when he said that “knowledge about health, illness and management can be said to be generally shared within and are determined by the culture”. Against this background the researcher hypothesized for testability in this study that *there is no relationship between cultural factors and non-utilization of orthodox medicine*.

Igun’s (2003) theory of ‘Characteristics treatment-Action choices would lead us to predict that there would be a significant inverse (negative) relationship between cultural factors and the use of orthodox medicine. That is we would predict that interviewees with high ratings on cultural factors would not use orthodox medicine. Is this true for the data in Tables 4 and 5?

STUDY AREA

The study was conducted among the natives of the geographically swampy Warri District in the oil-rich Niger Delta region of Nigeria. The area (consisting of five urban towns and fifty rural communities) has three ethnic groups: the peoples of Itsekiri, Urhobo and Ijaw. The population of the Warri area is about 155,021 (2007 estimate of the United States Census International Programs Centre). The Warri District traditionally has no medical infrastructure like hospitals except in the highbrow areas. But with the discovery, exploration and exploitation of crude oil resources in 1968 multinational oil companies such as Shell and Chevron, operating in the area started implementing their social responsibilities to the oil-bearing communities. This was when medical infrastructures started appearing in the district, particularly the urban areas like Warri city, unlike the rural areas like Ogidigben (Ewhrudjakpor 2008). Paradoxically, the oil exploration and exploitation are actually done in the rural areas but the ‘disease palaces’ (Hospitals) are situated in off-shore Warri (where the foreign workers and senior staff reside) (Ewhrudjakpor 2007).

MATERIAL AND METHOD

This contains the sample size/sampling technique, instrument for generation of data, reliability and validity of instrument, and procedure for data collection in this study.

Sample Size and Sampling Technique

200 natives (50 each) from urban settlements and 150 from rural settlements (see *Table 1*) were drawn from the population. *Table 2* shows the social characteristics of these respondents. Due to the prohibitively high costs and time of travelling on land

and on water throughout the Warri area in the Niger-Delta region of Nigeria, the researcher designated a cluster and multi-stage sampling technique within a three-stage design (see *Table 1*) of local government councils in the Warri area, the number of urban and rural communities in these councils and then sample of interviewees proportionately chosen from the designated communities for the study (see *Table 1*). Note that all the local government districts have only one urban settlement which usually is the seat of government, here due to their relatively large literate and dispersed population ten interviewees each were selected, while in the rural settlements the interviewees were sampled on a ratio of 1:3 (that is each community was represented by 3 interviewees).

Therefore the multi-stage cluster sampling technique was used to enable the researcher to conduct this study. This was to ensure that every person is given the probability of belonging to the sample from the population. This technique is useful because of its flexibility to gather information widely from a homogeneous and dispersed population.

Table 1. Showing the Selection of the Sample for this Study

| Number of Local Government Districts | Number of communities | | Number of selected interviewee | | |
|--------------------------------------|-----------------------|-------|--------------------------------|-------|-----|
| | Urban | Rural | Urban | Rural | |
| Bomadi Local Government | 1 | 6 | 10 | 18 | 49 |
| Burutu Local Government | 1 | 7 | 10 | 21 | 58 |
| Warri North Local Government | 1 | 13 | 10 | 39 | 28 |
| Warri South Local Government | 1 | 16 | 10 | 48 | 31 |
| Warri South-West Local Govt. | 1 | 8 | 10 | 24 | 34 |
| Total | | | 50 | | 200 |

Source: Fieldwork, 2007.

Instrument for Data Gathering

The researcher used a structured interview schedule itemizing cultural factors affecting the utilization of orthodox health services in Warri area in the oil-rich Niger Delta region of Nigeria. The questions in the interview schedule had two sections, namely;

Section A: Containing seven questions of social variables of respondents.

Section B: Five questions pertaining to cultural factors about health seeking behaviour. These five items or variables are: (a) knowledge, (b) custom such as patriarchy, (c) habits such as filthy environment, (d) beliefs such as 'igbe' or African traditional religion, and (e) perception of life in the present and future. The items in each of these categories are contained in *Tables 2 and 3*. The interviewees responded to these items rated on 'yes', 'No', and 'I don't know,' weighted (for the purpose of statistical analysis) as 2, 1 and 0 respectively.

Reliability and Validity

The reliability and validity of the structured interview schedule used for this study was derived after the researcher in a pilot study got 30 Nigerians in the Warri area to respond according to a 3-point (yes; No and I don't know) scale. The issues elicited 22 items of which 13 items were screened as appropriate to construct an individual structured interview schedule. These 13 questions generated, were pre-tested and yielded test re-test reliability of $r = 0.88$, $df = 28$, $p < .05$. Also, with a known-group method of construct validation, the researcher found a validity score, $t = 6.9$; $df = 28$, $p < .05$; known group of literate and illiterate respondents.

Procedure for Data Collection

The researcher selected ten interviewers (research assistants) who were his postgraduate students of medical sociology that hail from the five designated local government councils in the Warri area of Delta State in Nigeria. These students were debriefed by the researcher on the essence of the research and techniques to choose the sample, get the interviewees, the day, time, period and duration to conduct the interviews following instructions on the interview schedule. These interviewers were each given Micro Cassette Recorders for recording the interviews as backup to the structured interviews. The interviewers were not given any financial assistance since they were normally going home for vacation.

The interviews were conducted during the three-month vacation of the university where the researcher teaches medical sociology. This was between September 2007 and November 2007. Interviews were done only on Sundays between 4.00 p.m. and 6.00 p.m. when the people of the area were at home. The ten interviewers conducted 20 interviews with 200 interviewees (18 interviews in Bomadi, 31 in Burutu, 39 interviews in Warri North; 48 interviews in Warri South, and 24 interviews in Warri South-West). Note that, irrespective of the number of interviews, two interviewers conducted the interviews in each of the five local government districts.

The interview for both literate and illiterate participants was done in pidgin English which is generally spoken in the Warri area (however, the researcher did send two interviewers to their localities, where they also understand and speak their local dialects).

Results

Out of the 200 respondents originally sampled for this study only 190 respondents' were duly interviewed (in accordance with the instructions on the structured interview schedule). The information gathered from them is contained in *Tables 2 to 6*. *Table 2* shows the social characteristics of the 190 respondents who participated in this study. In *Table 3* a number of respondents' views about cultural factors blocking orthodox medicine are shown. And *Tables 4–6* show weighted responses in observed frequencies, expected frequencies and summary of chi-square statistical analysis

testing the hypothesis that *there is no relationship between cultural factors and non-utilization of orthodox medicine*. These findings are discussed afterwards.

Table 2. Respondents Social Characteristics (N = 190)

| Social Characteristics | No of Respondents | Percentage (%) |
|-------------------------------------|-------------------|----------------|
| Sex: | | |
| Male | 127 | 66.84 |
| Female | 63 | 33.16 |
| Total | 190 | 100 |
| Age: | | |
| 15-29 years | 39 | 20.53 |
| 30 – 49 years | 86 | 45.26 |
| 50 + | 65 | 34.21 |
| Total | 190 | 100 |
| Mean Age: | 41.26 | |
| Religion: | | |
| Christianity | 86 | 45.26 |
| Islam | 28 | 14.74 |
| African Traditional Religion | 76 | 40.00 |
| Total | 190 | 100 |
| Education: | | |
| No Formal Education | 66 | 34.74 |
| Primary | 67 | 35.26 |
| Secondary | 45 | 23.68 |
| Tertiary Institutions | 12 | 6.31 |
| Total | 190 | 100 |
| Marital Status: | | |
| Single | 40 | 21.05 |
| Married | 107 | 56.32 |
| Divorced | 14 | 7.37 |
| Separated/widowed | 29 | 15.26 |
| Total | 190 | 100 |
| Occupation: | | |
| Self employed | 68 | 35.80 |
| Civil servants | 70 | 36.84 |
| Company employed | 37 | 19.47 |
| Others (i.e. students/professional) | 15 | 7.89 |
| Total | 190 | 100 |
| Income: | | |
| Less than N12, 000 | 60 | 31.58 |
| N12, 000 – N24, 000 | 59 | 31.05 |
| N24, 000 – N 48, 000 | 43 | 22.63 |
| N48, 000 and above | 28 | 14.74 |
| Total | 190 | 100 |

Source: Fieldwork 2007.

*Table 3. Number of Respondents' Views
about Cultural Factors Blocking Orthodox Medicine*

| Cultural Factors | Urban (100) | | Rural (90) | |
|-------------------------------|-------------|------|------------|---------|
| | n | (%) | n | (%) |
| <i>Sources of Knowledge:</i> | | | | |
| Town Crier | - | - | 70 | (77.78) |
| Parents | 10 | (10) | 05 | (5.55) |
| Children | - | - | - | - |
| Neighbours | 15 | (15) | 02 | (2.22) |
| Media (Radio/TV Papers) | 70 | (70) | 08 | (8.89) |
| Posters | 05 | (5) | 05 | (5.55) |
| <i>Customs:</i> | | | | |
| Patriarchy | 60 | (60) | 70 | (77.78) |
| Rites | 02 | (2) | 10 | (11.11) |
| Fetishes | 13 | (13) | 10 | (11.11) |
| Exorcism | 25 | (25) | - | - |
| <i>Habits:</i> | | | | |
| Self Medication | 30 | (30) | | |
| Trustworthiness | 40 | (40) | 06 | (6.67) |
| Rebuff | 07 | (07) | 72 | (80) |
| Unhygienic | 13 | (13) | 07 | (7.78) |
| Religious | 10 | (10) | 05 | (5.55) |
| <i>Ethnic Beliefs:</i> | | | | |
| Germs cause illness | 45 | (45) | 08 | (8.89) |
| Hereditary cause illness | 05 | (05) | 02 | (2.22) |
| Curse/Punishment | 30 | (30) | 05 | (5.55) |
| Immoral Conduct | 05 | (05) | 05 | (5.55) |
| Witches/Wizards | 15 | (15) | 70 | (77.78) |
| <i>Perception:</i> | | | | |
| Effective | 40 | (40) | 10 | (11.11) |
| Shun | 20 | (20) | 60 | (66.67) |
| Prayers | 30 | (30) | 05 | (5.55) |
| Ambivalence | 10 | (10) | 15 | (16.67) |
| <i>Choice of Health care:</i> | | | | |
| Modern Medicine | 43 | (43) | 25 | (27.78) |
| Traditional Medicine | 15 | (15) | 51 | (56.67) |
| Faith Healers | 40 | (40) | 14 | (15.55) |
| Ambivalence | 02 | (02) | - | - |

Source: Fieldwork 2007.

Table 4. Recorded Responses of Interviewees' Ratings of Cultural Factors as they Affect the Use of Orthodox Medicine (observed frequencies)

| Cultural Factors | Yes | No | I Don't Know | Total |
|------------------|--------|--------|--------------|-------|
| Knowledge | 301(a) | 65(f) | 14(k) | 380 |
| Custom | 337(b) | 35(g) | 08(l) | 380 |
| Habits | 213(c) | 133(h) | 34(m) | 380 |
| Beliefs | 349(d) | 25(i) | 06(n) | 380 |
| Perception | 164(e) | 169(j) | 47(o) | 380 |
| Total | 1364 | 427 | 109 | 1900 |

Table 5. Recorded Responses of Interviewees' Ratings of Cultural Factors as they Affect the Use of Orthodox Medicine (expected frequencies)

| Cultural Factors | Yes | No | I Don't Know | Total |
|------------------|-------|------|--------------|-------|
| Knowledge | 272.8 | 85.4 | 21.8 | 380 |
| Custom | 272.8 | 85.4 | 21.8 | 380 |
| Habits | 272.8 | 85.4 | 21.8 | 380 |
| Beliefs | 272.8 | 85.4 | 21.8 | 380 |
| Perception | 272.8 | 85.4 | 21.8 | 380 |
| Total | 1364 | 427 | 109 | 1900 |

Table 6. Summary of chi-square Statistic for the Data from Tables 4 and 5

| Cell | fo | fe | fo-fe | (fo-fe) ² | (fo - fe)/ fe |
|------|-----|-------|--------|----------------------|---------------|
| A | 301 | 272.8 | 28.2 | 795.24 | 2.91 |
| B | 337 | 272.8 | 64.2 | 4121.64 | 15.11 |
| C | 213 | 272.8 | -59.8 | -3576.04 | -13.11 |
| D | 349 | 272.8 | 76.2 | 5806.44 | 21.28 |
| E | 164 | 272.8 | -108.8 | -11837.44 | -43.39 |
| F | 65 | 85.4 | -20.4 | -416.16 | -4.87 |
| G | 35 | 85.4 | -50.4 | -2540.16 | -29.74 |
| H | 133 | 85.4 | 47.6 | 2265.76 | 26.53 |
| I | 25 | 85.4 | -60.4 | -3648.16 | -42.72 |
| J | 169 | 85.4 | 83.6 | 6988.96 | 81.84 |
| K | 14 | 21.8 | -7.8 | -60.84 | -2.79 |
| L | 08 | 21.8 | -13.8 | -190.44 | -8.73 |
| M | 34 | 21.8 | 12.2 | 148.84 | 6.83 |
| N | 06 | 21.8 | -15.8 | -249.64 | -11.45 |
| O | 47 | 21.8 | 25.2 | 635.04 | 29.13 |

Degree of freedom (5-1) (3-1) = 8; $\chi^2 = 26.83$; critical χ^2 with $\alpha = 0.05 = 15.507$

DISCUSSION

Discussing the nature of health behaviour among residents of these communities in Warri area of Delta State takes into cognizance social characteristics (Table 2) that also impact on their choice of health care. The interviewees were 190, with 127 males (66.84%) and 63 females (33.16%). This reflects the patriarchal nature of the natives of Warri district in Nigeria. The respondents' age ranged from 15 years to over 50 years with a mean age of 41.26.

The preponderance of age, (30–49 years) of 86 respondents (45.26%) is due to the dominance and omnipresence of young adults in the Warri area. The majority of respondents are Christians, 86 people representing 45.26%, this is expected due to the early coming of the British Catholic missionaries to Warri area of Delta State. 76 respondents representing 40.00% practice African traditional religions. This is one expected reason why orthodox medical practices are blocked. Either Christianity or African traditional religion is used as curative and preventive disease therapeutic measures in place of orthodox medicine (Mbiti 1987; Tella 1992; Owumi 1994). The rate of literacy in this study area is significantly very low (see Table 2). It was only 6.31% of respondents who attended the tertiary institution. 66 respondents (34.74%) had no formal education. This of course can in itself affect negatively the use of orthodox medicine (Asuni 1979; Owumi 1994).

The respondent's marital status also in the literature is related to patriarchal control of household and medical decisions (Igun 2003). Even gynaecological concerns are directed by the men folk in a household (Mordi and Mordi 2004). In this study married respondents numbered 107 (56.32%). This is significant in this study because adults, particularly men are the decision makers in choices of health matters. (See *Table 2*).

The occupation of respondents cuts across the traditional ones: 68 (35.50%) respondents were self-employed (fishing and farming) and contemporary employment – civil servants and company employment – was represented by 70 (36.84%) and 37 respondents (19.47%) respectively. The majority of respondents had a monthly income of between N 12,000 and N 24,000.00, which when translated to international standard of living cost, is less than a dollar (\$1.00) per day. This affects negatively choosing orthodox medicine due to the exorbitant cost in consultation and the procurement of medicines in orthodox medical practices. (Asuni 1979; WHO 1998; Ichoku 2000; Igun 2003). Affordability is a basic condition for the utilization of orthodox medicine (Erinosho 1989; Ewhrudjakpor 2007).

Against these social characteristics in the background of the respondents in this study their responses in terms of their cultural factors blocking the use of orthodox medicine was statistically analyzed (*Table 3–6*). *Table 3* is a reflection of what obtains in most of Nigeria considering studies (Ohaeri et al. 1992; Tella 1992; Owumi 1994; Ewhrudjakpor 2004) in the literature.

It consists of five cultural variables: knowledge, customs, habits, ethnic beliefs, and perception, that affect the choice of health care (orthodox or unorthodox medicine). Knowledge about modern medicine among the urban dwellers sourced from the media (70%), in contrast among the rural dwellers it was 8.89%. But 70% of rural people sourced their knowledge from town criers, contrary to town criers' non-existence among urban dwellers. (See *Table 3*). This supports Igun's (2003) study of health seeking behaviour among Nigerians. Specifically, it corroborates Owumi's (1994) study among the Okpe-Urhobo ethnic group in Nigeria.

Significant in this study is that native customs encourage patriarchy amongst urban dwellers which was 60% and 77.78% in the rural area. The unanimity on this cultural variable is a major blockade to acceptability of orthodox medical practices in Nigeria. That is both urban and rural dwellers still believe strongly in husbands or male figures in the family deciding on health concerns for other members of the family. This confirms earlier studies (Palmer 1999; Igun 2003; Mordi and Mordi 2004; WHO 2005) that Nigerians, indeed Africans rely on the oldest male in the home to decide what treatment method to use during illness. See case 'A', a typical view of the interviewees in this study.

Case 'A'

... Oh! My brother (interviewer) are you not from this town – Burutu (an urban town in Warri area). You don't know that you need to see my 'oga' (husband) to tell you where we receive treatment if my children or me are sick?

Interviewer interrupts and asks further – where do you, Madam, go for treatment when you are sick? This time she replied in annoyance.

My husband usually directs where I go, I don't fall sick, but if I was to deliver my pregnancy (child delivery) my husband usually take me to the native birth attendant. And then she laughs and asks in return, are you not a man? Is it not you that take care of your wife when she is sick?

This is a typical statement from most of the interviewees in this study. It shows unanimously that women do not have a say in the choice of health services they receive, even in gynaecological matters. The patriarchal institution in Nigeria is deeply rooted to empower the men folk to decide where the pregnant wife should deliver her baby, not taking into cognizance the wife's medical and psychological states. In fact some male interviewees say they prefer traditional birth attendants, where juju, voodoo or fetish practices are used to process difficult deliveries and to confirm whether the pregnancy is actually their own.

Even among the urban inhabitants 13% and 25% believe in fetishes and exorcism respectively. Health habits are still below the World Health Organization standard of good medical practices in terms of clean environment. Data gathered (*Table 3*) show that among the urban interviewees self-medication (an unhealthy WHO practice) is 30% rampant. The majority of rural interviewees (80%) rebuff modern medicine. This is not unexpected considering the impact of low income, low education and distance from medical facilities. This fits the (Igun 2003) theory of 'characteristics treatment – action choices', derived from articulated submissions of (Fabrega 1973; Igun 1998; Grossmen 1999; and Ichoku 2000).

Ethnic beliefs are another very significant cultural variable that hinders the use of orthodox medicine in Nigeria. For instance, in this study, it was only 45% of respondents in the urban location that believed germs are the causative factor for illness. 30% and 15% of these urban dwellers still think that curse or punishment and witches are responsible for illness. This is paradoxical, considering the socialization agents like the media, religious organizations, educational institutions and neighbours from other nationalities (British and Americans) acculturate these, which should have effectively inhabitants.

However, the 77.78% of rural respondents that agreed that witches or wizards are responsible for illnesses. This cannot be said to be news. This is of primary expectation, against the background of social variables (*Table 2*) earlier discussed. This confirmed studies by (Asuni 1979; Mbiti, 1987; Owumi, 1994; Ewhrudjakpor, 2007).

By extension the culture variable of perception means how do these Nigerians living in the urban and rural areas view or see orthodox medicine? This study revealed that 40% and 11.11% of urban and rural dwellers respectively see modern medicine as effective. The reverse of 20% and 66.67%, urban and rural dwellers respectively shun modern medicine for alternatives like prayers or just resign to ambivalence. From the studies carried out by Erinosho (1989), Aina (1996) and Badru (2001) such characteristics that were found among the Yoruba people are also peculiar to the people of Warri area in the Niger Delta, with regards to their beliefs or perceptions about illness and the utilization of health care services. Such belief systems have been reduced among the urbanised people of Warri area as a result of Christianity and civilization, together with the mixed population of people from different ethnic groups

which made some of the communities urban. On the other hand, such beliefs are still very much intact among the rural people. Even with the advent of Christianity they still believe and hold strongly to their traditional belief systems and practices and this has gone a long way to affect their perceptions and approaches to remedy it. This is the reality on ground, argued one interviewee.

Case 'B'

...you see, but the medicine is good O! but the problem is that fake drugs and fake doctors and nurses have removed the little confidence, even educated people have no trust on these drugs. With the native medicine, you see how it is prepared, and it is very genuine... laughs... no wonder government wants to certify the use of traditional medicine.

It is true that the federal government of Nigeria has approved with limitation (treatment of psychiatric ailments) the practice of tradomedicine in Nigeria (Sallah 2007).

This situation described by an interviewee, confirmed this research investigation as revealed in *Table 3* about the choice of health care, 43% and 56.67% of urban and rural interviewees chose modern medicine and traditional medicine respectively as choice of health care.

Here is the opinion of another interviewee (a head teacher of a high school):

Case 'C'

I feel pains all over my body. The headache was pounding in the right side of my head. At night I sweat profusely. I have to go to 'chemist' (patent medicine shop) where I was given 'panadol and fansidar'. The pain was still there, after two weeks, so I went to my pastor to pray for me, he said I should see another physician who said I have acute malaria. Then the physician referred me again to the University Teaching Hospital. But I decided to collect herbs and boil which I drank and use to bathe. Look at me, since then (after drinking and bathing with the boiled herb) I know nothing like malaria. I also use that medicine (herbal therapy) for my wife when she had typhoid fever. The leaves (herb) is super good oh!

From the foregoing statement it can be said that the choice of health care is confirmed by even the educated like we have in case 'C', the head teacher of a higher school. *Table 4* describes the ratings of the responses, when interviewees were asked whether cultural factors affect the use of orthodox medicine. The scores recorded are observed frequencies of aggregated scores of the number of respondents as contained in *Table 3*. *Table 4* unanimously shows that interviewees' responses support significantly the negative relationship between cultural factors of (a) knowledge, (b) custom, (c) beliefs, and orthodox medicine. From *Table 4* it was only one cultural factor – perception that can be said not to reach the level of significance in relating to orthodox medicine.

However, *Table 5* (expected frequencies) shows the ratings of the interviewees on the relationship between cultural factors and non-utilization of orthodox medicine. This is based on the chi-square formula of $f_e = (\text{row total}) \text{ column total}$.

Tables 4 and 5 taken together as usually the case with chi-square (χ^2) statistic are analysed and summarized in *Table 6*. This gives the general χ^2 case of degrees of freedom $(5 - 1)(3 - 1) = 8$ using the 05 level of significance, the critical value of 15.507 was derived from the statistical table. Meanwhile the calculated χ^2 value is 26.83 (*Table 6*). Based on the statistical principle of rejecting the null hypothesis (H_0) when the calculated value is greater than the critical (Table) value, our stated null hypothesis – there is no relationship between cultural factors and non-utilization of orthodox medicine – is therefore rejected. This means that the alternative hypothesis, which states the contrary – cultural factors do relate to the non-utilization of orthodox medicine – is accepted. The result of the chi-square test can be reported thus, interviewees showed a significant support for cultural factors leading to non-utilization of orthodox medicine ($\chi^2 (8) = 26.83, P < .05$).

This result fits well in the (Igun 2003) theory of ‘characteristics treatment – action choices’. That is Nigerians’ choice of unorthodox medicine is a result of a combination of the nature of illnesses (believed here to be always a result of supernatural or preternatural forces), the demographic characteristics of general economic poverty and low education of the populace, and of course the omnipresence of unorthodox health care services and dearth of orthodox medical institutions. This finding is also generally supported in the literature (Ohaeri et al. 1999; Grossman 1992; Ichoku 2000; Owumi 1994; Mordi and Mordi 2004; WHO 2005; Ewruhjakpor and Ojie 2005; Ojie and Ewruhjakpor 2006; and Ewruhjakpor 2007).

Also, it shows that urbanization does not destroy cultural blockades to unorthodox medical practices (Tella 1992). See also the impact of 40% and 15.55% of faith healers in both urban and rural communities respectively, as an added impetus to positive attitudes towards unorthodox medicine. This is supported by Ohaeri et al. 1992; Badru 2001; Okujagu 2007; Sallah 2007 and situated within the theoretical frame of ‘characteristics treatment-action choices’ (Igun 2003).

CONCLUSION

This study revealed unanimously that some cultural factors block the utilization of orthodox medical services using a case study of Warri area in Nigeria. Beliefs in preternatural and supernatural systems are rampant. Patriarchal practices plaguing developing nations are deeply rooted in Nigeria. Health decisions are taken by husbands or oldest male in the family. There is now the issue of ambivalence on the part of governments in Nigeria whether to develop fully unorthodox medicine like practices in some continents of the world like Asia and South America among others. The major cultural ‘blockades’ of orthodox medicine here are some ethnic beliefs and customs of the peoples of the Warri area in Nigeria.

This author recommends that the Nigerian Governments at all levels should deliberately enforce measures to inform and educate Nigerians of the importance and

realism of orthodox medicine in managing medical ailments like HIV/AIDS, tuberculosis, leprosy and cancer. The Ministers of Health, Information, and Education should collaborate to put into practice information, education and communications practices showing the need to use orthodox medicine when the ailment is caused by natural or biological factors like germ or physical incapacitation. And when it is caused by preternatural or supernatural factors, it is exclusively a domain for unorthodox medicine. When men, women and youths are informed and educated, they can rightly choose the health care facilities that have the greatest merit, (orthodox or unorthodox medicine) depending on the nature of illness. HIV/AIDS, leprosy patients should choose orthodox medicine while orthopaedic ailments like fractured bones and functional schizophrenics, patients should choose unorthodox medicine (Ewhrudjakpor 2008). These examples are not exclusive of the comparative advantages that these two complementary health care types provide to Nigerians. It is against this background that the federal government in 2006 (Sallah 2007) passed a limited bill (only for some illnesses like psychiatry related to cultural causatives) regulating unorthodox medicine in Nigeria.

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