Exploring alternative spaces of WASH behaviors among migrants in the UK

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Understanding Medical Geography in a Globalizing World

The notion of 'context' has been central to geographers' conceptualization of health and place in manners focusing on place determinants of health dynamics, behaviors and health related outcomes (Cummins et.al 2007, Jones and Moon 1993, Kearns 1993). 'Context' evokes two interrelated geographical constructs of 'space' and 'place.' The former evolves from its earlier roots as abstract phenomenon, expressed in distance and location, to become an important framework for discussing social relations within the perspective of the social theory context (Soja, 1985; Dear and Wolch 1989). 'Place', on the other hand is framed to incorporate human experience. According to Gesler (1991: 165), '…place is studied with an eye for its meaning for people; space is analyzed in terms of its quantifiable attributes and patterns... ' (cited in Kearns and Joseph 1993: 712). Extending the argument, Kearns and Joseph (1993: 712, citing Griffiths and Johnson 1991) argued that whereas people's lives are shaped and influenced by processes that occur over geometric space, it is in places that '…people become what they are.'

Cummins et.al (2007: 1828, citing authors such as Hudson 2004, Conradson 2005 and Murdoch 1998) discourses on the diverse perspectives of spaces have deepened insight on the relativity of spaces and places as constructed entities of social relations. Hudson (2004: 463) is quoted as arguing that '…spaces, flows and circuits are socially constructed, temporarily stabilized in time/space by the social glue of norms and rules, and both enable and constrain different forms of behaviors.' Relational theories observed that places are produced and sustained by the activities of 'actors', proximate or distal to a particular place, who operate individually or conjunctively across a wide range of spatial scales (Conradson 2005). Murdoch's distinction between 'spaces of prescription'

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(spaces produced through formalized and standardized control and organization of access to resources) and 'spaces of negotiation' (spaces reflecting relative fluidity in its human organizational character) reinforces the social and political power dynamics and complexities embedded in everyday practices in spatial human configurations and contestations.

Theoretical notions of spaces as arena of social and political struggles have further expanded geographers' curiosity to consider some hidden aspects of spaces produced through social, economic and political struggles and practices. Studies on the geographies of organized crime (Carter 1997, Evans et.al 1992, Fyfe 2001); informal economies (Daniels 2004, Samers 2005, Williams 2006); prostitution (Hubbard 1999); drug trade and money laundering (Rengert 1996, Allen 2005) have brought new scope and opportunities for discussing and exploring another dimension of activities which serve to create invisible spatial boundaries between the 'licit' and 'illicit.' 'Licit' and 'illicit' here are used in oppositional duality, and we conceptualize 'illicit' spaces as spaces characterized and dominated by activities which depend upon the ability to evade the gazes or surveillance of the State and relevant regulatory and enforcement authorities. Zook (2003) has argued that the question of regulatory practices or rather the evasion of regulation seem to constitute the key factors driving the spatialities of a host of liminal and illicit activities. Of course, illicit spaces would equally include those spaces where State sovereignty is absent, uncertain or contested (see studies by Aas 2007, Bhattacharyya 2005, Castells 2000, Hall 2012, Nordstrom 2007).

Everyday struggles for spatial order, control and domination between socio-political interests and forces occasionally culminate in oppositional spatial patterning and practices of contestations, resistance and conflicts (Raby 2005, Kamete 2010), which tend to lead to actions taken by a subordinate group against the mainstream. The modernist and post-modernist conceptualizations of these struggles have served to produce two fundamental perspectives for understanding the dynamics of power and resistance in a spatial context. The modernist perspective, for instance draws a neat binary between dominance and submission in the sense that power is wielded by the dominant group against the subordinate and powerless (Raby 2005), who in turn would put up some resistance and counter practices. Scott (1990, cited in Kamete 2010) posits that resistance against the dominant power could assume many forms including overt collective action; localized individual action, passive collective or individual action; and the appropriation of symbols of dominance and using them in new ways. Resistance can be latent or manifest expression of attitudes, behaviors and actions (Fernandes 1988). In the modernist perspective, there are clear sources of agency and targets of resistance to overcome spatial oppression, which may manifest in protest, defiance, revolution and other forms of violent struggles.

One important limitation of the modernist discourse has to do with its inability to capture some subtle and complex forms of oppositional practices and resistance against the hegemonic power base. This fundamental limitation is the crucial point of post-modern discourse. Foucault's (1998:93) discourse and conceptualization on power, not as possession, but as existing in 'power relationships' and being present 'everywhere' imply a presence of some forms of complexities of resistance within power. Foucault noted that

resistance remains an integral component of power relations which is also made possible by power. The post-modern perspective on power and resistance hardly locate the locus and source of resistance, since all who are involved in power relations can exercise power. Unlike the modernist perspective of power, the post-modern discourse locate multiple subjectivities or locations in power relations which cannot give room for organized oppositional practices as the case of revolution or direct frontal attack on the State hegemonic power structure or authority.

The post-modern thesis on power and resistance offer remarkable scope for understanding the alternative geographies of medical practices, for instance how 'illicit' or 'alternative' medical norms and spaces emerge. In our earlier paragraph, we have highlighted that geographers' interest in exploring the 'illicit' or 'alternative' spaces have spanned across areas as diverse as crime, prostitution, drugs, informal economies and money laundering practices. The aspect of the 'illicit' or 'alternative' spaces of medical practices appears non-existent within geographical literatures. It is even more troubling especially in an era of globalization where international migration seems to shape the dynamics of individual and public health care practices and policy interest. Medical geography stands to be more relevant in exploring how individual health histories and experiences are continuously being shaped and reproduced through the mediatory lenses of space and place contexts. Traditional medical geography have over the years been built around the notions of space and place as foundations, whose boundaries according to Gesler (1986: 963) involves: a) the description of spatial patterns of mortality and morbidity, factors associated with these patterns, diseases and diffusion and disease etiology; b) the spatial distribution, location, diffusion and regionalization of health care resources, access to and utilization of resources and factors related to resource distribution and use; and c) spatial aspects of the interactions between disease and health care delivery.

Part of our contribution in this paper is to attempt to enrich the discipline of medical geography by exploring how the context of international migration and the corresponding State practices have served to open up new spaces of alternative medical and health care practices, outside the licit medical norms of the State. Although the study leading to this paper focused on the broad aspect of medical and health care practices of migrants, this presentation intends to focus on the aspect of water, sanitation and hygiene (WASH) practices of individuals and groups within the context of transnational migration. We draw on the concepts of medical worldview, health belief and medical pluralism to capture the dynamics and interplay of power between relevant actors as encapsulated in the post-modern discourse on power relations. Using the Ibibio migrants in the UK, we discuss their everyday WASH practices and behaviors by comparing their Nigerian experiences with the UK perspectives. We also focus on the various subtle but oppositional tactics utilized in the production and reproduction of alternative medical and healing practices, which tend to escape the surveillance infrastructures of the UK State medical institutions and norms. To be able to achieve our goals, the next three sections will focus on addressing a range of theories and concepts as basic frameworks for highlighting and discussing our findings.

Discourses on Medical Pluralism

By medical pluralism, we mean the co-existence of different medical practices and forms of knowledge. In medical pluralism, the medical landscape depicts multiple medical practices ranging from biomedical, herbal therapies, religious and other forms of healing practices. Gil-Soo Han (2002) saw medical pluralism in two perspectives. The first meaning refers to the co-existence of various health care systems such as orthodox medicine, chiropractice, acupuncture, herbal medicine, osteopathy, bonesetting, and so on. Consumers have a right to choose from the pool of various types of therapies, each of which is unique in its own right. The second kind of meaning refers to pluralism within a particular system. For example, with orthodox medicine, a client has a choice to go to a private or public hospital or to a doctor practicing in a village, or a town, or a distant city, or overseas. This paper uses the first definition.

The medical system of any society largely evolve, and vary from society to society, in relation to a range of historical, ideological, environmental, social, political and institutional contexts. Core differences between medical systems are symbolized by the level of social and institutional legitimacy and support, organizational practices, diagnosis and treatment methods. In this discussion, we explore medical systems differences and relations from the theoretical perspective, and within the context of medical pluralism. Throughout our discussion, we may be using terms such as orthodox or biomedicine simultaneously to represent western or scientific medical system; and traditional or non-orthodox to represent the non-western, traditional, non-scientific or alternative medical system. We aim to demonstrate how the phenomenon of cultural struggle and hegemony in the medical system has produced and sustained an alternative medical space in the UK.

Medical systems relations mostly reflect the structural fabric of a society in terms of prevalent socio-economic, political, and ideological relations of production, which explains why Navarro (1983: 184) used terms such as primitive medicine, feudal medicine, capitalist medicine or communist medicine to describe medical system articulated under specific modes of production system. In relating the modern capitalist system to medical mode of production, Gil-Soo Han (2002: 11, citing Berliner 1982) argued that today's capitalist societies are composed of at least a few kinds of medical modes of production. Some of these are: a home mode of production, a petty commodity mode of production, and a monopoly-capitalist mode of production. A home mode of medical production exists for the purpose of healing family members only; a petty commodity of medical mode of production translates its medical skill (e.g., diagnosis, cure) into the form of a commodity and its sale becomes the means of livelihood for some individuals; while the monopoly-capitalist mode of medical production involves a) the private producers of a health commodity in a centralized and concentrated system and operating in a large-scale health care organizations with salaried health workers, and b) State-provided medical services which offer a range of treatments partly on a commodity basis, partly free and subsidized through taxation. By these categories, the complete dominance of one kind of medical mode of production over another could lead to the latter's disappearance for a certain period or forever. Citing Fankenberg (1980) and with Chinese medical system in Australia for example, Gil-Soo Han further argued that most

medical systems are embedded in a broader context marked by a mixture of modes of production and are constantly articulated under the influence of the dominant mode of production.

Applying the dialectics argument, medical pluralism depicts situations of constant struggles between diverse forms of medical systems, which will eventually lead to the emergence of the dominant and subordinate relations. The capitalist system of medical mode of production is associated with the western or scientific medical system. According to Unschuld (1975: 303):

> *The fact that western medicine gains an ever-increasing proportion of any culture's medical system is more due to coercive factors of various kinds than to natural development and demands from the population (303).*

He further argued that:

> *Medical systems represent a momentary stage in the continuous competition of various groups for medical resources. As any culture is engaged in a continuous competition of various groups for favorable allocation of all resources available, not only medical ones and as every culture has a different environment as a start-off point, this struggle for resources leads to different results everywhere, that is to different cultures. Whatever constitutes a culture is also the outcome of attempts of various groups to allocate available primary and secondary resources most favorably to themselves. Cultural norms, ideologies, beliefs, etc., are techniques designed for and employed in this struggle to ensure improvement, or simply maintenance, of a given stage reached by given groups (304).*

The notion of the cultural embeddedness of development and its deployment in western modern ideological and geopolitical thinking served to raise the 'superiority claims' of the western power as, according to DuBois (1991: 19), 'uniquely efficient colonizers on behalf of central strategies of power', and its potential for spatial power was reflected in its forceful tendency to 'subordinate, contain and assimilate the Third world as other' (Slater 1993: 421, see Peet and Hartwick 2009: 221). Drawing extensively from Escobar's (1995) thesis of a spatial field of power/knowledge expanding outward from the West using development as a capturing mechanism, Peet and Hartwick (2009: 224-225) described how networks of power within the field bind people into western forms of thought, behaviors, and practices and which by implication tends to deny peoples' capacities to model their own behaviors.

The modernist ideas of development which tend to bind all other models into one patterns of western trajectory leaves little space of possibilities for autonomous other forms of cultural and pluralistic practices. Modernist ideas often look at development

from a monolithic hegemonic perspective with less space for pluralistic practices. By this other 'non-modern tendencies and localities' tend to be portrayed as passive followers and recipients of modernist development pathways. This tends to foreclose the possibilities for the emergence of alternative forms of cultural practices. A growing wave of post-modernist and post-structural criticisms of modernist development practice, with a bias in favour of local autonomy, culture and knowledge, implies there are theoretical limitations and possible directions on it. This paper uses the settings of medical pluralisms to demonstrate how the tactics and strategies of the dominant western medical system are undermined and resisted by other less dominant medical system in the UK. The UK medical space is dominated by biomedicine and state organized care through the NHS. There are other complementary and alternative health care practices, which have been in existence since the 1970s (Cant and Sharma 1999). Kraus (2011) observed that Westerners trained in non-western methods patronize some of the complementary health care practices. There are a range of other alternative non-biomedical and non-western medical practices mostly applicable to migrants who import products and perform healing practices within religious settings (spiritual healings and exorcism), which are hardly visible in complementary medicine. The idea centers on the argument that the struggle between diverse medical systems may not end with the institutional, technological, ideological, and political dominance of one system over others. Subtle tactics of resistance of other autonomous medical systems generates the potential for the emergence of diverse forms of 'illicit' medical and healing practices. We use the case of how the various medical and healing tactics of the Ibibios living in the UK survive rigorous and hegemonic UK medical institutional surveillance.

Medical worldview and the Dynamics of Change

The medical attitudes and behaviors of individuals evolve in direct relation to the contextual environment and development histories, which have been acknowledged by some writers (Morales et.al 2009, Muhlhausler and Peace 2006, Robbins 2004). It is the result of the interplay of cognitive and ecological factors which produce some patterns of locally sanctioned and meaningful norms, beliefs, behaviors and practices which define and shape the evolving medical landscape of the individuals. Therefore, a contextual view of medical attitudes that incorporate environmental and individual cognitive elements will enable an understanding of how the environment, beliefs, values and attitudes intersect to produce knowledge about an individual's conceptions of reality. This is what Schlitz et al (2010: 19) termed as 'worldview', which denotes the combination of beliefs, assumptions, attitudes, values and ideas to form a comprehensive model of reality, especially on how processes and events are interpreted, framed and treated.

Worldview largely conjures up the image of power bound-up in beliefs, knowledge, ideas, values and institutions. By Bourdieu's concept of 'habitus' individual's behavior and interactional habits are controlled in two ways namely, a) as 'structuring structure' which basically focus on the creative capacity, a generating principle and modus operandi for concrete actions; and b) as 'structured structure', which focuses on individual's incorporated history and experiences as modus operatum. As Mielke et.al (2011: 9)) described, the structured structure can be empirically traced in

practices and views. On the other hand, the structuring structure analytically looks at aspects of detectable structures, mostly emphasizing on what generates regular practical actions and patterns of perception, evaluation and thinking in general. Both the 'structured structure' and 'structuring structure' share common characteristics of largely deriving their influences from the broad socio-cultural environment and contexts of individual's experiences and socialization. The structuring structure, by this discussion, is more dynamic and capable of constant reproduction and change depending on socio-ecological and related circumstances.

Bourdieu's idea of habitus was basically centred on individual persons, but Mielke et.al (2011) extended the logic to incorporate group or community experiences with shared socio-cultural affinities. Shared mental models, ideas, habits and frames are a product of accumulated experiences and practices which get sedimented in human consciousness and later transformed into memory. According to Berger and Luckmann (1966: 72-73), the final materialization of the sediment takes place through the means of language transforming the initial experience into an accessible object of knowledge that is finally incorporated into the pool of traditions (cited in Mielke et.al 2011: 11). This explanation seems to carry the assumption that the behaviors of members in a given community comes from a common pool of perceptional structures which constantly serves the means for the perception, typification and interpretations of reality. Probably drawing from this basis, Royce and Mos (1980) distinguished three broad categories of worldview: rationalism (reliance on logical reasoning in making sense of the world), metaphorism (reliance on symbolic meaning), and empiricism (reliance on the senses). Each of these three dimensions characteristically evolves and captures the relative experiences, knowledge and history of a specific society. Which is why Keerney (1984) sees it as a

> *culturally organized macro thought: those dynamically inter-related basic assumptions [i.e., presuppositions] of a people that determine much of their behavior and decision making, as well as organizing much of their body of symbolic creations…and ethno philosophy (p.1 cited in Cobern 1994:5).*

One function of worldview is to direct the use of various sources of knowledge in different situations, as elaborated by Elkana (1981):

> *The different sources of knowledge are themselves ordered hierarchically according to importance and priority. This ordering is, according to yet other images of knowledge [i.e., worldview presuppositions], one level removed from the contextual framework within which the ordering is done. There is nothing in science, or in religion for that matter, to convince us that the evidence of the senses carries greater or lesser weight as a source of knowledge that does revelation. It is our conceptual framework [i.e., worldview] with its images which tell us whether to give primacy to the senses,*

or to revelation, or to say that in matters scientific we trust the senses, while in matters religious we turn to revelation. (Elkana, 1981, p. 21, cited in Cobern 1994: 15)

Given its relatively widely shared norms among individuals and groups, worldview to a large extent is an embodiment of power actively sustained by some forms of social legitimacies. In asserting this point we draw some theoretical base from Foucault's discourse on 'truth, knowledge and power' which he argued do not detach itself from its practical empirical roots to become pure thought, subject only to the demands of reason in his emphasis as follows:

truth is not outside of power…each society has its own regime of truth, its general politics of truth…there is a combat for the truth, or at least around the truth, as long as we understand by the truth not those true things which are waiting to be discovered but rather the ensemble of rules according to which we distinguish the truth from the false, and attach special effects of power to 'the truth (Foucault 1980, cited in Peet and Hartwick, 2009: 206

We see worldview as a form of situated mental model of reality which embodies some elements of power and social legitimacies. The growing popularity and acceptance of a worldview rest on its social legitimacy. Here, Max Weber's three ways of incurring and sustaining social legitimacy is worth highlighting. According to Weber (1964), the three routes to obtaining legitimacy include: a) ability to obtain popular support and enthusiasm; b) ability to develop a charter, lore, or scientific theory; and c) the ability to organize corporate affairs and exact internal standards, either of a rational or ethical nature (see Janzen 1978: 127). Elaborating further on these routes, Janzen's discussions brought out some categories of terminologies which effectively explain the worldviews around medical systems. With some examples from Asian, African and western medical systems, the author emphasized the interplay of medical system's popular demands is actively sustained by some forms of legitimacies which range from traditional to rational-legal norms. The existence of different routes to perceiving illnesses, disease occurrence, diagnostic, preventive and therapeutic management within given communities largely derive from predominant views of what have been tested, experienced, experimented and validated over time. These processes therefore construct the space of understanding and operation and structure emerging behaviors.

These debates demonstrate that the whole process of 'worldview-behavior outcome' is complex and often non-linear in form and fundamentally runs counter to the reductionist and conventional principles in the biomedical research methods with its presupposition of a unidimensional notions of sickness causality (Koithan et.al 2012). The post enlightenment and post structural critiques of modern development, supported by some growing body of literatures in biomedicine, nursing, medical anthropology and public health (Anderson et.al 2005, West 2006) have highlighted enormous limitations involved in applying scientific rationality to complex and dynamical processes related to health and specific treatment systems. Foucault (cited in Peet and Hartwick 2009: 204)

described this tendency as coercive rather than liberating, a force focused on controlling the minds of individuals rather than opening them to many possibilities. According to Ivan Illich (1997: 95):

> *We have embodied our worldview in our institutions and are now their prisoners. Factories, news media, hospitals, governments and schools produce goods and services packaged to contain our view of the world. We-the rich-conceive of progress as the expansion of these establishments. We conceive of heightened mobility as luxury and safety packaged by General Motors or Boeing. We conceive of improving the general wellbeing as increasing the supply of doctors and hospitals, which package health along with protracted suffering. We have come to identify our need for further learning with demand for even longer confinement to classrooms. In other words, we have packaged education with custodial care, certification for jobs, and the right to vote, and wrapped them all together with indoctrination in the Christian, liberal or communist virtues.*

Worldviews are never static or fixed, they are subject to change over time, but at what points does the dynamism of a specific worldview manifest in forms of change or stability? As a unifying construct which defines basic perceptions and understandings of the world, worldview has the potential for change. Its dynamism is bound-up by the interplay of equally dynamic environmental, social, economic, cultural and institutional settings. In migration setting, we conceptualize worldview change of an individual as a process actively mediated by cross-cultural experiences whereby individual's initial unified sets of personal cognitive, historical, social, cultural, institutional and environmental experiences of realities at primary areas of socialization are brought in a direct and frequent encounter with completely different but opposite sets of experiences and societal norms. This sets the stage for struggles between two opposing worldviews. Drawing from some psychology and anthropology literatures, we argue that the potential for worldview change or transition at that points of encounter depends on individual's critical self-evaluation or reassessment of the effectiveness or otherwise of a specific worldview among the contending ones. Conceptualizing worldview as the locus of change, Fank and Fank (1991) argued that many people tend to enter counseling because some aspect of their worldview has not been functioning effectively. It is also important to clarify that the potential for worldview change also depends on the mediating factors of the wider social, economic and cultural environment. The contexts of institutional interventions through regulatory practices; and the wider influences posed by the prevailing socio-economic environments of the new domain also constitute important decision aids for an individual in managing a specific worldview. The change as we conceptualize here does not mean a linear progressive situation. Individual worldview may experience progressive change or maintain its earlier status, all depends on some contextual filters already listed.

The Context of Worldview, Health Belief and Health Risk Perception

Worldview concept has been very important in the human ecology literature especially when situations are to be explained relative to the contextual environment. Bertalanffy (1981) had observed that human nature has two sides. The physical or material side is the one in which each human being lives 'with a biological body, physically equipped with impulses, instincts and limitations on each species. The other side is broader. Here each person creates, uses, dominates and is dominated by a universe of symbols. This vision allows for an association between ecology and cultures. Ecology is usually associated with the physical or material world and this world is interrelated with human being, and therefore, culture. In this form of relationship, humans are seen as part of an ecosystem, and such unity of nature and culture contribute in producing meanings and values over time. The question now is how does the worldview concept advance understanding of the health belief model and vice versa within the context of medical practice?

The health belief came as a framework (developed by Psychologists) in the 1950s to enhance deeper understanding of health behavior (Rosenstock 1966, Murphy 2005, Glanz et.al 2008). Through the framework, health related behaviors of individuals were judged as reflecting a person's level of fear, based on level of threat perceived, and a person's expected fear-reduction potential of taking action. The health belief model places an individual within a life space scenario composed of regions, some of which were positively valued (positive valence), others of which were negatively valued (negative valence), and still others of which were relatively neutral. Within this scenario, diseases and other medical problems should naturally occupy the negative valence, which is expected to exert a force that move a person away from that region, unless doing so would require him to enter a region of even greater negative valence. In medical health system, the model presupposes that individual daily health behaviors were controlled by 'pull' positive forces and 'push' negative forces. According to Rosenstock (1974: 330), the earliest characteristics of the Model were that in order for an individual to take action to avoid a disease he would need to believe 1) that he was personally susceptible to it; 2) that the occurrence of the disease would have at least moderate severity on some component of his life, and 3) that taking a particular action would in fact be beneficial by reducing his susceptibility to the condition or, if the disease occurred, by reducing its severity, and that it would not entail overcoming important psychological barriers such as cost, convenience, pain, embarrassment. These three parameters, according to the health belief model, represent individual's internal evaluation of the net benefits of changing their behaviors as guide to decisions on whether or not to act. The health belief model sounds more of an objective and individually centred analysis of health risk perception and behavioral response. Consequently the model has been widely criticized for not taking into account (super) structural factors such as social, economic and demographic factors as well as the wider physical, cultural and institutional environments, which constantly mediate health risk perception, beliefs and behavioral attitudes.

In migration context, the health belief model gets lost in explaining a range of factors shaping migrants health attitudes and behaviors. Understanding the health care challenges and behaviors of migrants in ethnically diverse societies with a conceptually limited model represented by health belief could be difficult. Most conclusions suggest that individuals' learned beliefs and socialized values motivate health seeking behaviors

and shape specific attitudes and orientations in space and over time. Other factors such as socio-economic, cultural and other constraints associated with access to public health services at points of destination have been reported in the literature (Dean and Wilson 2010, Gee et al 2004, Xueqin 1999). Xueqin (1999), for instance observed that Chinese immigrants' preference for diverse sources of health care services in the United States were influenced by a number of factors and experiences including a lack of health insurance, high cost of health services, cultural differences in beliefs and values, language and communication difficulties, issues of transportation and immigration status, and a lack of familiarity with the US health care system. Migrants' health perception and response are tied to a complex of socio-economic, spiritual, environmental and cultural factors (Xueqin 1999, Lassetter et al 2012, Conrad and Pacquaio 2005, Elliott and Gillie 1998, Papadopoulos et al 2003). As migration often leads to changes in cultural, physical and emotional conditions, substantial health impact often impose diverse forms of behavioral responses on migrants. Xueqin (1999) for instance reported that Chinese migrants in the West often depend on their ethnic health beliefs and perception of illness causation in addressing their diverse health needs. The health belief model can work in complementary perspective with the worldview concept to provide a holistic understanding of migrants' health attitudes and behaviors. But what role would the State perform within that equation especially in enhancing or constraining the realization of a certain medical worldview? Our next section addresses this issue.

Medical Worldview and the State

The medical system of any society cannot be understood outside the dominant social, cultural and historical structures. These frameworks provide a range of scope for empirical studies related to illness perception, disease occurrence, diagnosis, prevention, and therapeutic efforts within specific geographical communities or clinical settings. Janze (1978) attempted some analytical structural categories operating at micro and macro levels. At micro level, the medical system can be analysed from the perspectives of roles, statuses and patterns of relations embedded in the social systems mostly involving specific medical decisions, concepts and acts. The larger scale social entities of medical practice involve governmental and professional medical groups, academic medical establishments, political or popular medical movements, or economic and ecological forces as they influence individual behavioural patterns. This larger-scale level fundamentally deals with questions of power, ideology, resource allocation and organizational practices. The larger-scale framework offers greater scope for understanding the medical norms and practices, which according to Janzen has moved us into Radcliffe-Brown era's medical principles considered common across all medical systems: a) a culture's conceptualization and labelling of afflictions; b) techniques and material of medical healing traditions; c) the institutional framework of healing roles and resource allocations; d) the course of illness and disease in time through distinct episodes; e) the context of decision-making in the choice of appropriate therapy; and f) the relationship of socio-cultural activity and norms to bio-ecological factors.

The rise of industrial revolution served not only in significantly changing and modernizing the medical landscape, the colonial interest and expansion of the West equally served to produce and reinforce medical systems categories into 'modern' and

'others'   . These categorizations tend to stereotypically produce civilizational binaries of the 'developed west' and the 'under-developed others', thus enhancing the status of western medical system over others as aptly summarized by Lee (1975, in McDonald 1981: 104):

> *A characteristic of modernizing societies is the co-existence of modern and traditional professions that claim to perform the same function for the society. As a result of differential support by the dominant classes and their social values and by the academic and political authorities, the modern profession occupies a higher stratification ranking than the traditional professional*

In the global medical system, the dominant 'west' and the colonized 'others' readily offer the framework for understanding large-scale struggles of State in the art of reproducing and propagating dominant worldviews over others. The modern state, bolstered by its monopolistic advantages of modern science and technology of power continually remains at the centre of global competition which exercises both authoritative and defacto domination over groups within its territory (Berlant 1975). Gish (1977, cited in Elling 1981: 94) categorically summarized the historical basis for understanding how the modern medical worldview came to assume a dominant global position as follows:

> *The conquest of Asia, Africa and the Americas by Europe, and the consequent assumption of state power by Europeans, led to the virtually world-wide domination of European forms of organization and scientific systems. Western medicine, like virtually all other things European, received official support while traditional systems either received none or were consciously suppressed…the colonial powers began early to introduce their own medical care systems into overseas territories. In many cases, these early services were developed by, and were in the charge of military personnel. Typically the pattern of 'modern' medical care during the colonial era had three major components: the urban hospital; the rural dispensary-often Christian church related; and the hygiene or public health element. In essence this remains the pattern in the third World right up to the present (Gish 1977; cited in Elling 1981: 94)*

The assumed superiority of western/modern medical worldview over the non-western also plays out within the wider settings of social relations in a given geographical space. The medical systems of highly stratified societies most likely will tend toward serving the upper class citizens much more than the lower class. The determinant factors mostly relate to economic and social status as well as some regulatory practices (which serve to define what is acceptable and what is not). Elling (1981: 96 citing Croizier 1970) noted as follows:

This class connection is especially clear with respect to colonial powers. While government officials, the armed forces, business men, and tourists tend to have access to and use modern medicine, the peasant and working classes are more dependent upon traditional medicine. In industrialized capitalist countries, the spread of modern medicine to the working classes through national health insurance schemes may occur as a defusing move and carry with it other advantages for a 'professional' medical elite and the ruling bourgeoisie. Still waiting lines, maldistribution, and other problems make the system inadequate to meet the working and peasant class needs in these nations. Thus, although there is a predominance of modern medicine, whatever folk, traditional, and other forms of medicine there are will be taken more advantage of by the under classes (Elling 1981: 96 cites Croizier 1970)

The UK NHS: Institutionalized Medical Hegemony and Incentives for Illicit Healing Practices

The Marxist's dialectical thinking of 'cooperative or conflictual' relations as structuring catalyst for development and transformation significantly captures the perpetual tendencies for power struggles between worldviews and institutional bodies, and the potential for change it engenders. Dialectics is a theory of development that sees all things as complex wholes composed of parts. The 'inner' relations binding the parts of a thing together have to be complementary and cooperative so that an object has coherence-for example communities having cooperative social relations among one another within the society. When the inner relations assume contradictory character-for example communities riven with conflict as a result of struggle for dominance and exploitation-there are high potential for change. There is also an 'outer' external dimension to dialectical idea which are useful for theoretical speculations about earth space. Within the context of spatial dialectic, an object also develops through 'inter' relations with the external environment of other things, and these relations are likewise simultaneously cooperative (trade, when actually benefits all partners) and competitive (one society extracting value, resources, and people from another) (Peet and Hartwick 2009: 146). In all these significant transformative change emerges when contradictions build to the breaking point, for example when one class excessively dominates and narrows the space and scope of possibilities of another to the point that makes resistance possible.

The UK National Health Service (NHS) represents and symbolizes everything about the western medical system and practice, with a small body of experts and knowledge empowered to define and regulate the medical spaces, healing practices or treatment processes and options. Bourdieu's (1979/1999) writing made it clear that power is constantly produced and an outcome of social interactions manifest in permanent dialectic interplay between the structuring structure and the structured structure. According to Mielke et al (2011), 'this interplay of a pronounced political nature, i.e.,

institutionalized practices and the resulting relations are not only to be seen as the embodiment of knowledge, experiences and the history of a society, the relations as such are crystallized power' this theoretical basis suggest that the UK NHS is a crystallized form of the UK medical power, while its practices should be understood within that context. We use this setting as a powerful analytical basis to understand how the NHS as a crystallyzed form of the UK medical worldview/tradition relate with other medical worldview/power (in this context, the Ibibio medical worldview and tradition).

The NHS is a political institution in the UK which effectively came into being in 1948 as an institution of free healthcare for everybody. The NHS works at two stages namely: the primary care-delivered by a general practitioners (GPS) who cater to a community in a designated area (the Pharmacies, opticians and dentists are also considered part of the primary care) and secondary care encapsulates medical specialists who often work as consultants to GPS within a hospital context. The three core principles of the NHS includes: a) meeting the needs of everyone; b) it is free at the point of delivery, c) it is based on clinical need, not ability to pay. The NHS's central focus on everyone hardly demarcates who is or should be included and who is or should not be included. According to Kraus (2011) this has been the core focus of debates especially for cases in medical tourism whereby people come home from other countries to obtain free high quality healthcare from the UK. But the 1989 reforms addressed this through the introduction of charges for overseas visitors, although they also exempted those individuals from paying who had lived in the UK for at least 12 months and were considered 'ordinary residents'. This meant in practice that many who have been categorized as illegalized migrants still had the right to access free health care (Flood 2008: 7; Scott 2004; Farrant et.al 2006). In 2004 changes were introduced to these regulations as overseas visitors have been charged for secondary care apart from emergency services and the treatment of certain diseases.

The 2003 and 2004 amendment proposals to the NHS was conceived to link immigration control and access to health services:

> *' a person could be asked to provide his or her national identity card, after the proposed introduction in 2007/2008-subject to parliamentary approval. Under the Home office proposals, there would be a requirement for overseas nationals to obtain an identity card if their stay exceeded 3 months. If introduced, the identity card would establish a person's entitlement to free NHS primary medical services. Persons who have come to reside permanently in England would be expected to provide proof to support that they are living here permanently and entitled to do so. For example, a person coming for the purpose of employment will have a valid work permit and proof of employment or a person coming to study will have a valid student visa and confirmation from the University he or she is attending. There should be nothing to prevent frontline staff and/or PCT staff from asking for such forms of identity or from making any enquiries that they may deem necessary' (DOH 2004: 9-10)*

This proposal was indirectly framed to position health professionals as controlling agents, similar to migration officers. This linkage or synchronization of immigration control and health services caused considerable concern among medical profession. The ethical concern of placing the onus on the medical staff to act as State agents of a discriminatory health system, the financial and public health danger of not treating diseases which are easy and affordable to control but expensive to ignore was also raised. One mentioned example is insulin-dependent diabetes. Under the proposed regulation a person without documentation of the UK residency could be turned away for insulin maintenance medication, but would still have access to emergency care if she fell into a coma, although this is far more expensive than doses of insulin (Sheater and Heath 2004: 303, cited in Kraus 2011).

The stipulations, conditionalities, processes and practices enframed in the UK NHS hardly rhyme with the Ibibio medical worldview and tradition with diverse health care background and treatment possibilities. THE UK National Health System (NHS) remains relatively open to legal migrants with intention of 6 months or more residencies. Migrants are entitled to register with a community GP who serve as major gatekeepers to other NHS services through a process of referral. By this standard, migrants whose status is not appropriately recognized by the UK law are automatically ineligible for the NHS services. Such groups of non-eligible migrants include failed asylum seekers and irregular or undocumented migrants. Denying access to certain groups of migrants to the NHS invites resort to and patronage of alternative pathways to medical care. These are the basis for the emergence of illicit medical practices as ways of circumventing the system. Our next discussion will examine how these arguments play out by reviewing the basis and some of the tactics that are mobilized and utilized by migrants in sustaining illicit medical spaces in the UK using Nigeria's Ibibio migrants as a case.

The Ibibios in the UK: the population, research details and study limitations

Overview of the study population: The Ibibio ethnic group occupies the present Akwa Ibom State, south-south portion of Nigeria. In the literature all the ethnic groups in Akwa Ibom State have a common ancestral origin in Ibibio given their shared characteristics, namely mutually intelligible dialect, common ancestry, traditional modes of worship and organization (Faithmann 1999, Udo 1983). The Ibibios are dominantly Christians (over 90%) but there is also a blending of some basic elements of the traditional and Christian beliefs given some tendencies for ancestral worship, libation and incantations, beliefs in witchcrafts and sorcery, among several other traditional and religious taboos and norms.

The Ibibio ethnic group in the UK constitutes a smaller proportion of the over 500,000 Nigerians estimated in the UK. Ascertaining the actual data was difficult. However, estimates should fall in the region of very few hundreds, scattered across the major UK cities, with a large concentration in London. Notwithstanding their various settlements locations, the Ibibios are well connected and are easily united through diverse spaces of engagements/transactions including the associational/ethnic network and relationship (ethnic association, kinship relations), the social media (facebook, whatsapp, skype), spiritual and religious settings (Churches, spiritual centres), and business places (African/Nigerian shops, open/second hand markets). These spaces/platforms exist to unite and to encourage the reproduction of cultural values and medical idioms in a

manner often discussed as important avenues of successful cultural globalization (Robbins 2004).

Notions of health and sickness: Notions of health and sickness among the Ibibios still depend on the wider traditional/indigenous Ibibio worldviews of health and well being as the product of the interaction of an individual with the wider socio-cultural and supernatural environment. Health and well-being are believed to be determined by the dynamic unity and harmony of the body, mind and soul-to the extent that sickness or ill health would automatically imply a 'discord in the social body', a 'rupture of life's harmony' or the 'activation of supernatural forces' (Good 1987: 14, cited in Madge 1998: 294); which hardly fit with the western scientific explanation of health and illness. Within this framework, three broad illness categorizations are recognizable as natural, mystical and inherited (Izugbara and Duru, undated). Although these categorizations draw from the Igbo (Nigeria) ethnomedical cosmology, the Ibibios share a similar worldview as the immediate and closest neighbours distinguishable mainly by language dissimilarities.

Medical attitudes and the Ibibios: The Ibibios conduct their medical practices within the framework of the tradition and religious beliefs, which depends on rituals, plants and other natural substances as well as spiritual exercises (fasting and prayers), in addition to the use of the modern biomedicine in some contexts (see also Ekong 2001; Ajala and Wilson 2013). Knowledge of health, health care and the attitudes to being healthy still depends on individual's perceptions linked to personal health beliefs, social norms, spiritual problems and individual food/health habits and lifestyles.

Knowledge of simple diseases such as malaria and symptoms, typhoid fever, diarrhea, cholera, dysentery, etc could vary from blame on intestinal congestion (*udehe idib*), bad food, eating habits, changes in seasons, to spiritual problems and witchcraft, among several other causes. Ajala and Wilson (2013) observed that the Ibibios hold the belief that malaria (*utuo-enyin* or *utuo-enyin ekpo*) is caused by a plethora of different factors ranging from eating too much of oily foods, exposure to sunlight and witchcraft attacks. Similarly, Akpabio (2012) observed that the Ibibios see certain epidemics such as diarrhea, cholera, dysentery as associated with bad food, seasonal changes, while their severity could be linked to some spiritual attacks with common phrases such as *idoho nkana* (not normal), *utoro ikpu* and *utoro anwa ifot* (diarrhea or cholera linked with witches and witchcraft attack). Within this context, applying the logic of science in understanding certain categories of disease/epidemics is rather difficult among the Ibibios given a range of cultural perceptions and spiritual meanings associated with the etiology of some of the diseases and their symptoms (see Akpabio 2012).

These diverse knowledge, beliefs and practices associated with health and health care attitudes among the Ibibios open avenues for diverse management/treatment options depending on individual health biographies, knowledge and perception, but to what extent are they reproduced at transnational level? No research has attempted to understand how some specific elements of these health beliefs and attitudes are consciously mobilized in creating new or alternative spaces of health care practices in transnational contexts of migration. This study addresses the extent of consistencies and deviations over these issues in the UK while also paying attention to the influences of the UK environment and its medical system in shaping necessary therapeutic behaviours.

The study methods and ethical approval: This was a three-week exploratory research, which depended on one-off interviews, discussions and series of follow-ups in addition to the pre-and post- skype, telephone and e-mail communications. A total of 24 migrants were interviewed through a combination of structured, semi-structured and in-depth interviews while informant and follow-up discussions were helpful in addressing and clarifying sensitive issues. A large number of the respondents were tracked in London, Aberdeen and Dundee in Churches, family visits and during ethnic associational meetings facilitated through previous arrangements with few known Ibibio indigenes in the UK. While 14 respondents were interviewed in a semi-structured format (an average of between 25 and 30 minutes per interview), 8 were subjected to detailed and in-depth interview that lasted on average between 45 and 70 hours. 7 respondents opted to send in their response by post to the lead author's Oxford residence, out of which only 3 eventually honored the promise. The above interviews excluded the special Skype interaction we had with three individuals who had previously spent several years in the UK.

We used three volunteers as our informants who served to clarify some complex issues as need arose. Apart from repeated visits to some willing families at weekends or in the evening hours (for in-depth and follow-up interviews), we equally used the telephone interview option to track 12 respondents as follow-up procedure as well as when there were needs for some clarifications on some information supplied in the questionnaires. Telephone conversations were conducted mostly at night hours and could last as long as 60 minutes or more per conversation. It was very helpful as some respondents used the opportunity to explain in detail some issues discussed. All interviews were conducted in the Ibibio language. Overlapping responses were common given that some sicknesses (e.g., malaria) were discussed with its associated symptoms.

Several issues bordering on general and environmental health knowledge and behaviors that are associated with the medical geography of the Ibibio ethnic groups in Nigeria (Akpabio, 2012, Ajala and Wilson, 2013) were used as indices of comparison with their kiths and kins in the UK to understand their dynamics (in terms of what have changed or persisted and why) in the contexts of transnational migration. We focused on knowledge, norms and behaviors embedded in environmental health related issues and associated diseases and sickness causation, treatment practices and how the UK medical ideology, environmental and institutional systems have shaped their survival and continuity or discontinuity. Although a range of issues were discussed, this paper mostly focuses on discourses associated with medical experiences and treatment behaviors in relation to issues around water, sanitation and hygiene (WASH).

Notes on important points were taken throughout the interview. The results of each day's interview were immediately sorted, classified/thematized, which were subsequently compared with available/previous narratives for commonalities and differences. Follow-up interviews and informant clarifications were sought on some conflicting issues or when further explanations were needed. Given the very small number of the Ibibios identified, every adult (from 18 years) was automatically accepted for participation provided there was willingness and interest. The relevant ethical documentation and approval for this study was secured at the Kyoto University (Japan) and the University of

Oxford (UK) before the actual fieldwork. During the fieldwork process, all ethical concerns related to anonymity, confidentiality, informed consent and the ability to withdraw from participation were thoroughly addressed.

Study Limitations: This study has several limitations, which are hereby acknowledged. One, a fraction of data from a single and small ethnic group (the Ibibios) in the UK alone would not adequately generalize for a multi-ethnic Nigeria. While this study focused on comparing the health experiences and behaviours of the Ibibios within the context of transnational migration, no direct and similar fieldwork was organized for migrants' kiths and kins resident in Nigeria as far as this topic is concern. This gap was however bridged by the relevant fieldwork experiences of the lead author (an Ibibio indigen) in addition to the numerous secondary literatures addressing this issue (Ajala and Wilson 2013, Akpabio 2012, Udo 1983). Two, this fieldwork lasted for only three weeks, and was not designed to include the UK public health/medical institutions beyond little information from the secondary sources (see Krause 2014). As the health/medical experiences of migrants take place within the contexts and influences of the UK medical landscape and environment, findings from this study cannot be said to be truly objective without some inputs from the relevant UK public health institutions. More so, a study such as this requires very long term ethnographic data, which could not be realizable within a three-week period. However, it is very useful as starting points of discussions for future research**.**

Finally, several fieldwork challenges including difficulties in tracking down busy respondents, unwillingness to disclose vital information and some inconsistencies in some information (rhetoric and realities) provided by most respondents were encountered. Some respondents deliberately could not provide some information needed in spite of some clarifications on anonymity and confidential handling of information. Apart from the probable reason of holding irregular documents, some respondents seemed probably not quite knowledgeable of the system (especially on how the UK NHS works). These and related issues were addressed through persistent follow-up discussions in the evening/night hours, at associational meeting places, during weekend visits and telephone discussions, in addition to the services of the three informants who helped in tracing some willing participants while also serving to clarify or reconcile some cases of inconsistencies and irregularities in information supplied by some respondents. Despite these limitations, this study clearly lays a foundation for future research.

Some Observations and Conclusions

Although the fieldwork for this study was conducted to capture a range of medical and health care practices, these highlights specifically focus on some aspects of findings related to water, sanitation and hygiene (WASH) behaviors and practices. By our findings, not much has significantly changed in the medical worldview of the respondents on these particular issues. WASH related behaviors still draws on previous beliefs and attitudes especially on health systems and sickness causation, as well as depend on individual health experiences and biographies. The socio-demographic, economic and environmental factors introduced critical contexts for subtle changes and adjustments in some behaviors where it matters. For example, the use of multiple pathways to respond to some needs on accounts of exposure or some forms of limitations and; instances where

some previous behaviors and routines get challenged on accounts of environmental and other forms of social, economic and demographic influences.

In a broad perspective, the highest percentage of 58.4% of the respondents claimed their attitudes to simple health and health care behaviours have changed, while 73.3% indicated they patronize other forms of medical pathways outside the western medical system. There were clear overlaps in the attitudes of the respondents reflecting the tendency to depend on multiple medical behavioural pathways and traditions. Respondents who developed more bias towards the western medical system were mostly in the younger generations and British-born, who were not deeply exposed and integrated in the traditional medical pathways of their parents and relatives. On the other hand, the newly arrived and irregular immigrants tended favourably toward the traditional and ethnic pathways of medical tradition. Economic reasons were important as most migrants are so much interested in livelihood pursuits and regular remittances than engage in the luxury of regularly visiting the General Physician on the slightest case of sickness. More so, most respondents' health care attitudes remain poor. Back in their country of origin, many were not exposed or used to the culture of consulting physicians, doctors, booking appointments, etc before migration. Visiting the clinic for most migrants used to be in the context of emergency (at a dieing point which necessitates being forced by relatives to treatment centre), especially given the usual stigmatization that are often held of people with frequent sicknesses and regular visitation to the hospital. Consequently, self-management and self-medication have formed important avenues for addressing most health care challenges and medical needs.

These broad health care habits and medical attitudes dictate most WASH behaviors. Key issues such as hand washing after toilet with or without soap, regular bath, dental care, etc were linked to social habits. While in Nigeria, 57.5% of the respondents said they used to wash their hands after the use of toilet. In the UK, there was a progressive improvement as 83.3% of the respondents said they often wash their hands after every use of the toilet facilities. But when asked whether they wash hands with soap after every use of the toilet facilities, only 16.7% claimed they used to wash hands with soap after every use of the toilet facilities in Nigeria. A little higher number of same respondents (20.8%) claimed they wash their hands with soap after every use of the toilet facility in the UK (Table 1).

Table 1: could you please compare your attitudes to these issues over your life courses in Nigeria and the UK

WASH elements	Nigeria			UK		
	Yes (%)	No (%)	Neutral (%)	Yes (%)	No (%)	Neutral (%)
Wash hands after toilet	57.5	12.5	29.2	83.3	0	16.7
Wash hands with soap after toilet	16.7	61.7	8.3	20.8	58.8	20
Daily bath	83.3	16.7	0	53	32.5	12.5
Mouth brush first in the morning	95	0	4.2	100	0	8.3
Use of chewing sticks	70.8	29.2	0	33.4	62.5	4.2
Visit to dentist	16.6	45.8	37.5	12.5	75	12.5
Cover food against contamination	100	0	0	100	0	0
Wash fruits before eating	54.2	12.5	33.3	58	14.2	37.5
Wash hands before preparing food	91.7	0	8.3	100	0	0
Efforts to control flies/other insects in the house	95.8	4.2	0	29.2	70.8	0
Boil water before drinking	4.2	95.9	0	4.2	95.8	0
Pay attention to drinking water quality	63.1	4.2	33.3	83.9	4.2	12.5

Standard WASH infrastructure in the UK probably could explain migrants' significant adjustment in the form of improved sanitary practices. It is also possible that respondents who claimed the habit of regular hand washing/hand washing with soap while in Nigeria had some level of improved living condition, which enabled the use of modern toilet system.

For respondents who hardly adjust their habits in response to improved sanitary system, this may have to do with poor socio-economic background, which limits their exposure to messages and knowledge of standard practices. For bodily hygiene, about 83.3% claimed they never failed to take bath at least once in a day while in Nigeria but the percentage dropped significantly to 53% as some respondents claimed they do not follow such regularity while in the UK. Seasonal changes in the UK weather system especially in the winter were the commonest explanation for the slight adjustment in such habit. Most respondents agreed that regular bath, for them, is still the normal routine except in the winter, *'... but whatever is the case one must bath at least once in a day...'* argued a male respondent in his late 50s. The symbolic notion of beauty linked to cleanliness is the underlying reason, which is in line with the general belief in the Ibibio tradition (expressed in a local proverb) that cleanliness is beauty (translated in local dialect as *Nsana-idem ado uyai*) (Akpabio 2012).

For dental care, the use of chewing stick for toothbrush was highlighted with specific reference to its impact on dental health. Our questionnaire information showed that while in Nigeria, 95.8% of the respondents would clean their teeth first thing in the morning before meal, but in the UK, all the respondents (100%) said they clean their teeth first thing before meal. A follow-up question produced 70.8% in favour of those who claimed they had regularly been using chewing stick for tooth brush while in Nigeria, and 33.4% of the respondents who still continue in the same habit (though not on regular basis) while in the UK. Using chewing stick for dental care carries some health

implications for many who believe in it as one man observed, '...*I always bring them each time I travel home...I can also buy them here...*' Respondents who often bring chewing sticks back to the UK make careful selection of the type depending on the medical and health values particular specie of plant offers to the teeth and the health system in general. A combination of health experiences and histories both at home country and the UK deprive respondents from developing a culture of visiting the dentist while in the UK. This is true as the statistics showed that only 16.6% said they engaged in regular dental care beyond the use of chewing stick as against 45.8% who did not while in Nigeria. While in the UK only 12.5% claimed they engaged in regular dental care beyond self-management while 75% claimed they did not.

Engaging in regular dental care was interpreted to include only the occasional visits to the dentist. Some respondents who said they did engage in regular dental care did so only for their children and not for themselves. There was an interesting narrative from a family on the dental structure of their last-borne son, which according to them was embarrassingly irregular and wrongly positioned. The wife said when they arrived the UK and enrolled the boy in the school, their attention was immediately drawn to the boy's dental problem and irregularity as they were subsequently referred to the dentist for treatment. The parents were happy that the problem had been successfully solved. This context demonstrates an acknowledgment of the capability of the western medical system by the discussants. The case of a male respondent in his early 40s, was, however, different, and seems to emphasize his belief in the potency of his ethnic medical system over the western type as follows:

 '...*I had one occasion to visit a dentist and she asked me when last I visited a dentist...I told her I have never done that in my life...shocked, the woman invited her colleague to examine my teeth...they had expected some problems or decay, but they did not see any...they were surprised...*'

The respondent went on to add that*'' '...all these roots of plants and chewing sticks we use are very good...I keep using them once in a while since I cannot detach from such habit...*'

Mixed attitudes on the potency or otherwise of one medical system over the other have to do with diverse range of factors including personal experiences, circumstances of exposure and, to a large extent, the influence of economic factors. The diverse accounts provided by the respondents suggest that the contexts of individual and household experiences can serve to reinforce or undermine dominant attitudes and consequently influence potential choices over particular medical pathways or system. For the family who successfully restored the child's dental health, the benefit of being exposed to the western medical resources helped to strengthen confidence in the capability of the western medical pathways to healthcare; although we cannot determine the extent this has affected their belief in the integrity of their ethnic medical system. For the male respondent, the interface of encounter with the western medical system probably served to reinforce confidence and belief in his ethnic medical pathways to health care. We also argue that respondents' preference for self-management as demonstrated in the low patronage for western medical resources for dental care may have to do with economic reasons. It is of interest to understand that the economic background of most migrants

largely reflect low-income characteristics with larger responsibilities both within the UK and at home country of origin. Consequently, most respondents are deeply involved in daily existential struggles not only for their immediate needs in the UK but also to secure some remittances for their families and project back home. Negotiating time for regular appointment with the dentist and attending to some short-term, 'irregular' and 'sharp' job opportunities for money and survival most likely present difficult choices which are easily resolved in favour of self-medical care. At this point, the tendency to draw on the ethnic medical worldview and resources become particularly very compelling.

Besides our emphasis on WASH issues, we used many other informal health care behaviors and practices to understand how the hegemonic norms embodied in the UK society and its health care institutions has helped in opening up alternative spaces of health care practices among migrants. As a highly organized system, the UK medical field represents and symbolizes everything about the western medical ideology, which hardly conforms to migrants' medical worldview. The emerging contradictory relationship facilitates the emergence of alternative medical spaces that are not within the scope and regulatory surveillance of the UK medical institutions. Health belief, attitudes and complex processes associated with the UK medical institution and its immigration laws limit migrants' full participation in the system.

Within this context business and religious settings and kinship relationship have contributed in opening and expanding the phenomenon of alternative spaces for reproducing traditional and ethnic health care products and services to address the health needs of the respondents. Kinship relationship enhances the formation of established and stable network of non-western health products and services. The denser the social and ethnic network, the more available, accessible and cost effective the ethnic health care products and services for migrants. It is a two-way process given that the expanding informal spaces of health and health care transactions equally serve to expand and strengthen the existing processes of social network and ethnic and kinship relations. Kinships and social network thus serve as frameworks for traditional medical/health care practices; as well as useful platforms for tracking appropriate therapies. One respondent says: '...if you have problem you feel may not be understood by your GP, you contact people you know and they would further direct and introduce many others till you find the right cure...' this is how social network is expanded and deepened.

In conclusions, the study findings have demonstrated that worldviews once enframed keep being transformed and reproduced in constant adjustments to prevailing environmental, political, socio-cultural and institutional contexts. This point implies that worldview is dynamic and capable of constant adjustment and change within and across generations depending on structural and, socio-economic and environmental circumstances. Beyond the influences of the broader environment, individuals are conscious and active beings operating within the broader system and capable of conscious decision to continually take advantage of the environment and circumstances of operation. Research should focus more on exploring, in greater details, the ontological characteristics and contexts of medical worldview dynamism in different social-ecological, political-economic and institutional systems to understand the governing mechanisms, characteristics and drivers of adaptation practices. Comparative studies

stand to make significant contribution to medical pluralism through emphasis on regularities, commonalities and differences over such diverse settings. Future research could equally explore the interaction between the realms of the 'licit' and 'illicit' medical spaces focusing on the forms, nature and patterns of such interaction as well as the potentials for mutual cross-boundary patronage or a hybrid use of products from both spaces. Key questions should focus around those likely to be involved, what motivate them as well as the effects of such cross-spatial interaction on the State institutions and available regulatory practices.

Acknowledgements

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