Patterns of illness behavior among rural dwellers in Southeast Nigeria: a review of literature

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Abstract

Illness is the absence of health in an individual. Illness behavior is an individual's response to signs from the illness. Illness behavior has been related to social factors, such as family structure, religion, culture, among others. In this review paper, the Health Belief Model (HBM) was used to examine the pattern of illness behavior among rural dwellers in Southeast Nigeria. This model is hinged on four perceptions: perceived susceptibility, perceived severity, perceived barriers and perceived benefits. The literatures reviewed were awash with problems associated with illness behavior in Southeast Nigeria. The prevalent patterns of illness behaviour documented in literature about rural dwellers of Southeast Nigeria featured negative illness responses and patronage of traditional or private healthcare providers as popular options among the people. The paper recommended among other things that more health facilities be built and that cost of services be made affordable. Also, there is need for health workers to be regularly re-trained to adopt appropriate attitudes at their work places.
Keywords: Illness, Illness behavior, health, rural dwellers, Southeast Nigeria.

Introduction

Illness behavior is any behavior or set of actions taken by an individual who feels ill in order to relieve that experience or better define the meaning of the illness experience. (Christen, 2004). It describes the way individuals and social groups respond to abnormal signs and symptoms. Illness behavior could also be viewed as how a particular person monitors his or her symptoms, takes action and uses the health care system.

It is difficult to undertake a global approach of analysis on illness behavior because societal factors vary throughout the world and shape illness behavior differently. Thus, illness behavior is better sociologically examined and compared across societies with reference to traditional belief systems, economic factors, religion and cultures, among other factors.

Indeed, like other types of human behavior, many social and psychological factors intervene and determine the type of illness behavior expressed by an individual or a

social group. (Beker, 2012). There are obvious differences in patterns of illness behavior across societies over time and within sections of a society. For instance, the elite classes were most concerned with health, sanitation and illness in the ancient world. They were propelled by their educational background to desire good health and sanitation.

Writing on illness behavior among third world countries, Lipowski (2008) described their interpretation of illness as often associated to: challenges, the enemy, punishment from gods, body weakness etc. He argued that interpretation of symptoms influences the likelihood to adequately recognize an underlying illness and promptly seek medical-care. According to him, some of the description given in third world countries to illness situations are due to the developing nature of these countries and often give rise to seeking traditional remedies or self-help solutions.

Despite the introduction of western medicine and health care system in Africa, many African communities still rely on traditional health care (WHO, 2001). WHO (2001:1), defines traditional medicine or traditional health care as the 'total combination of knowledge and practice, whether explicable or not, used in diagnosing, preventing or eliminating physical illness. This practice exclusively relies on past experiences and observations handed down from generation to generation, verbally or in written form.

Illness behaviors in the form of patronage of traditional medicine have become a dominant mode of response among the people in many countries in Africa. This is partly because the use of herbal remedies has a long history and has gained tremendous popularity in Africa and even worldwide. For example, among Ghanaian communities especially in Akan communities, one could be ill through invocation of curse in the name of the river deity, *Antoa*, upon an unknown offender. Therefore, illness behaviors and actions often taken by the individual in order to relieve his or herself symptoms usually end up in traditional means. It includes trying to appease the offended deity. However, though these traditional means are easily accessible and cheap, they may not be always accurate.

Given that studies like Christensen (2004), Beker (2012), Lipowski (2008) and Mechanic (1960) have related illness behavior to a variety of factors like education, economic,

religion, family structure, culture, social network, psychological matters, among others; this review paper is thus an attempt to discuss the specific factors implicated in the illness behavior of rural dwellers in Southeast Nigeria. Studies that specifically focused on Southeast Nigeria are critically reviewed to bring to limelight the patterns of illness behavior that prevail among rural dwellers of the region.

Conceptualizing Illness Behavior

The concept of illness behavior has been defined in related dimensions by scholars. According to Berker (2012), it refers to the ways in which symptoms may be perceived, evaluated and acted upon at an individual level. He further argued that illness behavior across individuals and groups may vary greatly according to illness-related, patient-related and doctor-related variables and their complex interactions (Beker, 2012). Illness behavior can also be viewed as activities of a person that considers him or her to be ill for the purpose of defining the state of health and for seeking solutions.

Medical historian, Henry Sigerist (1929), had observed that different societies have organized and assigned specific social status to ill-persons characterized by privileges and obligations. Similarly, the American Sociologist, Talcott Parsons (1951), introduced the term 'sick-role', which allows some privileges to sick persons like being exempted from normal responsibilities and social duties (such as work). The concept of sick role also includes the obligation to try to get well and thus to seek qualified help and to cooperate or participate in processes aimed at recovering.

Mechanic and Volkart (1960) investigated the different ways people react to physical symptoms and the psychological and cultural factors affecting such reactions. They defined illness behavior as ''the ways in which given symptoms maybe differentially perceived, evaluated and acted (or not acted) upon by different kinds of persons. Subsequently, Mechanic provided the following specifications: illness behavior refers to the varying ways individuals respond to bodily indicators, how they monitor internal states, define and interpret symptoms, make attributions, take remedial actions and utilize various sources of informal and formal care. The simple fact that, in the presence of certain physical signs and symptoms (e.g. chest pain), some persons immediately seeks

medical help while others wait a long-time before consulting a physician or seek help suggests the likelihood of intervening factors which propel or restrict individual from acting promptly.

Illness behavior involves several variables related to health-care efficacy and outcomes. According to Mechanic and Volkart, the way persons react to an illness may depend on four characteristics of that illness:

- frequency in population,
- familiarity of the symptoms to the average member of the population,
- predictability of the outcomes and
- Degree of threat and loss.

The behaviors that are often considered as components of illness behavior include how individual monitors and interpret bodily sensations, utilize health care resources, discuss illness or symptoms with providers and adhere to prescribed medical regimen. All these components are geared towards getting physical and emotional relief.

Christensen (2004), further categorized illness behavior into two broad forms/types: self-care behavior and health care utilization behavior. Self-care behavior include any action taken to manage or improve health conditions in the absence of direct medical attention which include managing symptoms and caring for minor injuries. On the other hand, health utilization behavior is actions that involve direct use of health care services (Christensen, 2004).

Brief Overview of Southeast Nigeria

South East of Nigeria is one of the six geopolitical zones in the country. The other regions are South-south, South-west, North-east, North-central and North-west. The South East region consists of the following states: Abia, Anambra, Ebonyi, Enugu and Imo. Its population is characterized by the diverse Igbo cultures. There are equally diverse Igbo languages or dialets in the area, although English language is also in use thereat.

The major ethnic group in the Southeastern region part of Nigeria is the Igbo and their main occupation is farming, trading, iron-smiting, sculpture, among others. Craftsmen are

also found in this region. The most important crop in this region is yam which brings about the different cultural activities like the new yam festival, masquerade festivals and extended family ties where kin-group members support each other with seed yams for new planting season.

Their customs and traditions include the Igbo people's visual art, their religious beliefs in the Supreme Being *chi-ukwu*, birth, marriages and death rituals, unique Igbo attire etc. The major religions in this region are Christian and traditional religions.

Both traditional and modern health institutions exist in Southeast Nigeria upon which the population has relied in times of illness and other health challenges. Furthermore, the people's traditional religious belief systems have often played dual roles of enhancing spiritual growth and as a therapeutic option during certain forms of illness.

Theoretical Framework

The paper is anchored on the health belief model developed by Irwin M. Rosen Stock in 1966, for studying and promoting the uptake of health services. The health belief model is a health behavior change and psychological model for examining uptake of health services by the population. Originally the model was designed to predict behavioral response to treatment received by acutely or chronically ill patients, but in more recent years, the model has been used to predict more general health behavior. The core assumptions, prepositions and statements of health belief model are based on the understanding that a person's willingness to take health-action or change is hinged on his knowledge, attitude, and perception and belief system. They are also hinged on four perception as follows:

- perceived susceptibility (an individual's assessment of their risk of getting the condition preached against);
- perceived severity (an individual's assessment of the seriousness of the condition and its potential consequences);
- perceived barriers (an individual's assessment of the influences that facilitates or discourage adoption of the prompted behavior);

- and perceived benefits (an individual's assessment of the positive consequences of adopting the behavior).

Constructs of mediating factors were later added to connect the various types of perceptions with the predicted health behavior. These include demographic variables (such as age, gender, ethnicity, occupation); socio-psychological variables (such as socio-economic status, personality-coping strategies); perceived efficacy (an individual's self-assessment of ability to successfully adopt the desired behavior); cues to action (external influences promoting the desired behaviors may include: information provided or sought, reminders by powerful others, persuasive communications and personal experience); health motivation (whether an individual is driven to stick to a given health goal); perceived control (a measure of level of self-efficacy); perceived threat (whether the danger imposed by not undertaking a certain health action recommended is great).

The health belief model is chosen as a theoretical framework because to a large extent it best explains the concept of illness behavior. This is because illness behavior simply describes the way in which symptoms are perceived, evaluated and acted upon by a person who recognizes some pain, discomfort or other signs of organic malfunction (Mechanic and Volkart, 1960). In other words health belief model focus on the role that knowledge, belief, perception and attitude plays in personal responsibility decisions and actions towards an illness or health service. The knowledge an individual has will influence the way in which symptoms are perceived, evaluated and acted upon.

In further studies by Howard Becker (2012), he emphasized on the utilization of health services and what prompted people to patronize a particular health service. The therapeutic skills the individual possess in a particular health service will determine whom the patient will patronize. To this extent, this belief becomes a central factor facilitating use or non-use of health services. Since health belief model is a framework that tends to emphasize the role that knowledge, belief, perception and attitude plays in personnel responsibility, decisions and actions towards an ill-state or health service, it would be of immense help in understanding the illness behavior of rural dwellers in Southeast Nigeria. It would also help in understanding their thoughts, behaviors, actions and inactions towards attaining good health.

Prevalent Patterns of Illness Behavior among Rural Dwellers in Southeast Nigeria

The socio-economic status of people in Nigeria especially the Southeastern part has been seen to be a great factor to their illness behavior (Nwankwo, 2010). Ones socio-economic class influence how symptoms of ill-health are reacted upon. Lower class individuals are most likely to delay seeking professional health care services even when presented with severe symptoms. It is against the above background that Iyalomhe (2012) argued that illness behavior involves social processes that begins from individual interaction with social network and extends to the community interaction with health system.

On their part, Uzochukwu and Onwujekwe (2004) studied four local government areas that have operated the Bamako Initiative in Southeast Nigeria. The Bamako Initiative (BI) was introduced by African Ministers of Health at their meeting in Bamako Mali in 1987 and endorsed by Nigerian Government in 1988. Bamako Initiative (BI) sought to accelerate and strengthen the implementation of primary health care (PHC) services in countries with poor health care structures by making people pay for services in form of user fee. The four local governments studied by Uzochukwu and Onwujekwe were: Ihiala and Nnewi-South LGAs in Anambra State and Isi-uzo and Oji River LGAs in Enugu State. The people from all the study area are of "Igbo" ethnic groups and Christianity is the major religion in these communities, although traditional religion is still practiced by some people. Malaria was the major tropical illness followed by diarrhea, eye and respiratory diseases. Others include malnutrition, onchocerciaasis and HIV/AIDS. The study found that the initial choice of care for malaria among the people was the patent medicine dealers followed by the government hospitals and the health centers. About 11.7% consulted medicine dealers for treatment, private clinics and community health workers. Most of all these initial choices were private health facilities. The poorer the individuals, the more likely it is that they will resort to self-diagnosis and on family members. The richer households were more likely to use BI health centers. Therefore, socio-economic differences were a sharp factor in health seeking behavior of the people

Uzochukwu and Onwujekwe (2004) further found that availability of good health services, proximity of the centers to the homes and polite health workers influenced the population to adopt positive health behavior. Appropriate information, education and

communication were also organized to let the less informed know about the need for early solution to illness.

Another study on the residents of Abia State in Southeast Nigeria by Onyeonoro et al (2015) showed that patent medicine vendors were the most common sources of primary care following the onset of illness, while fewer individuals used formal care. The factors that give rise to this included their educational status, income, occupation and body mass index. These factors also differentiated the rural dweller from the urban dwellers.

A study conducted in North Central Region of Nigeria showed that individuals preferred seeking for solution to their ailment in private facilities rather than the government hospitals (Akande and Owoyemi, 2008). This finding could also be applicable to the Southeast area as the level of development of the two areas is not wide apart. Furthermore, Jackson (2012) reviewed illness behavior in some African societies and found that 70% of individuals accept the use of traditional remedies and faith based solutions. Again, this finding reflects the situation in Southeast Nigeria given findings by Uzochukwu and Onwujekwe (2004), and Onyenoro rt al (2015).

In a recent WHO study on Nigeria, as many as 71% of rural dwellers have reported inappropriate health seeking behavior during their last illness episode, while only 53% of urban dwellers reported inappropriate health seeking behavior during their last illness episode. Similarly the University College Hospital, Ibadan (2014) conducted a study between August-September 2014 on the civil servants which showed that variables influencing their health seeking behavior include: socio-demographic characteristics such as age, marital-status, highest level of education completed, family size and socio-economic status. These variables are highly relevant and applicable to the Southeast in Nigeria.

From the review of literature, the major problems related to illness behavior of people of Southeast Nigeria are as follows: loss of self, devalued self, depression, poor stress management etc. Loss of self was coined by Charmaz (1983) after her research in 1980s where she interviewed individuals with chronic illness through a symbolic interactionist perspective. According to her 'loss of self' develop from the illness conditions and illness

experiences. Charmaz describes individuals with illness experiences as living a restricted life, experiencing social isolation, being discredited and burdened by others. The individual with illness encounters loss of self-image, without the development of an equally valued new one.

Townsend, Wyke and Hunt (2006) in their qualitative study described the moral dimension of the illness experience. Their work contends that moral work is integral to the illness, similar to the biographical and everyday "work". Individuals under moral obligations tend to manage symptoms alongside their daily life. Anderson (1991) described the self-devaluation with an example of women with diabetes with devalued personalities (not only from the illness experience) but also of dealing with being marginalized and known. Interaction with health care providers, which were even frequently negative in nature, added additional sources of stress to further devalue these women.

On the other hand, this review also provide the evidence for under listed prospects for enhancing positive illness behavior amongst rural dwellers in Southeast Nigeria. Such prospect involves among other things, adopting Talcott Parson's sick role model which has four basic characteristics as follows:

- First, the sick person is freed from normal social roles and obligations such as attending a social gathering.
- Secondly, people in sick role are not directly responsible for their plight.
- Third, the sick persons try to get well. The sick role is regarded as a temporary stage of deviance that should not be prolonged if at all possible.
- Fourthly, the ill persons must seek competent technical help and cooperate with the care-givers.

This Talcott Parson's sick role model will serve as a guide to positive illness behaviors to individuals in Southeast Nigeria. Thorne's (1990) study of individuals with illness found out that their relationships with health care professionals evolved from what is termed "naive trust". Although sick role dependency may be adaptive in acute illness, medical expertise should always offer hope of a cure. Attempts to normalize interactions and

lifestyles during illness behavior of individuals are necessary in order to acquire positive disposition to their state of health.

Conclusion

This paper has reviewed literature on the patterns of illness behavior among rural dwellers in Southeast Nigeria. Such behaviors as documented in literature include patronage of traditional treatment options, delayed response due to cost, visit to private options among others. These illness behaviors can be as a result of factors such as: low level of education, economic status, religious belief systems, and social network, among others. The major problems of illness behavior in the area include losses of self, depression, anxiety, among others. The Health Belief model developed by Irwin M. Rosen Stock was used as theoretical standpoint. In line with Talcott Parson's proposition, the paper recommends that sick role should be promptly granted to individuals who are sick to enable them leverage on its advantages. The attitudes of health care providers must also improve, while advocacy should be stepped up to encourage extensive use of available modern health facilities in rural areas of Southeast Nigeria.

Recommendations

Based on the study, the following recommendations were made:

(1.) There should be intensive public enlightenment and health education of the public to sensitize them on available health services and the need for them to patronize them to their advantage.

(2.) Attitudes of individuals towards illness should be improved through dissemination of knowledge and other relevant information about illness, including the need for the population to always adopt positive illness behaviors.

(3.) Availability of health facilities should be enhanced for rural areas. Government and NGOs should build more facilities.

(4.) Positive attitude of health workers should be the norm in order to give individuals relaxed environment to access health care. This will be achieved through training and re-training programs for health workers.

(5.) The cost of health care services should be made affordable especially in the rural setting. Community-based health finance option could be introduced in such rural environment to cut cost of health services.

(6.) Private bodies, non-governmental organizations and even government should cooperate with health care practitioners to ensure adequate and effective ways of health care delivery to the rural dwellers in Southeast Nigeria.

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