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SOCIAL FACTORS IN HEALTH AND DISEASE

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SOCIAL FACTORS IN HEALTH AND DISEASE

Mr. Vice-Chancellor, Sir, the Registrar, colleagues, students, ladies and gentlemen, it gives me great pleasure to stand before you all, this afternoon, to give this inaugural lecture.

According to the Hippocratic tradition, well-being or good health was perceived as resulting from an equilibrium between environmental factors such as winds, temperature, water, soil, and food, and the individual's way of life, i.e. his or her eating, drinking and sexual habits as well as work, recreational behaviour and coping strategies. This external balance between man and his environment determines his internal balance, an equilibrium between the four humours of the human body: blood, phlegm, black bile and yellow bile. Within this paradigm, health care services were meant to assist nature's healing forces and public health care, through the understanding of the human echo system. Thus, health is a state of balance in both the human body and environmental factors.

Imbalance or illness was thought to result from a number of factors such as poor diet, lack of sleep, lack of exercise or disharmony within the family or society (Capra, 1983). According to the socio-medical paradigm, there is a clear link between the prevalence of health or ill health in any given population, and socio-cultural factors. For instance, there is a causal relationship between wealth and health, for wealthier nations are in a stronger position to provide better health care for their populations.

Again, during the period of early capitalism in Europe with its rapid industrialization and urbanization, poverty and adverse living and working conditions of the lower classes were seen to

account for their poor health and high rates of premature death. In addition, insufficient nutrition, poor housing, inadequate hygiene, the extremely long working hours, lack of recreation and the pressure of work were identified as militating against good health and well being (Roser, 1979). There is, no doubt, that these relationships between social factors, health and disease have long been recognised, and that they became more prominent as the fields of Sociology and Medicine developed over the years.

In the field of Sociology (Twaddle and Hessler, 1977), highlighted some theoretical studies that defined medicine as part of the subject matter of Sociology. Some of these studies include:

(i) The organic tradition where according to Spencer (1964), Sociology has a common ground conceptually with medicine by perceiving societies as organisms with parts affecting each other. Here the economy is seen to affect other aspects of society including politics and vice versa. For the economic process influences the political process and some of the policies adopted during the political processes could also influence the pattern of economic relations and wealth distribution in the society. These two areas (politics and the economy) can collectively or individually impact on the health state of the nation -through allocations to the health sector, the quantity and quality of health units available and the quality of life, e.t.c. Hence at the macro level - socio-political factors and economics affect health.

(ii) Durkheim's study of suicide which gave attention to medical specialists particularly psychiatrists, by emphasizing the role of environmental factors/social support in depressions and psychosis. In fact, according to Twaddle (1982), Durkheim might well be considered as the first Medical Sociologist.

Durkheim (1964), examined the relationship between the state of the economy and the degree of social support on one hand and the incidence of depressive syndromes and suicide rates on the other hand. According to him, in periods of boom, individuals tend to have exaggerated goals but end up not having the means to achieve those goals. They therefore fall into states of depression which when unchecked eventually lead them to commit suicide. This he termed anomic suicide. Then he talked of altrustic suicide which implies laying down one's life for the cause of the group. This was common among generals in the past. Some generals were known to become devastated after their battalions have been defeated, and instead of coming home in shame they committed suicide

Lastly, Durkheim talked about egoistic suicide, i.e. deaths caused by, or resulting from too much individualism, aloofness, lack of group support, or not having any emotional commitment. Those affected experience/ loneliness, severe depression and with the slightest irritation, they think of committing suicide to end it all. He claimed that this type of suicide was more common among bachelors than married men.

(iii) Lynd's study of Middletown (1929), was a major study of social class. Here, the influence of social class on American town life was observed. The findings showed that social class was responsible for the differences in health practices, and the treatment of disease among the different classes in society.

These efforts by leading theorists in Sociology not only made the establishment of Medical Sociology an accomplished fact and highlighted the areas of convergencies between sociology and medicine, but also drew further attention to the relevance of social factors in health and disease.

In the field of medicine, two developments are central to the growth of Medical Sociology, and to the discussion of the social factors in health and disease. These are the theoretical crisis associated with the collapse of the explanatory power of the germ theory of disease and the changes in the organization of medical services.

The first development is the theoretical crisis involving the germ theory of disease. This dominated medical thinking for much of the last century. With Pasteur's synthesis and observation of micro-organisms and the ancient Greek theory of contagion, micro-organisms had come to be thought of as the cause of disease. This led to the search for chemical substances that could be injected into the sick person, killing the micro-organisms without simultaneously killing the host and the search subsequently became a major research focus. But the crisis in the theory had been developing slowly for many

years. According to Dubos (1959), the germ theory is an ideology that makes an implicit claim that all diseases are ultimately conquerable. Dubos stressed that germs are necessary but not a sufficient cause of disease. They cause disease when other environmental conditions are present. Dubos thus concludes that social and environmental factors should be taken into account in disease causation.

Also, the development of psychiatry within the field of medicine showed that not all disorders had physical causes, and that some psychic and psychological factors are implicated in all diseases. This finding, coupled with the emphasis on the social environment in the development of the personality as highlighted by Erikson (1959), and Parsons (1964), revealed that it is not appropriate to treat any illness merely as a physical problem. Again, social epidemiology has shown that disease is socially patterned. For with the advancements in science and medicine, there should have been much reduction in overall disease patterns. However, social surveys and vital records have indicated that the rates of chronic diseases seem to be rising, thus pointing to the roles of social factors. Even health surveys have further demonstrated the relevance of social structures for both the patterning of disease and the utilization of health care resources. It seems, therefore that at the very least, a multicausal mode of diseases is needed to explain the phenomenon.

The second area in the development of Medical Sociology involves changes in the organization of services, which came about as a result of alterations/transformations in the socio-cultural milieu. For instance, in population changes, i.e.

increases in the proportion of the aged, there will be an increase in the prevalence of chronic diseases, and greater demand for medical care and services.

Strauss (1957), also made significant contributions to the relevance of social factors in health and disease through his efforts in differentiating 'Sociology in Medicine' from "Sociology of Medicine". He identified the goals of "Sociology in Medicine" as those of improving diagnosis and treatment of diseases. This means getting involved in medical education, medical settings and patient behaviour with the ultimate aim of making physicians more effective diagnosticians on the one hand, and improving the therapeutic process as a whole on the other. The goal of the "Sociology of Medicine", according to Strauss, then, is to learn about societies rather than understanding the disease process. This approach has led to a better understanding of the role of physicians, their socialisation, hospital organization and the social psychology of sickness and illness.

Saunders (1962), an American Anthropologist, fully addressed the relevance of social factors in health and disease in his works which drew heavily from his experiences with the health problems in the developing countries. He identified a historical association in the emerging convergence of interest between the behavioural and medical sciences. According to him, the phenomenon can be traced to some of the fundamental aspects of human health and of public health services. First, that social and cultural behaviours are important factors in the etiology, prevalence and distribution of many diseases. That is, how people live, what they eat, what they believe in, what they value and what

technology they command, are all significant determinants of their individual and collective health status. Second, that public health is a social and cultural activity. Hence the practitioners and the recipients of its services are in their various interactions and transactions fulfilling socially - determined roles in culturally determined ways. Consequently, most of their behaviour is motivated, directed and constrained by socio-cultural factors.

Concepts of Health and Disease

Further developments in sociology brought about a shift from Medical Sociology to health sociology, a shift which further drew attention to the role of social factors in health and disease. For while Medical Sociology emphasised the use of medicines and surgery (Sociology in Medicine), or a broader focus on the use of chemical substances and activity associated with health changes (Sociology of Medicine), health sociology tends to move towards a different conception of the main means of healing. This conception focuses attention on social factors such as social change, environmental control, smoking, nutrition and exercises. Again, while Medical Sociology perceives the goals of healing activity as bound up with already diseased individuals with the focus on cure of disease and illnesses (Sociology in Medicine), health sociology seems to perceive health goals as being bound up with the prevention of people from becoming diseased, by promoting their well-being and reducing mortality and morbidity in populations. In fact, the various definitions of health sociology attest to the role of social factors in health and disease. According to Anderson (1952), health sociology consists in the study of "social factors in illness".

The definition of 'health' by WHO as a "complete state of physical, mental and social well-being and not necessarily the absence of disease or infirmity" further suggests that health is shaped by factors which are not entirely 'medical'.

Existing theories of health and disease have further highlighted the different components of health, thus bringing into focus the role of, and the need for an appreciation of, non-medical and sociological factors in the etiology, course, and outcomes of illness.

A closer look at the concept of disease and in particular, the theories of disease, further highlights the roles of social factors in disease etiology in three significant ways namely: the medical model, psychological theory and the culture bound theory.

The medical model. This relates to the malfunctioning part of an organism which brings about some discomfort. This malfunctioning may be due to germs or hereditary factors. There are some diseases which are also associated with habits, lifestyles, behaviours and occupational types. Smoking, drug abuse, alcoholism e.t.c., are all examples of life styles which have been associated with various diseases. Unsafe sex has also been associated with HIV/AIDS while prostitution has been associated with STDs and the most dreaded disease,-AIDS.

Psychological theory of disease. Freud (1975), explained that later abnormalities in adults could be due to some disturbances they suffered as children. Using the Oedipus complex in describing the phallic stage, Freud claimed that children at such a stage experience severe turmoil which if not

properly managed, can result in severe emotional illness in adult life. His theory stimulated other psychological explanations of mental disorders i.e; the Labeling theories by Laing (1967). He described how the familial units can "conspire" to push or manipulate one of their members into mental illness through the labeling process. However, while Freud appears to blame the individual rather than the group, Laing tended to put the responsibility on familial units for labeling and stifling individualism.

Culture - Bound theory of Disease - The main thrust of this perspective is that health and disease are to some extent, shaped by culture. One of the pioneers in this field was T.A. Lambo of Nigeria (1955). Their main postulations are:

i) that the concept of disease is rooted in magic and religion as most people in non-Western societies attribute the incidence of diseases to witchcraft, sorcery or mystical forces because of their belief in such forces.

ii) that what is regarded as disease in some societies may be seen as normal conditions in other societies due to cultural factors. For example, obesity is regarded by Euro-American women and men as an abnormal condition which is often frowned upon, because their sacred concept of beauty is to be "twiggy". To achieve such a condition, girls in those cultures have been known to engage in complex slimming diet regimes that have in some instances resulted into disastrous and even fatal consequences. On the other hand, obese women are highly regarded in some traditional African societies, particularly in Cross River and Rivers

States of Nigeria. In fact, until recently, brides to be were kept in "fattening rooms" where they are fed to make them robust and succulent, so that they can be appreciated by their future husbands.

From the 3 perceptions of disease above, the roles of social factors are well delineated. In the first case, the import of habits and behaviours, are spelt out, in the second one, the relevance of the environment is well illustrated while in the third instance, the effects of culture, (practices, customs, beliefs) are stressed.

It is obvious therefore, that health problems have consequences which are primarily psychological and social in nature, and which are not reducible to biological, physical or chemical concepts. In other words, a good medical care system must take into account not only the patient, but also the social context in which he/she lives and the complementary systems devised by the society to deal with the disruptive effects of illness.

My Journey into the field of Health Sociology

My involvement in the area of Health Sociology began in 1969 when the late Professor G.M. Edington at the University College Hospital requested for a sociologist to assist him in unraveling the factors responsible for the decreasing incidence of cancer with age in African countries, as against the rising incidence of the disease with age in the developed countries of the world. He felt that some social factors may be implicated and he made available to me a Ford Foundation grant to undertake the study. The subsequent study showed that peoples' perception of cancer influenced the way in which they tackled it (Edington & Odebiyi, 1976). The study further revealed that the declining incidence

of cancer with age in the city of Ibadan,the target of the study, was due to under-reporting and the patronage of traditional healers by patients. The finding lent credence to the role of social factors in illness behaviour, and further gave me the urge to examine people's perception of other diseases and how they are managed. That was the beginning of my journey into the world of health sociology.

In examining peoples' perception of diseases, thereafter, I found that the way they defined ailments depended on their socio-economic status, i.e.: whether they felt a disease was due to natural, supernatural or preter natural forces depended on their socio-economic background (their educational level/beliefs etc). (Odebiyi & Ekong 1982a; Odebiyi 1980; Odebiyi 1977; Odebiyi & Ekong 1982b; Odebiyi & Togonu-Bickersteth 1987; Odebiyi 1992; Togonu-Bickersteth & Odebiyi 1985a. 1985b; Odebiyi 1989). In our study of Yoruba perception of deafness, (Bickersteth & Odebiyi 1985a), we observed that mothers with deaf children attributed the defect to a sin which they (the parents) must have committed. Thus they see the deaf child as a constant reminder of an earlier sin, they thus tried as much as possible to hide the child and the defect from the public. This type of perception dates back to the Biblical era as can be inferred from the following quotation below:

> ***And as Jesus passed by, He saw a man which was blind from his birth. And His disciples asked him. saying, "Master. who did sin, this man, or his parents, that he was born blind?"***
>
> ***- John 9: 1&2.***

Among the traditional healers too, diseases are often percieved as punishments from gods or ancestors for sins committed against the lineage (Odebiyi, 1980). Against this background, diseases and abnormalities were never perceived within the natural realm among most people in Nigeria. This belief tends to cut across different socio-economic groups and on those few occasions, when natural causes are ever attributed, there is still the fear that other secondary causes may be implicated, especially when symptoms persist. (Odebiyi & Ekong 1982a).

However, one important finding that emerged from the various studies is that a greater proportion of those on the higher socio-economic level conceptualized diseases more within the natural realm than the proportion of those on the lower socio-economic level. It is noteworthy, however, that a significant number of people in the high socio-economic group also believed in supernatural and preternatural causation of diseases, and that they consulted with traditional healers under the cover of darkness, or in disguise during the day by parking their cars way off and trekking down to the healers. The belief in the supernatural and preternatural forces in disease causation and death is further reflected in some "Obituaries" and " In memoriams" in our dailies, such as "The wicked have done their worst".

Socio-economic status, disease perception and illness behaviour

Our study of mothers' concept of measles and attitude towards the measles vaccine further showed a positive relationship

between mothers'socio-economic status and the etiology of measles (Odebiyi & Ekong 1982a). (See Fig.):

Fig. 1: Distribution of mothers response to the etiology of measles cross-tabulated with Mothers socio-economic characteristics

Disease etiology	Mothers' Level of Literacy		Mothers' Occupational Status	
	Literate	Non-literate	Higher (Professional, white collar, skilled	Lower (unskilled, traders, unemployed
Natural cause	56	4	51	9
Supernatural cause	21	56	9	68
Both natural & Supernatural	9	13	6	16
Don't know the cause	11	30	4	37
All mothers	97	103	70	130

$X^2 = 86.6$ $P < 0.001$ df $= 3$
$X^2 = 95$ $P < 0.001$ df $= 3$
(Source: Odebiyi and Ekong, 1982a)

Again, of the 200 mothers interviewed in the study, 54 believed implicitly in the efficacy of the measles vaccine, 112 did not believe in it as an adequate preventive measure, while the remaining 34 had no knowledge of the vaccine. 81 of the mothers who did not believe in the vaccine (72.3%) claimed that some of their children who had been immunized still contracted measles which is contrary to findings in studies in

the U.S.A. (Krugman *et al*, 1960). 9 of them (8.0%) said that the vaccine was dangerous and harmful to infants. This tends to corroborate reports on the harmful side effects of the vaccine (Hendrikse, 1964; Morley *et al,* 1963). However, 21 mothers (19.7%) stated that the vaccine should be combined with the traditional therapy of keeping a fruit "Tagiri" (Adenopus Breviflorus), in the house during the dry season. It is believed that this fruit will drive away the evil spirit of measles from the house. (It is interesting that some of those who shared this view are members of this University community and that we actually saw the fruit in their houses in the dry season).

Also noteworthy in the study, are the facts that:

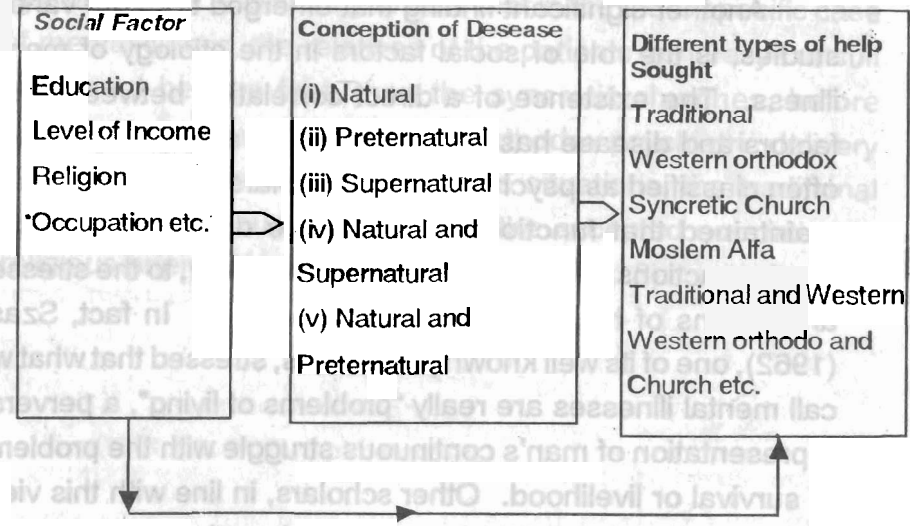
(i) the poorer mothers could not afford to pay for their prescribed drugs and other services provided,

(ii) generally, poor mothers suffer because of unclean and insanitary conditions in which they live, and that epidemics tend to break out among the poorer segments of the community.

In another study also designed to emphasize the effects of socio-economic indices on health, Pearce & Odebiyi (1980) found that although the incidence of congenital malformations increased with the age of mothers, the burden was greater among the less privileged groups. Odebiyi and Oyewo (1993), in a study of self-medication among market women in South Western Nigeria sponsored by the Canegie Corporation of New York, observed that unless the condition was really crippling, market women would not skip their daily trips to the market.

Moreover, they would prefer to buy drugs from drug vendors in the market instead of visiting the hospital. They complained of long queues and unnecessary delays in the hospital which could negatively affect the number of sales they would make per day. Social factors thus come to play in influencing how people react to symptoms and how they value their health. Also, Socio-economic indices such as education, occupation, income, belief, age etc, no doubt influence people's perception of diseases and the types of help they will seek (see Fig. 2).

Fig 2: Schema Showing the Relationship between social factors and Illness behaviour



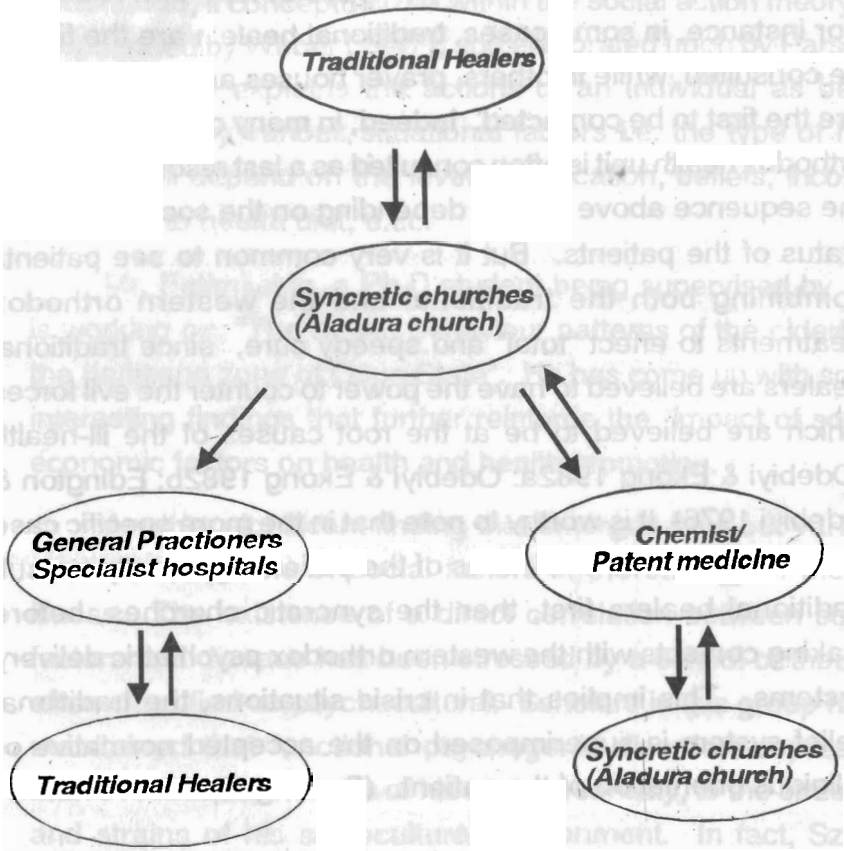
The above Schema or phenomenon can be better further understood, if conceptualized within the social action theory as propounded by Weber (1947), and elaborated upon by Parsons (1954) which explains the actions of an individual as being determined by various situational factors i.e. the type of help sought will depend on the level of education, beliefs, income, proximity to health unit, e.t.c.

Mr. Fatimilehin, a Ph.D student being supervised by me, is working on, "The health behaviour patterns of the elderly in the Ife/Ijesha zone of Osun State". He has come up with some interesting findings that further reinforce the impact of socio-economic factors on health and health promotion.

Another significant finding that emerged from our various studies, is the role of social factors in the etiology of mental illness. The existence of a direct correlation between social factors and disease has been stressed by a school of thought often classified as psychocultural. Scholars in this group have maintained that functional psychogenic disorders represent man's reactions, in terms of his own personality, to the stresses and strains of his sociocultural environment. In fact, Szasz (1962), one of its well known proponents, stressed that what we call mental illnesses are really "problems of living", a perverse representation of man's continuous struggle with the problems of survival or livelihood. Other scholars, in line with this view, see man's emotional disturbances (withdrawal syndromes e.t.c.) as stemming from, and reflecting difficulties in interpersonal relationships. This is important because in the traditional setting, there is the general belief that mental illness could be inflicted

on an individual for wronging his neighbour. These perceptions about diseases have dictated the types of help that is sought. For instance, in some cases, traditional healers are the first to be consulted, while in others, prayer houses and Moslem *alfas* are the first to be contacted. Indeed, in many cases, a western orthodox health unit is often consulted as a last resort. However, the sequence above varies, depending on the socio-economic status of the patients. But it is very common to see patients combining both the traditional and the western orthodox treatments to effect "total" and speedy cure, since traditional healers are believed to have the power to counter the evil forces which are believed to be at the root causes of the ill-health (Odebiyi & Ekong 1982a: Odebiyi & Ekong 1982b: Edington & Odebiyi 1976). It is worthy to note that in the more specific case of mental illness, the relatives of the patients generally consult traditional healers first, then the syncretic churches, before making contacts with the western orthodox psychiatric delivery systems. This implies that in crisis situations, the traditional belief system is superimposed on the accepted normative or religious orientation of the patient. (See Fig. 3).

Fig 3: Schema Showing the pathways to mental health care



normal route
other possible options
(Adapted from Erinosho, 1981)

Confronted with the above situation, there was need for us to examine who the healers are, and what contributions they could make to health care delivery.As a Ph.D student under my

supervision, Late Dr. Olanike Ogedengbe worked extensively in this area, with particular emphasis on the traditional psychiatrists. Our work/studies revealed that traditional healers, particularly the herbalists and the traditional psychiatrists, were making significant contributions to health care delivery and that their importance is based on people's belief in the efficacy of their drugs (Odebiyi & Ogedengbe 1995; Odebiyi 1983; Odebiyi 1990; Odebiyi 1989).

Apart from influencing the types of help sought, social factors also come into play in the management of disease as earlier mentioned, particularly in respect of the patient's career and its span. This factor can be better appreciated in the area of mental health when we consider the pre-patient, the treatment and the post-treatment phases of the affected individual. First, is when a case is established (which is a function of socio-economic factors), and then when the treatment begins, (this again depends on attitudes of patients, level of compliance e.t.c.) and finally, the post treatment/post hospitalization phase, which involves following the patients back to their respective familial units and communities. This last phase is largely influenced, especially in mental cases, by the attitudes of kins and significant others (i.e. their level of acceptance e.t.c.) as they may help either to facilitate, or undermine recovery or worse still, even encourage a relapse. There is need therefore, for health workers to recognize the important roles of next of kins in the management of mental illness.

Culture and Health

Health workers should be knowledgeable about the relevance of culture to health. They should also be acquainted with the norms that shape the behavioural patterns of their clients. This is important because sometimes untold harm, or even death could result if health workers are ignorant of the cultural backgrounds of their patients. A good example is Fulani women in labour. These women are known to repress their anguish during labour because of their belief in the cultural rites of passage. Hence, they have the capacity to withstand pain and hide their anguish. Consequently, health workers working with this group of women may not be able to assess when they actually need special assistance or emergency care. Similarly, there are food taboos for pregnant women, nursing mothers and even infants which have been observed to have serious health implications (Odebiyi, 1989). These issues should be addressed by health workers in today's Nigeria where Protein-Energy Malnutrition (PEM) is a major problem, and where three square meals per day have become a luxury enjoyed only by a few rather than the norm.

There is no doubt that the relevance of social factors in health and disease has not been given the desired attention by health professionals over the years with serious adverse consequences for their patients. For example, there are instances of Discharge Against Medical Advice (DAMA), (Odebiyi, 1984), which in most cases result from conflicts between doctors and patients. There are also cases where health intervention packages received with a lot of enthusiasm at the

initial stages, have failed to have the desired impacts (Odebiyi & Ondolo, 1993); Davis-Adetugbo & Odebiyi 1991). In a study we conducted for the World Health Organization on the social aspects of malaria, (Odebiyi *et al*, 1992), we found that most rural women do not believe in many of the anti-malarial treatments available because of their different perceptions of the causes of the ailment. For instance, some believed that one can contact malaria fever by sitting in the sun for long hours. Against this background, we felt that there was need to focus on a person centred therapy which will take into consideration people's perception of disease and their lifestyles, before the introduction of any health intervention packages. Also of interest in the study is the impact of the market institution, i.e., the nineth day periodic market in one of the communities during which the traders stay in the market overnight. This arrangement provides meeting places for friends and re ons from both the hinterlands and cities, thus serving as a mechanism for widespread malaria transmission. We therefore came to the conclusion that it is imperative to take into account socio-cultural factors in any malaria control programme in the country. Also, in another study carried out for the World Bank 1993 on Women and Children in Poor Households in Osun State, we observed that poor children were more prone to falling ill than those of richer families in the same neighbourhoods, a phenomenon which may not be unconnected with their monotonous and unbalanced diet regimes (Odebiyi *et al*, 1993)

From the above findings, it is clear that the people (their culture, life styles e.t.c.) should no longer be left out in designing

health care delivery programmes in the country, to ensure the acceptability, effectiveness and sustainability of modern therapies. A look at some other activities initiated by men in their bid to adapt to the environment and their relevance to disease prevalence at this juncture, will further highlight the need to involve the people in future health intervention strategies in Nigeria. The people could be educated on how best to perform some of their survival activities so as to curb the spread of some common diseases. Cultural practices may affect the environment and thus change the conditions under which disease organisms and their carriers breed and contact human beings. Read (1966) for instance, has attributed the prevalence of ***Schistosomiasis*** in parts of Africa to environmental or cultural factors. ***Schistosomiasis*** has as an intermediate host, a snail which is associated with stagnant water. The disease is a major public health problem in many parts of Africa. Read associated the high incidence of the disease, particularly in Egypt, to the opening up of more cultivable land through irrigation in that country. Again, river blindness (***Onchocerciasis***) reported in many parts of Africa (particularly in the Savanah areas), is caused by a particular type of fly, *Simulium damnosum*. The prevalence of these flies is attributed to grass burning, a technique used in primitive farming which also exposes the ground to erosion. Read accordingly concludes that "as soil erosion starts, the run-off of rain water into the river becomes more precipitated, rocks start to appear, and *Simulium damnosum* starts to breed a large scale".

Another typical example of this problem is industrialization,

an element of culture which again has had profound impacts on disease. Modern technology has severely altered the world's environment. People, especially in the developing world, are now faced with serious dangers from chemical pollutants in the air and in our water. These pollutants have severe health implications. In third world countries, rapid and unplanned growth in urban areas has created huge squatter settlements which are most often without pipe borne water. They also experience congestion and sewage problems. In such conditions, health problems such as tuberculosis, enteric fevers, venereal diseases, dysentary, alcholism are highly prevalent. Moreover, comprehensive analyses of theories on the causes of cancer which have been widely undertaken by researchers in many parts of the world, have further revealed that environmental factors either play a major role, or are dominant or secondary causes in the development of malignant diseases. Some examples of these diseases are industrial and occupational cancers.

At this juncture, I would like to emphasize that even the adherence to some cultural practices can be detrimental to health

There is an urgent need for health workers to correct these important issues which are being currently addressed by female NGOs and other Associations in the country. Unfortunately, they do not as vet receive the desired attention. But if health professionals were to provide the terrible tales and health implications being provided by the NGOs, the message is more likely to arouse fear and compliance among the populace. For instance, practices such as early marriage and Female Genital

Mutilation (FGM), which tend to have serious consequences for the victims such as *Vesico-Vaginal Fistulae (VVF)*, deserve greater attention. In the particular case of VVF, the girl who is given out in marriage at a very early age, is not fully grown physiologically. Hence the pelvic girdle is narrow and has insufficient space in the bony birthcanal for the passage of the baby's head during child birth. The labour is also usually prolonged, because of the tight fit of the baby's head. Many things could go wrong at this point, the bladder could be damaged, the nerves supplying the muscles of the lower limb could be constricted, while the lower end of the bowel could be adversely affected. The result, in many cases is that the girl ends up leaking urine and faeces uncontrollably (Odebiyi, 1984). Regrettably, such girls or wives, also end up being deserted by their husbands, a situation which even compounds their problems. In the case of FGM, the most sensitive part in the female reproductive organ (clitoris) is removed, primarily to prevent promiscuity. In places like Ibadan and among the Igbo, Ezumezu (1995), observed that there are men circumcisors who acquire the skills from Hausa barbers and that by and large, majority of such traditional circumcisors are non-literate and have no knowledge of human anatomy. In addition, the surgery is usually done outside hospitals in most cases, resulting in infections, keliod formation, haemorrhage and sometimes even death (Odebiyi, 1984). The Federal Ministry of Health and the Inter-African Committee, Nigeria, have waged war against some of these practices. But the practices are still very widespread partly because the agencies concerned have not adopted the participatory techniques of the social sciences. These are

techniques that would bring out what the people themselves perceive as the most appropriate ways of dealing with their own problems. For instance, in my 1985 study on child rearing practices among mothers in Ife, I observed that even mothers within the University environment believed in the continuation of the practice of FGM. They claimed that it is still functional in that it reduces the sexual urge in the female.

As early as 1977, I had highlighted other common beliefs and practices which tend to serve as bottlenecks, and which sometimes frustrate the efforts of health practitioners in discharging their daily duties. These beliefs and practices include opposition to blood transfusion by some religious sects, forced hand feeding of babies, applying powdered dung to the cut cord of new-born babies, e.t.c. In 1997, I also drew attention to the fact that cultural taboos which frown at speaking out about sexuality and genital diseases between parents and their children have led in some cases to unwanted pregnancies, unsafe abortions and even hindered communication about the recognition, prevention and treatment of STDs. In a recent study sponsored by the Union for African Population Studies (Aina & Odebiyi, 1997), we observed that the increasing rate of adolescent pregnancy and unsafe abortions could be attributed to several factors: (i) broken homes, (ii) illiteracy (illiterate parents tended to condone a lot of indisciplined acts among their school-age children), (iii) polygynous homes (where children are many and lack adequate care and attention), (iv) peer group influence, (v) hawking by girls to augment family income which tends to expose such girls to rape and sexual aggression/harassment, (vi) school closures due to teachers'

strikes which again expose the girls to idleness, roaming the streets and thus becoming vulnerable to rape, and even promiscuity. Of particular interest at this point is the fact that these adolescents were also not favourably disposed towards the use of condoms. Unmarried adolescent motherhood was thus a common feature. Such adolescent mothers in our study never had proper ante-natal care and ended up with complications or problems of low birth weight.

The negative attitude towards condom use among adolescents had been observed in an earlier study on AIDS awareness and condom use among students in a Nigerian University (Odebiyi, 1992), Surprisingly, I found that majority of the students were opposed to condom use. Some of the reasons given by the students were: "It is messy" "It removes the enjoyment", "it is like taking a shower with a raincoat on and you don't get the feel of the water, which is the main attraction", "it can even tear off, so what's the point", "one has to die of one thing or the other, if it is not AIDS it will be something else". The results of the study are similar to reports obtained among youths in other parts of the world (Otis *et al* 1990). But the danger in practising unsafe sex is that it could result in HIV/AIDS infection.

Apart from the practice of unsafe sex, other social factors are involved in the transmission of this dreaded disease i.e. transfusion of infected blood, sharing of shaving blades, re-using of needles, knives for incisions, tattooing, tribal markings without proper sterilization of instruments.

An area that should not be left out at this point, is the health implication of women's subordinate position and their financial

dependency on their husbands, which have subjected them to a lot of health hazards, such as frequent pregnancies as they cannot say "no" to their husbands' sexual demands. For most women, the only conditions under which they can say "no" are; during menstruation, breast-feeding and early pregnancy (Odebiyi, 1993). Also worthy of note in the study, is the fact that women delay in seeking medical help if their spouses were not at home to sanction it. This observation was confirmed by a recently concluded study for MacArthur Foundation - Male Factor in Emergency obstetric Care (Adewuyi, Odebiyi *et al*, 1999). We found that most women were unwilling to take immediate steps on their own volition in emergency situations if their husbands were not around. This was particularly noticeable in Ejigbo (a town in Osun State) where the men often travel to Ivory Coast to trade. From my earlier study (Odebiyi 1993) , it was also found out that husbands approval was an important determinant of wife's contraceptive use. Under such conditions, it is obvious that Nigerian women have no control over both their health and their sexuality. Moreover, in an attempt to please their husbands, Nigerian women often expose themselves to the risks of STDs and HIV/AIDS infection by adopting what I called the "culture of silence". That is, they do not openly express their dissatisfaction with the unequal sexual relationship between them and their husbands. This situation tends to be compounded in homes where there is no male child, or where there is barrenness. In such homes, the husbands are allowed to "shop around" literally, with the hope that they would be able to have a male child. This socially sanctioned male promiscuity involves multiplicity of sexual partners which aids the spread of STDs

and AIDS (Odebiyi, 1993). Other cultural or societal practices (with similar consequences) that adversely affect women health-wise, are polygyny and widow inheritance which are still being widely practiced in many parts of the country (Odebiyi, 1991). Also, many women take to prostitution in order to survive and such commercial sex workers are channels through which STDs, HIV/AIDs are transmitted. (Messersmith, Kane, Odebiyi *et al* 1994). A lecture on "Social Factors in Health and Disease" should not only highlight those factors that promote ill health and disease, for practices such as prolonged breastfeeding, abstinence and traditional emphasis on chastity do tend to promote good health and well-being. The issue at stake, therefore, is that the impacts of social factors on health and disease (whether negative or positive) should be taken into consideration in planning educational interventions.

Steps taken by Medical Schools/Physicians and Professional Bodies to address the Impact of Social factors in Health and Disease

The various medical schools and health practitioners in Nigeria have taken steps to mediate the impact of social factors in health and disease in the country. The University of Ibadan was the first to take the necessary steps in that direction, in its Department of Preventive and Social Medicine. The department, with the assistance of the Rockefeller Foundation established what is known as The Ibarapa Project. This is a community based project which gives students the opportunity of living within the community for a period of six weeks during their three years of training in clinical medicine. This affords them the opportunity

to participate in community diagnosis and assist these communities to overcome their common health problems. The Department of Psychiatry also stipulates that students spend some time in Aro village near Abeokuta. Other older Universities have similar programmes while the new Universities have even adopted more innovative community based approaches to medical education. But in all of these, what percentage of the time spent in the medical school is actually devoted to this vital aspect of their programmes? Nigeria has adopted Primary Health Care as the centre piece of its National Health Policy. This has added impetus to the call for change in the curricula of medical schools and further implied greater interaction between doctors and social scientists in recognition of the role played by social factors in health and disease within the context of bringing health to the grassroots. In line with this goal, I have collaborated and published articles with a number of physicians and health practitioners (Durosinmi, Odebiyi *et al,* 1995; Durosinmi, Odebiyi *et al* 1997; Jinadu, Odebiyi *et al* 1996; Jinadu, Fajewonyomi, Odebiyi *et al* 1994; Davis-Adetugbo & Odebiyi 1991). However, such collaborations are few and the real impact of such efforts is yet to be felt as there is need for major structural changes within the medical setting.

There is no doubt that the relevance of social factors in health and disease is appreciated by the health workers. For in 1991, the Association of Provosts and Deans of Medical Schools organized a National Conference in Ogere (in Ogun State) to appraise the possible contributions which social scientists can make to medical education. The meeting resolved to promote greater interaction between social and health scientists, and to

incorporate more social science courses to the curriculum for medical education. However, since there were no laid down structures for implementing these resolutions, not much has been achieved in that direction.

Nevertheless, social scientists do give some hours of lectures to medical students in the pre-clinical years, and to clinical students to expose them to the existing conceptions of diseases, and how they tend to affect illness and health behaviour, the role of kinsmen in the management of diseases, and even post-hospital care. But because these courses are not in the mainstream of medicine, they are not accorded much importance and the medical students themselves do not take them seriously.

According to WHO (1995), life style-related diseases and conditions are responsible for 70-80% of deaths in developed countries and about 40% in the developing world. Therefore, any health intervention geared towards reducing diseases, must be concerned with changing people's behaviour. In order to be able to do this effectively, one must understand the practices, behaviours and lifestyles of people as well as the rationale for engaging in such practices. This brings into the fore front, the need for sociological and anthropological data about communities. The teaching of social sciences to medical students therefore, deserves greater attention than is being accorded to it in the existing medical curricula. The Nigerian Anthropological and Sociological Association (NASA) which by the Grace of God, I am the current President, is working out a formal programme that will promote greater interactions between

Sociology/Anthropology and other disciplines such as Medicine, Law, Agriculture e.t.c. When this plan is properly put in place, the relevance of Sociological/Anthropological data not only to health and disease, but to nation building will become very glaring.

Recommendations

Mr. Vice-Chancellor, Sir, it is obvious from the foregoing that there is now a greater awareness and appreciation of the importance of social factors in health and disease among health workers in our great nation. However, what is still lacking is how the health workers can be assisted to acquire the relevant social science knowledge that will adequately prepare them for the tasks ahead. In the light of this, I am suggesting that there should be greater inter-disciplinary collaborative research involving social scientists and clinicians within a more formalized structure in the medical schools. That way, (i) total war can be waged against some harmful common practices and (ii) an effective health education programme can be pursued using the Participatory Rural Appraisal (PRA) techniques of the social sciences.

Moreover, given the limited social science input in the existing medical curriculum as earlier mentioned, there is need to reform the curriculum by including a well-conceived and integrated course which will ensure that the physicians-in-training are sufficiently grounded in the appropriate social science knowledge. This may actually imply a contraction of the curriculum so that all facets of the social sciences are taught throughout the medical programme, particularly, in the clinical

years, when the medical students are actually involved with patients and kins who belong to a different world from theirs, and whose conceptions of disease and health are totally different.

Mr. Vice-Chancellor, Sir, I would like to suggest that contacts be established between the relevant professional bodies (NASA/ NMC) to work out the modalities for effectively injecting a sufficient dose of social science into the medical curriculum.

Also, in order for the social sciences to gain a stronghold within the medical establishment, there is need for a total restructuring of the present system so that it will be possible to have a Department of Social Sciences within the medical schools. This proposal, if accepted will attract qualified social scientists who should enjoy equal rights with their medical counterparts. The proposed reforms should endear social scientists to medical schools, facilitate collaborative research, and also help to protect social scientists from professional domination in the medical schools. So far, there is no chair for a Medical Sociologist/Anthropologist in any medical school in Nigeria. I would like to suggest that creating one would be a positive step in the right direction. Perhaps our great institution would like to take the lead in that direction.

Lastly, Medical Sociologists and Anthropologists can be involved in programme formulation, monitoring of health projects and the implementation of health policies at the local, state and national levels in Nigeria. With their background knowledge of the culture, beliefs and practices of the people, social scientists will be able to make meaningful inputs into policy formulation and project implementation for effective health care delivery in

our great country at all levels. Following from this, I am suggesting that social scientists should occupy senior positions in the Ministries of Health, both at the state and national levels.

Mr. Vice-Chancellor, distinguished ladies and gentlemen, I thank you all for listening.

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