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Sociological analysis of health care seeking behaviour among the elderly in Kokona local government area of Nasarawa state, Nigeria

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Abstract

In the last few decades, there have been drastic changes in population, particularly in developed countries. The increase of the aged population is more than that of the general population. This study sought to sociologically analyze healthcare-seeking behaviour among the Elderly in Kokona Local Government Area of Nasarawa State, Nigeria. A survey design was adopted. A sample of 383 elderly persons aged 60 years and above was drawn, using multi-stage sampling techniques including simple random, systematic sampling, clustered and purposive sampling techniques in the selection of electoral wards, towns/villages, main streets, houses, households and individuals. Primary and secondary data were utilized in the study. The primary data were generated through the use of questionnaires. The questionnaires were analyzed quantitatively using cross tabulation and chi square tests. The results show that socio-demographic characteristics of the elderly such as level of educational attainment, sex of the elderly and occupation of the elderly have a significant impact on the health care-seeking behaviour of the elderly and most of the elderly visit both orthodox and non-orthodox health care facilities in Kokona Local Government Area of Nasarawa State, Nigeria.It is based on this that the paper recommends that there is a need for Government, Non-governmental organizations, religious organizations, mass media, and community/traditional leaders to create awareness programmes on the positive impact on improving healthcare-seeking behaviour among the aged. Increasing the coverage of the National Health Insurance Scheme to provide financial protection for elderly persons with lower socioeconomic status will promote the use of appropriate healthcare sources.

Keywords: Nassarawa, Health Care, Kokona, elderly, Sociology

Introduction

In the last few decades, there have been drastic changes in population, particularly in developed countries. The increase of the aged population is more than that of the general population. The global population increased by 37.6% between 1980 and 2000, while the 60+ group increased by 60.5%. In developing countries, the changes were 46.2% and 82.5%n respectively. Even the 80+ population which was 34.2 million globally in 1980 has increased to

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58.2 million in 2000 and is expected to reach 103.9 million in 2030, meaning an increase of 204% between 1980 to 2020 [1].

Aged people constitute a category of the population that demands attention. But when one considers the problems the aged face on social, economic and health grounds the urgency becomes more evident. Health condition becomes more important in elderly because of increased health care costs, increased demand, costly procedures, lengthy hospitals stay and long term care. Getting older persons to keep themselves healthy for as long as possible minimizes the cost and this has drawn the attention of the public health personnel.

Elderly persons, particularly frail older adults, have been the most significant consumer of health resources[2]. Old people need health care because old age is associated with pain and ill health[3]. According to Campbell[4], this rapid growth of the elderly population is a challenge to the medical profession, administration and society as well. The delivery of health care to older adults has been recognized to be more complex than that of younger adults because, according to Mion[5], elderly persons utilize the majority of health care services. The complex needs imply future health care delivery to the geriatric population. Specifically in Nigeria, the number of elderly citizens has been on the increase and their health needs receiving popular recognition[6].

Aging is a global phenomenon hence a critical policy issue receiving some recognition by governments of developed countries where it is reflected in the government's vital document of economic and social development strategy[7]. Furthermore, globally, the greatest increase in the number of older people is occurring in developing and middle-income countries. Nigeria is not an exception. Nigeria still has a relatively young population when compared to most European countries and other countries where life expectancy is high. However, as medical advances allow people to live longer, the proportion of the elderly will increase in Nigeria[8]

World Health Organization[9] observed that the population of Nigerians Elderly 60 years and above is already increasing. United Nation's population profile[10] ,

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[1] World Health Organization, (WHO).*Active Aging:* A Policy Framework. Geneva: World Health Organization. 2017

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[7] Okoye, U.O.. Family care-giving for ageing parents in Nigeria: gender differences, cultural imperatives and the role of education. *International Journal of Education and Ageing* 2012.

[8] Ibid., P. 139.

[9] World Health Organization (WHO) 2015.*Global Health Observatory Data Repository*.

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shows that there were 5 million Nigerians elderly 60 years and above in 2015 and the number will continue to increase by the year 2025, it is estimated that 6% of the population will be 60years and above. Abdulraheem[11] stated that it may be necessary for policy makers to consider establishing neighborhood adult daycare centres where elderly persons can meet each other during the day. Other services like medical, nutritional, recreational, and educational services can also be incorporated into the neighborhood day care centres[12]. The use of adult day care centres has been reported by many scholars to be very advantageous to elderly persons and their families.

To Paul[13], the delivery of health care to older adults has been recognized to be more complex than that of younger adults because the elderly persons utilize the majority of health care services while the complex needs imply future health care delivery to the geriatric population, specifically in Nigeria, where the number of elderly citizens has been on the increase and their health needs receiving no popular recognition. Findings on elderly health issues can be used to guide the formulation of comprehensive health services and health education policies and intervention programs for elderly men and women in Nigeria[14]. Moe[15] highlights that the aging process and problems related to the elderly should be better understood so that effective elderly health prevention can be planned and implemented. The need to improve the delivery of care for older adults in home and community settings will be unavoidable although the broad diffusion of transformative technologies offers a significant means to advance the effort of improving quality and reducing the cost of care[16].

The provision of health care services for older people is different across countries, continents, and cultural societies. In developed regions of the world, health care is often provided by well-equipped public health facilities and nursing homes designated for elderly individuals. In the United States, older adults have a higher frequency of primary care visits, 50% hospital consultation, 80% home care services and occupy 90% of all nursing home beds[17]. Paradoxically, in developing regions, the picture is rather different as the contemporary health care facilities might not be the first point of contact for an elderly person.

In most Sub-saharan African countries, the availability and utilization of health care services among the elderly are poorly reported. For instance, a study carried out in the Democratic Republic of Congo revealed that more than half of

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the elderly people (55.6%) consulted private facilities and traditional spiritual healers once they were ill. The public health facility was used by only 3.3% of elderly persons[18]. In Ghana, it was reported that in the last three years, about one-third of the elderly (31.5%) utilize health care and others utilize traditional healers[19].

In Nigeria, geriatrics care has not yet received its desire attention. Most elderly persons utilize conventional health care facilities whenever they fall ill while others subscribe to self-medication with orthodox medicine and traditional herbs. In Kokona Local Government Area of Nasarawa State, there are no known available social support services, elderly homes and designated health facilities where health care for the elderly population is prioritized. In some situations, most elderly persons tend to depend on their families, relatives, and friends for utmost care. This accounts for why they are care-dependent. However, studies have shown that healthcare-seeking behaviour among the elderly is suboptimal. A study carried out in Delta State in Nigeria reported that about 40.56% of the elderly patronized chemists and pharmacist's shop, 19.44% patronized traditional healers/herbalists, 16.67% and 15.55% of the respondents got their medical needs from medical hawkers and self-medication and only 17.18% sought treatment from regular hospitals and clinics[20]. In another household survey in Kwara State, Nigeria, most elderly persons (44. 6%) reported that family care/family consultation was the first choice of treatment for the most frequently reported illnesses irrespective of age group and sex[21].

A conglomerate of research has shown that certain factors affecting healthcare-seeking behaviour among elderly persons. It has been observed that distance, waiting for time, and attitude of health workers hinder adequate access and use of health services especially among older adult[22]s. A qualitative follow-up study in Hong Kong reported that barriers to healthcare-seeking behaviour among the elderly include; lack of knowledge about aged care services, poor transport system, long waiting time, lack of services during non- offices hours, lack of accommodation for people with disabilities or dementia and a complication of procedure (Moe, 2012). A household survey carried out in Nigeria revealed that several factors such as poverty (50.3%) followed by nature of the illness (25.2%), quality of service provided (10.8%), the attitude of health caregivers (3.6%), waiting for time (3%), availability of service (2.8%), distance (2.3%) and level of education (2%) influence healthcare-seeking behaviour among the elderly[23].. From the foregoing, the study is a sociological analysis of healthcare-

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[19] United Nations 2017. *World aging population*
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seeking behaviour among the elderly in Kokona Local Government Area of Nasarawa State, Nigeria.

Statement of the Problem

Health care services are the main component towards providing excellent living, it is a common predicament that such services have posed bigger challenges on the health seeking behaviour of the elderly individual in Nigeria. Health care is a top social predicament facing the elderly. Today the need for awareness of health care services has posed a threat to the health of the aged, inadequate and poor health care facility management are some of the factors affecting the seeking behaviour of the elderly towards practice and utilization particularly those residing in rural areas and poor implementation of National health policy. The greater part of the elderly persons had age-associated illnesses such as blood pressure, cardiac problems, diabetes, joint pains, kidney infections, cancer and tuberculosis that take a long time to treat which particularly affect their health-seeking behaviour. Elderly individuals are found to have patronized traditional healers, resorted to self-medication using local herbs, or visit chemists shops whenever they are sick. The severity of the disease among the elderly is influenced by one important factor which is healthcare-seeking behaviour. Health care-seeking behaviour refers to a decision or an action taken by an individual to maintain, attain, or regain good health and to prevent illness. This usually influences them to choose a public or private facility for health service. Few may go for traditional medicines, self-medication, or home remedies.

Healthcare-seeking behaviour is influenced by factors like illiteracy, misconception, income, family composition, social isolation and dependency. This can increase the magnitude of suffering and disability among the elderly. It is important to know about healthcare-seeking behaviour before setting a health care facility or for evaluation of the same in a particular geographic area. In Nigeria, Nasarawa State, and Kokona Local Government Area poverty are rife and elderly persons are more at risk since most of them are no longer in the economically active phase of life and there is no national social security to provide economic support in old age. Access to health care is severely limited both by the paucity of health facilities and manpower and by out-of-pocket payment arrangements. The social network is dwindling and traditional family support is decreasing as urbanization and migration take young members of the family away. Also, social changes are affecting the position of the elderly in society and leading to a reduction in their social status and influence in the community.

Studies have been conducted on health care-seeking behaviour among the elderly in many parts of the world including Nigeria. However, none of such studies, to the best knowledge of the researcher, has been conducted on a Sociological analysis of healthcare-seeking behaviour among the elderly in Kokona Local Government Area of Nasarawa State, Nigeria that is the gap the study intends to fill. Therefore, the study is a sociological analysis of health care-seeking behaviour among the elderly in Kokona Local Government Area of Nasarawa State, Nigeria. This is the major problem of the study

Research Hypothesis

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i. There is no significant relationship between socio-demographic characteristics of the elderly and their health-seeking behaviour

Conceptual and Theoretical Framework

Elderly

Defining "elderly" is challenged by the changing average lifespan of human beings. Around 1900, the average life expectancy was between 45 and 50 years in the developed countries of that time. Now, life expectancy in developed countries reaches 80 years. The United Nations uses 60 years to refer to elderly persons[24]. This line, which divides younger and older cohorts of a population, is also used by demographers. However, in many developed countries, the age of 65 is used as a reference point for older persons as this is often the age at which persons become eligible for old-age social security benefits. So, there is no exact definition of "elderly" as this concept has different meanings in different societies. There are other definitions of "elderly" that go beyond chronological age. Elderly as a social construct is often associated with a change of social roles and activities, for example, becoming a grandparent or a pensioner. Elder persons often define old age as a stage at which functional, mental and physical capacity is declining and people are more prone to disease or disabilities[25].

The World Health Organization[26] posits the chronological age of 60 years as an acceptable definition of elderly or older persons in developed countries. Many westernized concepts do not adapt well to the situations in Africa. Goman[27] defined the elderly in many developing countries to begin at a point where their contribution is no longer active or age at which one begins to receive pension benefits. Richman[28] defines "elderly" as a chronological age of 60 years old or older, while those from 65 through 74 years old are referred to as "early elderly" and those over 75 years old as "late elderly" For National Population Commission[29] elderly is a process that affects everyone between birth and death. From the demographic point of view, for individuals, the elderly is a function of mortality and is reflected in various measures such as the probability of surviving from one age to another, and life expectancy. At the individual level, elderly is both a state and a consequence. As a state, the elderly comprises three levels: the organic state, the social state and the psychological state. As in the past, the elderly process is considered an inevitable manifestation of the passing of time. Now, the elderly is less and less considered a natural phenomenon, as advancements made in the fields of medicine and nutrition demonstrate that what once was unavoidable, where

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[29] National Population Commission..*Projected Population of Kokona Local Government Area of Nasarawa State, Nigeria* 2017

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elderly is concerned, can now be prevented or delayed. People now live longer than a century ago, as the result of nourishment, hygiene, and health- care[30].
This paper concurred with the definition of Elderly as provided by Richman[31] who define "elderly" as a chronological age of 60 years old or older, while those from 65 through 74 years old are referred to as "early elderly" and those over 75 years old as "late elderly.

Health Seeking Behaviour

Health-seeking behaviour is a process by which individual acts to maintain the state of physical fitness and well-being that enables man to manage the physical, social and biological environments to his/her satisfaction. Adeniyi and Ogunsola[32] identified building conducive houses for a living, managing wastes and pollution to improve the potentials and limitations endowed in an individual by correcting the correctable limitations and preventing the health hazards that may result as evidence of environmental management by man. Shehu[33] described health behaviour as a pattern of choices constituting what one does and what one fails to do that affects fitness level and health status. Examples of such behaviour are physical activities, drug abuse, proper nutrition, alcoholism and indiscriminate sexual practices. He added that health-seeking behaviours are acts of making choices from the available alternatives and to the ease with which they can choose certain ones over others. The researchers observed that the effectiveness of using health behaviour for well-being depends largely on many factors among which demography plays a prominent role. Demographic factors are socio-economic characteristics of a population expressed statistically as age, gender, educational qualification, income level, marital status, occupation, religion, birth rate, death rate and size of the family[34]. The identified demographic factors have positive and negative effects on man's state of health, but the improvement, corrections and preventive measures are acquired through man's health-seeking behaviour.

For Olenja[35] Health seeking behaviour (HSB) is defined as, "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill to find an appropriate remedy". It can also be referred to as illness behaviour or sick-term behaviour. Health-seeking behaviour is situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing

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[34] Ibid. Shehu
[35] Olenja, J.. Health seeking behaviour in context. *East African Medical Journal*; 2003

with any departure from a good state of health[36]. In the context of this paper health-seeking behaviour (HSB) is any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill to find an appropriate remedy. It can also be referred to as illness behaviour or sick-term behaviour.

Theoretical Framework

This paper utilizes the Health belief model to explain the Health care-seeking behaviour among the elderly in Kokona Local Government Area of Nasarawa State. The Health Belief Model (HBM) is a Psychological Model that attempts to explain and predict health behaviours. This is done by focusing on the attitude and beliefs of individuals. The Health Belief Model was developed in the 1950s by Social Psychologists Hochbaum, Rosenstock and Kegels working in the USA public Health Services. This theory explains psychological health behaviour change, the model is developed to explain and predict health-related behaviours, particularly concerning the uptake of health services[37]. It remains one of the best-known and most widely used theories in health behaviour research. The Health Belief Model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action, and self-efficacy explain engagement (or lack of engagement) in health-promoting behaviour. [38]A stimulus, or cue to action, must also be presented to trigger the health-promoting behaviour.

The Health Belief Model attempts to predict health behaviour through a variety of means, health is influenced by behaviour and behaviour is modifiable[39]. According to MacKian[40], the process of health care seeking involves the identification of pathways to the formal health care system, often commencing with home care and traditional healers and extending to the formal system, pathways differing according to the present condition.

In a review of the Health Belief Model or theory, Chen[41] demonstrated that the decision to engage with a particular medical channel is influenced by a variety of variables, including sex, age, the social status of the aged, the type of illness, access to services and perceived quality of the service. Health-seeking behaviour looks at illness behaviour more generally and focuses in particular on motivating factors of illness perception and health belief. Health care-seeking behaviour studies look beyond the individual for social patterns or determinants of decision making. Health-seeking behaviour varies for the same

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individuals or communities when faced with different illnesses. For example, Barret[42] highlights contrasting pathways to care for aged women when faced with abnormal vaginal discharge, as opposed to malaria. For the former, the woman is bound far more by rituals and obligations, such as shaving beforethe examination and being accompanied to a medical consultation by her husband. The Health Belief Model is used to develop effective interventions to change aged health-related behaviours by targeting various aspects of the model's key constructs (susceptibility, severity, benefits, cue to action). Interventions based on the Health Belief Model may aim to increase perceived susceptibility and perceived seriousness of a health condition by providing education about prevalence and incidence of disease of the aged, individualized estimates of risks, and information about the consequences of aged related disease or illnesses (e.g., medical, financial, and social consequences). Interventions may also aim to alter the cost-benefit analysis of engaging in a health-promoting behaviour when seeking health care by the aged (i.e., increasing perceived benefits and decreasing perceived barriers) by providing information about the efficacy of various behaviours to reduce the risk of disease, identifying commonly perceived barriers towards health care, providing incentives to engage in health-promoting behaviours, and engaging social support or other resources to encourage health-promoting behaviours among the aged persons.

Furthermore, interventions based on the Health Belief Model may provide clues to action to remind and encourage aged persons to engage in health-promoting behaviours such as practicing healthy aging. Interventions may also aim to boost self-efficacy by providing training in specific health-promoting behaviours, particularly for complex lifestyle changes in aged persons (e.g., changing diet or physical activity, adhering to a complicated medication regimen). Interventions can be aimed at the individual level (i.e., working one-on-one with aged individuals to increase engagement in health-related behaviours) or the societal level (e.g., through legislation, changes to the physical environment.

Methodology

Kokona Local Government Area is one of the thirteen Local Government Areas in Nasarawa State. This paper adopts the social survey research design. The social survey entails a research design that allows the collection of data from a fraction of a study population, which can be seen as truly representing the larger population using the questionnaire. Kokona Local Government Area has a projected population of 146,500 populations as of 2018[43] (National Population Commission, 2020). However, the target population for this study is not the entire population of Kokona Local Government Area but the elderly persons, both male and female, who are 60 years and above in some selected electoral wards which include Agwada, Amba, Dari, Garaku, Kofar Gwari, and Kokona. The population of this category of people from the selected electoral wards is 32,325 (Kokona Local Government Primary Health Care Department, 2020). The sample size was determined using Yamane (1967) statistic, where n=

[42] Barrett L..*Healthy at Home.* Washington, DC: AARP Foundation; 2008
[43] National Population Commission..*Projected Population of Kokona Local Government Area of Nasarawa State, Nigeria* 2017

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required sample size, N=population size (the universe) e=sample error (usually 10,05 and 01 acceptable error) and n=raised to the power of 2

According to Yamane, (1967):

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

Where:
N = Total population,
n = required sample size
e = margin of error allowed (5%)

Hence
$e = (0.05)^2$,
n = 32, 325

$$n = \frac{32,325}{1+ 32,325\ (0.05)^2} = \frac{32,325}{32,326\ (0.0025)} = \frac{32,325}{80.813}$$

n = 399.9
n = 400 app.

Multistage sampling technique was employed in the selection of electoral wards; streets; houses/compounds, household and respondent/individual. The reliability and validity of information for the study demand both Primary and Secondary sources of data collection. For the primary data, the study relied on a Questionnaire. This paper elicits data from the quantitative method. Quantitative data were analyzed using bivariate analysis involving the use of cross tabulation of key variables and chi-square tests to show the relationship among the variables

Test of Hypothesis

The tables below are presented concerning the hypothesis formulated in this paper. To ensure this is achieved, cross tabulation and chi-square tests are used to indicate whether there is a relationship or not between socio-demographic characteristics of the elderly and their health-seeking behavior

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Table 1: The Relationship between the level of educational attainment and how often respondents visit/consult traditional health care services

How often do respondents visit/consult traditional health care services	**Level of Educational attainment of Respondents**				**Total**
	No formal education	**Primary**	**Secondary**	**Tertiary**	
Most often	93(44.7%)	4 (15.4%)	20(26.6%)	26(35.1%)	115(30.0%)
Often	42(20.2%)	8 (30.7%)	15(20.0%)	12(16.3%)	77(20.1%)
Not often	39(18.8%)	4(15.4 %)	18(24.0%)	16(21.6%)	74(19.3%)
Not at all	34(16.3%)	10(38.5%)	22(29.3%)	20(27.0%)	117(30.5%)
Total	**208 (100)**	**26 (100)**	**75 (100)**	**74 (100)**	**383(100)**

Pearson Chi-Square value= 7.514[a]; df =9, Asymp. Sig. (2-sided) = .584 and Critical value =16.919

Table 1 shows the cross tabulation result of the level of educational attainment and how often the respondents visit/consult traditional health care services. The findings revealed that the level of educational attainment affects the utilization of traditional health care services with a large proportion of the total respondents at 44.7 percent who have no formal education visit/consult traditional health care services more often. This is because uneducated elderly persons utilize traditional health care services more as compared to their educated counterparts.

The chi square test indicates the calculated value of 7.514 with the degree of freedom df. 9 and at .05 level of confidence while the critical or table value is 16.919 at a degree of freedom of 9 and at .05 level of confidence. Given that the calculated chi square value is less than the critical value, it is therefore concluded that there is no significant relationship between the level of educational attainment and how often respondents visit/consult traditional health care services

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Table 2: The relationship between the level of educational attainment and how often respondents visit/consult orthodox health care services.

How often do respondents visit/consult traditional health care services	**Level of Educational attainment of Respondents**				**Total**
	No formal education	**Primary**	**Secondary**	**Tertiary**	
Most often	24(11.5%)	7(26.9%)	9(12.0%)	35(47.3%)	56(14.4%)
Often	35(16.8%)	1(3.8%)	9(12.0%)	16(21.6%)	58(15.1%)
Not often	49(23.5%)	6(23.1%)	18(24.0%)	13(17.6%)	83(21.7%)
Not at all	100(48.%)	12(46.1%)	39(52.0%)	10(13.5%)	186(48.5%)
Total	**208(100)**	**26(100)**	**75 (100)**	**74 (100)**	**383(100)**

Pearson chi-square value=13.306[a]; df=9, Asymp. Sig (2-sided) =.149 and Critical value=16.919

Table 2 demonstrates the cross tabulation result of the level of educational attainment and how often the respondents visit/consult orthodox health care services. The findings showed that the level of educational attainment affects the utilization of orthodox health care services with an overwhelming proportion of the respondents who are educated utilizing the orthodox health care services. Educated elderly persons utilize orthodox health care services more as compared to their uneducated equals. This is because most of the educated respondents prefer orthodox or modern health care services to traditional health care services which for them is safer and has the correct dosage. The calculated chi square value of 13.306 with a degree of freedom df. 9 and at .05 level of confidence while the critical or table value is 16.919 at the degree of freedom of 9 and at .05 level of confidence. Given that the calculated chi square value is less than the critical value, it is therefore concluded that there is no significant relationship between the level of educational attainment and how often respondents visit/consult orthodox health care services.

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Table 3: The relationship between the level of Educational attainment of Respondents and whether respondents had medication without a doctor's prescription

Whether respondents had medication without a doctor's prescription	Level of Educational attainment of Respondents				Total
	No formal education	Primary	Secondary	Tertiary	
Yes	128(61.5%)	12(46.2%)	54(72.0%)	52(70.3%)	246(64.2%)
No	80(38.5)	14(53.8%)	21(28.0%)	22(29.7%)	137(35.8%)
Total	**208 (100)**	**26 (100)**	**75 (100)**	**74 (100)**	**383 (100)**

Pearson chi-square value=7.991[a]; df=3, Asymp. Sig (2-sided) =.058 and Critical value=7.81

Table 3 indicates the relationship between the level of educational attainment of respondents and whether respondents had medication without a doctor's prescription. Data in the table shows that an overwhelming proportion of the total respondent who had no formal education (61.5 percent) had medication without a doctor's prescription. This affirmed that educational attainment influenced medication without a doctor's prescription.

The chi square test shows that the calculated value is 7.991 with a degree of freedom df. 3 and at .05 level of confidence and the critical or table value is 7.815 at a degree of freedom of 3 and at .05 level of confidence. Given that the calculated chi square value is greater than the critical value, it is therefore concluded that there is a significant relationship between the educational attainment of respondents and medication without a doctor's prescription

Table 4: The relationship between the Sex of Respondents and medication without doctor's prescription

Whether respondents had medication without a doctor's prescription	Sex of Respondents		Total
	Male	Female	
	141(67.1%)	105(60.7%)	246(64.2%)
No	69(32.8%)	68(39.3%)	137 (35.8%)
Total	**210(100)**	**173(100)**	**383(100)**

Pearson Chi-Square value= 1.717[a]; df =1, Asymp. Sig. (2-sided) = .190 and Critical value=3.841

Table 4 indicates the cross tabulation on the relationship between the sex of respondents and medication without a doctor's prescription. The findings

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revealed that males with 67.1 percent of the total respondents prefer medication without a doctor's prescription. This implies that sex weights medication without a doctor's prescription.

From table 4.33, the calculated chi square value of 1.717 with a degree of freedom df. 1 and at .05 level of confidence while the critical or table value is 3.841 at the degree of freedom of 1 and at .05 level of confidence. Given that the calculated chi square value is less than the critical value, it is therefore concluded that there is no significant relationship between thesex of respondents and medication without a doctor's prescription

Table 5:The Relationship between the Occupation of Respondents and medication without doctor's prescription

Whether respondents had medication without a doctor's prescription	**Occupation of Respondents**					**Total**
	Civil/Public servant	**Farmer**	**Business/Petty trader**	**Artisan**	**Others**	
YES	63 (67.7%)	84 (71.8%)	28 (59.5%)	53 (64.6%)	18 (40.9%)	246 (64.2%)
NO	30 (32.3%)	33 (28.2%)	19 (40.4%)	29 (35.4%)	26 (59.1%)	137 (35.7%)
Total	**93(100)**	**117(100)**	**47(100)**	**82(100)**	**44(100)**	**383(100)**

Pearson Chi-Square value=14.278[a]; df =4, Asymp. Sig. (2-sided) = .006 and Critical value= 9.488

Table 5 shows the cross tabulation on the relationship between theoccupation of respondents and medication without a doctor's prescription. The data revealed that respondent's occupation influenced his/her involvement in medication without doctor's prescription with a larger percentage of respondents who are farmers at 71.8 percent of the total respondents engaged in medication without doctor's prescription. This is with the aim for a reduction in the time and cost of clinical consultation.

In decision making, the chi square test indicates the calculated value of 14.278 with a degree of freedom df. 4 and at .05 level of confidence while the critical or table value is 9.488 at the degree of freedom of 4 and at .05 level of confidence. Given that the calculated chi square value is greater than the critical value, it is therefore concluded that there is a significant relationship between the occupation of respondents and medication without a doctor's prescription.

Discussion of Findings

The paper findings revealed that socio-demographic characteristics of the elderly such as level of educational attainment, sex of the elderly and occupation of the elderly have a significant impact on the health care-seeking behaviour of the elderly in Kokona Local Government Area of Nasarawa State,

Nigeria. This was supported by Shehu[44] that socio-demographic characteristics like age, sex, educational qualification, income level, marital status, occupation, religion, birth rate, death rate and size of the family have positive effects on the elderly state of health, but the improvement, corrections and preventive measures are acquired through elderly health-seeking behaviour.

Findings also revealed that most of the elderly visit both orthodox and non-orthodox health care facilities. This is because those health care facilities are available in the study area. But the most utilized of these facilities are the hospitals. This is because they are readily available as most communities in the local government have primary health care centres. This corroborates with the findings of Agbogidi and Azodo[45] that about 40.56% of the elderly patronized chemists and pharmacist's shop, 19.44% patronized traditional healers/herbalists, 16.67% and 15.55% of the respondents got their medical needs from medical hawkers and self-medication and only 17.18% sought treatment from regular hospitals and clinics[46]. Also, Abdulraheem[47] that 73.7% of the elderly patronized the hospital/health centre whenever they fell sick. Also, findings show that some of the elderly engage in self-prescription as buying drugs from patent stores is cheaper and they don't have money to pay hospital bills. More elderly males than their female counterparts were found to have patronized traditional healers, resorted to self-medication using local herbs, or visited chemist shops whenever they were sick.

Conclusion and Recommendations

Aged people constitute a major category of the population that demands attention. When people begin to age, their physical body and the immune system begin to fail them. Thus most of them become vulnerable to different diseases such as high blood pressure, heart or cardiac problems, diabetes, joint pains, kidney infections, cancer and tuberculosis that take a longer time to heal. To improve their health status, most of the elderly utilize both orthodox and traditional medicine. While others visit hospitals and adhere to medical prescriptions, some of them prefer self-medication. This health-seeking behaviour is largely determined by the affordability of health providers, type and severity of the ailments/diseases, education background, age, gender, most importantly the availability of healthcare services. Based on the findings of the study, the following recommendations were made;

i. There is a need for Government, Non-governmental organizations, religious organizations, mass media, and community/traditional leaders to create awareness programmes on the positive impact of improving healthcare-seeking behaviour among the aged. These

[44] Shehu, R. A.. Relationship between demographic factors and lifestyle of the people of Kaduna State, Nigeria.
[45] Agbogidi J and Azodo C.. Experiences of the elderly utilizing healthcare services in Edo State.
[46] Agbogidi J and Azodo C.. Experiences of the elderly utilizing healthcare services in Edo State.
[47] Abdulraheem I.S.. Health needs assessment and determinants of health seeking behaviour among elderly Nigerians

programmes would educate the elderly on the importance of healthcare-seeking.

ii. There should be increased availability of key services by health administrators for the aged population which is a crucial approach to improve healthcare-seeking behaviouramong the old. Periodic orientation should be conducted by health administration for health care personnel on rudimentary principles of human relations to make better friendly services for the elderly who need special services.

iii. There is a need for Government, Non-governmental organizations, religious organizations and community/traditional leaders to create awareness on the negative/harmful effect of self-medication among elderly persons. Self-medication is the most common form of self-care which is becoming increasingly significant in many countries. The perception of elderly persons about self-medication indicates the need for more accurate information about the behaviours expressed by the elderly. This can be achieved not only through actual interaction but also through educating elderly persons at all levels on safe and appropriate/proper medication. Health care provision and advice should include education to increase awareness on good nutrition for the elderly, food supplements and adherence to a good dietary regime.

iv. Affordability of care providers, types and severity of ailments/diseases, availability and affordability of appropriate health facility and proximity were considered the most important factors affecting health care-seeking behaviour among elderly persons in Kokona Local Government Area of Nasarawa State. Thus, policy formulation and implementation by the government should be directed towards improving access to healthcare services. This can be done by increasing the number of health facilities in under-served areas, improved the quality of services in the existing ones, supportive supervision and other measures could be embarked upon to improve quality and accessibility to health care services.

v. The establishment of public health centers in the core rural areas by the government, Non-governmental organizations, religious organizations, communities, and spirited individuals would increase the proximity and accessibility of rural aged persons to health facilities.

vi. Health services can be addressed by up-scaling the coverage of the National Health Insurance Scheme, the country's flagship insurance scheme. This would provide financial protection for elderly persons with lower socioeconomic status to encourage the use of appropriate healthcare sources.

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