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Okoye, U. O. (2019). Health care social work in Nigeria. In Winnett, R., Furman, R., Epps, D., & Lamphear, G. (Eds.), *Health Care Social Work: A Global Perspective* (pp.149-161). New York: Oxford University Press

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Editorial

Over the years, the Niger Delta region has been in the radar of global research due to her numerous social challenges ranging from militancy, high rate of teenage pregnancy, kidnapping, pipeline vandalism, environmental degradation, etc. While, there have been journals within the region focusing exclusively on environmental or political issues, other journals have simply adopted a multi-disciplinary approach in their publications. Hence, there seems to be a knowledge gap in existing journals as none is completely dedicated to the sociological study of the Niger Delta Region. It is on this note that we have the great pleasure of announcing the maiden edition of the Niger Delta Journal of Sociology and Anthropology (NDJSA), an official journal of the Department of Sociology, Niger Delta University, Wilberforce Island, Bayelsa State, Nigeria. Though, the pioneering effort of this journal dates back to the early 2000s when the department of sociology was founded, but not until recently that the effort of both pioneering and new staff of the department has come to fruition. Thus, NDJSA was formally introduced in 2020 to the global research community as an effort to understand the social peculiarities and problems confronting the Niger Delta region and Nigeria at large.

While the scope of the journal is geared towards a sociological discourse of the Niger Delta region, issues within the Nigerian state and Africa at large are also highly welcome as most social problems within the African region are not independent of one another. Hence, NDJSA welcomes research, reviews, commentaries, case studies, and note to the editors which adopt a sociological or anthropological view of issues. The primary objective of NDJA is to encourage, promote, guide and disseminate high quality and original research papers which might be very useful for policy recommendations, and also increase the knowledge-base of social science practitioners. It is on this note that every work to be published in NDJSA shall be subjected to the rigorous peer-review process and academic standards.

It is expected that as the journal progresses in its journey to attain a world-class standard, improvements will be made subsequently in line with global best practices. Already, efforts are being made to register the journal with African Journal Online (AJOL) CrossRef. and distribute it under the creative commons license. This will, no doubt, give the journal very high visibility in the global community. The journal also hopes to metamorphose from its current biannual status to at least a quarterly publication.

The timely publication of this maiden edition would not have been possible without the efforts of our reviewers and advisers. On this note we wish to express our profound gratitude to all our reviewers and advisers; your continual collaboration as gatekeepers to the academic community is still highly solicited. We will not forget to acknowledge our esteemed contributors who chose to publish with us even at our infant stage. We hope that you will consider and recommend our journal to other colleagues around the globe. Finally, we wish to appreciate the support of members of the

Department of Sociology, the Faculty of Social Sciences, and the Niger Delta University administration who provided the platform for this journal to be hosted.

This maiden edition of the journal contains seven papers drawn from different areas of specialisation within sociology and anthropology, namely, medical sociology, sociology of development, criminology, industrial sociology and environmental sociology. The contributors cut across almost all the geo-political zones in Nigeria, with all their articles recommended for publication by the reviewers after major and minor corrections. This, no doubt, has set the journal on a very high pedestal. We conclude by calling others within the academia, development planners and policymakers, researchers and postgraduate students especially within the Niger Delta Region to consider our journal in publishing their research findings, and solicit other forms of support for the journal to prevail.

Dr E.A. Sibiri
Editor-in-Chief
Department of Sociology,
Niger Delta University, Wilberforce Island, Bayelsa State, Nigeria.
Tel: +2348064761059. **Email:** elliotsibiri@ndu.edu.ng

How Social Distancing Will Affect our Lives: A Commentary

[1]Endurance Uzobo, P.hD and [1]Ruth E. Omu

[1]Department of Sociology, Niger Delta University, Nigeria
Correspondence: enduzobo@gmail.com

The Coronavirus Disease which broke out in Wuhan, China in 2019 and was later declared a global pandemic by the WHO in March 2020 has not left the world the same (De Vos, 2020). Since the emergence of the coronavirus, there is barely any aspect of the social system that functions optimally (including the health institution). COVID-19 is an event that has challenged age-long beliefs about the socio-economic organisation of man's life.

There is no doubt that the impact of such social upheaval will not be forgotten in a hurry. The effect of this pandemic cuts across all social strata in society; though some have argued that it is taking more toll on the upper-class members of society. The first rule of staying free from the virus as almost every health professional has stressed is social distancing – a concept that only became relevant at the wake of the coronavirus. Social distancing as defined by the Apoorva Mandavilli in "*wondering about social distancing"* is the idea to maintain a distance between you and other people — in this case, at least six feet (cited in Engel, 2020). However, in its broadest sense, we could use it to mean minimising the level of contacts we have with people. That is; avoiding public transportation when and where possible, limiting of non-essential travels, staying away from the workplace or working from home were necessary and skipping any form of social gathering such as; worship centres, bars, wedding, burial ceremonies, etc.

Social distancing, no doubt, has helped to save millions of lives. In fact, as Dr Gerardo Chowell, chair of population health sciences at Georgia State University puts it; *"every single reduction in the number of contacts you have per day with relatives, with friends, co-workers, in school will have a significant impact on the ability of the virus to spread in the population"* (cited in Mandavilli, 2020).

For many, coronavirus is an event that will re-shape society in lasting ways cutting across travels, buying and selling, social bonding, security, etc. Thus, this pandemic that contained many at their homes is already reorienting our relationship to friends, family, colleagues, the government, and the

world at large. Some of these changes we are expected to see might feel so unfamiliar and unsettling. Hence, questions like; will people still maintain the convivial and touchy relationship they have so long practised, or will touching become a taboo (especially handshakes and kisses as a form of greeting)? What will become of social hang-out especially in clubs and bars? Will more events be organised through virtual platforms? These and more are some of the questions that are ahead of us in the coming weeks, months, year or years (Politico, 2020).

One basic issue that currently needs to be addressed is how social distancing is currently affecting our lives. The effect of social distancing can be likened to two sides of a coin as we will keep experiencing both positive and negative impacts. On a positive note, social distancing has made many to realise the fact that some things we do, places we go to, and travels we embark upon are not as important as we thought they were. Furthermore, families will have more time for themselves as they remain at home, therefore resulting in more social bonding between family members. On a negative note, it has disrupted the calendar of the people in the world as pre-planned activities such as family meetings, wedding and burial ceremonies, birthday parties, conferences and symposia, and sports activities have all been disrupted and subsequently postponed.

According to Deborah Tannen, a professor of linguistics and author of "*You're the Only One I Can Tell: Inside the Language of Women's Friendships"* (cited in Politico, 2020), we can suffer the calamities of past eras, like the economic meltdown of the Great Depression. For instance, we are now well aware of the fact that touching things or people, maintaining proximity with other people and sharing the same air space with others could be very risky. Inasmuch as we concur that the level of this awareness will recede with time (depending on the socio-demographic characteristics of the group), it might be impossible that it will disappear for people of our current generation. Therefore, it could become second nature for people to recoil from shaking hands, kissing, touching our faces. The washing of hands which most hygienic households have maintained might just become the norm of every household after they go out and come back.

In the months to come following the post coronavirus, the effects of social distancing will still be felt. As more individuals and organisations embrace virtual gatherings and meetings, several businesses may be affected leading to retrenchment, loss of jobs and source of livelihood. Also, students will experience a setback educationally as the majority of those affected do not have access

to the internet to study at home. Theda Skocpol, a professor of government and sociology at the Harvard University (cited in Politico, 2020) wrote: *"...but many will struggle with job losses and family burdens. They are more likely to be single parents or single-income households. They're less able to work from home, and more likely employed in the service or delivery sectors, in jobs that put them at a greater danger of coming into contact with the coronavirus. In many cases, their children will not gain educationally at home, because parents will not be able to teach them, or their households might lack access to the high-speed Internet that enables remote instruction".*

Additionally, social distancing could result in health issues such as isolation which could lead to loneliness and subsequently, depression, high blood pressure, and death from heart disease, weight gain due to less exercise and activities, etc. Married and cohabiting couples would engage in more sexual activities, this could also result in more births at the end of the social distancing period. However, People will learn how to do things they do not know how to do as they sit at home. In order to beat boredom and loneliness, more and more persons will engage in profitable enterprises at home. Notwithstanding, the social distancing period is not going to be an easy one, thus people are advised to brace up for whatever may come. In his *Palaces for the People: How Social Infrastructure Can Help Fight Inequality, Polarization, and the Decline of Civic Life*, Eric Klinenberg a professor of Sociology and Director of the Institute for Public Knowledge at New York University wrote: *"the coronavirus pandemic is going to cause immense pain and suffering. But it will force us to reconsider who we are and what we value, and, in the long run, it could help us rediscover the better version of ourselves"* (cited in Schwartz, 2020).

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Authors' Profile

Dr Endurance Uzobo is a lecturer in the Department of Sociology, Niger Delta University, Nigeria. He is a member of the International Sociological Association (ISA), Nigerian Anthropological and Sociological Practitioners Association (NASA), Population Association of Nigeria (PAN) etc. He has several articles published in reputable international and national peer-review journals and has attended and presented papers in reputable conferences in Nigeria. He is a two-time recipient of the TETFUND research grant and has consulted for Clear Water Initiatives (CWI). His area of research includes Sociology of Health and Illness Behaviour and Demography/Population Studies. He could be contacted via enduzobo@gmail.com

Ms Ruth Ebikaboere Omu is a Lecturer in the Department of Sociology, Niger Delta University, Wilberforce Island, Bayelsa State. Her area of research interests includes health and illness, and gender studies. She is a member of Nigerian Anthropological and Sociological Practitioners Association (NASA). She is currently a doctoral student of the Department of Sociology, University of Ibadan, Oyo State. She can be contacted via rutex02@gmail.com

Community Perception of Coronavirus Disease (COVID-19), Stigma and Preventive Practices in Lafia, Nasarawa State, Nigeria

[1]Joyce R. Akpenpuun, [2]Joy N. Waroh, [3]Bilkisu M. Aboda, [2]Andrew A. Kula & [2]Celina A. Eze

[1]Department of Sociology, Benue State University Makurdi, Nigeria
[2]Department of Sociology, Federal University of Lafia, Nigeria
[3]Department of Sociology, Kogi State University Anyigba, Nigeria.
Correspondence: joywaroh@gmail.com

Abstract

Coronavirus Disease (COVID-19) is a pandemic that has affected the whole world and Nigeria is not an exception. Perceptions about every disease determine attitude and behaviours towards it with significant consequences. This study examined community perception of COVID-19, stigma-generated fear and investigated adherence to COVID-19 preventive measures in Lafia Local Government Area (LGA). The study anchored on Social Cognitive Theory and the design was a cross-sectional survey. The study population was 463,989 people, resident in Lafia. Respondents were selected using a multi-stage sampling method. Instruments of data collection were questionnaire and Focus Group Discussion. 397 respondents completed the questionnaire while 2 FGDs were held in each selected ward for the study. Quantitative data were analysed using descriptive statistics. Qualitative data were content-analysed. Mean age of the respondents was 37.6 $\pm$ 4.6. Findings revealed that the community perception towards COVID-19 is negative (Rich/elites disease, White man's virus, exist only in big cities, cannot be transmitted under the sun, political disease). Fear generated stigma is high (62.2%) and adherence to Covid-19 preventive measures is generally poor. The majority (70.3%) do not observe all the preventive measures when they are in public places. The study recommends that the government and non-governmental organizations should sponsor educational campaigns through health extension workers to educate and enlighten people at the community level on COVID-19 to help in re-shaping community member's perceptions and attitude towards the disease.

Keywords: Adherence, COVID-19, Perception, Preventive measures, Stigma.

Introduction

The global community is facing unprecedented challenges due to Coronavirus Disease. Coronaviruses are emerging respiratory viruses that are known to cause illnesses ranging from the common cold to severe acute respiratory syndrome (SARS) (Yin & Wunderink, 2018). The coronavirus disease (COVID-19) is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Zhou, Yu, Du, Fan, Liu, Liu, Xiang, Wang, Song, Gu, Guan, Wei, Li, Wu, Xu, Tu, Zhang, Chen & Cao, 2020) and it is transmitted from humans to humans through droplets, feco-

oral, and direct contact and has an incubation period of 2-14 days (Backer, Klinkenberg, & Wallinga, 2020). Illnesses resulting from the virus could be fatal in severe cases.

The COVID-19 is reported to have originated from Wuhan, Hubei, China, in December 2019 (CDC, 2020) and has rapidly spread across the globe (WHO, 2020). COVID-19 is a public health emergency of international concern (WHO, 2020) and it is declared a pandemic by the World Health Organization (WHO, 2020). The disease has affected a lot of communities worldwide. The World Health Organization observed that COVID-19 pandemic has led to severe socio-economic disruption (WHO, 2020). The disease has also led to discrimination of people (Zhou, et al, 2020) as well as a high rate of morbidity and mortality across the globe. Nigeria confirmed its first case of COVID-19 in Lagos State in February 2020 (NCDC, 2020) and has continued to have her fair share of its effects. The disease is ravaging Nigeria as in many parts of the world (Olapegba, Ayandele, Kolawole, Oguntayo, Gandi, Dangiwa, Ottu, & Iorfa, 2020). According to the NCDC, all the 36 states and the FCT have been affected (NCDC, 2020).

Although, many countries across the globe, including Nigeria, are facing challenges as a result of the COVID-19 pandemic; there are yet no specific vaccines or treatments for the disease. Various non-pharmaceutical strategies have however been adopted to help in preventing and lowering spread and transmission of the disease. Social distancing is one of such non-pharmaceutical measures adopted. Social distancing aims to minimize physical contact between individuals and thereby reduce the possibility for new infections (ECDC, 2020). Regular hand washing for at least 20 seconds after visiting public spaces using soap and water or rubbing the hands with sanitizer that contains at least 60% of ethanol is also recommended (IPC, 2020.) The use of a face mask in public places is also recommended. It is believed that being well informed about COVID-19 and adhering to the adopted preventive strategies could help in preventing and slowing the transmission of the disease.

The benefit of the strategies adopted to mitigate the impact of COVID-19 in the world and Nigeria in particular can, however, be realised depending on the people's perception and attitudes towards the disease. Studies have proved that people's perception about a disease does influence their attitude and health-seeking actions/behaviours for the diseases concerned (Infanti, Sixsmith, Barry, Núñez-Córdoba, Oroviogoicoechea-Ortega, & Guillén-Grima, 2013). People's beliefs and

perceptions also shape their behaviour's and the ability to adopt or cope with existing health interventions (Tanner & Vlassof, 1998; Glanz, 2013). Perceptions about COVID-19 in Nigeria can, therefore, influence people's attitude towards the disease and their ability to cope with the preventive strategies adopted and this is capable of determining the rate of transmission and spread as well as health outcomes. Thus, assessing community perceptions of coronavirus disease (COVID-19), stigma and preventive practices becomes necessary. The study generally explored community perception of COVID-19, stigma and preventive practices in Lafia LGA.

Theoretical framework: Social Cognitive Theory (SCT)

This study was guided by the social cognitive theory developed by Albert Bandura. Social Cognitive Theory (SCT) started as the Social Learning Theory (SLT) in the 1960s by Albert Bandura. It developed into the SCT in 1986 and posits that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behaviour. Bandura argued that human behaviour is caused by personal, behavioural, and environmental influences (Bandura, 1986). According to this theorist, the environment does not only affect behaviours but it also leads to the development of thoughts and emotions that shape behaviour. This implies that individuals determine their behaviour while being influenced by environmental factors and their behaviour. Bandura (1986) also contends that behaviour is largely regulated by cognitive factors such as the perception of an issue and the pattern within the environment.

In the context of this study, it can be argued that perceptions, stigma-generated fear and preventive behaviour towards COVID-19 cannot occur in isolation; it could emanate from the interaction of individuals in their environment and reflect in their attitude towards the disease. In the process of interacting with others in the environment, people are more likely to adopt behaviours by observing attitudes of other individuals with whom they can identify. By identifying with others, the observer feels similar to such individuals and the observer could imitate their actions (Bandura, 1988).

Materials and Methods

The study was carried out in Lafia LGA, Nasarawa State. Lafia LGA is located in North Central Nigeria. Lafia is the capital city of Nasarawa State; it has a land area of about 2756.44 sq. km and shares boundaries with Nasarawa Eggon LGA to the North, Obi LGA to the South, Doma LGA to the West and Plateau State to the East. The LGA is made up of 13 council wards namely; Adogi, Agyaragu Tofa, Akurba/Bakin Rijiya, Arikya, Ashigye, Assakio, Chiroma, Gayam, Keffi Wambai,

Makama, Shabu/Kwandere, Wakwa and Zanwa. The population of Lafia based on the 2006 census results stands at 330,712 (National Population Commission, 2006). Based on projection the 2019 population of Lafia Local Government stands at 463,989 using 3.1% increment for 13 years.

The study was a community-based cross-sectional study and the populations of the study were total population in Lafia estimated at 463,989. Individuals from 20 years and above resident in Lafia LGA participated in the study. A sample size of 400 respondents was drawn using Taro Yamane sample size determination formula for a finite population.

Multistage sampling was used to select respondents. First, Lafia was demarcated into 13 clusters according to the number of existing wards that make up Lafia and six (6) wards were randomly selected and considered for the study. In each selected ward, a systematic sampling technique was employed in selecting households in the ward headquarters. In each selected household a respondent from 20 years and above was purposively selected after consent to participate in the study.

The instruments for data collection were the questionnaire and Focus Group Discussion (FGD) guides. A total of 400 copies of questionnaire were distributed and 2 FGDs were held in each of the 6 council wards selected for the study. Three (3) field assistants who were thoroughly trained on the instruments used for the data collection helped in the data collection process. During the Focus Group Discussions, social distancing and wearing of face mask were ensured and each group of discussants consisted of 8 members.

Face validity of the instruments used for data collection was ascertained by a team of researchers from Benue State University, Makurdi and the Federal University of Lafia after the instruments were thoroughly scrutinized for appropriate content.

Results

At the time of collation of the quantitative data, only 397 (99.3%) of the retrieved copies of the distributed questionnaire were completed correctly and found ready to be used. The 397 copies of the questionnaire formed the basis of the quantitative analysis. The qualitative data were transcribed, content-analysed and presented in narrative form. Result of the quantitative and qualitative data was triangulated and presented jointly.

Table 1: Socio-demographic variables

Variables	Frequency(N=397)	Per cent (%=100)
Age		
20-29	57	14.4
30-39	106	26.7
40-49	131	33.0
50 and above	103	26.0
Sex		
Male	240	60.5
Female	157	39.5
Marital status		
Single	100	25.2
Married	279	70.3
Divorced/separated	7	1.8
Widowed	11	2.8
Educational background		
Non-formal	4	1.0
Primary	106	26.7
Secondary	190	47.9
Tertiary	97	24.4
Occupation		
Self-employed	161	40.6
Public-employed	107	27.0
Private- employed	129	32.5

Source: Field survey 2020

Table 1 presents the demographic characteristics of respondents. The gender distribution shows that more males (60.5%) participated in the study. The low percentage of the female composition may be connected to gender bias occasioned by possible cultural issues found in most patriarchal communities which Lafia LGA may be no exception. It could be that males are more favourably disposed and more willing to air their views on the issue of COVID-19 in the study area. The age distribution shows that the respondents are adults who are capable of stating their opinions on issues of COVID-19 in their communities. Educationally, the distribution shows that only 4(1.0%) have a non-formal education. Majority of the respondents were literate enough to read and respond to questions.

Table 2: Community perceptions of COVID-19

Statements.	**Response Frequency/Percentages (%)**				
	S/A	A	U	D	S/D
COVID-19 has political undertone in Nigeria and is projected by politicians to their advantage.	149(37.5)	134(33.8)	1(0.3)	96(24.2)	17(4.3)
COVID-19 is a White man's virus and cannot survive in this region of the world.	77(19.4)	139(35.0)	17(4.3)	128(32.2)	36(9.1)
COVID-19 is a disease for only old people	19(4.8)	87(21.9)	5(1.3)	222(55.9)	64(16.1)
COVID-19 is a disease of the rich/elites in Nigeria.	10(2.5)	216(54.4)	2(0.5)	148(37.3)	21(5.3)
COVID-19 is just like any other flu out there and not as deadly as magnified in Nigeria.	11(2.8)	209(52.6)	21(5.3)	101(25.4)	55(13.9)
COVID-19 is not heat-friendly and cannot be transmitted when the sun is high.	56(14.1)	132(33.2)	37(9.3)	151(38.0)	21(5.3)
COVID-19 is transmitted and spread only in big cities and cannot be in rural communities.	99(24.9)	161(40.6)	2(0.5)	125(31.5)	10(2.5)
COVID-19 adversely affects only people with underlying health conditions such as diabetes, cancer, high blood pressure, kidney disease, stroke, HIV among other chronic diseases.	81(20.4)	183(46.1)	9(2.3)	120(30.2)	4(1.0)

Source: Field survey 2020

From the pattern of responses shown in table 2, it can be deduced that there is a negative perception of COVID-19 among members of the community. Participants at the Focus Group Discussions held also demonstrated negative perceptions. A 42-year-old male participant during a discussion stated thus:

> I don't think there is any serious COVID-19 in Nigeria as projected by our leaders; it is just a political disease. If there were COVID-19 in Nigeria the way they are carrying it half of Nigerian's would have been no more by now. This sickness is not our thing and not with us, those that went to the white man's country to bring it have passed away and so have the disease. The disease is now politically motivated. Our leaders pray for COVID-19 and scare us with it so that they can make money out of it but the Almighty God has shamed them, they will soon be tired and declare Nigeria COVID-19 free.

A 37 years old female participant, on the other hand, said:

> COVID-19 is just like any other flu out there that is cold friendly even if it is more chronic than the normal cough and catarrh we know. It is the rich people that can be most affected by it because they are always in cold environments in the name of big man, at homes they are in air-conditioners (AC), in the cars AC, in their offices AC even the water and drinks

> they take are usually chilled from the refrigerator. Do you see why it is their thing? She concluded.

Table 3: Fear generated stigma of COVID-19

Response	**Frequency(N=397)**	**Frequency Percent(%=100)**
High	247	62.2
Moderate	111	28.0
Low	39	9.8
Total	397	100

Source: Field survey 2020

Table 3 presents findings on fear-generated stigma of COVID-19. To assess the extent of fear-generated stigma, respondents were asked to rate their level of fear of stigma on the scale of 1-5 and points were given. The responses were then grouped into three categories which were high, moderate and low. All responses were then coded and manually entered into the computer and analysed with the aid of SPSS software version 23.0. Results were presented in simple percentages as shown in table 3. The result shows that there is a high level of fear-generated stigma (62.2%) in the communities. Majority of participants during the Focus Group Discussions also expressed that their level of fear of stigma is high. A 45-year-old female participant during a discussion in one of the communities observed:

> There is a high level of the fear generated stigma of COVID-19 in our communities because of the things we hear people say concerning victims, even if we do not know the victims it is normal for one to be anxious and afraid that you can be discriminated and stigmatized if you are in any way associated with the disease the same way they talk about the few people we heard suffered the disease and other imaginary victims.

A 35-year-old male participant also noted thus during a discussion:

> Everyone is afraid to be associated with COVID-19 because the government herself have created stigma factor by the way they handle and isolate people even without carrying out the test. We have heard of cases where a whole family is moved to isolation centre's after telling us that there is no cure so what exactly do, they take people away for? This creates fear of stigma and discrimination, the whole thing is just scary.

Table 4: Adherence to COVID-19 preventive measures

Variables	Response/Frequencies(N=397)	Frequency Percent (%=100)
Do you always wash your hands with soap and water whenever you visit public spaces?	Yes (168)	42.3
	No (229)	57.7
Do you always use alcohol-based hand sanitizers to rub your hands when you are in public space?	Yes (189)	47.6
	No (208)	52.4
Do you always wear a face mask when going out or in public places?	Yes (91)	22.9
	No (306)	77.1
Do you always maintain social distancing whenever you are in gatherings?	Yes (57)	14.4
	No (340)	85.6
Do you always observe all the COVID-19 preventive measures whenever you are in public places?	Yes (118)	29.7
	No (279)	70.3

Source: Field survey 2020

From the findings presented in table 4, it can be implied that, adherence to COVID-19 preventive measures is generally poor in the study area. 70.3% of the respondents do not observe all COVID-19 preventive measures. Majority of participants at the Focus Group Discussions held also demonstrated poor adherence to COVID-19 preventive measures. A 52-year-old male stated:

> I don't wash my hands regularly when I am in public space except if I am compelled to do so before gaining entrance in some places. To me, the so-called idea of washings hands with soap and water in Nigeria is just a public drama considering the nature of our society where we don't even have running water in public places even where we have we use our bare hands and open the tap or the container the water is stored in to wash our hands and close it again. Assuming the virus is on the surface of the tap handle as we touch it to open for water to rush, we pick the virus to wash it off then we use the same hands again to touch the handle to close the tap and pick up the virus again then walk away with it. Another person comes and repeats the process in the same way and manner so what is the logic here? If the virus is on the tap handle everyone coming to open and wash hands and then close the tap with bare hands is at risk. It is only God that is helping us from this COVID-19 if it is in Nigeria; it is not by regular hand washing.

Another participant, a 28-year-old male noted:

> Adherence to COVID-19 preventive measures is generally poor; hardly do you see people adhering to it and I don't regularly adhere to the preventive measures too. Some of the measures cannot even be observed even if someone is willing to try. Take the issue of social distancing for example, how do you think social distancing can be achieved in the market places? Putting on a face mask is not easy too, though I put on the face mask occasionally I am usually not comfortable with it on my face, it feels choky. Sometimes people even make jest when they see someone making conscious efforts to even adhere to the preventive measures. I once visited a friend with a face mask on and he told me to pull that thing off that there is no COVID-19 in this community except if I want to invite it.

Discussion

This study assessed community members' perception of COVID-19, examined stigma-generated fear of COVID-19 and investigated adherence to COVID-19 preventive measures in Lafia LGA. The study observed that community members have a negative perception of COVID-19 in Lafia LGA. This finding is in line with similar studies such as those carried out by Ahmad, Ahmed, Hussaini, Nuru and Shehu, (2020) in Gyadi-Gyadi, Kano State where they noted that perception towards COVID-19 in the communities was poor and the communities also had negative perception towards COVID-19 transmission and prevention. It could be that since the coronavirus disease is new with many yet to be known facts about it, a lot of people are, therefore, ignorant about the disease and hold negative beliefs towards it.

This study further revealed that the level of stigma-generated fear of COVID-19 among the community members is high (62.2%). The high level of stigma-generated fear could be due to misguided information about the disease. Studies carried out by Lai, Shih, Ko, Tang, and Hsueh (2020) noted that widespread misinformation about COVID-19 is a serious concern causing fear of people worldwide. Other studies by Banarjee, (2020) noted that misinformation about COVID-19 gives rise to mass hysteria and mistrust. Fear, hysteria and mistrust could heighten tension and anxiety in people which can lead to perceived stigma.

The study also revealed that majority (70.3%) of the community members do not adhere to all the adopted COVID-19 preventive measures when in public places. Adherence to preventive measures in the study area is generally poor. This finding is in contrast to studies carried out by Roy, Tripathy, Kar, Sharma, Verma, and Kaushal, (2020) in Indian where respondents' attitude towards COVID-19 showed a willingness to adhere to preventive measures. This contrast could be due to regional differences and the perceptions people may have about COVID-19 in these places may

vary and while this study was based on a physical self-report from respondents, the study by Roy, Tripathy, Kar, Sharma, Verma, and Kaushal, (2020) depended on an online survey.

Conclusion

This study has shown and concluded that perception towards COVID-19 in the study area is negative, fear-generated stigma is high, and adherence to preventive measures is poor in the study area. There is, therefore, need for the government and non-governmental organizations to intensify awareness and raise community consciousness on accurate information on the coronavirus disease, the modes of transmission and spread of the virus. The need for using the face mask, maintaining social distancing especially in gatherings, regular hand washing after visiting public places using soap and water or rubbing the hands with alcohol-based sanitizers should be emphasized in communities.

Recommendations

To ensure that COVID-19 does not remain a burden that will keep on spreading and affecting families, communities and the nation at large, this study recommends that:

i. The government and non-governmental organizations should sponsor educational campaigns through health extension workers to educate and enlighten people at the community level. This could help in reshaping community members' perceptions towards the disease since perceptions can determine an individual's attitude towards the coronavirus disease positively or negatively.

ii. Authorities in public health should intensify awareness on COVID-19 and also ensure accurate and necessary health information on COVID-19 is made available and accessible to people in all communities to prevent the problem of misguided information that is capable of creating a high level of tension, fear, stigma and discrimination.

iii. To curtail further transmission and spread of the virus, government should ensure that the adopted preventive measures are strictly enforced: it should ensure that people adequately adhere to such measures and that failure to comply attracts punishment.

Conflict of interest: The authors declare no conflict of interest.

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Authors' Profile

Joyce Rumun Akpenpuun is a Lecturer in the Department of Sociology, Benue State University, Makurdi, Benue State. She is an academic and a Medical Sociologist. Her area of research interests includes Maternal and Reproductive Health, Gender, Epidemiology and Mental health. She is an author of several publications and books in reputable publishing organisations. She is a member of learned societies such as the Nigerian Institute of Management (NIM) and Nigerian Anthropological and Sociological Practitioners Association (NASA). She has participated and presented papers in international and local conferences. She can be contacted via joycerumun@gmail.com

Joy Nguavese Waroh is a PhD candidate in the Department of Sociology, Federal University of Lafia, Nasarawa State. Her area of specialisation is Medical Sociology. Her area of research interests includes Epidemiology, Health Care Services and Maternal health. She has published several articles in reputable publication outlets and has participated and presented papers in local conferences. She can be contacted via joywaroh@gmail.com

Bilkisu Musa Aboda is a Lecturer in the Department of Sociology, Kogi State University, Ayingba, Kogi State. Her area of research interests includes Developmental and Gender studies. She has published articles in reputable journals and contributed in book chapters. She has also participated and presented papers in local conferences. She can be contacted via bilkismusaa@gmail.com

Andrew Aondofa Kula is the Registrar of Cooperatives in the Department of Cooperatives, Benue State Civil Service and is currently a PhD candidate in the Department of Sociology, Federal University of Lafia, Nasarawa State. His area of research interests includes Criminology, Medical Sociology and Education Cooperatives. He is a member of several professional bodies such as the Nigerian Institute of Management (NIM), International Project Management Professionals (IPMP) and Teachers Council of Nigeria (TCN). He can be contacted via kulaaondofa@gmail.com

Celina Ameachi Eze is a teaching staff in the Department of Sociology, Federal University of Lafia, Nasarawa State. Her area of research interest is Cultural and Social Anthropologist. She has published articles in reputable journals. She is a member of the Nigerian Anthropological and Sociological Practitioners Association (NASA). She has attended and presented papers at several conferences. She can be contacted through celinorganics@yahoo.com

Safety in the Health Industry: An Assessment of Doctors' Perception of Safety Culture among Healthcare Providers in the Bayelsa State Health Insurance Scheme

[1]Oyintonyo Michael-Olomu
[1]Department of Sociology & Anthropology, Federal University, Otuoke, Nigeria
Correspondence: tonyomic@gmail.com, michaelolomuoo@fuotuoke.edu.ng

Abstract
Several patients suffer from poor patient safety culture. Previous studies on patient safety culture largely focused on patient perception and bio-medical aspects. However, little attention had been given to patient safety culture from socio-cultural and doctors' perspective. This study assessed doctors' perception of patients' safety method in Bayelsa Health Insurance Scheme. Patient Safety Model was adopted, while the cross-sectional survey design was employed. A total of 371 doctors were randomly selected for the study and questionnaire administered. Data gathered were analysed using Percentages, Bar charts, Pearson Product Moment Correlation, and Linear Multiple Regression Analysis. The findings showed that doctors in private hospitals had a higher positive perception of patient safety culture than doctors in public hospitals. Factors that influence patient safety culture were teamwork in hospitals (23.5%) and communication openness (21.2%). The study found that there is a significant relationship between teamwork and doctors' perception of patients' safety culture ($r = -.177$, $n= 371$, $p (.002) < 0.05$). There is a significant relationship between communication openness and doctors' perception of patient safety culture ($r = -.177$, $n= 371$, $p(.002) < 0.05$). Teamwork, supervisors' actions, organisational learning, management support, communication and feedback about errors jointly predicted doctors' perception of patient safety culture ($R=.421$, $R^2=.177$, $F=8.477$, $P<.05$). However, only teamwork ($p=.001$), management support ($p=.000$) and communication openness ($p=.001$) had significant independent prediction on doctors' perception of patient safety culture. The study concluded that poor patient safety culture must be addressed. Health care providers should be enlightened to improve patient safety culture in hospitals.

Keywords: Patients' safety culture, doctors' perception, teamwork, communication openness

Introduction
An important component of the health industry is the maintenance of a very high form of patients' safety culture, especially among health practitioners. The World Health Organization (2009) defines patients' safety as "the prevention of errors and adverse effects to patients associated with health care" and "to do no harm to patients". If a health industry with health insurance scheme wants to improve patient safety, it is important to know more about the culture regarding patient safety. Patient safety culture is an overall behaviour of individuals and organizations, based on common beliefs and values (Bodur & Filiz, 2012; Webair, Al-Assani. Reema-Haddad, Wafa, Manal, & Alyamani, 2015). It reduces possible harm of patient to the lowest level in the service procedure

through hard efforts. Related research shows that positive patient safety culture could promote patient safety and could help to improve organization with safety behaviour, including reporting little errors, self-reporting errors, safety behaviours, safety audit rating, among others (Ghobashi et al, 2014).

There are millions of patients globally who suffer disabilities, injuries or die each year due to unsafe medical practices (Gonzalez-Formoso, 2011). This has led to the wider recognition of the importance of patient safety, the incorporation of patient safety approaches into the strategic plans of health care organizations and a growing body of research in this field. Patient safety is thus a fundamental concern in health care and has the potential for patient harm (Gaal, 2010).

Health care facilities that do not prioritize patient safety culture risk adverse consequences like under-reported safety events, non-improvement in health facilities, a higher rate of harm to patients, workforce burnout, poor turnover, and rising costs of care (Verbakel, Verheij, Wagner & Zwart, 2014).

Positive patient safety cultures in the health industry are as a result of strong leadership that drives and prioritises safety. Hence, commitment from leaders and managers in the health sector is important, as their actions and attitudes influence the perceptions, attitudes and behaviours of the wider workforce within the health industry. Other important aspects of positive patient safety culture include shared perceptions of the importance of safety, constructive communication, and mutual trust (Verbakel, Verheij, Wagner & Zwart, 2014).

Patient safety culture can be examined through surveys of hospital staff, qualitative measurement, ethnographic investigation or a combination of these (Gaal, et al, 2010). Surveys of hospital staff are the most common ways of measuring patient safety culture. Hospital staff are often the first to notice patterns of unsafe practice and the conditions which increase or decrease the likelihood of such practice (Hoffmann, 2014).

Patient safety in health insurance schemes has not been explored to the same extent as in the non-health insurance hospital industries (Zwart, Van Rensel, Kalkman & Verheij, 2011). However, more recently, there has been more research emerging in primary care settings concerning patients (Tabrizchi & Sedaghat, 2012; Bodur & Filiz, 2009). Achieving a culture of safety in an organisation requires an understanding of the values, attitudes, beliefs and norms that are important to health

care organization, especially in health insurance schemes and what attitudes and behaviours are appropriate and expected for patient safety.

To date, many countries have initiated patient safety culture research, especially in developed countries (Martijn, et al, 2013; Palacios-Derflingher et al, 2010). On a global basis, several international organizations have significantly contributed to the promotion of the culture of patient safety, such as the World Alliance for Patient Safety, the National Patient Safety Agency in the UK, and the Agency for Healthcare Research and Quality in the USA, among others (Verbakel, Verheij, Wagner & Zwart, 2014).

No doubt, research on patient safety culture has been growing in recent years. However, there has been no adequate quantitative evaluation of patient safety culture among health practitioners. Thus, it is difficult to analyse the extent these researches can be used to evaluate health-related policies; whether doctors' perception of patients' safety culture could influence safety in health facilities is yet to be determined. Previous studies have largely centred on the perception of patients about health workers – patients' relationships and the challenges confronting patients and health facilities, especially from the bio-medical perspective (Gaal, et 2010; Jacobs, et al 2012). Consequently, this study has been designed to assess patients' safety culture from the purview of doctors' perception of health care providers in Bayelsa Health Insurance Scheme.

Theoretical Framework

The theoretical framework this study is anchored on is, the Patient Safety Model, developed by patient safety expert, Robert M. Wachter in 2006. Wachter (2008) noted that humans understand that the ambulatory environment is different from the health industry that experts in hospital care might not predict excellent outpatient care and might even create skills and instincts that are harmful in the ambulatory environment. Based on Wachter (2008) work, a new conceptual model leading to improved patient safety in health care with the engagement of the patient, family, and community at its core was designed. In this model, partnership is key. The patient, clinician, and practice staff members are linked together in a relationship based on communication, respect, and trust. Enabling patient and family engagement strategies (triangle) are mechanisms for patients, providers, and practice staff to enhance this relationship with an open flow of information. The model reflects that health care practice does not exist in isolation but is part of a broader and a more

complex health care system that is subject to the tensile forces of culture, community, and external environment. The model, the "Cycle of Safety," is predicated on four simple concepts:

Partnership: Partnership refers to the relationships forged among the patient, provider, and practice staff within the primary care practice. Safe care is greatest when the relationships among these actors are strong. All three groups together represent the "health care team," moving away from the traditional paternalistic model of medicine into one of collaboration, mutual respect, and trust.

Teamwork: Strategies to improve teamwork and inclusion of the patient and family as part of the health care team are safety imperatives in health care. As a team, all partners know their roles and what is expected of them for the team to perform effectively. The model recognizes that patient engagement is a continuum from disengaged to activated and empowered. In a resilient team, the other members adapt and accommodate individual differences while pursuing a common goal. In the case of a disengaged patient, bringing in additional support networks, within the patient or provider nodes, may be required to move the patient onto the path toward activation.

Community: Another key component of our model is the concept of community. Here, community influences, including practice location, sociodemographic characteristics of the patients, and community-based resources (including grocery stores, pharmacies, and safe places for children to play and adults to exercise) are all contributing factors to safety in health care. Attention to the health of communities is vital to developing a safety culture.

Health care environment: The model also recognizes that the practice of health care is strongly influenced by external forces, including policy, health reform, and transformation efforts of the practice. By establishing the core values of the practice around partnership, teamwork, and community, a health care practice will create a resilient microsystem within which to promote patient safety.

This study is important because it helps to explain that patient safety culture requires a partnership among health care providers, patients, families and communities. The model indicates that partnership is key. It explained that the patient, clinician, and practice staff member are linked together in a relationship based on communication, respect, and trust. Enabling patient and family

engagement strategies are mechanisms for patients, providers, and practice staff to enhance this relationship with an open flow of information.

The model illustrated that health care practice does not exist in isolation but is part of a broader and a more complex health care system that is subject to the tensile forces of culture, community, and external environment. Hence, health practitioners must respect relevant personal and cultural opinions, beliefs and options of the patients to avoid risks or harms. Below is a diagrammatical framework for further illustration:

Roberts M. Wachter Model of Patient Safety in Primary Care and Health, 2006

Materials and Methods

Research Designs

The design adopted for this study is a descriptive cross-sectional survey design. This is because it is an empirical method, which presents a description of events as they are. The survey research design also facilitated the easy collection of factual information on the research problem and enhanced the systematic description of the existing situation surrounding the research topic. The study target population consisted of doctors in Bayelsa Health Insurance Scheme. It includes male and female doctors in both public and private hospitals that met the inclusion criteria.

Sample and Sampling Techniques

A total of 371 doctors in Bayelsa Health Insurance Scheme were randomly selected for the study as a sample using Cochran (1963) quantitative sample size determination formula. The use of this sample size was justifiable because the study was conducted in a setting where an actual number of doctors was not certain but was more than 10,000. Based on the fact that the study intended to

gather relevant information from doctors in Bayelsa Health Insurance Scheme, the study adopted a multi-stage sampling procedure. Bayelsa Health Insurance Scheme was purposively selected to begin the stage because of its peculiarity in health care provision in the state. The second stage included a systematic selection of hospitals that are in the scheme, using a table of random numbers to identify the first hospital for selection and subsequent hospitals chosen at every 5^{th} interval until a total number of 371 doctors were randomly selected for face to face questionnaire interview administration.

Data Collection

A single questionnaire titled, "Doctors Perception of Patients' Safety Culture Questionnaire (DPPSCQ)" was the major instrument used for the study. It was divided into two sections, namely; sections A and B. Section A contains 11 items measuring the socio-demographic variables such as age, sex, education, etc. Section B contains 18 items measuring doctors' perception of patients' safety culture. The items were drawn from Famolaro, Yount and Hare (2018) Hospital Survey on Patient Safety Culture Scale. The items in the scale were further divided into sub-groups. The responses were rated using 5-point Likert scale ranging from Strongly Agree (SA=5), Agree (A=4), Undecided (U=3), Disagree (D=2) to Strongly Disagree (SD=1).

To measure the extent to which the survey instrument has been able to achieve its aims, the process of content validity was employed by cross-examining and verifying of items in the information. The knowledge gained from other investigations, literature review, theoretical framework and research methods helped immediately to validate the content of the instrument. Besides, a more practical avenue of validity explored includes consultancy within and outside the department of the researcher. This provided the opportunity to check and test the items as the work progressed. Also, the researcher extended the frontiers of consultation to lecturers within and outside her department for necessary criticism and suggestions for amendment on the draft of the research instrument.

The test re-test reliability coefficient was used for the study. The instrument was pre-tested on 50 respondents which were not included in the scope of the main study to ascertain the reliability of the instrument. After the pre-test, the instrument was scrutinized and necessary modifications were made before final administration. The reliability coefficient of the instrument was determined, yielding at least 0.7 values.

Data Analysis

The data collected were collated, coded and processed into the computer frequency distribution and simple percentages were used for the demographic characteristics of the respondents. The hypotheses were analysed using Pearson Product Moment Correlation (PPMC) and Analysis of Variance (ANOVA) statistics.

Ethical Considerations

The protection and safety of research participants as a result of involvement in the research was considered a key preoccupation of ethical guidelines. In light of this, the ethics of social research were strictly adhered to. Permission was sought from the respondents. The purpose of the study was explained to them. The participants in the study were made to voluntarily participate. They were assured of the confidentiality of the information given. They were also made to understand that the study was mainly for academic exercise. Hence, the study abided by the ethical principle of confidentiality, beneficence, non-maleficence, and voluntariness.

Results

Socio-Demographic Characteristics of Respondents

Table 1 presents the socio-demographic characteristics of respondent doctors. The results indicated the highest number of respondents was aged between 40-49 years (30.2%). More than half of the respondents (58.2%) were male doctors, while the majority of the respondents (71%) were MBBS holders. More than half of the respondents (56.1%) were married, while most of them (29%) were from the Ijo ethnic group.

Furthermore, while the majority of the respondents (80.3%) were affiliated with the Christian religion, most of them (73.6%) worked in private hospitals/clinics. Those whose work area was in the non-surgical unit (19.4%) were more than those in other units. More so, over 70 percent of the respondents had worked with their current hospital for at least a year. Also, more than 70 percent had worked within their current work area for at least a year, notwithstanding tenure spent with the current hospital.

Table 1: Socio-Demographic Characteristics of Respondents

Characteristics	Frequency (N=371)	Percentage
Age		
18-39	97	26.1
40-49	112	30.2
50-59	95	25.6
60+	67	18.1
Sex		
Male	216	58.2
Female	155	41.8
Highest level of education attained		
Bachelor's Degree (MBBS)	265	71.4
Master's Degree	86	23.2
PhD Degree	20	5.4
Marital status		
Single	114	30.7
Married	208	56.1
Divorced/Separated	36	9.7
Widowed	13	3.5
Ethnic group		
Ijo (Ijaw, Nembe, Ogbia, Epie-Atissa)	107	28.8
Yoruba	98	26.4
Hausa	24	6.5
Igbo	99	26.7
Others	43	11.6
Religion		
Christian	298	80.3
Islam	48	12.9
Traditionalist	11	3.0
Others	14	3.8
Hospital Type		
Public	98	26.4
Private	273	73.6
Work Area		
Medicine (non-surgical)	72	19.4
Surgery	38	10.2
Intensive care unit (any time)	66	17.7
Emergency department	61	16.4
Obstetrics	47	12.7
Paediatrics	35	9.4
Others	52	14.0
Tenure with Current Hospital		
Less than 1 year	81	21.8
1 to 5 years	121	32.6
6 to 10 years	127	34.2
11years or more	42	11.3
Tenure with Current Work Area		
Less than 1 year	97	26.1
1 to 5 years	148	39.9
6 to 10 years	101	27.2
11years or more	25	6.7

Factors Influencing Doctors' Perception of Patient Safety Culture Among Health Care Providers in Bayelsa Health Insurance Scheme

In an attempt to examine the factors that influence doctors' perception of patient safety culture among health care providers in Bayelsa Health Insurance Scheme, the study examined the perception of

patient safety culture by hospital type to ascertain their perception before examining the factors that influence doctors' perception of patient safety culture.

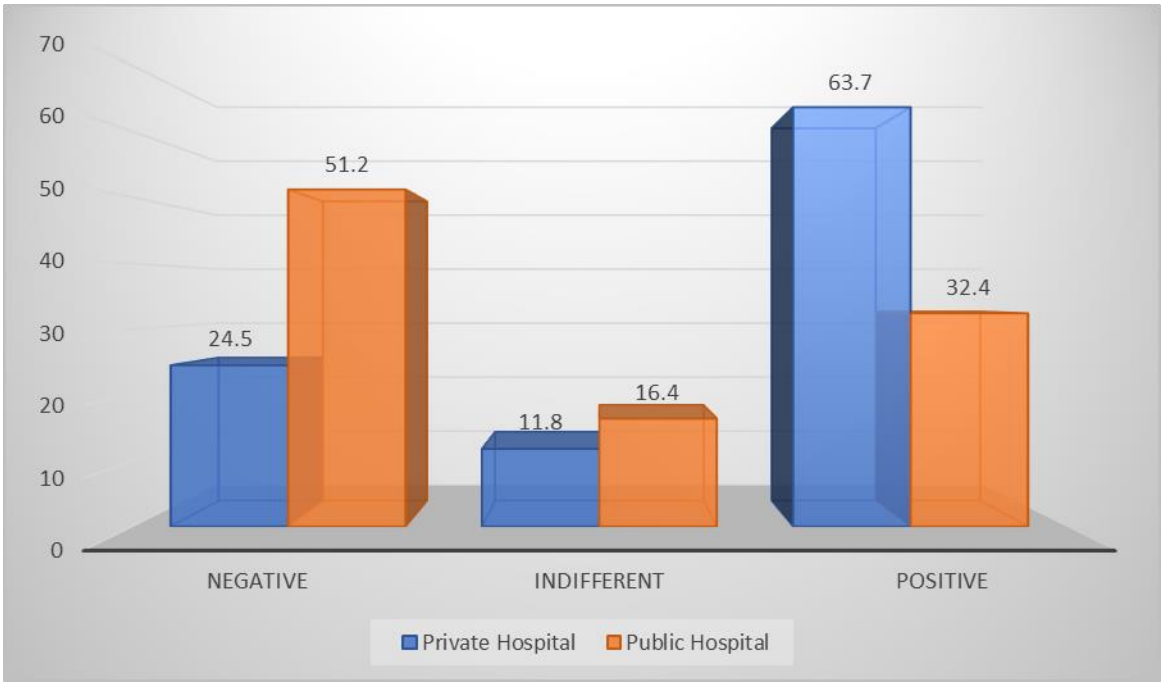

Fig. 1: Doctors' perception of patient safety culture by hospital types

Figure 1 presents doctors' perception of patient safety culture by hospital types. The results show that doctors in private hospitals had a higher positive perception of patient safety culture than doctors in public hospitals. For instance, 63.7 percent of the respondents in private hospitals had a positive perception of patient safety culture compared to 32.4 percent in public hospitals. Doctors that remained indifferent on the subject matter were 11.8 and 16.4 percent for private and public hospitals respectively.

Figure 2 shows the factors that influence doctors' perception of patient safety culture. The highest factor that influenced patient safety culture was teamwork within units in hospitals (23.5%). This was followed by communication openness (21.2%) among practitioners and management support for patient safety (19.5%). The least factors that influence doctors' perception of patient safety culture was feedback about the error encountered in the course of practice.

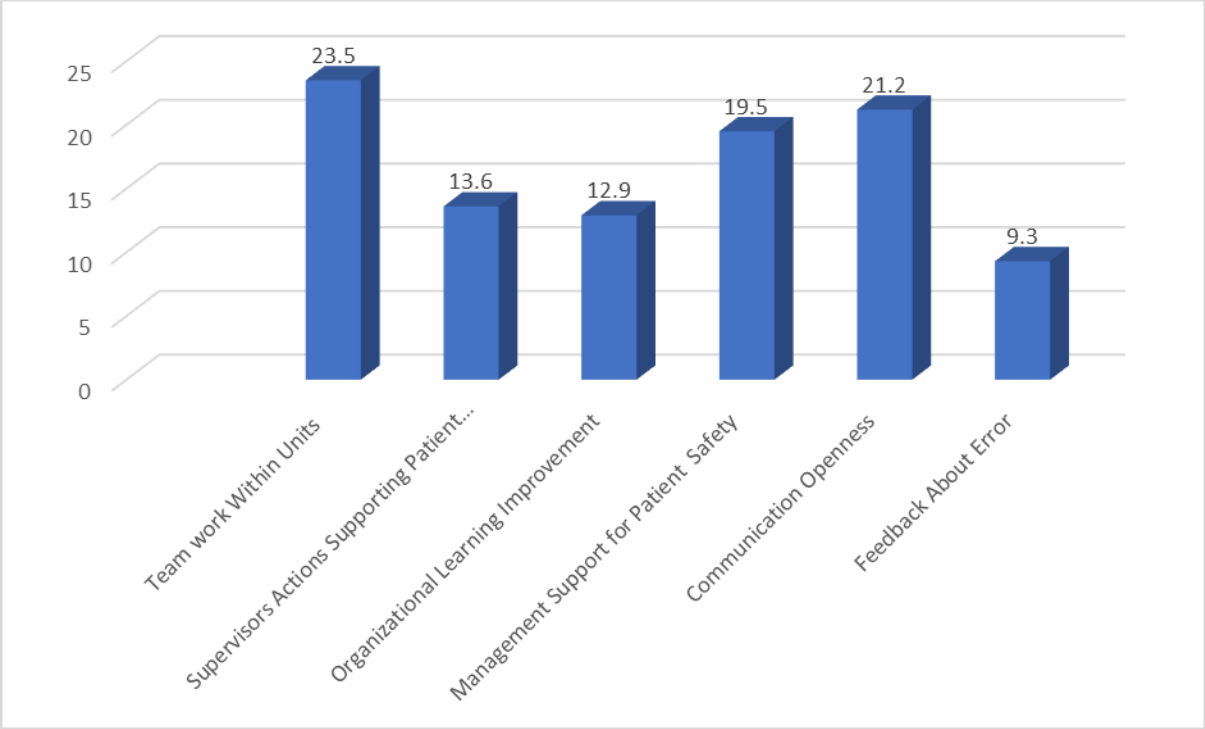

Figure 2: Factors that influence doctors' perception of patient safety culture

Hypothesis one: There is no significant relationship between team-work and doctors' perception of patient safety culture.

Table 2 shows that there is a significant relationship between teamwork and doctors' perception of patient safety culture ($r = -.177$, $n = 371$, $p(.002) < 0.05$). It indicated that teamwork has a positive influence on doctors' perception of patient safety culture in the study, i.e. the more the teamwork, the more doctors' positive perception of patient safety culture. Therefore, the null hypothesis is rejected.

Table 2: Pearson Product Moment Correlation (PPMC) Showing the Relationship Between Teamwork and Doctors' Perception of Patient Safety Culture

Variable	Mean	Std. Dev.	N	R	P-value	Remark
Teamwork	22.5143	4.4675	371	.177*	.002	Sig.
Doctors' perception	36.7532	4.7542				

* Sig. at 0.05 level

Hypothesis Two: There is no significant relationship between communication openness and doctors' perception of patient safety culture.

Table 3 shows that there is a significant relationship between communication openness and doctors' perception of patient safety culture (r = -.177, n= 371, p(.002) < 0.05). It indicated that communication openness has a positive influence on doctors' perception of patient safety culture in the study, i.e. high communication openness leads to doctors' positive perception of patient safety culture. Therefore, the null hypothesis is rejected.

Table 3: Pearson Product Moment Correlation (PPMC) Showing the Relationship Between Communication Openness and Doctors' Perception of Patient Safety Culture

Variable	Mean	Std. Dev.	N	R	P-value	Remark
Communication openness	21.5632	4.6414	371	.179*	.001	Sig.
Doctors' perception	36.7532	4.7542				

* Sig. at 0.05 level

Hypothesis three: There is no significant joint influence of influencing factors on doctors' perception of patient safety culture

Table 4 presents multiple linear regression analysis showing the independent and joint contribution of influencing factors on doctors' perception of patient safety culture. The results show that teamwork, supervisors' actions, organisational learning, management support, communication and feedback about errors jointly predicted doctors' perception of patient safety culture (R=.421, R^2=.177, F=8.477, P<.05).

Table 4: Multiple Linear Regression Analysis Showing Joint Factors that Influence Doctors' Perception of Patient Safety Culture

Independent Variables	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	S.E	Beta	t	Sig.	Lower Bound	Upper Bound
(Constant)	37.632	4.163		7.436	.000	32.643	44.513
Teamwork	.241	.031	.156	3.421	.001	-.091	.053
Supervisors Action	-.211	.043	-.268	-3.727	.070	-1.216	-.194
Organizational Learning	.163	.051	-.105	1.253	.066	-2.521	.073
Management Support	.372	.053	.074	2.764	.000	-1.327	.-1.576
Communication Openness	.363	.063	.134	2.563	.002	-.753	.184
Feedback About Error	-.124	.042	-.083	-1.639	.417	-.529	-.547

Model Summary

R	R Square	Adjusted R Square	Std. Error of the Estimate
.421	.177	.163	4.531

A N O V A

Model	Sum of Squares	df	Mean Square	F	Sig.	Remark
Regression	431.524	3	201.177	8.477	.000	Sig.
Residual	3814.431	367	21.048			
Total	4245.955	370				

Note: Dependent Variable: Doctors' perception; Significant at p<0.05*, p<0.01**, p<0.001***

This implies that the six variables jointly accounted for 17.7% variance in doctors' perception of patient safety culture. However, only teamwork (p=.001), management support (p=.000) and communication openness (p=.001) had significant independent prediction on doctors' perception of patient safety culture. Therefore, we reject the null hypothesis and accept the alternate hypothesis that there is a significant joint contribution of influencing factors on doctors' perception of patient safety culture.

Discussion of Findings

The study revealed that doctors in private hospitals had a higher positive perception of patient safety culture than doctors in public hospitals. This finding is consistent with an earlier study conducted by White (2004) who found out that structure, environment, equipment and technology,

system and processes, human factor, and leadership and institution culture affect perception of patient safety culture. However, findings from this study slightly deviated from White's (2004) study on the ground that it found doctors of a private hospital to have higher positive perception than a public hospital on patient safety culture. Simply because the management of private hospitals ensures strict supervisions and implement the values, missions and objectives of the hospitals as top priorities for doctors and patients.

This study also indicated that the highest factor that influences patient safety culture was teamwork within units in hospitals, while the least factors that influence doctors' perception of patient safety culture was feedback about error(s) encountered in the course of practice. This finding supports Pınar (2011) study that the people constituting the team are interdependent and act together, and they are constantly in interaction with one another influencing the perception of each in health facilities. Similarly, Kaya and Yağcı (2015) found that to ensure effectiveness in communication, team members have put into practice their skills such as listening, telling, interrogating, feedback, using body language and reading. Communication openness and management supports are sensitive in terms of ensuring coordination in the team, carrying out activities, enhancing motivation, preparing team members for a change, improving performance and increasing the effectiveness in extra team relations leading to a better perception among workers on patient-health workers relationship.

Additionally, the study found that there is a significant relationship between teamwork and doctors' perception of patient safety culture. It indicated that teamwork has a positive influence on doctors' perception about patient safety culture, i.e. the more the teamwork, the more doctors' positive perception of patient safety culture. This finding corroborates Kavuncubaşı and Yıldırım (2012) study which stated that the members constituting the team have certain qualifications for the success of the teamwork in health facilities. Similarly, Eren (2008) found that team norms facilitate life as they constitute references for the team members to distinguish the right from the wrong, especially among health care providers. Public hospital doctors tend to exhibit more teamwork activities whenever duties call as the management can fund staffing and more professional practitioners. However, these doctors are less committed when duty calls because most of them engaged in a private consultancy for economic reasons.

Furthermore, findings from this study indicated a significant relationship between communication openness and doctors' perception of patient safety culture. It indicated that communication openness has a positive influence on doctors' perception of patient safety culture in the study, i.e. high communication openness leads to doctors' positive perception of patient safety culture. This finding supports an earlier study by Tcbdevito (2011) that revealed that open communication in the workplace is essential with each staff member receiving information about the business or health care they are contributing to. His study noted that communication openness provides an avenue for a mission statement, annual goals and public financial information to be easily accessible to staff leading to a positive relationship between communication openness and health workers perception about the relationship with patients.

Finally, this study found a significant joint contribution of influencing factors on doctors' perception of patient safety culture. Teamwork, supervisors' actions, organisational learning, management support, communication and feedback about errors jointly predicted doctors' perception of patient safety culture. The six predictor variables jointly accounted for 17.7% variance in doctors' perception of patient safety culture. However, only teamwork, management support and communication openness had significant independent prediction on doctors' perception of patient safety culture. These findings aligned with Harbour (2020) study which noted that building trust through open communication, teamwork and effective administration leads to sharing important information in a timely and efficient manner to effectively shape positive perception among patients and staff in the health system.

Conclusion

Based on the findings of the study, it can be concluded that doctors in private hospitals have a higher positive perception of patient safety culture than doctors in public hospitals. However, the variables teamwork, management support and communication openness show to have a significant independent prediction on doctors' perception of patient safety culture in Bayelsa Health Insurance Scheme. In other words, there is a significant relationship between teamwork and doctors' perception of patient safety culture. Lastly, there is a significant relationship between communication openness and doctors' perception of patient safety culture.

Recommendations

Based on these findings, it was recommended that:

- Patient safety culture is an important issue that must be addressed. Health care providers must educate practitioners about its importance and the reason why it must be promoted to improve the health of patients within and outside hospitals environment.
- Doctors and other health care providers must be enlightened about the ills of perpetrating ill patient safety culture in hospitals as early as possible so that they will understand and appreciate the gains of healthy relationships between health workers and patients.
- Doctors and other health practitioners should be adequately guided on how to develop positive and healthy relationships that will be devoid of patient abuse, not only when they are before their supervisors, but also when they are alone with patients.
- As society progresses towards achieving positive patient safety culture during health workers-patient interactions in hospitals, the ultimate goal should be to stop all forms of ill-culture it starts; hence strategies that promote healthy relationships must be inculcated in practitioners from the outset of their training.
- During practice, doctors and other health practitioners need to learn skills that would make them develop positive relationships with patients. They must learn how to adopt an appropriate approach when treating patients and their families.
- Teamwork and communication openness must be encouraged among doctors and other health practitioners to promote positive patient safety culture.

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Author's Profile

Dr Oyintonyo Michael-Olomu is a lecturer in the Department of Sociology and Anthropology, Federal University Otuoke, Bayelsa State. Her research works range from cultural dynamics, industrial relations and institutional analysis. She is the author of "TEENS DIGEST". She is a teen mentor, a writer and has contributed to several book chapters in Sociology and the academia in general. She is the Assistant Director of Mike Olomu Foundation, a nonprofit organisation that takes medications to rural areas in the Niger Delta Region, she is a board member of Kingdom Heritage Mission School Swali (KHMS). She is also a member of several international and national learned societies in Sociology and Anthropology. She can be contacted via michaelolomuoo@fuotuoke.edu.ng; tonyomic@gmail.com

Collective Action: A Self-Help Approach to Building Adaptive Capacity in Oil Impacted Communities of the Niger Delta

[1]Jackson T.C.B. Jack, PhD

[1]Department of Sociology and Anthropology, Federal University, Otuoke, Nigeria
Correspondence: jackjt@fuotuoke.edu.ng
orcid.org/0000-0003-4326-8544

Abstract
The study examined the role that collective action plays as a self-help approach to enhancing the adaptive capacity of crude oil impacted communities in Nigeria's Niger Delta. Relying on triangulation of quantitative and qualitative approaches of data collection, the study was composed of 610 questionnaire respondents and 36 in-depth interviewees as well as 36 focus group discussants, all drawn from oil impacted communities in Rivers, Delta and Bayelsa states. The study revealed a significant sense of concern for community welfare amongst respondents and this has strongly improved the level of collective action among members of the communities. With a mean score of 3.7, the study indicates that respondents strongly linked their ability to adapt to the shocks arising from oil-induced environmental degradation to the levels of collective action obtainable in their various communities. Furthermore, the specific case study analysis of Bille Women's Forum, Age Grade Associations and the Umutu Development Union proved that local institutions were instrumental, not only to the well-being of their members, but they also provide opportunities for collective action through which communities' development and adaptive capacity are enhanced. Based on the findings, the study submits that collective action is a veritable approach to strengthening the adaptive capacity of oil impacted communities in the Niger Delta. The study recommends an urgent need for the government and non-governmental development interventionist organizations to robustly engage with and enhance the capacities of community institutions in the region.

Keywords: Adaptive Capacity, Collective Action, Environmental Degradation, Niger Delta, Self-Help.

Introduction

The place of collective action in engendering community development and self-help initiatives within communities is becoming increasingly recognized by scholars and development experts. This is even more evident in contexts where communities are faced with severe environmental and economic shocks that present livelihood uncertainties. In this regard, Jack and Eke (2018) posit that collective actions often mediated and pursued through formal and informal community groups have potential to be an effective tool for social resilience and adaptive capacity in polluted and marginal environments. Collective action in communities is also known to have the capacity to enhance the management of common-pool resources. Also, information/idea-sharing promotes the community's

potential to collectively proffer solutions to local problems including environmental change and management, while also enabling mutual benefits amongst community members (Cavaye, 2004).

Studies on collective action and its role in building community adaptive capacity such as Markelova, Meinzen-Dick, Hellin and Dohrn (2009), as well as Hellin, Lundy, and Meijer (2009) have shown that collective action is a significant ingredient for mainstreaming resilience into social systems. They further argue that local community institutions such as producer organizations can facilitate the collective action process and effectively help members to (i) share risks, (ii) access new markets, (iii) learn new skills, (iv) access new technologies and diversify income. Similarly, Ireland and Thomalla (2011) in their study of collective action and community adaptation to environmental risks in Asia, reported that collective action plays a significant role in building adaptive capacity mediated through social networks which are a particularly important component of collective action and the entire adaptation process. Drawing from the foregoing, it is evident that collective action plays a significant role in promoting the adaptive capacity of local communities to environmental shocks. The veracity of the above submission notwithstanding, its applicability to the grossly polluted environment of the Niger Delta region of Nigeria is yet to be ascertained, thereby, suggesting a gap in the existing literature. It is in an attempt to bridge this knowledge gap that this study explores the role that collective action plays in building the adaptive capacity of oil impacted communities of Nigeria's Niger Delta.

Conceptual Clarification

This section provides clarifications for the key concepts/variables utilized in the study.

i. Environmental Degradation

Environmental degradation as defined by the study refers to a situation when the state or quality of the environment is deteriorating as a result of the contamination and depletion of land, water and air resources as well as the destruction of ecosystems, habitat loss and biological diversity loss. The oil-rich Niger Delta region is known to be one of the most polluted and degraded ecosystems in the world as over 60 years of oil exploration according to Jack, Akujobi, Dan-Axe and Azubuike (2016) has resulted in widespread oil spillages, gas flaring and deforestation.

ii. Collective Action

Collective action refers to a situation where a group of people voluntarily engage in a common action to pursue a shared interest (Matta & Alavalapati, 2006; Meinzel-Dick, DiGregorio, et. al, 2004). For Scott and Marshall (2009), collective action is an 'action taken by a group (either directly or on its behalf through an organization) in pursuit of members' perceived shared interests. Collective action according to Fabusoro and Sodiya (2010) takes the form of organizing, through institutions, by which individuals adopt coordinated strategies to obtain higher collaborative benefits to reduce their joint harm. It can be in the form of resource mobilization, activity coordination, information sharing or development of institutions (Poteete & Ostrom, 2004). Collective action as applied in the study, hence, refers to a process through which social groups identify and define problems, as well as search for and collaboratively implement solutions.

iii. Adaptive Capacity

Adaptive capacity according to Nelson, Adger and Brown (2007 cf. Nyamwanza, 2012, p. 3) is the precondition necessary for a socio-ecological system to be able to adapt to disturbances: it is represented by the set of available resources and the ability of a system to respond to disturbances, including the capacity to design and implement effective adaptation strategies. On its part, the United States Agency for International Development (2009 cf. Colombi & Smith, 2012, p. 1) emphasizing the cultural dimension of adaptive capacity, argues that adaptive capacity depends on the following: (i.) economic well-being (ii) ecological well-being (iii) the extent of natural resource dependence (iv) infrastructure (human-built or natural) (v) effectiveness of institutions and governance systems (vi) insurance (vii) secure land tenure (viii) viable mediation measures (ix) viable information and communication systems. Extrapolating from the above, adaptive capacity as conceived in this study refers to the ability of a social group or community to develop adaptation strategies aimed at recovering from environmental stress and livelihood shocks arising from oil pollution and gas flaring.

Materials and Methods

The study utilized a mixed-method research design involving the triangulation of quantitative and qualitative methods of data collection and analysis. The study was conducted in 6 oil impacted communities of the Niger Delta including Bodo and Bille in Rivers state, Polaku and Ogboinbiri in Bayelsa state, as well as Umutu and Kokodiagbene communities of Delta state. The choice of the

study area, geographically speaking, is based on the fact that they constitute the core of the Niger Delta region and they are most disproportionately impacted by crude oil-induced environmental degradation.

For the quantitative aspect of the study, the Taro Yamane sample size calculation technique was utilized to derive a sample size of 610. Also, for the selection of households into the sample, the study relied on the systematic random sampling approach. To determine the sampling interval (the space between each selected household), the researcher divided the calculated sample size by the total average of the households sampled across the communities. Accordingly, the average household sampled across six communities becomes 610/6 = 101 while the sampling frame across the six communities is 610/101 = 6. This implies that 610 questionnaires were systematically distributed across the six communities and every 6^{th} household was selected to participate in the study.

On the other hand, the qualitative study involved 36 In-depth Interviews (IDIs) respondents and 36 Focus Group Discussions (FGDs) participants who were all purposively sampled from across the six communities. The quantitative data retrieved from the questionnaire were coded, cleaned and analysed using simple percentages as well as mean statistics and presented with the aid of descriptive tools such as graphs and charts. The qualitative data retrieved from IDIs and FGDs were transcribed and analysed using the thematic and content analysis techniques.

Results and Discussion

This section presents the analysis of the results and discussion of the findings of the study. The quantitative results were presented first, followed by the qualitative results in form of case studies.

Respondents' Concern for Community Welfare

To ascertain the willingness of respondents to pursue a collective action, the study examined the level of respondents' concern for the welfare of their communities. Findings from the survey as presented in Fig. 1 below reveal that whereas 80.3% of the respondents assert that they are always concerned with the welfare of their community, 9.5% of them reported that they are somewhat concerned.

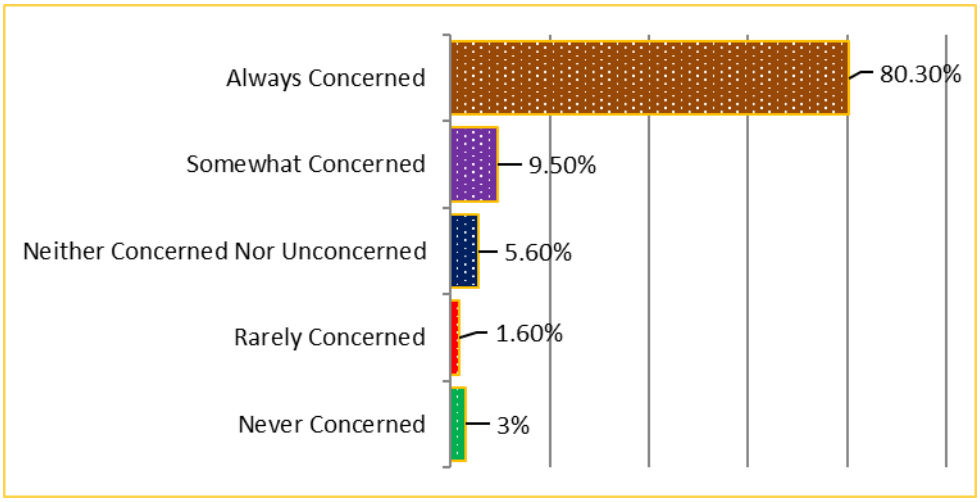

Fig. 1: Distribution of Respondents by Concern for Community Welfare
Source: Fieldwork, 2018

More so, while 5.6% of the respondents averred that they are neither concerned nor unconcerned with the welfare of their communities, 1.6% of the respondents said that they are rarely concerned and 3% of them argued they are never concerned with community welfare. This trend showed that majority of the respondents are always concerned about the welfare and well-being of their communities.

Respondents' Perceptions of Collective Action in Community

The survey also examined the perception of the respondents on whether community members contribute time, energy and monies in solving local common problems collectively.

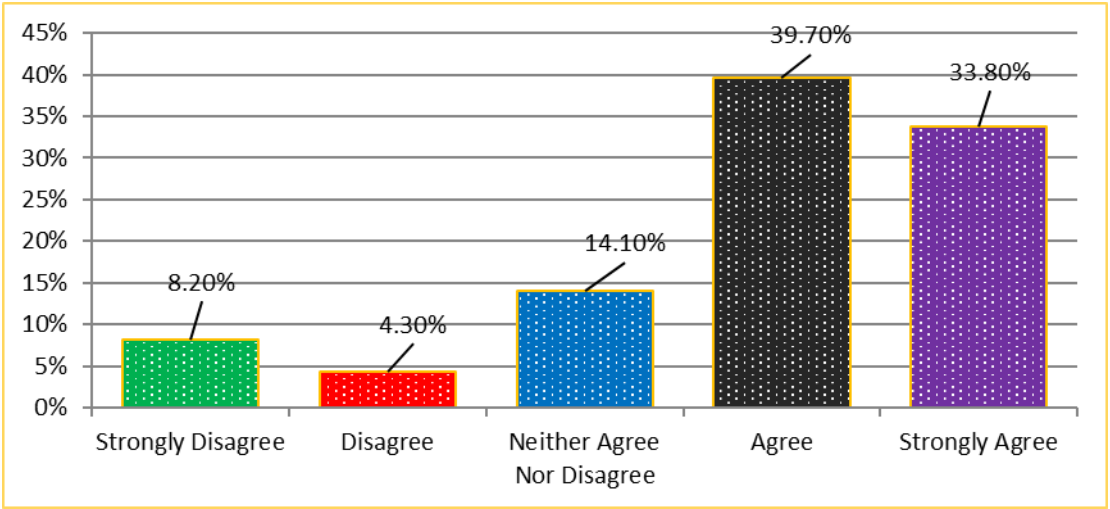

Fig. 2: Distribution of Respondents by Perception of Collective Action
Source: Fieldwork, 2018

Data from the survey as presented in Fig. 2 above indicate that whereas 8.2% of the respondents strongly disagreed with the notion that members of their communities contribute time, energy and money to solve common problems, 4.3% of them disagreed with the assertion and 14.1% of the respondents remained neutral as they neither agreed nor disagreed with the notion.

Also, while 39.7% of the respondents agreed to the notion that members of their communities contribute time, energy and money to solve common problems, 33.8% of the respondents strongly agreed to the assertion. The data, therefore, imply that the majority of the respondents (73.5%) attests to a strong presence of collective action in their communities.

Collective Action and Adaptive Capacity

The study further investigated whether collective action in communities promotes the capacity of households to adapt to the impacts of environmental degradation. Hence, respondents were asked if their participation in collective activities/actions has provided resources which have enabled them to adapt. The results as shown in Fig. 3 below indicate that whereas 8.5% of the respondents strongly disagreed with the notion, 7.9% of them disagreed. However, while 17.7% of the respondents neither agreed nor disagreed with the notion, 40.3% of the respondents agreed and 25.6% of them strongly agreed with the notion that participation in collective actions in their community promotes their capacity to adapt to environmental degradation.

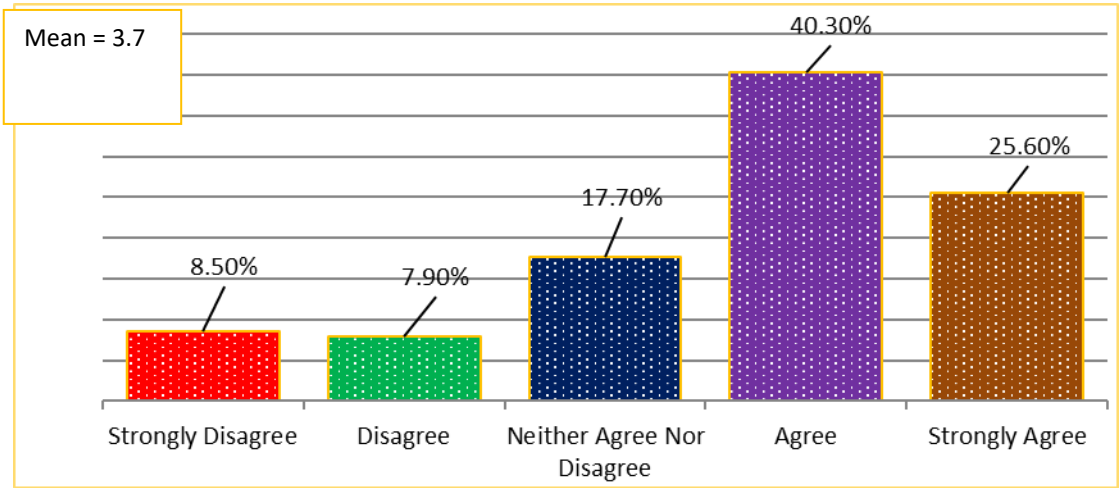

Fig. 3: Perception of Whether Collective Action Enhance Adaptive Capacity
Source: Fieldwork, 2018

Furthermore, the result produced a mean response of 3.7, which is far above the 2.5 mid mark thereby indicating that participation in collective activities has promoted the capacity of respondents to adapt to the impacts of environmental degradation in their communities.

Qualitative Case Studies

While the quantitative data presented in the previous section has shown that collective action initiatives promote communities' adaptive capacity, the study, however, revealed that collective actions are mediated through local community-based institutions. These institutions provide several benefits to members and provide them with the opportunities to collectively solve local problems and promote self-help developmental projects for the communities at large. This finding was corroborated by Jack and Eke (2008) who identified about 103 local institutions existing in these study communities that serve as safety nets and sources of local insurance which provide households with opportunities for resources and materials exchange as well as galvanizing collective action that promotes livelihoods and adaptive capacity.

Consequently, three local institutions were identified to be most remarkable and instrumental in promoting adaptive capacity in the study communities and these institutions are succinctly discussed below as case studies.

a. Bille Women's Forum

The Bille Women's Forum is a prestigious women-based organization which was established about two decades ago by women of Bille Kingdom in Rivers State to galvanize themselves for the pursuit of the collective interest and progress of the community. The forum is led by a three-year tenured executive with a president and 11 executive members of cabinet representing the 11 communities in Bille Kingdom. The members of the cabinet are nominated by their respective communities, the representatives of the Egbele-Ereme (society of menopausal women) and the Amayanabo-ta (wife of the Amayanabo – King of Bille) who acts as the patroness. The Bille Women's Forum has been instrumental to the promotion of the livelihoods of the women in the community as well as contributing to community development. This, it has been able to achieve through voluntary contributions by members of the forum, payment of levies and so on. In this regard, the forum meets once every month on the third Saturday of the month and during meetings, members pay an answering fee or due of ₦500. In addition to internal contributions by members, the forum also acts as a mediator between the women in the community and external actors such as

oil companies operating in the community and the government. The women's forum, over the years, has been able to attract soft loans to women in the Kingdom from the Shell Petroleum Development Company (SPDC) and this has largely impacted positively on their livelihoods as most women utilized such loans to diversify their livelihood with many engaging in petty trading and other business enterprises. Similarly, the women's forum has attracted skill acquisition training in areas such as hairdressing, tailoring, and so on from Eroton Exploration and Production Company as well as the Degema Local Government Council for women in the kingdom. Also, the women's forum has acquired a market cargo boat donated by the SPDC (see plate 1) which the women use to ferry agricultural and consumable goods between Bille and Port Harcourt. The forum generates its revenue from the market cargo boat from where finances for the welfare of the women and contributions to community development are sourced.

Plate 1: Bille Women's Forum Market Cargo Boat Donated by SPDC.
Source: Fieldwork, 2018

Describing the contributions of the Bille Women's Forum to the well-being of women in the Kingdom, the President of the forum asserts thus:

> The Bille Women Forum has been able to penetrate SPDC and secured soft loans for the women to trade with. That is why if you go to the town you would see many women with small kiosks all over. Also, we were able to assist in equipping the maternity clinic in the community … The forum also got the boat from SPDC, it has been in operation for 10 years ago. When the last one got bad SPDC built another one for us. We use to carry goods to and from Port Harcourt to Bille with it, and the

> monies that accrue goes into the women's purse and if we have any challenge, we solve it from our savings.
> KII/Female/President BWF/Bille/2018

Similarly, appraising the activities of the Bille Women's Forum as an institution that contributes to community development, the executive of the Bille youth organization had this to say:

> Yes, the women's forum is community nominees appointed for the welfare of the women… The women of this community appealed to these oil companies to give them a cargo boat and that boat is what they use to transport goods. They are getting small income from the boat from which they support themselves and the community. When there is a problem in the community and money is not available, the chiefs call them and borrow money from them. FDG/Youth Group Executive/Bille/2018

The findings from the study indicated that most respondents in Bille Kingdom attested to the fact that the women's forum as a self-help institution has been instrumental to the development of the community, as well as enhancing the adaptive capacity of members of the community.

b. Age Grade Associations

Age grade associations happen to be a strong source of social capital for individuals and households in the study areas, especially in Bille and Umutu communities. This position has been rightly observed in a previous study by Jack and Eke (2008) who reported that in Bille community alone, there are over 10 age grade associations and in Umutu, there are 8 age-grade associations to which some of the study participants belonged. About their roles in promoting adaptive capacity, the study discovered that age grades provide members benefits such as mutual support in times of crises or celebrations as well as providing them opportunities for collective action and engendering community development. In Bille Kingdom, the study revealed that age grade associations have contributed tremendously to the development of the community as grade associations have provided diverse forms of infrastructural amenities (see plate 2) for the communities thereby promoting the communities' adaptive capacity generally.

Describing the role of age grade associations in promoting the adaptive capacity and community development, a Chief in Bille Kingdom asserts thus:

> There are several age grade associations in the community, myself I belong to one. If there is any problem in the community, age-grade rally round their members, contribute monies and assist the community. Like the tomb of our late Amayanabo, HRM King Carrie Ogili, Agbaniye-Jike (XIII), Amayanabo of Great Bille Kingdom,

was erected by the 56 cultural age groups. Similarly, three different age grade associations contributed and built the internal bridge for us. My age group, the 58 association for instance when we celebrated our 50th anniversary, we bought some computer sets for the secondary school students. We are currently renovating the ICT centre as we expect to purchase more computers. Also, there is another group called Daughters of Bille Ambassadors, they are Bille daughters who are married outside, they are also contributing to the computer project. So, when they bring more computers, we would include it to ours and donate them to the students. KII/Male/Community Chief/Bille/2018

Plate 2: Infrastructural and Cultural Projects by Age Grades in Bille Community
Source: Fieldwork, 2018

The role of age grade associations in promoting community development and by extension adaptive capacity of communities cannot be overemphasized as they are a veritable tool that enables both poor and wealthy members of the community to galvanize themselves and initiate self-help projects, while also strengthening collective action in the community.

c. Umutu Development Union

The Umutu Development Union (UDU) is a community-based organization that has existed for close to five decades with the sole mandate of fostering development in Umutu community of Delta State. The UDU has its headquarters in Umutu with several satellite branches across the country and overseas where Umutu people are resident. The UDU is headed by a Chairman and his cabinet members who are elected for three years to serve the community through collective actions for community development. The study revealed that the UDU has been the pioneering agent of

development in the community before the creation of Delta state and the advent of oil and gas exploration in the area. One peculiar approach the UDU utilizes to engender collective action and raise funds for community development is the celebration of the Igili Day (see plate 3) which is held annually on the Saturday before Easter Sunday. The Igili Day is a festival that brings all the sons and daughters of the community both in Nigeria and overseas back home to feast and contribute monies for specific developmental projects in the community. Direct observations by the researcher during the 2018 Igili Day festivities revealed that several groups in the community such as age grade associations, social clubs, committee of friends' associations, cooperative societies and so on were present at the occasion with each group announcing their donations as contributions to the community purse for developmental projects. Also, several UDU chapters from across the country were equally represented by their members and executives.

Describing the emergence and primary function of the Umutu Development Union, the Secretary to the Umutu Community Oil and Gas Management Committee (UCOGMC) asserts thus:

> Before the discovery of this marginal oil field and oil exploration in our community, we have what we call the Umutu Development Union. It was previously a youth organization that metamorphosed into a community affair. We organized ourselves, family to family, because we have UDU Port Harcourt branch, we have UDU Bayelsa branch and in diaspora etc. Whenever they come back home, they make their contributions to the common purse. They have a central committee where delegates will be sent from different branches too, the chiefs, youth, age grade, women, would go and have discussions. They would decide on what to do with the money they have realized. The Igili Day celebration is all about fund-raising. This has been the mechanism the community has devised in developing itself. For example, the Umutu Secondary School we have today which the government now operates started as a self-help project. Every development in this community has started as self-help after which we hand over to the government. KII/Male/Secretary UCOGMC /Umutu/2018

Corroborating the above position and establishing the essence of the Igili Day celebrations, the Vice President of the Umutu Development Union added:

> We raise funds by asking families or individuals. For instance, today we had a festival called Igili day, and every year there must be Igili day set aside for fundraising purpose. It is usually held on the Saturday before Easter Sunday. We gather predominantly Umutu indigenes-sons and daughters and we may decide to invite one or two people from outside the community and what we normally do is to raise money for the community projects. Like now we are building another

> secondary school as this current one is overpopulated. That is how we help ourselves. KII/Male/Vice President/UDU/2018

Adding his voice to the essence and importance of the Umutu Development Union and the celebration of the Igili Day, an executive member of the Umutu youth organization had this to say:

> Due to this Igili day that we have just done, we raised money to enable us to execute one or two projects for the community. Our brothers and sisters from the diaspora and our families donate monies. Like this one we just did, the six major families in the community donated the sum of ₦50,000 each, while for individuals some donated ₦500,000, ₦300,000, ₦200,000 and so on. So, these are the monies with which we execute developmental projects in the community. FGD/Male/Youth Group/Umutu/2018

Plate 3: Igili Day Celebration, Umutu Community, 31st March 2018.
Source: Fieldwork, 2018

Consequently, it becomes evident that the Umutu Development Union and Day celebration approach is a model that has been highly successful and sustainable for the Umutu people. This approach has ensured their continued development even in the near absence of government or any other external intervention. This has strengthened the adaptive capacity of the Umutu people about the negative impacts of oil and gas exploration in their community.

Conclusion

The study investigated the role that collective action plays in building the adaptive capacity of oil impacted communities in the Niger Delta region of Nigeria. The study has demonstrated that where

there is a strong sense of concern for community welfare and well-being, the level of collective action among community members can be a source of interest-based support and community-wide development. More so, local community-based institutions such as development unions, age grades and socio-cultural groups provide community members with the opportunity to organize themselves and galvanize resources in solving common community-based problems. Collective action through these institutions has enabled and strengthened the adaptive capacity of individuals and the general community in terms of staying apace the socio-economic, livelihood, and socio-cultural risks arising from crude oil-induced environmental degradation. Given the foregoing, the study concludes that collective action is a veritable approach to strengthening the adaptive capacity of oil impacted communities in the Niger Delta region of Nigeria.

Recommendations

Based on the findings of the study, it is, therefore, recommended that the government and other non-governmental development interventionist organizations that are concerned with improving the livelihoods and well-being of the oil impacted communities in the Niger Delta region should robustly engage with and enhance the capacities of community-based institutions in the region. This can be achieved through regular stakeholders' engagements, townhall meetings and needs assessments of oil impacted communities, while development intervention resources, knowledge, technology and skills can be diffused into communities through community-based institutions.

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Author's Profile

Dr Jackson T.C.B Jack is a Lecturer at the Department of Sociology and Anthropology, Federal University Otuoke, Bayelsa State. He is a Development Knowledge Facilitator, and Sustainable Development Goals (SDGs) advocate with research interests in environmental sociology, socio-ecological resilience, indigenous knowledge systems, climate change, resource governance etc. He has made significant scholarly contributions in these research areas in book chapters, conference papers and publication in reputable local and international journals. He is a member of numerous learned societies including the International Sociological Association (ISA) and the Nigerian Anthropological and Sociological Practitioners Association (NASA). He can be contacted via jackjt@fuotuoke.edu.ng

"Where there is no Doctor": Determinants of Health-Related Practices among Rural People in Bayelsa State, Nigeria

[1]Iteimowei Major
[1]Department of Sociology, Niger Delta University, Nigeria.
Correspondence: drmajor2014@gmail.com

Abstract
The basic objective of the study is to investigate the factors that influence rural people's responses to illness in Bayelsa State. The Health Belief Model (HBM), and the sick role theory serve as the theoretical frameworks for this study. This qualitative study sampled 45 respondents drawn from three selected rural communities in Bayelsa State (Amatolo, Amurukeni, and Agorogbene) using a multi-stage sampling technique. Data for the study was collected through the qualitative tools of In-Depth Interview (IDI) and Focus Group Discussions (FGD). Collected data were analysed thematically using content analysis method. Findings from the study indicated rural people in Bayelsa State utilise traditional medicine as a result of their socio-cultural perception of illness. In addition to other probable reasons for rural people's response to illness is the invisible attacks (socio-cultural) which can lead to madness, blindness and other strange illnesses which only rural traditional doctors can treat. Lack of access to biomedical health facilities influences the pattern of the resort to healthcare services among rural dwellers in rural areas. Socio-economic status was implicated as having a direct impact on people's response to illness. Low-income earners are prone to negative responses to illness. Based on the findings of the study, it was recommended among others that harnessing and enhancing the skills of traditional healthcare practitioners to complement the orthodox healthcare settings will result in a more effective healthcare delivery system that will be beneficial to rural dwellers in Bayelsa State.

Keywords: Determinant of health, Rural people, Bayelsa State, Health Belief Model, Traditional medicine

Introduction
There is no doubt that mortality emanating from poor health are prevalent in rural areas due to a whole range of issues impacting on health status and the efficacy of health service interventions. While it is not possible to say what proportion of the excess mortality is due to the social determinants of health, one can be certain they play a major role. Lower incomes, lower levels of education and employment, and poorer access to health services are among the social determinants of poor health for people in rural and remote areas, who are also disadvantaged by a higher prevalence of common risk factors for health, such as higher rates of smoking and alcohol intake. Some studies have noted that in a pluralistic medical milieu in which the rural dwellers find themselves, the decision to seek care, where to do this and the form of care perceived as appropriate are all influenced by a multiplicity of factors relating to the person, the facility and the socio-

cultural environment (Fabrega, 1973; Tanahashi, 1978; Egunjobi, 1983; Aregbeyen, 1992; Orubuloye, 1991; Ademuwagun, 1998). According to Tanahashi (1978), the level of functionality of a health facility or service may be measured by the degree to which it is accessible, affordable, acceptable and available to its potential users. Other relevant socio-cultural factors which affect or determine an individual's response to illness and perception of health and wellbeing include the type of illness, severity of illness, age, gender, level of education, economic ability, religious beliefs, family decision, marital status, availability, affordability, acceptability and accessibility (Omotosho 2010).

It is no gainsaying, however, that rural Nigeria remains the most neglected, and its people, the most deprived concerning the provision of modern health care services. Even in the few areas where medical facilities exist, such facilities are bedevilled by a lack of medical personnel, equipment, and inadequate supply of essential drugs. This, in the views of Aregbenyen (1992), has created an enabling environment for such rural dwellers to easily resort to traditional medical practice and spiritual healing homes as health response alternatives. Also, rural people lack other basic infrastructural necessities like potable water and the likes that are essential to the maintenance and promotion of good health. The outcome of these inadequacies is that the rural dwellers are subjected to a high incidence of morbidity and mortality resulting from the prevalence of preventable diseases, (UNAIDS, 1997).

It is estimated that over 65% of Nigerian population who live in the rural areas are most neglected and deprived of modern healthcare services as well as other modern infrastructural necessities that are essential to the maintenance and promotion of good health (Olujimi, 2006; Ewhrudjakpor, 2008; Omotosho, 2010). This situation is unfortunate as the majority of the nation's population who produce the nation's food needs – including valuable export crops – reside in the infrastructurally underserved rural areas.

It is also obvious that rural dwellers in the developing world have different notions and perceptions about the aetiology of disease and illness. Once a person assumes a sick role or becomes ill, it is observed that he/she strives to seek medical advice based on all available healthcare options like: visiting a public or private biomedical facility, or traditional health facility, self-medication, spiritual healing homes and the use of home remedies. Health seekers in Nigeria, especially the

rural dwellers' determination to explore various treatment options is predicated on several factors which include: the severity of the illness/symptoms of illness, socio-cultural influences, distance to the place of treatment, income, level of education, and cultural prescriptions among other factors. All these determine the choice of healthcare provider the patients use in such rural areas. However, very little research has been undertaken to identify the factors/determinants of rural dwellers' responses to illness in Bayelsa State. This has necessitated this research to investigate the factors that influence the health-seeking behaviour) among rural dwellers in Bayelsa State, Nigeria.

Theoretical Framework

The theoretical orientation of this study is the Health Belief Model (HBM). The Health Belief Model (HBM) suggests that the beliefs and attitudes of people are crucial determinants of what they call disease and their health-related actions, (Jegede 1998). The Health Belief Model (HBM) was developed in the early 1950s by some social scientists including Rosenstock, Kegeles and Hochbaum at the US Public Health Service, to understand the failure of people to adopt disease prevention strategies or screening tests for the early detection of disease (Croyle, 2005). Later in the 1970s and 1980s, the HBM was further developed by Rosenstock, to focus on the relationship between health behaviours, practices and utilization of health services. In recent years, the HBM has been revised to include general health motivation to distinguish illness. This is done by focusing on the attitudes and beliefs of individuals; HBM suggests that a person's belief in personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood that the person will adopt a given health-seeking behaviour (Croyle 2005).

The HBM attempts to predict health-related behaviour in terms of certain belief patterns. HBM has been applied to study all types of health behaviour. According to this model, a person's motivation to undertake a particular health behaviour can be divided into three main categories: individual perceptions, modifying behaviours, and the likelihood of action. Individual perceptions are factors that affect the perception of illness or disease; they deal with the importance of health to the individual, perceived susceptibility, and perceived severity. Modifying factors include demographic variables, perceived threat, and cues to action. The likelihood of action discusses factors in the probability of appropriate health behaviour; it is the likelihood of taking the recommended

preventive health action. The combination of these factors causes a response that often translates in action.

Taking a cue from the Health Belief Model (HBM), it is pertinent to note that rural dwellers health-seeking behaviour are predicated on choices and alternatives they are disposed to in their environment. Hence, the tendency to easily resort to traditional medicine, home remedies, traditional birth attendants (TBAs), self-medication, patent drug stores (chemist) and spiritual healing homes. In this regard, primary health care centres (if available), and general/specialist hospitals in the urban centres only become last resorts.

Materials and Methods

Study Designs

This descriptive survey was conducted in the rural areas of Bayelsa State. The target populations were a mainly adult male and female (18 years and above) residing within the study area. Given the nature of the study, three Local Government Areas, and three rural communities namely; Amatolo town in Southern Ijaw LGA, Amurukeni in Ogbia LGA, and Agorogbene town in Sagbama LGA were selected for the study.

Sample and Sampling Techniques

The sample size for this study consisted of 45 respondents who were selected through a multi-stage sampling technique of stratified, simple random and purposive sampling. The procedure began with the stratified sampling technique which was used to divide the state (Bayelsa State) into Three (3) Strata covering the three Senatorial Districts namely; Bayelsa Central Senatorial District, Bayelsa East Senatorial District, and Bayelsa West Senatorial District. Simple random sampling technique through the balloting method was further used in the second stage to select one local government area from each of the three Senatorial districts namely; Southern Ijaw Local Government Area for Bayelsa Central Senatorial District, Ogbia Local Government Area for Bayelsa East Senatorial District and Sagbama Local Government Area for Bayelsa West Senatorial District.

In the third stage, purposive sampling technique was applied in selecting one rural community each from the three (3) selected Local Government Areas viz: Amatolo in Southern Ijaw Local Government Area, Amurukeni in Ogbia Local Government Area and Agorogbene in Sagbama Local Government Area respectively, based on remoteness geographically and poverty levels.

Finally, the simple random sampling technique was used to select 45 respondents from the selected communities for the study.

Data Collection and Analysis

Primary data were collected using a qualitative method of data collection. Two qualitative approaches were adopted in this study; In-Depth Interview (IDI), and Focus Group Discussion (FGD). Questions that featured in the interview guides were divided into two parts. The first part centred on participants' background characteristics while the second part concentrated on the study's specific objectives. While thirty-nine (39) IDIs were conducted with participants in the selected rural communities (11 in each community), one FGD session consisting of four members was conducted in each community. The interview and Focus Group Discussion (FGD) sessions were conducted in an interactive, conversational manner to enable the participants to express themselves freely on the questions raised.

In analysing the data for this study, descriptive statistics was used to interpret data on the socio-demographic characteristics of respondents, qualitative data were sorted and analysed using content and thematic analysis.

Ethical Considerations

Bearing in mind that every social research is based on ethical issues, permission to carry out the study at the community level was sought from their respective community heads before respondents were briefed about the study and its expected benefits. They were also assured of their confidentiality. Thus, individual respondents gave their verbal consent before proceeding with the interview. The researcher also ensured that all ethical standards were observed as set by the National Health Research Ethics Code (NHREC).

Results

The socio-demographic characteristics of respondents in this study revealed that 51.9% were males while 48.1% were females. Age of participants ranged from 20 years to 60 years and above; the highest respondents (31.9%) were within the age bracket of 45 to 59 years. Also, more than half of the participants 51.8% were married compared to the 24.7% who were single participants. The remaining were either divorced or widowered/widowed. Again, more than half of the respondents

(52.1%) were Christians, while 31.6% identified with the African Traditional Religion. Others were affiliated with some other religions. With regards to educational status, the bulk of the participants (45.9%) had at least attended a primary school. 23.8% had no formal education, 21.8% had secondary education, while only 8.5% had tertiary education. The occupational status of the respondents also indicated that 30% of the participants are engaged in farming, while 29%, 14.8% and 16.8% were engaged in fishing, hunting and trading respectively. Only about 8.8% of the respondents were in forms of occupation not identified in this study. The income level of the participants revealed that about 40.6% of the participants earn a monthly income below N15,000. 29.8% earn between N16,000 and N30,000 monthly, while 20.1% and 9.5% of the respondents earn between N31,000, N49,000, N50,000 and above. Finally, while 62.2% of the participants were heads of their respective households, 37.8% were not.

Healthcare Practices among Rural Dwellers in Bayelsa State

The first objective of this study is to examine the health practices among the rural dwellers in Bayelsa state. Majority of the respondents from the three communities involved in the study alluded to the fact that traditional healthcare system is still extensively utilized in their respective communities and that it plays a dominant role in the diagnosis, management, and treatment of diverse illness episodes in the study areas. In an IDI conducted in Amatolo, one of the respondents stated thus:

> Traditional medicine has been part and parcel of our rural lifestyle and culture, we were born into it through the aid of traditional birth attendants (TBA's), when sick, we are attended to by the traditional healer or medicine man (buru owei) with the use of herbs from our community environment. We have home remedies which are handy to treat common ailments and it is less expensive, the practitioners are well known to us in the community which builds our confidence on the efficacy and genuineness of the herbs and practice. (IDI 45, Farmer, from Amatolo interviewed 25/4/2018).

Another participant in one of the Focus Group Discussion sessions in Agorogbene community gave impetus to the fact that traditional birth attendants play a vital role as traditional health practitioners in rural areas. According to her:

> Our women never had issues with childbirth, especially if they strictly adhere to the traditional therapeutic regime as instructed, and equally come for body massage. We do body massage to help pregnant women to be flexible in preparation for labour…we also do body massage for pregnant women to position and reposition a wrongly positioned foetus. (FGD 58, TBA, from Agorogbene interviewed 10/5/2018).

Concerning traditional bone setting activities in the study area, most of the participants attested to the fact that when a person within the community has a broken bone or bone/joint fracture, going to the Hospital for Orthopaedic treatment is a waste of time and money as the person stands the chances of going through amputation. One of the respondents put it thus:

> We have seen several cases of people with broken or fractured bones due to occupational or domestic accidents been taken to Hospitals in the Urban areas, who eventually came back with one leg or hand amputated and work with the aid of Crutches or Wheelchair. In contrast, Traditional Bone Setters would have treated such cases without amputation, using natural Herbal medicine and massage with herbal lubricants. (IDI 65, Community leader from Agorogbene, interviewed 18/5/2018.)

In a related development, during an In-Depth Interview with a respondent on the efficacy of Traditional Bone Setters in the study domain, he has this to say:

> My son was in the Nigeria Police Force (NPF) and was a member of the Escort team to the Executive Governor of Bayelsa State. While on duty one fateful day on a travel mission with the Governor, some vehicles in the convoy were involved in a fatal accident and my Son was a victim among others. He escaped death narrowly, but not without a badly battered leg with multiple bone fractures. He was rushed to an Orthopaedic hospital in Yenagoa the state capital, but he was later referred to a more standard Orthopaedic Department of a teaching hospital in Enugu. However, the last resort from the teaching hospital was to amputate the affected leg, I refused to sign the consent form, but instead signed against doctors' advice and took my Son to a famous Traditional Bone Setter in a neighbouring community in Bayelsa State. After a prolonged traditional medical treatment that lasted over a year and six months, my Son gradually recuperated and was healed. Although he is never the same again in terms of physical fitness because he limps while walking…but the joy is that he escaped amputation as prescribed by the Orthodox doctors in the hospital. All thanks to Traditional Bone Setters, and long live Traditional Medicine. (IDI 68, Fisherman from Amurukeni interviewed 28/5/2018).

Health Alternatives Available to Rural Dwellers in the Study Area

The second objective of the study is concerned with finding out the health alternatives that are available to rural dwellers in the study area. In an In-Depth Interview conducted in Agorogbene community, a respondent asserted that the only available alternative healthcare systems in contrast to the dominant traditional medical practice are the Primary Health Care (PHC) and Patent Medicine Vendors (PMV). Other health facilities like the Federal Medical Centre, Yenagoa and the Niger Delta University Teaching Hospital, Okolobiri among others, are all situated in the urban areas which serve as referral centres during critical health situations for those that can afford the cost implication since there are no Cottage or General hospitals within the study area. In his words:

> We have a primary health care Centre in Agorogbene community built by SHELL oil company, however; it is not functional because there is only one community health worker in the PHC centre. We have made several appeals and request to the state commissioner for Health to send the appropriate number of medical personnel suitable to make the place functional but to no avail. We have one patent medicine store in this community, but patronage is relatively low. If an illness episode cannot be treated by traditional medical practitioners and sometimes over the counter drug application... then based on the availability of funds, the person is taken to a health facility in the urban areas for treatment" (IDI 31, Artisan from Agorogbene interviewed 15/5/2018)

Seeking medical care in clinics and other biomedical facilities including PHC centres, patent medicine vendors and faith healing were seen as alternative sources of seeking healthcare by various respondents in the study area as highlighted in the following excerpts from the three rural communities the study covered. This is based on a multiplicity of factors as narrated by various FGD respondents from the three communities. See the excerpts below:

Excerpt 1

> When my child was sick I applied home remedies but no improvement, I tried traditional medicine the situation deteriorated, a friend recommended some drugs from the patent medicine vendor which was purchased and administered, but the illness persisted, so finally I took the child to a hospital in the urban centres where the child was admitted for over a week before the child recovered. However, it impacted seriously on the family finances since am a peasant farmer. I don't pray for such experience again (FGD, 48 farmers, from Amatolo interviewed 29/4/2018

Excerpt 2

> The last time my wife was sick, we went and saw a traditional medical practitioner for treatment, but there was no improvement, so I took her to a faith healing tabernacle (Zion), fasting and prayer restored my wife's health (FGD, 52 fisherman from Agorogbene, interviewed 15/5/2018)

Excerpt 3

> It depends on the sickness: I will verify the symptoms and if it is something like fatigue, headache, general body pain, nasal congestion, or feverish condition... I will just go to the patent medicine vendor and explain to him and buy over-the-counter drugs as prescribed by the vendor, but when the condition persists then I will endeavour to go to the urban area to see a doctor (FGD, 45, Teacher, from Amurukeni, interviewed 3/6/2018

The responses from the excerpts reveal that beyond the traditional source of health care, some people are still interested in biomedical health care services irrespective of the fact that such services are marred with diverse shortcomings as attested to by some respondents.

Factors that Influence Rural Dwellers Response to Illness in the Study Area

The third objective of the study is to identify factors that influence rural dwellers' response in the study areas of Bayelsa State. There is a dearth of orthodox biomedical hospitals and clinics including qualified manpower in most of the rural areas in Bayelsa State. Rural dwellers are, therefore, encouraged to use unorthodox medical facilities due to multiple factors like affordability, acceptability, availability and accessibility.

Respondents/participants opined that the type of illness coupled with its severity are very significant factors that determine how rural dwellers respond to illness and the channel to follow. Some conditions, particularly those with mental health symptoms such as hallucinations or anxiety appear to be uniquely suited to traditional healing. An In-Depth Interview conducted in Amurukeni attested to this fact. According to a respondent:

> Some diseases and conditions are abnormal, take for instance someone who sleeps well and at midnight gets ill and starts screaming and calling out to people no one else can see, then we know that hospital cannot deal with this condition, so we take them to traditional healers who can see what the ill person can see (IDI, 55, Fisherman from Amurukeni Interviewed 28/05/2018).

In a related development, mother of a mentally ill girl from Amatolo has this to say:

> I decided to take my daughter to a traditional healer who knows the exact cause of the problem and how to appease the gods that are disturbing her. This is no hospital matter... It is spiritual and must be treated spiritually (IDI, 52, From Amatolo, interviewed 25/04/2018)

The responses from the respondents above reveal that cultural behaviour and belief system play a significant role in shaping the thought pattern and mindset of rural dwellers with regard to the aetiology of certain illnesses within their environment, which are anchored on superstition. In such instances, treatment is sought from spiritual healing homes and traditional healers who can interface with the spirit realm to proffer solutions to such strange illnesses that are beyond the physical dimension.

In a Focus Group Discussion session at Agorogbene, discussants alluded to the fact that the type of illness surely determines where to seek treatment as captured in the following extracts:

Excerpt 1

> I had a farmland boundary dispute with my neighbour, which was ruled in my favour by the village council. However, this did not go down well with my disgruntled neighbour who promised revenge. Two weeks after the ruling I was going to my farm since it was

> the beginning of the planting season. I got to the farm with my son and daughter, as we were about to start work, I felt something like a bullet hit my body and sent a shocking vibration on the left part of my body. I immediately fell to the ground shouting for help. I was taken to a hospital in the urban area and was diagnosed with a stroke. Around my abdomen region, I felt a sensation of a crawling movement inside of me. Scans were not able to reveal what was crawling in my abdomen, neither was the stroke getting any better, so after two months in the hospital, my husband and other family members decided to take me to a traditional healer who said that someone with an evil eye has sent spiritual bullet (Atamgba). After a session of incantation by the traditional doctor and pouring of libation and consultations with the supernatural, he placed his hand on my abdomen and extracted a living lizard out of my abdomen that brought an end to the crawling sensation. Sacrifices were made to appease the gods to turn away the evil eye from me before I was given some herbal roots to drink and bath with which ultimately led to my recovery from the stroke condition, and I have been able to resume my normal farming activities (FGD, 53, Farmer from Agorogbone interviewed 18/5/2018).

Excerpt 2

> I am a mother of three children and a trader from Amurukeni. Most nights when we are asleep, suddenly my fourteen years old daughter will scream for help from her sleep and be groaning as if under a weight. When I woke her up she would say a masquerade was chasing and flogging her in her dream, and she would complain of peppery feelings in parts of her body. On close examination we will discover thin incisions and stripes like marks in such parts of her body which was a frequent occurrence until we consulted a faith healer who conducted a deliverance session on her with anointing water and oil, the nightmare experience is now a thing of the past (FGD, 48, Trader from Amurukene interviewed 3/06/2018).

Excerpt 3

> In our community, it is a taboo to sleep (have carnal knowledge) with a woman in the forest. However, a young man from this community carried out the said act without the consent of the lady (rape) and threatened her to keep sealed lips or face his wroth, so she concealed the sexual transaction between them which was a taboo. Some months later the young man became very ill losing weight very fast and was pining away in silence. He was taken to so many hospitals for treatment but to no avail. He was finally taken to a spiritual healing home where his deeds of trespass were revealed, he later confessed as tradition demands, paid compensation to the girl's family, before purification and cleansing activities were carried out before he regained his health (FGD-65, from Agorogbne, interviewed 10/5/2018)

The above excerpts depict the fact that not all illness episodes are suitable for biomedical treatment. Thus, the type of illness determines the channel of treatment.

Another thematic factor that influences rural dwellers' responses to illness is economic consideration or the high cost of treatment or services and long distances to health facilities vis-a-

vis the riverine terrain of the study area. The problem of distance to a biomedical health facility is aggravated by the high poverty levels in rural communities as captured in the IDI below:

Excerpt 2

> ... I am a retiree and pension payments are not regular and very meagre so travelling to a distant hospital in the urban area for treatment is totally out of the question for me (IDI, 73, Retired Teacher from Amatolo interviewed 29/4/2018)

Excerpt 2

> ... even to eat properly is a problem, as a disabled person I depend on goodwill from friends and family, so I make do with traditional medicine and spiritual healing that is available in the community" (IDI, 48, from Amatolo interviewed 29/ 04/2018)

Excerpt 3

> ... As a pregnant mother, I may not attempt long distances to seek healthcare without adequate means of transport which is non-existent here. We live from hand mouth as peasant here so the cost of transportation, buying of drugs, and admission fee we cannot afford (IDI, Trader from Amatolo interviewed 27/4/2018)

Excerpt 4

> I would have loved to go to the hospital if it were free, but there is nothing for free... So it is better to patronize the traditional healers since it is comparatively cheaper, available in my environment where you are sure of getting immediate and direct attention from the practitioners (IDI 42, Farmer, from Amurukeni interviewed 4/6/2018)

Excerpt 5

> ... my religious beliefs do not accept blood transfusion hence I prefer and patronize complementary and alternative medicine use in times illness compared to going to the hospital (IDI, 55, Religious leader from Amurukeni interviewed 5/6/2018)

Excerpt 6

> ... my lean resources cannot be wasted in an urban hospital. I also heard that the nurses are very rude and insult patients and their relatives especially people who are not highly educated, and from the villages, so why will I waste my time going to a place that I will be dehumanized (IDI, 67, Retiree, from Amurukeni, interviewed 3/6/2018).

Excerpt 7

> The last time my uncle was admitted in the urban hospital for an undisclosed ailment, because of the high cost of fees charged we were left with no option than to sell a choice portion of the family land to the cushion the hospital bills before he was discharged (IDI, 26, a student from Agoregbene, interviewed 15/05/2018)

Excerpt 8

> As a graduate who is now enlightened, I prefer the hospital and biomedical treatment to traditional medicine because the personnel are trained and there are standardized procedures to follow compared to traditional medical practices that are shrouded in mystery and practitioners have no formal training, but practices in trial and error (IDI 35, Teacher from Agorgbene interviewed 15/5/2018)

Other relevant thematic factors include rural dwellers literacy level or level of education, age and gender including family decisions; all of these play significant roles in how rural dwellers in the study area respond to illness. Views from some participants in a Focus Group Discussion (FGD) session gave credence to the above. One of the participants stated thus:

> I am 80 years of age, I grew up in this community (Amurukeni) and I have spent almost all my life here, depending on traditional medicine for all my health needs, is it now that I am old that I will bother myself going for medical attention in the urban hospitals? No way!!! The gods of our land will continue to protect me till the day I join my ancestors (FGD, 80 Community Leader, from Amurukeni interviewed 28/05/2018)

In a related development, another participant in a Focus Group Discussion (FGD) has this to say about the role of the family in healthcare-seeking options:

> Family and kin groups have a key role to play when a member of my family is critically ill because my family has a name to protect in this community (Agorogbeni). An injury to one is an injury to all, so we do come together to find a solution to cure the sick member, and the decision on where to go will depend on the nature, cause and type of illness" (FGD, 48, a fisherman from Agorogbene interviewed 18/05/18)

Also, a pregnant participant in a Focus Group Discussion conducted in Amatolo Community, while commenting on government policy in the state (Bayelsa State Safe Motherhood Initiative) which pays a monthly stipend (₦3,000) to pregnant women who registered for ante-natal care with government hospitals in the state, has this to say:

> I cannot travel out of my community to any government hospital with my condition to register for ante-natal care because of ₦3000 which the state government promise to pay pregnant women on registration. The closest General Hospital is three communities away from my town, so transportation and feeding alone will take all the money considering our difficult terrain. Therefore, I prefer to patronize the traditional birth attendants in my town (FGD, 36, Housewife from Amatolo interviewed 29/04/2018)

Discussion of Findings

The findings of the study go in line with the objectives of the study and therefore shall be discussed in line with how they answered the research questions as follows:

On the first objective, it was discovered in the study that the traditional medical practice enjoys a wider acceptance than the orthodox medical practice in the rural areas of Bayelsa State. This may be as a result of the near non-existence of biomedical facilities in the rural areas. This finding is corroborated by the findings of Ewhrudjakpor and Ojie, (2005) which observed that there is a dearth of orthodox hospitals and qualified manpower in most of the rural areas in Nigeria.

Consequently, natives are encouraged to patronise traditional medical facilities as they are also more readily available, accessible and affordable. Other findings from the study confirmed that traditional medicine plays a complementary role to the formal healthcare systems hence, there still exists a high prevalence in the use of traditional medicine in the rural areas of Bayelsa. This is in line with the World Health Organization (2002) report on traditional medicine which states that at least 80% of people in Africa use traditional medicine at some point in their lives, which implies that the efforts to improve healthcare access in Africa cannot ignore traditional healthcare systems.

The study also revealed that rural dwellers in Bayelsa State, in line with their cultural belief systems and practices, are more disposed to traditional medicine in the diagnoses, management and treatment of mental illness. This corroborates earlier findings of Jegede (1998) that perceptions of mental illness are associated with supernatural forces. This viewpoint agrees with the research findings of Global Health Action (2011) which reveals that in Africa, mental healthcare is largely provided by traditional healers and a very high number of patients with mental illness seek help from these indigenous healers.

Concerning the second findings of the study, Primary Healthcare Centres and Patent Medical Vendors (PMV) readily serve as the alternatives to traditional medical practice. This study revealed the important role that PHC plays in rural areas. This supports earlier assertions by Onwujekwe and Uzochukwu (2005) that the concern for lack of healthcare in the rural areas led to the Alma Ata Declaration by the World Health Organization (WHO) in 1978 of Primary Healthcare (PHC) as the only viable strategy for providing health care to over 80% of the population of developing nations who reside in the rural areas.

Community health workers play a very significant role in healthcare delivery in the rural areas, hence the need for the Bayelsa State Government to recruit more of such health practitioners to bridge the existing gap in terms of bringing biomedical healthcare to the rural areas as established by the study. This finding is in tandem with an earlier study carried out by Musoke, Boynton, Butler (2014), which posited that the use of community health workers in healthcare service delivery is a strategy used in Uganda and other countries that serve as a community's initial point of contact for health because these CHWs are mandated to carry out community mobilization in terms of health

awareness and sensitization campaigns, health education, and referral of patients to health facilities especially secondary and tertiary health facilities.

On the third objective, findings revealed that the type of illness a person is affected with has a great implication on the channel of care to adopt—orthodox or traditional. Illnesses that are viewed as having supernatural causation are channelled to traditional health practitioners and spiritual healers. Studies by Omotosho (2010) support the above findings which state that people resort to the use of herbal medication when the illness is believed to be caused by witchcraft or sorcery, or attributed to the wrath of ancestors and supernatural forces, and include illnesses such as mental illness, epilepsy, bewitching and spirit possession among others.

Economic ability undeniably is a major encumbrance in the quest for prompt and appropriate healthcare as captured in the study. Even when some participants expressed the desire to seek healthcare in the secondary and tertiary facilities in the urban areas, the study indicates that rural people who cannot pay for health services in the urban areas could not access such services. Even for traditional medicine, some illness episodes like bone healing and other specialized services, based on cost implication, do stratify frequency of usage which is determined by household income levels. A previous study by Taffa and Chepngeno (2005) gives credence to the above when they asserted that the ability to pay determines the use of health services and that lack of finances seriously affect healthcare seeking to the extent that even when the willingness to pay for services may be there, the means to do so may not be there, hence, resulting in negative health outcomes for such people.

Religious beliefs were also implicated as deciding factors concerning the pattern of seeking healthcare among the rural populace in the study area. This supports earlier studies by Omeire (2017) which posits that some religious sects like the Jehovah's Witnesses do not opt for blood transfusion even when life is in danger, and also those who belong to the Faith Tabernacle do not subscribe to the administration of orthodox medication because of their religious inclinations. Thus, it is obvious that the religious mindset plays a significant role in healthcare-seeking behaviour.

The study also highlighted the importance of education and literacy in the study area. Some respondents maintained that education has transformed their worldview and thought pattern in favour of the orthodox medical practice, hence, they would seek its usage at all cost. This aligned

with Buor's (2003) observation that in rural Ghana, higher education results in higher utilization of health facilities. Moses (2002) also observed that higher education consistently correlates with modern family planning practices and contraceptive use and negotiation of these with a partner.

Age, gender and disability were also implicated as factors that determine people's response to illness in the study area. The aged, the disabled and pregnant women were less likely to seek healthcare outside their immediate environment based on the discomfort associated with such decisions and cost implications. The aged component of the study aligned with Fatima and Avan's (2002) observation that some patients including those that are disabled, aged, or pregnant may not attempt long distances to seek healthcare.

Conclusion

The study established a mixture of orthodox and traditional healthcare practices in the rural communities of Bayelsa State. The major reason the traditional healthcare practices still hold sway and gain more relevance is based on the fact that traditional medicine is easily accessible, acceptable and affordable to meet the rural dwellers' expectations compared to orthodox medicine; and the traditional medical practitioners who are well known in their respective communities go all out to satisfy their clients, in a bid to keep their reputation. Orthodox medicine, to a large extent, is beyond the reach of many rural dwellers due to the socio-cultural, environmental and economic factors.

The researcher discovered the untold narrative that the traditional healthcare practices of the rural dwellers of Bayelsa State are defined by their cultural orientation as evidenced in the way they look at the aetiology of illness from a natural and supernatural perspective, including but not limited to the traditional rites of cleansing and purification when taboos are breached.

The rural people of Bayelsa State are said to be mostly of low economic status, which has been seen to have a serious impact on their response to illness. The choice of what action to take, what health care channel to patronise during illness is determined, to a large extent, by one's economic status, and belief system of these rural communities.

Recommendations

Based on the findings, the following recommendations were made. Firstly, the Bayelsa State Government should build a synergy between orthodox medicine and traditional medicine by setting up a traditional medicine practitioners registration board, to formally register traditional medicine practitioners which include; (Traditional Birth Attendants (TBAs), Bone Setters, Herbalists, Diviners, and General Practitioners).

Secondly, the Bayelsa State Government in collaboration with the respective Local Government Area Councils should endeavour to establish functional Primary Healthcare Centres (PHC) in the rural areas to serve as the first resort for rural patients in terms of health-seeking. Also, regulatory agencies like the National Agency for Food and Drug Administration and Control (NAFDAC) and the Pharmaceutical Society of Nigeria (PSN) should be empowered and strengthened to effectively regulate the activities of Patent Medicine Vendors (PMV) in the rural areas of Bayelsa State.

Additionally, the Bayelsa State Government should endeavour to boost the local cum rural economies of the rural areas by way of helping these rural dwellers to form and register rural cooperatives that will benefit from Government agricultural and entrepreneurial soft loans to further enhance and empower their traditional livelihood coping mechanisms which are predominantly fishing and farming in a sustainable manner that will help them to escape the poverty trap that has served as an economic limitation in terms of their response to illness.

Finally, ambulatory services/Mobile Clinics (River craft ambulances/clinics) should be provided by the Bayelsa State Government and Multinational Oil Companies operating in the state as part of their corporate social responsibility (CSR), in a bid to help evacuate rural patients in case of an emergency, and during referrals from the respective Primary Healthcare Centres (PHC) to secondary and tertiary healthcare facilities as the case may be. The mobile houseboat clinics will help tremendously in bringing biomedical healthcare to the doorstep of the rural people.

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Author's Profile

Mr Iteimowei Major teaches at the Department of Sociology, Niger Delta University, Wilberforce Island, Bayelsa State, where his area of speciality includes; Medical sociology and Sociology of development. His P.hD thesis which he successfully defended in September 2019 at the University of Uyo, Akwa-Ibom state was on the determinants of People's response to illness among rural dwellers in Bayelsa State, Nigeria. He has published several articles on health and development related issues. He is a member of the Nigerian Anthropological and Sociological Practitioners Association (NASA). He can be contacted via drmajor2014@gmail.com

Collective Bargaining Process and Implementation of Agreements: An Appraisal of FG/ASUU Industrial Disputes

[1]Stephen Sunday Ojo

[1]Department of Sociology, Federal University, Gashua, Yobe State, Nigeria
Correspondence: drstephenojo@gmail.com

Abstract

In recent times, industrial relation has been characterized by perennial disputes particularly between Federal Government and Academic Staff Union of Universities in Nigeria. Collective bargaining as a viable tool for industrial relations has not been appropriately used in good faith, therefore leading to several inconsistencies in fulfilling the agreements reached. This paper attempts to historically review the extent to which collective bargaining process has influenced the implementation of agreements reached in resolving industrial disputes particularly between the Federal Government of Nigeria and Academic Staff Union of Nigerian Universities. Using data from a review of the literature and content analysis, the paper revealed that promotion of capital accumulation at the expense of labour, lack of political will and insincerity on the part of the government, corruption and leaders of government being ignorant of the cost of running university system have hindered the implementation of the agreements reached. It, therefore, concludes that deficient collective bargaining and failure to implement the agreements have been a dominant factor in the industrial conflict. The paper recommends that policies aimed at governing the university system must be products of painstaking deliberations so that collective agreements are reached to guarantee workable solutions following acceptable international standards.

Keywords: Agreements, Collective bargaining, Implementation, Industrial dispute, Industrial relations

Introduction

Collective bargaining consists of negotiations between an employer and a group of employees to determine the conditions of employment. The result of collective bargaining procedures is a collective agreement. Employees are often represented in bargaining by a union or other labour organization (Iyaji, 2010).

The machinery of industrial relations in Nigeria has proved particularly handicapped in dealing with industrial disputes. The success or failure of a system of industrial relations can only be measured by its efficiency in resolving industrial disputes. The drastic reduction of labour input in the industry particularly in the public sector and cross border movement of required knowledge workers have greatly affected the bargaining power of employees in the developing countries (Dauda, 2002). Employers are implementing a range of innovative practices to meet the challenges posed by globalization. For instance, Human Resource Management (HRM) advocates unitarism,

non-unionism, networking and individual bargaining as core tenets to manage people in contemporary society. In the face of growing challenges confronting traditional personnel management, the question that is frequently asked is whether collectivism in industrial relations has reached the end of the road.

This paper aims to historically review the extent to which collective bargaining process has influenced the implementation of agreements reached in resolving industrial disputes particularly between the Federal Government of Nigeria and Academic Staff Union of Nigerian Universities. It will also discuss the attitude of the Nigerian Government towards the use of collective bargaining in addressing the perennial problems of universities as well as the reasons responsible for such attitude, the consequences and make possible recommendations.

Conceptual framework/ Review of related literature

Collective Bargaining Process

Collective bargaining is the performance of the mutual obligation of the employer and the representative of the employees to meet at reasonable times and confer in good faith to negotiate wages, hours, and terms and conditions of employment; it is also, the negotiation of an agreement, or any question arising thereunder, and the execution of a written contract incorporating any agreement reached if requested by either party. However, such obligation does not compel either party to agree to a proposal or require the making of a concession (Dessler & Varkkey 2013). In other words, both management and labour are required by law to negotiate wages, hours, and terms and conditions of employment "in good faith." Good faith bargaining according to Tyler (2005):

> is the cornerstone of effective labour-management relations. It means that both parties communicate and negotiate, that they match proposals with counterproposals, and that both make reasonable effort to agree. It does not mean that one party compels another to agree to a proposal. Nor does it require that either party make any specific concessions (although as a practical matter, some may be necessary).

Also, Carrell and Heavrin (2011) deduced that bargaining is not in good faith when it has the following characteristics:

1. Surface bargaining: Going through the motions of bargaining without any real intention of completing an agreement.

2. Inadequate concessions: Unwillingness to compromise, even though no one is required to make a concession.
3. Inadequate proposals and demands.
4. Dilatory tactics: The law requires that the parties meet and "confer at reasonable times and intervals." Refusal to meet with the union does not satisfy the positive duty imposed on the employer.
5. Imposing conditions: Attempts to impose conditions that are so onerous or unreasonable as to indicate bad faith.
6. Making unilateral changes in conditions: This is a strong indication that the employer is not bargaining with the required intent of reaching an agreement.
7. Bypassing the representative: The duty of management to bargain in good faith involves, at a minimum, the recognition that the union representative is the one with whom the employer must deal in conducting negotiations.
8. Withholding information: An employer must supply the union with information, upon request, to enable it to understand and intelligently discuss the issues raised in bargaining.
9. Ignoring bargaining items: Refusal to bargain on a mandatory item

In collective bargaining processes, the negotiating teams are crucial; both union and management are to send a negotiating team to the bargaining table, and both teams usually go into the bargaining sessions having "done their homework" (Sloane and Witney, 2007). Union representatives will canvass the opinions of union members on their desires and confer with representatives of related unions.

Collective bargaining experts emphasize the need to weigh the union's demands carefully. The mistake, most often, is that government/management enters the negotiations without understanding the financial impact of their proposals.

The process of collective bargaining recognizes bargaining items. This implies that labour law has set out categories of specific items that are subject to bargaining: these are mandatory, voluntary, and illegal items. Mandatory bargaining items include wages, hours, rest periods, layoffs, transfers, benefits, and severance pay. Voluntary (or permissible) bargaining items are neither mandatory nor illegal; they become part of negotiations only through the joint agreement of both management and

union. Neither party can compel the other to negotiate over voluntary items. You cannot hold up signing a contract because the other party refuses to bargain on a voluntary item. Benefits for retirees might be an example. Illegal bargaining items, however, are forbidden by law. A clause agreeing to hire union members exclusively would be illegal in a right-to-work state, for example.

Bargaining Stages

According to Dessler and Varkkey (2013), actual bargaining typically goes through several stages. First, each side presents its demands. At this stage, both parties are usually quite far apart on some issues. Second, there is a reduction in demands. Here, each side trades off some of its demands to gain others. Third, the subcommittee studies; the parties form joint subcommittees to try to work out reasonable alternatives. Fourth, the parties reach an informal settlement, and each group goes back to its sponsors. Union representatives check informally with their superiors and the union members; management/government representatives check with top management/government. Finally, once everything is in order, the parties fine-tune and sign a formal agreement.

Theoretical Framework

This paper is presented from the sociological standpoint of conflict theory. Conflict theory has its roots in the works of Engel and most significantly Karl Marx. Marx's sociological perspective which was hinged on social conflict began with the assumption of class distinction and conflict as features of society. Accordingly, he saw the history of all hitherto existing societies as that of class conflict (Dahrendorf, 1976). Other notable conflict theorists who came after Karl Marx built on the notion that change is ubiquitous; conflict is also ubiquitous; some elements in society function towards its disintegration; society is based on coercion of some of its members by others; relationship to authority determines the class and class conflict in society and conflict in society is dissociated rather than superimposed (Okeibunor & Anugwom, 2003). Similarly, Coser (1957) adopted a conflict frame of reference and sees interaction as largely conflict-oriented.

The relevance of this theory to this study is that the industrial relations atmosphere and particularly as it affects collective bargaining processes and implementation of agreements from the conflict perspective shows that there exists antagonism between the employers and employees due, largely, to what Marx, Dahrendorf and Coser described as the desire to outdo one another by each of the parties. According to Marx, while the bourgeoisie (in this case, those who have been ruling Nigeria)

are out to cut cost through the payment of pittance to workers, reduced or poor funding, the infrastructural deficit in the institutions, interference in the running of institutions among others, the workers or the proletariats are interested in wage maximization, improved facilities, better working conditions and adequate funding of the institutions. With this, conflict ensues and this further explains why Nigeria's industrial relations are characterized by antagonism right from the pre-colonial era through the post-colonial days. This explains why governments in Nigeria do not consult with the workers through the machinery of collective bargaining when it comes to wage determination, funding and improved working conditions. Thus, using the assumptions of the conflict theorists and the evidence which abounds in Nigeria, the government in Nigeria can be seen as an instrument of class domination and the domination is made worse by the situation of autocratic leadership as will be seen in lack of sincerity in fulfilling various agreements reached through collective bargaining with the Academic Staff Union of Universities, particularly from 2009 till date.

Methodology

The paper essentially utilized data from a review of the literature. Thus, related literature from research reports, government documents and memorandum from Federal Ministry of Education, Federal Ministry of Labour and Productivity, National Universities Commission (2009-2019), institutional publications, Academic Staff Union of Universities (ASUU) bulletins (2019) for 31 years, magazines and journals were used. Because of the above, content analysis was adopted for the information gathered.

Overview of the Federal Government and Academic Staff Union of Universities (ASUU) Industrial Disputes in Nigeria

ASUU was formed in 1978, a successor to the National Association of University Teachers formed in 1965 which covered academic staff in all the federal and state universities in the country (ASUU, 1978). The Union was active in struggles against the military regime during the 1980s. In 1988, the union organized a National strike to obtain fair wages and university autonomy. As a result, the ASUU was proscribed on 7th August 1988 and all its property seized. It was allowed to resume in 1990, but after another strike, it was banned again on 23rd of August 1992 (Nwala, 1994). In 1994 and 1996 (during the regime of Late Sani Abacha), the ASUU carried out an industrial action throughout the federation over good working conditions; it lasted for more than one year and led to

the dismissal of staff. Also, in 1999, when Obasanjo came into power as a civilian President, ASUU went on a nationwide strike which lasted for five months before it was called off. In 2001, ASUU went on strike which lasted for three months. Also, in 2002, ASUU embarked on six months' strike action over bad working conditions (Doublegist, 2013). Similarly, in 2009, ASUU embarked on six months strike demanding a raised salary structure and better working conditions. It is interesting to note that in 2009, the lack of commitment on the part of the Nigerian government to collectively bargain with labour was demonstrated in the ASUU/FGN face-off. It would be recalled that the Onosode-led Federal Government team entered into a bargaining process with ASUU, but when it got to the signing of the agreement, the government backed out. This led to the closure of universities for about four months. It took the effort and pressure of well-meaning Nigerians before the Nigerian Government returned to the negotiation table to re-negotiate and subsequently signed an agreement with ASUU. No wonder, it is still very difficult for the government to implement the agreement till date.

In 2010, the academic staff union of universities embarked on five months strike over non-implementation of the 2009 FG-ASUU agreement. On June 2013, ASUU also embarked on nationwide strike which lasted up to eight months on the ground that the 2009 FG-ASUU agreement and revitalization of universities with 1.3 trillion naira over six years had not been fulfilled as earlier promised (ASUU, 2013). However, considering the history of Nigeria industrial relations, particularly between the Federal Government and Academic Staff Union of Universities, one may conclude that failure to implement agreement has been a dominant factor in the industrial conflict.

It should be noted that the main reason for the adoption of the unilateral approach is to advance capital accumulation at the expense of labour. Iyaji (2010), opined that those in government are there among other reasons to accumulate capital that would be used to start a private business when they retire from public service. They spend less on education, on salaries and other emoluments and award huge contracts for projects that are not executed or that are poorly executed (Obasi, 2004).

ASUU is saying that government must invest in the revitalisation of federal universities. The amount spent on universities is too paltry when compared to what other countries like South Africa spend for the same purpose. Government has reneged all the agreements which it signed with

ASUU in the past and ASUU is simply saying that the government must honour the agreements which it voluntarily entered on revitalization and funding of university education.

Ever since the beginning of the renegotiation of the ASUU-FGN 2009 agreement in 2017, the government side has shown an uncanny prowess for duplicity in an attempt to dodge its responsibilities. Government has shown no serious commitment whatsoever to invest in education. Three years after its inauguration, the Babalakin committee has not completed the singular task of renegotiating the 2009 ASUU-FGN agreement due to dirty antics from the side of the government.

Reasons adduced for not implementing agreements between FGN and ASUU include among others, the paucity of funds; blame game by successive governments; administrative bottlenecks; increase in government expenditure. However, for ASUU, lack of political will, insincerity on the part of government, corruption in the government at all levels and leaders of government being ignorant of the cost of running a university system have been the bane in implementing already reached agreement (ASUU, 2013). Collective bargaining is a fundamental right according to the ILO (1949) manual and it is a means through which employers and their organizations, trade unions can come to a collective agreement about fair wages and working conditions. Due to the interventionist tendencies of government in Nigeria industrial relations where issues are dictated by political interest and considerations, the beauty of collective bargaining as a means of economic, social, ecological, demographic and technological stabilization is not yet appreciated (Iyaji, 2010).

Conclusion and Recommendation

From the foregoing, it is evident that collective bargaining has not been put into good use. It has not been properly utilised to resolve the industrial disputes between the Federal Government and the Academic Staff Union of Universities. The serial infidelity in implementation of agreements has become a huge burden. Unilateral tinkering with a unanimous agreement between FG and ASUU has predominantly characterized FG-ASUU relationship, bedevilling the Nigerian university system with unending strikes. It reflects a critical industrial relations problem as witnessed in the incessant strike actions by the Academic Staff Union of Universities as a consequence of government's failure to collectively bargain and honour agreements reached through negotiation.

Therefore, policies aimed at governing the university system must be products of painstaking deliberations so that collective agreements are reached to guarantee workable as well as flexible

solutions following acceptable international standards. Also, the machinery set up for collective bargaining, such as Babalakin's committee should be made to work. The paper recommends that all critical issues in the university system should be addressed in an atmosphere of mutual respect between the stakeholders and that agreements reached between FGN and ASUU should be immediately implemented.

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Author's Profile

Dr Stephen S. Ojo is a Senior Lecturer in the Department of Sociology, Federal University Gashua, Yobe State, Nigeria. His area of research interests includes Industrial and Labour Relations, Gender and Development, Cultural Studies and Social Development. He has published extensively books, articles in reputable journals at both national and international levels. He is a member of Nigerian Anthropological and Sociological Practitioners Association (NASA), National Association of Social Workers (NASOW). He can be contacted via drstephenojo@gmail.com

Social Media and Dressing Pattern Among Female Undergraduate Students in the University of Ilorin

[1]Abdullahi Kayode Ibrahim
[1]Department of Criminology and Security Studies, University of Ilorin, Ilorin, Nigeria
Correspondence: Ibrahim.ak@unilorin.edu.ng

Abstract

This study investigated the impact of social media on dressing patterns of female undergraduate students at the University of Ilorin, Nigeria. A structured questionnaire comprising a 4-point scale was the instrument used for data collection. A population of 16,391 female undergraduates was obtained from the university. Sample size of 300 female undergraduate students was randomly selected for the study using Multi-stage and simple random sampling but only 280 subjects filled and returned their questionnaires. The data collected were statistically analysed using simple percentages. The findings of the study among others revealed that the female undergraduate students dressing patterns are greatly influenced by imitation of celebrities, western dress styles, peer influence, mass media and fashion in vogue. The findings of the study also showed, among others, that female students were exposed to rape/sexual harassments; the image of such students/family were perceived as tarnished; they are also addressed as prostitutes and they are related with poor academic performance. The study recommends, among others, that parents, school authorities, lecturers, media houses, etc, should make both individual and joint effort to curb indecent dressing in the institutions of higher learning in Nigeria.

Keywords: Celebrities, Dressing pattern, Female undergraduates, Social media, Tertiary institutions

Introduction

Historically, fashion plays a significant role and has greatly influenced the "fabrics" of societies all over the world. What people wear often depicts the social life of the people across the world (Anyakoha, Eluwa, 2008). The quest to cover the nakedness of mankind plays a significant role in defining the original purpose and intent of dressing. Thus, dressing is not just for clothing purposes but for adornments (Schall & Appiah., 2016). Clothing can be described as something worn on the body and this includes materials such as garments, shoes, jewellery, cosmetics, and others. It is also a form of cultural expression that depicts every aspect of human life (Kiran, Malik, Riaz, 2010). The human dress is a kind of "symbolic" way of communication and is usually the basis on which immediate impressions are formed (Uwakwe, 2010). The style of clothing that people wear, the fabrics, designs and colours can speak largely, the way an individual thinks and lives (Uwakwe, 2010). Ibrahim (2013) opined that the display of fashion designer's products via social media

platforms such as Facebook, Twitter, WhatsApp etc. often inspire and influence changes in the clothing of the people.

Similarly, clothing choice and practices are an important human activity that constitutes the selection, acquisition and utilization of clothes. These activities are affected by social reasons, values, goals and self-concept (Wole, Ibrahim, Shehu, John, et al, 2001). The way we dress is a significant way of revealing our culture and its differences in other societies. Unfortunately, the value of dressing and its purposes have been defeated by the current generation of youths in Nigeria (Omede, 2011). Over the years, there have been trends at which fashion and dressing have changed and evolved so to say. There is a new trend in dressing among young ladies which is in vogue at the moment, especially among students of the tertiary institution. This involves dressing in provocative or see-through outfits that expose the inner parts of the female body such as bare breast, tummy or the waistline among others (Azu, 2005). Currently, dressing to expose the sacred part of the body has become a modern dressing style (Mohammed, 2015). Culture, foreign influence, institutions, peer pressure and the media are the major factors, which influence the recent trend of dressing (Mohammed, *et al.,* 2015).

In Nigeria, for example, young girls, particularly students of tertiary institutions wish to be classy. Thus, they purchase any dress that is in vogue, these they get through social media and the social personalities they choose as role models, (Chukwudi & Gbakorun, 2011). On social media, celebrities are well-known personalities who are famous because of their achievements. According to Schlecht (2003), Celebrities are individuals who are recognized publicly by a great number of people. This recognition and achievements are usually known both locally and internationally. These celebrities and their display of fashion statements influence the dress culture of youth and the fashion industry, which is evident in specific fashion replications (La Ferla, 2009). Local and international celebrities, with a mode of dressing, which is usually that of Western wears often take pictures, record videos and published them on social media. The youth observe the celebrities closely and imitate every aspect of their social life, particularly dressing style. The youth pay attention to their advice even more than their parents, teachers and well-wishers (Norton, 2006).

Celebrities seen on television and other relevant social media platforms such as Instagram, Twitter, Facebook are all powerful tools for communicating dressing and clothing styles to students (Kiran,

Malik, Riaz, 2010). The act of copying celebrity's dressing style evolving among students often leads to over-exposure of the inner body and this has implications such as rape, sexual harassment, being tagged as prostitutes, molestation and poor academic performance and other vices (Folagbade, 2009). The causes of indecent dressing among female students can be traced to several forces such as fashion, value system, civilization and infiltration of Western dresses, the effect of the media, peer pressure, family orientation and poor parentage (Omede & Odiba, 2000).

Dress to kill has become a common phenomenon in the school of higher learning as students strive to look sexy or classy, forgetting that they ought to look responsible (Antonia and Bridget, 2015). Most Nigerian girls have dropped their traditional dressing styles for foreign styles as their dress patterns are most times against African culture (Omede, 2010). This form of dressing is provocative, according to Olori, (2003). Improper and unacceptable dress patterns are morally offensive and reveal the high rate of moral decadence in the society. Oji (2007) noted that the use of internet unscrupulously for anti-social activities other than academic activities has become a growing concern in Nigerian institutions. Universities in Nigeria are seriously struggling with incessant indecent dressing particularly among female students (Obilo and Okugo 2013). Many parents and institutions are worried about the students' habits on Facebook and other social media sites because they believe that the students now hardly have time for their studies and other responsibilities.

It is on this premise that this research intends to examine the influence of social media on dressing patterns among female undergraduate students at the University of Ilorin. Studies have been conducted on related issues; nonetheless, not much empirical work has yet addressed the issue thoroughly.

Theoretical Framework

The theory adopted for this study is the Social Learning Theory which was developed by Albert Bandura postulates that behaviour is a learning process. The theory posits that if humans were motivated to learn a particular behaviour, that particular behaviour would be learned through clear observations. By imitating these observed actions, the individual observer would solidify that learned action and be rewarded with positive reinforcement (Miller & Dollard, 1941). The proposition of social learning was expanded upon and theorized by Albert Bandura from 1962 to

the present. This theory posits that people learn from one another through observation, imitation and modelling. According to Bandura (1977), people learn through observing others' behaviour and attitudes and the outcomes form an idea of how new behaviours are performed and on later occasions, this coded information serves as a guide for action. Social learning theory explains human behaviour in terms of continuous reciprocal interaction between cognitive, behavioural and environmental influences.

It is a theory of learning and social behaviour which proposes that new behaviours can be acquired by observing and imitating others. Social learning theory also known as social cognitive theory is the idea that people learn by watching what others do and human thought processes are central to understanding personality. In applying the social learning perspective to dressing patterns, indecent dressing is learned through role models, celebrities' dressing styles, and peer influence (Mihalic & Elliot cited in Igwe, 2013). In relating social learning theory to indecent dressing among female undergraduates, one can rightly say that these female adolescents learn the dress pattern from peers and social media celebrities by observing, imitating and modelling. They learn these Western values of dressing from the internet, television, magazine and newspaper.

Methodology

The research study made use of a descriptive survey design using quantitative techniques of data collection to examine social media and dressing patterns of female undergraduate students of the University of Ilorin. The population of the study is made up of all the female undergraduate students from all the 15 faculties that make up the University of Ilorin. The population of female undergraduates in this institution is about 16,391. To get a truly representative sample, a convenient sampling technique was first used to select the University of Ilorin to participate in the study; a multi-stage sampling technique was used in dividing the institution into faculties and stages. A simple random sampling technique was further used to select the sample population from each faculty where data was elicited for the study. Participants selected were female undergraduates from all the departments under each of fifteen faculties making up the institution.

A total of twenty participants (female students) were drawn from each faculty making it three hundred respondents drawn from fifteen faculties which made up the sample size for the study. Although the population of female undergraduate students in each faculty is unequal for equal

representation, the same sample of 20 female students from each faculty was selected. Students who were present at the time of this research were sampled. The research instrument was the structured questionnaire designed to capture all relevant information using a variety of question types. The questionnaire items were constructed based on the information gathered from the review of related literature. It contained twenty-eight (28) questions and was validated by experts in related fields. The test-and-retest method was used to test for the reliability of instruments.

A total of 300 copies of the questionnaires were distributed by hand to the participants who made up the sample by the researcher and three research assistants. After thorough checking for omissions and other inconsistencies, out of the three hundred questionnaires taken to the field, fourteen were not returned while six were not appropriately filled.

A total of two hundred and eighty (280) questionnaires duly completed were, therefore, analysed using descriptive statistical tools which are: frequency tables and percentages. The study adopted a Likert modified four-point response scale. The copies of the questionnaire were coded and analysed using the simple descriptive statistical analysis.

This study was approved by the Ethics Committee of the University of Ilorin, Nigeria. A consent form that was explained to all participants was signed to allow them to voluntarily participate in this study. Participants were assured that their names and identities would not be stated in this paper to ensure confidentiality and maintain their anonymity.

Results

This section presents the analysis of the gathered data and the discussion of major findings. Table 1 shows the distribution of respondents by age, marital status and academic level of the students (respondents). On the issue of age, the table indicates that 52.15% (146) of the respondents are between the ages of 16-20, 34.64% (97) of the respondents are between the ages of 21-25, 9.64% (27) of the respondents are between the ages of 26-30, while 3.57% (10) of the respondents are between the ages of 31-35.

Table 1: Socio-Demographic Characteristics of the Respondents

Variables	Frequencies	Percentage (%)
Age		
16-20	146	52.15%
21-25	97	34.64%
26-30	27	9.64%
31-35	10	3.57%
Total	**280**	**100.0%**
Marital Status		
Single	263	93.93%
Married	17	6.07%
Total	**280**	**100%**
Level		
100	60	21.4%
200	89	31.8%
300	68	24.3%
400	63	22.5%
Total	**280**	**100.0**

(Source: field survey, 2019)

This figure indicated that majority of the respondents are between the ages of 16-20. This shows that majority of the respondents is still young. On marital status, the table indicates that 93.93% (263) of the respondents are single while 6.07% (13) of the respondents are married. This showed that almost all respondents were single. This is highly expected given the fact that the population of this study was students. On the issue of the academic level of respondents, the table shows that, out of the 280 students that participated in the study, 60 (21.4%) were in 100 level, 89 (31.8%) were in 200 level, 68 (24.3%) were in 300 level, and 63 (22.5%) were in 400 level. This revealed that the respondents were fairly distributed across levels.

From the table above, 68.9% (193) of the respondents strongly agreed and agreed that they prefer to dress in the latest fashion while 31.1% (87) of the respondents disagreed and strongly disagreed that they prefer to dress in latest fashion. This shows that majority of the respondents prefer to dress in the latest fashion introduced by the social media. 93.6 % (262) of the respondents agreed that most students nowadays dress to current trends.

Table 2: Distribution of Respondents on Female Dressing Pattern in the University of Ilorin, Nigeria

Do you prefer to dress in the latest fashion observed from social media?	FREQUENCY	PERCENTAGE
Strongly Agree	44	15.7
Agree	149	53.2
Disagree	64	22.9
Strongly Disagree	23	8.2
Total	280	100.0
Most students of nowadays dress to current trends	FREQUENCY	PERCENTAGE
Strongly Agree	135	48.2
Agree	127	45.4
Disagree	14	5.0
Strongly Disagree	4	1.4
Total	280	100.0
The popular form of dressing among students is now in tandem with international standard	FREQUENCY	PERCENTAGE
Strongly Agree	98	35.0
Agree	144	51.4
Disagree	28	10.0
Strongly Disagree	10	3.6
Total	280	100.0
Students do dress by civilisation	FREQUENCY	PERCENTAGE
Strongly Agree	102	36.4
Agree	134	47.9
Disagree	27	9.6
Strongly Disagree	17	6.1
Total	280	100.0
Female students often dress against dress code rules in the university	FREQUENCY	PERCENTAGE
Strongly Agree	67	23.9
Agree	138	49.3
Disagree	53	18.9
Strongly Disagree	22	7.9
Total	280	100.0

Source: Field survey, 2019

On whether the popular form of dressing among students is now in tandem with international standard, only 13.6% (38) disagreed and 86.4% (142) agreed to the idea of international standard. This result shows that the popular form of dressing has been fuelled by Western culture. On the issue of civilization, 84.3% (236) of the respondents supported that students do dress by civilisation while 15.7% (44) disagreed that students do dress by civilisation. From the results, students do dress by civilization. 73.2% (205) of the respondents strongly agreed and agreed that female undergraduate students now dress against the school rules and regulation while 26.89% (75) of the respondents disagreed that female students dress against the school regulations. The results revealed that there is a high-level deviation from the dress code of the University of Ilorin.

Table 3: Factor Responsible for Indecent Dressing Among Female Undergraduate Students

Do you believe that social media is a great factor to student's indecent dressing?	FREQUENCY	PERCENTAGE
Strongly Agree	128	45.7
Agree	110	39.3
Disagree	30	10.7
Strongly Disagree	12	4.3
Total	280	100.0
Does your wardrobe change as new dress appears on social media?	FREQUENCY	PERCENTAGE
Strongly Agree	104	37.1
Agree	125	44.6
Disagree	42	15.0
Strongly Disagree	9	3.3
Total	280	100.0
TVs, Magazines, Posters also contribute to indecent dressing	FREQUENCY	PERCENTAGE
Strongly Agree	117	41.8
Agree	116	41.4
Disagree	34	12.1
Strongly Disagree	13	4.7
Total	280	100.0
Do Peer pressure, Poor parenting, and others also contribute to indecent dressing pattern?	FREQUENCY	PERCENTAGE
Strongly Agree	140	50.0
Agree	109	38.9
Disagree	25	8.9
Strongly Disagree	6	2.1
Total	280	100.0

Source: Field survey, 2019

The table above shows that 85% (238) of the total respondents support that social media is a great factor to students' indecent dressing in University of Ilorin. On whether wardrobe changes as new dresses appear on social, 81.7% (229) of the respondents strongly agreed and agree that social media influences the change in their wardrobe while 18.3% (51) disagreed. This shows that social media influences the choice of clothes of most female students in the university. On what type of social media contributes to indecent dressing among students, 83.2% (233) acknowledged that TVs, Magazines, Posters, Internet and the social media like Facebook, Twitter contribute much to indecent dressing while 16.8% (47) of the respondents disagreed that the types of social media did not contribute to indecent dressing. 88.9 (249) agreed that peer pressure, poor parenting, wrong use of the internet, fading value contributes much to indecent dressing pattern while 11% (31) disagreed that peer pressure, poor parenting, wrong use of the internet, fading value contribute much to indecent dressing.

Table 4: Implications of indecent dressing among female students

Indecent dressing often leads to rape, sexual harassment or molestation	FREQUENCY	PERCENTAGE
Strongly Agree	91	32.5
Agree	113	40.4
Disagree	53	18.9
Strongly Disagree	23	8.2
Total	280	100.0
Students who dress indecently are mostly seen as prostitutes	FREQUENCY	PERCENTAGE
Strongly Agree	176	62.9
Agree	78	27.9
Disagree	26	9.2
Strongly Disagree	0	0
Total	280	100.0
Indecent dressing can tarnish the image of the student and their family	FREQUENCY	PERCENTAGE
Strongly Agree	64	22.9
Agree	140	50.0
Disagree	62	22.1
Strongly Disagree	14	5.0
Total	280	100.0
Indiscriminate use of social media often leads to poor academic performance	FREQUENCY	PERCENTAGE
Strongly Agree	153	54.7
Agree	95	33.9
Disagree	16	5.7
Strongly Disagree	16	5.7
Total	280	100.0
Indecent dressing can lead to punishment and suspension	FREQUENCY	PERCENTAGE
Strongly Agree	106	37.9
Agree	115	41.1
Disagree	39	13.9
Strongly Disagree	20	7.1
Total	280	100.0

Source: Field survey, 2019

The table above shows that 72.9% (204) of the total respondents supported the idea that indecent dressing often leads to rape, sexual harassment and sexual molestation while 27.1% (76) strongly disagreed and disagreed that indecent dressing leads to sexual molestation. This implies that the majority of female students believe that indecent dressing can lead to sexual harassment. 90.8(254) supported the idea that female students who dress indecently are often seen as prostitutes while 9.2 (36) rejected the notion. On the image of the student and their families, 77.9% (204) strongly agreed and agreed that indecent dressing can tarnish the student image and that of their families while 27.1% (76) declined the notion. 88.6% (248) submitted that indecent dressing often leads to poor academic performance while 11.4% (32) strongly disagreed and disagreed with the idea. On

the issue of punishment, 79% (221) believed that indecent dressing could attract school punishment while 21% (59) strongly disagreed and disagreed that indecent dressing can lead to punishment or suspension. From the table above, female students believe that indecent dressing can lead to sexual molestation, tarnished image, poor academic performance and even suspension from the school authority. Most female students have this belief and still dress indecently against the school rules and regulation.

Discussion of Findings

This study has established that social media influence the dressing pattern of female students at the University of Ilorin in a negative way. The findings revealed that the majority of the students emulate the Western style in their dressing pattern. It was also discovered that social media influenced the students' choice of dressing pattern in Nigeria. This is in line with Kiran (2002) who stated that people of many countries have abandoned their cultural dressing styles and adopted Western dress styles for everyday wear. This is manifested in the dressing pattern and styles these students adopt which is very embarrassing.

It is also noteworthy that this work further agrees with the view that factors such as social media, peer pressure, poor parenting and the wrong use of the internet are responsible for indecent dressing among female students of Nigerian universities. This can invariably establish that the social media have become one of the fastest means of communication in recent times due to the great level of (ICT) rapid development. This is in line with Olori (2003) who opined that the dressing pattern of female undergraduate students is determined by factors such as mass media, peer pressure, religion, and culture among others.

This has greatly influenced their indulgence into "Sexting" which promotes unethical sexual behaviours (Prather and Vandive, 2014). According to Wilcox (2012), the use of clothing ought to be based on needs such as physical need (protection), psychological needs (adornment and identification) and social needs (modesty and status). Female children are often left to themselves and they become rudderless because most parents have no time to check their children's wardrobes and the implication of this, is that, they can wear anything in the form of dress (Omede and Omede, 2004). Peer pressure and poor parenting have also been implicated as some of the factors responsible for indecent dressing among female undergraduate students. This is in line with A.O.

Obeta's (2010) earlier findings that some people tend to follow the change of fashion wrongly. She further enjoined that people should wear suitable dresses at all times and should stop the imitation of the Western style of dress. The mode of dressing pattern by students in tertiary institutions is a thing of concern, because of the alarming influence of celebrities' dressing patterns on youths; and this has become the apparent dress code for students on campuses today. The findings also revealed that the dressing pattern of female undergraduate students affect other students on the campus.

Unfortunately, because some the Western styles these female undergraduate students have adopted were not accepted by society, it is viewed as anti-African. In line with the findings above, Omede (2011) pointed out that the forms of dresses suggest that female students are craving for attention and in the process, become irresponsible. Indecent dressing among female students often leads to rape, sexual harassment, poor academic performance punishment and suspension from school. According to Nigerian Films.Com (Campus Dress Code…, 2009), when the parts of the body that are supposed to be closed are exposed, some students or men may be tempted and can employ all means including rape to get the students and have carnal knowledge of such student. Unprotected sexual intercourse may result and the victims may be exposed to all forms of venereal diseases, including HIV/Aids. These dressing patterns have so much tarnished the image of our society and have consequently, turned the society into a home for frustrated persons (Obeta & Uwah, 2015).

Conclusion

The study investigated the influence of social media on the dressing pattern of female undergraduate students in the University of Ilorin; the study examined the female dressing pattern, factors influencing indecent dressing pattern, and the implications of indecent dressing pattern among female undergraduates. The results indicated that imitation of Western celebrities' style, peer pressure, social media and poor parenting has a greater influence on the dressing patterns of female undergraduates. The dressing pattern of most female undergraduates in tertiary institutions is embarrassing and mostly unacceptable. Most Nigerian female students in higher institutions of learning often dress immodestly. Most female students are more interested in putting on clothes that can easily seduce the opposite sex than to have good academic achievement. The recent dressing pattern of most ladies has implications such as sexual harassment, rape, and other venereal diseases that can be contracted through sexual intercourse; the trend has also resulted in students being

addressed as a prostitute, unwanted pregnancies, poor academic performance, dented family image, punishment and suspension from school among others.

Recommendations

Based on the above findings and discussions, the following recommendations were made:

- There is need for undergraduate students to be encouraged to use social media platforms to promote decent dressing and academic excellence.
- The university authority should be actively involved in the control of dressing patterns of the female students within the school premises. The senate, the university council, student affairs, heads of departments and lecturers should re-orientate the students on good clothing practices to discourage using controversial, confused and uncultured clothing within the campus environment to avoid provocation, harassment, and distractions of all sorts.
- Students should practice good dress sense irrespective of fashion trends which can be achieved when they are conscious of their structures and dress to conceal their figure faults.
- Students should have a good relationship with each other irrespective of individual outfits and clothing should not be the basis of determining the social status of their fellow students.
- Celebrities should be encouraged to dress decently at all times and no matter their kind of programs they should know that they are role models and whatever they can be easily copied by the young ones.
- There should be moderation in the way celebrities dress.
- Good dress sense should also be motivated by the formation of campus brigade, this brigade or club is to stand against indecent dressing by sanitizing and promoting good moral values particularly, the modest African dress patterns.

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Author's Profile

Mr Abdullahi Kayode Ibrahim is a lecturer in the Department of Criminology and Security Studies University of Ilorin, Kwara State, Nigeria. His area of research interest includes the criminal justice system, criminal investigation and practices, social problems, law enforcement and social control mechanism among others. He has published articles and book chapters on these areas in reputable publication outlets. He is a member of several international and national learned societies including Nigerian Anthropological and Sociological Practitioners Association (NASA). He has participated and presented papers in several national conferences. He can be contacted via Ibrahim.ak@unilorin.edu.ng