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Household Health Seeking Behavior and Predicators of Health Care of Vulnerable Groups of Rural Dwellers in North Central Nigeria: A Mixed Method Study

Fabong Jemchang Yildam (PhD)
Director-General, Plateau State Contributory Healthcare Management Agency (Plaschema)

Benjamin Azi Madaki (PhD)

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ABSTRACT: *Despite all the numerous advances in medical knowledge, commentators agree that the greatest gains in health can only come through behavioral change. For a country like Nigeria, attaining behavioral change in its populace will impact greatly on aspects of her health development especially because majority of her populace dwell in the rural areas. Through a narrative review, this study examines household health seeking behavior and predicators of health care of Vulnerable Groups of Rural Dwellers (VGRD) in North Central Nigeria. The research survey adopted a mixed method design to collect both quantitative and qualitative data based on an existing report. Additionally, reviews of relevant literatures were also consulted. A total of 3981 household heads were interviewed and 119 key informant interviews were conducted. Findings showed that the most predominant reasons for unwillingness to participate was lack of funds (financial hardship). The level of educational literacy was also seen to be directly related to knowledge of health seeking behaviour. Findings also showed that though most of the communities have an existing healthcare facilities, majority of them do not have the requisite manpower to provide essential health care services to the populace. Respondents highlighted malaria, typhoid, and high blood pressure combined with financial hardship as the common health and socioeconomic problems in all the communities. Most people in the rural settlements have little or no background in western education leading to low income and productivity. Major challenges associated with access to healthcare are the high cost of services/fees, attitude of health workers, and lack of drugs among other things. The paper recommended the need to develop mechanisms for robust identification of vulnerable group in the society, designing effective stakeholders' engagement mechanisms, rigorous monitoring and evaluation as well as transparency.*

KEYWORDS: health care, health seeking behaviour, rural dwellers, vulnerable groups.

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INTRODUCTION

A healthy populace is most important in the attainment of developmental goals of any nation. Good health is not only primary to human welfare but also fundamental to social and economic development objectives. The World Health Organization (WHO) constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that to be healthy means more than not having disease or infirmity, but to be in harmony with oneself in all spheres. Therefore, Health is a central aspect of the overall functions in any integrated development of any functional society in all aspects. It is a major life event which may cause people to question their existence since health conditions may disrupts basic activities which are essential to a healthy living. As a result, people seek help on health issues based on several reasons and the factors which influence the choice of treatment sources when symptoms occur include socio-cultural factors, social networks, gender and economic status (Afolabi, Daropale, Irinoye and Adegoke, 2013). Health care seeking behaviour is not just complex but also involves a sequence of dynamic and multidimensional process that are influenced by an interwoven interaction between the individual, household and an entire community with the sole purpose of addressing perceived ill health. In seeking help on health issues, the behavior of individuals are influenced by belief systems, household decision-making to seek care, social network, and economic status (Adam and Aigbokhaode, 2018). Individuals differ in their choice of treatment sources depending on the type and perceived intensity of sickness; accessibility to the healthcare facilities and demographic characteristics in terms of cost of treatment and healthcare provider attitude. These factors are primary determinants of health seeking behavior because they play an integral part in what people do when they have symptoms of illness.

In Africa, Nigeria is one of the worst states concerning healthcare; Health indicators in Nigeria are some of the worst in Africa (USAID, n.d). Currently, there is a very high risk of infectious and parasitic diseases, including bacterial diarrhea, typhoid fever, hepatitis A, yellow fever, malaria, and meningitis in Nigeria. Malaria in rural Nigeria has a particular distribution and is found everywhere; she has the highest burden of malaria globally which remains the top cause of child illness and death. (WHO, 2015 and USAID, n.d). Over 60% of its population lives in the rural areas. These areas are most neglected and deprived of modern health-care infrastructures and services that are essential for the promotion and maintenance of good health (Omotosho, 2010). According to Kakwagh (2018), common health problems among rural dwellers in Nigeria are identified as yellow/malaria fever, typhoid, waist/back/joint pains, headache, and cough/catarrh. The practice of home treatment with drugs which could be herbal or, and orthodox medicines bought without prescription from drug stores appear to be a significant health seeking behaviour in rural areas, as observed in a Nigerian study, were most of the mothers within the first 24 hours of the child's illness gave them drugs at home (Tinuade, Iyabo, & Durotoye, 2010) . In most cases, there is a reasonably accepted spread of traditional providers. As a result, the use of complementary and alternative medicines is accepted within the vulnerable groups and rural

dwellers. This complicates attempts to understand factors driving the health seeking behavior of these rural dwellers. Health seeking behavior has to do with the intentional willingness of an individual to seek help when ill. Among other indices, it also extends to where an ill person seeks medical care and preferable treatment. Oberoi, Chaudhary, Patnaik and Singh (2016) defined Health care seeking behavior as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. Ihaji, Gerald and Ogwuche (2014) added that Health seeking behavior is preceded by a decision-making process that is further governed by individuals and/or household behavior, community norms, and expectations as well as provider-related characteristics and behavior. Some of the factors reported by several studies that significantly affect the health seeking behavior of vulnerable groups of rural dwellers include the availability of specialists, lack of resources and out-of-pocket financing of health-care services, socio-cultural influences and prevalence of traditional healthcare in the environment, distance, place and cost of treatment, poor access to good health-care facilities and services, and also the prevalence of traditional healthcare in the environment; educational attainment, family size, and perception of severity of illness (Afolabi, Daropale, Irinoye and Adegoke, 2013). In North Central states of Nigeria, 65% of the population live and work in rural areas where diseases and health-related conditions cause high morbidity and mortality. In addition, there is a wide gap between the desired and actual health-care services that the people get due to poor maintenance of civil infrastructures, lack of basic hospital equipment, lack of supportive services, poor quality of services, and poor facility utilization (Adam and Aigbokhaode, 2018). In spite of the fact that, there is widespread popularity of modern health care services especially the private health services which includes both formal and informal drug stores; the traditional and religious health services are still commonly used and according to World Health Organization, at least 80% of people in Africa have used traditional health service at one point or the other in their everyday lives (WHO, 2002).

Vulnerability

Vulnerability as a concept entails diverse understandings and interpretations depending on the disciplines and/or the perspectives of the organizations. Generally, vulnerability links the exposition of people, individuals or population groups, to threats, their capacity of reaction, and the consequences in terms of a decline in well-being (Lazarte, 2017). Thus, understanding the concept of vulnerability requires making a distinction between External and Internal factors. The external elements are those beyond the control of people while internal elements mainly refer to the people's resilience. The level of vulnerability depends in great part on the people's capacities to cope with external and internal situations like difficult times, and also cope with the social, economic, political and environmental systems in which they live in. Taking these factors into account is of utmost importance. For the purpose of this paper, the research focused on certain groups of vulnerable groups in the rural population such as women (especially the pregnant ones), Children under 5 years, the elderly ones, physical disability and mental disability:

Women

There is evidence that, on a global scale, women benefit less from rural employment, whether self- or wage employment than men do, and are more vulnerable to decent work deficits (Lazarte, 2017). This is linked to several factors like unequal power relations, discrimination, gender-based violence, inequitable laws and customary practices. Thus, women's representation and voice in rural areas in many aspects in their different endeavours are low, thus they have very limited bargaining power because it's more like the system is rigged against them. This further exacerbates women's vulnerability.

Children

Child labour remains a main issue in rural areas, with nearly 70% of working children (from 5 to 14 years old) in the agricultural sector. Poverty, limited access to education and the absence or lack of labour laws enforcement are among the drivers (Termine, 2011). Once parents do not have decent income/wages or insurance to sufficiently cater for the family, child labour is imminent. Thereby results to vulnerability because every hand in the family is useful. In African ruralities, families see this attitude as a way of transferring knowledge and skills in order to perpetuate the household traditional activity. Usually these children do not have any say in the way their parents or guardians decide the trajectory of their lives.

People with Physical and Mental disabilities

A huge majority of persons with disabilities worldwide are living in rural areas, thus the challenges to fulfill their right to decent work is further hindered (Lazarte, 2017). Most of these people live in developing countries where the informal economy employs a substantial proportion of the labour force. Due to stigma, inaccessible environments and other societal barriers, people with disabilities labour force participation rates are much lower than those of persons without disabilities. In most cases the rural people with disabilities face exclusion and marginalization in many ways. Added to the high level stigma and prejudice they face, they also have limited access to public infrastructures built to aid their unique situations like schooling, public buildings like hospitals, transportation, roads, etc.

Elderly people

World most developed countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person, but like many western concepts, this does not adapt well to the situation in Africa (Lazarte, 2017). Elderly people in many developing countries like Nigeria are one of the poorest population groups, especially because there are no systemic effective schemes in place to take care of them. In rural areas where the informal sector is predominant, the elderly poor ones usually have no choice than to still work. Especially on irregular activity like farming, which is mostly seasonal and other low-paid jobs that is often strenuous. Thus, they are vulnerable due to high unemployment and under-employment rates, age and gender discrimination. In addition, they also have limited or no access to social protection and lack income for proper security, legal protection for their rights as workers, and formal support mechanism or networks. In most cases

too, they are often disadvantaged through low education and literacy levels, poor health and malnutrition.

An in-depth analysis on these aspects highlighted above would go beyond the scope of this document if it lingers. However, these are some of the factors identified that classified these groups as vulnerable among the rural dwellers: visible poverty with its extreme manifestations, limited access to resources, excluded in the order of this based on geographic, political, social, gender and/or age marginalization, poor socio-economic empowerment of disadvantaged populations and those with a "limited voice", as a consequence of a weak social fabric. The above mentioned became particularly relevant in identifying the vulnerable groups among the rural dwellers in the cause of the research. This study therefore investigates Household Health Seeking Behavior and Predicators of Health Care of Vulnerable Groups of Rural Dwellers in North Central Nigeria.

Statement of the Problem

Health is an integral core in life. It is desired by everyone, but in reality, everyone is not healthy. An important aspect of ensuring a good health is to guide and guard the behaviors that enable one make health related decisions when ill. This will greatly reflect on the kind of lifestyle, medical care and treatment an individual will get. While it is ascertained that the decisions of people to behave a certain way when it comes to their health is influenced by a variety of factors such as educational, geographical, social, economic, cultural, and organizational factors which all varies from individual to individual, limited experience have been gathered on the vulnerable rural dwellers from the consulted literatures, especially in the aspects of the predators of their healthcare and health seeking-behavior. Vulnerable people face significant challenges in achieving equitable health care access and delivery. They are usually categorized as part of the general rural dwellers, but in reality, they are the vulnerable groups who are enmeshed in the entirety of rural placement. As a result, not much is covered on their unique struggles with the realities that determine their health seeking-behaviour.

Ideally, appropriate health seeking behavioural practices include healthy eating and standard of nutrition, adequate rest and sleep, regular exercise, regular medical check-ups, limiting or avoidance of alcoholic beverages, health education, genetic screening, vaccination or immunization as at when due, personal hygiene, environmental hygiene etc. Instead, inappropriate health seeking behaviours such as drug abuse, careless patronage to traditional medical practitioners, lack of proper medical diagnosis, replacing scientifically proven medical conditions with sheared myths and beliefs, exposure to harsh medical experiences in the hospitals among others have been observed among rural dwellers in North Central Nigeria (Jimoh & Oliver, 2019). All these result to worse health outcomes. This report and underlying observation led the researchers to begin to question the household health seeking behavior and predicators of health care of vulnerable groups of rural dwellers in North Central Nigeria.

Objectives of the Study

The general aim of this study is to examine household health seeking behavior and predicators of health care of vulnerable groups of rural dwellers in North Central Nigeria. The specific objectives include, to:

i. Identify the common ailments suffered by vulnerable groups of rural dwellers in North Central Nigeria.
ii. Ascertain the factors determining the health seeking behaviour vulnerable groups of rural dwellers in North Central Nigeria.
iii. Examine the challenges that healthcare seekers face in North Central Nigeria.
iv. Develop policies/intervention strategies for improving healthcare outcomes in rural areas in North Central Nigeria.

MATERIALS AND METHODOLOGY

Narrative Review

To attain the needed understanding of the health-seeking behavior of Vulnerable Groups (VGs) of Rural Dwellers in North Central Nigeria, the research deployed a narrative review approach. This agrees with Greenhalgh, Thorne & Malterud (2018) who recommended conducting a narrative review as opposed to a systematic review approach where the purpose of the review is to get a deeper understanding on a problem. Haven established that Health-seeking behavior is a broad topic that covers a wide range of health issues, with the use narrative review approach, the researchers were able to interpret the patterns of health-seeking behavior in various aspects with a wide range of literature available, including literatures that may have been excluded with a systematic search approach especially because it is targeted at the vulnerable groups among the rural dwellers in North-Central Nigeria. Therefore, a narrative review was carried out on data already generated.

Study Area and Population

Plateau State was created on 3rd February, 1976. It is the 12th largest state in Nigeria. It derives its name from the Jos Plateau. It is located in the North Central region of Nigeria, covering a land area of approximately 26, 899 sq. Kilometers with an estimated population of about 3.5 million people. The study population comprised male and female adults within households in communities in Plateau State, North Central Nigeria. Any individual above 18 years old who had lived in the study area for at least one year was selected and interviewed.

Data Sources

Data sources was mainly secondary sources form the Baseline survey (BS) on the disease burden, universal health coverage, health-seeking behavior, knowledge attitude and perception of Plateau Residents on Social Health Insurance Submitted to Plateau State Contributory Healthcare Management Agency PLASCHEMA, November 2021. This enabled us to isolate and develop deeper understanding on the health-seeking behavior of the vulnerable group of rural dwellers in North central Nigeria. The baseline survey utilized a mixed method design, comprising:

Desk review
A desk review of existing literature on health, health seeking-behaviour and healthcare facilities in North-Central Nigeria with emphasis in Plateau State. This included a review of relevant project documents, diverse literature or articles that are centered on North-Central Nigeria to develop data collection

Household Survey
Structured questionnaires were used to interview eligible household heads on Knowledge, attitude and perception on health seeking behaviour as well as healthcare demand.

Focused Group Discussion (FGD)
FGDs comprising of groups of 8 to 10 persons were conducted in 6 LGAs across the 3 senatorial zones (2 in each of the zones). These community members who participated in the FGD were selected through consultation with Key opinion leaders in the communities. Those interviewed were Women groups, men groups, youth groups and elder's forum.

Key Informant Interview (KII)
KII interview were also conducted for 7 key persons within the sample wards and the LGA. The Key informants comprised the Director PHC in each LGA, A member of the WDC and health facility managers in the sample wards, a client accessing care in a facility within the sample ward.

Health Facility Assessment
Primary healthcare centers across the state were assessed to determine their readiness to deliver basic healthcare services. Key areas assessed include the state of facility infrastructure; Types of services available at the healthcare facility; availability of commodities for health service provision; availability of state/ LGA/ community governance structures; facility governance; staff strength and availability; cost of accessing healthcare services; ease of accessing care.
A total of 3981 household heads interview, 6 FGD, and 119 KII were conducted and 325 health facilities were assessed.

Sample Technique
The respondents were selected purposively using knowledge of the community and health characteristics as pre requisite criteria. A multi-stage approach to sampling was employed. In the First stage, 2 communities were selected from a list of political wards in each of the 17 LGA s. This was done to bring to context the possibility of the existence of any rural-urban disparity in the assessment. In the second stage, household numbering and listing was done in the selected communities. Thereafter, 10% of the total households were selected using computer generated table of random numbers, household heads then sampled for interview.

Research Data Collection and Analysis
Quantitative data collection was carried out by experienced and trained data collectors selected across the 17 LGAs of Plateau State using structured electronic questionnaires. The questionnaire

was formulated in English; however, it was mainly administered in English and Hausa. Quantitative data analysis was conducted using a combination of MS Excel and SPSS applications. Qualitative data was analyzed using thematic frameworks based on NVIVO and later own transcribed to Excel. Data was collected, analyzed and interpreted.

RESULTS AND DISCUSSION FROM THE BASELINE SURVEY REPORT (BSR)

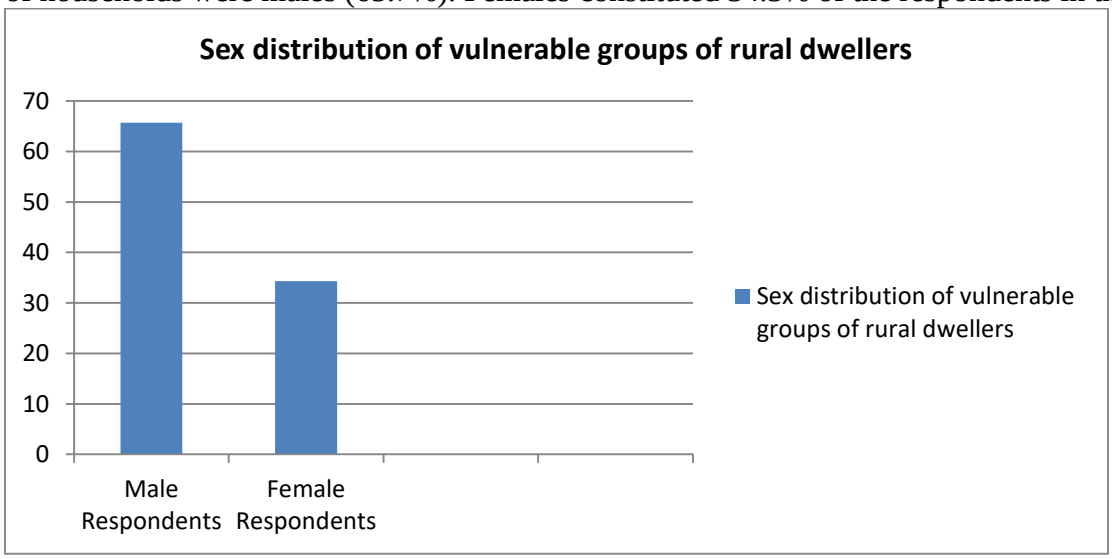
The predictor variables were grouped in four areas: Socio-demographic, socio-economic, health-related and health behaviour variables. Variables under Socio- demographic are gender, marital status, age, religion. The socio-economic and health related variables are dichotomous; such that they covered a different aspect like their Level of Education employment status as this determined their level of decision making and income to a great extent. The health behaviour variables are direct reactions from the above placements.

Socio-Demographic Characteristics of Respondents/Households

A total of 3981 household heads were interviewed during the household survey and most of household in the survey had a total number of members ranging between 16 and 20 people. Most of the household heads were young with their ages ranging between 26 – 30 years. About 25% of the respondents were influencers in the communities comprising of leaders of women, youth and elders' forums as well as traditional rulers.

Gender

The figure below shows the sex distribution of the respondents. Most of the respondents i.e., heads of households were males (65.7%). Females constituted 34.3% of the respondents in the survey.



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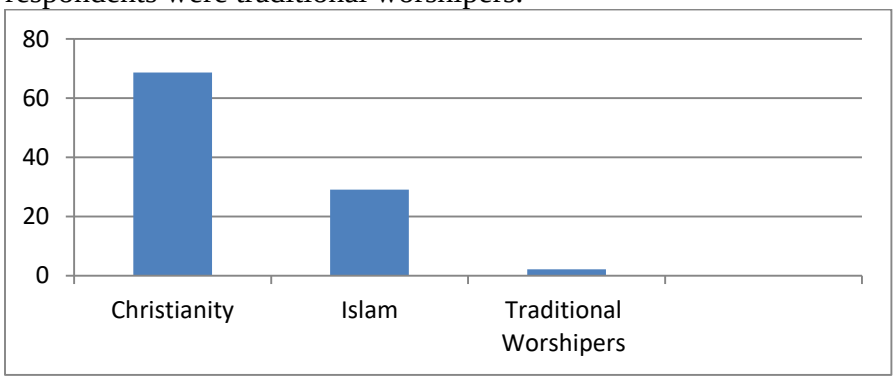
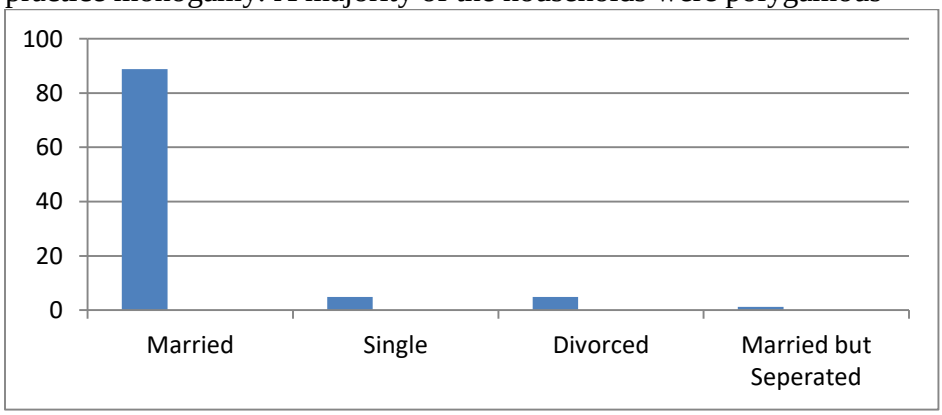
Religion

The figure below shows the religion of respondents. Most of the respondents practice Christianity (68.7%). A considerable percentage (29.1%) of the respondents practice Islam. Only 2.2% of the respondents were traditional worshipers.



Marital Status

The figures Below show the marital status of the respondents. Most of the respondents were married (88.8%) while 4.9% were single. A few of the respondents were either married but separated (1.2%), divorced (0.4%) or widowed (4.8%). Among the married respondents 46.7% practice monogamy. A majority of the households were polygamous



Level of Education

The BSR revealed that most of the respondents in the survey had completed secondary school. A considerable proportion of the participants had completed tertiary level of education. However, up to 17.5% of the respondents had no formal education.

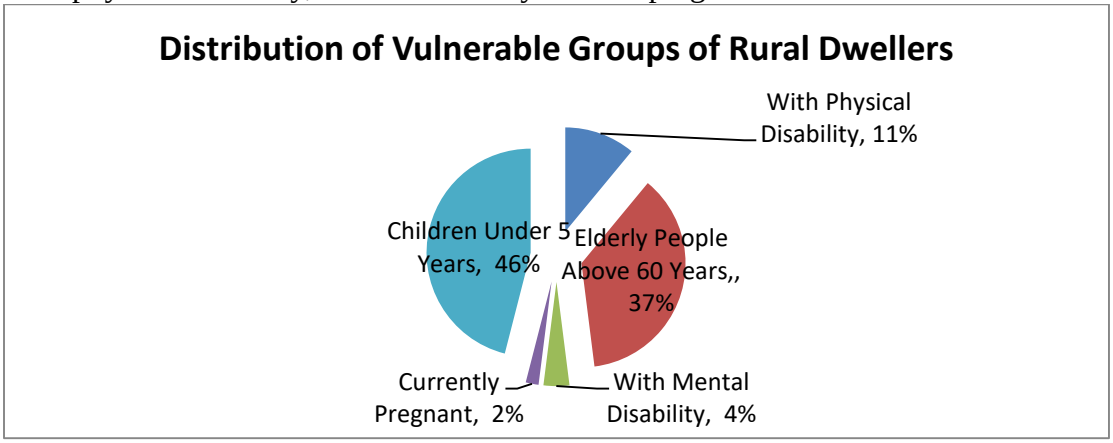
Employment Status

The report indicates that most of the residents were mostly self-employed; a majority of them are farmers and traders/ business people. A significant number of respondents are civil/public servants, only a few of them were retirees. Other notable occupations among respondents were clergy,

transportation, builders (Masons and carpenters), housewives, medical practitioners, volunteers, hunters, cattle raring and construction workers.

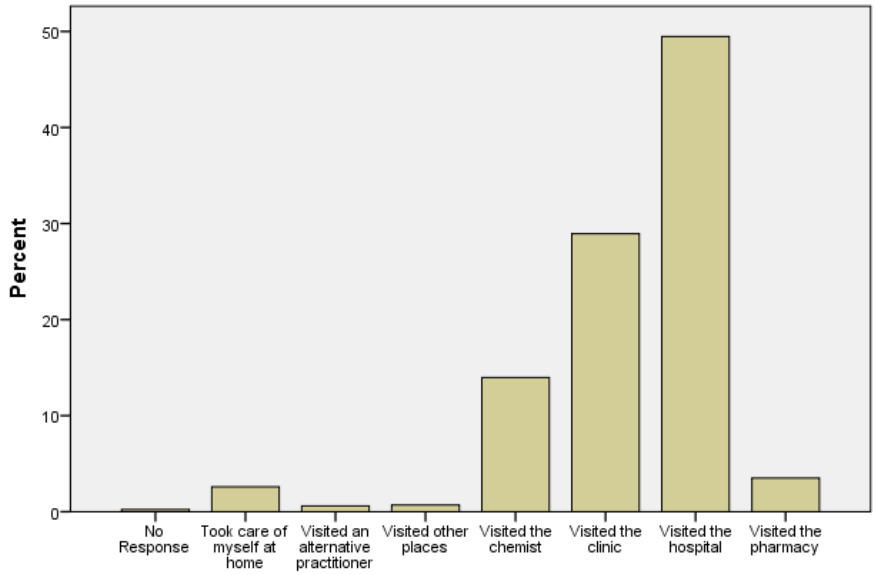
DISTRIBUTION OF VULNERABLE GROUPS OF RURAL DWELLERS IN PLATEAU STATE, NORTH-CENTRAL NIGERIA.

The chart below summarizes the distribution of vulnerable groups of rural dwellers in the Baseline Survey Report (BSR). Elderly persons form the bulk of vulnerable people, followed by children under the age of 5 years. Relatively significant proportions of a portion of the vulnerable groups have physical disability, mental disability or were pregnant.



Health seeking behavior of Vulnerable Groups of Rural Dwellers (VGRD) in Plateau State, North-Central Nigeria

Based on the BSR, the figure below reveals VGRD whose members fell ill in the last 3 years. A majority of the VGRD had a member who was ill within the last 3 years and most of them comfirmed they visited a hospital or clinic for care. A signifiacant proportion of them visited a chemist; patent medicine vendors (PMVs) or pharmacy. Only a very few of the respondents managed their ailments at home (refused to seek care), or visited an alternative medicine practitioner or herbalist.

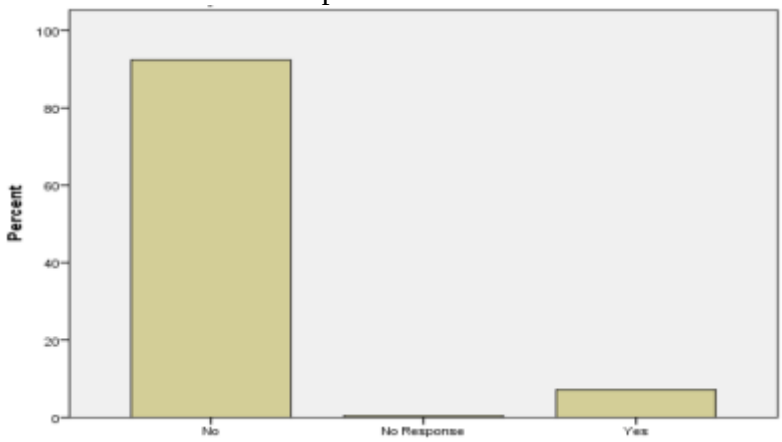


Qualitative Analysis of the BSR on Vulnerable Groups of Rural Dwellers (VGRD)

Heath Behaviour Variables:

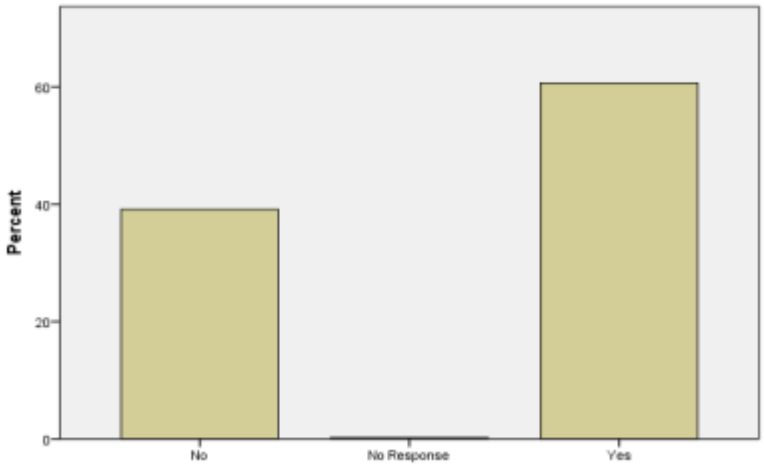
Health and Socio-economic challenges

The respondents 'highlighted health issues such as malaria, typhoid, and high blood pressure as the common health problems in virtually all the communities. They also mentioned that they suffer financial hardship when seeking for healthcare. It was also noted that most of those in the rural settlements have little or no background in western education and have a low income. The figure below shows the proportion of respondents who have declined healthcare services in the past. Only a few of the respondents confirmed declining healthcare services when ill. Lack of funds was found to be the commonest reason for declining healthcare. Other reasons mentioned by respondents were dislike for drugs, fear of being tagged Covid-19 patients and the believe that their illnesses cannot be cured in the hospital.



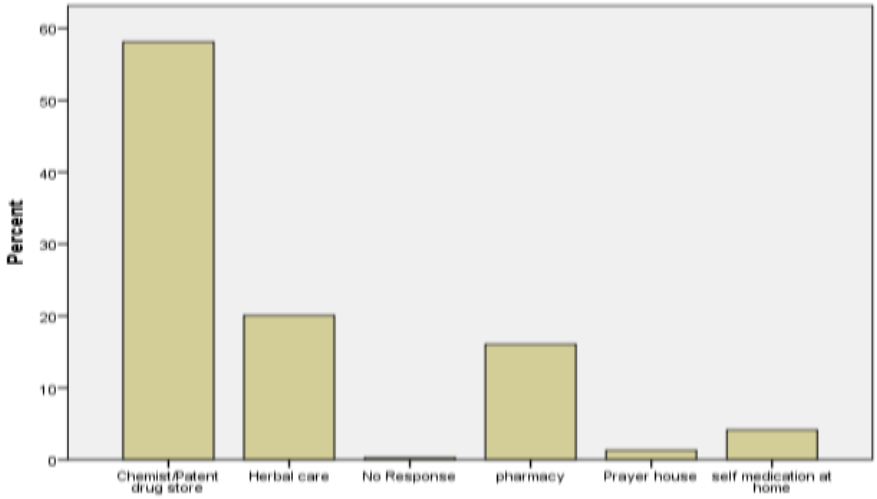
Health Seeking Behavior

Some respondents mentioned that they visit healthcare facilities for treatment but most respondents disclosed that they prefer going for herbal medicine as a means of treatment when they fall ill as the cost for hospital bills is relatively high and cannot be afforded. Some group also highlighted that they prefer going to chemist for self-medication than going to hospital because the cost of drugs at the hospital when compared to that of the chemist; patent medicine vendors (PMVs) is extremely high. Very few of them also opt for spiritual deliverance when they fall ill. The chart below indicates the proportion of respondents who sought for healthcare elsewhere before going to a healthcare facility. A majority of respondents confirmed seeking for care in various places before accessing a healthcare facility.



Service Accessibility

Respondents highlighted that the major challenge they face when accessing healthcare is the high cost of healthcare. They complained of bad states of the roads and the terrain which leads to the hospital as some communities have no health facilities and have to access hospitals in nearby communities. The attitude of health workers towards patients was also another issue highlighted by most of the respondents as an obstacle to service delivery utilization. Therefore, they have alternative places where they seek for healthcare. The chart below highlights alternative sources where respondents visit before visiting a healthcare facility. Up to two-thirds of the respondents and their household seek care for their illnesses elsewhere before presenting to a healthcare facility. The predominant source of alternative care for them was a drug store or chemist; patent medicine vendors (PMVs). Other places mentioned by a significant proportion of the respondents were herbal care, pharmacy and practice of self-medication at home. Few of the respondents also confirmed visiting prayer houses before seeking care in a healthcare facility.



Availability and Challenges of Health Facilities

Almost all respondents stated they have either visited a private, public or both facilities in their communities. The general condition of most of the facilities was of concern to the respondents. The respondents complained of inadequate skilled manpower in the hospitals, long waiting hours, high cost of health services, lack of drugs and inadequate space.

Income and Health Spending

Respondents stated that the major means of paying health care services is out of pocket payment (OOP) in which relatively all of them consented to. A very few out of them highlighted to have benefitted from charity and free service. The problem faced with OOP payment is lack of funds to afford payment due to financial hardship suffered by the populace.

Social Safety Benefits

It has been noted that a very few among the respondents have benefitted from social safety nets such as Charity from volunteers, Government Palliatives and initiatives from Non-governmental Organizations. A large proportion of the respondents stated they have never benefitted from any kind of support from anyone.

CONCLUSION AND RECOMMENDATION

No meaningful development can be seen or accorded to any society that majority of its populace are not healthy because health and development are interwoven, they influence each other. Thus, factors that affect individual's health seeking behavior vary between households and communities. In North central Nigeria, especially the vulnerable groups in the rural communities, from the BSR, lack of financial capability and literacy seem to be the prominent indicator. In addition, most of the public hospitals and healthcare facilities are not functioning optimally because of lack of adequate human resource, drugs, equipment and facilities. These challenges have continued to discourage people, especially the vulnerable groups among the rural dwellers, from patronizing

them as they have remained a huge hindrance for them to access affordable and reliable health care services. This situation has thus propelled many of them to develop and engage in various forms of health seeking behaviours. Based on findings, the study has shown that the most common health seeking behaviours by the vulnerable groups of rural dwellers were self-medication, patronizing patent medicine vendors (PMVs), Pharmacies, traditional practitioners (herbalists) and prayer houses. Therefore, there is the need to:

1. Develop mechanisms for robust identification of vulnerable group in the society.
2. Design effective stakeholders' engagement mechanisms between the targeted groups and the policy makers.
3. Put up rigorous monitoring and evaluation to monitor the progress of policies put in place to augment the health of vulnerable groups in North Central Nigeria
4. Integrate transparency, accountability systems in management processes of health facilities and services.
5. Rejuvenate community mobilization and sensitization on the importance taking the right health related decisions.
6. Facilitate unique health insurance coverage or subsidies to reduce financial barriers to the health care of the vulnerable groups of rural dwellers (VGRD).
7. Address cultural and religious beliefs and perceptions by collaborating with traditional healers and community leaders to bridge the gap between traditional healing practices and modern healthcare systems.
8. Strengthen health care work force in the rural areas by addressing the shortage of healthcare professionals.

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