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VOLUME 10

HEALTH-HYGIENE-NUTRITION

BORGOU



Multinational Agribusiness Systems Incorporated

PEOPLE'S REPUBLIC OF BENIN
MINISTRY OF PLANNING, STATISTICS AND ECONOMIC ANALYSIS

VOLUME 10

HEALTH-HYGIENE-NUTRITION

BORGOU

**SOCIO-ECONOMIC PROJECT FOR THE
DEVELOPMENT
OF
ONCHO-FREE AREAS**

**CENTRAL BUREAU FOR PROJECTS
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**MULTINATIONAL AGRIBUSINESS SYSTEMS, INC.
1401 WILSON BOULEVARD
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VOLUME 10: HEALTH - HYGIENE - NUTRITION

BORGOU

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VOLUME 10

BORGOU

DATA ON HEALTH - HYGIENE - NUTRITION

I. HEALTH

A. Infrastructure

Health organization is centered around the medical districts set up in each district capital. These districts are generally directed by a doctor, assisted by one or more nurses, according to the importance of the medical post. Some medical districts are, however, without a doctor (in these cases the dispensary is headed by male nurses). At the commune level, there is a medical post and a maternity ward, or a Center for Mother and Child Protection (Centre de Protection Maternelle et Infantile (P.M.I)). A certain number of communes are without them. These units are usually managed by a male nurse or a midwife. The village health units (Unités Villageoises de Santé - U.V.S.) have a first-aid worker or a midwife. Few villages have these facilities. Besides the medical districts, (including dispensaries) the medical posts, the P.M.I.'s (Centers for Mother and Child Protection) and the U.V.S. (Village Health Units), there are four hospitals in BORGOU, two of which are in PARAKOU (one national and the other headed by the missionaries). The third hospital, in BEMBEREKE, is headed by the American missionaries, and the fourth one, in BANIKOARA, is the result of German and Benin Cooperation. The health infrastructure is completed by numerous sales outlets of the Office National de Pharmacie (O.N.P. or National Pharmaceutical Office), but they are inadequately supplied. Thus, in NIKKI,

the doctor in charge of the medical district writes the following: "the supply in medicines reaches the district late and often does not comprise first-aid medications". In the case of N'DALI: "there is a complete shortage in essential prescriptions. The sick people rely on traditional medicines".

The good geographical distribution of the various health centers means that the distances to reach them in the event of need are not excessive. Table 25 reveals that 26.1% of the population has to travel less than two kilometers to reach them and that 50% of the population has to go less than 5 kilometers to get to them. However, 30% of the population has to travel ten kilometers or more. At this level, the Districts of NIKKI, GOGOUNOU and KARIMAMA are the least well served. Table 26 reveals that 50% of the population needs up to one hour to reach them and that three-fourths of the population (79.7%) can arrive there in less than two hours. In contrast, the sales outlets for pharmaceuticals are less numerous and only 9.1% of the people are located less than one kilometer from them; 50% of the population has to travel more than 11 kilometers (Table 27), which is equivalent to walking more than two hours (Table 28) with no guarantee that the prescription will be available. In the District of TCHAOUROU the head of the medical District writes the following: "considering the shortage in medicines, it happens that the patients often have useless pharmaceutical prescriptions since there are no medicines to buy, this condition discourages them". This situation prevails in a large number of centers and the problem contributes to the use of traditional remedies.

B. The Sick

Of 834 households surveyed in BORGOU, 280 had one or more members of the household who were sick during the course of the year preceding the survey (Table 1), which is to say that there were sick persons in 33% of the households surveyed.

The total number of sick can therefore be estimated at 10.3% of the population. Comparison of Table 2 and Table 16 of the population survey reveals that the population is equally distributed between the sick persons and the main activity of the household. This means that there are not any more sick persons in one social-professional category than in another. Also, careful comparison of Table 5 and Table 1 on population shows that the proportion of sick persons is higher in the age categories of 1 to 5 years, and in the category of more than 30 years of age. For those groups, the proportion of sick people is greater than the average, even reaching 12% for the age category of from 45 to 49 years, as can be seen from the next table:

**DISTRIBUTION OF SICK PERSONS WITH REGARD TO THE
POPULATION AND BY AGE GROUP**

AGE GROUP	POPULATION	SICK PEOPLE	PERCENTAGE
less than 1 yr	89	0	.0%
1 - 4 yrs	1312	96	7.3%
5 - 9 yrs	1465	64	4.3%
10 - 14 yrs	832	44	5.3%
15 - 19 yrs	707	24	3.4%
20 - 24 yrs	611	29	4.7%
25 - 29 yrs	609	43	7.1%
30 - 34 yrs	483	44	9.1%
35 - 39 yrs	329	29	8.8%
40 - 44 yrs	274	17	6.2%
45 - 49 yrs	207	25	12.1%
50 - 54 yrs	254	18	7.1%
55 - 59 yrs	135	11	7.4%
60 - 64 yrs	195	12	6.1%
65 - 69 yrs	80	9	11.2%
70 yrs and over	232	26	11.2%
TOTAL	7814	491	6.28%

A comparison between the distribution of the sick by age and sex and the total population (Table 6 : health and Table 3: population) shows that in all categories of age, the percentage of sick men is equal or greater than the women. This trend is revealed in the group of age between 15 to 19 years, 30 to 34 years, 50 to 54 years, and 65 to 69 years. The total percentage of sick persons is higher for the men than for the women: 6.9% of men against 5.6% of women, as shown in the following table:

AGE GROUP	MALE			FEMALE		
	POPULATION	SICK	%	POPULATION	SICK	%
less than 1 year	25	0	.0%	27	0	.0
1 - 4 yrs	652	49	7.5%	658	47	7.1
5 - 9 yrs	807	35	4.3%	657	29	4.4
10 - 14 yrs	459	24	5.2%	372	20	5.3
15 - 19 yrs	359	17	4.7%	347	7	2.0
20 - 24 yrs	246	12	4.8%	365	17	4.6
25 - 29 yrs	249	20	8.0%	359	22	6.1
30 - 34 yrs	209	25	11.9%	274	19	6.9
35 - 39 yrs	151	14	9.2%	177	14	7.9
40 - 44 yrs	108	10	9.2%	166	7	4.2
45 - 49 yrs	101	15	14.8%	106	10	9.4
50 - 54 yrs	130	11	8.4%	124	6	4.8
55 - 59 yrs	78	7	8.9%	56	4	7.1
60 - 64 yrs	115	7	6.1%	79	5	6.3
65 - 69 yrs	58	7	12.1%	21	1	4.7
70 yrs et plus	147	18	12.2%	84	8	9.5
TOTAL	3894	271	6.9%	3872	216	5.6

Table 9 shows that there is a relationship between the age of the sick persons and their kinship ($r = .43$). The largest percentage of sick persons is found in the infant group.

The most common sicknesses or symptoms are: headaches (16.5%), stomach aches (15.6%) flu (11.6%) and fevers (11%) (Table 49).

The most common illnesses treated by the doctors or nurses of the medical districts are malaria, measles, gastroenteritis and dysentery, broncopathies and pneumopathies. It should be noted that onchocerciasis is not mentioned among the sicknesses treated at the medical districts level. Indeed, the population seems to barely know onchocerciasis (Table 50), since only 11.3% claim to know this disease whereas 53.0% state that they do not know anyone with that disease (Table 54). Does this mean that onchocerciasis is not found in the region? No, it is a certainty, however, that at the province level onchocerciasis is not the priority health problem. Malaria, pulmonary diseases, gastroenteritis and infectious diseases (such as measles) affect the people the most. Young people have heard about onchocerciasis (Table 51), people who have had the most schooling (Table 52) and civil servants (Table 53). This is probably the result of awareness campaigns.

C. Attitude towards Medicine

Despite the fact that modern medicine arrived several decades ago, the people as a whole remain very much attached to traditional medicine. Doctors notice that "the visit to the health centers is insufficient: the case has to be serious before they go to the dispensary" (C.M. NIKKI). Although, Table 10 shows that 32.9% of the sick go to a doctor for treatment and 31.4% are treated by a male nurse, it can be conceived that the vast majority of these persons pay a visit beforehand or simultaneously to the witch doctor. Although, according to Table 34, 75.7% of the persons interviewed claim that they have greater confidence in modern medicine than in traditional medicine, the latter remains very popular. According to Table 10, 22% admit to having been treated by a faith-healer. Doctor (or male nurse) is consulted by priority for the following:

- infectious diseases..... 78.8%
- malaria 78.4%
- yellow fever 72.2%
- headaches 65.7%
- diarrhea 63.2%
- stomach aches 59.2%

The faith-healer is consulted in the first instance for unknown diseases (75%), eye diseases (38.5%) and body aches (38.1%).

Among the ethnic groups who have the most confidence in modern medicine are the FON (100%), followed by the DENDI (83.3%). The group with the greatest confidence in traditional medicine are the PEULH (28.2%) as shown by the following table:

NATIONALITY	CONFIDENCE IN MODERN MEDICINE
FON	100.0%
DENDI	83.3%
YORUBA	78.9%
BARIBA	74.1%
PEULH	71.8%

Table 35 reveals that among the heads of household the women have more confidence in modern medicine than the men. The next table shows that there is a relationship ($r = .12$) between that confidence and the age of the head of household. The older the head of household is, the more confidence he has in traditional medicine. There is also a relationship ($r = .06$) between this confidence and the main activity of the head of household. Civil servants and housewives have more confidence in modern medicine than farmers or stock breeders (Table 38). In contrast, there is no relationship between confidence in modern medicine and the schooling of the heads of household (Table 37).

The faith healer, or witch doctor, is consulted first of all for unknown diseases (75%), eye problems (38.5%) and body pains (38.1%). Witch doctors treat the symptoms rather than the diseases and this is why the health problems mentioned uniquely represent symptoms. It is interesting to note in Table 13 that when the sickness lasts more than 5 months the percentage of sick people who resort to faith healers for treatment is equal to those who have been attended by doctors. Also, if one type of medicine does not yield the desired results the combination can be more efficient. According to Table 14, it appears that the percentage of sick people who have been cured is higher in the case of those who were treated by a doctor than those who were treated by a faith healer but the percentage of deaths is greater among those who were treated by doctors. Concerning the treatment given and the fate of the sick people, Table 15 reveals the largest percentage of cure is in the category of those who receive pharmaceutical treatment (58.7%). The next is in those persons who receive both pharmaceutical and traditional treatment (40%) and then the traditional treatment (39.4%). It should be noted, lastly, that the percentage of deaths is the highest in the category of pharmaceutical and traditional treatment (40.0%). In other words, in the hopeless cases especially, both treatments are given.

Table 44 provides a list of the major remedies used in native traditional medicine: tree bark, plants and roots, are the three primary components.

Sicknesses are rarely attributed to a natural phenomenon, but are generally believed to be the result of supernatural forces surrounding man, or ancestors to whom respect has not been given, or unknown causes. Thus, 47.2% of the people interviewed did not know what caused their sicknesses; they assumed that the sicknesses were caused by the climate and only 8.9% consider the cause to be the absence of hygiene, or non-potable water (6.4%) used to prepare meals or for drinking (Table 39).

Table 56 reveals that only 1,026 men and 1,013 women have been vaccinated in their lifetime, which is equivalent to 26.3% of the men and 24.4% of the women. Of that group, those under the age of 15 are 53.2% women and 48.6% men. Half of the persons vaccinated are school-age children (Table 56). The vaccines received are Calmette-Guerin Bacillus (37.5%), measles (17.6%), smallpox (14.4%), tetanus (14.8%), yellow fever (6.5%) and tetracoccus (3.9%); 5.2% indeterminate (Table 57).

RELATIVE IMPORTANCE OF THE VARIOUS VACCINES RECEIVED

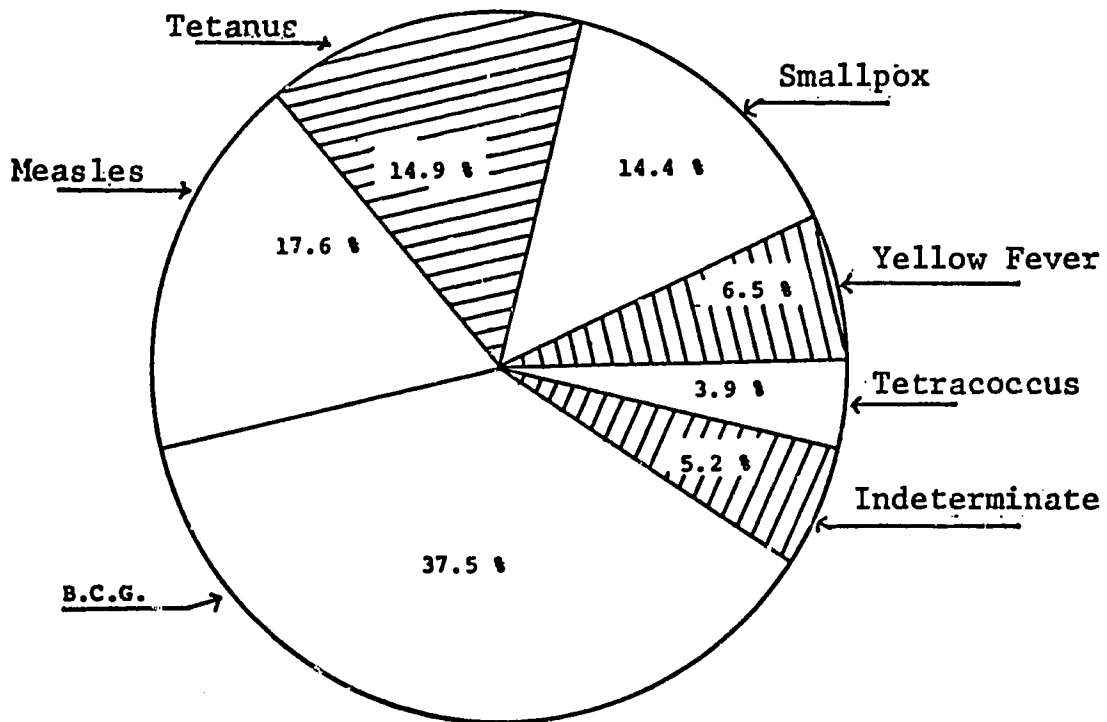


Table 58 shows that the children are the ones most vaccinated (41.8%). Among the persons vaccinated only 12.2% of the heads of household and 13% of the wives are included. With respect to the total population, this represents 30.2% of the heads of

household and 25.4% of the wives. Table 56 confirms, that regardless of the type of vaccine, the children are the most vaccinated, followed by the heads of household and then the wives or other relatives.

II. HYGIENE

Hygiene, one of the essential elements of disease prevention, is practiced at various levels. Thus, we may distinguish environmental hygiene, body hygiene and nutritional hygiene. Regarding nutritional hygiene, this study will only deal with water.

A. Environmental Hygiene

Table 1 reveals that for 84.6% of the population the customary place for relieving oneself is outdoors, while 13.7% of the population have septic tanks for that purpose. Examination of the tables by ethnic group reveals that the YORUBA (29.3%) and the DENDI (15.4%) have septic tanks. These are two groups that live mostly in the urban centers. In terms of the districts, the districts of PARAKOU has the most septic tanks (38.3%) and the district of N'DALI (30.8%).

Table 2 shows that there is a relationship ($r = -.10$) between toilet habits and the main activity of the head of household. Craftsmen have the highest percentage of septic tanks, followed by civil servants. Another important aspect of environmental hygiene is waste disposal. The best way to dispose of waste is to burn it or to bury it in the ground. However, 80.8% of the population throws the waste outdoors (Table 3). This is a significant source of contamination, in particular where animals, such as pigs, are freely roaming. In terms of the ethnic groups, the DENDI (18.1%) burn their waste the most.

In contrast, the BARIBA, the PEULH and the YORUBA, usually discard waste outdoors (about 80%). The practice of burying the waste is not widespread. This practice is followed only by some DENDI (18.1%) and YORUBA (21.9%). The districts of BEMBEREKE, KARIMAMA and MALANVILLE have the highest percentage in the categories of burning or burying waste, but this percentage remains low, since 60.7% of the population of BEMBEREKE and 60% of the population of KARIMAMA disposes of waste outdoors. Table 4 shows that there is no relationship between manner of waste disposal and the main activity of the head of household.

B. Body Hygiene

Body cleanliness of children is important to prevent infection. Table 5 shows that in the Province generally 93.3% of the children are washed daily and most children are washed at least every other day (98.2%). This is truly remarkable considering how difficult it is to obtain water. During the dry season, of course, one could be led to believe that the frequency of washing drops because water becomes a scarce commodity. If we classify the ethnic groups in descending order, the YORUBA (100%) wash their children most often and the PEULH (78.9%) the least often

NATIONALITY	CHILDREN WASHED DAILY
YORUBA	100.0%
BARIBA	95.6%
DENDI	95.1%
PEULH	78.9%

The Districts where the children are washed most frequently are BEMBEREKE, GOGOUNOU and NIKKI (100%), and KARIMAMA is the District where the children are washed least often, as can be seen from the next table:

DISTRICTS	CHILDREN WASHED DAILY
BEMBEREKE	100.0
GOGOUNOU	100.0
NIKKI	100.0
KALALE	98.6
PERERE	97.7
TCHAOUROU	97.5
SEGBANA	96.4
BANIKOARA	95.3
MALANVILLE	94.9
PARAKOU	93.5
SINENDE	93.0
KANDI	88.2
N'DALI	67.6
KARIMAMA	65.5

It should be noted that 68.0% of the population has access to a well (Table 7), compared to only 44.2% in ATACORA. The others obtain their water from the streams (25.5%) or rivers (3.8%). Some (2.7%) have access to a tank or to a faucet in their home. The PEULH have the least wells (44.9%) and have to resort to natural water sources (36.2%). For the wells they are preceded by the BARIBA (67.4%) and the DENDI (83.1%). The YORUBA are the group with the most access to a well (85.3%).

NATIONALITY	ACCESS TO A WELL %
YORUBA	85.3
DENDI	83.1
BARIBA	67.4
PEULH	44.9

In terms of districts, BANIKOARA and TCHAOUROU are the districts where the population has the greatest access to a well, whereas in BEMBEREKE only 38% of the population had access to a well and 62% of the people get water from streams.

DISTRICTS	ACCESS TO A WELL
BANIKOARA	88.0
TCHAOUROU	87.5
SEGBANA	83.3
PERERE	79.1
MALANVILLE	78.9
PARAKOU	77.8
NIKKI	69.0
GOGOUNOU	66.0
SINENDE	62.8
KANDI	53.9
KALALE	51.2
KARIMAMA	50.0
N'DALI	44.0
BEMBEREKE	38.0

The distances to get water are not, very great, except during the dry season. Table 8 reveals that 78.1% of the people have to travel one kilometer to reach a supply of water and 87.6% need less than one hour to get there (Table 9). In NIKKI, 38% of the people travel approximately 5 hours to reach a supply of water.

C. Nutritional Hygiene

In the field of health there are numerous cases of gastro-enteritis and dysentery. This is not surprising considering that 11.6% of the population claims to have no access to drinking water (Tables 10 and 11). What is even more interesting is that a large number of the 72.5% who claim to have access to drinking water think that if the water is clear it is potable and can be drunk. The groups with the greatest access to potable water are the YORUBA (90.0%) followed by the BARIBA (75.7%), whereas those with the lowest percentage in the category of potable water are the DENDI.

NATIONALITY	ACCESS TO POTABLE WATER	
	DRINKING %	COOKING %
YORUBA	90.0	90.2
BARIBA	75.7	74.6
PEULH	63.9	61.6
DENDI	60.0	57.1

The Districts best supplied with potable water for drinking or cooking are PERERE and NIKKI, whereas those least supplied are KANDI and MALANVILLE.

DISTRICTS	POTABLE WATER	
	DRINKING %	COOKING %
PERERE	90.9	93.0
NIKKI	89.7	89.7
KARIMAMA	86.7	86.7
SEGBANA	82.1	78.6
KALALE	81.1	78.1
PARAKOU	80.0	77.6
BEMBEREKE	78.6	76.8
SINENDE	76.7	76.7
N'DALI	75.7	67.5
TCHAOUROU	75.6	85.7
GOGOUNOU	73.1	68.6
BANIKOARA	57.1	56.6
KANDI	52.9	51.2
MALANVILLE	50.8	50.0

At TCHAOUROU, a great difference is noted between those who have potable water for cooking and for drinking: 14.6% are not sure that the water they use for drinking is potable, however, it is less important that the water they use for cooking is potable, since the water is boiled during the cooking. However, it is interesting to note, that while 220 households out of 823 replied to the question that they do not have potable water or that they do not know whether it is potable, 323 households (39.2%) of the households, treat the water, either by boiling it (43.9%), letting it set (4.7%) or filtering it (44.1%). This indicates that even those who believe that their water is drinkable take precautions. The population is consequently aware of the dangers of direct consumption of the water from the streams or rivers. The process of filtering the water consists in decanting the water to which an alum white stone has been added. The BARIBA and the PEULH "filter" the water, whereas the DENDI boil the water. Among the YORUBA as many boil the water as filter it.

In MALANVILLE, KARIMAMA, N'DALI, and PERERE, the water is boiled, whereas in the other districts the water is filtered. These practices are not a function of the age of the head of household (Table 14), the schooling of the head of household (Table 15) or even the main activity of the head of household (Table 16). These are, therefore, very widespread practices which maintain the health of the population.

III. NUTRITION

In general, in BORGOU, it is customary for the mothers to breast-feed their babies. Almost all of the babies are breast-fed (Table 1). Some few exceptions are to be found in the PEULH and the BARIBA, where 4.4% and 3.2%, respectively, of the babies are not breast-fed. Particularly in GOGOUNOU (21.6%) and PARAKOU (5.2%) the babies are not breast-fed. In such a case, the babies are fed milk (32.6%), or porridge (16.3%), or other foods (27.9%). The age for weaning babies is generally quite high, the average age being 24 months (Table 3). Some babies are not weaned until the age of 30 months, which is the upper limit. In the districts of KARIMAMA and SEGBANA, all of the babies are weaned between the age of 21 and 30 months, whereas in SINENDE 33.3% of the babies are weaned between the age of 16 and 20 months.

DISTRICTS**PERCENTAGE OF BABIES WEANED
BETWEEN AGE OF 21 AND 30 MONTHS**

KARIMAMA	100.0
SEGBANA	100.0
BANIKOARA	86.2
PERERE	83.3
KALALE	76.5
PARAKOU	75.0
MALANVILLE	75.0
N'DALI	75.0
GOGOUNOU	74.3
KANDI	73.3
TCHAOUROU	71.9
NIKKI	71.1
BEMBEREKE	62.3
SINENDE	61.1

Relatively few children have health problems (Table 4) by the time they are weaned (31.7%) which is understandable considering their advanced age. Those with the most health problems are the PEULH (42.6%), and those with the least are the YORUBA (21.1%), as shown in the following table:

NATIONALITY**HEALTH PROBLEM
AT TIME OF WEANING
%**

YORUBA	21.1
DENDI	22.1
BARIBA	32.5
PEULH	42.6

At the District level, in BEMBEREKE (46.3%) and SEGBANA (46.4%) babies have the greatest problems at the time of being weaned.

In SINENDE the babies have the least problems (17.9%). The major health problems encountered at the time of weaning are diarrhea (49.8%) and some cases of fever (14.6%) which causes loss of weight (12.6%) (Table 5). The PEULH seem to be the group most affected by the problem of diarrhea (68%). It is the most significant problem for all groups.

NATIONALITY	MAJOR PROBLEM AT TIME OF WEANING	%
PEULH	DIARRHEA	68.0
DENDI	DIARRHEA	61.9
BARIBA	DIARRHEA	49.8
YORUBA	DIARRHEA	25.0

The Table which follows reflects the distribution of the primary problem at the district level.

DISTRICTS	MAJOR PROBLEM AT TIME OF WEANING	%
BANIKOARA	DIARRHEA	88.9
BEMBEREKE	FEVER	40.0
GOGOUNOU	DIARRHEA	28.6
KALALE	FEVER	28.6
KANDI	DIARRHEA	82.8
KARIMAMA	UNDETERMINED	54.5
MALANVILLE	DIARRHEA	70.0
N'DALI	DIARRHEA	84.2
NIKKI	DIARRHEA	75.0
PARAKOU	DIARRHEA	43.2
PERERE	UNDETERMINED	36.4
SEGBANA	DIARRHEA	38.5
SINENDE	DIARRHEA	37.5
TCHAOUROU	LOSING WEIGHT	75.0

When health problems occur at the time of weaning, the households resort to pharmaceutical treatments (50.7%), and native remedies (39.4%). Table 3 shows that 9% do nothing, and 1% perform ceremonies. The YORUBA are the ones who resort the most to pharmaceutical remedies and the PEULH to native remedies.

NATIONALITY	PHARMACEUTICAL REMEDIES %	NATIVE REMEDIES %
BARIBA	51.3	31.7
DENDI	33.3	42.9
PEULH	44.0	56.0
YORUBA	85.7	14.3

In SINENDE and SEGBANA, pharmaceutical remedies are resorted to the most. Native remedies are resorted to the most in GOGOUNOU and PERERE.

Concerning the other members of the family, Table 7 shows that all complain of the lack of food (99.5%). No nationality, no district escapes from this. This is not a problem that occurs throughout the year, but during the period between the planting and the harvesting (see the commentary on the districts). Many who have used up their supplies suffer from famine. This is a problem that does recur each year. Table 8 shows that eating to one's fill is not related to the number of persons in the household, or the main activity of the head of household (Table 9). Civil servants, as well as merchants or farmers, complain of not always being able to eat to their heart's content. During the year, in general, the people take three meals per day (70.3%) and 22.3% take only 2 meals per day (Table 10). Discrepancies occur among the ethnic groups, as shown in the next table:

NATIONALITY	THREE MEALS %	TWO MEALS %
YORUBA	89.7	5.1
BARIBA	72.3	21.3
PEULH	66.1	14.5
DENDI	55.6	40.3

Thus, the YORUBA and BARIBA have the highest percentage of households eating 3 meals a day, whereas the DENDI 40.3% eat only two meals a day. The highest percentage of population who take 3 meals a day is in NIKKI (98.2%) and PARAKOU (90%), most of the population in KARIMAMA and MALANVILLE have only 2 meals. Table 11 reveals that there is a slight relationship ($r = .10$) between the number of meals per day and the size of the households: the larger the size of the household is the greater the number of meals. This implies that the large households have more food available than the small households. Also, there is a slight relationship ($r = .09$) between the number of meals and the main activity of the head of household: a larger percentage of civil servants than farmers eat 3 meals per day (Table 12).

Table^o13 shows that in general there is no regular time for the meals: only 23.9% of the households of BORGOU eat their meals at a regular time. The FON and the YORUBA are the ones with the highest percentage of regular time for meals and the PEULH have the lowest percentage:

NATIONALITY	REGULAR TIME
FON	52.9
YORUBA	41.0
BARIBA	23.4
DENDI	19.4
PEULH	17.2

Although there is no relationship between the fact that meals are eaten at a regular time and the size of the household (Table 14), there is a relationship ($r = .16$) with the main activity of the head of household. Merchants and civil servants have the highest percentage of a regular time for their meals. This can be understood in the case of the civil servants, since the working hours determine the meal times.

Tables 15 to 19 show that there is no difference between the composition of the meals of children and that of adults. Table 15 shows that at breakfast one eats either porridge, "pâte" or "pâte acide". Table 17 shows that at lunch people eat "pâte", porridge or yams, and for supper they again eat "pâte" (Table 19). About 80% of the population eat "pâte". The meals, are very simple and are composed essentially of cereals and tubers. Table 20 shows that the composition of the meals is the same regardless of the activity of the heads of household.