ORIGINAL ARTICLE

FACTORS INFLUENCING HEALTH SEEKING BEHAVIOUR AMONG RESIDENTS OF BASAWA COMMUNITY, SABON GARI L.G.A. KADUNA STATE, NIGERIA

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ABSTRACT

Background: The health of the citizenry is crucial to the growth and development of any nation. Nigeria is riddled with poor health indices ranging from maternal mortality to infant mortality rates. It has been established that health-seeking behaviour has a strong influence on health status, morbidity and mortality indices of a society. It also drives utilisation of health services and is affected by predisposing, enabling and need factors. This study assessed the factors influencing health-seeking behaviour among residents of Basawa community, Sabon Gari LGA, Kaduna State, Nigeria. Method: This was a descriptive cross-sectional study carried out in September 2017 among 125 residents of Basawa community selected by systematic sampling technique. Data was collected using asemi-structured interviewer-administered questionnaire and analysed with SPSS version 21. The results were presented as tables and charts among others. Level of statistical significance was set at $p < 0.05$. Results: The mean age of the respondents was 42±10 years. Majority of the respondents were male (60.8%) and married (90.4%). About two-thirds of the respondents delayed for more than 24 hours before seeking healthcare. Long waiting time (55.2%), the attitude of health workers (22.4%) and the high cost of drugs (22.4%) were given as barriers to health care utilisation. High cost of services, type and severity of illness and attitude of health care workers are the main determinants of health-seeking behaviour. There was a statistically significant relationship between education, monthly income and delay in seeking health care. Conclusion: The study showed several factors that influence health care seeking behaviour. In view of the multifactorial determinants of health-care seeking behaviour, there is need for health workers to be trained and retrained to improve on their attitude, and the provision of community-based social health insurance scheme by the government among others.

Key words: Basawa,Cost of care,Health-seeking behaviour, Waiting time

INTRODUCTION

The African proverb, “He who conceals a disease cannot expect to be cured”, highlights the importance of seeking health care when one is ill. Great strides have been made by developing countries like Nigeria in improving some health indices from 1990 to date.[1] However, there is still a long way to go as these indices are still quite high, reflecting the poor state of the health system in the country. In Nigeria, 12% of men and women are likely to die between the ages of 15 and 50 years.[2] Surveys have shown that childhood mortality indices have plateaued over the past five years. Infant mortality rate, under-five mortality rate and maternal mortality rate in Nigeria are 67 per 1000 live births; 132 per 1000 live births and 574 per 100,000 live births respectively.[1-2] It has been

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established that health-seeking behaviour has a strong influence on health status; mortality indices and measures of morbidity of a society.[3]

Health-seeking behaviour has been defined as "any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy."[4] It is the behavioural component of a healthcare utilisation model. Health-seeking behaviour is directly related to incidence, prevalence and complication of various diseases.[5] It has been determined that early recognition of symptoms, presentation to healthcare facilities, and compliance with effective treatment can reduce morbidity and thereby mortality. Health-seeking behaviour drives the utilisation of health services. It is affected by predisposing, enabling and need factors.[6] Once a person assumes a sick role, he/she is supposed to seek medical advice and medical care. Various illnesses cause different health-seeking behaviours in the same individual or community.[5]

The financing of a health system is a good indicator of the importance a country places on its people's health. In Nigeria, the financing of the health care delivery system is majorly through out-of-pocket payment or user fees, tax revenue, donor funding and social health insurance.[7] Economic factors contribute greatly to the delay in accessing health care. In view of the fact that the majority of health care expenditure is out-of-pocket, it is unsurprising that low-income earners make fewer trips to the health facility when they are ill due to high transport costs and high cost of health services.[3, 8] Regarding reproductive health, there is a wide gap between people in various wealth quintiles when considering reproductive health-seeking behaviour. A greater proportion of those in the highest wealth quintile accessed reproductive health services than those in the lowest quintile. This disparity was also marked in terms of utilisation of modern contraceptives, with those in the highest quintiles having greater utilisation.[9]

Many Nigerians lack adequate infrastructural facilities that are essential to promoting and maintaining good health. In the few areas where health facilities are available, they are usually short-staffed, poorly maintained and inadequately supplied with drugs. The outcome of this is linked to high incidence of morbidity and mortality resulting from illnesses that are largely preventable.[10] It has been found that only 42% of the population are located within one kilometre of primary health centres and/or dispensaries. It was also determined that 25.1% of the population travel beyond nine kilometres in order to get to the nearest hospital.[8] It is pertinent to note that geographical location also plays a role; with those who live the urban areas having greater access to adequate health facilities than those in rural areas.

The health of the citizenry is crucial to the growth and development of the nation. A health labour force will make meaningful contributions to economic growth and ensure productivity. Previous studies have focused on one aspect of health-seeking behaviour or another; instead of showing the multi-factorial influences of complex factors on an individual's behaviour. Most studies available have been for specific disease conditions or tailored to a particular socio-demographic group and as such there is limited knowledge on general health-seeking practices especially in North-west Nigeria.

This study was carried out to determine the factors which influence health-seeking behaviour among residents of Basawa LGA, Kaduna state and the factors that influence it.

MATERIALS AND METHOD

Study Setting

Basawa is a ward in Sabon-Gari Local Government Area of Kaduna State and it has a projected population (2016 from 2006 census)of 30,488. Basawa is an urban area consisting of various ethnic groups with Hausa being the predominant tribe; others include Fulani, Yoruba, Igbo, Bajju. Farming is the main occupation and serves as the principal means of livelihood for a lot of the populace; other activities include trading, civil service, and artisans. Sabon Gari has 22 primary health care centres consisting of8 family health units, 9 health clinics and 5 health posts. The health facilities are distributed between 6 health districts, they all

provide maternal and child health services. There are 25 registered private health facilities and 12 institutional clinics belonging to institutions or training facilities. Numerous patent medicine vendors, and chemists can also be found here. The tertiary hospital, Ahmadu Bello University Teaching Hospital serves as the main referral centre for the surrounding facilities.

Study Design
It was a descriptive cross-sectionalstudy that was carried out in September 2017.

Study Population
Those eligible for the study were people aged 18 years and above who had lived in Basawa for at least a year.

Sample Size determination and sampling technique
The sample size was determined using single population proportion formula considering the following assumption: 95% confidence level ($Z\alpha/2$), 5% margin of error (d) and proportion (p) ofrespondents who engaged in self-treatment 81%.

n (sample size)$=(Z\alpha/2)^2 \frac{P[1-P]}{d^2}$

n=114

Factoring in a non-response rate of 10%, the sample size became 125.

A multistage sampling technique was applied in this study. Stage 1: Households were selected from a sampling frame of a list of all the households in Basawa ward using systematic sampling technique. Stage 2: From the households selected, one eligible member was randomly selected to participate in the study.

Data collection tool and procedure
The tools for data collection were 125 pretested, semi-structured-interviewer administered questionnaires. The data collection was conducted by the researcher and 4 trained research assistants. The researcher supervised the overall data collection process and checked the filled questionnaires for consistency and completeness. The questionnaire was prepared in English language and translated to Hausa language and back to English to maintain the consistency of the data.

The questionnaire comprised five sections namely: socio-demographic profile of the respondents, patterns of health-seeking behaviour, factors affecting utilisation of health care facilities and factors influencing health-seeking behaviour.

Data processing and analysis
Data collected was entered, validated and analysed using Statistical Package for Social Sciences (SPSS, IBM Corporation USA) software version 21. Descriptive statistics were conducted using frequencies and proportions. Means and standard deviation and other descriptive measures were determined for quantitative variables. Chi-square and Fisher's exact test were applied for the comparison of proportions. Statistical significance was set at $p<0.05$.

Ethical consideration
Approval to carry out this study was obtained from the research and ethics committee of Ahmadu Bello University Teaching Hospital, Zaria. Permission to conduct the study was also sought from the Sabon Gari Local Government Authority and the ward head. The study participants were informed about the purpose of the study and were also informed that they could voluntarily withdraw from the study at any time. Written consent was obtained from all the participants before the questionnaires were administered to them. This study was limited by the fact that the respondents could give wilful misstatements to the researcher. However, to control for this, respondents were made aware that their identities would remain confidential and as such they could give true responses without fear of reproach. There was no conflict of interest in the conduct of this study

RESULTS
A total of 125 questionnaires were administered to the respondents. All questionnaires administered were completely filled, returned and analysed after validation (giving a response rate of 100%). The mean age of the respondents was 42 ± 10.3years. Majority of the respondents in this study were males (60.8%) and married (90.4%).The greater proportion (40%) of the respondents had tertiary education (Table 1).About two-fifths (40.8%) of the

respondents patronised pharmacy / chemist as their first place of consultation (Table 2). Majority of the respondents delayed before accessing health care. Type of illness, the severity of illness failure of other methods and emergency situations; were the reasons proffered for seeking care. Most of the respondents (83.3%) said the reason for the delay in accessing care was the thought of getting better without treatment (Fig.1). There was a statistically significant relationship between the educational level and monthly income of the respondents and delay in seeking care 0.007 and 0.002 respectively (Table 3). There was a statistically significant relationship between monthly income and the place of first consultation. There was a statistically significant relationship between monthly income and place of first treatment (Table 4). More than half of the respondents (55.6%) gave long waiting time as a barrier to utilisation of health services (Fig. 2). There was a statistically significant relationship between distance from the nearest health facility and the frequency of hospital visits (Table 5).

Table 1: Socio-demographic characteristics (n=125)

Variable	Frequency	Percentage
Age group (years)		
25- 29	16	12.8
30-34	16	12.8
35-39	21	16.8
40-44	14	11.2
45-49	20	16.0
50-54	19	15.2
55-59	9	7.2
60-64	10	8.0
Sex		
Male	76	60.8
Female	49	39.2
Marital Status		
Married	113	90.4
Single	4	3.2
Widowed	8	6.4
Tribe		
Hausa	52	41.6
Fulani	29	23.2
Yoruba	13	10.4
Igbo	19	15.2
Others	12	9.6
Educational level		
Quranic	9	7.2
Primary	17	13.6
Secondary	49	39.2
Tertiary	50	40.0

Table 2: Distribution of respondents' place of first consultation and reason for the choice (n=125)

Variable	Frequency	Percentage
Place of first consultation		
Self-treatment	12	9.6
Pharmacy / Chemist	51	40.8
Government hospital	22	17.6
Private clinic	40	32.0
Reasons for place of first consultation		
Proximity	47	37.6
Cost of care	35	28.0
Quality of care	43	34.4

Table 3: Distribution of the respondents' reasons for seeking health care (n=125)

Reason for seeking care	Frequency	Percentage
Type of illness	48	38.4
Severity of illness	33	26.4
Failure of other methods	31	24.8
Emergency	13	10.4

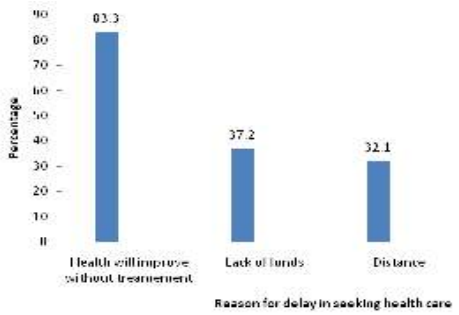

Fig. 1: Distribution of respondents' reasons for delay in seeking health care (n=78)

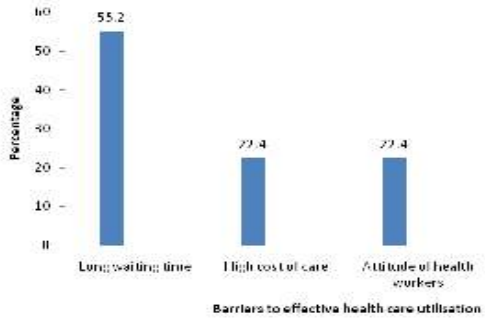

Fig. 2: Barriers to utilisation of health services among respondents (n=125)

Table 4: Relationship between Respondents' Educational level, Monthly Income and the delay before seeking health care (n=125)

	Delay period		
	Immediately	≥2 days	p-value
Educational level			
Quranic	2	7	
Primary	4	13	0.007
Secondary	13	36	
Tertiary	28	22	
Monthly income			
<25,000	7	26	
25,000-50,000	25	45	0.002
>50,000	15	7	

Table 5: Relationship between income and respondents place of first visit

Monthly Income (naira)	Place of first consultation				p-value
	Self-treatment	Pharmacy	Private Clinic	Government hospital	
<25,000	2	21	4	6	
25,000-50,000	9	28	12	21	0.002
>50,000	1	2	6	13	

Table 6: Relationship between the distance from the health centre and the frequency of hospital visits (n=125)

	Frequency of hospital visits a year			
Distance from the health facility	Once a year	Twice a year	Three or more times a year	p-value
<5km	9	14	1	
6-10km	48	29	29	0.0001
>11km	5	14	1	

DISCUSSION

The mean age of the respondents was 42±10 years. Majority of the respondents in this study (Table 1) were male (60.8%) and married (90.4%). That was not unexpected as most households were headed by married men. About two-fifths of the respondents were Hausa (41.6%) with tertiary education (40%). The study was carried out in North-west Nigeria where the predominant language is Hausa; the study area is an urban area so it is not surprising that a large proportion of the respondents have tertiary education. These findings are similar to a study carried out among civil servants in Ibadan where majority of the respondents were male and married with tertiary education.[11-13]

About a third (32%) of the respondents preferred to go private health facilities as their first place to seek care; with only 17.6% of them choosing government hospitals (Table 2). That means 49.6% of them sought care from formal health facilities. This was similar to other Nigerian studies which measured HSB using the source of the healthcare provider.[14-16] However, if the places are disaggregated, the studies in Ebonyi, Enugu and Anambra states, showed that a greater proportion of the respondents preferred private health facilities. This is likely due to perception that public health facilities are over-burdened and associated with patients' long waiting time.[14-16] About 40% of the respondents resorted to going to the pharmacy/chemistas their first contact with the health care. Similarly, majority of the respondents in the study in Enugu chose patent medicine stores.[16,17] The respondents' first instinct when coming down with an illness is to assume it is a common ailment that can be cured with over the counter drugs or after consultation with a chemist or pharmacist. Such behaviours were based on wrong perceptions as the pharmacists or chemists do not usually have good clinical acumen for proper diagnosis and treatment of diseases neither were, they licensed for such requirements.

The reasons given for their first choice of health facility were proximity, cost of care and perceived quality of care 37.6%, 28% and 34.4% respectively (Table 3). These reasons are comparable to a study in Ekiti state, south-west Nigeria, where affordable cost, proximity to the health centre, quality of service and staff attitude (35.9%, 24.3%, 16.7% and 10.3% respectively) were the reasons proffered.[10] The respondents from the study in Ibadan stated that proximity (23.9%), affordability(20.4%) good service delivery (34.5%) and prompt medical attention (8.8%). Other studies have shown that accessibility, affordability and condition of health facilities' were factors that influenced the choice of where to seek care.[18,19] The recurring theme was that cost of care that played significant role in their choices as the major means of health care financing was through the out of pocket spending.[20] In a country where about 70% of the population lives below the poverty line,[20] out-of-pocket spending could be catastrophic on the family's finances. Proximity is also a factor in the choice of health centre because it is essential for there a functioning health centre to be within a 5km distance for ease of access. The further away a health facility is the more likely it would be for the patients to seek health care from alternative sources.

Some of the respondents expressed reasons why there was an initial delay in seeking health care were belief that health would improve without medication, lack of funds and distance(Fig.1). Studies have shown that people are less likely to access health care if they are in the lower economic quintile.[3, 17] The choice of delaying seeking care, could be tied to cost of care and the fact that at the beginning of some illnesses the symptoms might seem mild and so the patients are likely to feel that it may resolve on its own. However, it is of utmost importance to present to the health facility early so that complications are avoided.

There was a statistically significant relationship between the educational level (0.007), income (0.002) and the delay before seeking care (Table 4). Similarly, there was a statistically significant relationship between education and seeking health care in a study in Malaysia and Ibadan.[5, 13] People with higher educational status are more knowledgeable about the benefits of formal health care. There was a statistically significant relationship between knowledge and seeking health.[21] The study in Malaysia showed that there

was a statistically significant relationship between income and health care seeking behaviour (0.010).[5] For people to access care, they need to be able to afford the cost of care. If they are unable to afford the cost of accessing care, they will seek alternative measures like traditional medicine.[3,17] This will likely lead to poorer health indicators as these alternate medical routes are no able to provide adequate health care. There was also a statistically significant relationship between income and first place of seeking care (Table 5) which further buttresses the point that income determines the kind of health care utilised by patients.

The barriers to utilisation of health facilities included (Table 6), long waiting time, cost of care and attitude of health workers (55.2%, 22.4% and 22.4% respectively). Studies have similarly shown that the cost of health services, perceived quality of care, waiting time, attitude of health workers and distance from the health facility.[13,18] The waiting time is a major barrier because it is especially stressful to spend long hours waiting to be seen by a health care worker. Negative attitudes of health care workers could be a deterrent to good health care seeking behaviour of patients. Barriers to the utilisation of health facilities will cause problems of poor utilisation in the long run which will negatively affect the health status of the surrounding community.

CONCLUSION

This study showed that the cost of care, distance from the health facility; the attitude of health workers, quality of care provided and waiting timewere factors that affect health-seeking behaviour.

RECOMMENDATIONS

In light of these findings, it is essential that alternative means of health care financing are provided for patronisers of health facilities to reduce the burden that comes with out-of-pocket spending. There is a need to train and retrain health care workers on how to properly interact with patients. The quality of the health care system should be addressed by the government with an overhaul of the entire system. Everyone has the right to good health and should have access to appropriate, efficient and effective health care.

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