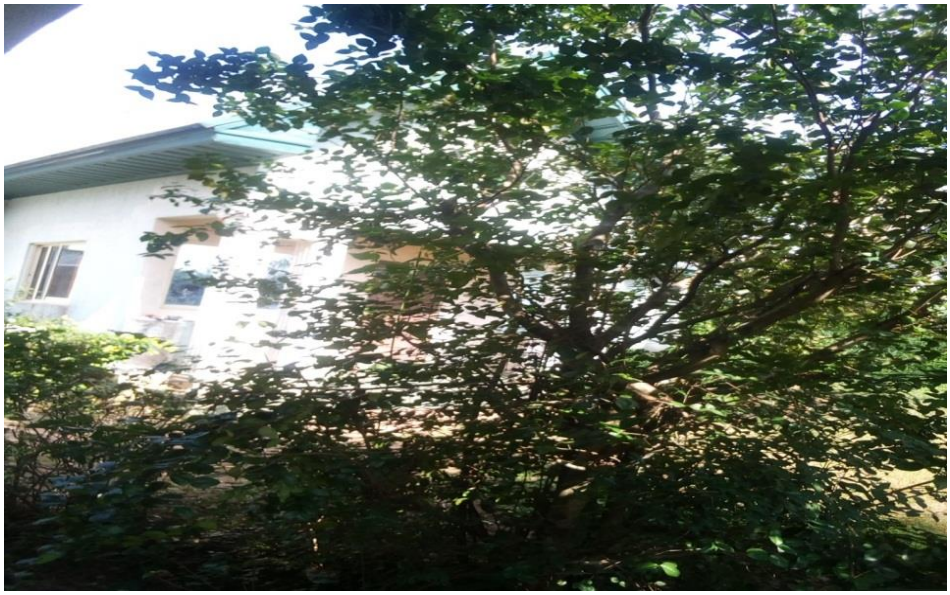
NATIONAL OPEN UNIVERSITY OF NIGERIA

FACULTY OF HEALTH SCIENCES

DEPARTMENT OF PUBLIC HEALTH SCIENCE

COURSE CODE: PHS809



COURSE TITLE: SOCIAL MEDICINE

MAIN GUIDE

PHS809: SOCIAL MEDICINE

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INTRODUCTION

PHS809 Social Medicine is a two (2) credit unit course undertaken by students pursuing Master's Degree at National Open University of Nigeria. Social Medicine is concerned with the relationships between health and social factors. It also focuses on the causes of human behaviours and the consequences of human behaviours, particularly as they relate to health and illness. Social medicine identifies man as a biological and a social being and that diseases have social causes, social consequences and social therapy. The importance and relevance of sociological approach to the study of health and medical practice cannot therefore not be over emphasised.

There is much to learn from the inclusion of non-medical factors in illness causation which was in the past given less attention in medical and health curriculum. The knowledge of Social Medicine has improved the understanding of belief system and cultural orientation of healthcare providers, which has increased the confidence of recipients of healthcare. This course also focuses on the formal organisation of healthcare, social functions of health institutions, as well as the social patterns of health services and the relationship of healthcare delivery system to other systems.

This course guide will expose you to what the course material has to offer you. You are therefore expected to read through this course guide before proceeding to the main course section.

WHAT YOU WILL LEARN IN THIS COURSE

You have this course guide which uncovers what this course is all about, by giving a general overview of the course materials which you will be using. It further spells out how to use the course materials for your maximum benefit as a student. The course guide aids your understanding of the importance of attending tutorials, carrying out Tutor-Marked Assignments (TMAs), which

will form part of your overall assessment at the end of the course and participating in the examination. This course material covers nine units of study organised in three modules which are of equal importance and you should therefore give them adequate time to enable you study and understand the contents. You are provided with list of reference materials relating to each study unit. You are to access them at your own time as they are beneficial and they are to your advantage.

COURSE AIM

The aim of this course is to provide you with a good understanding of the role of socio-psychological and cultural factors in disease etiology, medical care and health services utilisation with particular reference to Nigeria.

COURSE OBJECTIVES

To achieve the stated aim of this course, the following objectives are set to guide you. Each unit has its own set of objectives presented at the beginning of the unit to direct your focus. The comprehensive objectives for this course covering all the units are stated below.

At the end of this course, you should be able to:

i) Explain the concept of health
ii) Explain the concept of disease
iii) Explain the concept of illness
iv) State the etiology of disease and illness
v) Explain the concept of disease in Nigeria/Africa
vi) Explain social factors and health
vii) Explain health behaviour
viii) Explain illness behaviour
ix) Explain health seeking behaviour
x) Explain sick role behaviour
xi) Explain the meaning of social epidemiology

xii) Give brief history of social epidemiology

xiii) Explain significant concepts of social epidemiology

xiv) State the importance of social epidemiology

xv) Explain approaches to study incidence and prevalence of disease

xvi) Discuss research examples in social epidemmiology

xvii) Describe the organsation of healthcare system in Nigeria

xviii) Explain the delivery of healthcare services in Nigeria

xix) Explain the components of healthcare system in Nigeria

xx) Enumerate the common challenges facing healthcare system in Nigeria

xxi) State the concept of universal health coverage (UHC)

xxii) Explain complementary and alternative medicine/healthcare practices

xxiii) Discuss types of complementary and alternative medicine/healthcare practices

xxiv) Discuss traditional medicine/healthcare in Nigeria

xxv) State why people prefer traditional medicine/health care in Nigeria

xxvi) Explain socio-cultural factors influencing health services utilisation

xxvii) Explain perceptions of benefits and quality of healthcare rendered

xxviii) Explain factors that influence compliance with health professionals' orders

xxix) Explain the concept of behavioural maladjustment

xxx) State the characteristics of a maladjusted individual

xxxi) Classify the causes of behavioural maladjustment

xxxii) State the problems of behavioural maladjustment in children

xxxiii) Explain the concept of HIV and AIDS

xxxiv) Explain the progression stages of HIV

xxxv) Discuss prevention activities relating to HIV infection

xxxvi) Explain treatment options for HIV infection

xxxvii) State some common mental disorders associated with HIV and AIDS

xxxviii) Explain the concept of sexual violence

xxxvii) State the magnitude of the problem of sexual violence

xxxvii) Discuss the consequences of sexual violence

xxxviii) Discuss the public health approach to sexual violence

xxxix) Discuss 'Promote Social Norms that Protect Against Sexual Violence'

xxxx) Discuss 'TEACH' skills to prevent sexual violence'

WORKING THROUGH THIS COURSE

To successfully complete this course, you are required to read each study unit in the course materials provided by the National Open University of Nigeria. You are to consult the referenced materials as it will be of great assistance to you towards clearer understanding of the course contents.

This course is arranged in three modules and each module has three units presented in a sequence that will facilitate the process of studying and comprehension. The course covers all the components you require for your programme of study. Each unit has self-assessment exercises which you will work on and submit your work for the purpose of assessment at the stipulated time. You will also be required to take the prescribed examination at the end of the course.

COURSE MATERIALS

The materials for this course comprise mainly of:

i) The course guide

ii) Study units

STUDY UNITS

The study units for this course are nine (9) organised in three (3) modules. Each module contains three (3) units as presented below:

Module I	**Health and Disease**
Unit 1	Concept of Health and Disease
Unit 2	Human Behaviour in Relation to Health and Illness
Unit 3	Social Epidemiology
Module 2	**Pathways to Healthcare**
Unit 1	Organisation and Delivery of Modern Healthcare System in Nigeria
Unit 2	Healthcare Options
Unit 3	Factors Influencing Health Services Utilisation
Module 3	**Marginality and Mental Disorder**
Unit 1	Behavioural Maladjustment
Unit 2	HIV and AIDS
Unit 3	Sexual Violence

TEXT BOOKS AND REFERENCES

At the end of each study unit referenced and other useful materials consulted in the course of preparing this course material are listed for you. You are to widen your knowledge by accessing and reading them. You can also in addition access other useful materials that contain related information.

ASSIGNMENT FILE

There are two components of assessment for this course. They are the tutor-marked assignments (TMAs) and the final examination. They are both

important in assessing your performance in this course. In addition you should complete any exercise or activity required of you in the unit where applicable.

TUTOR-MARKED ASSIGNMENTS (TMAs)

The Tutor-Marked Assignments (TMAs) are the continuous assessment component of your course. Each study unit contains TMAs relevant to that unit. The TMAs account for 30 per cent (30%) of the total score for the course. The TMAs will be given to you by your facilitator and you will return them after you have done the assignments and within the stipulated time which will be communicated to you. You should endeavour to do all TMAs as directed because they constitute part of your final assessment.

FINAL EXAMINATION AND GRADING

You will take the examination at the end of the course and this concludes the assessment for the course. The final examination constitutes 70 per cent (70%) of the whole course assessment score. You will be informed of the time for the examination and you must present yourself and participate in the examination.

PRESENTATION SCHEDULE

All activities contained in this course have been scheduled appropriately. You are expected to follow the timetable of events religiously. You must carry out the Tutor Marked Assessments (TMAs) and any other prescribed assignment as instructed and within the recommended timeframe. The presentation schedule as contained in this course guide provides you with important dates for the completion of the course contents. You should therefore work with the schedule to meet up with deadlines.

COURSE MARKING SCHEME

Table 1: Distribution of scores

Assignments	**Marks**
Tutor Marked Assignments (TMAs)	3 Assignments: Total score of 30 per cent
End of course examination	Total score of 70 per cent
Total score for the course	**100 per cent**

Table 2: Course organization

Unit	**Title of Work**	**Weeks Activity**	**Assessment (End of Unit)**
	Course Guide	**Week**	
1	Concept of health and disease	Week 1	Assignment 1
2	Human behaviour in relation to health and illness	Week 2	Assignment 2
3	Social epidemiology	Week 3	Assignment 3
4	Organisation and delivery of modern healthcare system in Nigeria	Week 4	Assignment 4
5	Healthcare options	Week 5	Assignment 5
6	Factors influencing health services utilisation	Week 6	Assignment 6
7	Behavioural maladjustment	Week 7	Assignment 7
8	HIV and AIDS	Week 8	Assignment 8
9	Sexual violence	Week 9	Assignment 9

COURSE OVERVIEW

There are three modules and nine units which are arranged in such a way that each module contains three units.

Module 1 focuses on various dimensions of health and disease. In Unit 1, you will go through the concepts of health, disease and illness. You will be exposed to the etiology of disease, expounding the different models thereof, such as the medical, cultural and socio-psychological models. You will be able to appraise the concept of disease with particular reference to Nigeria while taking cognizance of how social factors affect health. In Unit 2 you will understand human behaviours as exhibited by persons in the society when they perceive they are in health to keep staying healthy or while ill so as to recover from illness and how the society responds to people who are certified to be sick. In Unit 3 you will deepen your knowledge on social epidemiology fathoming the meaning, brief history, significant concepts and research examples in social epidemiology.

Module 2 addresses the pathways to health and in Unit 1 you will be taken through the organisation and delivery of modern healthcare system in Nigeria. The unit will reveal to you the types of health services available, their ownership and objectives of delivery of health services. You will also be acquainted with the components of the healthcare delivery system in Nigeria, the common challenges facing the Nigerian healthcare system, and the concept of universal health coverage. Unit 2 gives you an understanding of healthcare options, comprising complementary and alternative healthcare, traditional medicine in Nigeria and why people prefer traditional medicine/healthcare in Nigeria. Unit 3 provides you information on factors that influence the utilisation of health services such as the socio-cultural

factors, perceptions of benefits and quality of healthcare rendered, as well as factors influencing compliance with health professionals' orders.

Module 3 addresses marginality and mental disorders and in Unit 1 you will learn about behavioural maladjustment. You will understand the concepts of behavioural maladjustment, its characteristic and its causes. You will also identify problems of behavioural maladjustment in children which include nervous, habit, behaviour disorders as well as psychotic disorders, and educational and vocational difficulties. In Unit 2 you will deepen your knowledge of HIV and AIDS as being more than a health problem but also a social problem with associated mental disorders which occur at times. You will learn how HIV infection is prevented and also how the associated marginalization can be prevented. Unit 3 exposes you to the magnitude of the social ill of sexual violence and its consequences. You will learn the public health approach to sexual violence and certain interventions that have been implement in some regions to engender positive behaviours geared towards preventing sexual violence in the society.

HOW TO GET THE MOST OUT OF THIS COURSE

Your study materials are designed to assist you in your learning and you are to study the materials diligently and systematically. The materials serve as the lecturers' lecture notes to you and the exercises therein such as TMAs should be taken seriously in terms of quality of work done and in always keeping to the completion and submission time.

There is a uniform format used in presenting the units and it will be beneficial to you if you follow that sequence while reading, for instance going through introduction, objectives, content, conclusion, summary, TMAs and references/further readings. Do not skip any section or think that any

part is less important as they are designed to guide you in your reading and thus improve learning capability.

FACILITATORS/TUTORS AND TUTORIALS

You will be informed of the scheduled time and location for your tutorial classes. You should get in touch with your facilitator immediately you are assigned to a tutorial group as the contact details of your facilitator will be made available to you. Your facilitator will give you all the relevant information and assistance you require to progress in your study. Your facilitator is saddled with the responsibility of marking your TMAs and to return same to you within a stipulated time. You will contact your facilitator any time you have challenges concerning this course or when you need any clarification concerning the study units, assignments or grading of the assignments.

You should realise that attendance to tutorial classes is important and necessary as it offers you the opportunity to have face to face interaction with your facilitator. Such interaction will enable you receive quick answers to pressing questions and to discuss first hand any other issue relating to your study.

SUMMARY

This course *Social Medicine (PHS809)* is arranged in three modules and nine units. The units cover such areas of interest as concept of health and disease, human behaviour in relation to health and illness, social epidemiology, organization and delivery of modern healthcare system in Nigeria, healthcare options, factors influencing health services utilization, behavioural maladjustment, HIV and AIDS and sexual violence.

At the end of this course you will have a deeper knowledge and understanding of these study units for proper application in the field of practice later. You must endeavour to attend your tutorials diligently, carry out all prescribed assignments and take your final examination. Your facilitator is available to guide you and answer your questions regarding your study, hence maintain meaningful contact with your facilitator and you will be glad you did.

MAIN COURSE

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MODULE I **HEALTH AND DISEASE**

UNIT 1: CONCEPT OF HEALTH AND DISEASE

CONTENTS

1.0 INTRODUCTION

The assertion that health is needed for optimum performance by every individual is an under-statement. There is a general view that health is not appreciated at the individual level until it is lost, and this accounts for the subjugation of health at this level to other needs such as wealth and power. Also, at the international level health was neglected until some decades ago when there was the reawakening of health as a fundamental human right and essential for attaining improved quality of life.

There are different perceptions of health which have informed the different definitions of health. However, the understanding of health is the basis for healthcare. The World Health Organisation (WHO) in 1948, in a preamble to its constitution defined health broadly so as to capture the important elements required for its comprehensiveness. The WHO's definition of health has been widely applied since the time it was published, but it has also been criticized for some existing gaps in the definition.

Health is influenced by varied factors such as adequate food (nutrition), housing, basic sanitation, healthy lifestyles, protection against environmental hazards and communicable diseases. Modern medicine has been accused of being preoccupied with the study of disease and neglecting the study of health resulting in profound ignorance about health. Despite this noted indictment of preoccupation with the study of disease, defining disease has proved more complex due to its different ramifications. It sounds logical to say that the absence of health is disease.

2.0 OBJECTIVES

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

i) Explain the concept health
ii) Explain social factors and health
iii) Explain the concept of disease
iv) Explain the concept of illness

v) State the etiology of disease and illness

vi) Explain concept of disease in Nigeria/Africa

3.0 MAIN CONTENT

3.1 CONCEPT OF HEALTH

Health is conceived from various perspectives resulting in the different definitions of health available in literatures today. These definitions are proffered from varied dimensions which include physical, mental, emotional and spiritual.

3.1.1 Varied perceptions of health

Some of the perceptions of health include:

i) It is reported that the oldest known definition of health is that health is the absence of disease.

ii) The ancient Indians and Greeks view health as harmony, which is translated to mean, being at peace with oneself, with the community, with god and with cosmos (Park, 2009).

iii) Health is seen by some schools of thought as the absence of symptoms of sickness or absence of pain or absence of disability.

iv) Others view health as a state of vibrancy, physical strength ability to perform the needed task.

v) Health has also been conceived as the condition under which the individual is able to mobilize all his resources, intellectual, emotional and physical for optimum living (Pulga, 1983).

vi) Health is that state of moral, mental and physical well-being which enables a person to face any crisis in life with the utmost grace and facility (Peery, 1980).

v) Health is the ability to function effectively within a given environment (Schiffer, 1980).

In recent years new thinking about health emerged which can be summarised as follows:

i) Health is a fundamental human right and this justifies why it should be available to all.
ii) Productive life is rooted in health and not based on medical expenditure.
iii) Health is inter-sectoral and cannot be achieved through a single sector effort.
iv) Health is a vital component of development and therefore a constituent of development goals.
v) Health is a crucial element in the concept of quality of life.
vi) Health is a multi-level responsibility carried out at the individual, state and international levels.
vii) Health and the maintenance of health constitute major social investment.
viii) Health is a global social goal.

3.1.2 World Health Organisation's (WHO's) definition of health

The World Health Organisation (WHO) defines health as a state of complete physical, mental, social, spiritual wellbeing and not merely the absence of disease and infirmities. Being physically well connotes absence of disease as evidenced by medical examination. Social wellbeing indicates that the individual is able to maintain social relationship and enjoys a reasonably good standard of living, while mental wellbeing has to do with having good psychological state. The individual who is mentally well is able to realise his/her abilities and is able to cope with normal stresses of life, work productively and fruitfully and able to make a contribution to his or her community (WHO, 2004). The definition of health by WHO is widely accepted for its comprehensiveness, but criticised on the other hand, for being too broad and for the inherent operationalisation and methodological

problems therein. Some argue that health cannot be defined as a state but should be seen as a process of continuous adjustment to the changing demands of living and of the changing meanings given to life.

It is easier to a certain extent to measure physical health by medical examinations and investigations, but this is different when it comes to social and mental wellbeing. What constitutes social wellbeing may differ from society to society, hence posing a challenge for its measurement. Similarly, measuring mental wellbeing poses its own challenge. Mental wellbeing is not merely the absence of mental disorder necessitating hospital attention.

One common factor in these definitions and concepts of health is that health is portrayed as a positive phenomenon associated with longevity, peace, soundness of mind, happiness and self-actualization. The environment and activities of man impact either positively or negatively on health. Attention is given to man's interactions as a social being; the society and social institutions; environmental factors which include physical, biological and social environment; lifestyle and the health system factors.

3.1.3 Changing concepts of health (Park, 2009)

i) Biomedical concept of health

Traditionally health is seen as an absence of disease, meaning that anyone who is free from disease is considered healthy. This assertion is what the biomedical concept of health represents, and it is based on the germ theory of disease. At the early part of the twentieth century the germ theory dominated medical thought. The human body was viewed then as a machine while disease was seen as the consequence of breakdown of the machine and the doctors were to repair the machine. Health has a narrow view in this concept and the concept has been criticised for not portraying the role of environmental, social, psychological and cultural factors of health. The

biomedical concept of health was found to be inadequate because of its inability to address some major health problems, such as malnutrition, chronic diseases, accidents, drug abuse, mental health disorders, environmental pollution and population explosion. This realization came as a result of developments in medical and social sciences.

ii) Ecological concept of health

The ecological concept views health as a dynamic equilibrium between man and his environment and disease. Any shift in the equilibrium becomes a maladjustment of the individual to his environment. This is buttressed by the definition of health by Dubos (1965) which states that an individual should in addition to having relative absence of pain and discomfort, adapt and adjust to the environment for optimal functioning. The ecological concept came up as a response to the gap that exists in the biomedical concept of health. The ecological concept raises the issue of imperfect man and imperfect environment. This concept according to WHO (1986), contends that improvement in human adaptation to the human environments can bring about longer life expectancies and a better quality of life even in the absence of modern health delivery services.

iii) Psychosocial concept of health

The psychosocial concept of health reveals the influence of social, psychological, cultural, economic and political factors on health. This view that health is both a biological and social phenomenon is rooted in the developments made in the area of social sciences. These psychosocial factors are very relevant in defining and measuring health because health is a biological phenomenon as well as a social phenomenon.

iv) Holistic concept of health

The holistic concept of health is a blend of the other three concepts stated above. It recognises the strength of social, economic, political and environmental influences on health. It has been described as a multi-dimensional process involving the wellbeing of the whole person in the context of his environment. This concept agrees with the view of the ancient, that health is a sound mind in a sound body, in a sound family, in a sound environment. This implies that health is affected by every facet of the society.

3.1.4 Dimensions of health

Health is multi-dimensional, spanning beyond the three dimensions contained in the World Health Organisation's definition of health (physical, mental and social) to encompass other elements such as spiritual, emotional, vocational and political dimensions.

i) Physical dimension

This is based on biological concept of health and implies a situation where the body cells, organs and systems are at optimum performance. The level of body functioning that meets optimum description may be difficult to define, nevertheless, some signs of physical health include; good appetite, bright eyes, good complexion, lustrous hair, regular bladder and bowel movement among others. Physical health can be measured in modern medicine using self-assessment of overall health, investigation of symptoms of illness and associated risk factors, medication and use of medical services, etc. On the other hand, the state of health can be assessed at the community level using certain indicators such as death rate and infant mortality rate among others.
ii)

ii) Mental dimension

Mental dimension of health denotes the ability to respond appropriately to experiences of life and not the mere absence of mental illness. A person with

mental health will exhibit sense of purpose and will relate with others harmoniously. Mental health refers to maintaining state of equilibrium between the individual and the world around him. Psychological factors can engender other types of illness other than mental illness, such as hypertension and peptic ulcer among others. Mental health can be assessed at the community level using a mental health questionnaire.

iii) Social dimension

Social dimension of health is a concept that emanated from the premise that human being is part of a family and also part of the larger society, who should live and relate with others cordially. Social health is portrayed in the quality of interpersonal relationship maintained by the individual, the level of positive involvement with the community (social networks), and favourable economic conditions that allows the individual to cope with resource demands.

iv) Spiritual dimension

The spiritual dimension of health focuses on that part of the individual which strives for meaning and purpose. It is described as intangible and goes beyond the level of physiology and psychology. The elements of spiritual dimension of health comprise of integrity, principles, ethics, purpose in life and commitment to higher being. Proponents of holistic health are of the view that spiritual health deserves serious consideration because it plays a great role in health and disease. Anyone who experiences spiritual uneasiness or who is not spiritually at peace is not likely to put up appropriate behaviour that reflects wholeness.

v) Emotional dimension

Emotional dimension is one of the new dimensions added to the concept of health. Mental and emotional dimensions were in the past considered as being very closely related that they were regarded as one element. Definite differences between the two elements (mental and emotional) have been reported which aligns mental health to cognition and emotional health to feelings. Emotional disturbances will affect the individual's response and adaptation to his environment and how he relates to other persons around him. Emotional dimension of health will no doubt stand on its own as a dimension of health considering the new findings on the influence of emotional aspect of human being on his health.

vi) Vocational dimension

Vocational dimension is one of the new dimensions ascribed to health and it focuses on the vocational aspect of life. Work is part of human existence and plays a role in promoting physical and mental health. Work should adapt to the human goals, capacity and limitation and should bring out improvement in physical capacity. Achievement of goals brings about self-realization, satisfaction and self-esteem. This dimension is appreciated when there is life event that reverses this process such as losing a job which can result in a crisis situation for the person concerned.

vii) Others

These are other dimensions that have been suggested and they include non-medical dimensions of health. They contribute to a level of health that allows for socio-economic productivity among persons. These dimensions include:

i) Philosophical dimension
ii) Cultural dimension
iii) Socio-economic dimension
iv) Environmental dimension
v) Educational dimension

vi) Nutritional dimension

viii) Curative dimension

ix) Preventive dimension.

3.1.5 Determinants of health

Health is influenced by many factors and these factors are both internally and externally located. Internally located factors are those factors found within the individual such as genetic factors, while those that are externally located are those found outside the individual but in the environment where the individual lives. These determinants include:

i) Biological determinants

ii) Behavioural and socio-cultural conditions

iii) Environmental determinants

iv) Socio-economic conditions

v) Health services factor

vi) Ageing of the population

vii) Gender

viii) Others include: transition from post-industrial age to information age, food and agriculture, education, employment opportunities and increase in wages.

3.2 SOCIAL FACTORS AND HEALTH

Social factors play important roles in determining health and illness among individuals and groups in the society. People are exposed to social conditions which expose them to the risk of illness or disability or on the other hand promote disease prevention or maintenance of good health. Social factors which affect health are shaped by distribution of money, power and resources at all levels of the economy. This explains why some authorities opine that these factors are subset of government policies, in addition to

individual behavioural choices. Some of such identified social factors that influence health positively or negatively include:

i) Income level
ii) Educational opportunities
iii) Occupation, employment status and workplace safety
iv) Gender inequity
v) Racial segregation
vi) Food insecurity and inaccessibility of nutritious food choices
vii) Access to housing and utility services
viii) Availability of healthcare
ix) Early childhood experiences and development
x) Social support and community inclusivity
xi) Crime rates and exposure to violent behaviours

Unhealthy lifestyle and high risk behaviours, are threats to health and physical wellbeing as evidenced with their association with diseases such as cardio-vascular diseases, sexually transmitted infection (STIs) and HIV infection. Accidents, injuries and violent behaviours are associated with drug and substance abuse. Conversely, when people practice healthy lifestyles as in maintenance of adequate diet, appropriate weight, regular exercise, avoidance of stress and avoidance of high risk behaviours, it is expected that they will experience healthy life which may lead to longevity.

3.3 CONCEPTS OF DISEASE

3.3.1 Perceptions of disease

Disease has been described as a deviation or departure from the state of health, which threatens the wellbeing of an individual. Disease is also viewed as impairment of body health and an alteration of the human body which interrupts the performance of vital functions. In a disease condition there is a pathological process underlying a clinical syndrome and there is

malfunctioning of certain part of body system. Diagnosis of a disease can be made based on clinical findings and this is objective as medical tests can be used to obtain the clinical picture. There are situations when the individual expresses objective pain which is not clinically substantiated, or which seems to have no bases. In such circumstances, basing disease condition only on pathological expression can narrow the scope, hence the definition of disease has been expanded to include subjective symptoms rather than only the objective symptoms. The expanded definition includes both the biological discontinuities and behavioural deviations such as psychological issues.

How much deviation or discomfort will exist for disease to be pronounced? There are theoretical issues about this concept leading to a more comprehensive definition by some authorities e.g. Talcott Parsons views disease as inability of an individual to perform his/her social functions. In a disease condition the capacity to function is temporarily or permanently impaired depending on the impact of that particular disease. Manifestations of signs and symptoms aid diagnosis and treatment of the condition. Signs are overt and can be detected through observation and diagnostic apparatus, while symptoms are covert and are experienced by the individual sufferer, which makes symptoms more subjective as feelings. Disease can be caused by the invasion of disease-causing organisms or from unhealthy lifestyles. The concept of disease can therefore be classified into the ecological concept and the sociological concept. The ecological concept views disease as maladjustment of the individual to his environment, while the sociological concept views disease as a social phenomenon which exists in every culture and is given definition in line with the prevailing cultural factors.

The World Health Organisation (WHO) is yet to have a definition for disease. This lack of definition of disease by WHO has been attributed to the

many shades of diseases that occur which range from the subclinical cases to those with severe manifestations. Also, diseases range from those with acute commencement (e.g. food poisoning) to those that are insidious (e.g. rheumatoid arthritis), those that are in carrier state but are still infectious (e.g. typhoid fever), where one causative organism causes more than one clinical manifestation (e.g. streptococcus), short course diseases and prolonged course disease, diseases without distinct normal and abnormal borderline (e.g. mental illness, diabetes and hypertension), etc. The opinion widely held is that an adequate definition of disease that will be acceptable to all players such as epidemiologist, sociologists and clinicians is yet to emerge.

3.3.2 Natural history of disease

Disease results from complex interaction between the individual and an agent which is the cause of the disease and the environment. The natural history of disease refers to the course or evolution of a disease in an individual without treatment from its pathological onset to its resolution which can be in form of complete recovery or disability or death. For instance, an untreated HIV infection begins with the seroconversion and progress to AIDS and may likely lead to death. In HIV infection this progression can take up to ten years or more to complete its course in the individual. Each disease has its own natural history, though many diseases show characteristic natural history but their time frame and their specific manifestations may vary from one individual to another.

Once the individual has sufficient exposure to the factor as to trigger off the disease process the natural history of disease commences in the susceptible host. Pathological changes which the individual is not aware of will begin to take place. This stage is known as the subclinical stage of the disease which extends from time of exposure to onset of symptoms and it is referred to as

the incubation period for the infectious diseases and the latency period for the chronic diseases. The incubation or latency period can last for just minutes as seen in toxic reaction or as long as many weeks as in hepatitis ‘A’ or even years as in leukemia. This variation that exist in the length of time it takes the disease to manifest among different individuals makes the general formulation of the natural history of disease arbitrary. As the inception of disease is a loosely expressed concept, the natural history is sometimes said to start at the moment of exposure to the causal agents.

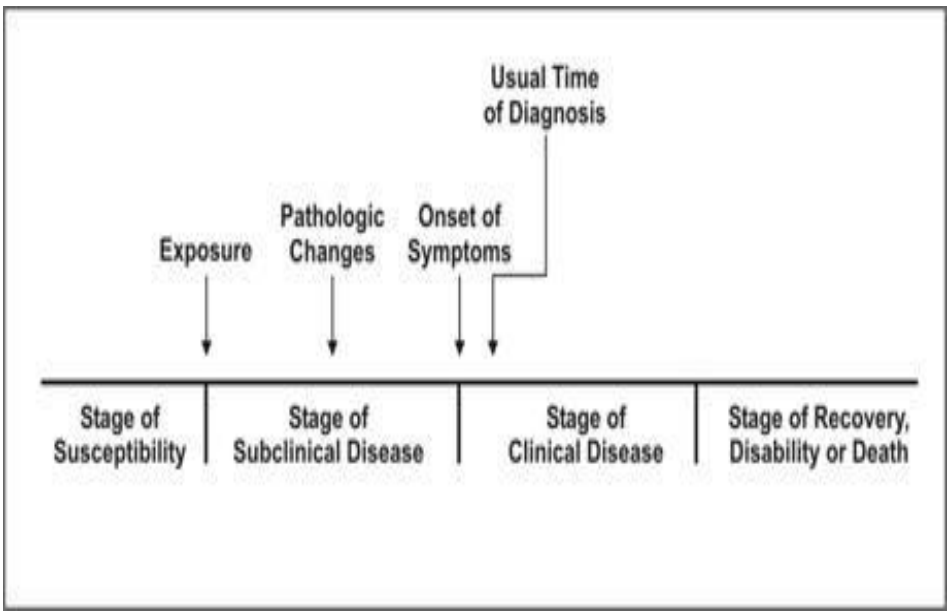

Fig. 1: Natural History of Disease Timeline
Source: Centers for Disease Control and Prevention (1992)

3.3.3 Disease control

Disease control is the ongoing operation to reduce the incidence, duration and risk of disease transmission, the effects of the infection including both physical and psychosocial complications and financial burden to the community. The focus of disease control activities is mainly on primary and

secondary prevention. Primary prevention are measures taken to prevent the disease from ever occurring. These measures are applied to a generally healthy population depicting that the measures should precede the disease e.g. immunization for the prevention of a disease that has not yet occurred.

Secondary prevention activities target early detection of the disease and the disease intervention activities e.g. screening for hypertension will enable the detection of the high-risk group or those at subclinical stage for early treatment, which will prevent heart attack or stroke. Furthermore, secondary prevention attempts to detect health problem at a stage when intervention may lead to its elimination or even its eradication. Disease agent can persists in the community at a level that it no longer poses public health problem because of the tolerance of the local population which is based on the equilibrium between the disease agent, host and the environment components of the disease process as seen with malaria control.

A disease can be eliminated and this occurs when there is interruption of the transmission of the disease. Similarly, a disease can be eradicated, which implies the termination of all transmission by extermination of the infectious agent. Eradication of disease is an absolute process that entails cessation of the disease globally, such as the case of small pox. At times there can be a re-emergence of a disease in a population years after it was last reported and believed to have been eliminated. Likewise, a new disease that has not been experienced in a population can emerge and it is referred to as emerging disease.

3.3.4 Changing pattern of disease

The pattern of disease changes from time to time and from region to region. There are some diseases that hitherto occurred in high income countries (HIC) but were not common in low and middle income countries (LMIC),

about less than a century ago. Today, there is increase in the occurrence these diseases in these societies which previously had very low occurrence e.g. the occurrence of cardiovascular diseases and cancers in LMIC. Most of the conditions were linked to the life style, occupation, environmental factors and other socio-economic factors operating in these countries. Social environment is a major determinant of health and disease patterns in any community.

The 19th century revolution in public health with its cornerstone as improvement in social and physical environment resulted in significant decrease in traditional health hazards in developed countries (Uutela & Tuomilehto, 1992). At the dawn of the 20th century three out of the ten leading causes of death in the developed world were infectious diseases but towards the close of that same century the pattern changed as there was a decline in infectious diseases in developed countries and there was emergence of new public health problems such as chronic diseases (coronary heart disease, cancer and road traffic injuries, etc.) (Park, 2009). This transition change is linked to changes in the social trends. The morbidity pattern in some developed countries has changed in recent years showing reduction in chronic diseases, a new trend which has been referred to as 'second revolution in public health' with remarkable increase in the occurrence of certain diseases/disorders such as mental disorders, Alzheimer's disease, chronic lung disease, social pathology linked to alcohol and drug abuse.

In a number of LMIC many people still suffer from those diseases that were taken care off by the 19th century public health revolution in HIC. The striking feature in the recent trend of disease occurrence seen in the LMIC, particularly in Sub-Saharan Africa is that there is a confluence of infectious diseases, chronic diseases and social pathology. The situation is attributed to

several factors such as; insufficient altering of the social environment to produce desired effect on health status, low socio-economic status, ageing populations, urbanization, adoption of western lifestyles, lack of political will, ignorance, poor funding of the health and education sectors.

3.4 CONCEPT OF ILLNESS

In illness situation the individual feels unwell with symptoms. Symptoms are subjective because it is the individual that feels unwell. This is why illness is referred to as the opposite of wellness. Armstrong (1980), identified some major problems with illness definition as reported in Jones (2003):

i) Symptoms that are very common or lasting for just few days, e.g. headache, muscle soreness, cut, cough and runny nose may not be considered serious enough as to seek treatment.

ii) Most symptoms are trivial and easily forgotten. Certain symptoms are short lived and the individual forgets that it even occurred, e.g. waking up with a headache that subsides in a very short while. Similarly, an individual may be used to a regular symptom which he/she has so adapted to, that it is no more a cause of concern to him/her except where the symptom becomes different from the usual experience.

iii) Severity or persistence of symptoms usually does not matter to the individual. In this case it is the meaning of the symptom rather than the symptom that is of concern to the individual. A sudden blurred vision may cause more worry than swelling from arthritis.

iv) The individual and symptom perception influence illness perception. The perception of meaning varies with the mood of the individual, the context of the symptoms, level of knowledge and

experience of the individual and coping strategies, among others. However, the way a symptom is explained may reduce its perceived seriousness.

3.5 ETIOLOGY OF DISEASE AND ILLNESS

Etiology of disease and illness refers to causes and origin of disease and illness. Etiology of disease and illness has been explained using different frameworks as presented below.

3.5.1 Medical Model

The medical model's explanation of the etiology of disease and illness is based on biological discontinuity. This is broadly classified into:

i) Intrinsic factors such as inherited, congenital, metabolic, etc.

ii) Extrinsic factors which can be inanimate (physical agent induced, temperature, radiation etc.) or animate (infections, pathogenic organisms, etc.)

iii) Idiopathic (unknown).

The above factors are vital but not considered sufficient etiology for diseases which led to the inclusion of other factors.

3.5.2 Cultural factors

Cultural factors affect behaviour of people and can contribute to disease causation because there is a relationship between culture and the interpretation or meaning given to a disease condition e.g. obesity is given different definitions in different cultures. The definition given to a condition will inform the perceptions held by the people towards that condition and by extension the actions that will be taken towards the condition.

3.5.3 Socio-Psychological factors

Origin of illness is also linked to various socio-psychological factors. The concept of psychosomatic illness was developed by people like Sigmund Freud, Harry Sullivan among others. Someone facing great pressure can develop biological disorder, for instance, stress can be the cause of peptic ulcer. Also, the family and the society can contribute to illness of a member through manipulative and oppressive actions.

3.6 CONCEPT OF DISEASE IN NIGERIA/AFRICA

In Nigeria as in other sub-Saharan African societies the cause of disease is explained along different beliefs such as:

i) Natural explanation to disease posits that disease can be as a result of natural factors such as heredity, environment and accidents. This concept aligns with the Medical Model of disease causation.

ii) Preternatural explanation to disease is based on the belief that disease is caused by factors beyond the natural or the normal events of life as seen in witchcraft and sorceries.

iii) Mystical explanation to disease is based on the context of the role played by ancestors and forces in the environment. It is believed that violation of rituals and the natural laws can lead to the invocation of ancestors who can respond by inflicting disease.

4.0 CONCLUSION

The concept of health has been expanded beyond the WHO's definition to fill the gap created by the difficulty in its operationalisation and measurement methods. Disease condition is based on pathological expression which is narrow and should therefore include subjective symptoms, rather than being based only the objective signs. It is pertinent to

note that disease and illness causation is multifactorial which is beyond just biological causes but includes the socio-psychological components.

5.0 SUMMARY

Health is a positive phenomenon associated with longevity, peace, sound mind, happiness and self-actualization. The definition of health by WHO is comprehensiveness though criticised for operationalisation and methodological problems. The environment where man lives and operates and the activities which man engage in on a daily basis impact on his health, either positively or negatively. Any deviation from the state of health is a threat to the wellbeing of the individual. Many factors therefore contribute to health and disease conditions and these factors can be biological, social, economic and environmental.

6.0 TUTOR-MARKED ASSIGNMENTS (TMAs)

1. Discuss in detail the social factors that contribute to health and disease in Nigeria.
2. Explain the natural history of disease.

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MODULE I: HEALTH AND DISEASE

UNIT 2: HUMAN BEHAVIOUR IN RELATION TO HEALTH AND ILLNESS

CONTENTS

1.0 INTRODUCTION

Understanding the behavioural accompaniments associated with changes at different stages of most disease progression is central to social medicine. These behaviours are actions, inactions and range of decisions exhibited by a person upon perception of symptoms and signs of disease, which include behaviours relating to seeking diagnosis and treatment. Ordinarily, the sequence is from health to the stage of asymptomatic disease susceptible to detection; symptomatic disease not yet diagnosed; manifestation of disease at the time of diagnosis; course of disease as influenced by treatment and the disease after therapy which could be cured, be in chronic state or lead to

death (Kasl, Cobb & Mich, 1966). The study of human behaviours in relation to health can be defined at four points along a continuum.

2.0 OBJECTIVES

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

i) Explain health behaviour
ii) Explain illness behaviour
iii) Health seeking behaviour
iv) Explain sick role behaviour

3.0 MAIN CONTENT

3.1 HEALTH BEHAVIOUR

Health behaviour is any activity that is undertaken by any individual believing himself/ herself to be healthy for the purpose of preventing disease or detecting it at an asymptomatic stage (Kasl et al., 1966). Health behaviours promote health and they include such activities as regular and appropriate exercise, adequate nutrition, adequate rest and sleep, disease screening exercises, regular medical checks and immunisation against certain diseases.

The pace at which health behaviour is carried out and also the emotional state of the individual while carrying out that behaviour are considered important, as well as the behaviour itself. The social and physical environment should be made conducive in order to support the health behaviour to occur and to be sustained. Behaviour becomes a habit when it is regularly practiced, and the practice becomes automatic. Some persons have tried to distinguish between health behaviour and risk reduction behaviour. Risk reduction behaviours are viewed as avoidance of unhealthy behaviours, like not smoking, moderation in alcohol intake and safe driving (Jones,

2003). Health behaviour and risk reduction behaviour are associated in terms of resulting to the overall wellbeing of the individual.

3.2 ILLNESS BEHAVIOUR

Illness behaviour consists of those actions taken by a person who feels unwell for the purpose of defining his state of health and discovering a suitable remedy (Kasl et al., 1966). A person who perceives that he is unwell will respond to that perceived disease process or impairment by taking certain actions such complaining to or consulting family and or friends or to health professionals for help. The decision to take action(s) or not to take any action in response to one's perception of illness can be self-initiated or influenced by other people, irrelevant of their level of knowledge of health issues. Some factors influencing illness behaviour include:

i) Search for relief or cure.

ii) Denial of illness status.

iii) Not all displays of illness behaviour are in response to the actual disease.

iv) Not all occurrences of disease are associated with illness behaviour.

v) It is a learned behaviour involving enculturation.

vi) It is related to what people make of their state of wellbeing and their response to signs and symptoms of disease.

vii) Varies among people of different socio-demographic, ethnic and economic groups.

viii) Specific illness behaviours are influenced by knowledge of disease and its symptoms, perception of severity of disease, perception of susceptibility of disease, perception of likelihood of amelioration of resultant impairment through some action.

3.3 HEALTH SEEKING BEHAVIOUR

Health seeking behaviour is defined as any action undertaken by an individual who perceive himself to have health problem or to be ill for the purpose of finding appropriate remedy (Ward, Mertens and Thomas, 1997). Health seeking behaviour is included in the illness behaviour.

Situational factors that influence health seeking behaviour include:

i) Economic factor (such as income and health care cost).
ii) Socio-demographic factor.
iii) Psychological factor.
iv) Organisational factor (such as service delivery system).
v) Cultural factor.

Other factors include:

i) The evolution of the illness episode.
ii) The individual's perception of his condition.
iii) The individual's response to each change that occurs in his condition.

People who belong to low income groups find it difficult to access health care services because of the high cost of health care. Drugs contribute remarkably to the cost of health care. In Nigeria 40 percent of the population lives below the poverty level. Many people in Nigeria cannot afford the cost of orthodox health care considering their meagre income. Geographical non-accessibility to the nearest health facility has posed great challenge to people in the rural and sub-urban areas in Nigeria. This includes poor road net-work, inaccessible roads, lack of transportation, high cost of transportation and long distances to travel. These challenges have increased patronage to unorthodox health care and even to quacks with the attendant problems.

Negative attitudes of some health workers have been implicated as contributing to the poor utilization of health facilities, as patients/clients are scared off and discouraged by this factor. Long waiting time and delays at

every stage of health service delivery pose concern as they are negatively associated with health service utilization opening other pathways to health other than the orthodox.

Gender affects health service use as women have been found to likely utilize health care facilities more than men. The reason for this difference in utilization of health clinics may be connected to the belief that females are more sensitive to discomfort, have more confidence in doctors and the society does not frown at women being expressive and dependent.

Perceptions of illness severity influence to a large extent the determination of choice of therapy, e.g. an individual is more likely to seek health care if he rates his health poorly. The rating or perception of seriousness may be subjective but still have basis in reality as the person compares his present disturbed condition with what it used to be in normal life situation. Social net-works of friends and relative equally influence decisions on when and where to seek care. This is a strong factor in Nigeria as well as in most African countries where family ties are very strong.

3.4 SICK ROLE BEHAVIOUR

Sick role behaviour is any activity undertaken by those who consider themselves ill, for the purpose of getting well, such as receiving treatment from appropriate therapist and a whole range of dependent behaviours that lead to some degree of neglect of one's usual duties. The sick role is conferred on a person, who after seeking competent health care is judged to be unwell. When in sick role, a person is usually exempted from many usual social obligations, but since illness is not a normal state of being the sick person is obliged to get well as soon as possible as that state is undesirable (Person, 1972).

Changes in the individual's capacity to carry out his normal social obligations as a result of being sick may not mean inability to perform customary duties either in part or totally, but adoption of a new role that supersedes others as sick role. There are two sets of expectation involved and they are; how the person in sick role is expected to behave and how other members of the society are expected to behave to the person in sick role. Therapeutic care is expected to reverse the disease process and return the person to his normal social role. Achievement of expectations demands some level of support, rewards and sanctions. Some critics feel that the sick role model is inappropriate for patients with chronic or psychological problems, since they cannot always achieve their former state of wellness. This informed the development of the concept of at-risk behaviour for those with chronic illnesses wherein the person takes those actions needed to maintain as high a level of health and function as possible and prevent crises, deterioration and death.

4.0 CONCLUSION

Certain behaviours when appropriately undertaken promote health and help prevent illness. Health and disease responses are socio-psychological presenting biological and behavioural changes. There are obligations and expectations required from the individuals who undergo any stage of disease which make them to occupy certain roles in the society. The society also expects that the individuals who are occupying any of these roles should take action that will return them to their normal social roles.

5.0 SUMMARY

There are behaviours that are socially expected from individuals in time of sickness and in time of health. A healthy person is expected to perform his social roles creditably. A person who perceives himself as being ill is expected to seek help through acceptable and established channels and if

confirmed ill he is placed on sick-role with certain expectations. A person in a sick-role is expected to take prescribed actions that will enable him get off the sick-role as soon as possible so as to continue with the performance of his social roles. There is a sequence of, from health to the stage of asymptomatic disease susceptible to detection; symptomatic disease not yet diagnosed; manifestation of disease at the time of diagnosis, then, the course of disease as influenced by treatment. An individual who receives therapy for his/her ill health should recover from his/her illness, but he may not recover as expected due to other complications which may even lead to death.

6.0 TUTOR-MARKED ASSIGNMENTS (TMAs)

1. State the major difference between illness behaviour and sick role behaviour.
2. State two behaviours expected from a person on sick role.
3. Enumerate three socio-economic factors that can adversely impact on seeking health care by an individual who perceive him/herself to be ill.

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MODULE I: HEALTH AND DISEASE

UNIT 3: SOCIAL EPIDEMIOLOGY

CONTENTS

1.0 INTRODUCTION

Social epidemiology is a subdivision of epidemiology which is the study of the distribution and determinants of health-related states and events in specified populations, and the application of this study to the control of

health problems (Last, 2001). Epidemiological information is needed for health and development planning. By identifying the risk factors of disease, the population at risk and incidence and prevalence of disease, epidemiology plays significant role in shaping policy decisions and evidence-based practice. It has been observed that people with different socio-economic and cultural characteristics respond differently to disease conditions. Naturally the question expected to be asked as a result of this observation is why this difference in individual responses to disease condition? One of the main and reliable ways to obtain the needed answer is through social epidemiological approach. Social epidemiology understands the role the social variables play in the determination of factors that influence health and illness.

2.0 OBJECTIVES

At the end of the end the unit, you should be able to:

i) Explain the meaning of social epidemiology
ii) Give brief history of social epidemiology
iii) State significant concepts of social epidemiology
iv) State the importance of social epidemiology
v) Explain approaches to study incidence and prevalence of disease
vi) Discuss research examples in social epidemiology

3.0 MAIN CONTENT

3.1 MEANING OF SOCIAL EPIDEMIOLOGY

Social epidemiology is the subdivision of epidemiology concerned with how social interactions and the combined activities of human beings influence health. Its focus is on the way social structures, institutions and relationships influence health (Berkman and Kawachi, 2014). The underlying assumption in social epidemiology is that the distribution of health and disease among members of any society is the reflection of the distribution of advantages and disadvantages in the society. The characteristics of the society that affect the

pattern of disease and health distribution and its mechanisms need to be understood because they influence individual and population health. Social epidemiology draws on methodologies and theoretical frameworks of other social science disciplines such as economics, medical anthropology, medical sociology, health psychology, medical geography and many domains of epidemiology. Social epidemiology has broadened the objectives of traditional epidemiology.

3.2 BRIEF HISTORY OF SOCIAL EPIDEMIOLOGY

Social epidemiology is saddled with the explanation of the effect of social factors on the health of the individual and that of the population. This concern has existed since the beginning of epidemiological history but the use of current epidemiological methods to address the issue is a relatively recent phenomenon. The earlier works reflecting social epidemiology were several investigations carried out at the beginning of the 19th century that were based on the idea that social conditions affect health.

In France, Villerme examined the differences in mortality between the poor and the affluent. He emphasized that improved schooling and working conditions would reduce disparities in mortality between the poor and the affluent. In Germany, Virchow reported the relationship between poor social conditions and the typhus epidemic in Upper Silesia. He speculated that unequal access to society's products was the fundamental cause of unequal distribution of diseases in the society and highlighted the central role of social conditions in population health.

In the middle of the 19th century, Chadwick reported that unsanitary soil, air, and water were major causes of diseases and promoted sanitation measures to improve the health of the poor (Tesh, 1998). At the end of the 19th century, germ theory came into fashion and germs were considered the

major cause of diseases. Epidemiological studies during this period shifted to identifying new germs that cause diseases and consequently, the idea that social conditions affect health was overshadowed at the period.

The early 20th century witnessed the flourishing of the idea that exposure to a single individual risk factor including germs was the cause of disease. With the rise in infectious diseases came the concept of "web of causation" which explained that disease is caused by exposure to multiple risk factors. Modern epidemiology has developed based upon this multi-factorial model. By the 1980s, several epidemiologists developed social epidemiology which underscores the importance of socio-structural factors on health of an individual as well as the population.

3.3 SIGNIFICANT CONCEPTS OF SOCIAL EPIDEMIOLOGY

Some significant concepts which apply to social epidemiology reported in literature include:

i) The bio-psychosocial paradigm.
ii) The population perspective.
iii) Use of new statistical approaches such as multilevel analysis.
iv) Significance of theory.

3.3.1 The bio-psychosocial paradigm

The bio-psychosocial paradigm is an important concept in social epidemiology which contrasts the biological paradigm which assumes that all diseases are biological phenomena and can be described fully in biological terms. It guides the views that a population is merely the sum of its individuals, and that the pattern of diseases in the population is simply a reflection of individual risk factors. Consequently, the social level factors cannot be considered as the "real" causes of diseases in the biological paradigm.

The bio-psychosocial paradigm of social epidemiology assumes that the biology of organisms is determined in multilevel, interactive environments. The bio-psychosocial paradigm assumes that diseases are products of mutual interaction among social factors, individual factors, and biological factors and that population is not merely the sum of its individuals, rather, every population has its own history and culture, which determine how and why people are exposed to specific individual risk factor. In social epidemiology, social factors can be risk factors of health by adding to or interacting with individual and biological factors.

3.3.2 Population perspective

Population perspective is another significant concept in the field of social epidemiology. In social epidemiology, an individual's risk of disease cannot be isolated from the disease risks of the population to which that individual belongs. To get a population perspective, a social epidemiologist will investigate:

i) Why the distribution of the social/biological factor is at a higher level within the population?

ii) What caused the difference in these distributions?

In order to answer these questions, it is crucial to consider the society as a whole. Asking why a population has a particular distribution of risk is different from the etiological question of why a particular individual got sick. Social epidemiology is particularly interested in the first question which has to do with distribution. Researchers in social epidemiology look for socio-structural factors that affect distributions of diseases and risk factors, and they propose measures to shift these distributions in the desired direction as a "population strategy". Population perspective and population strategy are essential to social epidemiology.

3.3.3 The use of new statistical approaches

The third important concept in the field of social epidemiology is the use of new statistical approaches, such as multilevel analysis, to determine the effects of socio-structural factors on health. Multilevel analysis allows several levels of analysis to be accounted for simultaneously and more effectively than in conventional multivariate analysis. Social epidemiology makes a distinction between compositional and contextual explanations of the effects of socio-structural factors on health. A compositional explanation asserts that a group includes different types of individuals, and that the differences among those individuals account for the observed differences. Multilevel modeling, which is a new statistical approach allows for the examination of the relative importance of individual and social factors or the interaction between individual and social factors which permits the several levels of analysis to be controlled simultaneously. This multilevel approach has been reported to allow epidemiologists to develop quantitative and structural analyses of social factors as they affect health, nevertheless social epidemiology does not require multilevel analysis in all cases. There are some cases in which other statistical approaches such as path analysis and ecological analysis are more appropriate than multilevel analysis.

3.3.4 The use of theory

The use of theory is another significant concept in social epidemiology. Social epidemiology uses theory to build hypotheses and interpret results. Social epidemiologists select variables in statistical models based upon a conceptual framework that indicates hierarchical relationships among factors and this conceptual framework is built upon theory. Consider this example reported in literature of a model of social class and congenital heart disease (CHD). The controlling for smoking implicitly assumes that social class has a direct effect on CHD independent of smoking. If a statistical association between social class and CHD disappears when smoking

behaviour is accounted for, the hypothesised theory will then show if the effect of social class on CHD is invalid or mediated by smoking behaviour. It is necessary to have conceptual clarity about the relationships between independent socio-structural factors, possible intervening variables and health outcomes.

3.4 IMPORTANCE OF EPIDEMIOLOGY

All aspects of human life are inextricably bound within the context of social relations and every conceivable epidemiological exposure is related to social factor (Chandola & Marmot, 2005). Some of the benefits of epidemiology include:

i) To ascertain the history of the disease in a particular population.
ii) To understand the pattern of a disease in a given population.
iii) To diagnose the health of the community and this is aided by the history collected.
iv) To determine effectiveness of health services showing areas of strength and weaknesses.
v) To ascertain the experiences of the various sub groups based on different variables so as to determine common problems and susceptibility levels.
vi) To ascertain perceived ways of solving identified health problems.
vii) To identify new diseases, disorders and syndromes in the community.
viii) To identify and link specific causes to health problem.

Social epidemiology emphasises the social distribution and the social determinants of health and their explicit analysis.

3.5 APPROACHES TO STUDY INCIDENCE AND PREVALENCE

There are various ways to achieve this:

i) Studying treated cases or known cases

This is health facility based and requires visiting the facility to know the people who report sick. This approach is easy and cheap in estimating number of people in the community who have the health problem but may not give accurate estimation because all concerned may not attend the facility. Some may engage in self-medication or access other pathways to health available to them. Also, some of the required records may be missing or manipulated rendering it unreliable.

ii) Community health survey

This approach targets both the treated and untreated cases in the community. When community health survey is employed the instrument for data collection is designed to capture wide range of factors such as socio-economic, demographic, illness behaviour, mental health status and medical test.

iii) Experimental Studies

Experimental studies in public health usually involve interventions at the individual and community levels. This is mostly employed when there is need to determine cause and effect and it is mostly quasi-experimental studies.

3.6 RESEARCH EXAMPLES IN SOCIAL EPIDEMIOLOGY

Honjo (2004) introduced two examples of social epidemiological research. The two examples are on social class and income distribution, however, income distribution and health is a relatively new concept in epidemiology unlike social class and health.

3.6.1 Social class and health

Studies on social class and health have identified disparities in health among different social classes. Some earlier studies assert that the relationship between health and social class cannot be fully explained by poverty. Examples of such theories that explain how health disparities are generated among social classes include:

3.6.1.1Social selection theory

This theory states that the health status of the individual determines his or her social class and not social class that determines the health status. According to this theory, the person with poor health is likely to belong to a low social class as poor health status will limit the chances of holding a job. This theory lacked evidence based support and contains some contradictions. Consider the following question; did people with respiratory problems become coal miners? Or, did coal miners get respiratory dysfunction from their work? It is more reasonable to think coal miners developed respiratory problems from their work, and several longitudinal studies have provided evidence of this (Hong, 2004).

3.6.1.2Socio-biological translation theory

This theory states that social class influences biological functions in many ways which consequently affect the health status e.g. the physical environments in which one lives and works are major pathways between social class and health. Health is affected by the physical environment because it can constitute source of exposure to carcinogens and other environmental hazard. It is assumed that the poor tend to live and work in more hazardous environments. Social environment can also affect health by:

i) Providing vulnerability to interpersonal aggression or violence to some persons.

ii) Providing access to social resources and support to some other persons.

iii) People in low social classes are more likely to live and work in unsafe neighbourhoods which provide higher chances of becoming victims of crimes, compared to people in high social class.

iv) People in low social class have limited access to social resources and social support when compared with those in high social class which offers comparatively more protection to the health of people in high social class when they are exposed to risk factors.

v) Socialization and experiences may differ among people in different social classes. Social experiences influence health by impacting on psychological development, ongoing mood, and cognition. Those in low social classes may exhibit more anxiety, anger, or depression than those in high social classes due to poor financial status.

vi) Those in low social class may have a more deteriorated health status due to a higher risk of coronary heart disease (CHD), accident, violence, or suicide when compared with those in high social class.

vii) Prevalence of chronic diseases is more among people of lower social class which can be as a result of their health behaviour. Health behaviours are socially patterned and many risky health behaviours which predispose to chronic diseases, such as smoking, physical inactivity, and dietary fat intake, are found more among persons in the lower social classes.

viii) Willingness to improve health behaviour can be marred by unfavourable social conditions. Comparatively people in low social classes face more barriers to behaviour change in their social conditions, resulting to differences in health status between classes.

3.6.1.3 Challenges faced by research in social class and health

i) Inexplicit model

The underlying model assumed in the research is often not explicit, making such research to be theoretically ungrounded and unclear, as to how social class affects health. The social class gradients can be seen as expressions of; differences in wealth and income, exposure to health-damaging physical environments, access to support and resources, and attainment of education and coping skills without often clear explanation of the assumed underlying model.

ii) Unavailability of valid and reliable measurements for social class

Having valid and reliable measurement for social class has equally posed a challenge. Explicit hypotheses are required to improve the measurement of social class and the aspects of social class that convey health risks. A great number of studies have shown a gradient effect of social class on health with the relationship between health and social class not fully explained by poverty. The effect of social class on health is not yet fully understood and this calls for more theoretically grounded researches that apply improved measurement of social class, for better understanding of the effect of social class on health.

3.6.2 Income distribution and health

The relationship between income and health is well established but income distribution and health is a relatively new area in social epidemiology. Examples of studies relating to income distribution and health which have been reported are; the relationship between the degree of household income inequality across the 50 U.S. states and state-level variation in age-adjusted total mortality rates (Kennedy et al., 1996), and the relationship between individual income, income distribution and self-rated health, conducted in Japan (Shibuya et al., 2002). This study reported that individual income has a

stronger association with self-rated health than income inequality at the prefecture level in Japan. Income distribution influences health through the following pathways:

3.6.2.1Underinvestment in human capital

Income inequality may lead to underinvestment in human capital. There is a significant correlation between the degree of income inequality and indicators of human capital (Kaplan et al., 1996). For instance, the result of the study showed that states with higher income inequality were found to spend smaller proportions of their state budgets on education resulting in lower educational outcomes. The divergence of interests of the rich from the poor is also a factor in income distribution which translates into human capital, e.g. the rich may lose interest in public education because they can educate their children privately but the poor may not be able to afford that. The greater the income gap is, the greater the disparity that will exist in interests.

3.6.2.2Disinvestment in social capital

Social capital refers to those features of social structures such as levels of interpersonal trust and norms of reciprocity and mutual aid, which act as resources for individuals and facilitate collective action. It is an ecological dimension of society, in contrast to concepts of social network or social support, which are individual characteristics (Kawachi et al., 2000). People living in states with high social capital are found to have higher self-rated health than those in states with low social capital. Unequal income distribution breeds conflicts among groups and erodes social solidarity. It also impairs individual health through violence, psychological anxiety, and concerns among members of the society, which is of disinvestment in social capital.

3.6.2.3Psychological process

Income inequality might produce ill health through a psychologically mediated effect of relative deprivation (Kawachi et al., 1994). Widening of income gap among people in a particular society may produce psychological frustration them through social comparison.

3.6.2.4Challenge faced by research in income distribution and health

The challenge on refining theories of income distribution lies in sorting out the confounding factors from mediating factors, which exist between income distribution and health. To tackle this challenge there is need to:

i) Identify the confounding factors which will help in determining the effect of income.
ii) Consider the appropriate geographical aggregation level where level of income distribution affect health. Is it at the country level, state level, or local government level? This calls for studies with multiple-level data on income distribution.
iii) Carryout time series analysis to understand time-trend in income distribution. Effect of income distribution on health is more than compositional effect (explaining the effect of income inequality based on concentration of poor people in an area with high income inequality), but includes evidence of contextual effect of income distribution on health.

4.0 CONCLUSION

Social epidemiology focuses particularly on the effects of social-structural factors on the state of health. The central and initial question posed by social epidemiology is, what are the effects of social factors, such as social

structure, culture, or environment, on individual and population health? Social epidemiology therefore plays crucial role by providing the required data upon which decisions concerning social, environmental, and political interventions are based.

5.0 SUMMARY

In this unit social epidemiology is explained as that branch of epidemiology which focuses on the way social factors such as structures, institutions, economic, political and their interplay affect the health of individuals and the population. Also, brief history of social epidemiology, significant concepts of social epidemiology, importance of social epidemiology, approaches to study incidence and prevalence and research examples are explained in this unit.

6.0 TUTOR-MARKED ASSIGNMENTS (TMAs)

1. Explain the distinguishing factors of social epidemiology based on its meaning.
2. Explain the research examples in social epidemiology.

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MODULE 2 PATHWAYS TO HEALTHCARE

Unit 1 Organisation and Delivery of Modern Healthcare in Nigeria

Unit 2 Healthcare Options

Unit 3 Factors Influencing Health Services Utilisation

UNIT 1: ORGANISATION AND DELIVERY OF MODERN HEALTHCARE IN NIGERIA

CONTENTS

1.0 INTRODUCTION

Health is a fundamental human right and as such the responsibility of the government to ensure that the people have and maintain good health. Healthcare has been defined as the services provided to individuals or communities by agents of health services or professions to promote, maintain, monitor or restore health (Last, 2001). Healthcare therefore comprises of both personal and non-personal health services while the agents of health services are all the health disciplines in the healthcare system. In Nigeria, the formal health system is modern in design and oriented towards the western style model. It was first introduced into the country by early European traders, later expanded by the colonial military and the early missionaries who came into the region for various purposes.

2.0 OBJECTIVES

i) At the end of this unit, you should be able to:
ii) Describe the organisation of healthcare system in Nigeria
iii) Explain the delivery of healthcare services in Nigeria
iv) Explain the components of healthcare system in Nigeria

v) Enumerate the common challenges facing healthcare system in Nigeria

vi) State the concept of universal health coverage

3.0 MAIN CONTENT

3.1 ORGANISATION OF HEALTHCARE SYSTEM IN NIGERIA

Organisation of healthcare system is the act of designing the administrative structure of the health system. The formal Nigerian or orthodox healthcare system is designed in line with the Western healthcare system. The orthodox healthcare services utilise conventional diagnostic and therapeutic techniques as found in the Western or modern healthcare. Nevertheless, in recent years, Nigeria has accorded some recognition to traditional healthcare but with notable reservation for the observed lack of desired level of openness from the traditional healthcare providers. The need to incorporate them into the Nigerian healthcare system has been an issue of long discourse which is welcomed by many stakeholders because of the remarkable patronage traditional medical care enjoys from the people. This mode of healthcare has been identified as a notable pathway to healthcare in Africa. Social factors influence the manner in which societies organise their resources to enable them cope with health hazards and the delivery of healthcare to their people. This underscores the influence of social factors in resource organisation for health in the society.

3.1.1 Elements of organisation of healthcare system

i) The health system is the management sector that delivers the health services.

ii) Health services are organised to meet the health needs of the entire population and not for selected groups.

iii) The health care system is vast and complex.

iv) Different stakeholders are involved in the organisation of health services, e.g. government at various levels, health agencies both governmental and non-governmental and communities.

3.1.2 Ownership of healthcare agencies

Healthcare agencies are those organizations that directly or through other organisations provide healthcare. Healthcare agency can be of public or private ownership. Ownership of healthcare agencies as it applies particularly in Nigeria are presented below:

i) Government agencies

These are official agencies that operate at various levels including international, national, state and local levels. These are publicly owned agencies and their functions are mandated by law and they are accountable to the government through appointed or elected Boards.

ii) Private agencies

These are non-governmental (privately owned or proprietary). They deliver services on the basis of fee-for-service. One-to-one relationship is usually maintained here. These agencies include those that run by private practitioners such as physicians, nurses etc., either in solo practice or in group practice. There are very few proprietary health services that are not for profit and even when not-for-profit they still generate revenue for operating cost.

iii) International non-governmental organisations

These are health agencies that are usually non-governmental organisations (NGOs), established and administered by private citizens as international organisations for some specific health related purposes. They can be run by

either groups of philanthropists, humanitarian organisations or civil societies. These may be health facilities such as hospitals and welfare agencies. These agencies exist often to respond to the health needs of the population especially those needs which are not addressed or not adequately served by government. The services of these organisations complement the national public health services. Sources of resources include voluntary contributions and fee for service. They are accountable only to their supporters. Examples of such organisations include foundations like the Carter Foundation and societies such as International Federation of Red Cross and Red Crescent Societies. In Nigeria, NGOs are extremely important contributors in the public health space.

3.1.3 Nigerian public health agencies

There are several public health agencies in Nigeria established by the federal government to safeguard the health of the people. They include:

i) Health Insurance Scheme (NHIS)

The National Health Insurance Scheme (NHIS) was established in Nigeria to improve the health of Nigerians at affordable cost. NHIS is a pre-payment plan that provides social health insurance from common pool of fund contributed by participants.

ii) National Institute for Pharmaceutical Research and Development (NIPRD)

NIPRD was established in Nigeria for the advancement of indigenous pharmaceutical research and development (R&D). It is charged with the function of enhancing development and commercialisation of pharmaceutical raw materials, drugs and biological products.

iii) National Agency for the Control of AIDS (NACA)

NACA is established to address the dearth of knowledge on HIV and AIDS in Nigeria. The agency is charged with the responsibility of facilitating all stakeholders involved in HIV and AIDS activities in Nigeria.

iv) National Agency for Food and Drug Administration and Control (NAFDAC)

The National Agency for Food and Drug Administration and Control regulates and controls the manufacture, importation, exportation, advertisement, distribution, sale and use of food, drugs, cosmetics, medical devices, chemicals and packaged water in Nigeria. NAFDAC checkmates illicit and counterfeit products.

v) Nigerian Primary Health Care Development Agency (NPHCDA)

The Nigerian Primary Health Care Agency was established in 1992 and was merged with the National Programme on Immunisation (NPI) in 2007. The agency advances the process of equitably improving the health and quality of life of the people of Nigeria. NPHCDA is the implementer of primary health care (PHC) in Nigeria.

vi) Nigerian Institute of Medical Research (NIMR)

The agency is set up to undertake basic, applied and operational research for promotion of national health and development in Nigeria. The agency undertakes researches on diseases of public health importance in Nigeria and also develop the structures for the dissemination of their research findings.

vii) Nigerian Centre for Disease Control (NCDC)

The Nigerian Centre for Disease Control is a national health agency which is saddled with the responsibility of ensuring preparedness, detection and

response to infectious disease out breaks and public health emergencies in the country.

3.2 DELIVERY OF HEALTHCARE SERVICES IN NIGERIA

This refers to the formal and non-formal activities employed in the provision of health services for any given population. The various ways by which health problems are responded to by a given society are intertwined in their culture, norms and values. The form and approach to healthcare delivery in any society are products of the prevailing social, political, cultural and economic factors in that society.

3.2.1 Elements of delivery of health services

i) Health care services are carried out by the healthcare delivery system.
ii) Health services are designed in line with the health needs of the population.
iii) Health services are influenced by the socio-economic situation of any country.
iv) The roles of health services vary amongst countries because of their varied socio-economic status.
v) Health services should use the available knowledge and resources to meet the health needs of the people.

3.2.2 Objectives of delivery of health services

Objectives of delivery of health services include the under-listed:

To;

i) Identify common endemic diseases in the community.
ii) Promote the prevention of diseases.
iii) Provide appropriate drugs required for the treatment of diseases.
iv) Train the needed personnel for healthcare delivery.

v) Ensure supply of adequate number of qualified and relevant personnel.

vi) Provide health care facilities.

vii) Guarantee equitable distribution of health facilities.

3.2.3 Types of health services

Health services are rendered to clients, patients, families, communities and populations. The types of health services rendered include such services as:

i) Restorative health service which addresses disease and illness care.

ii) Preventive health service with its focus on prevention of diseases and accidents.

iii) Promotive health service which aims at assisting people move close to optimal level of wellbeing or higher level of wellness.

iv) Rehabilitative healthcare aimed at restoring function and minimising disability.

Health service is delivered by the health team whose members are trained to provide the needed health services to those requiring them. Members of the health team include doctors, nurses, pharmacists, medical laboratory scientists and technologists, environmental health officers, nutritionists, social welfare officers, officers from allied sectors such as department of works, agriculture, transport, etc.

3.3 COMPONENTS OF HEALTHCARE DELIVERY SYSTEM IN NIGERIA

In Nigeria there are three levels or tiers of healthcare, which are the primary, secondary and tertiary levels. These levels are also referred to as components of healthcare delivery system in Nigeria.

3.3.1 Primary healthcare (PHC)

In Nigeria, PHC is the first tier of healthcare that is closest to the people. It caters for the healthcare needs of the majority of the population of all socio-economic profile in the community. On 12th September 1978 at the International conference held in Alma-Ata in the then USSR, the philosophical and practical underpinning of PHC were spelled out in the Alma-Ata Declaration. PHC was conceived as a means of addressing the high burden of health problems, inadequate health care and inequitable distribution of health resources among various countries. The health status of millions of people in the world, especially those in the low and middle income countries was found to be unacceptable because the people did not have access to adequate health care. This was evidenced by poor health indicators such as high infant, child and maternal mortality rates, poor child nutritional status, environmental degradation and in addition high poverty rates. PHC was then declared the strategy for the attainment of "Health for all by the year 2000". Primary Health Care was defined at the Alma-Ata Declaration as:

> PHC is essential health care based on practical scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and nation can afford to maintain at every stage of development in the spirit of self-reliance and self-determination. It forms an integral part of both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.

Nigeria started implementing PHC in 1986 and in 1987 the National Health Policy (NHP) was adopted which aimed at ensuring health for all Nigerians based on the national philosophy of social justice and equity which can only be achieved through PHC. In the year 2000, Nigeria's PHC system was revitalized by adopting the Ward Health System (WHS) because of the

observed sustainability gaps in PHC. The WHS is based on the notion that active involvement of community (mobilization and participation) will result in ownership which will bring about the desired sustainability. WHS provided a nationally acceptable targeted area of operation with clearly designed boundary, political representation and population. The former boundaries of health district are replaced with that of the electoral ward which elects a ‘councillor’ for the local government.

The position of PHC in relation to other levels of healthcare can be illustrated with an inverted cone as shown below. In the inverted cone below (Figure 1), PHC occupies the base and largest area on the cone, indicating that majority of the people seeking healthcare should access PHC. The provision and administration of PHC are statutory responsibilities of the local government in Nigeria. Primary healthcare facilities in Nigeria include; the health posts, health clinics, primary health centres and comprehensive health centres. At this first tier of healthcare, the scope of care to be provided to the population is as provided for by the Nigerian health policy

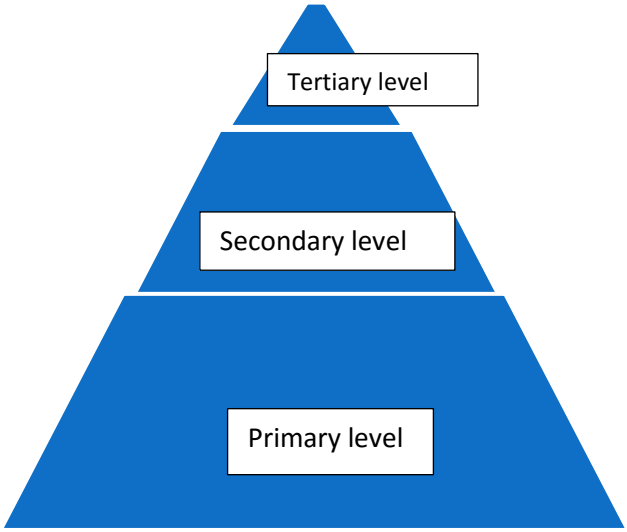

Fig. 2: Inverted cone showing relationship of the three levels of healthcare in Nigeria

3.3.2 Secondary healthcare

Secondary healthcare in Nigeria is also referred to as the secondary tier of healthcare. This level of care provides both general and specialized healthcare in the health facilities. Healthcare is provided by members of health team with different skills and specialization. Their different departments provide services to meet the healthcare needs of their patients/clients. Secondary healthcare is the level of care above the PHC (Figure 2) and the facilities at this level include the general hospitals and the specialist hospitals. Health conditions that are beyond the scope and competence of the workers at primary healthcare level are referred to the secondary level while the secondary level refers to the facilities in third level of healthcare. Provision and administration of secondary level healthcare are statutory responsibilities of the state government in Nigeria.

3.3.3 Tertiary healthcare

This is the apex healthcare delivery system in Nigeria. Tertiary healthcare services are provided by the teaching hospitals and the federal medical centres in various parts of Nigeria. The health care workers at this level are involved in researches, trainings and receive referrals from the secondary level healthcare system. The facilities are equipped for advanced level healthcare and their health personnel are specialists who render sophisticated, complex and expert medical and surgical interventions such as neuro surgery, cardiothoracic surgery, and management of complicated organ diseases among others. Provision of tertiary healthcare is the statutory responsibility of the federal government.

3.4 COMMON CHALLENGES FACING HEALTHCARE SYSTEM IN NIGERIA

Some of the challenges confronting the Nigeria healthcare system include:

i) Inadequate health manpower

Nigeria is yet to meet up with the recommended doctor-patient ratio, nurse-patient ratio and the situation is same with other health professionals such as pharmacists, physiotherapist etc. The deficiency in health manpower has been further exacerbated by the increasing rates of brain drain that occurred in the recent past, when health professionals from Nigeria migrated to the high oncome countries of world as a result of harsh economic conditions experienced in the country.

ii) Maldistribution of available of existing health manpower

Bulk of the health professionals want to stay and work in the urban areas consequently the facilities in the rural and sub-urban areas have fewer skilled

manpower. Maldistribution of health professionals limits access to the needed healthcare services by the affected population. Furthermore, there is maldistribution of health facilities in the country. Hospitals and other healthcare agencies are concentrated in the urban areas without due consideration for those residing in the rural areas.

iii) **Inadequate health facilities**

This has to do with either the quantity or quality of available health facilities across the country. In some areas of the country there are inadequate numbers of health facilities or none at all. People travel several kilometers, at times by foot to access modern healthcare service. Where the facilities exist, some are not adequately equipped, or they lack the required manpower to deliver services to the people. There is generally an absence of trained technical personnel capable of repairing medical equipment and this compounds the poor maintenance culture occasioning abandoning and dumping of broken-down equipment and infrastructures.

iv) Poor financial and organisational resources

Adequate resources are not channeled to the health sector in Nigeria, as evidenced by the percentage of annual national budget allocated to the health sector which for many years is far below the WHO recommendation, thus resulting in the deterioration of the healthcare infrastructure. Factors responsible for this include; poor resource base, corruption, insensitivity and poor organisational competence that exploit existing potentials.

v) High prevalence of preventable diseases

Prevalence of preventable and communicable and non-communicable diseases such as malaria, typhoid fever, meningitis, HIV infection, lower

respiratory tract infections, malnutrition, is still high. This overwhelms the healthcare resources as personnel, time and materials are unduly expended to manage the preventable conditions. Some of these conditions emanate from ignorance, poor environmental conditions, indulging in health risk behaviours and lack of access to preventive healthcare services.

vi) Delay in seeking healthcare

The tendency of seeking healthcare service late is high and this can be attributed to illness behaviour, perception of cause of illness, poverty, inaccessibility of health facility among other social hindrances. Also, attitude of health workers has been listed as one of the factors discouraging people from accessing healthcare from public health facilities.

3.5 UNIVERSAL HEALTH COVERAGE (UHC)

Universal Health Coverage (UHC) was conceived as a global response to the following existing situations:

i) At least half of the world's populations still do not have full coverage of essential health services.

ii) About 100 million people are still being pushed into extreme poverty (defined as living on 1.90 USD or less a day) because they have to pay for health care.

iii) Over 800 million people (almost 12% of the world's population) spent at least 10% of their household budgets to pay for health care.

Universal health coverage ensures that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship

(WHO, 2019). Three objectives are embodied in the above definition which are:

i) Equity in access to health services, meaning that everyone who needs health services should be able to get them and not only those who can pay for them.
ii) The quality of health services should be good enough to improve the health of those receiving services.
iii) People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

The United Nations Sustainable Development Solutions Network (UNSDSN) advocates universal health coverage (UHC) and pro-health policies in all sectors, for maximization of health and well-being for all ages (UNSDSN, 2014). All United Nations (UN) member states agreed to achieve UHC by the year 2030, as part of the Sustainable Development Goals (WHO, 2019). UHC has become a major goal for health reform in many countries and a priority objective of World Health Organisation. Nigeria is reported to have shown commitment to achieving UHC, with the National Health Insurance Scheme (NHIS) as their main strategic mechanism. The concern about NHIS is the low coverage (how many Nigerian are covered by NHIS?).

4.0 CONCLUSION

The Nigerian formal healthcare system is based on orthodox western style of healthcare system. Access to healthcare is largely influenced by social and economic factors as well as existing policies in the country. The health status of millions of people in Nigeria, as in other low and middle income countries is unacceptable. Universal Health Coverage and Primary Health Care approach to health and health care delivery is to address this high magnitude

of health problems, inadequate cares and inequitable distribution of health resources. For the healthcare system to function well as desired there must be adequate funding, skilled health personnel of various specialties distributed equitably and the crucial organisational competence must be available.

5.0 SUMMARY

In this unit, the organization and delivery of healthcare in Nigeria, the components of healthcare system and the common challenges facing healthcare system in Nigeria are explained. The formal health system in Nigeria is designed in line with the orthodox care of the colonial masters. The Primary Health Care is the bed rock of the health system in Nigeria and should be the first port of call for the people seeking healthcare. Sustainability of Primary Health Care System lies on the full participation of the people. The other levels of health care are the primary and secondary levels. These levels differ in their level of operation and there should be two-way referral system.

6.0 TUTOR-MARKED ASSIGNMENTS (TMAs)

1. Explain the component of the healthcare system in Nigeria.
2. Enumerate the common challenges facing the healthcare system in Nigeria and suggest ways to overcome the stated challenges.

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MODULE 2: PATHWAYS TO HEALTHCARE

UNIT 2: HEALTHCARE OPTIONS

CONTENTS

1.0 INTRODUCTION

Globally, not everyone who is sick or who needs healthcare seeks orthodox care by going to the formal health facilities. For various reasons ranging from social, economic, cultural, environmental, political, and accessibility, some people prefer to seek treatment elsewhere other than the orthodox. Such other pathways to seeking healthcare include the complementary and alternative medicine/healthcare and traditional medicine. Some forms of this option are considered in this unit.

2.0 OBJECTIVES

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

i) Explain complementary and alternative medicine/healthcare
ii) Discuss some types of complementary and alternative medicine/healthcare practices
iii) Discuss traditional medicine/healthcare in Nigeria
iv) State reasons why people prefer traditional medicine in Nigeria

3.0 MAIN CONTENTS

3.1 COMPLEMENTARY AND ALTERNATIVE HEALTHCARE

3.1.1 Complementary healthcare

Complementary medicine/healthcare employs diagnostic or therapeutic methods that are outside the mainstream of western or orthodox medicine/health care. It gained its name from the fact that its practices can be performed alongside conventional medicine. Its main characteristics include:

i) It employs diagnostic and therapeutic techniques that are non-conventional or non-orthodox (outside the mainstream of western medicine)

ii) It uses non-traditional methods.

iii) It is used along conventional medicine.

3.1.2 Alternative healthcare

Alternative medicine/healthcare like the complementary medicine/healthcare uses diagnostic or therapeutic methods that are outside the mainstream of western medicine or healthcare. However, the main difference between complementary medicine/healthcare and alternative medicine/healthcare practice is that, while complementary medicine/healthcare can go alongside western or conventional medicine/healthcare, alternative medicine/healthcare cannot.

3.2 TYPES OF COMPLEMENTARY AND ALTERNATIVE HEALTHCARE PRACTICES

3.2.1 Acupuncture

This is a Chinese indigenous traditional medicine in which solid metallic needles are pushed into the skin with hands or electrical stimulation. This practice sees the body as a delicate balance of two opposing but inseparable forces referred to as *Yin* and *Yang*. It is believed that where there is no balance between the two forces disease results. Therefore the balance of the forces is created by pushing pins into designated points in the skin. Yin is the cold, slow or passive principle, while Yang is the hot, excited or active principle.

3.2.2 Massage

This involves rubbing and moving the muscles and the soft tissues of the body using the hands and the fingers. The essence of this practice is to increase blood and oxygen supply to the specific area of the body. The

increased blood supply causes the relaxation of the tensed muscles and nerves relieving aches, pains and tension.

3.2.3 Acupressure

This practice combines acupuncture and massage. It is often termed acupuncture without needles. The fingers (thumb) or knuckles are used to apply gentle but firm pressure on the designated points.

3.2.4 Osteopathy

The major focus of osteopathy is orthopaedic and rheumatic disorders. It is based on the principle that diseases are chiefly as a result of loss of structural integrity which can be restored by manipulation. In osteopathy the dysfunctional structure is restored through physical manipulation and hence health is restored.

3.2.5 Chiro-practice

The focus of chiro-practice is to align the spine or any other part of the body that has lost alignment causing pain to the individual. The notion is that the relationship of the spine with the nervous system affects health and so the loss of proper alignment of this or any part of the body is believed to cause dysfunction and body pain. The chiropractor does this alignment thereby relieving pain and improving body function.

3.2.6 Aromatherapy

This practice uses the application of essential oils from plants and other aromatic compounds to alter the mind, mood and cognitive functions for health. It is applied in situations where there is need for reduction of pain and anxiety; need for enhancement of energy and memory; and need for

relaxation. Some school of thought is of the opinion that the aroma influences the brain through the olfactory system. The essential oils equally exert positive effect on the individual producing feeling of wellbeing.

3.2.7 Phyto-medicine

This is the use of herbs with therapeutic properties for the treatment of diseases and other health conditions. It is the practice of herbalism (preparation of herbal drugs) and has always been with humanity. Herbalism is traditional medical practice but in modern times botanical remedies are explored and turned into drugs for the treatment of various illnesses.

3.3 TRADITIONAL HEALTHCARE IN NIGERIA

Traditional healthcare is the healthcare service that is long established, part of the custom and indigenous to a particular group of people. The practitioners operate outside the conventional or orthodox health practice. The traditional healers and their practice differ from locality to locality but exist across Nigeria. Traditional healthcare is patronised by a reasonable number of people in Nigeria for various reasons.

Traditional healthcare/medicine in Nigeria has been criticised for lacking theoretical framework and for lack of scientific explanation. The therapies are also said to lack standardisation, while some people argue that it emphasises herbs, psychical and magical methods which lack scientific proof. Conversely, other school of thought supports traditional medicine in the country and argues that it is patronised by both educated and uneducated, people of different religious beliefs and social standing, particularly when they are faced with health challenges that defy modern medicine. There is need to encourage the good aspects of this practice and discourage the negative aspects of the practice. The Nigerian government in recognition of the role of traditional medicine in this society has put efforts in place to

maintain and encourage the growth and development of its practice in the country by constituting the coordination, control and promotion of research in traditional remedies. The government's efforts in this area include; incorporating traditional medicine into the National Drug Policy; there is a section in National Pharmacopoeia for traditional medicine; National Agency for Food and Drug Administration and Control (NAFDAC) is mandated to regulate and guide the use and distribution of herbal medicine to ensure quality (safety and efficacy).The practice of traditional medicine/healthcare in Nigeria can be broadly classified into the following categories as presented below:

3.3.1 Indigenous traditional healthcare

This is the type of healthcare that is traditionally practiced by the people and it is original or native to the particular society or culture. It can be adopted by another society or culture in which case it is a traditional healthcare practice but not indigenous to this society which adopted the practice. Medicinal preparation can contain any or combinations of herbs, roots, animal parts, alcohol and water. At times symbolic rituals such as incantations and sacrifices are performed to achieve or bring about the desired cure. Some of them rely on traditional myths and beliefs while others do not. Among the indigenous traditional healers are:

i) The herbalist

These are general practitioners who are inclined to treating ailments. Their medicine are usually concussions made from herbs, roots or combinations.

ii) Traditional bone-setters

They are the traditional orthopaedic doctors who set fractured bones of the body. Some apply only local preparations and immobilisation of the affected

part to heal, while others combine the local application with oral preparations and even rituals.

iii) Traditional psychiatrists

They attend to those with psychological and mental disorders. They employ different techniques and remedies including restraints, flogging, incantation and herbal preparations as therapy.

iv) Diviners

This category of traditional healers specializes in divination. They include fortune tellers, seers and forecasters. They see beyond the physical into the future and by so doing can make diagnosis or predict cause of illness or misfortune and equally prescribe the remedy.

v) Traditional midwives

Traditional midwives are also referred to as traditional birth attendants (TBAs). They attend to pregnant women and see them through childbirth. Due to lack of skilled manpower to attend to pregnant women, the Nigerian government has severally organised trainings for the TBAs to build their capacity to effectively perform their tasks pending when there will be adequate number of trained midwives to render the services in the country.

3.3.2 Faith healers

They exist both in the Christian faith and Islam. Their faith and healing activities are based on the Bible and Koran respectively. Prominent sects in Christendom that practice faith healing include; the Pentecostals, Celestial Church, Cherubim and Seraphim, among others. In faith healing, the

common belief is that certain illnesses have spiritual cause(s) such as evil projections, demon possession, activities of witches and wizards etc. and therefore will respond favourably to 'spiritual remedies' (e.g. healing prayers, casting out demons/deliverance, administration of holy oil and holy water). Prophesies and visions are often associated with faith healing.

3.3.3 Syncretic healthcare

This has to do with the situation where there is combination of different healthcare beliefs which may not necessarily agree, for instance, it is not uncommon to find someone accessing healthcare both from the faith healer as well as from the orthodox care provider simultaneously. At times even while on hospital admission the patient's relatives bring in remedies from unorthodox source such as from faith healers or indigenous healthcare provider which they administer to the patient without the knowledge of the health staff in the hospital. Others oscillate from one form of healthcare to the other, as they switch from traditional healer to hospital and wait for hospital discharge to swing back to the traditional healer. Syncretism is also practiced by those churches who practice exorcisms, psychotherapy and the administration of herbal drugs etc.

3.4 WHY PEOPLE PREFER TRADITIONAL MEDICINE/HEALTHCARE IN NIGERIA

Several factors propel people to seek the services of traditional healers and these include:

i) Concept of illness

Those who believe that illness emanates from magical or religious origin think the traditional healer will understand their problems better and they have the confidence that the traditional healer will correctly address their problem.

ii) Availability and accessibility of care

Traditional healers are available and easily accessible to their clients when compared with the modern healthcare providers. This can be viewed in terms of distance, waiting time, availability and attitudes of healthcare workers and even the affordability of service.

iii) Exhibition of familiar skills

Skills exhibited and procedures applied in rendering care by traditional healers are familiar to the people and easier to handle when compared with complicated and complex methods of diagnosis and treatment found in modern healthcare service such as in the hospitals. The recipients of traditional healthcare services are at home with their traditional healthcare providers.

4.0 CONCLUSION

There are other options to seeking healthcare other than the orthodox healthcare system. Choice of pathway to health is influenced by several factors related to the social, economic, religious, accessibility of care among others. Complementary and alternative medicine is of various forms and in the broad sense includes the traditional medicine. Societies have their indigenous traditional medicine but over the years some of such practices have been exported to other societies where they form part of their treatment/healthcare options.

5.0 SUMMARY

Complementary and alternative medicine (CAM) as health care option were discussed in this unit. There are various forms of CAM and traditional medicine being practiced in Nigeria. Some are indigenous while others originated from other cultures. Some of the practices can be performed

alongside conventional practices and are referred to as complementary healthcare, while some cannot be practiced alongside the conventional practice and hence referred to as alternative healthcare. Traditional medicine/healthcare that is indigenous to the people has always been with them before the introduction of the other types of care that are ‘imported’. Interestingly, all the available types of healthcare in the society enjoy the patronage of some people.

6.0 TUTOR MARKED ASSIGNMENTS (TMAs)

1. Explain the various types of CAM.
2. State the rationale for traditional healing in Nigeria.

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MODULE 2: PATHWAYS TO HEALTHCARE

UNIT 3: FACTORS INFLUENCING HEALTH SERVICE UTILISATION

CONTENTS

1.0 INTRODUCTION

Utilisation of healthcare services by people is a function of several factors which span across social and cultural factors. Other factors include what the people who are considering use of healthcare service perceive as benefit of that action when compared to the cost that will be incurred. Accessibility is not viewed only on the grounds of location and ease of reach but also in terms of economic accessibility, which is determined by economic power, which is the ability to pay for services especially in societies where cost of care is not subsidised in any form. Even in situations where healthcare is accessed, compliance to treatment regime is found to be equally important for a successful treatment outcome.

2.0 OBJECTIVES

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

i) Explain the socio-cultural factors influencing utilisation
ii) Explain perception of benefit and quality of care
iii) Discuss factors that influence compliance with health professionals' orders

3.0 MAIN CONTENT

3.1 SOCIO-CULTURAL FACTORS

Socio-cultural factors primarily influence decision-making on whether to seek or not to seek care. Even when an individual is motivated to use a particular health service, the person may be unable to do so due to some socio-cultural factors which are highlighted below.

3.1.1 Education

Education empowers an individual with increased knowledge and the right attitudes towards health, resulting in the acceptability of modern health services and positive perception towards the healthcare system. Education

equally brings about economic empowerment and better control of financial resources within the family as well as more decision-making power, increased self-confidence and ability to demand adequate service. Education enables an individual or family to take informed decision on healthcare utilisation and execute such decision without interferences. Understanding the medical culture will limit undue expectations and consequent complaints and discontinuation of use.

3.1.2 Income

Income is an economic factor which determines financial capability to offset costs of healthcare service. Affordability of healthcare service is the ability to pay for needed services which obviously determine the possibility of health service utilisation. Variables of income include education and occupation. Higher level of education is associated with occupation that will create opportunity for higher wage and access to peculiar social and economic benefits including health insurance benefits to leverage upon when seeking healthcare. Poverty plays a critical role in accessing healthcare, poor people tend to use non-formal sources of health care such as patent medicine dealers and health clinics owned by unqualified health professionals with whom they can negotiate the expenditure on medications and other services.

3.1.3 Gender Roles

In patriarchal societies marital status can influence a woman's decision on where to seek healthcare for instance a woman in marriage in most societies will be mindful of the choice or interest of her husband on where to access healthcare for herself or her children. This is more in African societies where a woman is expected to be under the authority of the husband. Most women in Africa are dependent on their husband financially as they are not financially self-sufficient or economically stable. The popular saying that he who pays the piper dictates the tune perfectly fits into this assertion. Single

or divorced women may be poorer but they enjoy greater autonomy than those who currently are in marriage and so can pursue their impulse without interferences. Young single mothers will have intrusions from natal family on where to seek maternity care for the singular reason that her family is responsible for procuring the required health services. This scenario is different in the case of men who are their own 'masters' with high level of autonomy and most times more financially stable than the wives. They are able to take decisions on where to obtain healthcare without interferences and they go ahead and effect their decision.

3.1.4 Religion and traditional beliefs

Religion and traditional beliefs are often considered as markers of cultural background and values when it comes to healthcare utilisation. Some religious groups such as the Apostolic Faith and Faith Tabernacle sect do not utilise any form of healthcare service apart from prayers for healing. Furthermore, pregnant women do not attend any health clinic for ante-natal care and delivery. They consider those who utilise healthcare services as not having adequate faith in the healing power of Jesus Christ. Similarly, there are diseases believed by the adherents of the African Traditional Religion to be caused by supernatural powers and therefore such disease will not respond to medical treatment. The African traditionalists believe that such health issues can only be managed with spiritual methods such as incantations and by appeasing the gods, particularly if the sufferer has engaged in any culturally abominable act. Apart from religion, traditionally in the African context, certain diseases have cultural connotation and the people believe that such diseases fall outside the zone of orthodox medical care and as such do not respond to orthodox treatment regimen, e.g. stroke, measles, convulsions, etc. Those with such complaints and manifestation are discouraged from utilising modern healthcare services.

3.1.5 Geographic accessibility

Geographical accessibility involves accessible distance in a reasonable time, available means of transportation, affordable means of transportation and ease of movement such as having less obstacles on the road. Geographical accessibility increases the possibility of people utilising the healthcare service while barriers to reaching care will discourage people from seeking such healthcare service.

3.2 PERCEPTION OF BENEFIT AND QUALITY OF CARE

Perception of care in this context is two pronged; the perception of the benefit of the care or the need for the care and the quality of care. How the individual perceives the benefit or the need to utilise healthcare services contributes to the possibility of healthcare utilisation. If there is no perceived seriousness of the disease the person will not see any need for accessing healthcare. Also, if there is no perceived benefit from utilising the healthcare or if the cost is perceived as out weighing the benefit then the likely action will be to refrain from accessing that healthcare. Likewise, if there is no perceived quality of healthcare, utilisation of that healthcare service will be hampered. Perception of quality can be based on the individual's previous experience with the health system, staff friendliness, availability of supplies and waiting time among others.

Perception may or may not represent the reality but may in part overlap with the reality. Whichever way, perception exerts influence on healthcare seeking and utilisation of healthcare services. Perception affects decision to seek healthcare service or to discontinue medical treatment and leverage access to relevant information. The common saying 'information is power' is apt here. Information can be accessed through different media such as radio, television, information booklets, internet, family and friends. Available information can shape perception and inform decision on health service

utilisation.

3.3 FACTORS THAT INFLUENCE COMPLIANCE WITH HEALTH PROFESSIONALS' ORDERS

Certain persons who visit the hospital for treatment comply with the management orders of the health professionals, while others do not. Some of the factors responsible for compliance or non-compliance are sociological factors which play important role in the outcome of treatment, and a number of them are considered below:

3.3.1 Personal characteristics

This is an important factor in compliance with health professionals' orders. Persons of different gender for instance, have been found to respond differently in compliance to doctor's order. Studies have shown that males are more likely to comply than female patients. Also, age of the individual is another factor as some studies reported that older people comply more than younger people with doctor's orders.

3.3.2 Nature of illness

The nature of illness plays a role on how much the patient complies with medical orders. Some illnesses persist for a short time (acute) while others persist for a long time (chronic). Those with long term illness who receive adequate explanation of their illness comply more. Similarly, people with episodic illness are found to comply more. Those with psychiatric problems are not likely to comply as they will not want to be associated with such conditions.

3.3.3 Nature of treatment

The nature of treatment in terms of compliance ease is a factor in the person's compliance to doctor's order. The more complex the therapeutic regime is the more difficult it is for the patient to comply with. For instance,

if the regimen requires taking several pills several times in a day, it may be difficult to comply with that.

3.3.4 Familial network

Strong family network has positive influence on compliance to doctor's order while weak family network produces contrary effect. Patients from integrated family get support from family members when sick especially at the onset of disease which aids compliance to treatment regimen.

3.3.5 Relationship between health worker and client

The health workers and their clients are the principal actors regarding this factor. At the onset of this relationship which is when the client/patient reports to hospital for care, both parties will be quite enthusiastic of the relationship. Nonetheless, the situation may not linger as such till the end. Patients have at times left disappointed, feeling unsatisfied, not accepted or not supported by the health workers. This kind of impression affects compliance adversely, while support from the workers will increase the tendency for the patient to comply with medical instructions.

4.0 CONCLUSION

Adequate knowledge, positive attitude and positive perception of the healthcare delivery system in relation to services offered, the members of staff that offer the services, their attitude and disposition towards their clients influence utilisation of the healthcare system. People access healthcare where they feel welcomed, understood and are respected as humans with worth.

5.0 SUMMARY

Factors that influence healthcare utilisation are numerous. Some that are of interest and discussed in this unit are; the socio-cultural factors which

include education, income, marital status, religion/traditional beliefs, geographic accessibility, perception of benefit and quality of care. Beyond accessing healthcare, the ability to comply with the order of healthcare providers remains paramount to treatment outcome. Several factors influence client's compliance behaviour which range from personal characteristics to nature of illness, nature of treatment, familial network and relationship between health worker and client.

6.0 TUTOR-MARKED ASSIGNMENTS (TMAs)

It has been observed that there is poor utilisation of a community health centre in your community. Discuss:

i) Likely reasons for the poor health care utilisation in Nigeria.

ii) What can be done to improve the current utilisation level?

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MODULE 3 MARGINALITY AND MENTAL DISORDER

Unit 1 Behavioural Maladjustment

Unit 2 HIV and AIDS

Unit 3 Sexual Violence

UNIT 1: BEHAVIOURAL MALADJUSTMENT

CONTENTS

7.0 References/ Further Readings

1.0 INTRODUCTION

Some individuals fail to cope with the demands of normal social environment. Disordered behaviour is a social construct and expectations and norms differ across ethnic and cultural groups. Maladjustment is a term used in the field of Psychology to describe the inability of an individual to react successfully and satisfactorily to the demand of his/her environment. Maladjusted behaviour can be frequent or habitual, ultimately harmful to the individual, environment, or other persons, and impedes adaptation and healthy development. Often, it occurs during early stages of childhood, when the child is in the process of learning methods to solve problem that occurs in interpersonal relationship in their social network. Measuring and interpreting disordered behaviour across time and settings is difficult, for instance how long will a student engage in a particular behaviour before that behaviour is considered as maladjusted?

2.0 OBJECTIVES

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

i) Explain the concept of behavioural maladjustment
ii) Enumerate the characteristics of a maladjusted individual
iii) Explain causes of behavioural maladjustment
iv) Discuss problems of behavioural maladjustment in children

3.0 MAIN CONTENTS

3.1 CONCEPT OF BEHAVIOURAL MALADJUSTMENT

Maladjustment is the inability of an individual to successfully and satisfactorily adapt to the demand of his environment, which may result in the disturbance of psycho-equilibrium. Maladjustment is a phenomenon with many dimensions. It covers a wide range of issues such as social, biological and psychological conditions that can be intrinsic or extrinsic. Intrinsic

means that it is innate or inherent. Intrinsic maladjustment occurs when there is no agreement between an individual's needs, motivations and evaluations, and what actually exist as recompense for the undertakings. The term extrinsic relates to outward or external and extrinsic maladjustment refers to a condition where the individual's behaviour is incongruent with the cultural or social expectation of the society where he belongs. Maladjusted behaviour is habitual in pattern and detrimental to the individual, other persons and the environment and impedes adaptation and healthy development. Maladjustment is often found in children and prompt intervention devoid of exclusion is required once it is observed to assist the individual.

Maladjustment oftentimes is conceived as a failure of an individual to meet the demands of the society or failure to cope with problems and social relationships which manifests in emotional instability. Often, maladjustment emerges during early stages of childhood, when a child is in the process of learning methods to solve problem that occurs in interpersonal relationship in their social network. A maladjusted person has development and interpersonal relationship challenges which if neglected may have adverse consequences.

3.2 CHARACTERISTICS OF A MALADJUSTED PERSON

An individual with maladjusted behaviour exhibits the following characteristics (EduGyan, 2017):

i) **Withdrawn and timid**

The individual does not like being in company of people and can be described as being inhibited or solitary. Persons who are maladjusted exhibit frequent withdrawals from situations that seem difficult to them. Their

inability to face challenging situations may result in their seemingly presenting as timid and weak when such situations arise.

ii) **Shy and self-conscious**

A person who is shy will look nervous, which is associated with self-consciousness. The individual is concerned about the impression of other people about him/her. Impression can often be based on negative evaluation. A shy person has low self-esteem and tends to anticipate adversities. He/she often keeps silent and avoid eye contact.

iii) **Fearful**

Fear is a strong emotion which involves the perception of danger and unpleasant agitation. A fearful person dreads certain situations and often exhibits phobia for certain things such as being in company of certain group of people, being alone in a room, fear of dogs, strange noises, the dark, etc.

iv) **Anxi**ety

Anxiety is a personality trait that is associated with nervousness and worry. It results from conflict situations which are inevitable in life. Anxiety describes an individual's level of emotionality which is inferred as it cannot be directly observed but can be measured through psychological tests/techniques.

v) **Delusion**

Delusion has to do with misconceptions and misbeliefs. It is an irrational and obstinate belief which the individual actively defends. Such misconceptions can be of wide range, for instance an individual may believe he is what he is actually not, such as believing he is a very rich person when he is actually a

poor person. This misbelief will hence inform his attitude and behaviour which will be incongruent with societal expectation of him.

vi) **Extreme aggressiveness**

Aggressiveness is linked to enterprising or energetic behaviour. Aggressive people exhibit domineering tendencies in any endeavour or group they find themselves. In situations which do not favour the exhibition of this tendency, such an aggressive person will channel that energy to other unconnected objects which is commonly referred to as misplaced aggression.

vii) **Tension**

Tension is associate with worry and nervousness. A tensed person lack inner freedom which can affect physical health adversely.

viii) **Unrealistic**

High aspiration and high hopes lead persons to set goals for future life. However, the dashing of this high hopes and not achieving one's ambition by events of life will cause the individual to become unrealistic with life issues.

ix) **Inferiority complex**

A person who feels inferior among peers or other cohorts usually manifests feeling of lowliness. Feeling of inferiority emanates from sense of imperfection and incomplete in a particular sphere of life. Feeling of inferiority punctures one's sense of complacency and provokes the individual to strive for a higher level of development. Once there is achievement of a new level, there will be a repeat of the previous activities that led to that achievement, and so the process continues to repeat, resulting in improvement in life situations and upward movement. However, if the feeling of inferiority becomes exaggerated as a result of adverse conditions

at home or physical challenges or mental disorders, then ‘inferiority complex’ may develop resulting in maladjustment.

x) **Emotionally disturbed**

When there is a lack of internal and external adjustment, there will be emotional disturbance or emotional imbalance. The individual may be agitated and unable to handle life issues as required resulting in maladjustment. If a child, may resort to weeping, quarreling, nail biting, thumb sucking, etc. and this results in maladjusted behaviour.

xi) **Isolated**

Maladjusted person has feeling of isolation which prevents them from mixing and interacting with others, be it with school mates, members of the family or the society. In a situation where there is neglect by family member it will lead to dejection.

xii) **Sensitivity**

Maladjusted persons are very sensitive as they get easily hurt by a tease or sarcastic remark from someone.

xiii) **Temper-tantrums**

Temper-tantrums are usually exhibited by toddlers as a show of strong emotion in children. This bad-tempered out-burst is found in maladjusted person when he feels there is no fair treatment, sympathy, cooperation and freedom of action within reasonable limits.

3.3 CAUSES OF MALADJUSTMENT

The main causes of maladjustment in behaviour are:

3.3.1 Family causes

The family can contribute to maladjustment or maladjusted behaviour. Parents' support to their children bonds those children to the family and builds their self-control. Lack of parental care, non-monitoring and non-involvement in their child's life serve as a very notable predictor of youth's delinquent behaviour.

3.3.2 Social causes

Complex social environment with abiding social ills will affect personality development negatively, while conducive, cordial and supportive environment will have positive influence. Children from homes disrupted by death, divorce, separation and other similar disruptive situations may be maladjusted in their behaviour if they lack balanced parental influence in their family upbringing.

3.3.3 Psychological Causes

In situations where parents are over possessive, highly authoritative, unrealistic in their expectations, incompatible and abusive, the children may be adversely affected. Also, when the psychological needs of the children are not met, the children can get frustrated and develop problems like nail biting, fear of darkness, lack of self-confidence, etc. Those who display large emotional variability over time are characterised by higher levels of depression, neuroticism and low self-esteem which are indicators of low psychological well-being.

3.3.4 Personal Causes

Disability, such as seen among the physically, mentally and visually handicapped can cause them to react in a socially unexpected manner. Inability to cope with adverse situations cause them to become maladjusted. A student who is unable to cope with his/her academic requirements may

develop an inferiority complex as he/she compares him/herself with his/her peers. He/she may resort to isolation and indulgence in daydreaming. Maladaptive behaviours can predispose to health problems and interfere with proper adjustment to classroom situation.

3.3.5 Peer pressure

Influence from members of one's peer group can affect an individual's behaviour. An unhealthy relationship with peers can disturb the psychological equilibrium of a student. Peer-pressure is the strongest predictor of delinquency when compared with family factors and childhood emotional and behavioural problems.

3.3.6 School related causes

Certain factors which are school related are responsible for maladjustment in behaviour among students. These factors include excessive and hard physical discipline, defective curriculum, faulty teaching methods, lack of recreational time, and authoritarian role of teachers, bullying including cyberbullying, among others. These students who are victims experience anxiety, fear, depression, etc. Furthermore, when growing children cannot channel their energy in a purposeful manner in the school, they will easily manifest maladjusted behaviours.

3.4 PROBLEMS OF BEHAVIOURAL MALADJUSTMENT IN CHILDREN

The UK Committee on Maladjusted Children headed by Underwood in its report listed the following problems and their manifestations:

3.4.1 Nervous disorders

Associated with the following:

i) Fears
ii) Anxiety
iii) Phobia
iv) Timidity
v) Oversensitivity
vi) Withdrawal
vii) Unsociability
viii) Solitariness
ix) Depression
x) Apathy
xi) Obsessions

3.4.2 Habit disorders

Associated with:

i) Stammering
ii) Speech defects
iii) Head banging
iv) Nail biting

3.4.3 Behaviour disorders

Associated with:

i) Defiance
ii) Disobedience
iii) Refusal to go to school or work
iv) Bullying
v) Destructiveness
vi) Cruelty
vii) Truancy
viii) Staying out late (keeping late night)

ix) Masturbation

x) Sex play

xi) Homosexuality (Note: this is not currently regarded as maladjusted behaviour internationally)

3.4.4 Psychotic behaviours

Associated with:

i) Hallucinations

ii) Delusions

iii) Extreme withdrawal

iv) Violence

3.4.5 Educational and vocational difficulties

Associated with:

i) Backwardness not accounted for by dullness

ii) Unusual response to school discipline

iii) Inability to concentrate.

The above classification was done about half a century ago. Recent classification does not include some of the characteristics earlier considered as maladjustment. This is as a result of redefinition of such characteristics, necessitated by changes that occur in the society. Some of these characteristics classified under maladjusted behaviour may also be found in a normal child, nevertheless, frequent occurrence of the characteristics is an indication of behaviour maladjustment. Below is an example of a current classification:

i) Nervousness behaviour

The child exhibits habitual biting and wetting of lips, nail biting, stammering, blushing, turning pale, constant restlessness, body rocking and inability to stay still, nervous finger movements and frequent urination, banging of head, and playing with hair.

ii) Emotional overreaction and deviation

Undue anxiety over mistakes, marked distress over failures, absent-mindedness, day-dreaming, refuses to accept any recognition or reward, evades responsibility, withdraws from anything that looks new or difficult, lacks concentration, unusually sensitive, exhibits unnecessarily excessive or extravagant emotions and actions, emotional tone in argument, feels hurt when others disagree, makes frequent efforts to gain attention of the teacher.

iii) Emotional instability/immaturity

Inability to fully control one's emotions, unable to work alone, relies on his own judgment, suffers from complexes, excessive self-conscious, over-critical of others, either too docile or too suggestive, shows unreasonable fears or worries.

iv) Exhibitionistic behaviour

Puts up behaviours to gain attention/portray positive image, cannot adjust to the school environment, tends to tease, push and shove other pupils, wants to be too funny or over-conspicuous, either bluffing or refusing to accept any lack of personal knowledge, agrees with whatever the teacher says or does, shows exaggerated courtesy, blames others for one's own failure.

v) Antisocial behaviour

Puts up hostile behaviour, cruel to others, bullies them, uses obscene language, shows undue interest in sex, tells offensive stories, dislikes school work, resents authority, reacts badly to discipline, runs away from the class, and shows complete lack of interest in school work and destructive.

vi) Psychosomatic disturbances

Emotionally distressed, vomits or develops constipation and diarrhea or tends to overeat and shows other feeling suggestive of disturbances and pain.

4.0 CONCLUSION

Many people especially young people experience behaviours that are not in line with, or violate social and cultural expectations. Such behaviours are referred to as maladjusted behaviours and they inhibit growth and development and are consistently detrimental to their ability to socially integrate. Maladjusted behaviour is not just slightly different from usual but extreme and does not resolve quickly. Those who are maladjusted should not suffer exclusion but should receive needed intervention.

5.0 SUMMARY

Maladjusted persons are often children who fail to adapt to their environment in a socially expected manner. Maladjustment can be intrinsic or extrinsic with certain characteristics that serve as indicators. Behaviours can portray excessive aggression or destructiveness or on the other hand, unnatural fears, excessive inhibition, and academic underachievement. Causes of maladjusted behaviour are classified along their predisposing factors for ease of association.

6.0 TUTOR-MARKED ASSIGNMENTS (TMAs)

Maladjustment affects the psycho-equilibrium of the individual who oftentimes is a child. Classify the possible causes of maladjustment.

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MODULE 3: MARGINALITY AND MENTAL DISORDER

UNIT 2: HIV AND AIDS

CONTENTS

1.0 INTRODUCTION

HIV infection and AIDS are more than medical issues but also social issues. People living with HIV and AIDS are often marginalised and discriminated against, because of the negative image painted about them in the earlier campaigns against the infection. Those infected at that time hid their status and never wanted to make it open to avoid marginalisation and discrimination from the society. The negative consequence of this behaviour was immense as it impacted negatively on prevention and control of the infection. Those infected and those affected by HIV and AIDS suffered stigmatization and emotional disorders which contributed to increased mortality due to their reluctance to access appropriate health care. However, based on reports of evaluation reports, policy makers and programme planners continually adopt new paradigms that are less offensive

to this populations. As a result, some of those living with the virus can now come out openly to declare their status without feeling shy or being afraid of marginalisation. More still need to be done as discrimination still persist in certain quarters in the society.

2.0 OBJECTIVES

At the end of the unit, you should be able to

i) Explain the concept of HIV/AIDS
ii) Explain the progression stages of HIV
iii) Explain HIV prevention activities
iv) State the treatment option for HIV
v) Explain HIV/AIDS and mental health disorders
vi) Enumerate common mental disorders associated with HIV/AIDS

3.0 MAIN CONTENT

3.1 Concept of HIV and AIDS

3.1.1 HIV

HIV is an abbreviation for **H**uman **I**mmunodeficiency **V**irus which attacks and weakens the immune system of the infected person. The immune system naturally defends the human body against invading organisms that are responsible for infections and diseases. HIV attacks the T-helper cells (CD4 cells) in white blood cells and replicates itself inside these cells. As HIV destroys more CD4 cells and makes more copies of itself, it gradually weakens a person's immune system and expose the infected person to opportunistic infections and finally AIDS. However, medical intervention slows down the rate at which HIV infection progresses.

3.1.2 AIDS

AIDS is the acronym for **A**cquired **I**mmune **D**eficiency **S**yndrome. It represents the advanced stage of HIV infection or late stage of HIV

infection. At this stage there is manifestation of complex set of symptoms as the individual experiences opportunistic diseases. The immune system at this stage is highly compromised and cannot fight any invading disease-causing organisms. Without adequate medical intervention, the infection eventually leads to death. Anyone who has AIDS must have been infected by HIV but not all those who are infected by HIV develop AIDS.

3.1.3 HIV transmission

HIV has been isolated in the blood, semen, vaginal and rectal fluid and breastmilk. The various routes of transmission include:

i) Through vaginal or anal sex which is the most common route.

ii) By sharing needles, syringes, and other items for injection drug use.

iii) By sharing tattoo equipment without sterilising it between uses.

iv) During pregnancy, labor, or delivery and from a woman to her baby
during breastfeeding.

v) Through "pre-mastication" or chewing a baby's food before feeding the baby with it.

vi) Through exposure to the blood of someone living with HIV such as through a needle stick injury.

3.1.4 HIV risky behaviour, risk factors and vulnerable groups

It has been argued that everyone is at risk of HIV infection but certainly some are more susceptible than others. In a society where the major route of transmission is the sexual route every sexually active individual is considered vulnerable. There are certain groups of people in the society who

are at higher risk of exposure to HIV infection as a result of their socio-economic circumstances. They include:

i) Highly mobile individuals

Those who are at risk because they are highly mobile or away from home for long periods of time such as, long distance drivers, miners, migrants, those in the uniformed service (army and police). They are often away from home without their families. They may likely indulge in casual sex with strangers. Also, refugees and other displaced people can be classified into this mobile population group.

ii) Commercial sex workers

This group of persons engage in sex work such as commercial sex workers and others who exchange sex for money and other material gains. Some people engage in sex work due to poverty while other do so for other reasons. They are highly susceptible to HIV infection because they have multiple sexual partners and may not practice safer sex.

iii) Health workers

Health workers can be infected from blood and body fluids of their seropositive patients while attending to them. It can be from exposure to blood and body fluids specimens as well as through needle stick injury. Universal precautions must be adhered to by health workers to protect themselves and their uninfected patients.

iv) Drug users

Drug users who inject and share injection equipment belong to high risk group in HIV infection, as well as those who use unsterilised injection equipment. Also, those who abuse substances are predisposed to HIV

because substance abusers lose judgement and are likely to indulge in at risk behaviour which they would not ordinarily indulge in, such as unsafe sex.

v) Women

Women are more susceptible to HIV infection than men for several reasons which include;

a) Their low economic status generally places them on a dependent position. Most of them depend on men for economic support. These men often demand sex in exchange of such support.

b) In most African societies women are socialised to be subservient to men and are not expected to query the sexual behaviour of the men even their husbands who may have multiple sex partners that put them at risk of HIV infection.

c) A woman has a greater chance of being infected than the man. Given the number of contacts, transmission from man to woman is approximately three times more than from woman to man. This is as a result of the anatomical structure of the female vaginal mucous which has a thinner lining than the normal skin.

d) Women are not only shy but they are not expected to negotiate for safer sex with their male partner not even their husbands who are responsible for the decision making in the family.

vi) Youths

Youths are vulnerable because they are more likely to engage in risky behaviours such as early and unprotected sex, multiple sexual partnering, sexual abuse and substance abuse. The abuse of substance like alcohol,

marijuana and cocaine is capable of negatively affect their judgement and leading to sexual abuse, domestic and road accidents.

vii) Children born to HIV positive mothers

Children born to HIV positive mothers could contract HIV during pregnancy, child birth or through breastfeeding.

3.1.5 HIV window period

The period between exposure to HIV and when it becomes detectable in the blood is called the HIV window period. Most people develop detectable HIV antibodies within 23 days to 90 days after infection. As soon as someone contracts HIV, it starts to reproduce in their body and the immune system of that individual responds by producing antibodies against the antigen which is what is detected by the test. If HIV testing is carried out during the window period the likelihood is that the test will yield a negative result because it was not able to detect the antibodies. Nevertheless, the infected individual at the window period can still transmit HIV to others during this period. If someone thinks that he/she may have been exposed to HIV but tested negative, he/she should repeat the test after three to six months, making sure he did not expose him/herself to any HIV at risk behaviour within the period.

3.1.6 Marginalisation and discrimination in HIV infection

Marginalisation is when an individual or a group is put into a position of less power or isolation within society because of discrimination. Discrimination plays out inequity and unfairness. People who are marginalised are sidelined in activities they are supposed to be part of. They are neither recognised nor given opportunity of participation based on negative opinion held against them. Marginalisation and discrimination can impact on health and well-being negatively.

People living with HIV and their family members were at the early stage of HIV epidemic highly marginalised in the community. Their HIV status was attributed to their evil deeds and it was regarded as already signed death warrant. People avoided them while those who were employed were sacked from their job and even students were dismissed from their schools. Those who were into small scale businesses had no patronage which worsened their economic situation. The situation then was linked to the way the initial information on HIV and the campaign for its prevention were presented to the public. Those who contracted the infection earlier were labelled as promiscuous, sinners and evil doers who were receiving judgment for their evil deeds. This scenario has changed with time as new strategies evolve in the response against the infection. As a result of the availability of drugs for managing HIV infection, it is currently being viewed as any other chronic infection and not a death sentence as earlier presented.

3.2 PROGRESSION STAGES OF HIV

HIV infection once contracted progresses through three stages.

3.2.1 Stage I: Acute infection stage

Acute infection stage is the first few weeks of contracting HIV when the virus reproduces rapidly. On the entry of the virus into the body, the immune system responds to it by producing antibodies to fight the infection. Some people show no symptoms at this stage, while others have symptoms in the first month or two of being infected but do not associate it to the infection as it can be mistaken for a flu at this time. The symptoms may be mild or severe and can last for between few days and several weeks. During this period the viral load which is the amount of HIV found in the bloodstream is very high.

3.2.2 Stage 2: Clinical latency or chronic stage

The clinical latency stage lasts from after the first month to few years or few decades. During this period some people do not present symptoms while others may have minimal or non-specific symptoms. Initial HIV symptoms usually resolve within a few months of entering the clinical latency or chronic stage, though, the virus is still being transmitted. How quickly a person with HIV progresses through the chronic stage varies significantly from person to person. In the absence of treatment, it can last up to a decade before advancing to AIDS.

3.2.3 Stage 3: AIDS

Normally, healthy individuals have a CD4 count of 500 to 1,500 per cubic millimeter. Without treatment, HIV continues to multiply and destroy CD4 cells. When HIV infection has gone untreated for many years the immune system is weakened and the CD4 count falls below 200, then the person develops AIDS. If HIV is found and treated early with antiretroviral therapy, the person does not usually get to the stage of AIDS. HIV may likely develop to AIDS if it is not diagnosed on time or if the individual is not on antiretroviral therapy or if the therapy is not taken consistently or if the individual has a type of HIV that is resistant to the antiretroviral treatment. With the use of antiretroviral therapy, a person can maintain chronic HIV infection without developing AIDS for decades.

3.3 Prevention Activities in HIV Infection

3.3.1 Prevention of HIV infection

From the time the infection was first described in the early 1980s, preventive measures have been designed and implemented using different strategies. These measures are not static but evolve with new findings and breakthroughs in the field. Basically prevention should address the low socioeconomic status of women, public awareness to increasing knowledge of HIV infection and its prevention, training and capacity building for health

workers on universal precautions, instituting programmes that will reduce the vulnerability of the different at risk groups, prevention of mother to child transmission and community based support programmes, among others. The ABC of prevention include; abstain from sex if not married, be faithful to your faithful sexual partner and consistent condom use. Furthermore, avoid sharing body piercing instrument, avoid using unsterile body piercing instrument, avoid contact with blood and body fluids, avoid transfusing unscreened blood, and observing universal precaution by health workers.

3.3.2 Prevention of marginalisation and discrimination

This will be achieved through continued public enlightenment. Agencies, both governmental and non-governmental should be involved in educating the public using appropriate strategies to reach every facet of the society. There should be formation of active support groups in the communities and communities should work out participation plans for support of those infected and affected by HIV and sanctions of those who marginalise them in the communities. Laws and policies to protect those living with HIV in Nigeria, such as the HIV/AIDS Anti-Discrimination Act 2014 which makes it illegal to discriminate against people based on their HIV status should be strictly enforced. It is not enough to pay lip service to this very important concern.

3.4 TREATMENT OPTIONS FOR HIV INFECTION

HIV-infection and AIDS has no cure and no vaccine as of now, but efforts are still channeled towards achieving that. The main treatment for HIV is antiretroviral therapy, a combination of daily medications that slows down the progression of the infection and helps reduce the risk of transmitting HIV to others. This antiretroviral therapy helps protect CD4 cells, keeping the immune system strong enough to fight off diseases. When treatment is effective, the viral load will be “undetectable.” The person still has HIV in

the body, but the virus is not visible in test results. This means that the individual has achieved viral suppression. If that person stops taking antiretroviral therapy, the viral load will increase again, and the HIV can again start attacking CD4 cells.

3.5 HIV/AIDS AND MENTAL HEALTH DISORDER

People with HIV/AIDS are at a higher risk of mental health disorders because they have an increased risk for developing mood, anxiety, and cognitive disorders. People living with HIV are twice as likely to have depression when compared with those who are not infected with HIV. Some forms of stress which people living with HIV face can contribute to mental health problems. Such stress can emanate from:

i) Having trouble getting the needed services.
ii) Experiencing a loss of social support resulting in isolation.
iii) Experiencing a loss of employment or worries about sustained ability to perform at work as before.
iv) Having to tell others of HIV- positive status.
v) Managing HIV medicines.
vi) Going through changes in physical appearance or abilities due to HIV and AIDS.
vii) Dealing with loss, including the loss of relationships or even death.
viii) Facing the stigma and discrimination associated with HIV and AIDS.

3.6 SOME COMMON MENTAL DISORDERS ASSOCIATED WITH HIV AND AIDS

People living with HIV have increased risk of developing mental disorders than when not infected with HIV. Mental disorder among this group could be associated with the stress they go through, or the effect of the presence of the

virus (HIV) in the brain. Some opportunistic infections can affect the nervous system and lead to changes in the person's behaviour and functioning. Neuropsychological disorders, such as mild cognitive changes or more severe cognitive conditions such as dementia are associated with HIV disease. According to The National Institute of Mental Health some common mental disorders associated with HIV and AIDS include:

3.6.1 HIV- associated neurocognitive disorders (HAND)

HIV- associated neurocognitive disorders (HAND) represents the range of neurocognitive complications associated with HIV infection. Currently there is no cure for HAND but combined antiretroviral therapy is reported to be the only option in preventing or delaying the progression of HAND. A remarkable number of people living with HIV have mild forms of HAND and significant progress in the treatment of HAND has been reported. Majority of those affected by the disorders experience more subtle abnormalities in memory and cognition. Diagnosis of HAND is made after carefully ruling out other conditions that may present similar symptoms. There are three major types of HAND and they are:

i) Asymptomatic neurocognitive impairment (ANI)

Asymptomatic neurocognitive impairment (ANI) is diagnosed when testing reveals HIV associated impairment in cognitive function but everyday functioning is not affected.

ii) Mild neurocognitive disorder (MND)

Mild neurocognitive disorder (MND) is diagnosed when there is HIV associated impairment in cognitive function in addition to mild interference in everyday functioning.

iii) HIV- associated dementia (HAD)

This is the most severe form of HIV associated neurocognitive disorders (HAND). The diagnosis of HIV associated dementia is made if there is marked impairment in cognitive function, particularly in the learning of new information, information processing, and attention or concentration. This impairment significantly limits the ability to function day-to-day at work, home, and during social activities.

3.6.2 Major depressive disorder (MDD)

Major depressive disorder (MDD) is a common psychiatric disorder in people living with HIV (PLWH). It is reported that about 22 per cent to 45 per cent of people living with HIV and AIDS (PLWHA) will experience depression in their life time compared with 5 per cent to 17 per cent of the general population. Diagnosing depression in HIV and AIDS can pose a challenge as associated symptoms of depression such as fatigue, decreased appetite and libido, and poor memory can also be present in HIV infection even in the absence of depression. There is no difference between the lifetime prevalence of depression among young and older individuals with HIV and AIDS in the general population. Another concern in depression is that it is associated with higher rates of non-adherence to medication regimens which is an undesirable behaviour with negative health consequences.

3.6.3 Psychosis

Psychosis is a serious complication of HIV infection found in few of the HIV infected individuals, particularly those who are severely immunocompromised. The incidence of first psychotic episodes in people living with HIV is estimated to range from less than 1 per cent to as high as 15 per cent. The first episode of psychosis in people living with HIV (PLWH) is often associated with paranoid delusions. Also, psychosis among PLWH is associated with drug abuse, affective disorders, cognitive

impairment, dementia, and untreated HIV infection. High mortality rates have equally been reported in PLWH who are psychotic. On the other hand schizophrenic patients are listed in literature as having increased risk of HIV infection because of their poor discernment understanding of risk behaviours.

3.6.4 Anxiety disorders

Anxiety disorders have received less attention than some other disorders, such as mood disorders and schizophrenia among PLWH. The prevalence of anxiety disorders among PLWA is estimated at about 38 per cent. Anxiety as found in this target group produces negative impact on health-related quality of life, a situation which was not positively influenced by early access to antiretroviral therapy. Symptoms of anxiety were reported to have increased the risk of suboptimal adherence by up to 5-folds.

3.6.5 Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder (PTSD) has been reported to be more prevalent among those living with HIV than those who are not, and it has been linked to faster progression of HIV and AIDS. It is worth of note that persons with post-traumatic stress disorder (PTSD) have 48 per cent higher odds of adhering sub-optimally to dose instructions.

3.6.6 Other psychiatric conditions associated with HIV infection

Other psychiatric conditions associated with HIV infection include; personality disorders, addictions, and aversive life experiences. These conditions increase the risk of HIV infection as well as worsen the problem of poor adherence to antiretroviral drug regimens.

i) Personality disorders

Personality disorders will often result in decreased access to care, a situation which can be attributed to both the client/patient's factors and also to the healthcare providers' reactions to the difficult characters as may be presented by the client/patient.

ii) Addiction and intoxication

Addictions and intoxication with addictive drugs will escalate the risk of HIV and other infections as well as non-adherence to prescribed regimen, because of the likelihood of the addict engaging in high-risk behaviours such as unprotected sex.

iii) Aversive life experience

Aversive life experience refers to undesirable, negative or unpleasant encounters which the client/patient had with health agencies and healthcare providers. This adverse experience affects trust and access to care negatively. The person who has experienced unpleasant encounter may default in keeping medical appointment or in accessing any form of healthcare to avoid the recurrence of such experience. Similarly, indigent and marginalized persons are less likely to access health care because of their socio-economic status and hence miss the benefits there of such health action.

4.0 CONCLUSION

HIV infection is both a health and social issue. Many are at risk of the infection as a result of their socio-economic status especially women particularly in some African societies. Certain mental disorders increase the vulnerability to HIV infection as well as the negative outcome of healthcare offered. Ideal care model should be integrated, incorporating treatment for HIV infection, substance use, and mental illness, along with provision of

social rehabilitation and psychotherapy in a single clinical setting. Timely intervention with adequate treatment will slow the process and progress of HIV and the individual may never get to the stage of AIDS. Communities should play active role in the support of people living with HIV and those affected to reduce marginalisation and discrimination for them to live to their full potentials.

5.0 SUMMARY

HIV is a virus that damages the immune system. The immune system helps the body fight off infections. Over time, as HIV kills more CD4 cells, the body is exposed to opportunistic infections and eventually AIDS. HIV can be prevented but have no cure for now. Transmission of the infection occur through various routes and certain groups of people are most at risk of the infection. Prevention programmes should target the general public but particularly the at-risk populations. HIV affects mental health in various ways and can result from the virus gaining entry into the brain cells and or from unpleasant experiences based on HIV positive status. People living with HIV and AIDS are at a higher risk for mental health disorders when compared to those who are not infected with HIV. PLWHA are at increased risk of developing negative mood, anxiety, and cognitive disorders. Therefore, an ideal model of integrated care should include treatment for HIV infection, substance use, and mental illness, along with provision of social rehabilitation and psychotherapy in a single clinical setting, with the community offering social support.

6.0 TUTOR-MARKED ASSIGNMENTS (TMAs)

1. Marginalisation and stigmatisation of people living with HIV and AIDS (PLWHA) can put them at higher risk of developing mental disorders. Discuss possible ways to reduce marginalisation and stigmatisation in the society.

2. Explain three reasons why women are more susceptible to HIV infection than men.

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MODULE 3: MARGINALITY AND MENTAL DISORDER

UNIT 3: SEXUAL VIOLENCE

CONTENTS

1.0 INTRODUCTION

There is increasing incidence of sexual violence globally. Sexual violence is a serious public health and human rights problem with both short- and long-term consequences on women's physical, mental, and sexual and reproductive health. Sexual violence can also profoundly affect the social wellbeing of victims as they may be stigmatised and ostracised by their families and others. Whether sexual violence occurs in the context of an intimate partnership, within the larger family or community structure, or during times of conflict, it is a deeply violating and a painful experience for the survivor. United Nations Report described the act of sexual violence as hostile, degrading, dominating, humiliating, terrorizing, dehumanizing and controlling.

2.0 OBJECTIVES

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

i) Explain concept of sexual violence
ii) State the magnitude of the problem of sexual violence
iii) Explain types and context of sexual violence
iv) Discuss consequences of sexual violence
v) Discuss public health approach to sexual violence
vi) Discuss ‘Promote Social Norms that Protect against Violence’
vii) Discuss ‘Teach Skills to Prevent Sexual Violence’

3.0 MAIN CONTENT

3.1 CONCEPT OF SEXUAL VIOLENCE

Sexual violence is a global issue and it impacts greatly on physical and mental health. Sexual violence has been defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by

any person regardless of their relationship with the victim, in any setting, including but not limited to home and work. The term ‘coercion’ covers a whole spectrum of degrees of force apart from physical force. People have employed coercion in different situations to achieve their nefarious desires such as psychological intimidation, blackmail and threat (e.g. to inflict physical harm or dismissal from a job) and when the person aggressed is unable to give consent as seen in when drunk, drugged, asleep or mentally incapable of understanding the situation.

Assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus are listed under sexual violence. Sexual violence can take place in different circumstances and in different settings such as, at home, in the workplace, at school, lonely walkways, prisons and police custody. Its negative impact has been reported on mental health and physical health with risk of sexual and reproductive health problems which has both immediate and long term consequences.

3.2 MAGNITUDE OF THE PROBLEM OF SEXUAL VIOLENCE

Sexual violence is under reported particularly in developing countries such as Nigeria because of the stigma attached to such act from which the survivors (mainly females) suffer more than the perpetrators (mainly males). Available data on sexual violence are from the police, clinical settings, non-governmental organisations and survey research. Available data have been described as scanty and fragmented, often incomplete and limited. Data from medical and legal clinics are believed to be biased towards the more violent incidents of sexual abuse. The proportion of women who seek medical services for sexual violence and related problems are equally comparatively small.

The available data and the actual global magnitude of sexual violence has been described as a tip of the iceberg, where the visible tip represents cases reported to police, survey research data and the work of non-governmental organisations (NGOs) and beneath lies the substantial but unquantified part of the problem which reflect the unreported cases. Many women are ashamed of reporting their ordeal due to stereotypes while others are scared of being labeled, blamed or turned away in disbelief of their account. In Nigeria, there are notable advances made in recent times by designated agencies and NGOs such as Mirabel Sexual Assault Response Centre to expose acts of sexual violence. These efforts have improved reporting, data collection and even prosecution of perpetrators, though, a lot still needs to be done. Due to cultural differences there is observed gap in willingness to disclose sexual violence to researchers making global comparison of prevalence of sexual violence unrealistic.

3.3 TYPES AND CONTEXTS OF SEXUAL VIOLENCE

The term sexual violence is an all-encompassing non-legal term. It embraces crimes such as sexual assault, rape, and sexual abuse among others, as described below:

3.3.1 Sexual assault

Sexual assault refers to sexual contact or behavior that occurs without explicit consent of the victim. The majority of perpetrators are someone known to the victim. Approximately eight out of 10 sexual assaults are committed by someone known to the victim, such as in the case of intimate partner sexual violence or acquaintance rape. Sexual assault can take different forms, but in all it is not the victim’s fault. Sexual assault include:

i) **Blitz sexual assault**

This occurs when a perpetrator quickly and brutally assaults the victim with no prior contact, usually at night in a public place. Females are usually victims of such offence.

ii) **Contact sexual assault**

This occurs when a perpetrator contacts the victim and tries to gain her trust by flirting, luring the victim to their car, or otherwise trying to coerce the victim into a situation where the sexual assault will occur.

iii) **Home invasion sexual assault**

This is when a stranger breaks into the victim's home to commit the assault.

3.3.2 Rape

Rape is the legal definition for physically forced (without consent), or otherwise coerced penetration of the vulva or anus, using a penis, other body parts or an object, no matter how slight it may seem, or oral penetration by a sex organ of another person, without the consent of the victim. When it is only an attempt to rape it is referred to as attempted rape. Forms of rape include:

i) Date rape

This type of rape is sometimes referred to as acquaintance rape and the perpetrator may be a date, a classmate, a neighbour, a friend or a co-worker. Although date rape and acquaintance rape are used interchangeably, there is still a difference. In date rape there exist some sort of romantic or potentially sexual relationship between the two concerned parties, but acquaintance rape includes rape that occurred in among parties (perpetrator and victim) who are not in any romantic or sexual relationship, but they are known to each other. Nevertheless, dating instances or past intimacy and/or other acts such as

kissing should not be regarded as consent for increased or continued sexual contact.

ii) Stranger rape

In the case of stranger rape neither the victim nor perpetrator knows the other in any way. There has been reports of rape committed by unfamiliar person met in the escalator, train or attacker who gained entry into ones' apartment. This type of rape can occur in several forms, but the distinguishing factor is the violator is a stranger to the victim.

iii) Gang rape

In gang rape there are more than one person involved in committing the act of rape. The perpetrators may or may not be known to the victim. There are occasions when gang rape is committed by friends, members of cult groups or other groups such as those involved in substance abuse or members of violent groups among others.

iv) Rape within marriage or dating relationships

There are stereotypical beliefs regarding rape within marriage. There have been arguments on if rape can occur within marriage. Some people are of the view that conjugal right permits a spouse to have nonconsensual sexual intercourse with his partner. In recent times rape within marriage has received great attention as human rights advocates continued to condemn the act as violation of human right. Spouse rape is now listed as an offence, nevertheless, reporting of such violation remains an issue as people find it difficult to talk about such act openly when it involves an intimate partner such as spouse or even a partner a courting relationship.

v) Systematic rape during armed conflict

Armed conflict is defined by United Nations Development Programme (UNDP) as a contested incompatibility that concerns government and/or territory where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths in one calendar year. During armed conflicts such as wars and all other forms of battles for supremacy or freedom where arms and weapons of destruction are employed, women and girls in particular are greatly traumatised, being victims of rape by gun and dangerous weapons carrying fighters who intimidate and debase them by raping them. In armed conflict as reported in many countries right from the Second World War to the recent arm conflicts such as seen in Liberia and Rwanda, rape remained a deliberate strategy to undermine communities. Rape has been reported among refugees fleeing armed conflict or natural disasters. Most times the rape is committed under horrifying situations that cause nightmares to the victims, if they survive it, for a long time to come.

3.3.3 Unwanted sexual advances

Unwanted sexual advances can also be referred to as **sexual harassment** which includes the demand of sex in return for favours and fondling or unwanted sexual touching. This can be seen in schools where teachers have been reported for sexually harassing their students. Other accounts of sexual harassment are in the workplace where superiors at a place of work make unwanted sexual advances to their subordinates. In some occasions, sexual harassment is accompanied by threats such as ensuring the failure of the harassed person in school examinations and consequently repeating of the class in school or denial of merited promotions and stagnation at work, or even sack from job in extreme circumstance.

3.3.4 Sexual abuse

In sexual abuse the attacker perceives the victim as being weaker than him and the act is believed to emanate from the intent to control and humiliate the victim, and not from uncontrollable sexual urge. Sexual abuse comprises of:

i) Sexual abuse of mentally or physically disabled people.
ii) Sexual abuse of children.
iii) Forced marriage or cohabitation.
iv) Child marriage.
v) Denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases.
vi) Pornography.
vii) Violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity.
viii) Forced prostitution.
ix) Trafficking of people for the purpose of sexual exploitation.
x) Another form of sexual abuse is conducting unwarranted or forced gynaecological examination such as vagina examination on clients by male medical and health workers.

3.3.5 Child Sexual Abuse

Child sexual abuse is a form of child abuse but in this case, there is involvement of sexual activity with the minor. Child abuse occurs when a perpetrator intentionally harms a minor physically, psychologically, sexually, or by acts of neglect. A child cannot consent to any form of sexual activity because she lacks the capacity for making such decision. Any sexual activity involving a minor therefore amounts to the offence of sexual abuse which often than not have lasting effects on the child victim. Some forms of child sexual abuse include:

i) Exhibitionism, or exposing oneself to a minor.
ii) Fondling.
iii) Sexual intercourse.
iv) Masturbation in the presence of a minor or forcing the minor to masturbate.
v) Obscene phone calls, text messages, or digital interaction.
vi) Producing, owning, or sharing pornographic images or movies of children.
vii) Sex of any kind with a minor, including vaginal, oral, or anal.
viii) Sex trafficking.
ix) Any other sexual conduct that is harmful to a child's mental, emotional, or physical welfare.

3.3.6 Sexual assault of men and boys

Anyone can experience sexual assault irrespective of sex, age, sexual orientation or gender identity. Males who have been sexually assaulted or abused may share several feelings and reactions that are same with survivors of other forms of sexual assault. However, they may face some additional exceptional challenges due to social attitudes and stereotypes about men and masculinity. Men may exhibit feeling of shame and/or self-doubt about their physical strength since they were unable to fight off the perpetrator. Where there was an experience of penile erection or ejaculation during the assault that can raise confusion as to such a normal physiological response which does not imply wanting, inviting, or enjoying the assault. Men who were sexually abused as boys or teens may respond differently from men who were sexually assaulted as adults but some common reactions include:

i) Anxiety, post-traumatic depression, post-traumatic stress disorders, flash backs and eating disorder.
ii) Avoiding people or places that remind them of the assault or abuse.

iii) Concerns or questions about sexual orientation.

iv) Fear of the worst happening and having a sense of a shortened future.

v) Feeling like "less of a man" or that you no longer have control over your own body.

vi) Feeling on-edge, being unable to relax, and having difficulty sleeping.

vii) Sense of blame or shame over not being able to stop the assault or abuse, especially if you experienced an erection or ejaculation.

viii) Withdrawal from relationships or friendships and an increased sense of isolation.

ix) Worry about disclosure, for fear of judgment or disbelief.

3.3.7 Intimate partner sexual violence

Sexual violence most often is perpetrated by someone known to the victim which includes intimate partner. Intimate partner sexual violence include; domestic violence, intimate partner rape and marital rape. Intimate partner sexual violence can occur in all types of intimate relationships regardless of gender identity or sexual orientation. It is not defined by gender or sexuality but by abusive behaviour. It often occurs alongside other forms of abuses, such as physical and emotional abuse from the same partner and it often starts with controlling behaviour that can escalate to other forms of abuses.

3.3.8 Incest

Incest refers to sexual relationship between persons who are closely related to each other that marriage is not permitted between them. This implies having sexual contact with a family member such as parent, child, sibling, grand child and the like. Societies define what constitute incest and it may have some variations among societies which will inform their laws on the

offence of incest. Nevertheless, unwanted sexual contact from a family member can have a lasting effect on the survivor, regardless the society concerned and their law. Most times it is difficult for an individual to disclose sexual assault or abuse when the perpetrator is known to be a family member. Reasons for not disclosing the abuser may include:

i) Fear of what will happen to the abuser if disclosed because the abused cares for the perpetrator.
ii) Concerned about other family members' reactions and fear that people will not believe that it happened.
iii) Previous experience of being ignored about such report.
iv) Convinced by the perpetrator that what happened was normal or happens in every family.
v) Not realizing that the act is a form of abuse.
vi) Ignorance of availability of help and not knowing whom to trust.
vii) Fear of getting into trouble for speaking out or the abuser’s threats.

3.3.9 Drug-Facilitated sexual assault

Drug-facilitated sexual assault occurs when alcohol or drugs are used to compromise an individual's ability to consent to sexual activity. Alcohol and some other drugs inhibit a person’s ability to resist the sexual advances and can equally prevent that person from remembering the assault. It is easier for a perpetrator to commit sexual assault to the victim who is under the influence of such substances. Drug-facilitated sexual assault can happen to anyone and may be perpetrated by anyone who may be a date partner, a stranger, or someone known just for a short while. Drug-facilitated sexual assault occurs in two ways:

i) Perpetrator takes advantage of a victim who is under the influence of drugs or alcohol taken voluntarily

ii) Perpetrator intentionally forces a victim to consume drugs without her knowledge

3.4 CONSEQUENCES OF SEXUAL VIOLENCE

Some of the consequences of sexual violence reported in literature include:

i) Physical effects such as bruising and genital injuries.

ii) Psychological effects such as depression, anxiety and suicidal thoughts.

iii) Chronic consequences such as post-traumatic stress disorder, re-occurring gynaecological, reproductive and sexual health problems.

iv) Negative health behaviours such as smoking, substance abuse and risky sexual activity.

v) Poor job performance such resulting from absenteeism, lack of concentration which will lead to job loss.

vi) Disrupted earning power which will adversely affect economic well-being of survivors and their families.

vii) Difficulty in maintaining personal relationships, in returning to work or school.

viii) Predisposed to other forms of violence e.g. girls who have been sexually abused are more likely to experience other forms of violence such as intimate partner violence in adulthood.

3.5 PUBLIC HEALTH APPROACH TO SEXUAL VIOLENCE

Sexual violence can be prevented using a comprehensive approach with preventive interventions on multi-level social ecological model targeted at the individual, relationship, community, and societal levels. Various approaches have been employed by different programmes to address sexual violence in societies. One such approach which is comprehensive in design is the **STOP SV Strategy Approach.** STOP SV is a technical package to

prevent sexual violence developed by Centers for Disease Control and Prevention (Basile et al., 2016) and it is presented below.

3.5.1 STOP SV Strategy Approach

STOP SV is an acronym which stands for the following strategies:

S- Promote **Social Norms** that Protect Against Violence

T- Teach Skills to Prevent Sexual Violence

O- Provide **Opportunities** to Empower and Support Girls and Women

P- Create **Protective Environments**

SV- Support Victims/Survivors to Lessen Harms

3.5.1.1 Promote social norms that protect against violence

This strategy advocates the changing of existing social norms that accept or allow indifference to sexual violence. This is because the existing gender norms that are restrictive (i.e., rigid ideas about the appropriate roles and behaviour of men and women) indirectly support or condone violent behaviour in both intimate and other relationships. The change of these social norms will bring about protection against sexual violence through the following approaches:

i) Bystander approaches

In this approach individuals are engaged to change social norms and to provide leadership around preventing sexual violence. Youth are often engaged for the promotion of social norms that protect against violence. They motivate their peers through peer programmes to prevent sexual violence and for the prevention of others at risk behaviours.

ii) Mobilizing men and boys as allies approaches

Men and boys become allies in preventing sexual and relationship violence. They work to prevent violence, support victims, teaching skills and reinforce

norms that reduce the risk of sexual violence. This approach fosters healthy and positive norms about masculinity and gender to prevent violence among individuals with such potentials and this spreads through their social networks.

3.5.1.2 Teach skills to prevent sexual violence

Learning skill has been used as part of a comprehensive approach to the prevention of sexual violence. Social and emotional learning skills (e.g., empathy, conflict management, and communication), healthy dating and intimate relationship skills, skills related to healthy sexuality, and empowerment skills are taught. This increases the ability of the participants to empathize. Teach skills to prevent sexual violence strategy employs the following approaches:

i) Social-emotional learning approach

This approach targets enhancing social and emotional skills comprising communication and problem-solving skills, empathy, emotional regulation, conflict management, and by-standing skills in children and adolescents. Information is provided about focusing on violence and changing the way children and adolescents think and feel about violence. Equally opportunities are provided to practice and reinforce skills learnt. This approach has been used in school settings.

ii) Teaching healthy, safe dating and intimate relationship skills to adolescents

Communication and conflict resolution skills are built, as well as expectations for caring, being respectful, and non-violent behaviours. This

approach provides built in opportunities to practice and reinforce these skills and it has been found to be useful among young adults.

iii) Promoting healthy sexuality

The focus here is on comprehensive sex education that addresses sexual communication, sexual respect, and consent. Increased awareness of risks factors is targeted as well as improved communication between parents and youths. It can also focus on sexual health (e.g., risk for HIV or STIs, pregnancy prevention) as well as empowering youth to reduce risk of sexual violence and dating violence. Positive results are achieved by encouraging sexual communication and healthy sexual behaviour.

iv) Empowerment-based training for women to reduce risk for victimization

The focus of this approach is on strengthening the ability of women to assess risks of violence in relationships and situations and empowering them to act appropriately. Potential emotional and physical barriers that may inhibit actions required to reduce risk for sexual victimization, such as fear, internalized sex role norms, or physical size and strength are addressed.

3.5.1.3 Provide opportunities to empower and support girls and women

Empowering and supporting girls and women through education, employment, income supports and providing other opportunities, such as leadership and civic participation. This approach is important for reducing women and girls' risk of sexual violence. Two approaches that were documented for empowering and supporting girls and women to reduce risk of sexual violence are strengthening economic supports and increasing leadership opportunities.

i) Strengthening economic support for women and families

This approach addresses poverty, economic security, and power imbalances between women and men. For families to have economic security women must have access to participate in full and also to have equal labour force. This entails having comparable salaries with men, income generating options, and work supports. This will improve their economic status and equally promote family stability while reducing gender inequality and its associated sexual violence.

ii) Strengthening leadership and opportunities for adolescent girls

This approach emphasizes the building of confidence, knowledge, and leadership skills of young women which will yield positive outcomes in education, employment, community engagement and political participation. The programme is designed for girls to participate as leaders in planning, development, and implementation. The programme supports the involvement of family and opportunities for girls to connect with their cultural and community identities. It is a safe space for girls to develop leadership skills and abilities, improve educational and occupational opportunities and raise the status of women in the society. Improving the girls' educational and occupational opportunities will improve their status of women in society and possibly reduce the risk of sexual violence.

3.5.1.4 Create protective environments

These approaches target modifying characteristics of the community, rather than individuals within the community, hence they are community-level approaches. It is based on the premise that creating protective community environments is a necessary step towards achieving population-level reductions in sexual violence. Community can be schools, neighborhoods, cities, organisations such as workplaces or institutions. It can result in changes in policies, institutional structures, or the social and physical

environment geared towards reducing risk characteristics, while increasing protective factors that will affect the entire community. Approaches that can be employed here include:

i) Improving safety and monitoring in schools

This approach focuses on monitoring and modifying physical and social characteristics of the school environment, with the view of reducing sexual violence. The approach addresses the areas where students feel less safe and safe spaces are also identified, while staff support for students is elicited to create atmosphere of zero tolerance for harassment and violence. This approach yielded positive impact when implemented on its own, nonetheless, it can be implemented in conjunction with other efforts that educate, teach skills, and change social norms related to sexual and relationship violence in schools.

ii) Establishing and consistently applying workplace policies

Workplace policies address risk factors of sexual violence to create healthy organizational climates. These policies help both employees and managers know the expected standards of behaviour required to prevent workplace bullying and sexual harassment. In any environment where sexual harassment is tolerated there is an interaction of individual characteristics and organizational characteristics that allows that. That engenders the need for necessary modification of these influencing factors. The individual characteristics can be modified by changing the organizational culture that favours the tolerance of sexual harassment.

iii) Addressing community-level risks through environmental approaches

The interest of this approach is on aspects of the neighborhood and other community settings to prevent sexual violence. The approach addresses

community-level risk factors by changing, enacting, or enforcing laws, regulations, or organizational policies, such as policy on alcohol use. It can also focus on all or any of the following; changing the physical environment, economic or social incentives, or consequences for behaviour, or other characteristics of the community (e.g. increased social controls).

3.5.1.5 Support victims/Survivors to reduce harms

The essence of this effort is to reduce long-term risks of negative psychological and behavioural consequences. This is because violence victimisation in childhood, adolescence, or adulthood can have long-term effects on the psychological well-being and functioning of survivors. Sexual violence victims can also have increased risk of sexual violence perpetration. This strategy employs the use of evidence-based therapeutic and victim centered approaches to address the needs of survivors. The approaches address the needs of youths, including those at risk of, or who have engaged in sexual offending behaviours, as well as their family. The essence of the intervention is to improve parent-child relationships and increase the supports available to youth and their parents in their homes and communities. Approaches that can be engaged in under the support victims/survivors to lessen harms include:

i) Victim-centered services

This approach encompasses a range of formal services such as support groups, crisis intervention, medical and legal advocacy, and access to community resources. The aim is to help improve outcome and alleviate long-term negative health consequences for survivors. The services delivered are tailored towards the unique needs and circumstances of victims and survivors and are coordinated among community agencies and victim-advocates.

ii) Treatment for victims of sexual violence

This approach comprise evidence-based psychological interventions conducted in therapeutic settings by licensed providers. These psychosocial interventions address depression, fear and anxiety, problems adjusting to school, work or daily life and other symptoms of distress associated with the experience of sexual violence. It is expected to result in improved psychological health and have long-term positive impact for victims/survivors of sexual violence. Programmes are designed to suit specific populations of sexual violence victims, such as child and adult.

iii) Treatment for at-risk children and families to prevent problem behaviour, including sex-offending

An intensive therapeutic approach directed to the individual, family, school and community factors that are associated with perpetration of violence. It is documented that many youths who are at risk of violence perpetration and other serious behavioural problems in childhood and adolescence were exposed to violence in their homes or communities, either as witnesses or victims. An important aspect of this approach is the focus on strengthening parent-child relationships and parental outcomes, such as stress and depression which influence parenting behaviours that may influence the children's risk of perpetrating sexual violence.

4.0 CONCLUSION

The available evidence-based data on sexual violence are less comprehensive when compared with other types of violence such as youth violence or other public health issues such as HIV and AIDS prevention. There is need to explore approaches that will change this situation by improved reporting, improved quality of collected data and uniform definition of elements of sexual violence. This will facilitate comparison within and among societies

and there is need to intensify the implementation of prevention strategies that will produce the desired result.

5.0 SUMMARY

Sexual violence is a serious public health and human rights problem that can be prevented. A wide range of sexually violent acts can take place in different circumstances and settings. Sexual violence is an all-encompassing, non-legal term that refers to crimes like sexual assault, rape, and sexual abuse. Sexual violence results in adverse effects on the victim which can be acute and chronic. Sexual violence can be prevented through comprehensive approaches targeting individuals, family, community, and the larger society.

6.0 TUTOR MARKED ASSIGNMENTS (TMAs)

1. Explain the different types of sexual violence.
2. Explain ‘Promote social norms that protect against violence’ as an approach to prevent sexual violence.

7.0 REFERENCES/FURTHER READINGS

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