Original Article

Health-seeking Behavioural Practices of the Elderly in Rural Community of Ekiti State, Southwestern Nigeria

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Abstract

Background: The aging process increases the risks of contracting a disease among elderly people. Health-seeking behaviour is poor among the aged in sub-Saharan countries like Nigeria, escalating the burden of noncommunicable diseases and the cost of health care which further impact the utilisation of orthodox medicine. **Aim:** This study aims to assess the health-care-seeking behavioural practices and associated factors among elderly people in Ido-Ekiti. **Materials and Methods:** A descriptive cross-sectional study was conducted among 420 elderly respondents in Ido-Ekiti. An interviewer-administered semi-structured questionnaire was used to collect information. The data collected were analyzed using SPSS version 25 and results were presented in the form of tables and bar charts. Chi-square tests were used to test for associations. All data analysis was done at a 5% level of significance. **Results:** The age range of respondents was between 65 and 95 years, with a mean age of 73.88 ± 6.84 years and 64.0% within the age range of 65–75 years. About 63.3% of the respondents have had an episode of illness in the last year preceding the study and only 35.3% consulted a doctor for treatment (good health-seeking behaviour); however, 57.9% of the respondents admitted utilising any of the following: self-medication, consult spiritualist, and use of herbal medicine (poor health-seeking behaviour). The factors statistically significantly associated with respondents' health-seeking behavioural practices are employment status ($P < 0.001$), educational level ($P < 0.002$), cost of health care, access to the health facility, length of time before consultation, beliefs, and lack of support from relations ($P < 001$). **Conclusion:** This study shows that the majority of the elderly had poor health-seeking behaviour due to educational and economic factors. Making the free or subsidized cost of health care for the elderly in rural communities and the provision of monthly financial support to the aged by the government will promote and encourage good health-seeking behaviour of old people.

Keywords: Elderly, health-seeking behaviour, Nigeria

Introduction

An elderly person according to the World Health Organisation is an individual who is 65 years and above and this definition is adopted by most developing countries.[1] The United Nations agreed cutoff is 60 years and above for an elderly person.[2] In Nigeria, those aged 65 years and above make up 3.1% or 5.9 million of the total population of 191 million.[3,4] As medical advances allow people to live longer, the proportion of the elderly will increase in Nigeria.[5] Aging causes people to be less active, frail, and exposed to more risk of contracting diseases.

The elderly, being considered the most vulnerable group of individuals, face a myriad of problems varying from medical problems to psychological and social problems. The elderly are more predisposed to developing cardiovascular diseases, respiratory diseases, gastrointestinal diseases, and mental illnesses among many other medical problems. In addition, other problems of the elderly include poverty, unemployment, abuse, stigmatisation, isolation, and depression among others.

Health-seeking behaviour is defined as a sequence of remedial actions that individuals undertake to rectify perceived ill-health. Today, it has become a tool for understanding how people engaged with the health-care systems in their respective

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sociocultural, economic, and demographic circumstances.[6] Majority of the aged persons have associated illnesses such as hypertension, diabetes, joint pains/arthritis, kidney infections, cancers, and tuberculosis that take a long time to treat which particularly affect their health-seeking behaviour. Elderly individuals are found to have patronised traditional healers, consult Christian/Islamic clerics, resorted to self-medication using local herbs, or visit chemist shops whenever they are sick instead of seeking orthodox care.[7]

A study revealed that more than two-thirds (68.8%) of the respondents had never visited health facilities in the last year even for medical checkups.[8] Some of the reasons for not patronising orthodox health facilities include the cost of orthodox health-care services, cultural beliefs, availability, and a distance of the health facilities among others. Several studies have also documented an association between certain sociodemographic and socioeconomic variables and health-care-seeking behavioural practices.

This study aims to determine the health-care-seeking behavioural practices among the elderly in rural settings of Ekiti State, Nigeria, and to identify factors that influence the practices. This study will provide information that will assist the policymakers to formulate policies that will reduce morbidity and mortality associated with old age. A limited study on this has been carried out in the study area on the health-seeking behavioural practices among the elderly.

Materials and Methods

Study area

This study was conducted in Ido-Ekiti town in Ido-Osi Local Government situated in the northern part of Ekiti State, Southwest Nigeria. It is bounded in the east by Ipere and Iludun, in the south by Igbole and Ifinsin axis, and in the north and northwest by Usi and Ilogbo Ekiti.[9,10]

Ido-Ekiti town consists of two wards: Ido 1 and Ido 2 which are subdivided into 22 settlements. There are three health facilities in Ido-Ekiti: a Basic Health Centre, a Comprehensive Health Centre, and a Federal Teaching Hospital, Ido-Ekiti. Yoruba is the predominant tribe, and Christianity is the predominant religion practiced. The population of people in the Ido-Osi Local Government Area according to the 2006 census is 160,001, and the population of the elderly is 6060.[9,10]

Study population

The study is a cross-sectional study design that assessed the health-care-seeking behavioural practices among the elderly in Ido-Ekiti. The study population was all elderly persons aged 65 and above in Ido-Ekiti, Ekiti State, Nigeria. The study included the elderly of both sexes 65 years and above, who were willing to participate in the study. However, elders 65 years and above who were not willing to participate were excluded from the study.

Sample size and sampling technique

The sample size was calculated using Fisher's formula for estimating the minimum sample size for descriptive studies using the proportion of older people above 50 years who consulted a health practitioner (53%),[11] with a P value set at ≤ 0.05 and confidence interval of 95% and a nonresponse rate of 10%. The final estimated sample size was 420.

A cross-sectional study design method was employed using a multistage sampling technique in the recruitment of eligible participants. In Stage 1, Ido Ward 2 was selected by simple random sampling technique by balloting out of the two wards in Ido-Ekiti. In Stage 2, four settlements, Oke-Isoko, Ijemu, Alapo, and Isolo, were selected by simple random sampling. In Stage 3, a street was selected in each of the settlements by simple random sampling using all the streets in the settlement as the sampling frame. Moreover, in Stage 4, the houses along the street selected in Stage 3 were numbered and simple random sampling was employed to select the houses to visit. Equal allocation was used to determine the number of participants in each street, and the required respondents were selected from among all eligible individuals by simple random sampling technique using balloting.

Data collection

Six trained data collectors and one supervisor were involved during the data collection process. An interviewer-administered, standardised semi-structured questionnaire was developed and used to obtain information from participants. The questionnaire had four sections that addressed the sociodemographic characteristics, level of awareness of illnesses, the pattern of health-care-seeking behavioural practices, and factors affecting the health-care-seeking behaviour of participants. Data collection was subject to strict controls and procedures which were followed precisely, to ensure that the data were valid, reliable, and useful.

Data management

Data collected were checked for completeness, edited, coded, and entered into IBM SPSS version 25 statistical software for analysis. Descriptive statistics were presented as frequency distribution, means, and percentages. Questions regarding the pattern of health-care-seeking behavioural practices were 12 with "Yes," "No," and "I don't know" responses. A correct response was assigned 1 point while an incorrect or I don't know response was assigned 0. The total pattern of health-care-seeking behavioural practices score varied between 0 and 12. A cumulative mean cutoff was set at 6 such that respondents who scored this value and above were deemed to have a good pattern of health-care-seeking behavioural practices while those who scored below 6 were regarded as having poor pattern of health-care-seeking behavioural practices. Chi-square and Fisher's exact were used to determine the association between sociodemographic variables, health-care-seeking behaviours, and factors associated with health-care-seeking behaviour. Results were interpreted and a conclusion was drawn using a P value set at 0.05.

Ethical approval

Institutional ethical approval was obtained from Health Research and Ethical Committee of Federal Teaching Hospital,

Ido-Ekiti, Ekiti State. Permission to conduct the study was also sought from the Ido community leaders and verbal and written consent was obtained from the participants before the study was conducted.

Results

Sociodemographic characteristics of respondents

The result of the study shows a response rate of 100%. The age of elderlies ranged between 65 and 95 years, with a mean age of 73.88 ± 6.84 years [Table 1]. More than half of the respondents (64.0%) were within the age range of 65–75 years with females constituting 61.0%. The majority of the respondents were Christians (80.0%) and 97.1% of them were of the Yoruba tribe. More than half (60.5%) of the respondents were married and 37.9% widowed. The majority (87.4%) of the elderly were unemployed and about half (52.4%) of them had no formal education. The majority (61.7%) had their source of income from work/trades and 32.1% of them were from family. Most of the respondents (82.6%) do not live alone, with the majority living with their spouse (66.9%) and one-quarter (25.4%) living with children. Moreover, about half (50.7%) of the respondents are taken care of by their spouses and 44.0% by their children [Table 2].

Respondents' health-seeking behaviour

Figure 1 is a bar chart which shows that majority of the respondents in the study have poor health-seeking behavioural practices 172 (64.7%) while 94 (35.3%) have good health-seeking behavioural practices. Respondents who were considered to have poor health-seeking behavioural practices in this study were those who either self-medicated, did nothing, pray and seek for supernatural healing, or visited a patent medicine store while those respondents who consulted a doctor in either a public or private health-care facility were considered to have good health-seeking behaviour [Figure 1].

Distribution of respondents' health-seeking behaviour to their illnesses

Table 3 shows the health-seeking behaviour and health problems of the respondents; 63% of the respondents reported having a health challenge within the last year. The health challenges reported by the respondents include joint

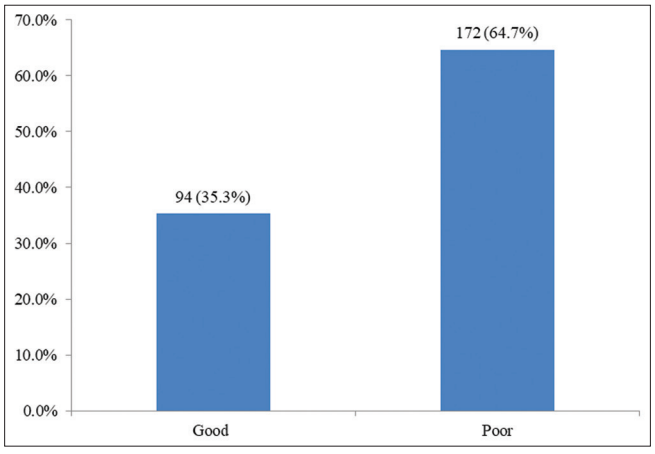

Figure 1: Respondents' health-seeking behaviour

Table 1: Sociodemographic characteristics of the respondents

Variable	Frequency, *n* (%)
Age (years)	
65–75	269 (64.0)
76–85	123 (29.3)
86–95	28 (6.7)
Mean±SD	73.88±6.84
Range	65–95
Gender	
Male	164 (39.0)
Female	256 (61.0)
Marital status	
Married	254 (60.5)
Separated/divorced	7 (1.7)
Widowed	159 (37.9)
Religion	
Christian	336 (80.0)
Muslim	81 (19.3)
Traditionalist	3 (0.7)
Tribe	
Yoruba	408 (97.1)
Others	12 (2.9)
Employment status	
Employed	43 (10.2)
Unemployed	367 (87.4)
Retired	10 (2.4)

SD: Standard deviation

Table 2: Sociodemographic characteristics of the respondents

Variable	Frequency, *n* (%)
Highest level of education	
No formal education	220 (52.4)
Primary school	150 (35.7)
Secondary school	32 (7.6)
Tertiary school	18 (4.3)
Source of income	
Family	135 (32.1)
Work/trades	259 (61.7)
Farming	26 (6.2)
Do you live alone	
Yes	73 (17.4)
No	347 (82.6)
Persons living with (*n*=347)	
Spouse	232 (66.8)
Children	88 (25.4)
Other relatives	20 (5.8)
Not stated	7 (2.0)
Relationship with caregiver	
Nobody	10 (2.4)
Spouse	213 (50.7)
Children	185 (44.0)
Relatives	12 (2.9)

pain (arthritis) (28.6%), malaria fever (29.7%), high blood pressure (13.2%) as most prevalent, diabetes (3.0%), and prostate problem (3.0%) were least reported. Only about one-third (35.3%) of the respondents sought health care from doctors. More than half (57.9%) of the respondents who had poor health-care-seeking behaviour practiced self-medication.

Respondents' sources of orthodox care

In Table 4, two-third (68.0%) of the respondents who utilised orthodox health care visited a public health facility, whereas 29.8% visited a private facility. Less than half (46.8%) of them were satisfied with services rendered, and on the other hand, 53.2% of them were dissatisfied. The majority (90%) of the respondents who were dissatisfied with the services reported the length of time for consultation, the attitude of health workers, unavailability of a physician, poorly organised hospital services, and high cost of services as reasons for dissatisfaction. About 48.9% of those who had visited health-care facilities for health challenges indicated not being willing to patronise the hospital again when sick. For respondents who fell sick more than once in the last year preceding the study, the last episode was taken as a reference point in the study to minimise recall bias.

Factors that hindered respondents from seeking orthodox care

Table 5 shows factors that hindered the respondents from seeking orthodox care. This includes the respondents' knowledge of the disease (87.4%), cost of health care (85.7%), length of time of consultation (79.0%), poor access to a health-care facility (79.3%), and lack of support from relations (73.8%). Confidentiality issues and beliefs of respondents least affected their seeking orthodox health practitioner care.

Association between sociodemographic variables and health-seeking behaviour among the respondents

Tables 6 and 7 show the association between sociodemographic variables and health-seeking behavioural practices among the respondents who fell sick within the last year preceding the study. Only employment status and levels of education were statistically associated with health-seeking behavioural practices. About 61.3% of employed elderlies had good health-seeking behaviour as compared to the unemployed (32.5%) and the retired (0%). Furthermore, 84.6% of those with tertiary education as their highest level of education had good health-seeking behavioural practices as compared with those with no formal education (29.1%), primary education (35.9%), and secondary education (44.4%).

The following factors are statistically significant to the health-care-seeking behavioural practices among the respondents, namely the cost of health care, accessibility of health facility, beliefs of respondents, length of time before consultation, confidentiality issues, and lack of

Table 3: Distribution of respondents' health-seeking behaviour to their illnesses

Variable	Yes ($n=420$), *n* (%)
Ever fell sick in the last year preceding the study	266 (63.3)
Nature of illness ($n=266$)	
Malaria fever	79 (29.7)
Dental problem	7 (2.6)
Joint pain (arthritis)	76 (28.6)
Visual problem	28 (10.5)
High BP	35 (13.2)
Prostrate problem	8 (3.0)
Hearing problem	11 (4.1)
Respiratory problem	5 (1.9)
Headache	9 (3.4)
Diabetes	8 (3.0)
What was done to treat illness ($n=266$)	
Nothing	7 (2.6)
Self-medicate	154 (57.9)
Consult the doctor in the health-care facility	94 (35.3)
Pray, seek, supernatural healing	7 (2.6)
Patent medicine store	4 (1.5)

Table 4: Respondents' sources of orthodox care

Variable	Yes ($n=420$), *n* (%)
Seek orthodox care for health challenges in health-care facility ($n=94$)	
Facility used	
Public health facility	64 (68.0)
Private health facility	28 (29.8)
Satisfaction with services rendered ($n=94$)	44 (46.8)
Reasons for dissatisfaction ($n=50$)**	
Length of time of consultation	45 (90)
Attitude of the health workers	45 (90)
Unavailability of physician	36 (72)
Dirty hospital environment	23 (46)
Hospital services not well organised	41 (82)
Hospital bill was much	39 (78)
Would you patronise the hospital again when sick ($n=94$)	46 (48.9)

**Multiple responses allowed

Table 5: Factors that hindered respondents from seeking orthodox care

Variable Factors that hinder from seeking for orthodox care	Yes ($n=420$), *n* (%)
The cost of health care	360 (85.7)
Beliefs (traditional/religious)	117 (27.9)
Accessibility of health facility	333 (79.3)
Length of time before consultation	332 (79.0)
Knowledge of the disease	367 (87.4)
Confidentiality issues	58 (13.8)
Lack of support from relations	310 (73.8)

**Multiple responses allowed

Table 6: Association between sociodemographic variables and health-seeking behaviour among the respondents

	Health-seeking behaviour				
Variable	**Good (*n*=94) (%)**	**Poor (*n*=172) (%)**	**Total (*n*=266)**	**χ^2**	***P***
Age (years)					
65–75	59 (39.6)	90 (60.4)	149	4.057	0.132
76–85	30 (32.6)	62 (67.4)	92		
86–95	5 (20.0)	20 (80.0)	25		
Mean±SD	74.27±7.15	75.84±7.09		−1.729[t]	0.085
Gender					
Male	40 (41.7)	56 (58.3)	96	2.633	0.105
Female	54 (31.8)	116 (68.2)	170		
Marital status					
Married	49 (35.3)	90 (64.7)	139	0.197[F]	1.000
Separated/ divorced	1 (25.0)	3 (75.0)	4		
Widowed	44 (35.8)	79 (64.2)	123		
Religion					
Christian	72 (34.8)	135 (65.2)	207	0.126	0.722
Muslim	22 (37.3)	37 (62.7)	59		
Tribe					
Yoruba	91 (35.1)	168 (64.9)	259	0.178[F]	0.700
Others	3 (42.9)	4 (57.1)	7		
Employment status					
Employed	19 (61.3)	12 (38.7)	31	11.209[F]	0.002
Unemployed	75 (32.5)	156 (67.5)	231		
Retired	0	4 (100.0)	4		

*P<0.05, [F]Fisher's exact P value. SD: Standard deviation

Table 7: Association between sociodemographic variables and health-seeking behaviour among the respondents

	Health-seeking behaviour				
Variable	**Good (*n*=94), *n* (%)**	**Poor (*n*=172), *n* (%)**	**Total (*n*=266)**	**χ^2**	***P***
Highest level of education					
No formal education	43 (29.1)	105 (70.9)	148	17.363	0.001
Primary school	28 (35.9)	50 (64.1)	78		
Secondary school	12 (44.4)	15 (55.6)	27		
Tertiary school	11 (84.6)	2 (15.4)	13		
Source of income					
Family	32 (29.9)	75 (70.1)	107	5.460	0.065
Work/trades	54 (37.0)	92 (63.0)	146		
Farming	8 (61.5)	5 (38.5)	13		
Do you live alone					
Yes	17 (41.5)	24 (58.5)	41	0.796	0.372
No	77 (34.2)	148 (65.8)	225		
Persons living with (*n*=225)					
Spouse	45 (34.1)	87 (65.9)	132	1.099[F]	0.794
Children	24 (32.4)	50 (67.6)	74		
Other relatives	6 (46.2)	7 (53.8)	13		
Not stated	2 (33.3)	4 (66.7)	6		
Who takes care of you					
Nobody	1 (16.7)	5 (83.3)	6	1.872[F]	0.604
Spouse	46 (39.0)	72 (61.0)	118		
Children	44 (32.8)	90 (67.2)	134		
Relatives	3 (37.5)	5 (62.5)	8		

*P<0.05, [F]Fisher's exact P value

support from relations, with their $P < 0.001$, as shown in Table 8. Respondents' knowledge of the disease was not significantly associated with their health-seeking behavioural practices ($P = 0.190$).

Table 8: Association between perceived factors for seeking orthodox care among the respondents and health-seeking behavioural practices

	Health-seeking behavioural practices				
Perceived factors	**Good (*n*=94), *n* (%)**	**Poor (*n*=172), *n* (%)**	**Total (*n*=266)**	**χ^2**	***P***
The cost of health care					
Yes	68 (30.0)	159 (70.0)	227	19.629	<0.001*
No	26 (66.7)	13 (33.3)	39		
Accessibility to health facility					
Yes	50 (25.5)	146 (74.5)	196	31.484	<0.001*
No	44 (62.9)	26 (37.1)	70		
Belief (traditional/religious)					
Yes	38 (56.7)	29 (43.3)	67	17.912	<0.001*
No	56 (28.1)	143 (71.9)	199		
Length of time before consultation					
Yes	56 (26.8)	153 (73.2)	209	31.160	<0.001*
No	38 (66.7)	19 (33.3)	57		
Knowledge of the disease					
Yes	83 (34.2)	160 (65.8)	243	1.718	0.190
No	11 (47.8)	12 (52.2)	23		
Confidentiality issues					
Yes	29 (76.3)	9 (23.7)	38	32.578	<0.001*
No	65 (28.5)	163 (71.5)	228		
Lack of support from relations					
Yes	52 (26.3)	146 (73.7)	198	27.919	<0.001*
No	42 (61.8)	26 (38.2)	68		

*P<0.05

Discussion

This study sought to assess the health-care-seeking behaviour of elderly people and determine the associated factors and predictors of their health-seeking behaviours. Out of 420 respondents, 266 respondents reported falling sick in the last year. The majority of the respondents who fell sick in the last year (64.7%) had poor health-care-seeking behavioural practices and about one-third (35.3%) had good health-seeking behavioural practices. These findings were similar to a survey conducted in Ilorin, Nigeria, in which the majority of the sick elderly people engaged in self-medication in the past year.[8] Another study in a rural community in Nigeria showed that most elderlies sought health-care services from patent medicine stores which indicate poor health-seeking behavioural practices.[12] This is most probably due to the high cost of seeking orthodox health care as seen in this study where the majority of the respondents who perceived the high cost of orthodox care services as a barrier to seeking orthodox care had poor health-seeking behavioural practices.

Dissatisfaction with the quality of services rendered at the orthodox care may also be another reason for the poor health-care-seeking behavioural practices among the respondents as shown in this study where more than half of the respondents with good health-seeking behavioural practices expressed their dissatisfaction with the orthodox care services. Reasons for their dissatisfaction included length of time of consultation, the attitude of the health workers, unavailability of physicians, dirty hospital environment, hospital services not being well organised, and high hospital bills. All these factors might also be responsible for the nonpatronisation of orthodox health-care services as shown in this study where 46 out of 94 respondents with good health-care-seeking behavioural practices gave a positive response as regards patronising the hospital again when sick.

However, the finding in this study is in contrast with the findings from other studies in a rural part of Wolaita zone, Ethiopia, where 57.9% of the elderly had good health-care-seeking behaviour[13] and Nepal study where 83.7% sought treatment from modern medication with the majority having chronic health problems and health-seeking behaviour associated with nature of disease.[14] This is in contrast with findings in Calabar, Nigeria, whereby majority were satisfied with services and would repeat the visit.[15]

The study also showed that sociodemographic variables such as employment status and level of education are important predictors of health-seeking behavioural practices among the respondents as shown by a statistically significant relationship between the variables and health-care-seeking behavioural practices. This is in keeping with findings in a rural community in Nigeria[12] and another study in Ekiti State, Nigeria, which reported educational level, nature of the disease, economic status, age, religious beliefs, and illness severity as factors associated with the health-seeking behaviours of the elderly.[16]

Furthermore, a Zambian study among the elderly reported elderly people with lower educational status were more likely to skip treatment than those of middle and higher educational status.[17] Previous studies have also shown that people make better health choices when they are educated. Education is known to be associated with improved health knowledge and better employment opportunities which will create economic empowerment and lead to financial access to quality health-care services. This was also in contrast to a study among Indonesia's rural elderly population which reported that age was the only demographic factor significantly associated with health-care-seeking behaviour for chronic illness. The utilisation of health services was less as the age advances.[14] In another study in Myanmar, health-seeking behaviour was associated with the educational status and income level of the elderly but not with their gender, ethnicity, or religious beliefs.[18]

There was a statistically significant relationship between the health-care-seeking behavioural practices and the following as mentioned by the respondents as factors that hindered them from seeking orthodox care, namely cost of orthodox care, accessibility to the health facilities, traditional/religious belief, length of time before consultation, confidentiality issue, and lack of support from relations. The majority of the respondents who reported that they were not challenged by access to health care, their beliefs, duration of time in accessing care, and support from relations had good health-seeking behaviour, but the majority of those who were challenged had poor health-seeking behavioural practices. This is in tandem with the findings in Calabar where the cost of health care was identified to be the major factor hindering the seeking of orthodox care among the elderly.[15] Similar results were also found in Ibadan where affordability and proximity were the major hindering factors.[19]

Conclusion

The majority of the respondents who fell sick in the preceding year before the study had poor health-seeking behavioural practices. Education and employment status had a positive influence on health-seeking behavioural practices. The cost of health care, accessibility to the health facilities, and lack of support from relations are some of the factors mentioned by the majority of the respondents who would hinder their seeking for orthodox care. The government should either make the free or subsidized cost of health care for the elderly, especially those living in rural communities. There should be the provision of a monthly stipend for the aged by the government. There is a need to employ more core health workers at all three levels of care. The issue of confidentiality should be taken very seriously by the health workers when interacting with the patient.

Availability of data and material

The data presented in this study are available from the corresponding author upon reasonable request.

Authors' contributions

Conceptualization of the research: K. R. A. and S. K. A. Analysis and interpretation of data: D. S. E. and S. K. A. Funding acquisition: K. R. A., S. K. A., T. S. A., T. M. I., and A. O. I. Writing the original draft: K. R. A. Review and editing: S. K. A, T. S. A, T. M. I., and A. O. I. All authors have read and agreed to the final version of the manuscript.

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Conflicts of interest

There are no conflicts of interest

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