

## Healthcare-Seeking Behaviour in Anyigba, North-Central, Nigeria

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**Abstract:** This study of health seeking behaviour of household members in Anyigba, North Central Nigeria. Total 333 respondents were randomly selected and self-administered structured questionnaires were used to collect data on household health seeking behaviour. Descriptive and inferential methods were used to analyze the data. The mean age of respondents was 39.65±11.12 years, >3 quarter were married. The mean, median and mode delay time before seeking treatment were 9.89±46.03, 3.0 and 2.0 days, respectively. The major reason for the delay in seeking treatment as reported by 56.9% was the thought that they would get over the ailment without treatment and 25.4% of respondents delayed because of lack of money for treatment. Less than half (44.7%) of those who sought treatment patronized public health facility. The study showed that significantly higher proportion of the low income than high income people patronize drug sellers for treatment and higher proportion of the high income people than low income patronize private health facilities. Delay in receiving care for health problems can be costly and dangerous, it is necessary to increase awareness and to health educate people on this problem. Generally, more people in the study population patronize private health facilities, people's confidence in public health facilities need to be improved in Nigeria and should be made more accessible to people for improvement in the health status of Nigerians.

**Key words:** Health, care, seeking, behaviour, north-central, Nigeria

### INTRODUCTION

In addition to other basic needs of man like shelter, clothing and food, health is a basic need that is very important. Health is desirable by all people and as such every citizen is entitled to enjoy good health, protection from diseases and proper medicare for survival, personal growth and development. Health according to World Health Organization is a state of complete physical, mental, social and spiritual well-being, not merely the absence of disease or infirmity (Lucas and Gilles, 2004). To be healthy means more than not having disease or infirmity, but to be in harmony with oneself and the environment. In this sense, disease is a threat to harmonious functioning of the body system. Thus, the need for protective mechanism of the body to remain healthy in order to avoid sickness is imperative (Insel and Roth, 2002). Health is a sine qua non for the socioeconomic development of individuals and the nation. Good health does not only contribute to better quality life but is absolutely essential for a virile labour force for the creation and maintenance of a nation's wealth (Lucas and Gilles, 2004; The World Bank, 1994).

Once a person assumes a sick role, it is observed that he/she seeks medical advice and cooperate with medical experts and seek for medical care. Health seekers in Nigeria, like any developing country, tend to do so based on the resources at the disposal of the family (Nyonator and Kutzin, 1999; HERFON, Nigerian Health Review, 2006). Several other factors are involved in health seeking behaviour among households in Nigeria. These factors include; the severity of the symptoms of illness, socio-cultural influences, distance, place and cost of treatment, income, level of education and quality of health care facilities. HERFON, Nigerian Health Review (2006) and Sullivan (2001). This study therefore, investigates the health seeking behaviour of households in Anyigba, Kogi State, Nigeria.

### MATERIALS AND METHODS

This is a cross-sectional survey which aimed at investigating the health seeking behaviour of households in a peri-urban community. The study setting was Anyigba, a University town in Igalaland of North Central

Nigeria. The community has witnessed rapid urbanization as a result of the establishment of Kogi State University in the town in 1999.

Data were collected using structured pre-tested questionnaire. Multi-stage cluster sampling technique was used to select 400 adults in their households. In each of the 5 clusters in the town 80 respondents were selected. Total 333 respondents filled and returned the questionnaire. Informed consent was obtained from each of the respondents. Data collected were entered and analyzed using Epi-Info 2000 computer software.

**RESULTS**

A total of 333 respondents returned the filled questionnaires given a response rate of 83.3%. Table 1 and 2 show the respondents' demographic characteristics. Male respondents constitute 65.0% while, females were 35% of the study population. Majority of the respondents (74.1%) were aged >30 years. The mean age of the respondents was 39.65±11.12 years while, the median age was 40.0 years. Most of the respondents (77.4%) were married, 13.6% were single, 6.3% were widows or divorced and 2.7% were separated. Sixty percent of the respondents were Christians, 36.7% were Muslims and 2.4% were practicing traditional religion.

Among the respondents who indicated their educational status, almost three-quarters (72.6%) had post-secondary education while 17.4 and 5.5% had secondary and primary education, respectively and only 4.6% had no formal education. About half (51.2%) of the respondents were civil servants, while the rest engaged in diverse jobs including teaching, trading and farming. Monthly income of 14.2% of the respondents was <5,000 Naira (US\$41.7), 50.5% of them earned between 5,000-25,000 Naira (US\$41.7-\$208.3) and only 35.3% earned >25,000 (US\$208.). The mean, median and mode of the respondents monthly earning was ₦26,412.66±₦29,362.57 (USD 220.1±244.6), ₦19,000 (US\$ 158.3) and ₦10,000 (US\$83.3), respectively.

Majority of the respondents (85.4%) waited for less than a week after onset of illness before seeking treatment, 6.3% waited for 7-14 days, 3.8% waited for between 2-3 weeks and 4.5% waited for over a month (Table 3). The mean, median and mode delay before seeking treatment were 9.89±46.03, 3.0 and 2.0 days, respectively. The major reason for the delay in seeking treatment as reported by more than half of respondents (56.9%) was the thought that they would get over the ailment without treatment. About a quarter (25.4%) of respondents delayed because of lack of money for treatment while, distance to the health facility was the reason for 5.1% of respondents delay.

Table 1: Age and sex distribution of respondents

Age group (years)	Sex		Total
	Male	Female	
≤20	3 (75.0)	1 (25.0)	4
21-30	49 (62.0)	30 (38.0)	79
31-40	58 (54.7)	48 (45.3)	106
41-50	64 (71.1)	26 (28.9)	90
51-60	24 (98.0)	6 (20.0)	30
≥60	10 (90.9)	1 (9.1)	11
Total	112	208	320

Table 2: Distribution of socio-economic characteristics of respondents

Variable	Frequency	Percentage
<b>Marital status (n = 332)</b>		
Married	257	77.4
Single	45	13.6
Separated	9	2.7
Widowed	16	4.8
Divorced	5	1.5
<b>Religion (n = 330)</b>		
Christianity	198	60.0
Islam	121	36.7
Traditional	8	2.4
Others	3	0.9
<b>Educational status (n = 328)</b>		
None	15	4.6
Primary	18	5.5
Secondary	57	17.4
Post-secondary	238	72.6
<b>Occupation (n = 328)</b>		
Civil service	168	51.2
Teaching	62	18.9
Trading	32	11.9
Farming	20	6.1
Artisan	5	1.5
Others	10	3.0
Unemployed	24	7.3
<b>Income (Naira) n = 281</b>		
≤5,000	40	14.2
5001-15,000	85	30.2
15,001-25,000	57	20.3
25,001-35,000	35	12.5
≥35,001	64	22.8

Less than half (44.7%) of those who sought treatment patronized public health facility at first consultation. The place of first consultation as reported by the respondents; 54.6% visited private health clinic or hospital or sourced drugs from pharmacies and patent medicine stores. About 39.0% sought consultation from public health facilities like government hospitals, primary health centers and comprehensive health centers. Only 4.5% had traditional healers or spiritualists as first point of consultation.

Reasons given by respondents for the choice of first place of consultation include: quality of service (35.5%), proximity (31.4%) and inexpensive treatment (23.1%). Majority of the respondents (85.6%) reside <5 km away from the health centre, 6.6 and 7.7% of the respondents reside at a distance of 5-10 km and >10 km away from a health facility (Table 3). Less than a third (29.1%) of the respondents reported that they could not afford spending 500 Naira (US\$ 4.2) on drugs for an episode of illness,

while about half (54.7%) could afford between 500-2,499 Naira (US\$ 4.2-21.0) and only 4.6% could afford to spend between 2,500 and 4,499 Naira (US\$ 21.0-41.7) on drugs for an episode of illness.

Table 3: Place of consultation and waiting time before reporting

Variable	n (%)
<b>Distance to facility (Km) (n = 271)</b>	
≤5	232 (85.6)
6-10	18 (6.6)
≥11	21 (7.7)
<b>Delay period (days) (n = 287)</b>	
≤7	245 (85.4)
7-14	18 (6.3)
14-21	11 (3.8)
≥21	13 (4.5)
<b>Reasons for delay (n = 295)</b>	
Hope to get over illness without treatment	168 (56.9)
No money for treatment	75 (25.4)
Distance to health facility	15 (5.1)
Others	37 (12.5)
<b>Type of facility visited (n = 304)</b>	
Private	168 (55.3)
Public	136 (44.7)
<b>Place of first consultation (n = 313)</b>	
Pharmacy/chemist store	68 (21.7)
Patent medicine store	22 (8.9)
Primary health centre/clinic	45 (14.4)
Comprehensive health centre	13 (4.2)
Private clinic	75 (24.0)
Government hospital	64 (20.4)
Traditional healer/spiritualist	20 (4.5)
Others	6 (1.9)
<b>Reasons for place as first choice (n = 312)</b>	
Quality of care	117 (37.5)
Nearest	98 (31.4)
Cost least expensive	72 (23.1)
Free treatment	17 (5.4)
Others	8 (2.6)

During episode of illness, about two-third (64.3%) reported that they use their personal savings as their main source of fund for care, 13.8% borrowed money from friends, 7.2% got assistance from people, 16.5% sold their belonging, while 3.3% paid for their treatment in kind (Table 4). The study showed that there was no significant difference across educational status in the type of health facility patronized and the waiting time before reporting for consultation ( $p > 0.05$ ) (Table 5 and 6). However, the study showed that significantly higher proportion of

Table 4: Drug bills considered affordable and source of fund for payment

Variable	n (%)
<b>Affordable drugs bill in Naira (n = 278)</b>	
≤500	81 (29.1)
501-1500	107 (38.5)
1501-2500	45 (16.2)
2501-3500	16 (5.8)
3501-4500	5 (1.8)
≥4501	17 (6.1)
<b>Source of money for payment of bills (n = 305)</b>	
Savings	196 (64.3)
Borrowed from friends	42 (13.8)
Assistance from people	22 (7.2)
Sales of belonging	16 (5.2)
Paid in kind	10 (3.3)
Others	19 (6.2)

Table 5: Educational level and type of health facility patronized

Educational status	Type of facility patronized		Total
	Public	Private	
None	6 (40.0)	9 (60.0)	15
Primary	5 (35.7)	9 (64.3)	14
Secondary	17 (32.7)	35 (67.3)	52
Post-Secondary	107 (48.6)	113 (51.4)	220
Total	135	166	301

$\chi^2 = 5.0, p = 0.1719$

Table 6: Educational level, income of respondents and waiting time before seeking care

Educational level	Delay period (days)			Total	p-value
	≤7	8-14	>14		
<b>Educational level (n = 285)</b>					
None/primary	24 (80.0)	2 (6.7)	4 (13.3)	30	
Secondary	40 (81.6)	3 (6.1)	6 (12.3)	49	
Post secondary	179 (86.9)	13 (6.3)	14 (6.8)	206	0.626
<b>Monthly income (Naira)</b>					
≤5,000	31 (81.6)	4 (10.5)	3 (7.9)	38	
5001-15,000	66 (89.2)	4 (5.4)	4 (5.4)	74	
15,001-25,000	43 (89.6)	3 (6.3)	2 (4.2)	48	
25,001-35,000	26 (86.7)	4 (13.3)	0 (0.0)	30	
≥35,001	48 (87.3)	3 (5.5)	4 (7.3)	55	0.702

Table 7: Monthly income of respondents and place of first consultation

Monthly income	Place of first consultation					Total
	Drug seller	Public health centre	Public hospital	Private health facility	Traditional/spiritualist	
≤5,000	12 (31.6)	11 (29.0)	7 (18.4)	3 (7.9)	5 (13.2)	38
5001-15,000	30 (37.6)	14 (17.4)	8 (10.0)	18 (22.5)	10 (12.6)	80
15,001-25,000	11 (20.8)	9 (17.0)	18 (34.0)	13 (24.5)	2 (3.8)	53
25,001-35,000	7 (21.2)	3 (9.1)	6 (18.2)	13 (39.4)	4 (12.2)	33
≥35,001	11 (18.3)	10 (16.7)	17 (28.3)	18 (30.0)	5 (8.3)	60
Total	71	47	56	65	26	264

$\chi^2 = 20.0, p = 0.00584$

the low income than high income people patronize drug sellers for treatment and higher proportion of the high income people than low income patronize private health facilities (Table 7). The level of income of the respondents did not significantly affect the period of delay before reporting for consultation.

## DISCUSSION

The educational status of most respondents in this study is high when for because the study was conducted in a community that is host to a university and quite a number of the university staff are resident in the town which had high influx of people into it after the establishment of the Kogi State University. The relatively high mean monthly income of USD 220.1±244.6 is likely to be as a result of the high proportion of people with tertiary education when compared with average monthly income of Nigerians. Using a monthly income level of \$8.20 to indicate poverty line and \$4.00 dollar to indicate extreme poverty level, in the period 2000-2003, the poverty level remained at 70.2% of the population in Nigeria (HERFON, Nigerian Health Review, 2006).

The high level of education may also explain the relatively shorter period of delay before reporting to health facility when ill. In this study the mean period of delay before reporting illness in a health facility is 9.89±46.03 days. Early reporting of illnesses in health facilities is likely to reduce the degree of complication of such illnesses and also to some extent will reduce cost of care. Delay in reporting illnesses in hospital is known to be influenced by cultural beliefs and ability to pay for care (Nyonator and Kutzin, 1999). In this study, more than half of the respondents delayed in reporting because they thought the illness would be self-limiting and will not require treatment. About a quarter of the respondents delayed because they had no money to take care of their treatment. The need to make the National Health Insurance scheme in Nigeria to have wide coverage is urgent so that many more people can overcome the problem of out-of-pocket mode of taking care of their health facility bills. The World Health Organization (WHO) is promoting the principle that whatever system of financing a country adopts should not deter people from seeking and using services. In most cases this will mean that payment at the point of service will be eliminated, or at least be related to ability to pay (HERFON, Nigerian Health Review, 2006). Only about 5.0% of respondents reported distance to health facility as reason for the delay. This is probably, because the study was conducted in an urban settlement. Health facility distribution in Nigeria significantly favours urban settlement to the detriment of rural communities where majority of people live (HERFON, Nigerian Health Review, 2006, 2007).

The common first point of consultation by respondents in this study are; private clinic followed closely by, pharmacy/chemist shop, government hospital and then followed by primary health centre, patent medicine store and traditional/spiritualist. In a study, on health seeking behavior among women in South-Eastern Nigeria it was found that the initial choice of care for malaria was a visit to the patent medicine dealers for most respondents. This was followed by visit to the government hospitals, the BI health centres, traditional medicine healers, private clinics, community health workers and does nothing at home. In this survey, like in the survey in south-eastern Nigeria the private health facilities were the initial choice of treatment for the majority (Uzochukwu and Onwujekwe, 2004).

Patronage of traditional/spiritual healers is much lower than was found in a similar study in Cameroon (Nchinda, 1977). Spiritual cause of diseases is not also reported significantly in this study as reported in other studies, such beliefs is well known to contribute to delay in accessing health care. The Cameroon study was conducted in 1977 as compared with this study conducted 30 years later; this may explain the difference in patronage of traditional healers. Geographical access to health facility was not a problem in the study population as majority (85.6%) could access health facility within 5km to where they live.

Less than 5% of the respondents could afford to spend more than US\$21 on drugs for an episode of illness. This shows that affordability of health care is quite low and this can be responsible for delays in seeking treatment as reported in this study. Personal savings was reported to be the major source of funding health care by the respondents. Since, most of the respondents reported they could not afford more than US\$21 on drugs for an episode of illness they are likely to also need to borrow money or rely on other people if they have to spend more than this for their healthcare.

A situation where as much as 16.5% of the respondents had to sell properties to pay for cost of health care should be a cause for worry, as most of these property are likely to be disposed at 'give-away' prices. Health Insurance Scheme is therefore the most reasonable option for financing health care in this part of the world. The apparently slow place in the implementation of the scheme will continue to deprive a large number of people financial access to good healthcare.

A study among Nigerians found that there was no relationship between income level and delay in seeking medical care Okolo (1988), some other studies reported that the poor delay in seeking health care. McIntyre *et al.* (2007) while, Okolo (1988) study found a significant relationship between educational level and delay in

seeking consultation, this study did not show significant relationship between educational level and waiting time in seeking health care.

Delay in receiving care for health problems can be costly and dangerous, it is necessary to increase awareness and to health educate people on this problem. Generally more people in the study population patronize private health facilities, people's confidence in public health facilities need to be improved in Nigeria and the public facilities should be made more accessible to people for improvement in the health status of Nigerians.

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