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NATURE OF HEALTH CARE SEEKING BEHAVIOUR AMONG THE ELDERLY/AGED IN KOKONA LOCAL GOVERNMENT AREA OF NASARAWA STATE, NIGERIA

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Abstract
Elderly persons, particularly the frail older adult, have been the most significant consumer of health resources. This paper examines the nature of health care seeking behaviour among Elderly persons in Kokona Local Government Area of Nasarawa State, Nigeria. A social survey design was adopted. A sample of 383 elderly persons aged 60 years and above was drawn, using multi-stage sampling techniques including simple random, systematic sampling, clustered and purposive sampling techniques in the selection of electoral wards, towns/villages, main streets, houses, households and individuals. Primary and secondary data were utilized in the study. The primary data were generated through the use of questionnaires and in-depth interview. The questionnaires were analyzed quantitatively using descriptive statistics, such as frequency distribution, mean and percentage. The qualitative data were analyzed using content analysis. The results show that most of the elderly visit both orthodox and non-orthodox health care facilities. The paper recommends that there is need for Government, Non-governmental organizations, religious organizations and community/traditional leaders to create awareness on the negative/harmful effect of self-medication among the elderly persons. Also, Health care provision and advice should include education so as to increase awareness on good nutrition for the elderly, food supplements and adherence to good dietary regime.

Introduction

Elderly persons, particularly the frail older adult, have been the most significant consumer of health resources (Young, 2013). Old people need health care because old age is associated with pain and ill health (Chen, 2012). According to Campbell (2012), this rapid growth of the elderly population is a challenge to the medical profession, administration and the society as well. The delivery of health care to the older adults has been recognized to be more complex than that of younger adults because, according to Mion (2003), the elderly persons utilize the majority of health care services. The complex needs have implication for future health care delivery to the geriatric population. Specifically in Nigeria, the number of elderly citizens has been on the increase and their health needs receiving popular recognition (Abdulraheem, 2007).

Ageing is a global phenomenon hence a critical policy issue receiving some recognition by governments of developed countries where it is reflected in the government's vital document of economic and social development strategy (Okoye, 2012). Furthermore, globally, the greatest increase in the number of older people is occurring in the developing and middle income countries. Nigeria is not an exception. Nigeria still has a relatively young population when compared to most European countries and other countries where life expectancy is high. However, as medical advances allow people to live longer, the proportion of the elderly will increase in Nigeria (Okoye, 2012).

World Health Organization (2013) observed that the population of Nigerians Elderly 60 years and above is already increasing. United Nation's population profile (2015), shows that there were 5 million Nigerians elderly 60 years and above in 2015 and the number will continue to increase by year 2025, it is estimated that 6% of the population will be 60 years and above. Abdulraheem (2007) stated that it may be necessary for policy makers to consider establishing neighborhood adult day care centres where elderly persons can meet each other during the day. Other services like medical, nutritional, recreational and educational services can also be incorporated into the neighborhood day care centres (Okoye, 2012). The use of adult day care centres has been reported by many scholars to be very advantageous to elderly persons and their families.

Provision of health care services for older people is different across countries, continents and cultural societies. In developed regions of the world, health care is often provided by well-equipped public health facilities and nursing homes designated for the elderly individuals. In United States, older adults have a higher frequency of primary care visit, 50% hospital consultation, 80% home care services and occupy 90% of all nursing home beds (Moe, 2012). Paradoxically, in developing regions, the picture is rather different as the contemporary health care facilities might not be the first point of contact for an elderly person.

In Nigeria, Nasarawa State and Kokona Local Government Area poverty is rife and elderly persons are more at risk since most of them are no longer in the economically active phase of life and there is no national social security to provide economic support in old age. Access to health care is severely limited both by paucity of health facilities and manpower and by out-of-pocket payment arrangement. Social network is dwindling and traditional family support is decreasing as urbanization and migration takes young members of the family away. Also, social changes are affecting the position of the elderly in the society and leading to a reduction in their social status and influence in the community.

In Nigeria, geriatrics care has not yet received its desire attention. Most elderly persons utilize the conventional health care facilities whenever they fall ill while others subscribe to self medication with orthodox medicine and traditional herbs. In Kokona Local Government Area of Nasarawa State, there are no known available social support services, elderly homes and designated health facilities where health care for the elderly population is prioritized. In some situations, most elderly persons tend to depend on their families, relatives and friends for utmost care. This accounts for why they are care-dependent. From the foregoing, the paper examines the nature of health care seeking behaviour among the elderly/aged in Kokona Local Government Area of Nasarawa State, Nigeria.

Conceptual and Theoretical Framework

Elderly

Elderly is a process of growing old. It is a normal phenomenon which includes growth and maturity of the body. There are many physical and psychological changes in the process of aging or growing old. These changes are not harmful but bodily function is gradually being decline (Pasco & Pinellas, 2013).

Rajan, (2010) opine that, elderly is a biological, social and psychological process. Because elderly is essentially a cultural category, its meaning and significance vary both historically and culturally, elderly, in almost every society, is one of the major characteristics that determine groupings and role assignments. How elderly people are, or the reaction of other people to them, play a larger part in affecting how they feel about themselves and whom they interact with, and what the society expects of them. Cultural definition of the elderly varies from society to society. In most societies, elderly served as a basis for defining cultural and social characteristics of human beings for the formation of some of their natural allocation of social roles. Aluko (2007) added that, the elderly as an integral component of social life is highly valued in indigenous African societies where it is celebrated as 'the age of wisdom and of teaching. In modern non-Western pluralistic societies, e.g. Nigeria, India, and China, elderly are highly respected as the repositories of inherited wisdom and experience and they are the principal decision-makers. However, in our constantly changing societies, the accumulated knowledge of the elderly is rarely viewed as the source of wisdom; it is commonly regarded as something outdated and obsolete (Paul, 2011).
Many westernized concepts do not adapt well to the situations in Africa. Goman (2000) defined elderly in many developing countries to begin at a point where their contribution is no longer active, or age at which one begin to receive pension benefits. In this paper the researcher defined "elderly" as a chronological age of 60 years old or older, while those from 65 through 74 years old are referred to as "early elderly" and those over 75 years old as "late elderly.

Health Seeking Behaviour

Health-seeking behaviour is a process by which an individual acts to maintain the state of physical fitness and well-being that enables man to manage the physical, social and biological environments to his/her own satisfaction. Adeniyi and Ogunsola (2009) identified building conducive houses for living, managing wastes and pollution to improve the potentials and limitations endowed in individual by correcting the correctable limitations and preventing the health hazards that may result as evidences of environmental management by man.

For Olenja (2003) Health seeking behaviour (HSB) is defined as, "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy". It can also be referred to as illness behaviour or sick-term behaviour. Health seeking behaviour is situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a good state of health (MacKian, 2003).

The paper concurred to the definition offered by Olenja (2003) that health seeking behaviour (HSB) as any action or inaction undertaken by individuals who perceive themselve to have a health problem or to be ill for the purpose of finding an appropriate remedy. It can also be referred to as illness behaviour or sick-term behaviour. For the purpose of this study, health seeking behaviour of the elderly is assessed by the types of medicine (orthodox or traditional) they rely on when they are sick. Also, the health facilities they are disposed to attend or to patronize (Government or private) to use when they are sick.

Theoretical Framework

This paper is situated within the Max Weber's Social Action theory. Max Weber (1864-1920) was one of the founding fathers of Sociology. Weber saw both structure and action approaches as necessary to developing a full understanding of society and social change. In one of his most important works 'Economy and Society', first published in the 1920s, he said 'Sociology is a science concerning itself with interpretive understanding of social action and thereby with a causal explanation of its course and consequences.'

Weber's extensive contribution to Sociology was grouped into three things; firstly he argued that '*Verstehen*' or empathatic understanding is crucial to understanding human action and social change, a point which he emphasized in his classic study 'The Protestant Ethic and the Spirit of Capitalism'; secondly, he believed we could make generalizations about the basic types of motivation for human action; and thirdly, he still argued that structure shaped human action, because certain societies or groups encourage certain general types of motivation (but within these general types, there is a lot of variation possible). Weber argued that before the cause of an action could be ascertained you had to understand the meaning attached to it by the individual. He distinguished between two types of understanding.

First he referred to *Aktuelles Verstehen* or direct observational understanding, where you just observe what people are doing. For example, it is possible to observe what people are doing for example, you can observe someone chopping wood, or you can even ascertain (with reasonable certainty) someone's emotional state from their body language or facial expression. However, observational understanding alone is not sufficient to explain social action.

The second type of understanding is *Eklarendes Verstehen* or Empathetic Understanding in which sociologists must try to understand the meaning of an act in terms of the motives that have given rise to it. This type of understanding would require you to find out why someone is chopping wood. Are they doing it because they need the firewood, are they just clearing a forest as part of their job, are they working off anger, just doing it because they enjoy it? To achieve this Weber argued that you had to get into the shoes of people doing the activity (Weber, 1960).

Weber posited that the action of an individual towards an issue or object is determined or influenced by the definition of the situation. This sociological perspective focuses on the acting individual and the acting group. The social action theory gives a complete and comprehensive picture of the interaction between the actor and the environment in which the actor operates. As explained by Weber (1960), explanation of social action must arise from the definitions of the situation and purposes of the actors. In action is included all human behaviour when and insofar as the acting individual attaches a subjective meaning to it. Action in this sense may be overt or purely inward or subjective (Weber, 1960).

Weber postulated that cultural values circumscribe and direct social action and as such, another main defining agency is the community. Owing to Weber's overt emphasis on individual meaning, Talcott Parsons Voluntaristic Social Action Theory was employed to strengthen the shared meaning aspect of human action, which is the main force in individual behaviour. Parson's Voluntaristic Action Theory is a variant of the functionalist perspective. This theory emphasizes constraint of individual within particular customs and values. This helps to explain human behaviour with regard to socio-cultural factors and their influence on perceptions and attitudes. Much like Weber's action theory, which asserts the primacy of the society over the individual (Giddens 2000), it argues that societies exert social constraint over the actions of individuals.

This perspective focuses on the course of action as determined by the conditions of the cultural, physical and social environment; society influences the end which the actor seeks and the means he/she will use in attaining them. Parsons' theory like that of Weber states that action can be explained in the context of the subjective meaning, given to it by the actor and that actions are always directed at the attainment of goals with the choice of the most appropriate method by the actors (Weber, 1960).

Applying Max Weber's social action theory to the study of health care seeking behaviour among the elderly in Kokona Local Government Area of Nasarawa State, the assumption is that social action (in this case; health care seeking behaviour) must arise from the definition of the situation, which is to a great extent

culturally defined. That is to say that how the elderly persons seek for health care is determined by the cultural beliefs of the elderly people. This definition of the situation also influences the behaviour of the elderly. It is this culture's ability to define the situation for the person that is responsible for these uniformities in behaviour of a particular people (in this case health care seeking behaviour among the elderly among the elderly in Kokona Local Government Area of Nasarawa State).

Literature Review

Nature of Health Care Seeking Behaviour among the Elderly/Aged

The nature of Health care seeking behaviour among elderly in Nigeria is a growing concern in contemporary times due to the increasing proportion of the elderly population in all societies of the world (UNFPA & Help Age International, 2017). In seeking health care, elderly behaviour differ in relation to the number and type of health care services sought, which is influenced by the nature of the disease and who is experiencing it within the context of what they believe is the causation; and also, when it comes down to individual choices, people with care options will seek the care that perceivably meets their quality, convenience and cost (Mazzilli & Davis, 2009).

Health care behaviour involves a combination of different responses such as seeking traditional care, spiritual care, drug store services, private and public orthodox care which differ over time, opportunity and circumstance in terms of the type of care individuals seek for themselves and members of their family (Mazzilli & Davis, 2009). This behaviour of serial or simultaneous engagements with different health care services are probably due to the belief that, one of the services may provide answers as to the cause of the disease or provide some form of relief or cure (Awusabo-Asare & Anarfi, 1997).

In Nigeria, the practice of home treatment with drugs which could be herbal or, and orthodox medicines bought without prescription from drug stores appear to be a significant health seeking behaviour among the elderly, as observed in a Nigerian study, were most of the elderly within the first 24 hours of the illness use (Tinuade, Iyabo & Durotoye, 2010).

In spite of the fact that, there is widespread popularity of modern health care services especially the private health services which includes both formal and informal drug stores; the traditional and religious health services are still commonly used and according to World Health Organization, at least 80% of people in Africa have used traditional health service at one point or the other in their everyday lives. The practice of traditional health services involves the use of herbs, spiritual intervention and local practices which are occasionally based on superstition. Herbs are natural and as such, its use is believed to be safe, but due to the potential for undesirable interactions with orthodox standardized medicines, the inappropriate combined use, can produce harmful effects. It has been suggested that due to the different perceptions of the nature of an illness, individuals and families either seek traditional health care treatments first, prior to orthodox health care treatments or vice versa, depending on the perceived degree of its potential effectiveness with respect to the different aspects of the illness; and also, the level of satisfaction received during their first treatment contact. However, this implies that both treatments are used concomitant during the course of the same illness, with traditional and orthodox health care treatments being viewed as complimentary and not as alternative treatments (Mazzilli & Davis, 2009).

It is obvious that people, due to a variety of reasons within a variety of contexts, are using traditional health care treatments and probably, increasingly combining them with orthodox health care treatments as observed by their movement back and forth between health services rather than receiving care from one care point. This could potentially have significant effects on health; and therefore, it is important to

recognize this reality of health seeking behaviour (MacKian, 2003). In Nigeria, the use of combined orthodox and traditional health care treatments by the elderly appear to be significant, as prevalence rates of 31%, 61.4% and 63.7% respectively have been reported in different studies (Adibe, 2009).

The complex nature of health seeking behaviour especially in taking a decision towards a particular health care service is further emphasized by the fact that, educating and providing knowledge alone, is not sufficient to influence this behaviour; as other factors are required such as, the individual attitude which contributes to making the individual purposive and decisive; and also the household and the community that makes the individual interactive and dynamic (MacKian, 2003). Furthermore, socioeconomic factors such as sex, age, status, nature of illness, access and perceived quality of services have also been reported to influence the individual health decisions (MacKian, 2003). However, health care generally, and especially for the rural and urban poor elderly cannot be effectively provided, unless there is a basic understanding of their individual and environmental characteristics, health practices and also, their value and belief system which is embodied in their attitudes towards seeking health care (Adibe, 2009).

It is not uncommon for people to fall sick and die of disease that can be easily prevented and treated, many communities do not have access to simple remedies of proven or aware of where the services are provided, many people fail to make appropriate use of them, individuals and communities often lack the awareness and essential knowledge on how to keep healthy, how to recognize hazardous situation in the environment and how to mobilize resource to solve health problem, one of the basic problem is the health service provision and management.

The health service management is a process of mobilizing and developing resource for the efficient provision of health service management, environmental health system promote awareness of health care service such as, the socio- cultural norms, belief, attitudes and practice of the people, social infrastructure; road, housing, availability of water, educational strength, health services all within the reach of the individual, the population geography dissension or settlements demographic characteristic, political environment; political ideology, political orientation, political climate, economic environment, government policy, legal and regulatory environment (Okoye, 2012).

Campbell (2012) opines that awareness and provision of health care services for the elderly has not been the priority to successive government in Nigeria, according to him, that the 6th senate has passed a bill for an Act to establish a national centre for elderly persons for general purpose of providing welfare and recreational facilities for the elderly and the designing of developmental programmes and activities for the advancement of elderly in Nigeria, the bill sponsored by Senator Ganiyu Solomon was passed in July 14 2009. Another similar bill sponsored by Senator Anyin Ude in June 2010, the bill titled an Act to provide social security for unemployed graduate and the Elderly in Nigeria for purpose connected thereto. Campbell (2012) asserts that the bills were never implemented and for the elderly to be aware of health care services, training and engagement of social workers to publicize government implemented policies for the Elderly and where and when to receive health care services made for them, formulation of a state policies on the care for the elderly , national policy on the care and welfare of the elderly, health service centre should be located within the reach of the Elderly and that will create awareness on services available to them for use.

Elderly persons, particularly the delicate older adults, have been the most significant consumer of health resources (Young, 2003). Old people need health care because old age is associated with pain and ill-health (Patterson, 2012). Worldwide, the increase in the proportion of elderly is in response to improvement in health technologies and life expectancy of people (Moe, 2012). For Mannisto, (2010), this rapid growth of the elderly population is a challenge to the medical profession, administration and the society as well.

To Ajomale (2007) that many Nigerians do not benefit fully from modern technology that could have protected and resorted their health, therefore questions are rise in respect of health care, how can health service be organized to ensure that maximum from the current knowledge and available technology, for promotion, maintenance, and restoration of health?

Kaur (2009) asserts that to enable health care practice for the older age, it is paramount that quality should be emphasized, quality in health care is a product of cooperation between patient and health care provider in a supportive environment, health care quality is the only means through which people will appreciate , accept, and practice optimal healthful living. According to Kaur (2009) health care quality can be improved by supportive visionary leadership, proper planning, education and training of social workers and medical personnel, availability of resource, collaboration and cooperation among providers.

Methodology

Kokona Local Government Area covers an area of 1,844 km². The Local Government Area is bounded to the west and north-west by Karu Local Government Area, also to the west by Keffi Local Government Area, to the north-east by Kaduna State, to the east by Akwanga, Nasarawa Eggon and Lafia Local Government Areas, and to the south by Nasarawa Local Government Area. Kokona Local Government Area is one of the thirteen Local Government Areas in Nasarawa State, Nigeria. This study adopts the social survey research design. The social survey entails a research design that allows the collection of data from a fraction of a study population, which can be seen as truly representing the larger population using the questionnaire and In-depth interview (IDI). Kokona Local Government Area has a projected population of 146,500 populations as at 2018 (National Population Commission, 2018). However, the target population for this study is not the entire population of Kokona Local Government Area but the elderly persons, both male and female, who are 60 years and above in some selected electoral wards which include Agwada, Amba, Dari, Garaku, Kofar Gwari, and Kokona. The population of this category of people from the selected electoral wards is 32,325 (Kokona Local Government Primary Health Care Department, 2008).

Sample size was determined using Yamane (1967) statistic, where n= required sample size, N=population size (the universe) e=sample error (usually 10,05 and 01 acceptable error) and n=raised to the power of 2

According to Yamane, (1967):

$$n = \frac{N}{1 + N(e)^2}$$

Where:
N = Total population,
n = required sample size
e = margin of error allowed (5%)
Hence
$e = (0.05)^2$,
n = 32, 325

$$n = \frac{32,325}{1+ 32,325\ (0.05)^2} = \frac{32,325}{32,326\ (0.0025)} = \frac{32,325}{80.813}$$

$$n = 399.9$$

$$n = 400 \text{ app.}$$

The study employed multistage sampling technique. A multistage sampling technique involves selecting sample from another sample. In this sampling procedure, the primary groups and sub-groups are selected on the basis of geographical distribution rather than other characteristics. Multistage sampling technique was employed in the selection of electoral wards; streets; houses/compounds, household and respondent/individual. In the In-depth interviews, purposive sampling technique was employed in the

selection of respondents for the study. Purposive sampling involves purposive selection of sample units. The sample units were chosen on the basis of the judgment of the researcher.
The reliability and validity of information for the study demand both Primary and Secondary sources of data collection. For the primary data, the study relied on Questionnaire and In-depth interview (IDI). This paper elicits data from quantitative and qualitative methods. Quantitative data were analyzed using univariate analysis. The univariate analysis involves the use of descriptive statistics, such as frequency distribution, mean and percentage. The qualitative data were analyzed using content analysis.

Table 1: Responses on type of medicine respondents rely on when sick

Response	Frequency	Percentage (%)
Orthodox medicine	240	62.7
Traditional medicine	143	37.3
Total	**383**	**100.0**

Source: Field Survey, 2019

Table 1 explains the channels most respondents in the sampled areas of the study rely mostly on medical help when sick. The data show that 62.7 percent of respondents use orthodox or modern medical channel. This is because of the growing popularity and safety of orthodox or modern medicine among African societies. In addition to that, the dominant religion in the sampled areas of the study which is Christianity discourages the utilization of traditional/complementary medicine. This may have equally influenced the utilization of orthodox or modern medicine when respondents are sick.

This attracted a strong support from interviewees during an in-depth interview (IDI) conducted in the sampled areas. Overwhelming proportion of the interviewees accepted with one voice that they rely more on orthodox or modern medicine than traditional or complementary medicine because it is safe, more preferable and appropriate dosage compare to traditional medicine. An interviewee, a traditional leader captured the general position of the interviewees' thus:

> *For me no matter the cost of medication I prefer going to hospital. You get good drug prescription, with no side effect, more preferable and correct dosage*

Table 2: How often respondents visit/consult Traditional health practitioners when sick

Traditional healer	**Frequency**	**Percentage (%)**
Most often	56	14.6
Often	58	15.1
Not often	83	21.7
Not at all	186	48.6
Total	**383**	**100.0**
Herbalist	**Frequency**	**Percentage (%)**
Most often	49	12.8
Often	43	11.2
Not often	90	23.5
Not at all	201	52.5
Total	**383**	**100.0**
Sorcery	**Frequency**	**Percentage (%)**
Most often	34	8.9
Often	38	9.9
Not often	59	15.4
Not at all	252	65.8
Total	**383**	**100.0**
Native doctor/medicine man	**Frequency**	**Percentage (%)**
Most often	55	14.4
Often	56	14.6
Not often	91	23.8
Not at all	181	47.3
Total	**383**	**100.0**
Soothsayer	**Frequency**	**Percentage (%)**
Most often	30	7.8
Often	35	9.1
Not often	74	19.3
Not at all	244	63.7
Total	**383**	**100.0**
Native healer	**Frequency**	**Percentage (%)**
Most often	58	15.1
Often	49	12.8
Not often	62	16.2
Not at all	214	55.9
Total	383	100.0

Source: Survey Field, 2019

Table 2 shows how often respondents visit/consult traditional health practitioners when sick. Majority of the respondents don't often visit the non-orthodox or traditional practitioners when they are sick. This can be attributed to the fact that most of them visit hospitals and other patent stores when they are sick. Also, the low patronage of the traditional health practitioners in the sampled areas is as a result of exorbitant

charge by the traditional health practitioners. Majority of the respondents in the sampled areas are low income earners.

This was corroborated in an in-depth interview (IDI) conducted where interviewees confirmed with clear agreement that majority of the elderly persons in the sampled areas do not patronize the traditional practitioners. One of such interviewees (community leader) had this to say:

> *One common thing is that when an individual is sick he/she can reach out easily and faster to hospital and chemist/patent medicine shops. Currently, there is a programme for indigent elderly persons sponsored by World Bank and the health care services are free. The Primary Health Care has outreach programme for the elderly persons in the community. That's why majority of the elderly persons don't patronize the traditional practitioners such as herbalists, traditional healers, prayer houses, native doctors/medicine men, native healers and soothsayers.*

Table 3: How often respondents visit/consult health workers when sick

Nurse	**Frequency**	**Percentage (%)**
Most often	45	11.7
Often	96	25.1
Not often	98	25.6
Not at all	144	37.6
Total	**383**	**100.0**
Midwife	**Frequency**	**Percentage (%)**
Most often	40	10.4
Often	61	15.9
Not often	126	32.9
Not at all	156	40.7
Total	**383**	**100.0**
Pharmacist	**Frequency**	**Percentage (%)**
Most often	72	18.8
Often	102	26.6
Not often	98	25.6
Not at all	111	29.0
Total	**383**	**100.0**
Medical doctor	**Frequency**	**Percentage (%)**
Most often	80	20.9
Often	74	19.3
Not often	112	29.2
Not at all	117	30.5
Total	**383**	**100.0**
Dentist	**Frequency**	**Percentage (%)**
Most often	48	12.5
Often	45	11.7
Not often	119	31.1
Not at all	171	44.6
Total	**383**	**100.0**
Optometrist (eye specialist)	**Frequency**	**Percentage (%)**
Most often	44	11.5
Often	70	18.3
Not often	101	26.4
Not at all	168	43.9
Total	**383**	**100.0**

Source: Field Survey, 2019

Table 3 indicates how often respondents visit/consult health workers when sick in the sampled areas. Overwhelming proportion of the respondents visit/consult medical doctor most often than any other orthodox health practitioners with 20.9 percent of the total respondents. Also, some proportion of the elderly in the sampled areas said that they often visit the pharmacist for consultation and for medicines when they are sick with 18.8% of the total respondents. Large percent of the respondents in the sampled areas have easy access of seeing medical doctors than any other orthodox health practitioners because most of the health care centres are superintendent by medical doctors

Table 4:Responses on whether respondents ever had medication without doctor's prescription

Response	Frequency	Percentage (%)
Yes	246	64.2
No	137	35.8
Total	**383**	**100.0**

Source: Field Survey, 2019

In Table 4, 64.2 percent of respondents agreed that they have ever taken medication without a doctor's prescription. This is because majority of the respondents in the sampled areas engaged in self-medication because they do not need to pay consultation fees, it is very cheap, convenient and the accessibility to chemist/patent stores. Also they believe that self-medication reduce the bureaucratic bottleneck involved to see medical doctors and other health workers since overwhelming proportion of the respondents engaged in farming and others activities.

Table 5: Responses on how often respondents used medication without doctor's prescription

Response	Frequency	Percentage (%)
Most often	51	20.7
Often	93	37.8
Not often	102	41.8
Total	**246**	**100.0**

Source: Field Survey, 2019

Table 5 indicates how frequent respondents use medication without doctor's prescription as result shows that a total of 58.5 percent of respondents frequently use medication without doctor's prescription. This shows that majority of the respondents in the sampled areas of the study engaged in medication without doctor's prescription.

Interviewees in the in-depth interview (IDI) pointed out that medication without doctor's prescription is common in the sampled areas. That high number of respondents (elderly persons) engaged on self-medication because of accessibility to chemist/patent shops, convenience and affordability. This was corroborated by traditional leader that:

> *Elderly persons in the area engaged in self-medication. They prefer buying drugs from chemist/patent stores and do self-medication. They believe it cheap, convenient and no time consuming.*

In a different opinion a religious and women leaders in the sampled areas had this to say:

Personally I don't do self-medication and I don't advice anybody to do that. My brother is not well self and I advised him to go to clinic for proper medication. I give herbs for backache even medical doctors and big men come to collect it from me but I also seek orthodox health care services. One common thing is that most people still engaged in medication without doctor's prescription in my community.

We have hospital in this village but some elders' people don't go to hospital they believe in self-medication through patronizing chemists/patent medicine shops, herbalists and prayer houses. Whenever I'm having signs I go to hospital to run test.

Table 6: Respondents view on health facilities they patronize most when sick

Response	Frequency	Percentage (%)
Government hospital/health centre	240	62.7
Private hospital/health centre	143	37.3
Total	**383**	**100.0**

Source: Field Survey, 2019

Table 6 explains how respondents patronize government hospitals and health centres than private health facilities. Larger percentage of the respondents in the sampled area attests that they patronize government hospital/health centre more with 62.7 percent of the total respondents. Government's policy of subsidizing health care services to its citizenry in all nooks and crannies of the nation may have given rise to this level of patronage because, health care services and drugs are subsidized for all citizens in rural and urban areas of the country, and hence, they utilized the publicly owned hospitals and health care facilities than private hospitals or health centre.

This was corroborated in an in-depth interview (IDI)conducted in the sampled areas which the interviewees affirmed that they prefer government hospitals to private hospitals because government subsidizes the services offer by the hospitals or health care centre and it is also accessible to larger number of citizens even in rural areas of the country. The position of an interview (a community leader) was captured as thus:

In this community elderly persons prefer to go to government hospital or health care centre than private hospital. They believe services rendered by government hospitals are affordable, safe and cheap. Already there is a World Bank sponsored programme for the indigent elderly persons in the community which is free.

Table 7: Respondents reasons for the choice of Government Hospital

Response	Frequency	Percentage (%)
It is cheap	114	29.8
They have good drugs	50	13.1
They are the only care provider in my village	75	19.6
Provide quality care	54	14.1
Convenience	28	7.3
Has qualified personnel's	62	16.2
Total	**383**	**100.0**

Source: Field Survey, 2019

Table 7 revealed that most of the respondent said their main reason of visiting the Government hospital is because it is cheap with 29.8 percent of the respondents in the sampled areas of Kokona Local Government Area of Nasarawa State. Others said their choice of government hospital is because good drugs are available

while others said it's because they have qualified personnel's. Larger proportion of the respondents affirmed that they visit Government hospital because it is cheap.

Table 8: Respondents reasons for the choice of Private Hospital

Response	Frequency	Percentage (%)
Faster in attending to patient	141	36.8
Reliable	74	19.3
Frequent strikes in Government Hospitals	104	27.2
Efficiency in service delivery	64	16.7
Total	**383**	**100.0**

Source: Field Survey, 2019

Table 8 indicates respondents' reasons for the choice of Private Hospital in the sampled areas of the study with 36.8 percent of the total respondents attesting that they visit or patronized private hospital because it is faster in attending to patient. Others said the choice of private hospital is because it is reliable, frequent strikes in government hospitals and efficiency in service delivery as reasons for the choice of private hospital over government hospital. From the data in the table, it is clear that overwhelming proportion of the respondents visit or patronized private hospital because they are faster in attending to patient in the sampled areas of Kokona Local Government Area of Nasarawa State.

Discussion of Findings

Regarding the nature of health care seeking behaviour findings revealed that most of the elderly visit both orthodox and non-orthodox health care facilities. This is because those health care facilities are available in the study area. But the mostly utilized of these facilities are the hospitals. This is because they are readily available as most communities in the local government have primary health care centres. This corroborates with the findings of Mazzilli & Davis, (2009) that in spite of the fact that, there is widespread popularity of modern health care services especially the private health services which includes both formal and informal drug stores; the traditional and religious health services are still commonly used and according to World Health Organization, at least 80% of people in Africa have used traditional health service at one point or the other in their everyday lives. The practice of traditional health services involves the use of herbs, spiritual intervention and local practices which are occasionally based on superstition. Herbs are natural and as such, its use is believed to be safe, but due to the potential for undesirable interactions with orthodox standardized medicines, the inappropriate combined use, can produce harmful effects. It has been suggested that due to the different perceptions of the nature of an illness, individuals and families either seek traditional health care treatments first, prior to orthodox health care treatments or vice versa, depending on the perceived degree of its potential effectiveness with respect to the different aspects of the illness; and also, the level of satisfaction received during their first treatment contact. However, this implies that both treatments are used concomitant during the course of the same illness, with traditional and orthodox health care treatments being viewed as complimentary and not as alternative treatments

Conclusion and Recommendations

Aged people constitute a major category of population that demands attention. When people begin to age, their physical body and immune system begins to fail them. Thus most of them become vulnerable to different diseases such as high blood pressure, heart or cardiac problems, diabetes, joint pains, kidney infections, cancer and tuberculosis that take a lengthy of time to heal. To improve their health status, most of the elderly utilize both orthodox and traditional medicine. While others visit hospitals and adhere to

medical prescriptions, some of them prefer self-medication. This health seeking behaviour is largely determined by the affordability of health providers, type and severity of the ailments/diseases, education background, age, gender, most importantly the availability of healthcare services. Based on the findings of the paper, the following recommendations were made;

i. There is need for Government, Non-governmental organizations, religious organizations and community/traditional leaders to create awareness on the negative/harmful effect of self-medication among the elderly persons. Self-medication can lead to serious drug-related problems in the form of therapeutic failure or toxicity, drug addiction, allergy, habituation, worsening of ailment, incorrect diagnosis and dosage, or even disability and pre-mature death. The perception of the elderly persons about self-medication indicates need for more accurate information about the behaviours expressed by the elderly. This can be achieved not only through actual interaction but also through educating elderly persons at all levels on safe and appropriate/proper medication.
ii. There should be an increase availability of key services by health administrators for the aged population which is a crucial approach to improve health care seeking behaviour among the old. Periodic orientation should be conducted by health administration for health care personnel on rudimentary principles of human relations to make better friendly services for the elderly who need special services.
iii. Health care provision and advice should include education so as to increase awareness on good nutrition for the elderly, food supplements and adherence to good dietary regime.
iv. Establishment of public health centers in the core rural areas by the government, Non-governmental organizations, religious organizations, communities and spirited individuals would increase the proximity and accessibility of rural aged persons to health facilities.

References

Abdulraheem I.S. (2007). Health needs assessment and determinants of health seeking behaviour among elderly Nigerians. *A Household Survey, Ann Afr Med, 6(2) 58- 63*

Adeniyi, T. & Ogunsola, M. T. (2009). Nature and nurture as determinants of health status among secondary school students in Atiba local government, Oyo State. COEASU book of Readings: *A Multidisciplinary Studies. A Publication of Federal College of Education Abeokuta, Nigeria.* (2), pp.56-63.

Adibe, M.O. (2009).Prevalence of concurrent use of herbal and synthetic medicines among out patients in a mission hospital in Nigeria. *International Journal of Drug Development and Research,* 1 60-66.

Ajomale, O. (2007). Country report: ageing in nigeria current state, social and economic implications. *African Gerontological Society.*

Aluko Y.A. (2007). Old age and social security in nigeria: challenged of the new world order: *International Journal of Social and Management Sciences.* Vol. 1 No. University of Ghana http://ugspace.ug.edu.

Asagba, A. M. (2005). School of public health, Tehran University of medical science, *Iran International Journal on Health Policy Management 77 and 89.*

Awusabo-Asare, K. & Anarfi, J.K. (1997). Health-seeking behaviour of persons with HIV/AIDS in Ghana. *Health Transition Review,* 7, 243-256.

Buor, D. (2003). Analysing the primacy of distance in the utilization of health services in the Ahafo-Ano South district, Ghana. *International Journal of Health Planning &Management*, 18(4), 293-311.

Campbell, C. (2012). *Essentials of Health Management Planning and Policy.* Lagos: University of Lagos Press.

Chen, C. Y. (2012).*Cooking Frequency May Enhance Survival in Taiwanese Elderly.* Public Health Nutrition: p. 1-8.

Federal Republic of Nigeria (2006). Population census of the Federal Republic of Nigeria: *Preliminary Report. Abuja: National Population Commission*

Giddens, A. (2000). *Sociology,* 3rd ed. Oxford, Polity Press.

Goman, H. (2000).*Elderly in Modern Society: An Africa Experience.* New York: International Federation on Aging.

Kaur, S. (2009).Interventions that can reduce inappropriate prescribing in the elderly: *a Systematic Review. Drugs Aging. 26(12): p. 1013-28*

Mackian, S (2003).*A Review of Health Seeking Behaviour; Problems and Prospects. University of Manchester Health Systems Development Programme,* UK Department of International Development, United Kingdom.

Mamman M.S, & Attah, A.P, (2019) *Socio-Demographic Characteristic of the Elderly and their Health Care seeking Behaviour in Kokona Local Government Area of Nasarawa State, Nigeria. International Journal of Peace and Conflict Studies (IJPCS),* Vol. 6, No 1, June/July, 2019. http://www.rcmss.com/index.php/jggsda; DOI URL:https://doi.org/10.36758/ijpcs/v6n1.2019/06

Mannisto, S. (2010).Monitoring diet and in Finland. *Public Health Nutrition,. 13: p. 907-914*.

Mazzilli, C. & Davis, A. (2009). *Health Care Seeking Behaviour in Somalia:* A literature review.UNICEF,10.https://www.unicef.org/somalia/SOM_HealthcareseekingbehaviourReport_10-WEB pdf

Mion, L. C. (2003). More provisions for the older adults: who will provide? *Online journal of issues on nursing,* 8(2), Retrieved from: www.nursingworld.org.

Moe, S. K. (2012). Health seeking behaviour of elderly in Myanmar, *International Journal of Collaborative Research on Internal Medicine and Public Health, 4(8), 1538-1544.*

National Population Commission (2003) Nigeria Population census 1991 analysis Volume 3.

National Population Commission (2017).*Projected Population of Kokona Local Government Area of Nasarawa State, Nigeria*; Retrieved on December 14, 2017 from http//www.citypopulation.de

Okoye, U.O. (2012). Family care-giving for ageing parents in Nigeria: gender differences, cultural imperatives and the role of education. *International Journal of Education and Ageing 2 (2), 139–154.*

Olenja, J. (2003). Health seeking behaviour in context. *East African Medical Journal*; 80(2):61-62.

Parsons, T. (1937). *The Structure of Social Action.* New York, McGraw Hill.

Pasco & Pinellas (2013). Household food insecurity and coping strategies in a poor rural

Patterson, S.M. (2012), Interventions to improve the appropriate use of polypharmacy for older people. *Cochrane Database System Rev.*

Paul, O. K, (2011). *Family Support for the Elderly in Delta State.* Department of Sociology and Psychology, Delta State University, P.O. Box 1, Abraka Delta State, Nigeria Telephone: +234-803-7645-971, ghene_okumagba@yahoo.com

Rajan, S. I. (2010). *Demographic Ageing and Employment in India.* Bangkok, Thailand:

Shehu, R. A. (2005). Relationship between demographic factors and lifestyle of the people of Kaduna State, Nigeria. *Unpublished Doctoral Dissertation.* Ahmadu Bello University, Zaria, Nigeria.

Tinuade, O., Iyabo, R.A. & Durotoye, O. (2010). Health-care-seeking behaviour for childhood illnesses in a resource-poor setting. *Journal of Paediatrics and Child Health, 46 , 238-242*. https://doi.org/10.1111/j.1440-1754.2009.01677.x

UNFPA (2017). *World Population Prospects*. The 2006 revision population database United Nations Population Division New York: United Nations.

Weber, M. (1960). *The theory of Social and Economic Organization*. New York, Free Press.

World Health Organization, (WHO) (2013).*Abuse of the Elderly (Fact sheet).*Available at www. who.int/violence.injury.prevention.

Yamane, T (1973). *Statistics, An introductory Analysis,* 2nd Ed., New York: Harper and Row

Young, H.M. (2003). Challenges and solutions for care of frail older adults. *Online Journal of Issues on Nursing, 8(2)*