

**Determinants of Healthcare Utilization
among Older Adults in Igbeagu Community,
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Aphriapub.com/index.php/JPSS***Abstract**

Effective healthcare service and healthcare utilization are a sine qua non for healthy living and successful aging among the older adults. This study utilized a cross sectional survey design to explore the socio-cultural factors that influence healthcare utilization among older adults in Igbeagu community of Ebonyi state Nigeria. Data for the study were both quantitative and qualitative, obtained by means of questionnaire and Focus Group Discussions (FGDs). A total of 397 respondents aged 60 years and above took part in the questionnaire study. Respondents were drawn using multi-stage sampling (simple random sampling (SRS) and cluster sampling). Two gender-balanced FGDs were conducted for different, but, homogeneous groups in a culturally appropriate setting, chosen by the participants themselves, and on a non-market and festival-free day. The FGD participants were drawn from older adults within the inclusion criteria, using Snowball sampling technique. Quantitative data were analysed using SPSS version 20.0, while tables and bar charts were used for data presentation. Hypotheses were tested using X^2 statistic at 0.05 alpha level. Results indicate that 53.9% of the respondents have more preference for traditional medicine, 31.2% use both traditional and orthodox medicine, while only 14.9% have preference for orthodox medicine. Comments from the FGDs indicate that their preference hinged on factors like assumed cause of disease, assumed efficacy of treatment option, cost, distance, as well as attitude of care-givers and healthcare providers. 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 moving a long distance to access healthcare facilities. Finally, it is imperative that care-givers and the general public be enlightened on the need to accord older adults their respect by discussing with them a treatment option before embarking on such treatment so that these older adults will be part of decision that concerns their own health.

Keywords: Healthcare, utilization, older adults, determinants**Introduction**

Health is an invaluable asset anywhere on the globe. This is evident in the myriads of references to health in the media (print or electronic), proverbs, greetings, pleasantries and even conversations (Park, 2009). Good health is, in itself, both an end and a means to an end. It is a fundamental prerequisite for acquiring wealth, attaining long life, happiness and self-actualization, hence the aphorism “health is wealth”. However, achieving good health requires a constant and cumulative routine of positive health practices. Thus, Abanobi and Ewuzie

(2000) maintain that the ability to enjoy good health is within the reach of most people – old and young – but requires their active participation on daily basis.

Older adults, especially the infirm 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 (Young, 2003, Odaman & Ibiezugbe 2014). On the other hand, Osuchukwu et al. (2016) observed that utilization of regular medical and healthcare services by the elderly is still at low ebb in many places in Nigeria. Again, issues about healthcare utilization among the older adults should be a matter of great concern in view of the current demographics of the world and the peculiar circumstances faced by the elderly ones. There seem 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 60 years and above accounts for about 3% of the total world population (CIA Factbook, 2015; Osochukwu et al., 2015). Indeed, the population of the aged ones in the world has substantially increased from less than 90 million in 2005 to about 901 million in 2015 and the figure is expected to rise to about 1.4 billion by 2050 (Mudiare, 2013; UN, 2015; Osochukwu et al., 2015).

Nigeria, like many other developing countries in the world, is experiencing unprecedented increase in the population of the older adults (Mudiare, 2013; Dergisi, 2015). Indeed, it has been observed that although the general population of Nigeria is growing quite rapidly, however, the population of older adults is even growing more rapidly than the generality of the Nigerian population (Okoye, 2012). Nigeria is said to have the largest number of the older adults 60 years of age and above, south of the Sahara (Mudiare, 2013).

The increase in the number of the elderly ones will mean having greater number of older adults who will in turn have more health needs. These health needs, if left unaddressed, will lead to high rate of ill-health, disability, emotional and psychological problems like depression, anxiety, frustration and even death.

Many researchers believe that culture plays a very important role in the management of health problems and healthcare service utilization (Owumi 2002; Fawole, 2006; Erinsho, 2006; Okumagba, 2011; Odaman & Ibiezugbe, 2014). Thus, Owoseni et al. (2014) observed that among the Yoruba people of South-western Nigeria, the perception of illness or disease centres on three basic etiological or primary factors these are: the natural, preternatural and mystical factors. This perception, according to him, often influences the choice of healthcare of the people. He stressed that one's choice of particular healthcare service is often a function of one's belief and attitude about the perceived cause of the disease and effectiveness of a particular healthcare service. In the same vein, Owumi (2002) posits that the belief that witchcrafts are a major cause of ill-health is well entrenched in the culture of Okpe people of Delta State, Nigeria.

Among the Igbeagu Izzi people of Ebonyi State, explanation and remedy to disease conditions appears to be highly influenced by their cultural beliefs, assumptions and superstitions. Steensel (2009) observed that in a typical traditional setting, the Izzi people consult fortune-tellers in confusing situations such as prolonged labour, serious sickness, and sudden death of a young person, fearful dream, or bad omen (*ahuma*). The fortune-teller will invoke his juju to reveal to him what should be done to solve the problem. He will invoke the land goddess (*Ali*) heavens (*Igwe*), creator (*Okekūwa*) and the ancestors (*Ndu-Itchéé*). After the revelation of the problem, the fortune-teller explains to his client why he got the problem and what should be done to remedy it. Sometimes, a sacrifice would be needed, sometimes a protective juju would be provided and in some cases the fortune-teller advises the client to go

to the hospital or clinic. All these go a long way to affirm the mutual synergy between health, disease and culture. Thus, Erinisho (2006) aptly observed that among many Nigerians, diseases do not just happen by accident or through natural factors but are brought about through witchcraft, mystical or spiritual forces.

The present study examined the socio-cultural factors that influence healthcare choice of older adults in Igbeagu community. Among the socio-cultural factors explored are gender, level of education, cost of healthcare service, belief system, family structure, attitude of care givers and healthcare providers, as well as healthcare decision-making.

While gender role can influence choice and decision, scholars have divergent views on whether or not gender strongly influences healthcare choice. Some scholars such as Mayorlas, Rodriguez and Rajo (2000); Dunlop, et al. (2002); Rocland, et al. (2003); Redondo-Sendino, et al. (2006) established no gender link in healthcare choice. However, Ay, et al. (2009); Okumagba (2011); Muriithi, (2013); Kaur, et al. (2013) recorded gender differences in healthcare preference and choice. Similarly, Odaman and Ibiezugbe (2014) observed that females in Edo Central are more likely to choose hospital care when they are sick than their male counterparts. The present study is also interested in exploring the impact of gender role on healthcare choice of older adults in rural Igbeagu community.

Cost of healthcare service is another factor that can influence healthcare choice. In fact, humans have been observed to conform to some basic economic principles which aim at optimality of utility in choice of goods and services (Okumagba, 2011). This means that people tend to buy things that are cheaper more than when they are exorbitant. Some scholars argue that this does not necessarily apply in healthcare choice. For instance, Mwabu, Ainsworth and Nyamete (1994); Dow, (1995); Gupta and Dasputa (2000) observed the demand for healthcare service to be inelastic with respect to price. This shows that hike in the cost of healthcare service

does not deter people from seeking medical care and that people can ordinarily spend all they have to care for their health needs. On the other hand, some African researchers have observed that when the cost of healthcare service rises above what an individual can pay, or above what he considers appropriate, then, that form of treatment loses its appeal to the person (Nguji, 1991; Litvack & Bodart, 1993; Lavy & German, 1994; Owoseni, Jegede & Ibikunle, 2014). It is therefore necessary to examine if cost affects the healthcare choice of older adults in Igbeagu community in the present study.

The role of education in the healthcare choice is also quite critical. Many scholars have observed that level of education can have a profound impact on people's healthcare choice and healthcare utilization (Mwabu, Ainsworth & Nyamete, 1993; Jaurez, 2002; Cisse, 2006; Muriithi, 2013). In fact, Jegede (2002) posits that education heightens people's demand for healthcare services especially orthodox healthcare services. A few other studies indicated otherwise. Erinoshio (2006) observed that even medical students of higher institution still hold to primordial belief with respect to causes and remedy for certain ailments. However, it is not very clear if educational level can affect people's healthcare choice especially in the rural areas. This is another central focus of the present study.

Some studies have examined healthcare decision-making and healthcare utilization among various segments of the society. Azuh, Fayomi and Ajayi (2015) studied healthcare decision making among married women. Similar study was conducted earlier in Turkey and India among pregnant women and nursing mothers (Ay et al., 2009). Poorly documented in available literature therefore, is the healthcare decision making vis-à-vis healthcare choice of the older adults in the rural communities. Indeed, no such study has hitherto been conducted in Igbeagu community of Ebonyi state. Hence there is a need to examine such factor and the present study is positioned to fill that lacuna.

Cultural perceptions of disease and belief system are critical in explaining illness behaviour. This is because the concept of health and disease are to a large extent shaped by culture. Culture affects the way people interact with physicians, the way they relate to their families when they are sick, the way they think about health, disease or even death (Quah, 2001; Erinosh, 2006; Ewruhjakpor, 2008; Nwosu, 2011). For instance, in many non-western societies like Africa, the concept of disease is strongly entrenched in superstition, magic and religion. Many people in Africa attribute the incidence of disease to witchcraft, sorcery and mystical forces. In Japan, organ transplants are rare. The Japanese culture does not favour harvesting organ from a donor to care for the health need of another person (Schaefer, 2005). Similarly, the Koreans and Navajo Indians are opposed to hearing a terminal prognosis from a healer or physician. In fact, “truth-telling is like a death sentence to traditional Koreans, because of their view that the body will react to ominous news received by the mind” (Schaefer, 2005:442). Therefore, physicians in this area are expected to be optimistic and positive in their communication with patients. Like the traditional Koreans, the Navajo Indians believe that language or speech shape reality. Therefore, physicians and other healers are never to offer a terminal diagnosis or use any negative language that could trouble or hurt a patient. A mention of death to a patient is said to be “sharper than needle” (Carrese & Rhodes 1995:828). Again, what is regard as disease in some societies may be seen as normal conditions in other societies due to cultural factors. Simply put, no uniform notions exist for various health disorders across all human societies.

Consequently, Erinosh (2006) observed that normality is determined to a large extent by socio-cultural factors. This is because, behaviour patterns which are regarded as normal in one society, may be seen as abnormal in another. For example obesity, which Euro-American women regard as abnormal condition and which is symptomatic of rejection because the sacred concept of beauty is the slim, twiggy structure (Erinosh, 2006; Harambos & Holborn, 2008).

It is therefore not uncommon for seemingly obese Euro-American women to develop negative self-concept which may push them into excessive starving or undergoing cosmetic surgery simply to reduce body fat (Harambos & Holborn, 2008). On the contrary, obese women are highly cherished in some traditional African societies. Here, seemingly obese women are considered sexually attractive and sought after by men. According to Erinoshio (2006), this is the case in some parts of Nigeria like Cross River State, where women are deliberately kept in homes where they are fattened prior to their betrothal. Similarly, married women in some places in Nigeria are expected to add more body weight as this is adjudged as evidence of good living and happiness in marital life. These examples demonstrate that the concept of disease is better understood if the social structure or normative patterns of various societies are taken into consideration and carefully studied. Therefore, in order to understand reasons for a given healthcare choice among the elderly in Igbeagu community of Ebonyi state, it is imperative to examine the cultural interpretation of the disease condition as well as the social impetus in healthcare decision-making.

Most recent studies done on healthcare utilization focused on the urban areas (Abdulraheem, 2007; Agba, Ushie & Osuchukwu, 2010; Okumagba, 2011; Mahapatro, 2012; Murihi, 2013; Ibitoye, Sanuade, Adebowale & Ayeni, 2014; Oladipo, 2014; Owoseni, Jegede & Ibikunle, 2014; Osuchukwu et al. 2016). There is also a need to carry out such study in rural areas. This study therefore intends to fill the gap by exploring the socio-cultural factors that influence healthcare choice of older adults in Igbeagu community, a rural community in Ebonyi state Nigeria.

Theoretical Framework

The Health Care Utilization Model

This model was first propounded by Anderson and Neuman (1975) and was later expounded by Weller and Klein (1997). The essence is to encapsulate the major factors that determine healthcare utilization specifically, as well as health and illness behaviour generally. The health care utilization model is grouped in a four sequence cluster of factors, which include predisposing factors, enabling factors, need factors and treatment option. These are factors that are capable of influencing health behaviour generally and healthcare utilization specifically.

i. Predisposing Factors: These are basically social and demographic factors that influence healthcare utilization. The predisposing factors include age, gender, religion, global health assessment, prior experience with illness, formal education, general attitude toward health services, and knowledge of illness, among others.

ii. Enabling Factors: These are basically socio-economic factors that influence health service utilization. They include availability of services, financial resources to purchase services, health insurance, social network and support, etc.

iii. Need Factors: This has to do with the seriousness of the disease condition as well as whether or not the illness interferes with the person's social roles and activities. Need factors include perception of severity, total number of sick days for a particular illness, total number of days in bed, days missed from work or school, etc.

iv. Treatment Action: this refers to the array of treatment option, whether orthodox or traditional. These includes home remedies (herbal or pharmaceutical), pharmacy, over-the-counter drugs, traditional healers, private and public health services etc.

This model which focuses particularly on treatment selection has also been used for gaining evidence on the weight of different factors for health service utilization such as the factors that influence choice of health service utilization by the inhabitants of Delta State, Nigeria (Okumagba, 2011). Similarly the model is also a reliable guide in determining the socio-cultural determinants of health care utilization among the older adults in Igbeagu community of Ebonyi state Nigeria as justified below.

Finding in the present research shows that economic factors such as cost of treatment is a major factor in determining healthcare utilization. An overwhelming majority of the respondents 82.6% confirmed that cost of treatment affect their healthcare choice.

The predisposing factors such as age and sex played little role in the healthcare choice of older adults in the present study, this is because, the chi-square test indicates no significant relationship between sex of an older adult and healthcare choice; and there is no strong relationship between age of an older adult and healthcare choice. However, social factors were of great significance. People's attitude and belief about healthcare service highly influenced their healthcare choice. In the present study, the older adults expressed a more positive attitude toward traditional medicine. More than half of the respondents (53.9%) indicated using only traditional medicine, 31.2% use traditional and orthodox, while only 14.9% use only orthodox medicine.

The influence of attitude of significant others on healthcare choice of the older adults was also observed. This was evident on the side of care-givers and healthcare providers. It was observed that attitude of care-givers and that of healthcare providers significantly affected the healthcare utilization and healthcare choice of the older adults in the present study.

The need factors in the healthcare utilization model have to do with the seriousness of the disease condition as well as whether or not the illness interferes with the person's social

roles and activities. There is an indication in the present study that the type and severity of disease condition affects healthcare choice of the older adults. Some participants in the FGDs are of the view that certain diseases are better treated with traditional medicine than with orthodox type. They identified some of those diseases like anthrax and hiccups – these are some of the diseases that one must not attempt using orthodox medicine, else the person may just die instantly. Similarly, others expressed the view that in certain other diseases such as yellow fever and typhoid, one may start with orthodox medicine to reduce the symptom (because of its severity) but continues with traditional medicine afterwards for comprehensive and complete cure. All these are consistent with the postulation of the healthcare utilization model that nature of disease and its severity can shape people's treatment option.

The treatment action of the healthcare utilization model refers to the array of treatment option, whether orthodox or traditional. It also includes home remedies (herbal or pharmaceutical) pharmacy, over the-counter drugs etc. Indeed, it includes different channel of care. Suffice it to say that result from the present study indicates various channels of care among the older adults. Depending on the type and severity of the disease condition, those that patronize both traditional and orthodox medicine indicated sometimes starting with orthodox and concluding with traditional and vice-versa. All these show the synergy between the present research findings and the theoretical framework.

Material and Method

Study Design

A cross sectional survey design was used in this study. This was to enable the researchers collect data on the knowledge, behaviour, beliefs, opinions, practices and other variables that influence healthcare utilization by older adults in Igbeagu community. Also it enabled them to collect data at one point or period from the sample of the entire population.

Scope of Study

Health as a biosocial concept is multi-faceted. Health care utilization is as well influenced by several factors. This work was set to examine the socio-cultural determinants of healthcare utilization among the older adults. The study was conducted in Igbeagu community, Izzi Local Government Area of Ebonyi state Nigeria. The choice of the community was purposive, but, was informed by a number of factors. First, the area has a large number of older adults, in fact, Ugwuja (2015) put the number of individuals aged 60 years and above at 10, 082. Second, the researchers are very conversant with the local language and custom of the people in the area.

The participants in the study were older adults, which, according to this study are individuals aged 60 years and above. In the questionnaire study, no upper limit was set for the age of older adults that participated. However, in the FGD sessions, lower and upper limits were part of inclusion criteria for participation, designed to ensure relative homogeneity of participants. Thus, the age range for participation in the FGDs was 60-69 years. Other criterion for participation is that participants must be 'ever married' (this means those who are currently living with their spouse, widowed, separated or divorced).

Study Area

Igbeagu (or Igbegu) community is one of the eight autonomous communities in Izzi Local Government Area of Ebonyi State; which has a population estimate of 313,200 according to the National Population Commission population estimate of 2016. It is made up of 56 villages and 3 political wards. Igbeagu community is the youngest among all the communities that make up Izzi clan. The community is bisected by Abakaliki-Ogoja road and has a boundary

with the Cross River State in the east, Ebonyi river to the west, Inyimagu to the north and Amachi community to the south.

The community has one mission hospital located at approximately the epicentre of the community, Ndubia, two public hospitals, a dispensary, two private hospitals and a number of private maternity homes (Ugwuja, Ezenkwa and Nnabu 2015). Similarly, traditional healers of various types are found in every nook and cranny of the community; such traditional healers like the herbalists, traditional bone setters, traditional birth attendants, traditional psychiatrists, spiritual healers among others. Igbeagu people are predominantly farmers. The staple foods include locally processed cassava, rice and yam. Yam production is probably the major occupation of the people of the community. Indeed, they have been described as “yam farmers per excellence” (Echiegu, 1998:48). Primary source of water for domestic use are stream, well and borehole. Commercial activities take place at some strategic junction and at different local market places scattered in most of the villages.

Sample Size

The sample size for the study was determined statistically using Taro Yamane formula thus:

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

Where:

n = required sample size

N = Total Population (10, 082)

e = accuracy level or error margin (0.05)

Applying the formula

$$\begin{aligned} n &= \frac{10, 082}{1 + 10, 082 (0.05)^2} \\ &= \frac{10, 082}{10, 083 \times 0.0025} \end{aligned}$$

$$\begin{aligned}
 &= \frac{10,082}{25.2075} \\
 &= 399.9 \\
 \underline{\underline{\quad}} &= 400
 \end{aligned}$$

The total number of questionnaire distributed were 400, 3 copies were discarded for inconsistency, so, the valid 397 copies were used in analysis.

Sampling Procedure

Simple Random Sampling (SRS), cluster sampling and purposive sampling techniques were used in this study for the purpose of selecting the respondents, and the procedure is described below:

Stage 1: Simple Random Sampling was used to select ten villages out of the 56 villages that make up the community. This was done through simple balloting. Numbers were assigned to each village, folded, put in a basket and shaken vigorously. A research assistant was asked to pick a piece of folded paper; this process was repeated until all the required number of villages for the study (i.e. ten villages) was picked. The selection was done with replacement. This was to ensure that each element had equal chance of being selected.

Stage 2: Each of the villages selected was divided into four clusters. A hamlet or “integration” (Mbukobe) or village road (uzogbaroro) was used as clusters. Two clusters were selected from each of the four clusters using simple random sampling or balloting as described above. This provided a total of 20 clusters (i.e. $10 \times 2 = 20$). Again, 20 respondents were drawn from each of the clusters. This gives a total of 400 (ie $20 \times 20 = 400$) respondents for the entire 20 clusters.

Stage 3: Compounds in each selected cluster were numbered and the research began with the first compound on the list until the required number of respondents for that cluster was achieved. This gave a total of 20 respondents from each selected cluster in the village.

However, when a cluster did not produce the required number of respondents an additional cluster was selected to complete the number.

More so, two Focus Group Discussions were conducted for two different, but, homogenous groups to provide a complementary triangulation for the questionnaire findings. Separate FGD was conducted for male and female older adults in a culturally appropriate setting chosen by participants themselves, and on a non-market and festival free day. Inclusion criteria for the FGD included the following: participants were within the age bracket of 60 – 69 years. Participants in each FGD session must be of the same sex. They were ever married (that is, currently married, widowed, separated or divorced) and must not have participated in questionnaire study. Discussions were held with the respective homogenous groups in the local language and captured by a trained research assistant (note taker) and complemented with the use of a digital recorder. Participants were drawn purposively with the help of a community leader.

Methods of Data Collection

Instrument for the study was other-administered. The researcher, along with a research assistant administered the questionnaire and conducted the FGDs. The questionnaire was written in English language, translated into Izzi and back again into English so as not to lose its original meaning. Thus, on the course of administering, it was orally translated into the vernacular to aid comprehension especially by the illiterate respondents.

Method of Data Analysis

Data was analysed using both quantitative and qualitative methods of data analysis. Quantitative data was analysed using SPSS version 20.0 and presented in charts and tables.

Chi-square was used in testing the hypotheses. On the other hand, in-depth and thematic analyses were employed for the qualitative data.

Limitations of the Study

There were a number of constraints and challenge on the course of this study. To start with, there was initial challenge of getting respondents to be interviewed. This is because the field work coincided with the time for the local government chairmanship and councillorship elections in the area. Hence people at first took the research work as part of political activity and therefore demanded gratification before they could participate. In the same vein, some others were sceptical and apprehensive of volunteering their comment, especially in places where police had just arrested some stake holders in the village over election irregularities and violence.

Apart from the above constraint, the study was conducted in one community with only 411 participants (397 for questionnaire study and 14 for FGDs). Similar study should also be carried out in other communities and local government areas to ensure a more reliable generalization. Again, only two FGDs were conducted because of time constraint and financial reasons. This was another limitation of the present study. Increasing the number of FGDs would have provided a more expanded response on the research topic which can ensure a more reliable generalization. Finally, the study focused on the older adults vis-à-vis factor that affect their healthcare utilization. The present study did not include the healthcare providers. So, similar study to include the healthcare providers (orthodox and traditional) would be necessary so as to get a more balanced view of the socio-cultural determinants of healthcare utilization of the members of the community.

Findings

Table 1: Socio-demographic characteristics of respondents

Socio-demographic variables	Frequency	Percentage (%)
Sex		
Male	185	46.6
Female	212	53.4
Total	397	100.0
Marital Status		
Never Married	9	2.3
Married	155	39.0
Separated/Divorced	63	15.9
Widowed	170	42.8
Total	397	100.0
Age		
60-69	149	37.5
70-79	115	29.0
80-89	91	22.9
90 and above	42	10.6
Total	397	100.0
Educational Attainment		
No formal education	236	59.4
Primary education	121	30.5
Secondary education	31	7.8
Tertiary education	9	2.3
Total	397	100.0
Religious Affiliation		
African Traditional Religion	124	31.2
Catholic	129	32.5
Protestant	71	17.9
Pentecostal	61	15.4
Others	12	3.0
Total	397	100.0

Source: Field work 2017

The result from the table indicates that more than half of the respondents (53.4%) were females. On the other hand 46.6% of the respondents were males. This shows that more women responded to the questionnaire than men. This could be partly because there are greater numbers of female older adults in the study area than male older adults and partly because

women appear to be more disposed to engage in health-related discussions than their men counterparts.

The table also shows that vast majority of the respondents were already widowed. Almost half of the total respondents (42.8%) were widows and widowers. On the other hand 39.0% of the respondents are still having their marriage mates alive. Divorce/separation stood at 15.9%, while never married is only 2.3%. This highlights the importance attached to marriage and family life in the community of study.

The result also indicates that out of the 397 respondents, 149 (37.5%) were between the age range of 60-69 years. This is the age range with the highest frequency. This was followed by those 70-79 years which are 115, accounting to 29.0%; while those aged 80-89 are 22.9% of the respondents. Those aged 90 and above are fewest having only about one tenth or 10.6% of the respondents. This shows a drastic reduction in the number of the older adults in the area as they move into late older adult.

A close look at the table indicates that respondents with no formal education accounted for more than half of the total respondents. A total of 236 respondents representing 59.4% have no formal education. Similarly, slightly above three tenth or 30.5% of the respondents had primary education experience or its equivalent. However, 7.8% of the respondents had secondary education or its equivalent. On the other hand, only 2.3% had tertiary education. This shows a high level of illiteracy among these older adults as more than half had no formal education experience.

The result also indicates that members of Catholic Church have slightly more than one-third of the respondents, constituting 32.5%. Members of African Traditional Religion amounted to 31.2%. This shows that although many people in the study area have embraced Christianity, quite a large number, especially among the older adults are still adherents of traditional religion. Similarly, slightly above one-sixth are members of Pentecostal churches,

constituting 15.4%, while those of protestant churches were 17.9%. On the other hand adherent of other religious groups outside what is mentioned above constituted 3.0% of the respondents. This shows that Catholicism and African Traditional Religion are having the largest number of adherents, especially among the older adults in the study area.

Table 2: Socio-demographic characteristics of respondents for the FGDs

Socio-demographic variables	Frequency	Percentage (%)
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
Not Educated	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

Source: Field work 2017

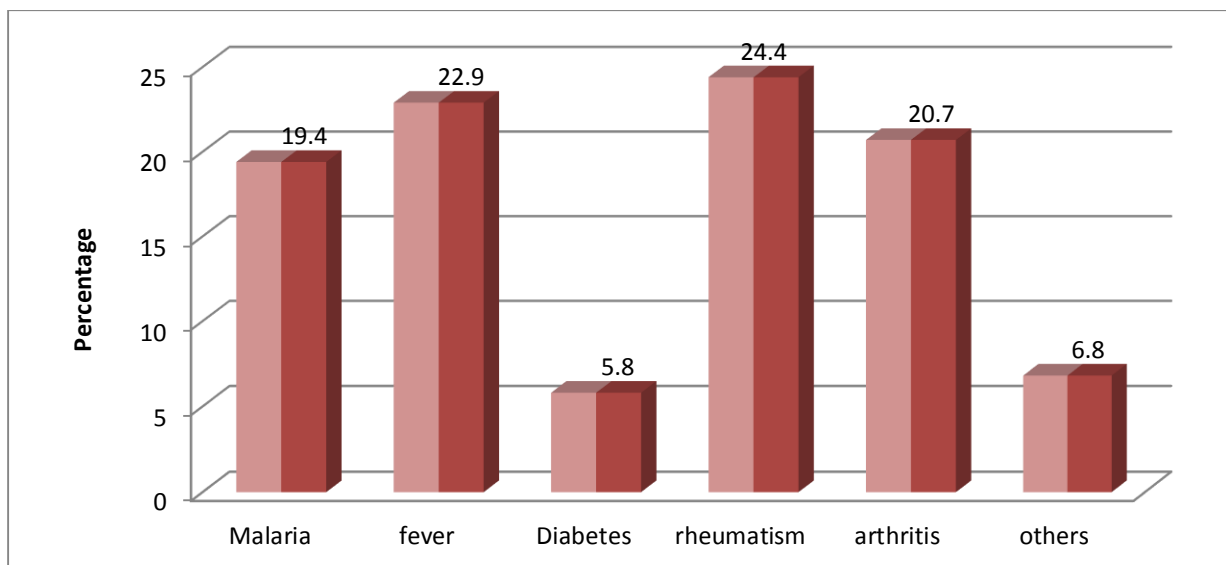
Table 2 above shows the socio-demographic characteristics of the FGDs participants. Two FGDs were conducted for male and female participants respectively within the inclusion criteria. There were equal numbers of male and female older adults that participated in the two FGDs. Thus, there were 50.0% males and 50.0% females. All the participants were within the age bracket of 60-69 years. The mean age of male participants was 68.0, while that of their female counterpart was 67.3. All the participants in the FGDs were ever married. However, more than half of the participants are 64.3% were still living with their marriage mates, while

those that were separated, divorced or widowed constituted 35.7%. Again, almost all the participants have no formal education amounting to 85.7% of the participants, while those with formal education were 14.3%. Similarly, most participants were farmers. Indeed, farmers constituted 57.1% which is slightly higher than half of the entire participants. Those engaged in petty-trading, artisan and the unemployed have 14.3% respectively. Exactly half of the participants are members of Catholic Church amounting to 50%, while Protestant and Pentecostal Churches have 28.6% and 21.4% respectively.

Substantive Issues and Cross Tabulation of Variables

a. Common health related problem

Figure 1: Distribution of respondents on the most common health-related problem



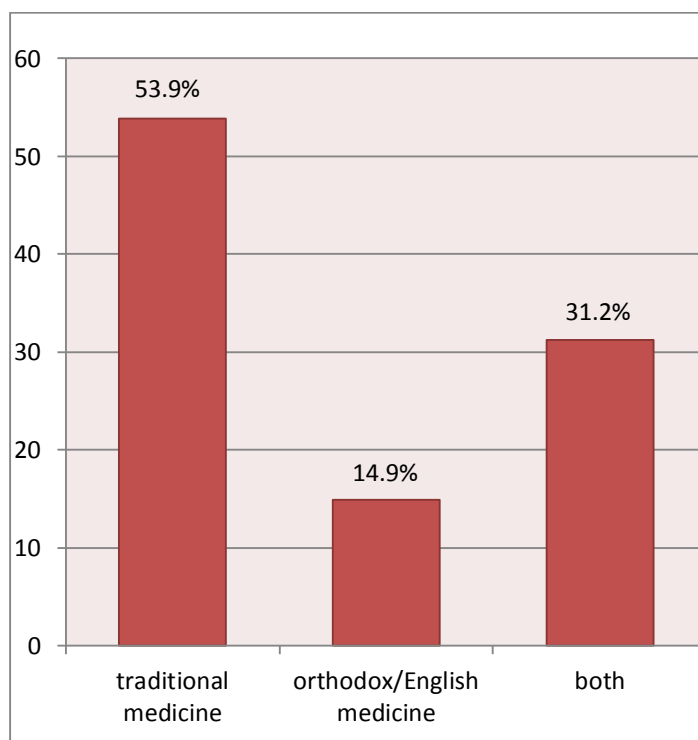
Source: Field work 2017

From figure one above, it can be observed that slightly above one-fourth of the respondents (24.4%) indicated that rheumatism was their most common health problem. On the other hand, slightly above one-fifth that is 20.7% answered that arthritis was their own most common health challenge. This is understandable because of the strenuous physical activities (hard work) these older adults were exposed to when they were younger. Again, 22.9%

answered that their own most common health problem was fever. This comprises both yellow fever and typhoid fever, while 19.4% answered malaria. These basically could be attributed to the type of water these older adults make use of and the type of food they eat. The sources of drinking water for many of them are open wells, streams and ponds. These can predispose them to typhoid and other similar diseases. On the other hand, 5.8% of the respondents indicated that their major health problem was diabetes, while various other diseases indicated by these older adults as their major health problem accounted for 6.8%.

b. Healthcare Preference

Figure 2: Healthcare preference of the older adults



Source: Field work 2017

The chart above (figure 2) presents the healthcare service preference of the older adults. More than half of the older adults have preference for traditional medicine (53.9%). Similarly, almost one-third of the respondents expressed preference for both traditional and orthodox medicine (31.2%). On the other hand, only 14.9% expressed preference for English or orthodox

medicine. This show that greater number of the respondents expressed preference for traditional medicine over the orthodox medicine. This correlates with the responses from the FGDs. Here the older adults equally expressed preference for traditional medicine. Reasons for their preference include: assumed efficacy, proximity, cost and perceived benevolence and humane disposition of the traditional medicine dealers over the orthodox counterpart, as well as 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 mansaid: “I 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 other participants echoed similar view. Another respondent aged 69 years commented “I prefer traditional medicine because it is what I can afford”. One woman retorted: “I prefer the one we have, that is the traditional medicine....We don’t have hospital in our village and again I don’t even have the money for hospital”. Others were of the view that orthodox medicine does not provide lasting cure for some diseases. Such diseases, they said, should be treated with traditional medicine or at least a combination of traditional and orthodox medicine. Such diseases according to them include: hiccups (*native name: etúú*), anthrax (*oke-edjonwo*), and yellow fever (*otchalenya*) among others.

c. Socio-demographic variables and healthcare choice

The table below presents a cross-tabulation of the socio-demographic characteristics of the older adults and their choice of healthcare service. As shown in the table, variables such as gender, age marital status and educational status do not predict older adults’ choice of health care service.

Table 3: Relationship between socio-demographic variables and healthcare utilization of older adults

Socio-demo. Variables	Healthcare choice of older adults						df	X ² critical	X ² (0.05) P-value
	Traditional	Orthodox	Both	Total					
[F (%)]	[F (%)]	[F (%)]							
Gender									
Male	74 (40.0)	31 (16.8)	80 (43.2)	185					
Female	101 (47.6)	27 (12.7)	84 (39.6)	212					
Total	175 (44.1)	58 (14.6)	164 (41.3)	3972	2.715			0.257 > 0.05	
Age (in years)									
60-69	80 (53.7)	23 (15.4)	46 (30.9)	149					
70-79	62 (53.9)	17 (14.8)	36 (31.3)	115					
80-89	45 (49.5)	16 (17.6)	30 (33.0)	91					
90 +27	(64.3)	3 (7.1)	12 (28.6)	42					
Total	214 (53.9)	59 (14.9)	124 (31.22)	3972	3.4			0.739 > 0.05	
Marital status									
Never married	5 (55.6)	2 (22.2)	2 (22.2)	9					
Married	80 (51.6)	28 (18.1)	47 (30.3)	155					
Divorced/Sep.	40 (63.5)	4 (6.3)	19 (30.2)	63					
Widowed	86 (50.6)	26 (15.3)	58 (34.12)	170					
Total	214 (53.9)	60 (14.9)	126 (31.22)	3972	11.192			0.083 > 0.05	
Educational status									
Not educated	129 (54.7)	31 (13.1)	76 (32.2)	236					
Educated	85 (52.8)	28 (17.4)	48 (29.8)	161					
Total	214 (53.9)	59 (14.9)	124 (31.2)	3972	2.915			0.23 > 0.05	

Source: Field work 2017

The table shows no association between gender and healthcare choice of older adults. It can be observed that 40% of male respondents utilize traditional medicine, 16.8% utilize orthodox medicine, while 43.2% utilize both English and traditional medicine. Similarly, 47.6% of female respondents utilize traditional medicine, 12.7% utilize orthodox, while 39.6% utilize both English and traditional medicine. A chi-square test ($X^2 = 2.715$, $df = 2$, $P = 0.257$) reveals no significant relationship between gender of older adults and healthcare choice. This

means that being a male or female does not have significant impact on one's choice of healthcare service. But surprisingly, findings from some FGD participants indicated otherwise. Gender disparity in healthcare choice among males and females was recorded. However, this was not in relation to healthcare choice (traditional or orthodox) per se, but in relation to the gender of the healthcare provider. A 67-year old woman reasoned: "say I am going to buy medicine... 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".

The table indicates that of the 214 older adults that utilize traditional medicine, those within the age range of 60 – 69 accounted for 53.7%, those within the age range of 70 – 79 are 53.9%, those 80 – 89 are 49.5% while those 90 years and above are 64.3%. On the other hand, of the 59 respondents that utilize orthodox medicine, those aged 60 – 69 years are 15.4%, those 70 – 79 years are 14.8%, those 80 – 89 years are 17.6% while those 90 years and above are 7.1%. Again, of the 124 respondents that utilize both traditional and orthodox medicine, 30.9% are within 60 – 69 years. Those 70 – 79 years are 31.3%, those 80 – 89 years are 31.0%, while those 90 years and above are 31.2%. The chi-square test showed no significant difference in healthcare utilization based on the age of the older adults.

The table above also indicates that of all the 214 older adults that utilize traditional medicine, 55.6% are never married, 51.6% are married, 63.5% are either divorced or separated and, 50.6% are widowed. Again, of the 59 respondents that utilize orthodox medicine, 22.2% are never married, 18.1% are married, 6.3% are divorced/separated while 15.3% are widowed. Similarly, of the 124 respondents that utilize both traditional and orthodox medicine, 22.2% are never married, 30.3% are married, 30.2% are divorced/separated while 34.1% are widowed. The chi-square test showed no significant difference in healthcare utilization based on the marital status of the older adults ($X^2=11.192df=2, P = 0.083>0.05$).

Again, the table shows that 54.7% of older adults with no formal education prefer traditional medicine, 13.1% prefer orthodox, while 32.2% utilize both orthodox and traditional medicine. On the other hand, 52.8% of older adults with formal education prefer traditional medicine, 17.4% prefer orthodox medicine, while 29.8% use both traditional and orthodox medicine. The chi-square test also reveals that there is no significant relationship between level of education and healthcare choice of the older adults ($X^2 = 2.915df=2 P =0.23 > 0.05$).

d. Cost, care-givers' attitude and healthcare utilization of older adults

The table below presents a relationship between cost, care-givers' attitude and healthcare utilization of the older adults.

Table 4: Relationship between Cost, care-givers attitude and healthcare utilization of older adults

Variable	Response		Total	df	X ² critical	X ² (0.05) p-
	Yes	No				
value [F (%)]	[F (%)]					
Does cost affect your choice of healthcare service?						
Male	145 (78.4)	40 (21.6)	185			
Female	183 (86.3)	29 (13.7)	212			
Total	328 (82.6)	69 (17.4)	397	4.34	0.037	<0.05
Does the attitude of your care-giver affect your healthcare utilization?						
Male	111 (60.0)	74 (40.0)	185			
Female	150 (70.8)	62 (29.2)	212			
Total	261 (65.7)	136 (34.3)	397	5.07	0.024	<0.05

Source: Field work 2017

The table shows that out of the 328 older adults that indicated that cost of treatment affect their healthcare choice, 78.4% are males while 86.3% are females. On the other hand, only 21.6% and 13.7% of male and female older adults respectively indicated that cost of treatment does not affect their choice of healthcare service. This shows that vast majority of

the male and female older adults alike see cost of treatment as a major determinant factor in healthcare choice. The chi-square test shows an association between cost of care and utilization of healthcare services by the older adults in Igbeagu community ($X^2=4.34$ df=1 P= 0.037 <0.05). This was further corroborated by the responses from the FGDs. There was a relatively unanimous view especially among the elderly ones who sponsor their healthcare services that cost and distance are great barriers to accessing healthcare services. 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”. Another 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”.

Again, 60.7% male and 70.8% female respondents indicated that the attitudes of their care-giver or family members affect their choice of healthcare service. Only 40.0% male and 29.2% female respondents indicated otherwise. The X^2 test indicates a relationship between attitude of care-givers and healthcare utilization of older adults in Igbeagu community ($X^2= 5.07$ df=1 P=0.024 <0.05). This observation is in line with the result of the FGDs which explains further how the attitudes of family members or care-givers affected the healthcare utilization of the older adults 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 [*her children*] 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. Some older adults complained that their children who were supposed to be their care-givers had abandoned them. One man, in a polygynous marriage aged 69 years old commented: “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”. Another elderly man 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”. This shows that fear of bewitchment from their elderly parents may even prevent some children from caring for them.

Discussion

Healthcare Preference of Older Adults

In the literature, it was observed that utilization of regular (orthodox) medical facilities is still at sub-optimal level in the Sub-Saharan Africa (Mezey & Fulmer, 1998; Abdulraheem, 2007; Okumagba, 2011; Osochukwu et al. 2016) This is consistent with the findings in the present study. As shown in figure 2, it can be observed that more persons expressed preference for traditional medicine over the orthodox counterpart. A total of 53.9% indicated using traditional medicine alone, 31.2% indicated using both traditional and orthodox medicines while only 14.9% go for orthodox medicine when they are sick. Reasons for this as obtained from the FGD participants include among other things assumed cause of the disease, assumed efficacy or effectiveness of treatment option, cost, distance as well as attitude of care-givers and healthcare providers.

However, contrary to the above, result from Edo central, Nigeria revealed a higher preference of orthodox medicine. In a survey involving 512 participants, it was observed that close to three-quarter of respondents (73.7%) patronized orthodox medicine (Odaman & Ibiezugbe, 2014).

Cost of Treatment and Healthcare Choice

In the present study, cost of treatment was found to be a major factor in healthcare choice. Result presented on table 4 shows that as many as 82.6% agreed that cost of healthcare affects their choice and utilization of healthcare services. Only 17.4% indicated otherwise. The cross tabulation of gender and cost of treatment indicates that there is no significant difference among male and female older adults in relation to cost effect on healthcare utilization.

Finding from the quantitative data is consistent with the result from the FGDs. Participants in the FGDs admitted that they usually opt for traditional medicine because it is cheaper and payment can also be made on instalments. Again, payment can be made with other items like agricultural produce rather than money, this makes payment more flexible for them.

Earlier studies have emphasized the significance of cost of healthcare service on utilization of such services. For instance, Ntembe (2009) observed that cost of healthcare service and cost of consultation significantly determine choice of healthcare service utilization. Similarly, study by Nguyen, et al. (2009) observed that consumers choose the facilities “to which access is easier and where payment is flexible” other studies in various African countries like Cameroon, Ghana and Cote d Ivoire have reinforced the assertion that high costs or user fees reduce patronage or usage of public health facilities (Ngugi, 1991; Litvack & Bodart, 1993; Lavy & Germain, 1994).

On the other hand, some other studies that examined cost and healthcare choice have found the demand for healthcare to be inelastic with respect to price (Mwaba, et al., 1994; Dow, 1995; Gupta & Dasputa, 2000). Study conducted in some Nigerian cities by World Bank (1990) posits that patients may patronize a given medical treatment irrespective of the cost, if they are convinced that they will receive the needed quality service and prompt attention. According to the findings, “many Nigerians prefer to use the more costly cosmopolitan private healthcare

providers than those within the public sector because it is believed that more quality care and attention is provided by the former". In the present study, cost remains a major determinant of healthcare utilization by the older adults in Igbeagu community as observed earlier. Hence, these older adults (especially those who sponsor their healthcare service) opt for traditional medicine which they consider cheaper and mode of payment easier.

Gender and Healthcare Choice

Findings from this research show that there is relatively no gender difference in the healthcare choice of male and female older adults. From table 3, it can be observed that 40% of male respondents utilize traditional medicine, 16.8% utilize orthodox medicine, while 43.2% utilize both English and traditional medicine. Similarly, 47.6% of female respondents utilize traditional medicine, 12.7% utilize orthodox, while 39.6% utilize both English and traditional medicine. A chi-square test ($X^2 = 2.715$, $df = 2$, $P = 0.257$) also reveals no significant relationship between gender of older adults and healthcare choice. This means that being a male or female does not have significant impact in ones choice of healthcare service. This is consistent with the findings of Dunlop et al. (2002) in a study of Spanish older adults aged 70 years and above, where no gender differences was recorded in the number of medical contacts by males and females respectively. Similarly, Redondo-Sendino et al. (2006)observed that neither functional status nor cognitive deficit explains a significant gender difference in healthcare utilization among the geriatric population.

But surprisingly, findings from some FGD participants in the present study indicated otherwise. Gender disparity in healthcare choice among males and females was recorded. However, this was not in relation to healthcare choice (traditional or orthodox) per se, but in relation to the gender of the healthcare provider.

Level of Education and Healthcare Utilization

Findings from this research show that 54.7% of participants with no formal education patronize traditional medicine, 13.1% patronize orthodox medicine, while 32.2% go for both orthodox and traditional medicine. Similarly, 52.8% of educated older adults patronize traditional medicine, 17.4% patronize orthodox medicine while 29.8% patronize both orthodox and traditional. However, the chi-square test ($X^2 = 2.915$, $df = 2$, $P = 0.23 > 0.05$ alpha level) indicates that no significant relationship exist between level of education and healthcare choice. This means that both educated and non-educated older adults in Igbeagu community think and behave alike when it comes to healthcare choice. This is consistent with the findings by Erinoshio (2006) in his study of the perception of medical students in their penultimate and final years in medical school on mental illness. His findings show that level of education can have a minimal impact on people's response to disease condition. This is because those final year students he studied still shared the viewpoint that mental illness may be attributed to bewitchment or other supernatural factors.

Contrary to the above finding, Jegede (2002) in a study carried out among the Yorubas in Akinyele Local Government Area arrived at the conclusion that education influences people's choice of healthcare service. This is because, education, according to him, "modifies [people's] beliefs about disease causation and cure, and thus, induces receptivity to modern health services". This, according to him is because "education improves people's cognition and ability to communicate with modern healthcare providers, increase the value they place on good health and results in heightened demand for modern healthcare services".

Care-Givers Attitude and Healthcare Utilization

Findings from the present study indicate that attitude of care-givers or family members are a strong factor in determining healthcare utilization of the older adults in Igbeagu

community. This can be illustrated from data on table 4 wherein 60% of male older adults indicated that the attitude of their care giver affect their healthcare utilization, while 40% indicated otherwise. The cross tabulation further reveals that both male and female older adults share the same view. The chi-square test reveals a significant relationship between the attitude of care-givers and healthcare utilization of the older adults ($X^2 = 5.07$, $df = 1$, $P = 0.024 < 0.05$ alpha level). Similarly, comments from the FGDs show the dimension of care-givers attitude *vis-à-vis* healthcare utilization of the older adults to include: being overbearing and negligence.

Some care-givers tend to exercise overarching and totalitarian healthcare decision on the older adult under their care. Such older adults feel aloof or alienated from the decision that involves their own very health and life. On the other hand, some care-givers or rather, nominal care-givers go to the other extreme: negligence. Some respondents feel abandoned by persons who were supposed to be their care-giver. Reason for the negligence according to some participants is the obnoxious culturally held belief that that elderly ones should not be cared for because prolonging their life would mean more death for the younger members of the family.

Conclusion

This study sought to explore the socio-cultural determinants of healthcare utilization by older adults. Since effective healthcare service is a sine qua non for healthy living and successful ageing of these older adults, issue of healthcare utilization should not be taken for granted. This is in line with the saying that 'health is wealth'. 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 especially 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 and make healthcare services more accessible and affordable. 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. Also, it is imperative that care-givers and the general public be enlightened on the need to accord older adults their respect and dignity by discussing with them a treatment option before embarking on such treatment so that these older adults will be part of decision that concerns their own health.

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