

EXPERIENCES OF OLDER ADULTS IN HEALTHCARE CHOICE: VOICES FROM IGBEAGU, IZZI LOCAL GOVERNMENT AREA, EBONYI STATE NIGERIA

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Abstract

Nigeria, like many other developing countries in the world is experiencing an upsurge in the number the older adults. These individuals need to be given adequate health care services to enable them go through ageing process successfully. This study was carried out to determine some personal circumstances and socio-cultural factors that drive healthcare choice of older adults in the rural areas of Ebonyi state. Data for the study was purely qualitative, obtained by means of Focus Groups Discussions (FGDs). Two FGDs were conducted for two different, but, homogeneous groups in a culturally appropriate setting chosen by the participants themselves, and on a non-market and festival-free day. Respondents were drawn from older adults aged 64 – 69 years within the inclusion criteria, using Snowball sampling technique. Results indicate that most participants have more preference for traditional medicine like herbal medicine and faith healing over orthodox medicine, arising from factors like cost, distance, gender, trust, and general attitude of home care-givers and healthcare providers. Few others patronize hospitals and clinics, though, not voluntarily. It was recommended that healthcare services be subsidised for the elderly ones especially in the rural areas. Again, there is a need to provide and/or equip healthcare centres in the rural communities to mitigate the impact of having to travel long distance to access healthcare facilities. Finally, it is imperative that care-givers and the general public be enlightened about some stereotypical, pejorative misconceptions and obnoxious beliefs about the elderly, as some erroneously believe that the elderly ones should not be cared for because prolonging their life would mean more death for the younger members of the family.

Keywords: *experiences, older adults, healthcare, choices.*

INTRODUCTION

There seems to be a paradigm shift in the demographic configuration of the world population. Like never before, it has been observed that the percentage of individuals aged 60 years and above accounts for about 3% of the total world population (CIA Factbook, 2015; Osochukwu, et al, 2016). Indeed, the population of the aged in the world has substantially increased from less than 90 million in 2005 to about 901 million in 2015 and the figure is projected to rise to 1.4 billion by 2050 (Mudiare, 2013; UN, 2015; Osochukwu et al, 2016).

The trend is not very different in Nigeria either. Nigeria is said to have the largest number of the elderly, 60 years of age and above, south of the Sahara (Mudiare, 2013). These elderly ones are usually faced with enormous health needs. This is so because old age is associated with frailty such as diabetes, rheumatism, arthritis, high or low blood pressure, kidney infections, cardiac problem, to mention but a few (Hanks Bell, Halvey & Paice, 2004; Odaman & Ibiezugbe, 2014).

As a result of their peculiar health needs, older adults especially the frail ones have been observed to be the most significant consumers of health resources and services in some places like the United States and United Kingdom (Young, 2003; Zayas, et al, 2016). However that is not the case in many other places like in most rural areas of Ebonyi State Nigeria. It has been observed that there exists high mortality rate especially among the aged in those rural areas. For instance, Owoseni, Jegede and Ibikunle (2014) observed that a lot of mortality has been recorded in rural communities than in the urban centres in Nigeria. The reasons for this could be dearth of functional healthcare facility in the rural communities on the one hand and deficient or poor utilization of the existing healthcare services on the other hand. Thus, use or non-use of health facilities can have a profound effect on the life and health of an older adult.

Nevertheless, the propensity to utilize a given form of healthcare service by the older adults can be shaped by socio-cultural forces. Indeed, social-cultural stimuli have been observed to exert the greatest influence on healthcare choice (Quah, 2001, Ewhrudjakpor, 2008). Therefore, since cultural practice is a relative phenomenon, socio-cultural factors that influence healthcare utilization among the older adults could as well vary across cultural spectrum. Hence there is a need to examine such factors especially as it concerns the elderly in the rural areas. This is because; any effort towards improving the health of the older adults may not yield the expected result if the issue of utilization of those services are not adequately addressed, as utilization is both action-oriented and consume-driven (Oladipo, 2014). Thus the World Health Organization has identified knowledge, perception and access (KPA) as important ingredients in healthcare choice. It indicated that issue of utilization should be given serious attention in planning any healthcare delivery system in order to achieve the desired outcome (WHO, 1985).

There has been a growing interest among scholars on issues concerning the elderly in the society. Researchers have investigated perception of old age by various segment of the society, with emphasis on the dwindling intergenerational relationship among younger and

older generations, which hitherto characterized African Societies (Okoye, 2005; Mudiare, 2013). Others have researched on the economic and demographic determinants of health-seeking behaviour paying specific attention to variables like, occupation, income and age as health determinants (Murihi, 2013; Owoseni, Jegede & Ibikunle, 2014). Similarly, there have been researches on the factors affecting utilization of healthcare services by the pregnant women (Ndie & Idam, 2013; Okonkwo & Ngene, 2014). A host of other scholars have investigated the determinants of healthcare utilization among immigrants, urban residents and the homeless (Kushel, Vittinghoff & Haas, 2001; Omotoso, 2010; Sanjel, Mudbhari, Risal & Khanal, 2012; Oladipo, 2014; Osochukwu et al, 2016).

Researches in Bangladesh and in Edo central Nigeria have revealed coping strategies in cases of illness among elderly people. (Biswas, Kabir & Nilsson, 2006; Odaman, & Ibiezugbe, 2014). Similar studies have been carried out in the Northern Nigeria and in Calabar Municipality of Cross River State Nigeria which examined determinants of geriatric healthcare services in the urban centres (Agba, Ogaboh, Ushie & Osochukwu, 2010; Ibitoye, Sanuade, Adebowale & Ayeni, 2014). Other scholars have investigated the socio-cultural determinants of health care utilization among the women with special emphasis on the role of gender in health care choice and utilization (Azuh, Fayomi & Ajayi 2015).

Poorly documented in existing literature are the socio-cultural determinants of healthcare utilization especially among the rural older adults. Indeed, there seem to be no detailed micro-level study of healthcare service preference among the elderly in the rural areas of Ebonyi state and Igbeagu community in particular. This study, therefore, seeks to fill that lacuna. The study was carried out to determine some personal circumstances and socio-cultural factors that drive healthcare choice of older adults in the rural areas of Ebonyi state. This is necessary in view of the need to enhance the quality of health for the growing number of senior citizens in our various communities.

MATERIAL AND METHOD

Study Site

The study was conducted in Igbeagu community, which is one of the eight autonomous communities in Izzi Local Government Area of Ebonyi State; which has a population of about 234, 072 according to the National Population Commission 2006; with about 10, 082 older

adults aged 60 years and above (cited in Ugwuja Ezenkwa & Nnabu, 2015). It is an agrarian community with a limited number of public healthcare facilities.

Participants and Procedure

Data for the study was purely qualitative obtained by means of Focus Group Discussions (FGDs). Two FGDs were conducted for two different, but, homogeneous groups in a culturally appropriate location chosen by the participants themselves, and on a non-market and festival-free day. Respondents available and willing to participate in the FGD were within the age range of 64-69 years. Participants were selected using Snowball Sampling technique. A total of fourteen respondents participated in the FGD. The first group was composed of seven elderly men and the second group comprised of seven elderly women, all within the inclusion the inclusion criteria.

Discussions were held with the respective homogeneous groups in the local language and captured by a trained research assistant (note taker) and complemented with digital recorder. The discussions were transcribed using verbatim reporting to avoid diluting the significance of the comments by respective participants. Participants gave their oral consent, participated voluntarily and were assured of the confidentiality of the information they would provide.

Thematic analysis was adopted in order to highlight the salient issues raised by the respondents relating to particular themes and to facilitate identification of common and essential elements of healthcare utilization by the participants. Specifically, the themes were built from the research questions guiding the study. Care was taken to ensure that context and choice of words used by the respondents to explain certain circumstances, feelings and situations were not lost.

The socio-demographic characteristics of the respondents are shown below

Table 1: Socio-Demographic Characteristics of Respondents

Variables	No of Respondents (%)
Sex	
Male	7 (50%)
Female	7 (50%)
Marital Status	
Married	9 (64.3%)
Separated/Divorced/Widowed	5 (35.7%)
Educational Attainment	

Educated	2 (14.3%)
No Formal Education	12 (85.7%)
Occupation	
Farming	8 (57.1%)
Petty-trading	2 (14.3%)
Artisan	2 (14.3%)
Unemployed	2 (14.3%)
Religion	
Catholic	7 (50%)
Protestant	4 (28.6%)
Pentecostal	3 (21.4%)

A total of 14 respondents participated in the FGD. This comprised of seven male and seven female older adults. The mean age of male participants was 68.0 while that of their female counterpart was 67.3. Respondents were within the inclusion criteria defined by certain socio-demographic parameter, designed to ensure homogeneity of the respective groups. The greater number of participants was married, while almost all the participants had no formal education, hence discussion was held with the local dialect. Again, 57.1% of the participants were farmers, 14.3% were petty-traders, and 14.3% were artisans while 14.3% also were unemployed. On religious affiliation, half of the participants 50% were Catholics, 28.6% were Protestants while 21.4% belong to Pentecostal churches.

Results

In analysing the result of the FDG some questions were raised to guide the evaluation of the healthcare choice of the older adults in the rural community of study area. The result will be discussed thematically as follows:

(a) Healthcare Preference

The researcher raised a question to ascertain the healthcare choice of the older adults and reasons for the choice. Nearly all the participants expressed more preference for traditional medicine over orthodox medicine. Some of their reasons range from assumed efficacy, proximity, cost and perceived benevolence and humane disposition of the traditional medicine dealers over the orthodox counterpart, as well possible mode of payment for the traditional

medicine which could be done on instalments. Others are of the view that better result is achieved when traditional and orthodox medicine are taken simultaneously as they tend to complement each other. A 66- year old man said: *"I use to take traditional medicine; that is the medicine from our fore-fathers. But I was later told that it drains blood, so I started buying medicine from the chemist here and drink it with the traditional one"*. Some of the participants concord with him. A male respondent aged 69 years commented *"I prefer traditional medicine because it is what I can afford"*. Another aged woman said: *"I prefer the one we have, that is the traditional medicine, who gives monkey banana? (Her words: ònyé nurum nwenwe ka agu nwadaka?) We don't have hospital in our village and again I don't even have the money for hospital"*. A 66-year old woman expressed preference for traditional medicine based on the attitude of the practitioners toward their patients. According to her, *"it is not as if there is anything wrong with English medicine, but the way they behave at the hospital is what I don't like"*. Another male respondent, aged 68 years expressed the opinion that medicine is more effective when inherited than when learnt. He said: *"my wife is a traditional medicine practitioner. She inherited it because the medicine runs in their family. Her grandmother did it, her own mother practiced it and now she is doing very well in it. You cannot compare her own with the ones people go to learn. Her medicine is so effective that I take it along anytime I am travelling so that should I become sick there, I will not be left stranded"*.

Similarly, another woman aged 67 years old expressed the view that traditional medicine could be more effective in certain form of diseases. She revealed her personal experience thus: *"the last time I had hiccups (etiúí) my children took me to a hospital in Abakaliki, but I know it was not a hospital thing. I quietly took my medicine (traditional medicine) into my bag, after they had done their own in the hospital; I will just take my own medicine from my bag and lick. I normally take it secretly so that they will not be able to find out and stop me"*. These findings indicate more preference of traditional over regular or orthodox type by the older adults in the study area. This corroborates with findings in various other parts of the country. Studies in Delta State, Kwara as well as Calabar municipality of Cross River State, Nigeria revealed low utilization of regular health facility per year (Okumagba, 2011; Abduraheam, 2007; Osochukwu et al 2016). This is similar to findings in various parts of the African sub-region (Exavery, Klipstein-Grobush & Debpuur 2011; Mezey & Fulmer, 1998). However, this is different from what is obtainable in other advanced nations of the world like the United States where older adults constitute the top users of regular healthcare services (Zayas et al 2016).

(b) Accessibility and Healthcare Service Utilization

It was important to find out whether accessibility affects older adult's healthcare choice. Accessibility of healthcare services is usually measured in terms of cost and distance. Most respondents expressed a unanimous view on the accessibility of regular healthcare services. There was a unanimous view especially among the elderly ones who sponsor their healthcare services that cost and distance are great barriers to accessing healthcare services. Some respondents expressed preference for traditional medicine over the orthodox type on those grounds. Similarly, some expressed the view that hospital should be visited as a last resort when all other ones such as self-medication and use of traditional medicine have failed to provide remedy. One of the participants, a 66 year-old man remarked: *"you know money is hard these days. I hardly go to hospital because there is no money. The last time I went to hospital was about 5 years ago"*. Another male participant aged 69 years expressed his concern thus: *"I don't have money. That is why I go for traditional medicine; there I pay any amount I have and pay the rest bit-by-bit later"*. A 69- year old woman shared her feeling this way: *"cost of treatment affects my choice of healthcare service. I am not working nobody gives me money"*. She then posed these rhetorical questions: *"Do you expect me to use my hand and go to hospital? Is it not when you have money that you begin to talk about hospital?"* Some other respondents said they had resorted to buying medicine from a nearby chemist shop because they could not afford the bill for treatment in the hospital. A woman aged 67 years remarked: *"I hardly go to hospital these days I prefer buying medicine from the chemists shop here and use it with our traditional medicine"*.

Distance to place of treatment was also observed to be a hindrance for the elderly ones in the community. A 68-year old male respondent summed it up this way: *"before, I use to ride my bicycle to very far places. I had been using it to go to Ndubia for treatment, but now I cannot ride bicycle again"*. Corroborating this view another 68 year old woman observed: *"my knee cannot allow me trek a long distance as I used to do when I was selling yam. Then, I used to trek to Abakaliki to sell my yam, and afterward trek back home, but now I cannot do it"*. On the other hand, some other respondents explained that they have resorted to self-medication as a result of not having access to other treatment options. A 69-year old man commented: *"sometimes I may not have money to buy English medicine... and no fowl to give for the traditional one, so I will just gather leaves, boil them and drink"*. The interconnectedness of cost and healthcare choice seems very obvious in the study. Almost all the older adults studied

expressed preference for traditional medicine as a result of the perceived cost of the orthodox type. When cost of treatment rises above what an individual can pay or above what he considers appropriate *vis-à-vis* the perceived severity of the illness, then, that form of treatment loses its appeal to the person. This reinforces earlier findings in parts of Nigeria as well as other African countries like Cameroon, Ghana and Cote d' Ivore, where high cost of treatment was observed to be a factor that reduces patronage or utilization of public health facilities (Ngugi, 1991; Litvack & Bodart, 1993; Jegede, 2010). This is contrary to the findings of World Bank (1990) on the utilization of healthcare services by the middle-class and affluent Nigerians; which revealed that such ones prefer to use the more costly cosmopolitan private healthcare facilities than those within the public sector because it is believed that more quality care and attention is provided by the former.

Again, the older adults are attracted to the traditional form of treatment because of the mode of payment. They indicated that in this form of healthcare service, treatment can be received while payment made "*bit-by-bit*" (that is in instalments) later at their convenience. More so, payment can be made with other items such as fowl, yam and other agricultural produce at their disposal. Reverse is the case with modern, orthodox medicine where payments or fees follow a standardized and fixed rates and pattern. Findings by Erinoshio (2006) also show that traditional healers in Nigeria can accept a variety of item other than money in therapeutic regimen..

(c) Gender and Healthcare Decision-Making

It was important to find out from the participants whether gender affect their choice of healthcare service. The role of gender in healthcare decision-making was observed to be of two folds: (a) prerogative of decision-making (b) choice of healthcare service.

(i) The Prerogative of Decision-making

There was an indication of strong gender influence in determining who is in a position to make healthcare choices. It was observed that many men make such decisions themselves, especially those who fund their healthcare services. A 69-year old man explained using a rhetorical question: "*who should decide for me, does any of them give me money? I am only managing my life the way I can see it!*" Another man aged 66 years remarked: "*Am I not a man? Is it a woman that will make decision for me? Never! I decide it by myself because I am a man*". However, there is a strong indication that such

prerogative of decision-making shifts to the children when they are the ones providing the money for the treatment. A 68-year old man observed: *“sometimes I decide, especially if it [the sickness] is mild, but if it is more serious my children simply take me to wherever they want to”*. In the same vein, another respondent, a 69-year old man commented *“Ah, it is my son. In fact he doesn’t even allow me to have a say because he considers me as an old man, but that is stupid”*.

Gender role in healthcare decision-making was also observed on the part of female respondents. Virtually all of them indicated that either their husband or their children make such decision. These women appear to have been socialized into accepting a subservient position as natural as a result of patriarchy prevalent in the community. A 67-year old woman commented: *“sometimes I meet my pastor to pray for me when I am sick. But whenever my children are aware of it, they come home and take me to wherever they want”*. Another participant, a 66-year old woman remarked: *“Ah, it is my husband. What are women to make that type of decision? At other times my children make the decision, especially if the sickness is a more serious one”*.

(ii) Choice of Healthcare Service

There is no strong indication of gender differences in the choice of places for healthcare service. Most participants indicated that men and women do not have different places they go for healthcare services. A 66-year old woman observed: *“sickness is sickness; the important thing is to pray to God to help you”*. Another male respondent aged 68 years, whose wife is a traditional medicine dealer said: *“I don’t think there is a different place for males and females, like this my wife’s medicine, both men and women come for it and none has ever complained”*. Another participant aged 68 years commented: *“I don’t think there are typically different places for males and females. Like me I can go to a man or woman provided I get cured”*. Corroborating these views another participant aged 64 years indicated that what matters is that person, in whose hand medicine works for you, not minding whether the person is a male or female, she said: *“you know diseases vary and individuals vary as well; you go to the person from whose hand medicine works for you, that is the most important thing, not minding whether the person is a man or woman”*. This contrary to earlier findings in Turkey where a strong influence of gender in health-seeking behaviour was established (Ay et al 2009). Nevertheless, some participants did not share the same view. In their own view they prefer going to a person of the same gender. A woman aged 67- years reasoned: *“say I am going to buy medicine from*

a chemist or from a traditional medicine dealer and the person is a man, what will I tell him? But if it is my fellow woman I will cool down and tell her everything". Again, another male participant aged 66 years reasoned: *"would you expect a man like me to visit Mama Sam for treatment? That place is for women everybody knows that. But for us men we prefer going to Nwamgbo for treatment"*.

(d) Care-givers' Attitude and Healthcare Utilization

The researcher asked the respondents whether attitude of their care-givers affect their healthcare utilization. There was a strong indication of care-givers' influence in the healthcare choice of the elderly ones in Igbeagu community. Some participants indicated that their healthcare services are being dictated by their care-givers who are usually their husband or their children. A 68-year old woman commented: *"most times... when I am sick, they will just take me to the hospital even without asking me where I would like to go"*. Another 66 years old woman remarked: *"my husband will sometimes force me to go to where he chooses"*.

However the attitudes of care-givers affect others in quite a different way. Most men in polygamous marriage complained that their children, who, in their expectation, were supposed to be their care-giver, had abandoned them. One man in a polygamous marriage aged 69 years old commented: *"my wives and my children have all left me. None cares for me. They are all waiting for the day they will hear I am dead. But now to come and know how I am doing no way. Sometimes even to give me food, I will shout and shout"*. He also indicated: *"I married many wives. Many of my children have grown... but none of them cares for me they are all interested in their respective mothers' house (households) that is why I am suffering not as if I didn't born children"*. Another man 68 years old corroborated that view saying: *"my wives spoiled their [his children's] mind into believing that if they should continue to prolong my life they stand the risk of losing their own lives. So they all decided to abandon me"*. A 69-year-old destitute woman shares here experience: *"I don't have a care-giver. The only son I have listened to what the people are saying and ran away from home... you know our people are wicked, they said I was the one that killed my husband and my children. They caused my remaining son to run away; but how can I kill them?"* This shows that fear of bewitchment from their elderly parents may prevent some children from caring for them. This was also found to be the case with another woman aged 69 years, she said: *"you give birth to children for them to take care of you when you are old, that is how life should be (her words: onye zua nwa, nwa*

azua ya), but in my case it is not like that. My children are running away from me because they say I am wicked”.

Effects of Healthcare-providers’ Attitude on Healthcare Choice of the Older Adults

The researchers also wanted to know whether the attitude of healthcare providers affect the older adults’ healthcare choice. The general attitudes of healthcare-providers to the elderly ones were observed to be among the factors that shape the healthcare choice of these elderly ones. This was observed in terms of waiting time, unavailability, and language of communication. One participant, a 66-year old man recounted his experience some five years ago when he went to the hospital for treatment, he said: *“that time I went to the hospital, I spent a whole day there before I could see the doctor, when I came back it was already night. I could not go to my farm just because I went to hospital. But if it is chemist here or traditional medicine, you go for treatment when you had come back from your farm”*. This indicates how some older adults decry the long period of time spend waiting to be attended to in public hospitals. Waiting time has also been observed to be related to patient’s satisfaction in previous studies (Umar, Oche, & Umar, 2011).

On the other hand, the availability of a care-giver or otherwise was also observed to be a strong determinant in healthcare choice. Even some participants that have public healthcare centre in their village indicated that absence of healthcare personnel was their own challenge. A 68-year old man recounted: *“before it was easier for us to go to the health centre in our village for some treatments. But, now, the nurse that used to attend to us hardly comes around. The only person we usually meet there is a woman she kept there that normally stay there to plait women’s hair. When you come for treatment, she will write down your name and ask you to wait that the nurse is coming. Sometimes, we will wait for the whole day, but she will not come. As time went on I become tired of going to the health centre”*. Another woman from the same village also shared her experiences: *“like my village, we have a small hospital (Health Centre) but the nurse that uses to attend to us there, we heard she has opened her own place somewhere. She got another woman who is a hair dresser to be staying there. Whenever you go there, she will write your name in a book and tell you that the nurse is coming; you will wait and wait and she will not come. Another day, will you be interested to go back there? Ohoo!”*

Language of communication was also observed to be another factor that shapes the older adults' choice of healthcare service. A 66-year old woman observed: *"in the big hospital, when I tell them my problem, they will keep asking me question upon question (nwanyi, isigini? Nwanyi, isigini? Woman, what did you say? Woman what did you say?) Because of this language problem I simply go to where I will both understand and be understood. If it is hospital, then there will be another person that can speak with them. But sometimes, they may not explain things exactly as it is happening to me"*. Corroborating this view another participant aged 67 years retorted: *"they will be speaking mbekee (English) or ijekebe (Central Igbo) and they will think you understand what they are saying"*.

DISCUSSION

Findings presented here came from fourteen older adults who participated in an FGD conducted in a rural community of Ebonyi State, Nigeria who shared their experiences on the socio-cultural factors that influence their healthcare choices. This has helped to appreciate the lived experiences of these elderly ones *vis-à-vis* healthcare utilization. Findings indicate that utilization of regular healthcare services by the older adults is still at low ebb. This corroborated with findings in various other parts of the country. Studies in Delta State, Kwara as well as Calabar municipality of Cross River State, Nigeria revealed low utilization of regular health facility per year (Okumagba, 2011; Abduraheam, 2007; Osochukwu et al 2016). This is similar to findings in various parts of the African sub-region (Exavery, Klipstein-Grobush & Debpuur 2011; Mezey & Fulmer, 1998). However, this is not in line with what is obtainable in other advanced nations of the world like the United States where, as pointed out earlier, older adults are among the top utilizers of regular healthcare services (Zayas et al, 2016).

The interconnectedness of cost and healthcare choice seems very obvious in the study. Almost all the older adults studied expressed preference for traditional medicine as a result of the perceived cost of the orthodox type. When cost of treatment rises above what an individual can pay or above what he considers appropriate *vis-à-vis* the perceived severity of the illness, then, that form of treatment loses its appeal to the person. This reinforces earlier findings in parts of Nigeria as well as other African countries like Cameroon and Ghana, where high cost of treatment was observed to be a factor that reduces patronage or utilization of public health

facilities (Ngugi, 1991; Litvack & Bodart, 1993; Jegede, 2010). On the other hand, it has been observed that some Nigerians especially the affluent class patronize more expensive form of treatment provided that such will meet their health need (World Bank, 1990).

More so, traditional medicine seems more attractive to the older adults arising from the possible mode of payment. Participants indicated that in this form of healthcare service, treatment can be received while payment made in instalments later at their convenience. More so, payment can be made with other items such as fowl, yam and other agricultural produce at their disposal. Reverse is the case with modern, orthodox medicine where payments or fees are made following a definite monetary. This is consistent with earlier findings that traditional healers in Nigeria may accept various other items after treatment other than money (Erinosho, 2006).

Like cost, distance was also observed to be a major factor militating against accessibility of orthodox healthcare services by the older adults. Functional orthodox healthcare facilities were not within the reach of most of these elderly ones. This significantly impeded the utilization of healthcare services especially by the elderly ones who do not have care-givers readily available to convey them to the place of treatment.

The findings reveal a divergence of opinion on the role of gender in healthcare choice of the older adults. Some expressed a strong preference of treatment by an individual of the same sex. This is consistent with the earlier findings in Turkey where a strong influence of gender in health-seeking behaviour was established (Ay et al 2009). However, some elderly ones seem indifferent to the gender of the health care provider, as their interest centre more on the efficacy and cost of the treatment. This is in line with a study of Spanish older adults wherein no difference in the number of medical contacts by males or females was established vis-à-vis the gender of the healthcare provider (Dunlop, Manhein, Song & Chang, 2002).

In the present study, findings reveal that attitude of care-givers affects healthcare utilization of the older adults. Most elderly women indicated that their healthcare needs and treatments are being dictated by their spouse or children. Even some of the women admitted that such decision is not the responsibility of a woman. Such domineering and overbearing attitude of men over their wife or male children over their mother is a salient demonstration of patriarchy. This is in line with the findings of Azuh, Fayomi & Ajayi (2015) in their study in Ado-Odo community of Ogun State Nigeria wherein they observed that in male dominated or

patriarchal society, women are usually not allowed to visit a healthcare facility or care provider or to spend money on healthcare without the approval of their husbands.

On the other hand, a different scenario was observed among male older adults. Elderly men in monogamous family enjoy more support from their care-givers. This is contrary to elderly men in polygynous unions, who complained of abandonment by their children and wives. It seems therefore that children born into polygynous families tend to render more care to their aged mother than they do to their aged father. More so, some elderly ones pass through excruciating difficulties as a result of neglect they suffer in the hands of their children who presume that caring for aged ones in order to prolong their life is an indirect way of reducing their own life span. Consequently, some care-givers are sceptical about providing the needed care to their elderly ones. To such elderly ones, their expectation that bearing children would be a source of succour for them at old age appears to be dashed to the ground. This condition adversely affected the aptitude and capacity of these older adults to seek needed healthcare services.

Results also show that waiting time, unavailability of healthcare personnel as well as language of communication reflect some attitudes of healthcare providers that affect healthcare utilization by the older adults. Some older adults decry the long period of time spent waiting to be attended to in public hospitals. Waiting time has also been observed to be a factor in patient's satisfaction in some previous studies (Umar, Oche & Umar, 2011). Visibility of healthcare providers strongly influenced healthcare choice. Some healthcare personnel in some clinic at the rural communities were said to be hardly visible in their place of work. This condition had diverted the interest of some of the older adults who need healthcare service into utilizing the always-available alternative, the traditional medicine.

Language barrier was also observed to be another major issue affecting healthcare choice of the older adults. Elderly ones were observed to be more disposed to seek healthcare service in a place they can be communicated with language of their heart. Such language also affords them greater latitude to express their pains and feelings more liberally. Some complained that expressing themselves through an interpreter does not really reflect their real thought and therefore lead to distortions. Hence they are more inclined to utilize healthcare services where they can both effectively understand the care-provider, and be accurately understood as well.

Limitations of the Study

The major limitation of the present study comes from methodology. The sample for the study was not randomly drawn, thus, it can hardly be said to be a true representation of the population. Again, only two FGDs were conducted in the study; so triangulating the instrument with other forms such as in-depth interview or questionnaire would increase the validity of the data and the research findings.

CONCLUSION

The foregoing observations have revealed a dearth of functional healthcare facilities and high cost of treatment as factors affecting effective utilization of healthcare services by the older adults in the area of study. It is therefore imperative that healthcare centres be provided and/or equip in the rural communities to mitigate the impact of going long distance for healthcare service. Also, the government should implement those policies geared toward providing economic and social services such as free medical treatment and recreational facilities for the older adults in the rural areas.

More specifically, a political willpower toward full implementation of the bills aimed at alleviating the plight of the elderly is urgently needed. Such bills include: A Bill for an Act to Establish National Centre for the Elderly Persons for General Purpose of Providing Welfare and Recreational Facilities for the Elderly Persons in Nigeria 2009; as well as A Bill for an Act to Provide Social Security for Unemployed Graduates and the Aged in Nigeria for the Purpose connected thereto 2010. The full implementation of these bills may help in addressing some basic needs of the older adults such as access to healthcare services. More so, in order to accelerate a move away from negative stereotyping of the elderly ones, there is a need for enlightenment and re- socialization of care-givers and the general public about some pejorative misconceptions and obnoxious beliefs about the elderly, as some erroneously think that prolonging the life of an older adult would mean more death for the younger members of the family. Finally, proper supervision of the healthcare providers in public clinics, serving in the rural areas should be put in place by the concerned authority. This will ensure that healthcare providers in those areas are always on hand to render prompt medical services as needed; and they should be trained to speak and communicate in the language of the community people as

much as possible. This would endear them to the people and enhance their communication quality with the ailing older adults in a manner that would make sense to these elderly ones.

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