Influence of Socio-Economic and Demographic Variables on the Choice of Integrative Healthcare System among Rural Communities of Nasarawa State, Nigeria

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Abstract
The controversy for and against the right or appropriate healthcare system among rural communities of Nasarawa State, Nigeria was examined using the socio-economic and demographic variable. The main objective was to determine the extent to which educational, religion, social status, and economic variables influence the choice of healthcare system in treatment of ailments. Taro Yamane sample size determination was used to select 440 respondents including ten per cent additional respondents for probable missing questionnaire. 105 respondents were also selected for in-depth interview using purposive sampling method, based on social statuses; giving a total sample of 545 respondents. From a total of 148 INEC electoral wards in Nasarawa State, 15 electoral wards were selected across the three senatorial zones, using Black and Champion sample size determination formula. 440 structured questionnaires were administered; while in-depth interview was conducted on 105 respondents using seven social statuses within the selected INEC Electoral wards. Data collected was analysed using SPSS version 25, and content analysis. The mathematical tools used were mean standard deviation regression and stepwise regression. The fundamental question in the study was; the extent by which economic and social demographic variables influenced the choice of appropriate healthcare system for complete healthcare in the rural communities of Nasarawa state. The result revealed high influence of education in decision-making process in favour of inclusive healthcare system that integrates traditional and orthodox medicine as the appropriate healthcare system. It was also revealed that knowledge about a matter influences choice than culture or religion. The study recommends education, through adult classes and awareness creation for sustainable healthcare in the rural communities of the State (269 words).

Key Words: Socio-economic, demographic, healthcare, healthcare systems and rural communities

Influence des variables socio-économiques et démographiques sur le choix du système de santé intégratif parmi les communautés rurales de l'État de Nasarawa, Nigéria

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Abstrait
La controverse pour et contre le système de santé adéquat ou approprié parmi les communautés rurales de l'État de Nasarawa, au Nigeria, a été examinée à l'aide de la variable socio-économique et démographique. L'objectif principal était de déterminer dans quelle mesure l'éducation, la religion, le statut social et les variables économiques influencent le choix du système de santé dans le traitement des maladies. La détermination de la taille de l'échantillon de Taro Yamane a été utilisée pour sélectionner 440 répondants, dont 10 % de répondants supplémentaires pour le questionnaire probablement manquant. 105 personnes interrogées ont également été sélectionnées pour un entretien approfondi à l'aide d'une méthode d'échantillonnage raisonné, basée sur les statuts sociaux ; soit un échantillon total de 545 répondants. Sur un total de 148 circonscriptions électorales de l'INEC dans l'État de Nasarawa, 15 circonscriptions électorales ont été sélectionnées dans les trois zones sénatoriales, à l'aide de la formule de détermination de la taille de l'échantillon Black et Champion. 440 questionnaires structurés ont été administrés ; tandis que des entretiens approfondis ont été menés auprès de 105 répondants utilisant sept statuts sociaux dans les circonscriptions électorales sélectionnées de l'INEC. Les données recueillies ont été analysées à l'aide de SPSS version 25 et d'une analyse de contenu. Les outils mathématiques utilisés étaient la régression de l'écart-type moyen et la régression pas à pas. La question fondamentale de l'étude était; la mesure dans laquelle les variables démographiques économiques et sociales ont influencé le choix du système de santé approprié pour des soins de santé complets dans les communautés rurales de l'État de Nasarawa. Le résultat a révélé une forte influence de l'éducation dans le processus de prise de décision en faveur d'un système de santé inclusif qui intègre la médecine traditionnelle et orthodoxe en tant que système de santé approprié. Il a également été révélé que la connaissance d'un sujet influence le choix plutôt que la culture ou la religion. L'étude recommande l'éducation, à travers des cours pour adultes et la sensibilisation pour des soins de santé durables dans les communautés rurales de l'État (269 mots).

Mots clés : Socio-économique, démographique, santé, systèmes de santé et communautés rurales

Introduction

Healthcare, a desirable healing process in human existence is precious and necessary for functionality. This affirmed the World Health Organisation (WHO, 2015) and Alubo (2012) contentions that, better health is central to human happiness and well-being. Therefore, seeking to be healthy is normal by individuals, or groups, to ensure that they get well from whatever ailment they suffered from (Parsons' 1957). The implication is, without good or better health, individuals, groups and communities may hardly achieve any form of development. The rural people of Nasarawa State seek medication from two healthcare systems-the orthodox or conventional and or alternative or traditional healthcare services.

Traditional medicine is a cultural gem of various communities around the world and all kinds of folk medicine. The traditional type of medicine; also known as alternative, complementary or wholistic comes in form of therapies such as herbal medicine, massage, homeopathy, outside orthodox medicine (White, 2021). This

includes any kind of therapeutic methods that had been handed down by the tradition of a community or ethnic group (WHO, 1976). It was in line with diverse cultures and traditions in Nigeria that Adesina (2003) saw a Nigeria, that was rich in herbal medicine that had eminent and respected herbalists to take care of the teeming population outside the orthodox medicine.

Anzaku (2020) in a study to determine the usefulness of traditional/complementary medicine on health conditions of the rural populace of Nasarawa State, found out that, the much-acclaimed orthodox medicine as the sole means of treating ailments failed short of its claim. The result revealed that ailments like cancer, diabetes, hypertension among other were better managed by alternative medicine. This result was earlier affirmed by Sayer (2019) and later by White (2021) in the treatment of cancer. The fact that orthodox medicine cannot cure all ailments, it gives opportunity to alternative medicine which has been proven to treat such ailments (Anzaku, 2020). As important as healthcare is needed, individuals or groups are influenced by certain variables; in this case, education, income, gender, culture and religious variables. Knowledge, is said to be power; and an informed individual, group, or community is a powerful one. This may explain to a greater extent the cognitive development as the crux of sustainable human development (Batten, 1958). This paper tries to determine the extent to which socio-economic and demographic variables influence the choice of healthcare system, among the rural people of Nasarawa State, Nigeria.

The Health Belief Model proposes that a person's health-related behaviour depends on the person's perception of four critical areas: the severity of a potential illness, the person's susceptibility to that illness, and the benefits of taking a preventive action, and the barriers to taking that action. The model also sees personality variables such as patient satisfaction, and socio-demographic variables as modifying variables. It assumes that, a person's beliefs and attitudes about health behaviours influence their actions just as much as their knowledge of the consequences of these behaviours. The assumption that everyone has access to equal amounts of information on the illness or disease; and that cues to action are widely prevalent in encouraging people to act, and that "health" actions are the main goal in the decision-making process; is a concern to be verified. This is because, people may not have same level of knowledge and equal access to information as assumed by the proponents of the Health Belief Model. Though, it opens our eyes to what might be more effective social teaching methods around healthy habits, sameness in knowledge and access to information may vary.

This paper was the outcome of a study that tested the influence of five socio-economic and demographic variables (education, culture/religion, gender, income level and social status); in determining the choice of healthcare system by the rural people of Nasarawa State, Nigeria.

The study was based on one hypothesis-which was to test the extent to which education, culture/religion, income, gender and social status influence the choice of community issues for integrated healthcare. Selected Socioeconomic and demographic factors were operationalised to include education, and religion/culture, while economic was measured by income

Operationalisation of Key Words

Scio-cultural and Economic Variables—These are things that allow people realise what they need and desired in appropriate way and manner. These things are not the same but vary from one individual to another. They are aspects of people's lives that help in decision making. Examples:

- **Level of Education**------level of knowledge/literacy level as it influences the choice of an appropriate healthcare system
- **Income Level**-----one's level of earnings and its influence on the choice of an appropriate healthcare system
- **Culture/Religion/Belief**------one's life and all that he or she does, eats, wears, trusts in and worships, and its influence on the choice of an appropriate healthcare system
- **Gender-**---- the societal expectations of the roles assigned to man and woman and influence and decision on choice of the choice of appropriate healthcare.
- **Social status** positions ne occupies in the society

Healthcare Systems—A healthcare process that is used in treatment of ailments.
Integrative healthcare system: This is a combination of healthcare systems for the treatment of ailments. For example, there are two processes or systems of treatment in our communities. These are the alternative and orthodox healthcare systems.

Rural Communities—People living in less developed areas of Nasarawa State; They are the villagers, where most of the social amenities are lacking, especially adequate and desired healthcare centres. For example, there are two processes or systems of treatment in our communities. These are the alternative and orthodox healthcare systems.

Integration of healthcare: According to Maruthappu, Hassan & Zeltner, (2014), integration in a given health system, is "the combination of vertical processes aiming to improve the management of patients". Vertical integration focuses on networks and groups at different stages of care within the health system. Vertically integrated care pathways take patients from first contact to specialist to ongoing care. On the other hand, horizontal integration focuses on competing or collaborating organizations, networks, or groups in the health system and might involve, for instance, grouping outpatient clinics within a geographic network of providers. To achieve such integration, Edwards, & Miller (2003) defined a framework that coordinates care that necessitates and required vertical pathways, in addition to identifying professionals who can coordinate care. Integration encourages a comprehensive approach to patient care, which is more likely to address health inequalities.

Integrated care holds prospect to reduce overtreatment, waste, and redundancy, eliminating inefficiencies and controlling costs, while providing higher quality coordinated care (Atun, de Jongh, Secci, Ohiri, & Adeyi, 2010).
A health-based definition of integrated healthcare according to WHO (2016) is:

> An approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care (p.4).

The definition of integrated healthcare by WHO (2016) explains a health system that ensured optimal outcomes and appropriate use of resources with available evidence only through an effective management system. The benefits of which ensure continued improved performance and enhancement of well-being. National Voices (2013) defined integrated healthcare as "My care is planned with people who work together to understand me and my care (s), put me in control, coordinate and deliver services to achieve my best outcomes." However, a "process-based" definition of integrated care by Kodner, Spreeuwenberg (2002), adopted by WHO working document (2016) is

> A coherent set of methods and models on the funding, administrative, organizational, service delivery, and clinical levels, designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for people by cutting across multiple services, providers and settings (p.56)

Unlike the above and other meanings or definitions, the usage in this study refers to collaborated efforts between the alternative and orthodox healthcare providers for wholistic care of community members. That is, instead of segregated treatment based purely on medical profession, there should be a mutual collaboration by the orthodox and alternative/traditional treatment. The two should join efforts to treat and manage patients/clients. This may be done for very specific cases that could warrant such collaboration. For example, the orthodox medicine has incorporated Traditional Birth Attendants (TBAs) in to delivery system whereby, they are trained and recognised as traditional midwives. This has invariably solved part of the problem of inadequate midwives in many rural communities. It is also possible that such collaboration could be extended to several other areas of health needs in the rural communities. The traditional Birth Attendant extracts and use medicinal properties of plants for muscle relaxation to assist deliveries (Adesina, 2013). According to Adesina (2013), the usage of medicinal plants by TBAs is a pointer to the importance and the development of traditional medicine in present day Nigeria. This could be by identifying and training of personnel from alternative healthcare providers for the benefit of the rural people especially where such expertise is not found within the medical profession.

Orthodox, Western or Conventional medicine is used interchangeably to mean one and the same thing.

According to cancer.gov/ Modern medicine is a system in which medical doctors and other healthcare professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery; which are also called allopathic medicine, biomedicine, conventional medicine, mainstream medicine, and Western medicine. Wiseman (2004), defines orthodox or Western medicine as the medicine that is taught in medical colleges which was, until recently, the absolutely dominant medicine in the West and beyond.

The word 'medicine' according to Wiseman (2004), refers "to numerous different forms of healing that have existed over the centuries, derives from the Latin medicina, which is related to medico, to heal or cure". The word 'medicine' thus, essentially means the art of healing. This medicine, by its seemingly incomparable achievements, has attained dominance not only in Western homeland, but also beyond. Even though it is not necessarily the main provider of health care in every country, Western medicine is the arbiter of health matters for the government of virtually every nation of the world. 'Western medicine' labels the medicine it denotes by its origin. The usage of orthodox health care in this research refers to the process of attaining to well-being through clinics, primary health care (PHC) centres, cottage hospitals, tertiary health centres; which emphasizes drug availability, laboratory tests/diagnostic centres and pharmacists. This also include personnel availability and their attitudes in handling cases brought to them, distance and cost implication. The providers of which are government/public or private

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Theoretical frame for analysis in this paper was Rational Choice Theory (RCT) by Adam Smith (1776) refers to a set of guidelines that help understand economic and social behaviour (Blume and Easley, 2008; Sen, 2008; Raymond, 2003). Rational Choice theory explains why actors in international relations behave the way they do. The theory argues that individuals pursue their preferences in a self-centered and rational manner. It views social interaction as a type of exchange where an actor interacts with another when interaction outweighs the costs of such interaction. Individuals act rationally in pursuit of self-interest and not in the interests of others. Individuals seek to maximize their gains and minimize their losses. An individual is said to have sufficient information upon which to establish his or her rational analysis. Finally, preferences are transitive in nature. This is a logical principle that sounds more implicated than reality. The theory's assumptions were criticised despite its acceptance as a theory that provides a nice clean model for explaining decision making that makes intuitive sense. In this paper, Rational Choice Theory is considered as appropriate as it buttressed the importance of knowledge in understanding issues of choice and cost.

The study adopts descriptive survey design, where analysis was purely based on respondents' views and opinions. 15 INEC electoral wards out of 148 wards in Nasarawa State were determined, using Black and Champion (1976) sampling technique. Black and Champion (1976) sampling technique states that, ten per cent of any population is a good enough representation to conduct a study. Nasarawa State has 148 INEC electoral wards and 15 electoral wards were selected using Fish bowl technique. A sample of 400 respondents was selected out of a total population of 1,192,057, using Taro Yamane (1967), sampling size determination formula. 40 additional respondents were added representing 10% of 400 to make up for incomplete and non-return of questionnaire. Giving total sample of 440 respondents. To triangulate results, in-depth interview was conducted on 105 respondents using purposive random sampling, and on the basis of social statuses. Data collected was analysed using SPSS version 25 and content analysis. Hypothesis was tested using mean and standard deviation, correlation Matrix and Stepwise Regression, to determine the result of each variable.

Analysis and Result

Test of hypothesis: Ha (I): Community-issues for integrated healthcare are positively associated with educational level, religion/culture and income level of the rural dwellers of Nasarawa State.

Hypothesis (Ha: I) sought to find relationships between community issues for integrated healthcare and selected sociocultural and economic variables. Socio-demographic variables were operationalised to include education, and religion/culture, while economic was measured by income (table1

Table 1: Rating of Socioeconomic Variables and Health Conditions that Influenced the Needs for Integrated Health Care.

Socio-economic variables and health condition	Rating (%)					
	SA	**A**	**UD**	**D**	**SD**	**Mean**
Level of Education	17.60	55.75	10.76	14.67	1.22	**3.74**
Religion/Culture	8.07	33.50	1.47	22.49	34.47	**2.59**
Social Status	0.00	4.89	1.22	52.81	41.08	**1.94**
Gender	12.47	53.54	2.20	12.71	19.07	**3.28**
Income	3.18	12.47	1.47	25.67	57.21	**1.79**
Type of Ailment/Health Condition	8.56	77.02	2.20	3.67	8.56	**3.73**

*** SA=Strongly Agree; A=Agree; UD=Undecided; D=Disagree; SD=strongly disagree.**

Source: Computed from field data using SPSS Version 25, 2021

The specific objective of this study was to find out the extent to which education, culture/religion, gender, income level and social status of the rural dwellers, and existence of ailment/health conditions; that orthodox medicine cannot cure, affect integrative healthcare system in the rural communities of Nasarawa State. Respondents were asked to rate the variables on an ordinal scale that ranged from “strongly disagree” to “strongly agree” **(**table 1**).** The means scores revealed differences in rating. While the highest mean score was on “educational level of community members” (mean = 3.74), income of community members” received the lowest mean score of 1.79. It is surprising that income which is one of the reasons why people (poor people) patronize alternative care was not rated highly in this study. The reason may be that types of ailments and or health conditions tended to become motivating factors or issues seeking inclusive healthcare. In this context, many ailments may be those that orthodox healthcare cannot cure completely, and thus the need for integrated healthcare. This finding also suggests that level of income, education, religion and gender exert

influence on the choice of collaborative healthcare system. This was affirmed by in-depth interview, where majority of the respondents (n=89 or 93.5%) attested their ignorance of what constituted appropriate healthcare system. For example, a respondent showed clear evidence of ignorance in choosing what constitute appropriate healthcare system. The respondent stated thus:

> I use both traditional and orthodox healthcare for my illness without knowing the best to rely upon. This is because anytime I fell sick I sometimes go first to the hospital and later, recourse to alternative or traditional medication, when the first fails (a 45year male respondent, 2021**).**

It was established in the study that education and /or knowledge help people make right choices in life**.** This was confirmed during in-depth interview**;** where respondents affirmed the need for education as a factor in determining choices in life. It was also affirmed that, other variables like income exert influence on choice of integrated healthcare, culture influence especially the female gender to the of choice healthcare system. For instance, a female respondent said; “the decision to choose any thing within the family rests on male gender”. However, educated women have more independence to choose their healthcare system.

Table 2: Mean, Standard Deviation and Correlation Matrix of Association between Community Issues for Integration of Health Care and Sociocultural and Income Level.

S/N	Variable	Mean	SD	1	2	3	4
1	Issues for integration of health care	3.19	1.27	1.00			
2	Level of education	3.74	.96	.77**	1.00		
3	Religion/culture	2.59	1.45	.89**	74**	1.0	
4	Income level of respondents	1.79	1.15	.68**	.67**	83**	1.00

Source: Computed from field data using SPSS Version 25; **P = 0.01. 2021

Table 2, summarised the results of the descriptive statistics ran to determine the mean, standard deviation and correlation between the variables. The mean scores of the rating of the variables suggests the importance that respondents attach to them. While the issues for integration of health care was highly rated (X = 3.19), the standard deviation of 1.27 suggests that diverse opinion existed among respondents on the topic; whereas the rating of the importance of education was high (X = 3.74) with very little divergence in the opinion of the respondents. Income was not highly rated. In a measurement scale of 5, the rating of income as a Variable in the requests for integration of health care was below average. The relationship among the variables was high and positive, but not significant at 95% confidence level. In order to test the impact of the socio-economic and income variables on community issues for integrated healthcare, the researcher regressed respondents’ rating of the variables on the mean score of “community issues” using step wise regression analysis. The consideration here was to be able to select the alpha level of 5% and see the impact of each

independent variable (socio-economic and income) on the dependent variable (community issues). The result is reported in (table 3).

Table 3: **Stepwise Regression** showing the Contribution of each of the Socio-demographic and Income factors in the choice of healthcare system

S/N	Predictor variables	R-square	R-square Change		Sig
1	Religion/culture	.748			.000
2	Religion/culture, Level of education	.782	.034		.000
3	Religion/Culture, Level of education, Income level of respondents	.790	.008	.042	.000

Source: Computed from field data using SPSS Version 25 2021

Table 3 Shows the influence of religion/culture on integration of healthcare in the rural communities of Nasarawa State to be about 74.8% of the factors. When the rating of level of education among the rural populace as a factor in the determinant of community issues in integration of healthcare was added to religion/culture, it increased the R-square to .782, thus suggested a percentage of only 3.4%. The addition of "income" as a factor in the determination of community issues for integration of healthcare increased the R-square to 79%, thus meaning a change by only 0.08%. Although the factors were significant, it also accepted the hypothesis. It was however, noted that income level constitutes very little influence in the issue of integrated healthcare when compared to education and religion/culture

Discussion of findings

The main objective of this study was to determine the influence of each of the following variables- education, income, social status, gender and culture/religion has in the choice of healthcare system by the rural communities, of Nasarawa State. Within the context of the Health Belief Model (HBM) that shapes the argument of this work, the perceived cost of medication takes cognizance of the complexity involved in the choice of medication, including its accessibility, and affordability. These two conditions are factors of the level of income of the respondents. In the findings of Beagle, Frankenberg, and Thomas (2001), gender, attitudes, and culture particularly are important determinants of health seeking behavior in the rural communities.

In the findings of this study, education, exert significant influence on the "integration of healthcare in the rural communities". This is a confirmation of rational choice theory, that knowledge influences the issues of choice and cost. One of the advantages of integrative healthcare system is reduction in cost of healthcare (Atun, de Jongh, Secci, Ohiri, Adeyi, 2010). The influence of education in this study attests to that fact knowledge influences choice. The multiple regression analysis conducted to test the influence of socio-economic variables on integration of healthcare revealed that religion and culture alone contributed 74.8% of the variances that explained influence of the need for integrated healthcare. When education was added to religion and culture, the percentage of influence increased by a further, 3.4%, thus increasing the percentage of influence to 78.2%. This was confirmed during in-depth interview; where respondents affirmed the need for education as a factor in determining choices in life. It

was also affirmed that, other variables like income exert influence on choice of integrated healthcare, culture influence especially the female gender to the choice of healthcare system.

For instance, a female respondent said; "the decision to choose any thing within the family rests on male gender". However, educated women influence their choice of healthcare system. This again affirmed the influence of knowledge on our choices.

The addition of the income variable revealed a percentage increase of 4.2% (more than education variable). The findings in this study confirmed the earlier findings by Adefolaju (2014) that culture and belief influence the choice of healthcare system. The various societies that make up the Nigerian State have for long relied on the indigenous healthcare system which was developed as a response to their environment and it involves the use of locally available resources to prevent and cure diseases. In similar manner, Osborne (2007), specifically testified that Nigerians, have a deep belief and reliance on traditional medicine, hence about 80 per cent of the populations rely exclusively on traditional medicine, while the rest used both orthodox and traditional medication concurrently. In the finding of this study, the belief that orthodox medicine cannot solve certain heath problem exerts significant impact on concurrent use of orthodox and traditional medicine. As Roan (1999) and Osborne (2007) argued, combining herbal and conventional medication is fast becoming a norm in Africa and Asia, and it may not be entirely restricted to rural communities. It therefore underscores the need for integrated healthcare system.

The policy/theoretical implication of this finding

The euro-concentric theories that hitherto, influence African healthcare system as the best healthcare for attaining to good health is questioned. African centred theories of development founded on togetherness may be considered as most important. This justifies the "we" concept of well-being as a collective tendency that when an individual in the family, community or the larger group is sick, the family is equally sick. Samkange and Samkange (1980) share their view on the concept of togetherness thus:

Ubuntuism permeates and radiates through all facets of our lives, such as religion, politics, economics, etc. Humanism or Ubuntuism are applicable to the present and future as they were in the past…It is the duty of African scholars to discern and delineate humanism so that it can,when applied, provide African solutions to African problems (Samkange and Samkange, p.103).

From this study, orthodox medicine alone can hardly ensure inclusive healthcare agitated by Nasarawa State. The traditional African society based on its tested traditional medicine; can cure some ailments that is difficult for orthodox medicine. This may be a major source of policy review if wholistic and inclusive healthcare is to be attained in Nasarawa State and possibly other Africa countries. Education and other variables as tested in this study confirmed this fact.

Conclusion

The need for the choice of healthcare service was tested using education, culture, economic, social status: against type of ailment or health condition. The result revealed two most important variables in determining the type of healthcare system among rural communities in Nasarawa State; to be education and culture/religion. However, the

most important variables that determine the need for integrating orthodox and traditional medicine has to do with educational level of the rural communities of Nasarawa State. Indigenous healthcare system is though important as indicated by respondents in the study, it also saw the need to use orthodox medicine to collaborate traditional as equally necessary.

Recommendations

1. Education should be encouraged at community level by Social and/development workers, as a tool for community liberation and development
2. Government (States and LGAs) in conjunction with ministry of Health should consider the establishment of an indigenous healthcare system for the benefit of inclusive healthcare of its citizens.

Refences

Adefolaju, T. (2014). Traditional and orthodox medical systems in Nigeria: The imperative of a synthesis. *American Journal of Health Research,* 2 (4), 118-124.

Adesina, S. K. (2013). Traditional medical healthcare in Nigeria. Http:/www.google.com/ serach? hl=en-GB&redir---es---, Retrieved January 2013

Adesina, S. K. (2003). Traditional medicine http://www.onlinenigeria.calth blurb=574#i xzz4xDZq LE1e

Alubo, O. (2012). Ontological response to illness in Africa. *Jos Journal of Social Issues*, 6, 1- 6

Anzaku, E. D. I. (2020). Issues in Integrative Community- Healthcare and Health conditions of the rural populace of Nasarawa State. A research Thesis in the Department of Sociology; University of Jos, Nigeria

Atun, R. de Jongh, T, Secci, F, Ohiri, K. &Adeyi, O. (2010). A systematic review of the evidence on integration of targeted health interventions into health systems. Health Policy Plan, 25(1),1-14

Batten, T. R. (1957). *Communities and their development: An introductory study with special reference to the tropics*. London: Free Press.

Beagle, K. Frankenberg, E. & Thomas, D. (2001). Bargaining power within couples and the use of prenatal and delivery care in Indonesia. *Study Family Planning*, 32,130-46; *143-150.*

Edwards, M. & Miller. (2003). Integrating health and social care and making it work London: OPM;

Maruthappu, M., Hasan, A., Zeltner, T. (2015). Enablers and barriers in implementing Integrated care. *Health System Reform*.1:250256/doi:10.1080/23288604.2015.107 7301. Google Scholar Crossruff.

National Population Census (NPC) (2006). National population estimâtes. Abuja: Author.

National Voices (2013). A narrative for person-centred coordinated care. (http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf). Assessed: 28.05.2018.

Parsons, T. (1951). *The Social System*. in Strecher, V. J. & Becker, M. H. (1994). The Health Belief Model and HIV Risk Behaviour Change. in R. J. & Peterson J. L. (Eds.), preventing *AIDS: Theories and methods of behavioural interventions* (pp 5-24). New York, NY: Plenum Press

Roan, S. (1999 & 2008.). *Alternative medicine*. Encarta yearbook and the nation, August, 28, p. 44

Sayer, JiS .F. (2019). Ginseng may work better than chemo and radiation. Available: *Journal of Green Medical Information.com; Assessed:* 2(2) 2019

Wiseman, N. (2004). Evidence-based complementary and alternative medicine. *Journal of Evidence Based Complementary Alternative Medicine* 1(3), 327-329

World Health Organisation (1976). Traditional, Complementary and Integrative medicine. Geneva/https://www.who.int/traditional/complementaryandintegrativemedicine

World Health Organisation Regional Office for Europe (2016). *Strengthening people-centred health systems in the WHO European Region: Framework for action on integrated health services delivery*. New York: Author