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Synthetic medicare: An essential element for integrative health care delivery system in Nigeria

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Abstract

The age-long neglect and rejection of the traditional medical practice in Nigeria despite its huge and ever-increasing patronage, raises concern in terms of Policy formulation and implementation to redress this trend. Most Nigerians usually resorted to the orthodox health care approach as a last resort only when attempts at the traditional health care failed. This results in a situation where preventable, treatable and curable ailments get out of hand, progressing to chronicity when they are reported to the orthodox medical approach. This ugly picture informs this article which calls for a synthesis in the health care delivery system in Nigeria if the goal of objective health attainment must be achieved. This is if the potential and actual hurdles militating against this integration are dismantled giving way to a full utilization and enjoyment of the benefits of this marriage.

Keywords: Synthetic medicare; Traditional healer; Orthodox medical practitioner

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1. Introduction

The principal aim and goal of any planned health care system is the provision of best medicare to majority of people. This goal implies two basic elements of quality as well as quantity. As a result of low economic and technological development, underdeveloped countries of the world usually have extensive needs for medical care but do not possess the necessary resources for providing sufficient and high quality western medical care. This creates a tendency where this limited medicare facilities favour the relatively rich minority at the expense of the masses who are in the poverty-stricken rung of society. It may take many years to give accessible high-quality health care to the entire population, a goal which at times is unrealizable for a long period of time. In order to foster a meaningful development of both quantitative and qualitative medical care, a concomitant effort aimed at the development of its indigenous and oriental health care approaches should be pursued. This developmental strategy should incorporate the mobilization and refinement of its medical manpower and facilities. This is tailored at the provision and administration of qualitative and quantitative health care to the people.

Before the advent of colonialism and its artefacts into Nigeria, her people have developed their own tradition of medical care. They were dependent upon it until the introduction of the western scientific or orthodox medicine in Nigeria in the late 19th century. Since then, the efficacy of traditional medicine has been under critical challenge. According to Oke and Owumi (1996) a major criticism against the traditional medicine is that, it is scientifically unverifiable and therefore superstitious and unreliable. It cannot be denied that traditional medicine has no scientific basis. But its knowledge and skills are developed out of, and have been tested by, the empirical experience of millions of people over a very long period of time. As was observed by Croizier (1968:14), although traditional medicine failed to establish a scientific methodology for observation of data and verification of its theoretical principles, it has been naturalistic and rationalistic as opposed to magic and superstition. Hence, it would be unprofitable if we gave up the entire heritage outright merely on grounds of scientificity.

The 1996 Nigerian National Health Policy prescribes the integration of both the orthodox and traditional medical practices in order to meet with the demand of health care delivery. In spite of this policy's prescription, a true or complete intercourse and synthesis of these two polaristic or dichotomised domains of health care is still not practicable and/or palpable. This failure of an integrative and effective health care has produced more health and social challenges than solutions. Ideologically, both domains of health care are antagonistic to each other and this creates more confusion as to which method a client has to choose from (Mume, 1975; Freidson, 1972; Etobe, 2002). It is important and intriguing to observe the inability or difficulty of health care planners and designers to harmonize both methods/types of health care administration, with a view to appreciating their areas of convergence and/or divergence. This negligence has generated and perpetuated the age-long squabbles and cold war between operators of these methods of health care systems on the one hand, and their teeming clients on the other. Emphasis over the last two decades by successive Nigerian governments at all levels has been directed at the development and betterment of the orthodox medical care approach to the deliberate neglect and detriment of the traditional

health care. This act gave birth to a situation in which the more preferred and favoured health care approach assumes an air of superiority and dominance over the other in all health care matters in Nigeria.

The socio-cultural consciousness of Nigerians was ignited when in 1999; the Nigerian Television Authority (NTA) the government television network organized a "Macro-vision Herbal Fair" across the country aimed at promoting awareness, availability and efficacy of indigenous or alternative medicine in Nigeria. During this Fair, most traditional treatment typologies, methods, techniques and strategies were exhibited, demonstrated or experimented to the teeming masses who visited these Fairs across the thirty-six States and Abuja, the Federal Capital Territory. It has been observed after these Fairs that most traditional healers constantly seek to improve the quality of their care and therapeutic agents in order to broaden the utilization of their services by clients. Their devoted and persistent hard work over the last decade has made remarkable contributions not only to the advancement of medical knowledge and skills, but also to the increase in the quantity of medical care. In spite of this, it is disheartening to note that, there has been no tangible or practical effort made by the health care planners to move this sector forward by integrating or synthesizing this health care approach to the mainstream health care delivery system. The specific questions this paper is poised to find answers to are that, in what ways are the traditional health care practice in Nigeria related to the modern western medical system? Should we and how do we push toward a unification or synthesis of these two seemingly divergent medical traditions? In other words, we shall examine the conventional patterns in both systems with a view to suggesting a radical but realizable approach for developing and integrating the traditional and orthodox medical practice in Nigeria. It is our intention not to be completely value-free. As social scientists and ordinary citizens, we intend to be critical of the existing order and make suggestions for effecting changes.

2. Traditional medicine in Nigeria: Evolutionary trend

In Nigeria, anybody who uses herbs, bark of trees or any other traditional substance to attain a cure, ward-off calamities or prevent disease claims to be a traditional healer. This stance is supported by Read (1966) as he defines traditional healer as anyone who has the local skills and techniques to use the local materials available at his disposal for the maintenance of health. This has given rise to a high proportion of the rural population professing to be traditional doctors and the reason for the influx of people in this art of healing. The National Health Policy of 1988 states that, the term traditional medicine is difficult to conceptualize since there is no uniform system of traditional medicine in Nigeria. In addition to a wide range of variations of its practice, lack of governmental recognition and control has contributed to the substandard, unethical and unprofessional conduct of traditional healers. This according to Sofowora (1993:15) has resulted in the birth of numerous scholars and practitioners as well as the emergence of a wide range of terminologies referring to this type of medicine. Some of them include native medicine; herbal medicine; indigenous medicine; folk medicine; preventive medicine; black medicine; quack medicine; "juju"; amongst others (Sofowora, 1993; Etobe, 2005; Oke and Owumi, 1996). Oke and Owumi (1996:224) note that, the reasons for these differences may be due to the various biases held by writers and the way practitioners of the art have professed it. Also,

the various cultures in which this art is practiced play a significant role in the way it is seen and conceptualized in society. Ozekhome (1992:17) for instance, defines traditional medical practice based purely on the theory of the laws of nature which provide in its kit, curative and restorative processes devoid of any scientific or empirical corruption. Again, Komolafe (1992) in Sofowora (1993:12) defines traditional medicine as the health care delivery method and practice which is directly or indirectly traceable or related to the culture and ancestral heritage of a particular community or locality. On its part, the World Health Organization (WHO) defines traditional medicine as "the sum total of all knowledge and practices whether explicable or not, used in the diagnosis, prevention and elimination of physical experience and observation, handed down from generation to generation whether verbally or written".

Although there have been no historical records about the birth, growth and development of traditional medicine in Nigeria until the 20th century, patches of the historical artefacts about this type of medical practice are embedded in myths and legends. According to legend notes Sofowora (1993:12), the first man to practice the art of healing in the Yoruba-speaking part of Nigeria was the legendary Orunmila who was endowed with this knowledge by God. Although it is not known exactly when the first real human being practised herbalism or traditional medicine in Nigeria, a number of theories have been advanced by scholars and traditional medical practitioners alike to explain the acquisition of this knowledge. One of such theories, notes Sofowora (1993:12) assumes that the early man deliberately selected specific plants for the treatment of his ailments. Some anthropologists opine that since the early man lived in fear, he indulged in mystical and religious rituals to allay his fears. This led to the initial selection of plant materials for medicinal purposes. It has also been proposed by scholars that knowledge of medicinal plants was gained by accident. That is, the early man must have gained some scientific knowledge by watching the effect of these plants when eaten by domestic animals (Oke and Owumi, 1996; Sofowora, 1993). Another legend has it that knowledge of traditional therapies came from witches and wizards. It is believed that some witches/wizards living or dead, usually attended village markets in strange forms like goats, sheep, dogs, cats or birds. If their presence in these disguised forms were detected by a traditional medical practitioner, he was promised some reward in the form of useful herbal therapies in return for not exposing these witches/wizards (Sofowora, 1993; Ozekhome, 1992; Mume, 1975). The same reward could be offered if a real witch/wizard was caught physically by someone in the process of carrying out a malevolent art. Sofowora, (ibid) again observes that traditional practitioners could be taught the properties of herbs by the spirit of an ancestor who practised herbalism in her/his dream or trance.

Although traditional medicine seems to be saladic or all encompassing, a colossal examination of its operations shows that its functionality can be better appreciated and appraised in these three principal dimensions of disease prevention, health promotion and the attainment of cure (Crozier, 1968; Freidson, 1972). Like its orthodox counterpart, the traditional medical practice can be measured in terms of how health is promoted, illnesses and diseases prevented and/or treated toward attaining a total cure. Certain applications, incantations, local immunization technique and the use of pomades or powders are also used in traditional therapies. In addition, medicinal rings, amulets, waist bands, talisman or necklaces are often worn as preventive measures to wade-off witchcraft spells, accidents or poisoning by an enemy (Sofowora, 1993:16). Among the Yorubas of western Nigeria for example, wives are given medicinal waist bands called

"magun" as a check against infidelity or promiscuity. It is believed that if any man "trespassed" by making love with a woman with "magun," he tumbles seven times and dies stiff (Sofowora, 1993:17). Also, certain sacrifices or rituals could be done as preventive measures against the wrath of ancestors or gods believed to cause sporadic epidemics like small pox, chicken pox, cholera, meningitis, yellow fever, etcetera. Measures directed at health promotion include regular seasonal sacrifices to appease the gods, regular ablutions incantations, divinations and counselling on good dietary habits (Offiong, 1991:27).

Traditional health curative measures could take the forms of hydrotherapy, concoctions, decoctions, creams, poultices, bloodletting, bone-setting, massaging, faith healing, spinal manipulation, therapeutic occultism and enemata (Etobe, 2005:29). The use of these traditional care approaches for health promotion, disease prevention and curative purposes by many Nigerians is an undeniable fact. This is the primal reason for calls for an integration of this type of health care approach to the mainstream health care delivery system in Nigeria is necessary.

3. Orthodox medical practice in Nigeria: Then and now

This is health care based on scientific and technological know-how. Its ideologies are founded on theory and research hence seeks to ascertain the correlation between antecedent and consequent with a view to predicting the prognosis of any disease condition (Oke and Owumi, 1996:225). According to Mume (1975:35), its modus operandi is methodological and systematic thus giving room for verifiability of its novel findings. Practitioners undergo a stated period of training in the medical school and are qualified, certificated and licensed to practice. Their proficiency is not measured by their popularity but prognostic evaluation of clients attended to, and through research (Ozekhome, 1992; Etobe, 2005:30). It has a patterned procedural approach which is almost universal in practice. Clients to be attended to must first go through the Medical Records Unit for documentation before consulting the doctor. Treatment is initiated or administered via the out-patient and in-patient departments. Clients with minor health problems are treated in the out-patient department after consultation, and appointments made with them for follow-up management. Clients with serious or critical health problems may require thorough clinical investigations before admission for observation and treatment as in-patients. Treatment typologies include surgery, oral medications, parental medications, topical poultices or applications, enemata, psychotherapy, occupational therapy, diversional therapy, behaviour therapy, amongst others. These therapies could be specific, general or symptomatic and are initiated when laboratory and/or radiographic investigations are completed in order to confirm a diagnosis. Most often, drugs pathogenic sensitivity or resistance investigation is done to rule out trial and error regimen (Etobe, 2002; Etobe, 2005; Oke and Owumi, 1996; Sofowora, 1993).

It is important to note that the orthodox medical system is polaristic and entrepreneurial. There exists a great variety of medical and health care services, both public and private. The emphasis of this system of health care practice is on individual responsibility of medical care; fee-for-service; solo practice and free choice of physician (Crozier, 1968:396). Although the government supports and funds the public health care facilities, the centre of gravity of this medical practice remains in private practice. As a result of its scientific

nature and western origin, the orthodox medical practice has been tied to the political power structure of Nigeria; and as a function of this power structure, enjoys governmental support, funding, regulation and control. Due to this preference enjoyed, it has continued to dominate the entire health care delivery system from its inception.

4. Potential hurdles of the synthesis

The Nigerian Medical Council plays the most crucial role in the legitimization of medical practice, formation and implementation of social policies dealing with medicare. The Council consists of representatives from government medical services, the university medical schools, the Nigerian Medical Association and the armed forces. However, all these representatives are western-trained doctors who do not represent the interest of the traditional medical practice. Furthermore, only the western-trained practitioners can be registered with the medical council and thus are recognized by law as qualified medical doctors to practice (Oke and Owumi, 1996:225). This implies that, traditional medical practitioners cannot be registered with the medical council and are not regarded by the legal authority as duly qualified doctors. Traditional practitioners for instance, have no legitimate right to issue medical certificates of birth or death; medical sick report or excuse duty and are not entitled to practice surgery. According to Etobe (2005:34), this discriminatory act is based on the argument that traditional practitioners do not have proper sterilization procedure, instrumentation and aseptic techniques. This was also observed by Crozier (1968:401) when he noted that traditional medicine has been denied its right place in society as a result of its methodology and procedures. The orthodox medical practitioners do not see the traditional doctors as qualified to be called as such, and do not have any trust in their claims of being doctors as well as the efficacy of their practice. They see them as quacks and label them as witch doctors, having no faith or confidence in their therapies (Crozier, 1968; Freidson, 1972). The Medical Schools' curricula of our universities are drawn to cater for the training of orthodox doctors only, concentrating on western medical science and neglecting training of traditional doctors. The government on its part provides and subsidizes a number of medical and health care programmes, but none of them is oriented toward traditional medicine. Social workers, government or private hospitals do not refer their clients to traditional practitioners. Clients treated by traditional doctors must obtain medical reports and "false" hospital bills invoices from the orthodox medical practitioners before they are officially recognized as being sick and refunds for hospital bills made by their employers. All these observable discrepancies overtly indicate that, the traditional medical practice is subordinate to its orthodox or western counterpart. This western medical practice dominance however, has by no means wiped out the widespread existence of traditional medicine and its utilization by the masses in Nigeria.

Another evident hurdle to the realization of a synthetic medicare is the skyrocketed, unaffordable and increasing cost of the orthodox medical practice. Many Nigerians especially the ruralites have persistently complained of the increasing expensive health care services received from the health centres, dispensaries, health posts and hospitals. Akin to its high cost, is the fact that most health care beneficiaries complain of the problem of "out of stock" syndrome which makes them lethargic and affects their help-seeking behaviour.

Most health care facilities do not have the essential required equipments, drugs as well as trained personnel to handle serious health problems common among the citizenry. This explains why the "out of stock" syndrome is used whenever medications are prescribed for clients and are unavailable in the hospital's pharmacy department. Yet, another hurdle to an integrative health care system in Nigeria is the fact that traditional health practitioners conduct their procedures in secrecy. Their pharmacopoeia, modus operandi of investigation and treatment are conducted with utmost secrecy so that even a fellow traditional practitioner does not know what his counterpart uses to treat the same health condition. The problem of drug preparation, storage and sanitary standards is also a setback to the realization of a synthetic medicare system in Nigeria. It takes long periods of time for traditional practitioners to go to the bush/field to get the appropriate herbs or barks of trees especially in times of emergency. It also takes time to prepare their drugs which are grounded, roasted or squeezed into the form(s) they are needed for use by clients. Another serious hurdle is the "non-standardization of medical practice and absence of ethical code to regulate traditional medical practice" (Crozier, 1968). The traditional practitioners do not have a regulatory body to set standards and monitor or censor the excesses or otherwise of its members. This makes it difficult if not impossible for deviant and defiant members to be disciplined or sanctioned. Most often, claims made by traditional practitioners are not tested or validated as a result of non-standardized code of practice.

5. Dismantling the hurdles

We have earlier argued in this discourse that most Western-trained doctors distrust the quality of traditional health practitioners. The authorization, licensure and registration of medical doctors is limited and reserved only for the orthodox medical practitioners. This translates that only the western-trained doctors are allowed by law to be addressed as "doctors", issue sick reports, and administer health advice, because they are trained, registered and licensed. This discriminatory treatment of practitioners of one domain of health care system at the detriment of the other constitutes injustice and treating equals unequally. Therefore in order to achieve an integrative health care system, this hurdle must be dismantled. Both health care practitioners should be given some form of formal training to equip them with the necessary knowledge and skills for the administration of health care to clients. In the same vein, they should both be registered and licensed to practice, and in the same setting. That is, both should consult in the same hospital or clinic, with authority of referral of complicated cases to each other. Government and society should be made to recognize birth, death, sick report and medical examinations issued or conducted by the traditional and orthodox practitioners alike. Both domains of health care administration should complement each other to achieve holistic approach to client services. It is imperative to assert that a major prerequisite to the utilization of traditional medicine is the control and improvement of the technical quality of medicare in Nigeria. Granted that the medical knowledge itself is sound, the most serious challenge faced by traditional medicine is the lack of uniform control over the education and practice of its practitioners. Some of its practitioners are educated but others are stark illiterates.

To overcome this deficiency, government should establish a college of traditional medicine, preferably affiliated to a university as well as a Traditional Medical Council in Nigeria. These institutions would be charged with the responsibility of providing and maintaining minimum technical standards of traditional medical practice. They would also have control over the training of students, the registration and licensing of practitioners, as well as the ethical conduct of practitioners (Crozier, 1968; Standway, 1986; Freidson, 1972). Medical practitioners who are trained by the college and are registered with the Council should be recognised by law as duly qualified doctors. It has been established without controversy that the scientific method is the most effective approach to the development of valid knowledge and betterment of social life. This should be introduced into the traditional medical system for the purpose of testing, validating and improving the medical effects of traditional pharmacopoeia and techniques.

It has been observed that the economic interest of western-trained doctors appears to be the resistant force militating against the legitimization of traditional medical practice in Nigeria. Oke & Owumi note that, legitimizing practitioners of traditional medicine will imply an increase in existing rivals in the free market of medicine and health which orthodox doctors are opposed to. Hence, it will be helpful if government can play an active role in the process of legitimation and development of traditional medical practice. With its political power and authority, government should enforce a legal recognition of traditional medical training, and the affiliate university should as well confer a technical competence of traditional medical practice which will contribute to its social legitimation. In addition to its function of control, both the college and traditional medical council should aim at systemizing and upgrading the knowledge and skills of traditional medicine (Standway, 1986:72). In view of existing deficiencies in the traditional medical services in Nigeria, our advocacy here is that, attempts should be made to increase the supply of orthodox medical practitioners and facilities in the short run, while mobilizing and developing existing traditional medical resources for efficient and effective use. Its potential value and contributions cannot be overlooked or disregarded merely on grounds of its theoretical inadequacy and unscientificity. Instead, we should tap and harness its rich reservoir of experience and resources and use them to remedy its deficiencies.

There should as well be joint research for both practitioners toward an all-encompassing healthiness of the population. The central question to be addressed should be: which method is the best for dealing with which disease? Both orthodox and traditional practitioners should collaborate in conducting researches and evaluate in a scientific manner, the relative efficacy of pharmaceutical agents used by both. Concomitant to joint research, students and practitioners should be encouraged to learn the basic logic and foundational traditions of both domains of health care practice. This should take the form of intercommunication and mutual understanding of the modus operandi of both traditional and orthodox medical practice (Standway, 1986:71). This will reduce the scepticism between the two groups of health care, and consequently contribute to the confluence of both traditions. As well, they should preferably maintain close contact and frequently exchange findings with those doing similar researches internationally. Both practitioners should as a matter of volition see the well being and healthiness of their clients as central and primal than economic motive for practising. This ingredient will impel them to find areas of confluence than contradictions and criticisms in the discharge of their expert services to their teeming clients. This would as well reduce if not totally eradicate issues of the cold war and antagonism between operators of these polaristic domains of

health care. In order to increase the availability of adequate medical care to the public especially the rural poor, government and voluntary agencies should offer or support accessible, low-cost quality medical services to the people. This will bridge the gap between the minority rich population who patronize the orthodox and the majority poor who cannot afford the westernized medical practice hence revert to herbalism for solace.

6. Benefits of synthetic medicare

We are advocating in this paper for increasing the utilization of traditional medical resources in Nigeria, and controlling and improving the technical quality of medical practice. We have identified some possible ways of achieving this prescription. Both western and traditional medicine should be combined and integrated into a cohesive whole. This integration we believe will upgrade the efficacy and efficiency of the Nigerian health care system. However, it is doubtful if the orthodox medical practitioners would be willing to let go their dominance and benefits of the health care system which they enjoy since the inception of Nigeria's health care system, and accept the idea of integrative or synthetic medicare.

It should be underscored that the development and functionality of a synthetic health care system will contribute to the quantity and quality of medicare in general. This is because the combination of the orthodox and traditional approaches is more efficient than when used in isolation. This is the doctrine of holism which premised that the whole is more than the sum of its parts (Etobe, 2002:8). It is not only more effective and efficient but also safe, simple, more economical and qualitative. Its success in China indicates that the efficacy of medical care will be improved if we push forward the growth of traditional medicine and systematically combine it with the orthodox method into an integrated whole.

With an integrated or synthetic health care system, lives of the rural population will be saved. This is because traditional practitioners who hitherto operated hazardously and as quacks will now be registered and licensed to practice formally and being monitored for standardization of practice. Practitioners will as well be free to refer serious and complicated health conditions to the orthodox counterparts for prompt and proper management. Currently the doctor-patient ratio in Nigeria is disproportionately higher and equally uncomfortable. Therefore a joint approach in the administration of health care will not only be meaningful but beneficial and cost advantageous to both the clients and government alike.

Another benefit of synthetic medicare is the socio-economic development of the community. Both traditional and orthodox practitioners would be registered and licensed before practising. This will increase government revenue generation and improve social development. Like earlier argued, the quantity of patrons using this integrated health care system will increase and the quality of health care improved as a result of governmental regulations, monitor and control standards. Members' ethical conduct will be monitored and evaluated regularly with a view to sanction aberrational behaviours and stop the excesses of deviant members.

7. Conclusion

We have extensively examined the traditional and orthodox medical approaches in Nigeria with a thorough analysis of their history of origin, quality of practitioners, pharmacopoeia, modus operandi and the benefits of each method. It is without controversy that the relationship between these two approaches of health care is non-interactive and unequal which has hindered its integration over the years. With government support, the orthodox or western medical practice has dominated the entire health care system from the inception of health care delivery in Nigeria. This preferential treatment accorded it by the government has given its practitioners the feeling of superiority over the traditional medical practitioners. Although the locational distributions of orthodox and traditional services are strongly associated and are both dependent on population size and socio-economic status, there exists very little interaction and exchange between practitioners of both traditions. There are more traditional medical practitioners than orthodox. This is explained on the basis that anybody in Nigeria who uses herbs, roots or barks of trees in the treatment of illness or disease claims to be a traditional doctor.

Most Nigerians especially the ruralites generally favour the traditional medical practice. This is because of its proximity, availability, affordability and its assumed efficacy. They also flirt with both orthodox and traditional methods. Offiong (1991:47) observes that most Nigerians' patronage of the orthodox medical approach comes only when their trial with the traditional method had failed them. Majority of them classify diseases or illnesses into two namely; the African and European illnesses. The African illnesses are those that will not respond to orthodox medical treatment, hence must be treated in the African way via traditional method (Rufus, 1986:23). Those illnesses classified as European are those whose aetiology is pathologically demonstrable and usually responded to orthodox treatment.

We have proposed that traditional medical resources in Nigeria should be developed and its use sustained. This is because orthodox medical facilities are grossly inadequate in meeting the health needs of Nigerians especially the rural residents. Again, the efficacy of traditional medicine should not be out rightly rejected merely on grounds of unscientificity. In order to attain an increased utilization and improvement of medical efficacy, uniform standards and scientific methods should be introduced into the general health care system. Furthermore, the medical knowledge and skills of both traditions should be systematically combined into an integrated whole through joint research, exchange of information and the coordination of medical practice. These prescriptions will benefit users of a synthetic medicare if objective health care delivery is to be achieved in Nigeria. The time for action is now.

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