Editorial Office

Tajudeen Abiola
Department of Medical Services, Federal Neuro-Psychiatric Hospital, Kaduna-Nigeria.
E-mail: abiolatob@yahoo.com

About the Journal

IMAN Medical Journal (IMJ) is an international peer reviewed journal published by Islamic Medical Association of Nigeria. The journal is designed for the publication of original articles, case reports, review articles, book reviews, historical/faith-based perspectives, editorials and letters to the editor in all aspects of medical, health, ethical and related research.

Article format

Manuscript must contain the following headings – title; author(s) names; tagging; conflict(s) of interest; consent for publication; abstract; manuscript; references.

Title – must reflect the content of the article.

Author(s) names – Surname followed by initials of other names (e.g. Bala BST.); author(s) affiliation(s) and email address(es).

Tagging – specify in which of the following your article(s) falls into: original research article(s); review article(s); case report(s); Islamic perspective(s); book review(s); medical ethics; and history of medicine, health-related article(s).

Consent for publication – Authors are required to give IMJ consent for publication of the submitted paper, which must be done by filling in a consent for publication form containing: title of the publication; statement that the undersigned authors hereby transfer/assign or otherwise convey all copyright ownership of the manuscript to the IMJ; authors' names, signatures and dates; and the date of the submission. (Please note! If it's not possible to sign in to the word document, IMJ accepts submissions wherein only the author names and date are included.

Abstract – to have the following subheadings: introduction; methodology; results; and conclusion.

Keywords – not less than three and not more than five (i.e. between 3-5)

Manuscript (i.e. full length article) – to have the following subheadings: introduction; methodology; results (including tables and figures); discussion; and conclusion.

References – to be in citation-sequence style (i.e. Vancouver).

Acknowledgment - All persons who have made substantial contributions to the work reported in the manuscript, but who are not authors are credited here with the understanding that they have given the authors their written permission to be named. Non-inclusion of an Acknowledgment means that the authors have not received substantial contributions from non-authors and no author has been omitted.

Editorial process

Manuscripts are reviewed with the understanding that they represent original material, have never been published before, are not under consideration for publication elsewhere, and have been approved by all authors. Prior publication constitutes any form of publication other than an abstract and includes invited articles, proceedings, symposia, and book chapters. Authors must fully inform the Editor during the submission process if the submitted manuscript contains data and/or clinical observations that have been published or submitted for publication elsewhere, supply copies of such material, and explain the differences between the previous and submitted works. All accepted manuscripts become the property of Islamic Medical Association of Nigeria and may not be published elsewhere without written permission from Islamic Medical Association of Nigeria.

Contents

IMAN community-based epilepsy treatment gap intervention model in a rural area in Kano: the Kumbotso experience

[1]Suleiman M., [2]Abiola T.

[1]Department Of Nursing Services Aminu Kano Teaching Hospital Kano; [2]Department of Medical Services, Federal Neuro-psychiatric Hospital, Kaduna. Kaduna State.

Corresponding author:

Suleiman M. Department Of Nursing Services Aminu Kano Teaching Hospital Kano. Email: upmahmud@gmail.com

Abstract

Background: Epilepsy is a common chronic noncommunicable brain disease affecting all age groups. It is noted with different and debilitating comorbidities, challenges of treatment side effects, poor quality of life (QoL) and even early death in some. More burdensome is the fact that about three in every four individual with epilepsy do not have access to evidence-supported treatment, especially in low income countries. Meeting up with the treatment needs of people living with epilepsy (PLWE) is a worrisome dilemma. This study provided the analysis of a model that bridged the treatment epilepsy gap in a rural treatment center with good epilepsy management plan.

Methods/Results: The paper presented the analysis of the strategic treatment gap measure, practiced by Islamic Medical Association of Nigeria (IMAN), Aminu Kano Teaching Hospital Chapter, Kano-State. The framework is tagged the Kumbotso Model, comprise the giving free antiepileptic drugs (AEDs) to the indigents who are the larger part of PLWE, publication of a handbook titled "111 questions and answers on epilepsy" in Hausa language for education, improving awareness through some Radio/TV programs, the training of patients relations and members of the public on first aid measures for seizures, as well as in economic empowerment to ease the affordability challenge and improve medication adherence and follow-ups.

Conclusion: The Kumbotso model provided a strategic framework for bridging the AEDs treatment gap for PLWE. This marked a revolution in providing more than AEDs by reducing stigma and discrimination against PLWE, changing seizure-associated misconceptions, alleviating related poverty a little and contributing to the sufferers' improve QoL. It demonstrated further how epilepsy might be better managed in the rural community and advocated for why epilepsy should be integrated into the Primary Health Care Centers services.

Key words: Epilepsy, Treatment gap, Kumbotso Model, IMAN, PLWE.

Introduction:

According to World Health Organization (WHO)[1], epilepsy is one of the most common chronic noncommunicable brain disease affecting all age groups. Epilepsy is a recurrent seizures often associated with unconsciousness with(out) loss of bowel or bladder control functions. In addition, epilepsy has been noted with different and debilitating comorbidities, challenges of treatment side effects, poor quality of life (QoL) and even, early death in some[2].

Nearly 50 million individuals have been estimated to be suffering from epilepsy globally. Out of these, about four out of every five persons with epilepsy live in low and middle income countries. Despite the success rate associated with treatment, high level of stigma and discriminations are being experienced by people living with epilepsy (PLWE) globally. More burdensome is the fact that about three in every four individual with epilepsy do not have access to evidence-supported treatment, especially in

low income countries. This poor access to treatment by PLWE can be due to several issues including, living in rural areas, which are several distance to the treatment facilities, need to walk these long distance due to poverty, high community stigma and discriminations, poor epilepsy management plan in Primary Health Care Center that might be close by etc. A fall out of having to pay from pocket in obtaining health services in most part of Nigeria is the worrisome dilemma of not being able to afford anti-epileptic drugs (AEDs). This is especially for the teaming epilepsy population now reaching out to rural centers with good epilepsy management plan[1-3]. A study in southeast Asia provided two strategies involving the use of health workers volunteers, one visiting villagers with epilepsy and the other living with the villagers[4]. This study provided the analysis of another strategy, different from the above two models and was started about 13 years ago. This strategy framework, or the Kumbotso Model, was brought up from the treatment intervention provided by the Islamic Medical Association of Nigeria, Aminu Kano Teaching Hospital (IMAN-AKTH) Chapter, as a way to bridge the treatment gap on access to AEDs for PLWE and receiving treatment at the Kumbotso Comprehensive Treatment Center.

Methodology/Results

Kumbotso and Epilepsy

Kumbotso is a village and the headquarters of Kumbotso Local Government Area in Kano State, Nigeria. It is about 20km away from Kano metropolises. It has an area of 158 km² and a population of 295,979 according to the 2006 census. The people are predominantly peasant farmers and cattle rearers, Muslim and Hausas. Kumbotso also house the Comprehensive Health Centre, a primary care facility providing health services to its inhabitants and environs.

In Kumbotso and among other Hausa speaking people, epilepsy is locally referred to as “farfadiya”. It is believed to have been caused by evil spirit and it is contagious in nature. This belief is still pervasive in parts of Africa and the world. Hence, the locally preferred place of treatment, and across some parts of Africa is with the traditional healers and spiritualists. Due to this belief, PLWE may attend hospital mainly for the treatment of secondary injuries like burns and bruises, from recurrent seizures, and often not for the treatment of the epilepsy. Epilepsy is seen as a hope lost, known by all, and nobody wants to be associated with it.

Starting Epilepsy Clinic in Kumbotso

In 1998, the story began, when the Hungarian, Neuro-psychiatrist and Head, Department of Psychiatry, Aminu Kano

Teaching Hospital, Kano, Dr Istivan Patkai, led the opening of a community epilepsy clinic in Kumbotso Comprehensive Health Centre. The clinic is managed by doctors and nurses in Department of Psychiatry, AKTH Kano. The clinic took off as a bi-weekly clinic and presently, it is weekly (and on Mondays).

The visionary opening of a community epilepsy clinic in Kumbotso was a welcome idea to few, but to many, it was a misplacement of priority. The later might be due to lack of awareness on the rising number of PLWE in Kumbotso and surrounding environs. From inception, focus was on the establishment of a sustainable program. Thus, a dialogue took place between the Department of Psychiatry, AKTH Kano and the Kumbotso community stakeholders, leading to community participation. The clinic started with no patient, and 20 years later it has registered more than 7000 PLWE. The clinic is patronized by the forty four local government areas of Kano state, neighboring states and also the far away Niger Republic. The epilepsy clinic has facilitated AKTH Kano, to take over the running of Kumbotso Comprehensive Health Centre, and to open more clinics, both general and specialty, running on all days of the week.

Running the epilepsy clinic now

Patients and relations start arriving at the clinic as early as 6.00am from far and near. Some patients come on foot walking for an average of 2 to 20km, few on bicycle, fewer on motor bike and commercial transport buses. While those from very far distance or neighboring state and the Niger Republic come a day earlier and pass the night in the Hospital or in the Kumbotso village. After consultation, most patient still could not afford AEDs. This treatment gap leads to the effort of some clinical staff of the Department of Psychiatry AKTH-Kano to start providing free AEDs. However, the treatment gap is still huge and then come the more supply of free AEDs from IMAN-AKTH chapter. This kick-start the Kumbotso Model of giving free AEDs to the indigents who are the larger part of PLWE.

The drug of choice is based on the epilepsy treatment plan and may range from mostly phenorbabitone, then carbamazepine and phenytoin, and rarely sodium valproate and leviteracetam. Appointment is given from 2 to 12weeks depending on level of seizures control, distance of client's village to the clinic, availability of free medications and affordability to buy drugs. And with the provision of free drugs, optimal medication compliance and seizure control are often achieved. At times, the patients might enjoyed some assistance for other basic needs, in addition to AEDs.

Next addition to the growing model is on education and awareness, that soon start to receive remarkable attention on epilepsy.

Henceforth, on first day of visit to the clinic, patient is given a handbook titled: "111 questions and answers on epilepsy" written in Hausa language i.e. "tambayayo dari da sha daya akan ciwon farfadiya". This handbook, written by the first author of this work, is produced to provide a practical knowledge and skills to PLWE, their family members, and members of the public. This awareness on epilepsy soon received booster with some Radio/TV programs on epilepsy by experts (also from the clinic) and occasionally the clients themselves, where myths, ignorance and discrimination against epilepsy and PLWE are roll backward. Another feature contributing to reducing treatment gap in the clinic now is in the training of patients relations and members of the public on first aid measures for seizures, as well as in economic empowerment to ease the affordability challenge and improve medication adherence and follow-ups. All these, or the Kumbotso Model, have contributed to improve understanding, attitude, and care, for PLWE and in transforming the wrong perception of the public.

Some specific outcomes of the Kumbotso Model noted in PLWE

The following are some of the noted Kumbotso Model outcome that are specific to PLWE:

- Controlled seizures, contributed to mental stability among clients, and enhanced their social acceptance and involvement in social decision making.
- Children with epilepsy now seizure free have been privileged to be enrolled in schools or go back to school in the case of those who dropped out because of the illness.
- Many destitute, beggars and divorcees as a result of the illness are able to go back to their homes to reunite with their children, relatives and society.
- The socio-economic burden for people with epilepsy and their families has drastically reduced.
- With seizure controlled, employment becomes a necessity, many patients are able to start work or go back to work either on their farms, paid jobs or other productive activities.
- They become very knowledgeable on safety at places of work and the need to avoid jobs that are hazardous to self and others.
- Some were able to control, own or recover their lost or inheritable properties.
- Many who have earlier lost hope in marriage were able to realize their dreams.

Some generally noted successes of the Kumbotso Model

In the 20years under review, the singular role of IMAN-AKTH in bridging the treatment gap and the tireless efforts of the staff of the Department of psychiatry AKTH Kano, has been noted with the following overall successes:

- The quality of lives of Kumbotso clients living with epilepsy has improved remarkably;
- For most of them, the seizure is now under control and for few with residual symptoms, the frequency of seizures and injuries have reduced remarkably
- Despite the observation of minimal drug side effects reported, the overall level of independence is on the increase as their activities of daily living (ADL) improves, level with their productiveness and recreational activities enhanced;
- Most stigma or discriminations noted before are now replaced by care and understanding;
- The clinic has continued to function for more than 20years without any interruption, and it has never been closed, even when there is public holiday or health workers strike actions.
- It has provided a platform to increase awareness on facts about epilepsy, and reduction in misconception, stigma, discriminations and sudden death associated with epilepsy;
- It has provided a life purpose for staff, increased their team work, improved the health-worker-patient's relationship;
- It has led to the formation of PLWE association in the place of review. (This was inaugurated a year ago. After getting the Hospital Management approval, it was registered with Kano State Government as community development association and patrons, executives and members meet periodically to discuss issues concerning the members in accordance with the constitution);
- It has facilitated the running of more specialty clinics at the Kumbotso Comprehensive Health Centre i.e. it has facilitated more health services for more members of the rural community with(out) epilepsy.

Some challenges worth pointing out:

Despite the establishment of Kumbotso epilepsy clinic and the positive changes it has brought to the lives of PLWE and those who care for them, there are still few challenges. The following are worth bring forward:

- Awareness still needs to be intensified, as anecdotal report showed that about 40% of the PLWE in the Kumbotso area and environs are the ones using the facility's care plan and hence seizure free with relatively improved QoL. This might not be unconnected to the supernatural causation belief that evil spirit are responsible. This can be anecdotally inferred from more than 2 in 7 PLWE utilizing the Kumbotso Comprehensive Health Centre services still solicit for the service of herbalists/spiritualists.
- Despite the 20 years of providing epilepsy services and collaborating with community leaders, the Kumbotso Local Government Authority is yet to prioritize epilepsy as a public health challenge.
- Till the time of this analysis, no similar clinic has been set up by surrounding Local or State Government, even though their citizens travelled far to benefit from the current effort.
- Despite the attainment of being seizure free among PLWE utilizing the center's services, just a handful are able to get reintegrated into the community social

roles like gaining employment, getting re-married, living without disability etc.

- Caregiver burden which is relatively high among care providers of PLWE is yet to be addressed as part of the treatment package. Although, the free AEDs made available by IMAN-AKTH do appear to provide some of the relief expected.
- Transportation to clinic also remains a major constrain, either in terms of cost, safety or long distance. Hence, patients and/or relation might be easily worn-out as they trekked or cycled long distance, and/or the stress might provoke seizure that might lead to fall, fracture and other injury. Also, for some, money spent on transportation translate to less available for medication. The cost of transportation and medication might also meant missed appointments and follow-ups, which might hinder medication adherence.
- The cost of accompany patients to the clinics might also include foregoing opportunities that might contribute to family income and wellbeing.
- The mental health law in Nigeria is not in cognizance of the plight of PLWE, nor does any policy provides for limiting the stigma, segregation and discriminations faced by PLWE.
- When children with epilepsy are denied the rights to be enrolled in schools or adults denied employment, it increase the suffering faced by them and their perpetrators are never brought to book because of ignorance and poverty.
- A major constraint in the management of PLWE in the place of analysis is the occupation of some of them. Some work as taxi drivers, local fishermen, street hawkers etc. These occupations carry high hazard for PLWE for any bout of seizure while at work might come with life threatening consequences. Hence, the need for policy makers and job providers to provide safer jobs and opportunities for these group of people.

Sustaining the epilepsy clinic and care program

The primary role of providing AEDs by IMAN-AKTH chapter has been central to the successful running of this community care program for PLWE. This is very practical in helping to reduce the treatment gap faced by PLWE. The Kumbotso experience gives a vivid account of a sincere and accurate vision of improving the quality of lives of PLWE in their rural localities. This experience also shows how a group of committed health care team as the tireless financial and moral support of IMAN-AKTH Kano, brought health care to the door steps of PLWE in rural African societies. It demonstrates practical strategies towards fighting misconception and stigma and how they could be replaced with care and understanding. Despite its many challenges and constraints, this laudable project and model might serve as an example for more IMAN chapters and other community-based organizations to emulate. This model might fast track the integration of epilepsy services into existing Primary Health Care programs, as it provide an efficient system for procuring and supplying AEDs, as well as providing a format for caring for PLWE. It is also quite instructive for the ongoing BRIDGE Project on epilepsy in Africa.

Conclusion

Despite epilepsy, being a major chronic non-communicable disease with less than a quarter of PLWE having access to the needed AEDs, this experience in Kumbotso might provide a model for bridging the treatment gap. The Kumbotso experience and model, marked a revolution in providing more than AEDs by reducing stigma and discrimination against PLWE, changing seizure-associated misconceptions, alleviating related poverty a little and contributing to the sufferers' improve QoL. It demonstrated further how epilepsy might be better managed in the rural community and advocated for why epilepsy should be integrated into the Primary Health Care Centers services.

References

1. World Health Organization. Epilepsy. 2019. On: https://www.who.int/news-room/fact-sheets/detail/epilepsy. (Accessed on 15-08-2021)
2. Institute of Medicine (US) Committee on the Public Health Dimensions of the Epilepsies; Editors: Mary Jane England, Catharyn T Liverman, Andrea M Schultz, and Larisa M Strawbridge. Epilepsy across the spectrum, promoting health and understanding. National Academies Press, Washinton DC, 2012.
3. Fodjo JNS, Dekker MCJ, Idro R, Mandro MN, Preux P-M, Njamnshi AK. And Colebunders R. Comprehensive management of epilepsy in onchocerciasis-endemic areas: lesson learnt from community-based surveys. Infectious Diseases of Poverty, 2019; 8(11).
4. Boumediene F, Chhour C, Chivorakoun P, Souvong V. Odernmatt P, Hun C, Thebaut C, Bounlu M, Chum N, Vorachit S, Ros S, Chan S. and Preux P-M. Community-based management of epilepsy in Southeast Asia: two intervention strategies in Lao PDR and Cambodia. The Lancet Regional Health Western Pacific, 2020;4.

Conflict of interest: Nil

Healthcare financing in Nigeria – an analysis of the Islamic model

[1,2]Oseni TIA, [3]Oseni UA, [2,4]Affusim CC.

[1]Department of Family Medicine, Ambrose Alli University, Ekpoma, Nigeria; [2]Institute of Health Insurance and Managed Care of Nigeria; [3] Chief Executive Officer, International Islamic Liquidity Management Corporation, Kuala Lumpur, Malaysia; [4]Department of Family Medicine, Irrua Specialist Teaching Hospital, Irrua, Nigeria.

Corresponding Author:

Dr Tijani Oseni, Department of Family Medicine, Ambrose Alli University, Ekpoma, Nigeria. Tel: +2348036281897; Email:

tijanioseni@yahoo.com

Abstract

Background: Healthcare in Nigeria is poorly funded. Most payments are out of pocket. This has affected the quality of health of the populace, as the majority of the populace cannot access basic healthcare. A recommendation to bridge this wide gap is through the establishment and utilization of health insurance, especially through the National Health Insurance Scheme (NHIS). Currently, it is only the formal sector social health insurance programme (FSSHIP) that accounted for only less than 5% of Nigerians, that is in operation. This study proposed Islamic healthcare financing as a viable alternative model.

Methodology/Results: A review of Islamic healthcare financing (Takaful), as an exceptional faith-based model, provides an alternative model of healthcare financing. The analysis of Takaful, as a unique value proposition for healthcare financing, is literarily an Islamic insurance model. In this model, the clients or participants make their contributions to the *Tabarru* (donation) fund while the Takaful company, acting as their agent, invests the funds in Sharī'ah compliant investments such as Sukuk and other permissible investments. The unique features of Takaful make it suitable for Islamic health financing in Nigeria.

Conclusion: The analysis revealed that the Islamic health insurance through Takaful is viable option for Muslims and the public at large, to reduce the low coverage of the current model. It recommended the establishment of more Takaful companies, and their utilization as a unique healthcare financial model.

Key Words: Islamic, health, financing, takaful, insurance

Introduction

The Covid-19 Pandemic has exposed the vulnerabilities inherent in the healthcare systems of not only the developing counties but also the developed countries. On the flip side, the pandemic effectively unravelled the invaluable role of the healthcare workforce and the need. One thing the pandemic has taught people is the need to ensure they can access affordable healthcare services. It is surprising to note that just before the pandemic set in, countries across the world reaffirmed their commitment to Universal Health Care (UHC) at the United Nations General Assembly High Level Meeting on Universal Health Care in 2019.

Accordingly, the World Health Organization (WHO) has been spearheading this initiative since 2015, hence, UHC is targeted at ensuring all human beings and communities get the required healthcare services without going through any financial hardship.[1] It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.[1]

One model that has been identified as a viable method to address the UHC deficit is Health Financing. Health Financing refers to the use of financial resources to ensure adequate coverage of the collective health needs of every person.[2] It is a foundational component that impacts the entire health system's performance, including the delivery and accessibility of primary healthcare. In some countries, the health system's financing strategy creates an imbalance that favours more expensive hospital care over primary healthcare.[3]

In Nigeria, primary healthcare has virtually collapsed. It appears healthcare is skewed in favour of secondary and tertiary healthcare, with primary healthcare mostly neglected. Consequent upon this neglect, Nigerians go to General and Teaching Hospitals to access care for minor ailments. This neglect of the primary health centres has put much pressure on the secondary and tertiary facilities, and as expected, with increased healthcare spending.

There has been recent experience of health insurance coverage in Nigeria but due to the huge population of the country, there has not been much impact. According to a 2019 PwC study, health insurance has been operating in Nigeria for over 17 years; however, there has been a very low uptake. In 2016, a meagre sum of 3% of total healthcare expenditure was applied to health insurance.[4] It has also been reported by the National Health Insurance Scheme (NHIS) that as of 2019, the scheme's coverage was below 5% of Nigerians which largely comprises the employees of the Federal government and their dependents.[4]

Though it is argued that massive investments in quality primary healthcare is necessary to achieve UHC globally, it appears there is still a long way to go in achieving this in most developing and least developed countries. And in spite of the efforts of NHIS and other state- driven initiatives, there has not been much impact on the vulnerable segment of the population. The wide health financing gap existing, therefore, needs a viable option and model like the private sector. Their active involvement tends to augment the existing government initiative through a health insurance model, where the so-called policy

holder becomes a key stakeholder than just paying premiums. It is against this backdrop that this study seeks to examine Islamic Health Financing, as an alternative model of health financing in Nigeria. This unique model, from previous assessment, does not only provide affordable and accessible healthcare services, but also build in some inherent principles that add value to the economic life of the policy holder. Furthermore, this study also provides a snapshot of such model that can be easily implemented under the existing legal and regulatory framework that underpins the insurance sector in Nigeria.[5] The analysis will explore the current health financing system in Nigeria, and the unique value of Islamic model being proposed as a model to bridge the existing wide healthcare gap.

Methodology/Results

Healthcare financing in Nigeria

The major healthcare financing mechanisms in Nigeria are namely: (i) government budget using general tax revenue; (ii) direct out-of-pocket payments; (iii) a social insurance scheme known as the Formal Sector Social Health Insurance Programme (FSSHIP) that is implemented by the NHIS; and (iv) donor funding. Other health financing mechanisms include: demand-side financing through conditional cash transfers (CCT), and community-based health insurance (CBHI).

Healthcare in Nigeria is poorly funded.[6] Most payments are out of pocket.[7] This has affected the quality of health of the populace, as the majority of the populace cannot access basic healthcare. This is due to the high poverty level in the country, where the majority of the populace are poor, unemployed or at best under-employed. The security challenge in most parts of the country has further crippled economic activities, worsening the poverty level in the country. The increasing cost of laboratory investigations, medications and dearth of physicians have also contributed to the increased cost of accessing healthcare in the country.

Donor funding can come in form of free medical outreach by religious or non-governmental organisations, building and equipping of hospitals by companies and firms as part of corporate social responsibilities, special programmes like Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) intervention programmes where free diagnosis and treatment are given to persons with specific health challenges. Donor funding is a big source of health financing for the poor. However, the major drawback is that persons and services covered are determined by funders and not universal. The timing of the intervention is also determined by the donor thus the sick may not get healthcare service when needed, unless a medical

outreach is being organised for his community at that time, or his ailment is covered by a specific intervention being organised for his people at that material time.

The other form of healthcare financing, the Community based health financing mechanism, involves households in a community financing or co-financing, the recurrent and capital costs associated with a given set of health services, thereby being involved in the management of the community financing scheme and organization of health services.[8] Philanthropists, community leaders, non-governmental organisation and government can also donate to the scheme. Two or more common ailments such as malaria, diarrhoea diseases and pneumonia particularly in children and maternal services are usually covered by the scheme.[8] It affords the community access to basic healthcare particularly the vulnerable population (women and children).

Health insurance in Nigeria

Health insurance is a form of funding of healthcare, whereby people forego a part of their income in exchange for guaranteed protection from Catastrophic Health Expenditure (CHE), which have negative effect on households.[9] It involves the pooling of funds to finance healthcare, with the financial risk of health spread among the insured. Therefore, the larger the pool of resources, the more efficient and sustainable the services that will be provided to the insured. It also ensures the populace get the best of care irrespective of their income level as the burden of health is shared.

The two main types of health insurance are private health insurance and public health insurance. Public health insurance is provided through the government, while private health insurance includes plans you get through an employer or the marketplace.

The National Health Insurance Scheme (NHIS) was introduced in 2005 to guarantee accessibility to health for Nigerians.[10] This scheme (NHIS) is a form of managed care that pools regular financial contribution of members and pays a network of providers of health care (health maintenance organizations and health care providers), for defined specific set of health care services, who in turn are accountable for cost containment and improving health outcomes. A contribution entitles the insured person, the spouse and four children under the age of 18 years access to health care. The client will register with NHIS approved Health Maintenance Organization, and thereafter, the primary health care provider of his choice from an approved list supplied by Health Maintenance Organization.

The role of insurance in health financing is double-fold, one, to raise revenue for health care services, and two, to pool these resources so that health risks can be effectively shared among the members of the insurance scheme.[11] The main objective of NHIS therefore is to achieve equitable access to health care in Nigeria, as an alternative source of funding for a rapidly extending and increasingly costly health care system. In order to ensure that every Nigerian has access to good health care services, the National Health Insurance Scheme has developed various programmes to cover different segments of the society, and these are:[12]

Table 1: NHIS Categorization of Different Segments of the Society

Formal Sector	***Informal Sector***	***Vulnerable Group***
1. Formal Sector Social Health Insurance Programme 2. Mobile Health 3. Group, Individual and Family Social Health Insurance Programme	1. Tertiary Institution Social Health Insurance Programmes 2. Community Based Social Health Insurance Programmes 3. Public Private Partnership Social Health Insurance Programmes	1. Pregnant Women 2. Children Under five 3. Prison Inmates 4. Retirees 5. Aged

Thus, the Scheme is designed to provide comprehensive health care delivery at affordable costs, covering employees of the formal sector, self-employed, as well as rural communities, the poor and the vulnerable groups.[13] However, it is only the formal sector social health insurance programme (FSSHIP) that is currently operational, accounting for only less than 5% of Nigerians. This is because it is mandatory for all federal government employees to enrol into the programme. State and local governments are also keying into the scheme through the State Social Health Insurance Agencies (SSHIA), with Bauchi and Cross Rivers states achieving full coverage.[12] Other states like Edo are gradually following suit.

The National Health Insurance Scheme is bedevilled with many problems including; corruption, fragmentation of resources, policies, efforts and strategies. These have become great impediment to the full realisation of NHIS, which is key to the attainment of Universal Health Coverage. There is therefore, the need to develop an appropriate and enabling setting, which will be the matrix of coverage, with a systematic

arrangement that facilitates the achievement of set objectives. To this end, the management of the NHIS has come up with the concept of 'Health Insurance Under One Roof' (HIUOR). Under this concept, there should be a clear definition of scopes of health insurance in Nigeria, and the determination of who covers each of the segments between NHIS and the State agencies. The examples may include NHIS remaining responsible for the formal sector, while the State Health Insurance agencies took charge of the informal sector population at the grassroots, which is closer to the state government system. The HIUOR concept is therefore aimed at accelerating Universal Health Coverage, and decentralization of the NHIS. The scheme has also been affected by inadequate political commitment to the health of the populace, lack of confidence in the scheme by the public leading to very poor voluntary enrolment, moral and ethical issues on the side of the Health Maintenance organisation (HMO), the service providers and the enrollees.

The Islamic healthcare financing plan

As an alternative model of healthcare financing, Islamic healthcare financing is a faith-based model that provides a unique value proposition for the up takers. Islamic healthcare financing can be achieved through Islamic insurance popularly known as Takaful. Takaful has been defined as a concept of insurance based on Islamic principles in which a group of individuals agree mutually to guarantee themselves against the occurrence of loss or damage relating to a specifically identified risk through *tabarru* (voluntary donation) into mutual *takaful* fund.[14] It is based on the principles of mutual cooperation *(ta'awun)* and donation *(tabarru')* whereby participants' risks are shared collectively and voluntarily by participants to guarantee mutual protection of the members.[15] Thus, a group of individuals pool funds together with a mutual agreement that in the event of ill-health of any of the contributors, part of the fund would be used to provide healthcare services to him based on the agreed amount.[16]

There are numerous differences between the conventional insurance and Takaful. Some of the core differences are summarised in Table 2 below:

There are various Takaful models which can be used to structure Islamic health financing plan. The major Takaful models used in the market globally include Mudārabah (Joint venture partnership), Wakālah model (agency contract), and the Hybrid model (partnership and agency).[18] As a matter of fact, some of the models have been used in structuring health plans in jurisdictions such as Malaysia, Pakistan, United Arab Emirates and many more.

In Nigeria, Takaful commenced with the incorporation of Jaiz Takaful Insurance Plc in December 2013. However, it received its operational license to offer insurance products in on 19 August 2016. There are currently several insurance companies offering Takaful products and these include Noor Takaful Insurance Plc, Salam Takaful Insurance Ltd and Cornerstone Takaful Insurance Ltd. However, patronage of these services has been considerably low.[16]

There are various Takaful models which can be used to structure Islamic health financing plan. The major Takaful models used in the market globally include Mudārabah (Joint venture partnership), Wakālah model (agency contract), and the Hybrid model (partnership and agency).[18] As a matter of fact, some of the models have been used in structuring health plans in jurisdictions such as Malaysia, Pakistan, United Arab Emirates and many more.

In Nigeria, Takaful commenced with the incorporation of Jaiz Takaful Insurance Plc in December 2013. However, it received its operational license to offer insurance products in on 19 August 2016. There are currently several insurance companies offering Takaful products and these include Noor Takaful Insurance Plc, Salam Takaful Insurance Ltd and Cornerstone Takaful Insurance Ltd. However, patronage of these services has been considerably low.[16]

Despite the promising nature of Takaful as obtained in other countries such as Malaysia, the patronage of Takaful services in Nigeria appears to be deteriorating rather than improving.[16] According to the

National Insurance Commission (NAICOM), Takaful and microinsurance accounted for less than 1% of all the premiums in the insurance industry paid in 2019.[19]

How Takaful can enhance universal health coverage

The underlying principles of Takaful such as *tabarru* and *ta'awun* suggest that there is the communal dimension to insurance in Islam rather than the individualistic arrangements in conventional insurance. A financial product where participants in an insurance plan mutually contribute to help one another through donations and mutual assistance is different from the premium-based insurance policy. Therefore, considering the unique features of Takaful, one would consider an example of how Takaful can be used for Islamic health financing in Nigeria.[20]

1

Table 2: Major Differences between Takaful and Insurance[17]

	Takaful	Insurance
Conceptual elements	Based on the concepts of *Ta'awun* (mutual help or co-operation), *Aaqilah* (shared liability), solidarity, trusteeship, and brotherhood.	Based on seeking material gain on behalf of other.
Contract	A combination of *Tabarru* contract (donation), *Dhaman* (indemnity) and usually an agency or profit sharing contract.	Contract of exchange (sale and purchase) between insurer and insured.
Ownership	Policyholders – will try minimise operational costs – operator receives fees or profit share. Profit generation is not main goal.	Shareholders of the insurer– will try to maximise profits.
Responsibility policy holders / participants	• Participants make the contributions to the scheme. • Participants mutually guarantee each other under the scheme.	Policyholders pay premium to the insurer who assumes the risk of the uncertain, future event.
Liability insurer / operator	• *Takaful* operator acts as the administrator of the scheme and pays the *Takaful* benefits from the *Takaful* funds. • In the event of deficiency in the *Takaful* funds, the *Takaful* operator will provide an interest-free loan to rectify the deficiency.	Insurer is liable to pay the insurance benefits as promised from its assets (insurance funds and shareholders' fund).
Access to capital	Access to share capital by *Takaful* operator but not to debt, except for interest free loan from operator to underwriting fund.	Access to share capital and debt possible use of subordinated debt.
Investment of fund	Assets of the *Takaful* funds are invested in Shari'ah compliant instruments.	There is no restriction apart from those imposed for prudential reasons.
Operating profits	Operating profit may be re-distributed to the eligible policyholders or is sometimes shared with the operator based on the pre-agreed ratio.	All the operating profit will be allocated to the insurers' shareholders fund.
Winding up	Reserves and surpluses donated to charity or returned to the eligible policyholders.	Reserves and surpluses belong to the shareholders of the insurance company.

For this purpose, this study will use the Wakālah model which is based on the concept of agency. The first step is to establish a Takaful company who manages the fund. Thereafter, the clients or participants make their contributions to the *Tabarru* (donation) fund while the Takaful company, acting as their agent, invests the funds in Sharī'ah compliant investments such as Sukuk and other permissible investments. The funds contributed are usually divided into two sub-funds: Participants Risk Fund (PRF) and the Participants Investment Funds (PIF).[21] While the PRF is used to meet the general

Takaful claims relating to healthcare risks specified in the Takaful Certificates, the PIF is the other sub-account, where the contributions made by participants are credited for savings and investments. In fact, the healthcare financing plan can be structured in a Sharī'ah-compliant manner where the PIF will generate regular dividends or profits for the participants while also being fully insured for all their health-related needs. And at the same time, making their contributions to the fund, participants identify and agree on the insurable interests which in this case include all health-related matters, including visits to General Practitioners, minor surgeries and other related issues as agreed in the Takaful contract. Therefore, once a participant needs primary healthcare services, he or she proceeds to any panel clinic or hospital for treatment while the latter files the claim directly to the Takaful company based on the authorization of the participant.

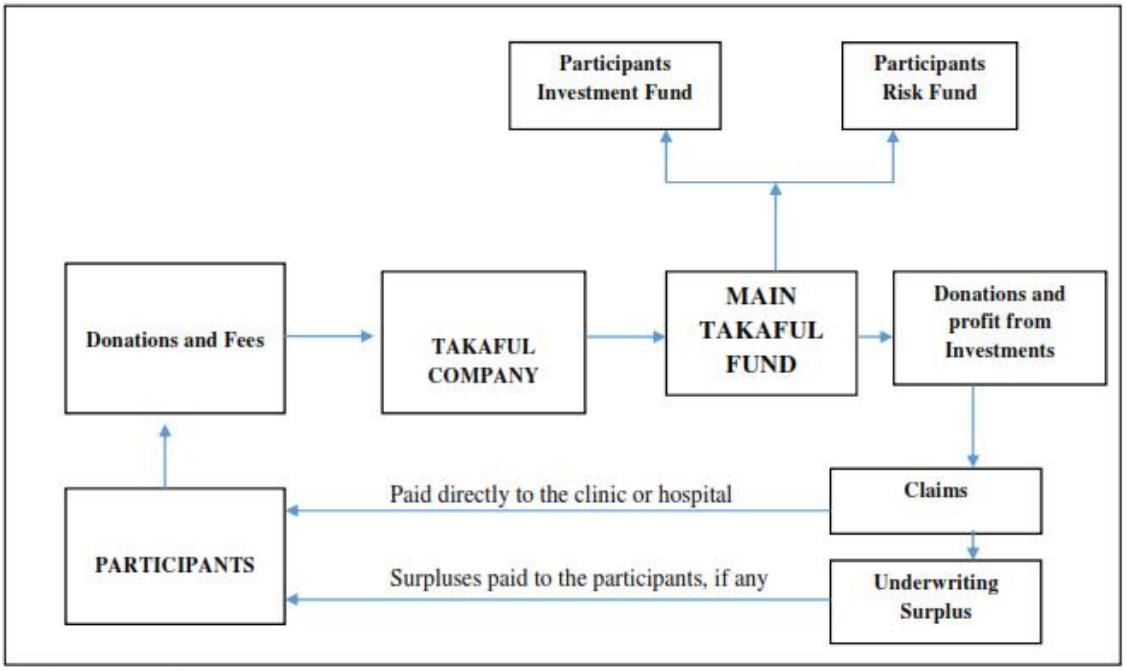
The key question that readily comes to mind is that how will the Takaful company make money and cover its operations? The Takaful operator will receive a pre-agreed fee for managing the funds and the claims. This is usually a fixed amount, or a percentage of the total gross profit as agreed by all the parties. One unique feature of the plan is that when there are underwriting surpluses, some Sharī'ah scholars allowed the distribution of such surpluses among the participants at the end of the financial year, as the participants are deemed to be the owners of the fund. This could also be implemented in a different way, where participants' contributions in subsequent years are discounted on the basis of low or non-utilization of the policy.

The above example provides a snapshot of the value propositions of Takaful in health financing in Nigeria. It is important to reiterate the five unique value propositions which are not available in the conventional insurance products offered in the country. First, the participants own the fund which is managed by the Takaful company. Second, the participants contribute based on their own volition to assist one another – an endeavour which earns them not only financial reward but also spiritual reward from the Islamic perspective. Third, depending on how the financial product is structured, the participants may be entitled to regular profits/dividends. Fourth, in case there is surplus at the end of the financial year, participants will get additional funds. Finally, representatives of the participants could be considered as part of the Board of

Directors of the Takaful Company. Above all, while enjoying the above benefits, participants get full health coverage. This makes Takaful a veritable product for enhancing the UHC.

Conclusion

Achieving universal health coverage in Nigeria involves the participation of everybody. Health insurance including Islamic health insurance (Takaful) is a major instrument for the achievement of universal health coverage. Muslims and the public should consider establishing Takaful companies or the existing Takaful companies could offer health insurance utilizing any of the widely used models. The regulator, NAICOM, is open to ideas and will be willing to license Takaful companies that are specifically established to manage health insurance in accordance with Islamic principles to achieve a healthier ummah. While this study focuses on the need to provide accessibility to affordable primary healthcare, which is crucial to Nigeria, future studies could focus on other areas such as compassionate healthcare financing which is mostly required for secondary and particularly tertiary health financing. Even the middle-class population in Nigeria cannot afford major surgeries without insurance. This makes a case for future research on compassionate financing based on Takaful and other principles of Islamic social finance. Going beyond Takaful for primary healthcare, compassionate financing is mostly used in advancing healthcare financing. Compassionate financing provides an affordable plan for patients who cannot fund very expensive medical procedures such as gene therapies. Gene therapies are specifically used to cure rare medical conditions, which positively transform patient's life. However, the cost element is huge, as the first licensed gene therapy was priced at super high cost of USD 1 million. This has the potential of financially excluding patients without targeted financing, and such patients are left to bear the burden of rare or ultra-rare medical conditions for life. In the developed world, some existing financing models include outcome-based model in form of pay-for-performance agreements, upfront payment, annuity-style payment, intellectual property-based payment, and fund-based payment.



Source: Authors

Fig 1: A simplified model of Wakala Takaful for healthcare financing

References

1. World Health Organization, "Universal Health Coverage (UHC)", 1 April 2021. Available at https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

2. World Health Organization. Monitoring the Building Blocks of Health Systems: a handbook of indicators and their measurement strategies. Geneva, Switzerland: WHO. 2010.

3. Joint Learning Network for Universal Health Coverage (JLN), Financing and Payment Models for Primary Health Care: six lessons from JLN country implementation experience. Washington, DC: Results for Development; 2017.

4. PricewaterhouseCoopers Limited, "Sustainability of State Health Insurance Schemes in Nigeria Beyond the Launch", 2019. Available at https://www.pwc.com/ng/en/assets/pdf/sustainability-state-health-insurance-nigeria.pdf

5. Oseni UA, "Dispute resolution in the Islamic finance industry in Nigeria." European Journal of Law and Economics 40.3 (2015): 545-564.

6. Tayo-Ladega O, Abdullahi TM, Islam KA. Factors Militating Against Public Health Financing In Nigeria: An Empirical Review. American International Journal of Multidisciplinary Scientific Research. 2021 Apr 12;7(2):1-0. Also see, Asakitikpi AE. Healthcare delivery targets and the national health insurance scheme limitations in Nigeria. International Journal of Business and Social Science. 2016 Mar;7(3):55-64.

7. Asakitikpi AE. Healthcare delivery targets and the national health insurance scheme limitations in Nigeria. International Journal of Business and Social Science. 2016 Mar;7(3):55-64.8. Sheshi IM, Ahmed A, Sani MD, Issa YF, Agbana BE. Willingness to Pay for Community Health Financing: An Approach to Financing and Sustainability of Integrated Community Case Management of Childhood Illness in Rural Communities in Niger State. Current Journal of Applied Science and Technology. 2021 May 4:82-92.

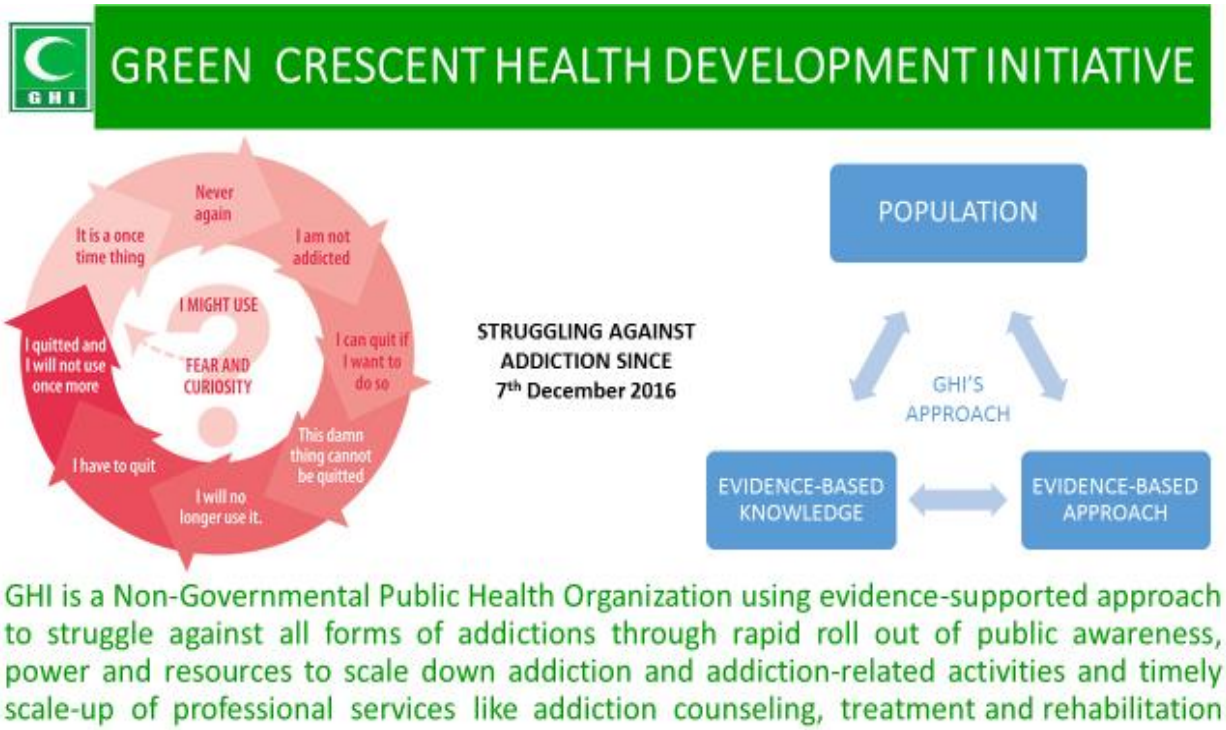
9. Adisa O. Investigating determinants of catastrophic health spending among poorly insured elderly households in urban Nigeria. International journal for equity in health. 2015 Dec;14(1):11.

10. Aregbeshola BS, Khan SM. Predictors of enrolment in the National Health Insurance Scheme among women of reproductive age in Nigeria. International journal of health policy and management. 2018 Nov;7(11):1015.

11. Ekman B. The impact of health insurance on outpatient utilization and expenditure: evidence from one middle-income country using national

household survey data. Health Research Policy Systems 2007; 5: 6.
12. National Health Insurance Scheme. Handbook. Accessed at: nhis.gov.ng/2020/11/19/handbook/
13. Sanusi RA, Awe AT. An Assessment of awareness level of National Health Insurance Scheme among Health Care Consumers in Oyo State, Nigeria. The Social Science 2009; 4(2):143-148.
14. Kazaure MA. Extending the theory of planned behavior to explain the role of awareness in accepting Islamic health insurance (Takaful) by microenterprises in northwestern Nigeria. Journal of Islamic Accounting and Business Research. 2019 Jul 8.
15. Fadun OS. Takaful (Islamic insurance) practices: Challenges and prospects in Nigeria. Journal of Insurance Law & Practice. 2014;4(2):12.
16. Kazaure MA, Abdullah AR. The Microenterprising Size And Acceptance Of Islamic Health Insurance (Takaful) In Northwestern Nigeria. Journal of Islamic Monetary Economics and Finance. 2019 Nov 1;5(3):541-58.
17. Paul Wouters, Takaful (Islamic Insurance) Concepts and Perspectives, https://v1.lawgazette.com.sg/2012-07/469.htm
18. Hassan K, Kayed RN, Oseni UA. Introduction to Islamic banking & finance: Principles and practice. United Kingdom: Pearson Education Limited, 2013.
19. Middle East Insurance Review, "Nigeria: Takaful contributes less than 1% to total insurance market", 8 October 2020. Available at https://www.meinsurancereview.com/News/View-NewsLetter- Article?id=74013&Type=MiddleEast
20. Dandago KI, Muhammad AD, Oseni UA, "Essentials of Islamic banking and finance in Nigeria", Abuja, Nigeria: Benchmark Publishers Limited, 2013.
21. Oseni UA, Hassan MK, Hassan R. Emerging Issues in Islamic Finance Law and Practice in Malaysia. United Kingdom, Emerald Publishing Limited, 2019.

Conflict of interest: Nil



The health rights of *al-Majirai* children under the Nigerian Law: problems and the need for a new discourse

Sadiq A.A.

Legal Unit, National Orthopaedic Hospital, Dala, Kano.

Corresponding author:

Sadiq A.A. Legal Unit, National Orthopaedic Hospital, Dala, Kano. Email:

abusaefullah@yahoo.com

Abstract

Background: *al-Majirai* (singular, *al-Majiri*) pupils are one of the most vulnerable child in northern part of the country. Beside socio-cultural challenges that have always been their lots, the *al-Magirai*, as children, were not on many occasions given recognition as a human being that deserve to have right to standard health care. On many occasions, they were caught in the midst of ravaging epidemics, outbreak of banditry and politico-economic and social downturn. To avoid taking responsibility, and in trying to downplay the consequence of this neglect, many parents try to shift blames of the neglect to the society or the government as if they were the author of the rot. This paper discusses the health rights of *al-Majirai* children under the Nigerian law and some problems associated with this development that hampered the realization of the health rights *al-Majirai* children .

Methods: The research methods in this paper are of combined nature. On the one hand is the use of doctrinaire method, which involves exploring available literatures, relevant statutes, and court cases on the topic. On the other hand, the paper uses the findings as provided in the secondary empirical data from other previous studies to analyse the topic.

Results: The research shows that there were enough provisions for the health rights of *al- Majirai* children under the Nigerian law. Such provisions are found in the Child Right Act (CRA), the African Charter on the Rights and Welfare of the Child [ACRWC]) and the Convention on the Rights of the Child [CRC]) etc., at the national, regional and international level accordingly. It also identified weak family system, ineffective public policy and maladministration at all level of government as some of the problems hampering the realisation of the health rights of the al-Majirai children. In order to overcome this problems, the paper advocates that parents of the al-*Majirai* children need to be more responsible by providing healthcare to their wards , and the Muslim *Ummah* and the government, on their part, to discharge their social responsibilities as required.

Conclusion: The health rights of the *al-Majirai* children are among the fundamental rights of every human being. These rights are available for every child under the Nigerian law irrespective of its tribe, colour etc. By charting a new discourse where the health rights of the *al-Majirai'* children are protected by the families , the Muslim *Ummah* and the government, the rights would be protected.

Key words: *al-Majirai*, health, rights, vulnerable, children

Introduction

Generally, *al-Majirai* children are just like other children born by other parents. And, like every normal child, they are expected to enjoy certain rights towards their physical and mental development in life. Among rights they can enjoy as provided by the

law include, but not limited to, right to life, right to human dignity, right against all sorts of degrading and inhuman treatments etc. These cumulative health rights developed from the time of their birth until they are matured enough to take care of themselves.

However, the reality in Nigeria is that these children, instead of enjoining all these rights, are, on the contrary, exposed to all societal neglect and nonchalant attitude of those who are supposed to protect their rights. It all starts from the family and sustained by ineffective public policy of the government and large scale level of maladministration of resources to provide all the needed health care in the country.

Therefore, in order to enjoy the health rights, there is need to embrace a new line of discourse where individuals have to provide health care to their wards rather than expecting the society or the government to carry out this task. This, of course , does not absolve the government or the Muslim *Ummah* of their social responsibilities; rather, it is a duty to assist individuals that genuinely need support and the government must provide the conducive environment for people to live a normal live.

Methodology/Results

This paper adopted the combined methods of research (which comprises the doctrinaire and empirical secondary data) to discuss it. At the doctrinaire level, it explored relevant laws – especially the Child Right Act (CRA),[1] the 1999 Constitution of Federal Republic of Nigeria (as amended, CFRN),[2] the African Charter on the Rights and Welfare of the Child [ACRWC]), the Convention on the Rights of the Child [CRC]) etc.,[3] court cases and literatures on the health rights of the *al-Majirai* children. Furthermore, the findings in some previous research studies were also used as secondary empirical data to explain the topic under study.

The results of the research shows that the child health rights are provided for under the national, regional and international legal regimes. It equally shows that weak family system, ineffective public policy and maladministration in the country, constitutes hindrances to the effective and successful implementation of the health rights of the *al-Majirai* children. It suggests that in order to prevent further perversion of the health rights of the *al-Majirai* children, there is need to chart a

new discourse where health rights of the *al-Majirai* children becomes the primary responsibilities of the parents and government to provide enough fund to the healthcare system in Nigeria.

Definition of terms

Magashi *writes* that *Al-Majiri (singular) or Al-Majirai* (plural) are Hausa words that means "child-student." The two words are derived originally from the Arabic word, *al-Muhajir*, which literally mean "a migrant." Beyond its literal meaning, it was used in sociological term to represent any person of different ages (but most often used for a child-student in Northern Nigeria) who migrate from his place to another area in search of Islamic education.[4]

As to the meaning of child (plural, children), the *Microsoft Encarta Dictionary* defines it as "somebody not yet of age: somebody under a legally specified age who is considered not to be legally responsible for his or her actions." In Nigeria, such a child by section 277 of the CRA, is defined as a person below the age of 18 years.

Another important term is health. According to the World Health Organisation (WHO), it mean "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."[5] As to what a right means, there are many definitions given to it by many law jurists. But, for the purpose of this paper, it can simply means what Nchi defines as , "an advantage, interest or a claim due to a person which is decreed by law…"[6] In other words, it is the law that defines rights and makes provisions for its availability and how to enforce it.

Concept of health rights of *al-Majirai* children in Nigeria

The health rights of the *al-Majirai* children are derived essentially from some of other rights often described as human rights.[7] These rights are regarded as God given and arose from the reality that men are created equally. And since all *al-Majirai* children are human beings, it thus means that they are entitled to them accordingly. In other words, every *al-Majirai* children is entitled to these rights by virtue of his humanity.

Normally, the issue of rights do not arise in isolation. Under the human rights law, there is always a reciprocity between rights and duties such that, in this context, the rights of *al- Majirai* children impose duties

on their parents (or anyone that serves as *loco parentis* to him).[8] Put differently, since they do not give birth to themselves, it presupposes that the duties of taking care of them lies with those who brought them to life. In Hohfeldian analysis of rights, this kind of relationship created what is called correlativity of rights and duties.[9]

The above concept establishes that the right of a person correlates with the duty which other person owes the former. As such, by the correlativity of rights and duties, it thus means that if such rights are denied, whoever is instrumental to the infringement would be liable under the law. Where there is liability, sanction follows. In other words, where rights are violated, the law provide penalty for the violation.

Legal regimes protecting the health rights of *al-Maqirai* children

Generally, there are many provisions in Nigeria statutes protecting the health rights of all citizens. However, besides the general provisions, there are some laws specifically meant for the protection of the health rights of the child in the country. One of these Nigerian laws is CRA, which replaces, supplements, or complements other relevant laws on children like the Lagos States Children and Young Persons' Law ([CYPL])[10] and the Children and Young Persons' Act ([CYPA]).[11]

At the regional level, based on Nigeria being a signatory to regional Charters, adopted charter protecting the rights of the child known as the African Charter on the Rights and Welfare of the Child [ACRWC]).[12] At the international level, the Convention on the Rights of the Child [CRC]), was adopted by the country and has since been domesticated as CRA (now part of the indigenous law of the Federation of Nigeria).

Under the Interpretation section of the CRA, Sect. 277 of the CRA, provide a definition of a child as "a person below the age of 18 years," thereby settling the dispute about who a child is under other Nigerian law.[13] The above definition supersede all other definitions provided based on the provision in section 274 of the CRA titled, the Suspension and Inconsistence.

Health rights of al-Magirai children under the Nigerian laws

The health rights of every child – be he *al-Majiri*, albino, or other classification of children, are not left without being provided for under the Nigerian law. Since these rights are so fundamental to the survival of a child, the drafter of the law took further steps to see that these rights are not just provided but are enforceable through the machinery of the law.

In the next few lines, we shall outline some of these health rights with court cases that interpreted them as a binding law. These rights are:

a) Fundamental human rights: The CRA in its Sect. 3 provides that the Chapter IV of 1999 CFRN is applicable to the children as well, when it restates that;

> (1) The provisions in Chapter IV of the Constitution of the Federal Republic of Nigeria 1999, or any successive constitutional provisions relating to Fundamental Rights, shall apply as if those provisions are expressly stated in this Act.
>
> (2) In addition to the rights guaranteed under Chapter IV of the Constitution of the Federal Republic of Nigeria, 1999, or under any successive constitutional provisions, every child has the rights set out in this Part of the Act.

These fundamental rights include rights to life,[14] which by Sect. 33 states that 'no one shall be deprived intentionally of his life, save in execution of the sentence of a court in respect of a criminal offence of which he has been found guilty in Nigeria.' In Sect. 41(1) of the CFRN, there is right to freedom of movement, which every Nigerian - sick or well is entitled to throughout Nigeria. It include the right to reside in any part thereof, and no citizen of Nigeria shall be expelled from Nigeria or refused entry thereby or exit there from.[15]

Another rights provided by the CFRN is freedom from all forms of discrimination. Sect. 42(1) states that a citizen of Nigeria shall not discriminated upon based on communities, ethnic groups, places of origin, sex, religion or political opinions.[16]

b) Right to survival and development: Sect. 4 of the CRA states that, "(E)very child has a right to survival and development." Therefore, there is no justification for anyone to deprive a child of this right simply because he is suffering from physical disability (e.g., autism, albinism, dwarfism, Post-Polio Residual Paralysis [PPRP] etc), and mental disorder (e,g., mongolism, cretinism etc.,). Any attempt to kill the child by "mercy killing" (*euthanasia*) amounts to a felonious criminal act of acceleration of death punishable with death as provided under Sect. 311 of the Criminal Code Act (CCA).[17]

c) Right to prompt referral: Where there is no adequate facility or where the patient needs specialized medical care that may not be available in the medial facility of first instance, Sect. 17(2) of the NHA provides that such child in needs of such treatment shall, as of duty, be referred promptly to a care centre with better facility.[18]

d) Right to emergency care - one of the rights of *al-Majirai* children is to be treated in the case of emergency regardless of whether there is money or not. In fact, in such emergency, like gunshot injury, treatment should be given regardless of whether money was paid or not as stipulated under Sect.3(1) of the Treatment and Care for Victims of Gunshot Act (TCVGA).[19]

In Sect. 20 (1) of the NHA, it was stated that 'health care provider, health worker or health facility, shall not refuse a person in need of emergency medical treatment for any reason. Where this right is contravened, Sect. 20(2) of the NHA provides that such contravention is a crime punishable upon conviction with a fine of ₦100, 000.00 or to imprisonment for a period not exceeding six months or both.

e) Right against indecent act – the law protect a Child undergoing medical care, just like any other Nigerian citizen, from being victimised in an indecent manner. Sect. 231(2) of the CCA provides that any person who 'wilfully does any indecent act in any place with intent to insult or offend any person; is guilty of a misdemeanour, and is liable to imprisonment for two years.'(Sect. 231(2).

f) Freedom from all forms of discrimination. Like an adult, a child undergoing medical treatment must not be subjected to any form of discrimination based on Sect. 10 (1) of CRA, which provides that "belonging to a particular

community or ethnic group or by reason of his place of origin, sex, religion or political opinion." In fact, Sect. 10(2) of CRA further adds that the child should not be "subjected to any disability or deprivation merely by reason of the circumstances of his birth."

Thus, while undergoing medical treatment, an autistic, Albino, or even HIV positive child must not be discriminated against by anyone. Even while the child is in isolation centre due to severe communicable diseases, the paramount rule is that all care that he needed must be in his best interest and in the protection of his health rights.

g) Right of reasonable care: the *al-Majirai* children are also entitled to enjoy this right under the Nigerian law. Thus, according to Sect. 303 of the CCA;

> whoever undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act; and he is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty.

h) Right to health and health services: The child is not only entitled to right to health and health services, but all these must be the best attainable in specific condition. Sect.13 (1) of the CRA, expect caregiver to package the care so that he/she can "enjoy the best attainable state of physical, mental and spiritual health."

Furthermore, Art. 14 (a) – (c) of the ACRWC , apart from providing that " right to enjoy the best attainable state of physical, mental and spiritual health," also requires all state parties to the Charter to "pursue the full implementation of this right and in particular shall take measures:

> (a) to reduce infant and child morality rate;
> (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
> (c) to ensure the provision of adequate nutrition and safe drinking water;"

i) Right to dignity of the child. The protection of the dignity of any individual is not based on age factor. A child, among other individuals, is universally recognised as a free person and entitled to be respected as such. Sect. 11(a) to (d) of the CRA outlines some protectable areas on the dignity of the citizen. These are:

> Every child is entitled to respect for the dignity of his person, and accordingly, no child shall be;
> (*a*) subjected to physical, mental or emotional injury, abuse, neglect or maltreatment, including sexual abuse;
> (*b*) subjected to torture, inhuman or degrading treatment or punishment;
> (*c*) subjected to attacks upon his honour or reputation; or
> (d) held in slavery or servitude, while in the care of a parent, legal guardian or school authority or any other person or authority having the care of the child.

j) Right to the best attainable state of physical and mental health - Art.16 (1) of the African Charter of Human and People's Rights (ACHPR)[20] provides for every child the right to enjoy the best attainable state of physical and mental health. Interestingly, Nigeria not only adopt and ratify it, but has gone further to domesticate the Charter through the enactment of the African Charter of Human and People's Rights (Ratification and Enforcement) Act.[21]

In Art. 16(2) of ACHPR any state who is a party to the Charter, is under obligation to provide necessary measures 'to protect the health of their people and to ensure that they receive medical attention when they are sick.' The Court, while interpreting this article in the case of *Odafe and Ors. v. Attorney-General and ors*,[22] explains this point clearly as follows;

> Article 16 of African Charter Cap 10 which is part of our law recognizes that fact and has so enshrined that '[e]very individual shall have the right to enjoy the best attainable state of physical and mental health'.

Article 16(2) places a duty on the state to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Problems of enforcing the health rights of *al-Majirai* children in Nigeria

With all the provisions for various health rights of the child, one would expect that these rights are enjoyed by those they were meant for. On the contrary, there were many problems impeding their enforcement and enjoyment. Some of these problems are discussed in the following lines under three sub-headings. These are:

a) Weak family system – Black, while trying to define family described it as a "collective body of persons who form one household under one head and one domestic government and who have reciprocal natural and moral duties to support and care for one another."[23] Therefore, where such 'reciprocal natural and moral duties' were absent or lacking, such family is referred to as been weak or dysfunctional.

One of the weaknesses is the sending of underage children to study miles away without adequate healthcare provisions. In a study by Khalid, it was found that about 83.49% of the *al-Majirai* children are between the ages of 5 -15 years, out of which 33.33% are in the age category of 5-9 years.[24] This means that the child were two young to cater for themselves. Today, this is the reality before us, which some members of our Muslim *Ummah* try to explain away.

Another fact is, the children are learning under extreme condition, exposing them to psychological trauma. In another study conducted by Zakir et al on 300 *al-Majirai* children, the researchers revealed that: "99% of the participants interviewed gets daily food from begging on the streets, (90%) eat food twice a day with carbohydrates as common type of food they consume. This predisposes them to malnutrition and several types of disease due to lack of nutrients required to build and repair their body system. This shows 50% of the participants suffer from illnesses such as typhoid fever, malaria, skin rashes, cholera and most of them are treated in a chemist, because they cannot afford hospital treatment. So they can only go to a chemist and receive treatment without an accurate diagnosis and wrong treatment may be given while some cannot even afford chemist due to insufficient resources."[25]

Today, we have seen evidence of this systemic failure in reality where on many occasion the *al-Majirai* children is denied of health care because of lack of fund. The current author has worked as a bedside

nurse for over two and half decades in the hospital and has witnessed instances where child was brought to the health facility with grade six third degree bedsore/pressure ulcer (according to the European Pressure Ulcer Advisory Panel Grading system). On many occasions, some *al-Majirai* came with gas gangrene on one of the upper or lower limbs. In some of these situations, the father complained of lack of means or do not even appear at all.

There are separation between the parents and the *al-Majirai* children over a long period. In fact as Amzat writes, " for most people, *al-majiri* is not an enviable reference category in the social realm. It is not controversial to conclude that the *al-Majirai* children live in a deplorable condition. Neither is it controversial to submit that they form part of the under-class, which needs help of other people in order to live."[26]

Ordinarily, for a child to migrate inpursuit of Islamic knowledge is not also a problem. After all, many children of their ages are in boarding schools receiving good feeding, under comfortable accommodation and receiving good health care. It hence, becomes a problem, where, parents absolve themselves the responsibility of providing adequate health care.

Therefore, the *al-Majirai* children deprived of parental care cannot access health care service. One of the cause of this neglect was attributed to the prevailing view among some parents attributing the provision of free medical care as the responsibility of the government or duty of the Muslim *Ummah*. It thus means that whoever fail to help their *al-Majirai* children has not done well. Unfortunately, such mentalities was shared by most of the grown up *al-Majirai* children, this author has had discussion with some years back. A study comprising of 150 *al- Majirai* participants in Borno states was carried out, by, Chukwu, Haruna and Fiase, on the question of whether the Almajiri feel neglected by the society. They found out that out of the 150 participants, 103 (69%) felt neglected while 47 (31%) do not felt neglected.[27]

b) Ineffective public policy – Nigeria, by the WHO standard, was expected to allocate minimum of 15% of its national budget for effective health care delivery in the country. It is however on record that from the past ten years, the range was between 5-8%. Although, Nigeria is a signatory to many regional Charters and

international Convention on the need to improve the healthcare of its citizens, the healthcare service is grossly inadequate.

For instance, Sect.13 (1) of the CRA and Art. 14 (a) – (c) of the ACRWC at the national and regional level respectively, made provisions for child to "enjoy the best attainable state of physical, mental and spiritual health." The result was abysmal as such, the vision remains a mirage.

During the outbreak of the COVID-19 pandemic all over the world, Nigerians were embarrassed to hear that many Intensive Care Units in Nigeria lack ventilator for resuscitating dying patient.

This ineffective policy of the Nigerian Administration becomes glaring in basic care support. In fact, the Federal Government, in order to implement the Basic Minimum Package of Health Services (BMPHS) provided by Sect.11(1) of NHA, set aside only 1% of its consolidated Revenue Fund, grants by international donor partners; and funds from any other source (Sect.11(3) of the NHA). Besides all this, Sect. 20 of NHA) provides penalty for failure to treat emergency patient but because of the ineffective public policy, the same legislatures that passed the law failed to indicate how such hospital or clinic that give the emergency treatment, may be reimbursed. All these inconsistency hinder the proper implementation of the health rights of the child.

c) Maladministration of health care system at all levels of Government – Another problem impeding the effective healthcare system is lack of priority for health care system at all level of administration. In most instances, healthcare facilities lack equipment to work with couple with shortage of medical staff. Ambulance services are either not available or too inadequate to provide prompt service in emergency cases.

In a study conducted by Ogbonna[28] on sectorial expenditure for selected sectors, the allocation to health has always been low with 6.24%, 4.64%, and 6.0% in 2015, 2016 and 2017 respectively. While discussing this statistics, the researcher states as follows:: Since 2016, government reform programmes in the northern part of Nigeria has targeted rehabilitating, feeding and educating the Almajiris who are usually exploited by criminals for social and criminal vices. A sum of N575million ($1.1million) was released to feed schoolchildren in five states in January 2017. However, this is grossly inadequate considering the population

involved and sustainability is largely a problem to grapple with. In government hospitals, welfare services are comatose. Occasionally, hospitals use selected criteria to pay for patients who have been discharged and cannot pay for their bills. This is only available to less than 5% of the people.

Charting a new discourse

Based on all the analysis made so far, it becomes imperative that for *al-Majirai* children to enjoy their health rights as human beings, both the individuals and the Muslim *Ummah* have to embark upon a new discourse, a paradigm shift that would insist parents of the al-*Majirai* children must be made to provide the healthcare of their wards as expected. Over the years, some parents try to shift their responsibility to the *Ummah* or the government by claiming to be incapable financially. In fact, many *al-Majirai* children have to be taken away from the hospital in a critical condition after signing Leave Against Medical Advice (LAMA). This is unacceptable and it is such situation we must discouraged - especially with the level of global economic downturn.

It is true a child can be in al-*Majiri* , *Tsangaya* or *Islamiyyah* schools and study with comfort under good atmosphere as done in other Muslim countries. Where the parents still think he can apply the same form of al-*Majiri* system of the past to solve todays' social problem, calls for rethink. Parents should stop day dreaming of the past; the past characterised by era of pyramid of groundnut in the North, abundance food and cash crops that allow farmers to provide *al-Majirai* children with free food to eat to their satisfaction etc., without hesitation has gone.

Today, the reality is that parent must be responsible for the healthcare of their children , otherwise the children would grow up to constitute a recruiting ground for insurgence, banditry, and kidnapping as documented in many research studies. [29] In a study conducted by Sarkingobir et al (using a structured questionnaire applied on 120 *al-Majirai* respondents in Sokoto metropolis), the result of the study shows that they were Muslims, Hausa/ Fulani, males and Nigerians. The major occupations of their fathers were farming (66.7%), business (16.7%), and those without any job (16.7%). Thirty three point three percent of the fathers were married to two wives; 25.0% married to three wives; 16.7% married to one wife each, and 16.7% married to four wives.

The researchers while discussing the outcome of the field work state the following findings: "American Psychological Association (n.d.) said the children with food problems experience psychological effects. From these findings, it can be seen that, *Almajiri* children failed to come with enough food or money to sustain them throughout their stay at school. Moreover, this determined that, the main food of the *Almajiri* children is the carbohydrate, which they got in an uncertain, unacceptable and socially problematic way. Remnants, lowly, and unchosen food is served to the pupils." 30

In order to prevent this, there may be need for our legislature to pass law to compel parents that have the means, but refused to spend it on their children waiting for the government to provide and protect the rights of their *al-Majirai* children. The situation deteriorate to this extent because, for some times, some of these parents slept comfortably at home, eat regular diets, but send away their children to study under humiliating environments, were not made to pay for the neglect. Such parents want the society to take pity on their children but they themselves lacks such pity. It is these kind of parents who must be stopped. "We are shepherds," so says the Prophet (SAW), and "we shall be asked on how we shepherd our flocks."

Conclusion

From the foregoing, it has been able to show that the health rights of *al-Majirai children* are provided for under the Nigerian law . These rights are not only provided for but are enforceable. Today, the *al-Majirai* children have become victims of the infringement of their health rights. On one part is the contribution of the parents to this violation as they failed woefully to secure rights of their children by trying to shift the responsibilities to the societies and the government. On the other hand is the failure of the Muslim *Ummah* and the government to ensure these rights are protected and applied to those that deserve them. Therefore, to prevent further infringement of these rights, every parent of these *al-Majirai* children must wake up to provide the desired health care to their children, and where they are negligent, they must be compelled through law to perform their duties. Also, the Muslim *Ummah*, through pressure group, must not allow individuals who have failed to perform their responsibilities drag the country inside cesspool of insecurity. Through check and

balance, the health right of al-*Majirai* children would gradually be restored and stability would be maintained in all our home.

References

1. Child Rights Act, No.6, 2003 LFN 2004. It started as a draft Child's Rights Bill with the aim of enacting it into Law in the country. The Act incorporates United Nation's Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). The Bill was eventually passed into Law by the National Assembly in July 2003 and thereafter was assented to in September 2003, and promulgated as the Child's Rights Act 2003 by the regime of the former President, Chief Olusegun Obasanjo.
2. 1999 Constitution of Federal Republic of Nigeria (as amended), CAP C23, LFN 2004.
3. UN General Assembly Resolution 44/25. November 20,1989. http://www2.ohchr.org/ English/ law/ crc.htm. Accessed 14 November, 2009.
4. Magashi SB. Education and the Right to Development of the Child in Northern Nigeria : A Proposal for Reforming the Almajiri Institution, Africa Today 61(3), April 2015, 65-83, page 66
5. See the definition at http://www.publichealth.com accessed on 23 July 2021
6. Nchi S. The Nigerian Law Dictionary, Greenworld Publishing Company Limited, Jos, Plateau State of Nigeria, 2000, page 462
7. Shaw MN. International Law, 4th edition, Cambridge University Press, U.K., 1997; page 196
8. Hohfeld W.N. Fundamental Legal Conceptions As Applied In Judicial Reasoning, and Other Legal Essays, 2nd edition, (Yale: Yale University Press, 1920), page 36.
9. Sadiq AA. and Aliyu NA. Medical Negligence and Violation of the Rights of Patients under the Nigerian Law, Unimaid Journal of Public Law, Vol. 6 Issue 1, 2019, page 135-148, page 138.
10. Cap C!) Laws of Lagos State.
11. Formerly Children and Young Persons Ordinance, 1943, and later becomes an Act, Cap 485 Laws of the Federation of Nigeria (LFN) 1990 (Abuja), now Cap 22, LFN, 2004.
12. African Charter on the Rights and Welfare of the Child , 1989 was adopted by the 26th ordinary session of the Assembly of the heads of States and Government of the OAU, Addis Ababa , Ethiopia, July 1990. Nigeria later ratified it in the year 2000 and so bound by its provisions.
13. AjaNwachuku M.A. The Nigerian Child and the Right to Participation: A Peep through the Window of "The Best Interest" Clause of the Child's Rights Act. Beijing Law Review, 2017; 8, page 161; Abdulraheem-Mustapha M.A 'Child justice administration in the Nigerian Child Rights Act: Lessons from South Africa' (2016) 16 African Human Rights Law Journal, page 440; F.D. Nzarga, Impediments to the Domestication of Nigeria Child Rights Act by the States, Journal of Culture, Society and Development, Vol.19, 2016, page 48.
14. Bello v. A.G. Oyo State (1986) 5 NWLR (pt 42), p 828 SC; Musa v. State (1993) 2 NWLR (pt 277), p 550 CA; Ibe v. State (1993) 7 NWLR (pt 304), p 185 CA; Odogu v. A.G. Federation (1996) 6 NWLR (pt 456),p 508, SC; Okonkwo v. State (1998) 4 NWLR (pt 544), p 142 CA; Adeniji v. State (2000) 2 NWLR (pt645), p 354 CA.
15. Shugaba Darman v. Minister of Internal Affairs and Ors(1981) 2 NCLR, 459; Ubani v. Director S.S.S. (1999) 11 NWLR (pt 625), p 129 CA; Director S.S.S v. Agbakoba (1999) 3 NWLR (pt 595), p 314 SC; Eguanwense v. Maghizemwen (1993) 9 NWLR pt 315, p 1 SC; Ikem v. Nwogwugwu (1999) 13 NWLR pt 633, p 140, CA.
16. Commission of Racial Equality v. Dutton(1989) 2 WLR, 17, CA; Folami v. Cole (1990) 2 NWLR (pt 133), page 445, SC; Badejo v. Federal Ministry of Education (1996) 8 NWLR (pt 464), page 15,, SC;Mojekwu v, Mojekwu (1997) 7 NWLR (pt 512), page 283, CA; Salubi v. Nwariaku (1997) 9 NWLR (pt 505), page 442, CA; Muhammadu v. Muhammadu (2001) 6 NWLR (pt 708), page 104, CA;

Aderounmu v. Aderounmu (2003) 2 NWLR (pt 803), page 1, CA.
17. Criminal Code Act Cap 77 LFT, 1990 Act, Cap C38 LFN, 2004 Act.
18. The National Health Act No.8, LFN 2014, with official gazette vol. 101, No. 145, on 27th October 2014.
19. The treatment and care of victims of gunshot Act, Cap C735, LFN, 2009.
20. African Charter on Human and Peoples' Rights (Banjul Charter), 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), available at: http://www.achpr.org/english/_info/charter_en.html. last accessed 20 February 2014.
21. African Charter of Human and People's Rights (Ratification and Enforcement) Act, Cap 10 LFN 1990, Cap A9 LFN 2004. See also Ekhator, E. O. (2015). The Impact of the African Charter on Human and Peoples' Rights on Domestic Law: A Case Study of Nigeria. Commonwealth Law Bulletin, 41(2), 253-270.
22. AHRLR 205, NgHC 2004.
23. Black H.C., Black's Law Dictionary, Revised 4th edition, (Minnesota, 1968), page 72-79; See the American cases of Krug v. Mills, 159 Md. 670, 152 A. 493, 495; and Hartley v. Bohrer, 52 Idaho 72, 11 P.2d 616, 618.
24. Khalid S., .Nigeria's Educational Crisis: The Al-majiranci System and Muslim Realities., Islamic Culture Vol. Lxxxv(3): 85.103, 2001.
25. Zakir A., Abubakar U., Lawal U. S., Imrana H., Habibu I. T., Hassan I. H. and Harande M. M. The practice of Almajiri: Prospect and socio-medical challenges in Northern part of Nigeria, Journal of African Studies and Development, Vol. 6 (7), pp. 128-131, September 2014, page 130.
26. Lumpen AJ. Childhood in Nigeria: A Case of the Almajirai in Northern Nigeria, Hemispheres, No. 23°, 2008, pg 56.
27. Emmanuel O., Haruna CH., and Fiase TM. An Assessment of the Psychosocial Effects of Almajiri system on Child's Development in Gwange Ward Maiduguri, Borno State, Nigeria, Texila International Journal of Public Health, Vol.4, Issue 4, Dec 2016, page 9.
28. Ogbonna BO. Social welfare scheme; a neglected component of public health care services in Nigeria, MOJ Public Health, Vol. 5 Issue 3 – 2017, 101-104, page 102-103
29. Abubakar‐Abdullateef A., Adedokun B. and Omigbodun O. A. Comparative study of the prevalence and correlates of psychiatric disorders in Almajiris and public primary school pupils in Zaria, Northwest Nigeria, Child Adolesc Psychiatry Ment Health (2017) 11:29, page 1-12; Iro Aghedo and Surulola. James Eke, From Alms to Arms: The Almajiri Phenomenon and Internal Security in Northern Nigeria, The Korean Journal of Policy Studies, Vol. 28, No. 3 (2013), pp. 97-123; Asogwa Ikechukwu Sebastine & Asogwa Dominic Obeta, The Amajiri Schools and National Security: A Critical Analysis and Social Development Implication, Global Journal of Management and Business Research: B Economics and Commerce, Vol. 15 Issue 5 Version 1.0, 2015, page 1-5; Usman Abbo , Zawiyah Mohd Zain and Bashir A Njidda, The Almajiri System and Insurgency in the Northern Nigeria: A Reconstruction of the Existing Narratives for Policy Direction, International Journal Of Innovative Research & Development, Vol 6 Issue 8, August, 2017, page 346- 357.
30. Sarkingobir Y., Sahabi M., Saadu A., Bello MM., and Bakwai, MS., Assessment of Food Insecurity among Almajiri in Sokoto Metropolis and Selected Environs (Gwadabawa and Kware), Sokoto State, Nigeria, Journal of Applied Science and Environmental Management, Vol. 23 (9) 1625-1629 September 2019.

Impact of Islamic Spirituality on Psychosomatic Illnesses

[1]Bulus Y. M., [2]Abiola T.

[1]University of Maiduguri Teaching Hospital Hematology and Blood Transfusions Laboratories. Borno State; [2]Department of Medical Services, Federal Neuro-psychiatric Hospital, Kaduna. Kaduna State.

Corresponding author:

Bulus Y. M. University of Maiduguri Teaching Hospital Hematology and Blood Transfusions Laboratories. Borno State. Email:

yusufmustaphab@yahoo.com.

Abstract

Background: The quest for meaning and purpose has gained traction as a vital component of obtaining, preserving and sustaining optimal mental health and wellbeing. One of the most recent and interesting tradition and custom to have championed this is Islamic Spirituality. How does the Islamic Spirituality achieved this is the focus of this study, and especially in offering strong protective and therapeutic benefits against psychosomatic diseases.

Methods: The study explored the rich sources of Islamic theology, the belief system and the manner it conceptualizes and influence Islamic Spirituality to mitigate against psychosomatic diseases.

Results: The paper identified how believers conceptualized Islamic Spirituality, and utilized Islamic religious rituals like observing regularly 5 daily prayers, contemplative meditation, recommended supplications, giving charity, fasting, practicing forgiveness, Quranic recitations, etc. to directly mitigate and/or offer buffering against the pains of psychosomatic illnesses.

Conclusion: The reviewers concluded that Islamic Spirituality functions for believers as both a source of intangible and ritualistic behaviors that might reduce and/or cushion the sufferings from psychosomatic illnesses. Implications of these are discussed to help highlight the need for the proper understanding and application of Islamic Spirituality.

Key words: Islamic Spirituality, Religious Rituals, Psychosomatic Illnesses

Introduction

One of the most common mental health challenges among individuals seeking care in Primary Health Care setting in Nigeria is psychosomatic illnesses[1]. The psychosomatic illnesses appeared to have been first recognized in medieval Islamic world by Ahmed ibn Sahl al-Balkhi and Haly Abbas[2]. They described psychosomatic illnesses as a function of how the human mind (i.e. the psychospiritual entity) and body (i.e. physiology) influence one another. This in recent time is broadly referred to as the mind-body medicine.

Psychosomatic illnesses like migraine, asthma, chronic pain, hypertension etc. are theorized to be bodily manifestation of mental malfunctioning and/or the associated impoverished meaning[3]. In other words, psychosomatic illnesses are bodily manifestation of dysregulated homeostasis

from constant mental allostatic overload[4]. This understanding suggests that some factors, especially the psychospiritual stressors, could influence the intensity of psychosomatic illnesses' symptoms. For emphasis, psychospirituality has a major therapeutic value for dealing with the pains of psychosomatic symptoms.

Psychospiritual stressors are triggers of spiritual crisis as it relate to beliefs, values, meaning and most importantly life purpose and connectedness to supreme being[5]. It hence follows that distress from psycho-spiritual crisis is an important contributor to psychosomatosis. Therefore, it is worthy of note to study psychospirituality and its impact on psychosomatic illness. Specifically, this study examined the role of psychospirituality from an Islamic perspective, considering that available studies[3,5-8] and applied instrument of studying spirituality are from the Euro-American Christian world view.

Methodology

This study explored available data from the rich sources of Islamic theology, the Islamic belief system, the Islamic religious rituals and practices, and identified the manner Muslims conceptualize and utilize Islamic Spirituality to mitigate against psychosomatic symptoms and diseases. These rich sources were gotten from the two main reservoir of Islam (i.e. the Quran and Hadith) and other published materials available and relevant to the aim of this review.

Results/Discussion

The survey identified how believers conceptualized Islamic Spirituality, and utilized Islamic religious rituals like observing regularly 5 daily prayers, contemplative meditations, recommended supplications, giving charity, fasting, practicing forgiveness, Quranic recitations, etc. to directly mitigate and/or offer buffering against the pains of psychosomatic illnesses.

Conceptualizing Islamic Spirituality

The concept of spirituality in Islamic belief is likened to as having a "Sound Heart"[9]. This is by possessing a calm, confident and optimistic soul, the hope for God's mercy, and satisfaction with destiny as a divine ordain. A study identified Islam and spirituality has not two independent entities commonly proposed by the Euro-American philosophy. In Islam, both religion and spirituality are complementary of each other[10]. Hence, making Islamic belief as the zeal of understanding and practicing intentional enlightenment in reality and fulfilling life purposes extending to the ethereal. This empowers Islamic Spirituality

with the transcendental capacity to influence different dimensions of wellness and vitality. A unique aspect of Islamic Spirituality is to rely solely on Allah i.e. the sealing attachment to God. This help to further the understanding of Islamic Spirituality as "the presence of a relationship with Allah that affects the individual's self-worth, sense of meaning, and connectedness with others and nature[11,12]. It is this sublime relational quality that pushes every Muslim to be closer to Allah and in the process attain self-worth, personal actualization and transcendence. That is Islamic Spirituality help in the attainment of a balance among the physical, psychological and social aspects of the material and non-material life[13]. Such is the value of Islamic Spirituality that can help in preventing the onset of psychosomatosis and in reducing the related sufferings arising from psychosomatic illnesses.

Basics of Islamic Spirituality

The five pillars of Islam (shahada, Salat, Saumul Ramadhaan, Zakat, and Hajj) and the six articles of Faith (i.e. belief in existence and unicity of Allah, and in His Angels, Revealed Books, Messengers and the seal of them Muhammad [SAW], Day of Judgment and Divine Decree) set the minimum basic for having the right Islamic Spirituality. These basics rightly influence: 1) the spiritual principles of God consciousness in strengthening the willpower and self-control that predict positive thoughts, emotions and behaviors; 2) the spiritual preferences that influence rational reasoning, good decision and moral choice; 3) and the spiritual education that motivates the acceptance and adaptation to inevitable challenges, constant changes and unavoidable predestinations in life.

Some Features of Islamic Spirituality

Islamic spirituality comprise belief, faith, values and practices in cascades of intellectual and transcendental experiences that often manifest as: 1) sublime connectedness with Allah and His creations; 2) becoming on to God (i.e. breathed in spirit of God) in growth, meaning, development, values and purpose; 3) expressing ones soulfulness as the peaked dimension of moral principles; 4) harmonizing the will of the soul to the Will of Allah; 5) living beyond the existential and in the essential; 6) attaining the state of conviction, hope and trust in Allah that bequeaths inner peace and ultimately well-being i.e. ability to regulate psycho-emotors related to psychosomatosis and/or trigger the psychophysiological process related to synthesis of stem cells, cellular repair, healing, restoration and sustenance of normal body functions.

Contextualizing Islamic Spirituality to Psychosomatosis

Contextually, Islamic Spirituality is a peacefulness of the mind in positively beneficial belief, thinking and emotions as employed in our day to day encounters. It encompasses the easiness of the mind-body in positive attitudes, behaviors and lifestyles through submission to the "Wills" of Allah (SWT) and adoption/adaptation to the "Models" of Prophet Muhammad (PBUH). Practicing the principles of Islamic Spirituality in: performing obligatory and supererogatory acts of worship; granting the rights of self, family, relations, neighbors and the needy; avoiding resentments of envy, anger, and jealousy; practicing forgiveness; praising and contemplating about God; and expressing gratitude etc. provided context for living Islamic Spirituality. Figuratively, the seat of Islamic Spirituality in the mind-body context has been traditionally referred to as the "heart". This is excellently illustrated in the ending sentence of the following hadith:

> *Beware! There is a piece of flesh in the body if it becomes good (coherent) the whole body becomes good (ease/healthy) but if it gets spoilt (incoherent) the whole body gets spoilt (diseased/unhealthy) and that is the heart.*[14]

The above hadith seem very relevant to psychosomatic illnesses using the analogy of the "intelligent heart" and its function in health and illness. This appear to have been broaden in the strict sense of illness by the scientific maxim of the 4th Caliph Ali ibn Abu Talib (ra) that:

> *The disease of the heart (psychosomatic disease) is worse than the disease of the body (somatic)*

Such is the richness of Islam that contextualizes wellbeing as a value of Islamic Spirituality. This is because Islamic Spirituality provides coherency of the mind, a universal mindset ingredient in preventing, buffering and/or limiting the misfortunes of diseases, especially that arising from psychosomatosis. How Islamic rituals and practices (like Faith, five daily prayers, praying for healing, listening to Qur'anic recitation, meditation (Zikr), alms-giving, practicing forgiving, fasting and remote and touching intercessory prayers) help in achieving the value of Islamic Spirituality as health promotive will be further discussed.

Impact of Faith on Health

The benefits of living faith according to the basics of Islamic Spirituality confers as feedback spiritual health, wisdom, chastity, justice, kindness, and sincerity. Faith

promotes both remembrance and attachment to Allah that caution against adopting and living unhealthy lifestyle, risky behaviors, and destructive excitements, while eliminating fear, anxiety, sadness and disappointment in individuals with psychosomatic illnesses[9]. This is the theme of the following verses from the Glorious Quran (i.e. 16:97; and 58:22)[15]:

> *Whoever works righteousness, man or woman, and has faith verily, to him (or her) will we give a new life (change in life) a life that is good (happier) and pure (wholeness) and we will bestow on such their reward according to the best of their actions (behaviors).* (Qur'an 16.97)

> *…It is they (those who lived a spiritual life) in whose hearts Allah has inscribed faith and has strengthened (healed, protected and motivated) them with a spirit of His own…* (Qur'an 58:22)

Several studies have demonstrated the theme of the verses above as the positive impact of Islamic Spirituality on physical health, mental health, subjective well-being, health-related quality of life, coping skills, recovering from physical and mental illness, and less addictive and suicidal behaviors[16-20].

Impact of Five Daily Prayers on Health

Salat as practiced at least in the five daily prayers offer unique postures and routine exercises in that promotes physical fitness associated with improved muscle flexibility, strength and endurance[21]. Also, the peri-salat activities like ablution (which promote hygiene), distance walked to meet up with congregational prayers (that offers exercise, intra-salat recitations, listening and heeding to the rhythm and meanings of the Glorious Qur'an) and after-salat azkars, all resonating the heart to the state of God-consciousness, self-control and self-restraint. In other words, all the peri-salat activities, compliment the salat to confer some prevention against psychosomatosis and/or relief to the suffering emanating from the psychososmatic diseases. Thus, the five daily prayers is primarily worship that also confers protectiveness against loneliness, sedentary lifestyle, and other life stressors[22]. It also buffers against worries, fears and distress, thereby bring a sense of peacefulness[23] characteristics of the Islamic Spirituality. All these have been re-emphasized several years ago in the Glorious Quran (i.e. 29:45)[15] and in the Hadith of Nobel Prophet Muhammad SAW (e.g. in Sahih Muslim 668)[24] as follows:

> *…For (five daily) prayer restraint from shameful and unjust deeds*

> *(health risk behaviors); and remembrance (meditation/zikr) of Allah is the greatest (stress coping strategy) without doubt. And Allah knows the deeds that you do.* (Qur'an 29: 45)[15]

> *The similitude of five daily prayers is like an overflowing river passing by the gate of one of you in which he washes (detox) five times a day. Hassan said: No filthiness (negativities) can remain on him.* (Muslim 668)[24]

Impact of Dua (i.e. invocation and supplication) for Healing on Health

Dua is a prayer to invoke or supplicate for help from Allah (SWT). This act of worship is universal and in specific needs, like request to ease the suffering of psychosomatic illness or contemplate on the process, intercessory prayers are invoked. In Islam all prayers entail the following: the art and act of supplication as modeled by the ideal man, Prophet Muhammad (SAW) (see the Hadith collected by Sahih Muslim below)[24].

> *Place your hand at the place where you feel pain in your body and say: (pray) Bismillah (in the name of Allah) three times, and seven times: I seek refuge with Allah and with His Power from the evil that I find and that I fear. Muslim 1033.*

> *When the prophet (pbuh) visited any ailing member of his family, he would touch the sick person with his right hand and supplicate: O! Allah the Lord of mankind, remove this disease and cure him (or her)! You are the Great Curer. There is no cure but through You, which leaves behind no disease. –Bukhari and Muslim* (Riyad as-Salihin 902)

Using this model has been observed to help switch off the fight-or-flight response and turn on the rest-and-repair mode. This mode supercharge the immune system to incredible healing process, whether under stress or having actual illness or in trying to prevent illness or stress[25]. The divine basis to seek help from Allah has been well illustrated in the Glorious Quran (26:78-81; 12:92)[15].

> *"Who (Allah) created me and it is He Who guides me; "Who gives me food and drink; "And when I am ill it is He Who cures me; "Who will cause me to die and then to live (again).* (Qur'an 26.78-81)

> *Go with this my shirt, and cast it over the face of my father: he will come to see (clearly)* (Qur'an 12.92)

Impact of Listening to Qur'anic Recitation on Health

Studies have discovered that exposing the brain to certain wave sounds can affect it positively or negatively. The rhythmic recitation of the Holy Quran has a soundwave of positive frequency and wave length. These soundwaves resonates the brain positively and restore its balance[26]. Studies on cell culture suggests that Qur'anic recitation can be a healing medium within the context of sound healing technique. The positive effects of sound on biological and physiological processes that were depicted in various researches could be further studied[27]. These studies hereby affirm the message of the Glorious Quran about how to use it to seek healing (see 10:57 and 20:124)[15].

> *O mankind! there hath come to you a direction from your Lord and a healing (psychotherapy) for the (causes of psychosomatic diseases) in your hearts and for those who believe a Guidance and a Mercy.* (Qur'an 10:57)

> *But whoever turns away from my message, verily for him is a life narrowed down (distressed and depressed life), and we shall raise him up blind on the day of judgement.* (Qur'an 20:124)

Impact of Meditation (Zikr) on Health

Some studies have shown that 10 to 20 minutes of meditation twice a day moderated the following vital functions of the body: heart rate, respiratory rate, metabolism and brain waves. In the same vein, the meditative practices will also confer some benefits for the treatment of sufferings related to chronic pain, insomnia, anxiety, depression, premenstrual syndrome, infertility, stress-related irritable bowel syndrome, post-traumatic stress disorder, fibromyalgia, cancer or HIV[28,29]. A proposed mechanism was deduced from the reduction in inflammatory response to stress, a process vital to reducing psychosomatosis. All these have been recommended to the Muslims and all humanity since the dawn of Islam as the following verses of the Glorious Quran[15] show:

> *Those who believe, and whose heart found satisfaction in the remembrance of Allah: for without doubt in the remembrance (meditation) of Allah do hearts find satisfaction.* (Qur'an13.28)

> *Those who fear Allah, when a thought of evil (negative thought) from Satan assault them, brings (meditates) Allah to remembrance, when lo! they see (inspired with positive thoughts and ideas).* (Qur'an 7.201)

Impact of Alms-Giving on Health

Giving alms, a process of reaching out to help others with tangibles, stimulates brain's pleasure circuits that release positive emotion molecules such as endorphins (which gives a sense of euphoria), and oxytocin (that promotes to some extent tranquility and inner peace). Also, giving (in)tangible assistance has been proven to decrease blood pressure and reduce stress. The intention, art and act of alms-giving reducing stress, alleviates pains, promotes longer life and confers better health[30,31]. These recent understanding have been echoed far longer than now to the Muslims and humanity to emulate and practice for its spiritual, social, economic, health and wellbeing benefits[15,15,24].

> *Nor can Goodness (giving, forgiving, kindness, volunteerism) and Evil (niggardliness, resentments, wickedness) be equal. Repel Evil with what is better: then will he between whom and you was hatred become as it were your friend and intimate (in healthy relationship)!* (Qur'an 41.34)

> *Those who spend (give) their wealth for increase in self-purification.* (Qur'an 92.18)

> *The Messenger of Allah, upon whom be peace, said: … and a gift to strengthen the ties of relationship (socialization) increases one's life span (longevity).* (Figh-us-Sunnah Vol.3 No.97b)

Impact of Forgiving on Health

Chronic anger activates the fight-or-flight mode, which results to unhealthy changes in heart rate, blood pressure and immune system, an important pathway in psychosomatosis[3-5]. These changes, might increase the risk of infections, depression, cardiovascular disease, diabetes and other inflammations. The art and the practice of forgiveness, have been found to however, calms stress

levels, leading to improved health[32]. Hence, an intentional and purpose-driven disposition of forgiveness reduces negative affect, improve discerning sensibilities of spiritual growth, and in facilitate the identifying of a sense of meaning and purpose in life, as well as a greater sense of empowerment[14,15,24,33].

> *Those who spend, whether in prosperity, or in adversity; who*

restraint anger, and pardon (all) men, for Allah loves those who do good. (Qur'an 3:134)

…So overlook (any human faults) with gracious forgiveness (letting go) (Qur'an 15:85)

…let them forgive and overlook, do you not wish Allah should forgive you? For Allah is Oft-Forgiving, Most Merciful. (Qur'an 24:22)

The Impact of Seeking Forgiveness on Health

The following effects of seeking forgiveness on health are identified: peace of mind, reassurance, and joy (mental health); strong and healthy body free of diseases and disabilities (physical health); life free from disasters, accidents, Fitnah (trials) and afflictions (social health)[14,15,24,33,34].

Seek Forgiveness of your Lord and repent to Him, and He Will Let you enjoy a good provision (socioeconomic health). (Qur'an 11.3)

Ask Forgiveness of your Lord and then repent to Him. He will send [rain from] the sky upon you in showers and Increase you in strength [added] to your strength. (Qur'an 11.52)

Whatever misfortune (illness, disaster, accidents, failures, etc.) happens to you, is because on the things your hands (sins) have wrought, and for many (of them) He grants forgiveness. Qur'an 42.30;

But Allah would not punish them while you, [O Muhammad], are among them, and Allah would not punish them while they seek forgiveness, (Qur'an 8.33)

Impact of Fasting on Health

Fasting, a modern miracle of health promotion, but an integral aspect of Islamic worship and spirituality[14,15,25,37], regulates the following changes: drop in body insulin that facilitates increase in growth hormone (for fat burning, muscle gain, cellular repairs); facilitating detoxification in the body; enhancing gene expression related to longevity; and protection against disease[35]. In addition, fasting is associated with a wide array of potential health benefits, including: weight loss, improved blood sugar control, heart health, brain function and cancer prevention. Intermittent fasting helps promote weight loss and help in lowering the

risk factors related to heart disease and type 2 diabetes[36]. The followings are showing how, fasting serves as an anecdote for reducing food intake i.e. emptying the stomach, and by so doing promoting health that hinders psychosomatosis and relief the suffering of psychosomatic illnesses

> *Narrated Al-Miqdam ibn Ma'dikarib: Al-Miqdam heard Allah's Messenger (peace be upon him) say, "A human being has not filled any vessel which is worse than a belly. Enough for the son of Adam are some mouthfuls which can keep his back straight (body fitness): but if there is no escape he should fill it a third with food, a third with drink, and leave a third empty."* (Tirmidhi No.1355)[37]
>
> *"Do not overeat; that invites disease."* (Khalifa Umar (RA)

Conclusion/Recommendations

The review conceptualizes what Islamic Spirituality is and contextualizes how it is position as a main spiritual health boosting ingredient helpful in understanding psychosomatosis and in reducing the suffering from psychosomatic illnesses. The reviewers concluded that Islamic Spirituality functions for the believers as both a source of intangible and ritualistic behaviors that might reduce and/or cushion the sufferings from psychosomatic illnesses. To this end, the study recommended that: 1) Islamic Spirituality is vital to understanding psychosomatosis and in relieving pains of psychosomatic illnesses; 2) it very necessary to fill the spiritual vacuum of needs of patience with psychosomatic diseases, and all other diseases; 3) health practitioners and institutions need to incorporate Islamic Spirituality in medical curriculum and clinical practices; 4) there is a need to intensify health literacy for the health practitioners and the public on the scientific benefits of Islamic Spirituality both in health and illness; 5) more research needs to be carried out to provide further insights into the proper understanding and application of Islamic Spirituality as it relates to faith-based healings, especially on the value of the God's Spirit breathed into man.

References

1. Lasebikan VO, Ejidokun A, and Coker OA. Prevalence of mental disorders and profile of disablement among Primary Health Care service users in Lagos Island. Epidemiology Research International, 2012.
2. Nurdeen D. and Mansor AT. Mental health in Islamic medical tradition. The International Medical Journal, 2005, 4(2):76-79.
3. Gubb K. Psychosomatics today: a review of contemporary theory and practice. Psychoanalysis Review, 2013, 100(1):103-142.

4. Guidi J, Lucente M, Sonino N. and Fava GA. Allostatic load and its impact on health: a systematic review. Psychotherapy and Psychosomatics, 2021, 90:11-27.
5. Friedman WJ. Types of stress and their symptoms. On: https://www.mentalhelp.net/blogs/types-of-stress-and-their-symptoms/. (Accessed on 15-08-2021)
6. Irmis F. Spirituality and ethics in psychosomatic medicine. Cas Lek Cesk., 2015; 154(3):115-121.
7. Manshaee G. and Amini K. The relationship between spirituality with emphasis on religious orientation and psychosomatic disorders (asthma, migraine and blood pressure). Procedia – Social and Behavioral Sciences, 2013; 84:1260-1264.
8. Nakao M. and Ohara C. the perspective of psychosomatic medicine on the effect of religion on the mind-body relationship in Japan. Journal of Religion and Health, 2014; 53:46-55.
9. Asadzandi M. Effect of spiritual health (Sound Heart) on the other dimensions of health at different levels of prevention. Clinical Journal of Nursing Care and Practice, 2018.
10. Dover H. The varieties of religious therapy: Islam. On: https://www.psychologytoday.com/us/blog/in-therapy/201109/the-varieties-religious-therapy-islam. (Accessed on 15-08-2021)
11. Nasr SH. Islamic spirituality: foundations. Crossroad Publishing Company, New York, 1997.
12. Bonab BG, Miner M. and Proctor M-T. attachment to God in Islamic Spirituality. Journal of Muslim Mental Health, 2013; 7(2):77-104.
13. Ghaderi A, Tabatabaei SM, Nedjat S, Javadi M. and Larijani B. Explanatory definition of the concept of spiritual health: a qualitative study in Iran**.** J Med Ethics Hist Med. 2018; 11:3.
14. Bukhari MI. Sahih al-Bukhari. Karachi: Muhammad Sarid, 1966.
15. Ali AY and Abdullahi YA. The Meaning of the Holy Qur'an. Beltsville, Md, Amana Publication, 2001.
16. Unterrainer HF., Lewis AJ. and Fink A. Religious/spiritual well-being, personality and mental health: a review of results and conceptual issues. J. Relig. Health 2014, 53, 382–392.
17. Bozek A., Nowak PF., Blukacz M. The relationship between spirituality , health-related behavior and psychological well-being. Frontiers in Psychology, 2020.
18. Kharitonov SA. Religious and spiritual biomarkers in both health and disease. Religion 2012, 3, 467–497.
19. Miller WR. and Thoresen CE. Spirituality, religion, and health: an emerging research field. Am. Psychol. 2003, 58, 24–35.
20. Mueller PS., Plevak DJ. and Rummans TA. Religious involvement, spirituality, and medicine: implications for clinical practice. Mayo Clin. Proc. 2001, 76, 1225–1235.
21. Kamran G. Physical benefits of (Salah) prayer - Strengthen the faith & fitness. J Nov Physiother Rehabil. 2018; 2: 043-053.
22. Watts F. Prayer and psychology. In F. Watts (Ed.), Perspective on prayer. Chippenham: Rowe, 2001;39–52.
23. Hamdan A. (2010). A comprehensive contemplative approach from the Islamic Tradition. In T. Plante (Ed.), Contemplative practices in action: Spirituality, meditation, and health. Santa Barbara: Praeger, 2010;122–142.
24. Muslim al-H. Sahih Muslim: trans. Abd-al-Hamid S. Ontario: Kitan Bhavan, 2000.
25. Andrade C, and Radhakrishnan R. Prayer and healing: a medical and scientific perspective on randomized controlled trials. Indian Journal of Psychiatry, 2009; 51(4):247-253.
26. Abduldaem Al-Kaheel, A. (2020). Healing by listening to Quran, http://kaheel7.com/eng/index.php/secrets-of-quran-a-sunnah/238-healing-by-listening-to-quran
27. Hashim, R., Sha'ban, M., Zainuddin, Z. I. (2017). Healing with Sound: Exploring Possible Applications of Qur'anic Recitation in Cell Culture. Revelation and Science Vol. 07, No. 01 (1438H/2017) 32-41
28. Jawaid H. (2014). Impact of Religion/Spirituality on Health: What are the Evidences? Journal of Psychiatry, Jawaid, J Psychiatry (2014), 17:6 DOI:10.4172/2378-5756.1000164
29. Thorpe M. and Link R. 12 Science-Based Benefits of Meditation. 2020. On: https://www.healthline.com/nutrition/12-benefits-of-meditation. (Accessed on 15-08-2021)
30. Stafford K. 4 Health Benefits of Giving to Others. 2016. On: https://www.conehealth.com/services/behavi

oral-health/4-health-benefits-of-giving-to-others-/. (Accessed on 15-08-2021)
31. Marsh, J. and Suttie, J. 5 Ways Giving Is Good for You. 2010. On: https://www://greatergood.berkeley.edu/article/item/5_ways_giving_is_good_for_you. (Accessed on 15-08-2021)
32. John Hopkins Medicine. Forgiveness: Your Health Depends on it. 2021. On: https://www.hopkinsmedicine.org/health/wellness-and-prevention/forgiveness-your-healthdepends-on-it. (Accessed on15-08-2021)
33. Akhtar S, Dolan A, Barlow J. Understanding the Relationship Between State Forgiveness and Psychological Wellbeing: A Qualitative Study. J Relig Health, 2017; 56(2):450–463. doi:10.1007/s10943-016-0188-9
34. Islamweb. Benefits of Seeking Forgiveness. 2016. On: https://www.islamweb.net/en/article/166349/benefits-of-seeking-forgiveness. (Accessed on 15-08-2021)
35. Gunnars K. 10 Evidence-Based Health Benefits of Intermittent Fasting. 2016. On: https://www.healthline.com/nutrition/10-health-benefits-of-intermittentfasting#TOC_TITLE_HDR_2. (Accessed on 15-08-2021)
36. Link R. 8 Health Benefits of Fasting, Backed by Science. 2018. On: https://www.healthline.com/nutrition/alternate-day-fasting-guide. (Accessed on 15-08-2021)
37. Tirmidhi MI. Jami' al-Tirmidhi. Karachi: Karkhana Tijarat Kutab, 1990.

Conflict of interest: Nil

Assessment of teaching strategies used by lecturers at the College of Nursing and Midwifery, Yola, Adamawa State

Galadima, A.U.

Adamawa State College of Nursing and Midwifery Yola, Adamawa State

Corresponding author:

Galadima, A.U. Adamawa State College of Nursing and Midwifery Yola, Adamawa State.Email: galadimawa2002@gmail.com

Abstract

Background: The need for utilization of various teaching strategies by lecturers when facilitating learning cannot be overemphasized. Teaching strategy refers to methods used to help students learn the desired course contents and be able to develop achievable goals in the future. In other words, teaching techniques are teacher's activities in the class to involve students in the subject matter, and requires that students participate in learning activities, share equally with other learners, and react to the learning experience. This study assessed the teaching strategies of nurse educators in a College of Nursing and Midwifery.

Methods/Result: Data for the research was collected from both primary and secondary sources. The primary data was gathered with the consolidated questionnaire while the secondary data was collected through literature review. The instrument was administered to the participants within a period of two weeks. Descriptive statistics was used to summarize the data regarding the type of teaching strategies used. Two null hypotheses were set and tested using cumulative frequency. The data revealed that the teaching strategies mostly utilized were teacher-centered namely, Lectures 18 (60%) and Discussions 11 (36.6%). The majority of the respondents 16 (53.3%) were utilizing whiteboard as teaching aid at the expense of CD/discs and Video/DVDs.

Conclusion: Various teaching strategies have been used to facilitate learning in learners at the place of study. However, they were not utilized to the full extent. Teacher-centred teaching strategies have been found to be so commonly used by lecturers in our school. If the lecture teaching strategy is combined with other teaching strategies, the outcome might yield more effective learning among nursing students.

Key words: Teaching strategies; Lecturers; students; Teacher-centred teaching

Introduction

The need for utilization of various teaching strategies by lecturers when facilitating learning cannot be overemphasized. Teaching strategies are methodologic teaching techniques described as teacher's activities in the class, to involve students in the subject matter, and requires that students participate in learning activities, share equally with other learners, and react to the learning experience[1]. While engaged in the teaching activities, the recognition of individual differences in the learners is a basic concept for the teachers. This is hinged on the fundamental assumption of strategic teaching and learning, that what we choose to teach in the classroom, should be an interaction of what we know about, the variables of instruction, learning,

achievement, and contextual factors. This assumption has driven the strategic teaching quest as individuals and groups to develop an instructional framework[2].

Application of teaching strategies to nursing education is of dual purpose. That is what nurse tutors and nursing students do in the classroom is important for passing knowledge and also in readiness for patient's care. Hence, teaching activities for nurse tutors strive to provide real life experience and opportunities in the transfer of knowledge, which are adapted to practical clinical scenarios for students.

To justify the enormous activities in the classroom and clinical education in nursing, nurse tutors must have clear, realistic expectations of the desired outcome of both classroom and clinical learning process. This is because the effectiveness of classroom and clinical teaching should be judged by the extent to which it produces the standardized outcomes. This is only done if nurse tutors follow the teaching strategies that are student centred with all the teaching needs available. Such strategies in gaining and keeping students' attention, according to Yelon[3] is by: varying instructional procedures as in a lesson is to break up explanations with examples, demonstrations, practice, and feedback; varying program format across lessons like explaining the idea to students, making leaners to discover the concept from examples provided, facilitating students' discussion that will bring out the meaning of a subject/study, and sometimes run a simulation; making students work individually and/or in groups; utilizing varied techniques within a lecture for instance, using a series of short lectures followed by exercises, intersperse short readings or videos in the lecture; and by asking students to briefly discuss a point with a partner or write a reaction to an issue during a lecture.

There are numerous teaching strategies that suit the pedagogical learning but not all can yield the desired outcome and be properly applied by nurse tutors in both classroom and clinical area[4]. The Nursing and Midwifery Council of Nigeria (NMCN) shares the same view. In order for this goal to be achieved, the NMCN emphasize the integrating of theory with related practical demonstration and clinical experience. The council recommended interactional teaching methods to achieve the desired outcome and may include a combination of the followings: lecture, discussion, practical demonstration, clinical practice, group discussion, projects, clinical rounds, field trip, role play/skit, group work, patient/client care study, role modelling, tutorial, clinical conference,

problem solving technique, team teaching, electronic assisted techniques e.g. Video, Computer etc., seminar, and problem-based learning curriculum for general nursing education in Nigeria.

Objectives of the Study

The aim of the study was to establish if the lecturers at College of Nursing and Midwifery Yola were utilizing various teaching strategies prescribed by the Nursing and Midwifery Council of Nigeria to facilitate learning to ensure the personal development of nursing learners.

Methodology

A descriptive survey method was used to assess and describe the teaching strategies used by lecturers at the College of Nursing and Midwifery Yola (CONMY). The sample population in this study comprised all lecturers in the school. Data were collected through structured close ended questionnaires; the instrument was administered to the participants within a period of two weeks. The questionnaire which upon completion was retrieved by the researcher. Simple descriptive statistic (using frequency and percentage) in tabular form was employed to analyse data in this study.

Results

Table 1 shows that majority of the participants were above 29 years of age (96.7%), of male gender (53.3%), nursing lecturers (70%), teaching for more than 5 years (60%), and more than half belong to the department of Nursing and Midwifery (56.6%). As shown on Table 2, the most frequently used means of teaching students were lecturing (80%), practical demonstration (63.3%) and team teaching (46.7%). Table 3 reported the most widely used teaching aids were white board (96.7%) and models (40%).

Discussion

The findings of this study revealed that more men are now teaching in the College of Nursing and more nurses and midwives are now pursuing higher educational qualification unlike before. This might be related to the starting of Bachelor of Nursing Science (BNS) degree in Nigeria.

The use of teaching strategies that are teacher-centered (i.e. lecturing and practical demonstration) was reported by the majority of participants as their favourite teaching strategy. This response suggested that the participants preferred non-active learner participation and probably due to the large

Table 1: Socio-demographic characteristics of participants (N = 30)

Categories	Frequency	Percentages (%)
Age of participants (years)		
20 – 29	1	3.3
30 – 39	13	43.3
40 – 49	8	26.6
50 and above	8	26.6
Sex of participants		
Male	16	53.3
Female	14	46.6
Rank of participants		
Lecturer	21	70
Nurse/Midwife Educator	9	30
Clinical Instructor	0	0
Teaching experience of participants		
Less than 1 year	3	10
1 – 5 years	9	30
6 – 10 years	5	16.6
11 – 15 years	7	23.3
16 years and above	6	20
Department of participants		
Nursing	11	36.6
Midwifery	6	20
General Studies	5	16.6
Basic Science	8	26.6
Educational Level of participants		
Diploma	3	10
HND	1	3.3
Degree	17	56.6
Masters	9	30

number of students per class. This agrees with the findings of VanWyngaarden[5], which revealed that formal lectures were still very much utilized by nurse educators as a teaching strategy with 76% response. However, the rate in this study is still lower than in the South African study (60%). This difference might be related to different region of study and nature of study participants.

The use of learner-centred strategies frequently used in this study (i.e. team teaching = 40%; discussion and project = 36.6% each; seminar = 23.3%; group work = 20%) is lower than in a previous South African study by Maunye and colleagues[6], where majority of the participants (86%) preferred to give students formal/informal assignments and facilitate learner led class

Table 2: Types of teaching strategies used by participants (N = 30)

Variables	Frequency	Percentages (%)
Lecture		
Rarely-Sometimes Used	6	20
Frequently-Heavily Used	24	80
Discussion		
Rarely used	3	10
Rarely-Sometimes Used	13	43.3
Frequently-Heavily Used	17	56.6
Practical Demonstration		
Not Used	1	3.3
Rarely-Sometimes Used	10	33.2
Frequently-Heavily Used	19	63.3
Clinical Practice		
Not Used	6	20
Rarely-Sometimes Used	13	43.3
Frequently-Heavily Used	11	36.6
Group Discussion		
Not Used	4	13.3
Rarely-Sometimes Used	20	66.6
Frequently Used	6	20
Project		
Not Used	5	16.7
Rarely-Sometimes Used	9	30.0
Frequently-Heavily Used	16	53.3
Clinical Round		
Not Used	12	40.0
Rarely-Sometimes Used	10	33.3
Frequently-Heavily Used	8	26.7
Field Trip role/Skit		
Not Used	17	56.7
Rarely-Sometimes Used	10	33.3
Frequently-Heavily Used	3	10.0
Group Work		
Not Used	4	13.3
Rarely-Sometimes Used	19	63.3
Frequently-Heavily Used	7	23.3
Patient/Client Care Study		
Not Used	9	30.0
Rarely-Sometimes Used	7	23.3
Frequently-Heavily Used	14	46.7
Role Modelling Tutorial		
Not Used	4	13.3
Rarely-Sometimes Used	19	63.3
Frequently-Heavily Used	7	23.3

Table 2 continues:

Variables	Frequency	Percentages (%)
Clinical Conference		
Not Used	11	36.6
Rarely-Sometimes Used	15	50.0
Frequently-Heavily Used	4	13.3
Problem Solving Technique		
Not Used	4	13.3
Rarely-Sometimes Used	17	56.6
Frequently-Heavily Used	9	29.9
Team Teaching		
Not Used	5	16.7
Rarely-Sometimes Used	11	36.6
Frequently-Heavily Used	14	46.7
Electronic Assisted Technique		
Not Used	3	10
Rarely-Sometimes Used	18	60.0
Frequently-Heavily Used	9	30.0
Seminar		
Not Used	3	10
Rarely-Sometimes Used	19	63.3
Frequently-Heavily Used	8	26.7
Problem-Based Learning		
Not Used	5	16.7
Rarely-Sometimes Used	18	60.0
Frequently-Heavily Used	7	23.3

presentations. This is surprising considering more teachers in this study had postgraduate Masters degree (30%) when compared to the south African study (14%) carried out several years ago. This difference might be related to the older age of the South African study participants (71% are more than 45year-old) compared to the current study (53.2% are more than 39 year-old).

On using teaching aid during teaching-learning process, this research findings revealed that majority of the participants were using white board as teaching aid (96.7%), and occasionally used power-point presentation (26.6%). This is quite different from a previous south African study[5] where use of white board as a teaching aid was 47% and power-point presentations was 53%[5]. This reverse observation is quite surprising considering that this study being recent ought to have improved on prior research findings.

Some limitations of this studies include the omission of supportive resources (like library, simulation room, model room, and

Table 3: The extent of use of teaching aids by the participants (N = 30)

Variables	Frequency	Percentages (%)
White board		
Rarely used	1	3.3
Most of the time	13	43.3
All the time	16	53.3
Power point presentation		
Not at all	2	6.6
Rarely used	8	26.6
50% of the time	12	40
Most of the time	6	20
All the time	2	6.6
Model		
Not at all	3	10
Rarely used	7	23.3
50% of the time	8	26.6
Most of the time	9	30
All the time	3	10
Poster		
Not at all	7	23.3
Rarely used	13	43.3
50% of the time	4	13.3
Most of the time	5	16.6
All the time	1	3.3
Overhead projector		
Not at all	6	20
Rarely used	7	23.3
50% of the time	11	36.6
Most of the time	5	16.6
All the time	1	3.3
Training CD's/Disc		
Not at all	10	33.3
Rarely used	13	43.3
50% of the time	4	13.3
Most of the time	3	10
Videos/DVDs		
Not at all	11	36.6
Rarely used	14	46.6
50% of the time	2	6.6
Most of the time	3	10

one-way mirror ect.) that are available in the place of study and some variables that should enhance use of leaner-centred teaching (e.g. human resources, teachers-learners ratio, capacity building, and management support).

Conclusion

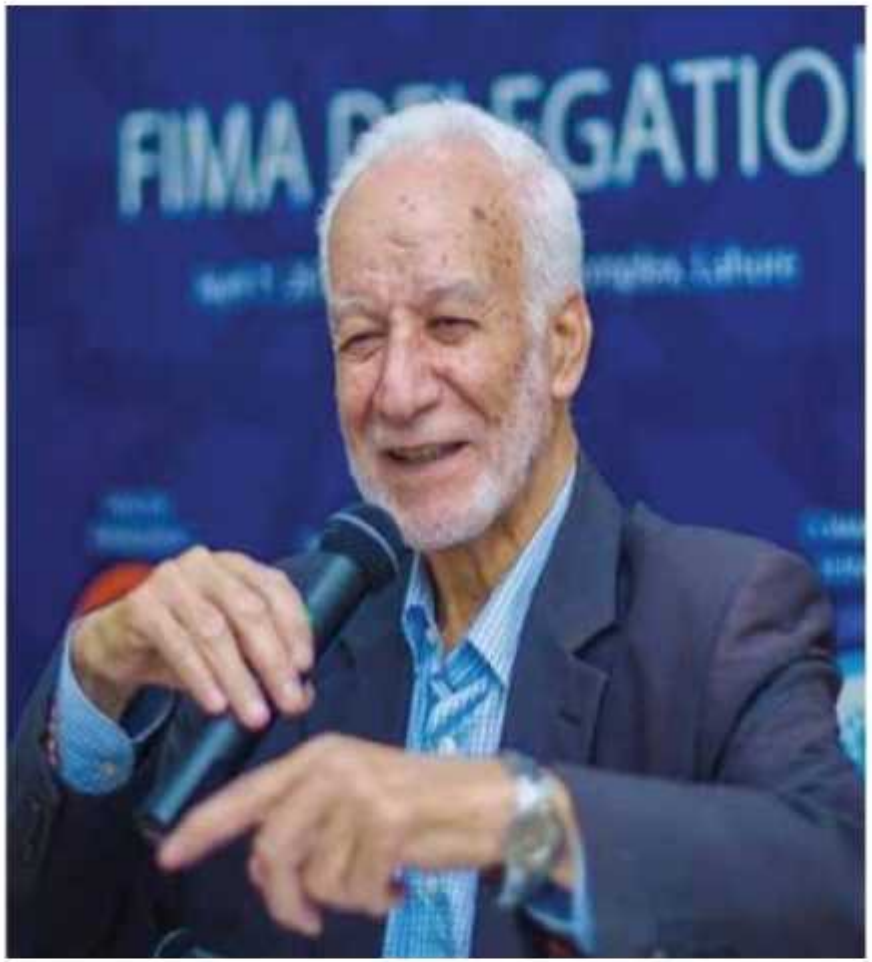
This study found that teachers-centred approach to teaching is the most common practice in the place of study. This were demonstrated by the use of white board makers and lecturing as the most widely used method of teaching. The study recommended that nursing education that should yield optimum outcome to meet the dual purpose of teaching could benefit by modifying its strategies towards learner-centred approaches.

Reference

1. Kassem, A. K. Teacher Perceptions of Agricultural Teaching Practices and Methods for Youth and Adults in Iowa. Doctoral dissertation, Iowa State University. Proquest Dissertations Publication, 1992. 9311501. Available at http://www.proquest.com/openview/03525783e52768da9851d4/1?pq-origsite=gscholar&cbl=18750&diss=y.
2. Jones, B. F., Palincsar, A. S.,Ogle, D. S., & Carr, E.G.. Strategic Teaching and Learning Cognitive Instruction in the Content Areas. Association for Supervision and Curriculum Development in cooperation with the North Central Regional Educational Laboratory 1987.: p. 5
3. Yelon, S. L. Powerful Principles of Instruction. Lancing. Human Resource Development Quarterly, 1996;8(2):190-192. Available at https://doi.org/10.1002/hrdq.3920080213
4. Mbirimtengerenji, N.D. and Adejumo, O. Utilization of Teaching Strategies among Nurse Tutors in Malawi Nursing College. Journal of Nursing, 2015;5:276-294. Available at http://dx.org/10.4236/ojn.2015.53031
5. VanWyngaarden, A. Teaching Strategies for Theory Content in an Outcome-and Problem-Based Nursing Education Programme. Unpublished project work, University of Pretoria. South Africa; 2008.
6. Maunye, T.J., Meyer, S.M. and Van Velden, C.E. An Assessment of Teaching Strategies Used by Lecturers at a Nursing College in Mpumalanga. Curationis; 2009; 32: 30-37.

Conflict of interest: Nil

ICON IN MEDICINE



PROF. DR. ALY MISHAL

1938 - 2018

NATIONALITY: JORDANIAN

FOUNDATION

Unrivaled stewardship of the Federation of Islamic Medical Associations (FIMA) from inception; Brainchild behind FIMA's charitable efforts and has earned the Linda Rosenthal Foundation Award 2009 from the American College of Physicians for seeing over 1.5 million outpatients in more than 600 eye camps across 20 countries; Together with his Jordanian friends, funded water treatment plant in Gaza and rolled out by Viva Palestine Malaysia in 2018.

PIONEERING IDEAS/ACTIVITIES:

Pioneer most of FIMA's medical and humanitarian relief programs (e.g. Save Vision); Flagship Islamic Hospital (IH) Amman Jordan as Model of Shariah Driven Hospital; Inspired the establishment of FIMA Islamic Hospital Consortium (IHC); Editor of the Islamic Perspectives of Medical Ethics of FIMA's Year Book (2002-2018); Provide editorial leadership to FIMA's International Journal of Human and Health Sciences; See to the operation of mobile clinics for Rohingyas in 2017 at the Cox's Bazaar refugee camps.

CALLING:

Service to his Creator, Medical Community and Humanity; Inspiration to the fraternity of physicians and allied health professionals in Islamic Medical Associations (IMA) in more than 50 countries.

POSITIONS:

FIMA's President 2001-2005; FIMA's Executive Director from 2005 till his demise in 2020; Chief of Medical Staff (1986-2009) of The Islamic Hospital (IH), Amman, Jordan; Chairman of IH Institutional Review Board (1987-2018).

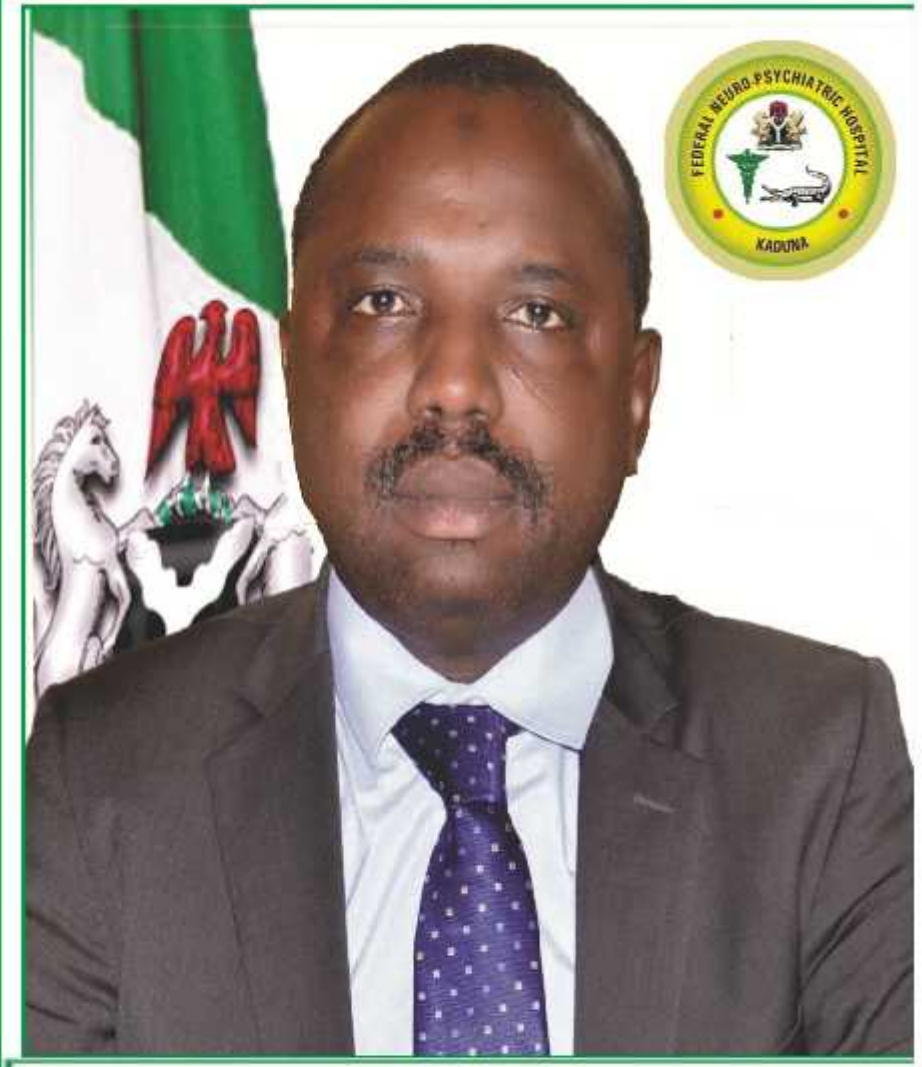
EDUCATION:

Postgraduate residency training in the University of Illinois Chicago (1971-1974); Board Certified in Internal Medicine (1976).

SPECIALITY:

Endocrinology and Metabolism.

ICON IN MEDICINE



LATE PROF. ABDULKAREEM JIKA YUSUF

MBBS, MD (ABU), FWACP FMCPsych.

1971 - 2021

PIONEERING IDEAS/ACTIVITIES

- ✓Old Age Psychiatry in Northern Nigeria
- ✓Community Mental Health Services for the Elderly in Zaria City, Nigeria
- ✓Research work in the field of Psychogeriatrics

CALLING:

Service to his Creator and Humanity

POSITIONS:

- ✓Medical Director Federal Neuropsychiatric Hospital, Barnawa, Kaduna State
- ✓Head of Department of Psychiatry Ahmadu Bello University Zaria, Kaduna State
- ✓Psychogeriatric Section of Association of Psychiatrist in Nigeria
- ✓Curriculum reviewer of Old Age Psychiatry/Psychogeriatrics for National Postgraduate Medical College of Nigeria
- ✓Member Faculty board of Studies ABU Zaria
- ✓Departmental Examination Officer ABU Zaria
- ✓Lifetime member Association of Resident Doctors
- ✓Honorary Consultant Psychiatrist ABUTH

EDUCATION:

- ✓Polytechnic Road Primary School Kaduna
- ✓Government Secondary School, Kurmin-Mashi, Kaduna State
- ✓Graduate: Ahmadu Bello University
- ✓Postgraduate : West African College of Physician
  : National Postgraduate Medical College of Nigeria
  : Doctor of Medicine (MD)

SPECIALTY:

Old Age Psychiatry (With Special Interest in Dementia)