

Research Article

Assessment of Health Seeking Behaviour of the Elderly in a Rural Community of Sokoto State, Nigeria

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Abstract

Introduction: The ageing populations of Nigeria has increased from 4.61% in 2020 to 4.78 % in 2022 and are vulnerable to long term diseases of insidious onset such as cardiovascular illness, Cerebrovascular accident (CVA), cancers, diabetes, and musculoskeletal disease. This study was carried out to assess the health problems of the elderly and their health seeking behaviours. **Materials and methods:** This was cross-sectional descriptive study carried out amongst elderly persons aged 60 years and above in Wamakko Local Government Area of Sokoto state. Using a combination of multistage and systematic sampling methods, a total of 347 respondents were recruited into the study. A set of pretested questionnaire was used for data collection after obtaining ethical approval and informed consent from study subjects. **Results:** Less than half of the respondents (47.8%) had appropriate health seeking practices by visiting health facilities during spells of illness. The commonest illness experienced by the elderly in this community was musculoskeletal diseases followed by hypertension and visual problems. A total of 95.7% of the respondents were not covered with any form of health insurance scheme. Predictors of health seeking behavior included duration of illness more than ten years and belonging to upper socio-economic class. **Conclusion:** Very few of the elderly in this community had appropriate health seeking behavior with most of them not covered by any health insurance. There is the need to establish the community based health insurance scheme and bring on board all elderly persons so as to minimize out of pocket expenses by the aged.

Keywords

Health Seeking Behavior, Elderly People, Health Care Utilization, Morbidity, Sokoto

1. Introduction

Ageing is one important demographic indicator that has no specific or easily adoptable definition. It has been shown that the rising trends in life expectancy, decrease in mortality rate and prolonged fertility reduction may not be unrelated to the

increase of the aging population in LMICs [1]. In Nigeria both men and women are regarded as elderly on getting to age 60 years and above [2]. Nigeria, Africa's leading economy and most populated country has the highest number of older peo-

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ple in the continent and the 19th highest across the globe with the proportion of the elderly in Nigeria increasing from 4.61% in 2020 to 4.78 % in 2022 [3]. In low-and middle-income countries (LMICs), the population of older adults increased by 3.7% between 2010 and 2015 and is estimated to reach 2.9% yearly before 2050 [4]. In similar vein, sub-Saharan African witnessed an increased in the population of older adults from 23 million in 1990 to 46 million in 2015 and this figure is expected to rise to 161 million by 2050 [5].

Old age in itself is not a disease, but it becomes a problem when the obvious physical and mental changes brought by the advancing age make them unable to tend to their own basic needs [6]. They are vulnerable to long term diseases of insidious onset such as cardiovascular illness, Cerebrovascular accident (CVA), cancers, diabetes, musculoskeletal disease, anemia, chronic bronchitis, cataract, hearing problem, dental problem, neurological problem and mental illnesses. A fall in bone mass leads to osteoporosis and fractures, cartilage degeneration leads to musculoskeletal problems, muscle loss leads to functional weakness, a decline in immune function causes increases in infections and cancer, and increased neuronal degeneration leads to a decline of cognitive function and dementia [7, 8]. Adults and the elderly with chronic conditions may receive care from multiple providers across multiple settings, yet this care is more often than not poorly structured [8]. For all countries, the old age dependency ratio has been showing a steady rise [9]. The rise in the number of elderly people increases the burden of providing social services, including health care services for these populations [10]. Available research from LMICs has observed a linkage between the aged population and the demand for social and healthcare services [11], which most often than not places a high burden on health resources. This is largely attributable to the increasing ageing population with existing multiple comorbidities [12, 13] such as diabetes, stroke etc., [14] that invariably lead to increased healthcare needs thus influencing their healthcare seeking behavior (HSB) [15, 16].

Policies that support the elderly such as pensions, free health care, and treatments of chronic disease have been slow to evolve in developing countries compared with the fast rise in the numbers of those people [17]. Nigeria presently has no functional welfare packages for the elderly, with them depending heavily on youthful population for survival and care thus stressing the already dysfunctional health and economy of the country. These invariably affect HSB of the elderly population and could ultimately lead to seeking help from alternative care such as traditional and spiritual healers. Defined as an action undertaken by people who are perceived to have a health problem for the purpose of health restoration, Health seeking Behavior (HSB) further explains people's behavior in terms of seeking for healthcare through provided health services [18]. The health needs of older citizens needs to be addressed as their vulnerability is reflected in a higher ill-health burden and disability [19].

It is in the light of this that we undertook this study with the

following objectives: (a) To assess the various health problems of the elderly in the study area (b) determine the health seeking behaviour of the elderly and (c) identify factors associated health seeking behaviour of elderly in Wamakko LGA of Sokoto State.

2. Background to the Study Area

This study was carried out in Wamakko local government area (LGA) of Sokoto state Nigeria. Wamakko is one of the 23 Local Government Areas (LGA) in Sokoto State, Nigeria. It lies between latitude 12°N and 13°58N and longitude 04° 8'E and 6° 54 E. Wammako was estimated to have an area of 697km² and a population of 209,204 (national population census). The current estimated population of wamakko LGA is put at 245,611 inhabitants. It is bordered to the north by Tangaza LGA, to the south by Bondinga LGA and Yabo LGA, to the west by Silame LGA and to the east by Sokoto North and Kware LGA. The LGA witnesses two distinct seasons which are the rainy and dry season with the Sokoto River flowing through the area. Its headquarter is in the town of Wamakko. Wamakko Local government is mainly populated by Hausa people. It comprises of four villages, namely; Kammata, Gwamatse, Kauran Kimaba and Kokani Cidawa. Inhabitants are mostly farmers and cattle rearers.

2.1. Study Design

The Study Utilized a Cross-Sectional Descriptive Design.

2.2. Study Population

This comprised of elderly people (aged 60 years and above) in Wammako local government area of Sokoto State.

2.2.1. Inclusion Criteria

Elderly people who must have resided in their present place of abode not less than two years before the commencement of the study.

2.2.2. Exclusion Criteria

Elderly Persons Who Are Critically Ill.

2.3. Sample Size Determination

The minimum sample size was determined using the formula

$$n = Z^2pq/d^2.$$

Where:

n = minimal sample desired.

Z = standard normal deviate at 95% confidence interval = 1.96.

p = prevalence of health seeking behaviour among elderly in a previous study [4] = 68.7% = 0.687

q = complimentary probability of p = 1-p.

d = tolerable alpha error or level of precision = 5% = 0.05.

Therefore, $n = \frac{1.96^2 \times 0.687 \times (1-0.687)}{0.05^2} = 330$.

A response rate of 95% is anticipated, the final sample size n_f was determined using the formula $n_f = \frac{n}{0.95}$.

Therefore, $n_f = \frac{330}{0.95} = 347$.

Sampling method

A multistage sampling method was utilized for the selection of the study subjects. Wamakko LGA has 11 wards.

Stage 1: selection of three (3) wards out of the 11 using a simple random sampling by balloting; the selected wards were Bado/Kasarawa, Arkilla and Gwiwa Low cost Housing estate.

Stage 2: Selection of one settlement each from the wards by simple random sampling by balloting. This was followed by line listing and numbering of houses.

Stage 3: Proportionate to size allocation of sample size was made for each of the settlements and using systematic sampling method, the required households were selected with the assumption that each household has an elderly person there. The elderly in the household was then selected and interviewed, where there was no elderly in the selected household, the next house was chosen and this was continued until the desired sample size was attained. Also, where there was more than one elderly in a house, one was selected by simple random sampling using the roll of papers.

2.4. Instrument of Data Collection

Data was collected using a pre-tested standardized interviewer administered questionnaire downloaded into Open Data Kit (ODK) version 1.23.2. The questionnaire had three sections. Section A (socio-demographic profile), Section B (medical history), Section C (health seeking behaviour).

2.4.1. Pretesting

The research instrument was pre-tested among 23 elderly people at Gobirawa Area, of Sokoto South LGA which was not among the LGAs selected for the study.

2.4.2. Personnel/Training

Three researcher assistants were trained by the researchers for a day and the content of training included objectives of the study, principles and conduct of the research, interpersonal communication skills and the use of ODK.

2.5. Method of Data Collection

Data was collected using ODK installed on android devices.

2.6. Data Analysis/Management

Completed forms were down-loaded from the ODK server in excel format and then analyzed using Statistical Package for Social Sciences (IBM SPSS) version 23. A frequency run was done to check for completeness of the entered data. Continuous variables were summarized as means and standard deviation and categorical variables were summarized as frequencies and percentages. Chi square test was used to test the significance of association between variables. The level of statistical significance was set at 5%.

2.7. Ethical Considerations

Ethical approval was obtained from the Research Ethics Committee of Sokoto State Ministry of Health and permission was obtained from LGA authority and the Community Leaders. Individual informed consent was also obtained from the respondents before the questionnaire was administered. All information sought was handled with utmost confidentiality.

3. Results

Table 1. Socio-demographic Characteristics of the Respondents.

Variable	Frequency (n = 347)	Percentage (%)
65 – 75	276	79.6
76 – 85	51	14.7
86 – 95	16	4.6
96 – 100	2	0.6
>100	2	0.6
Gender		
Male	286	82.4
Female	61	17.6
Marital status		
Single	3	0.9
Separated	4	1.2
Divorced	6	1.7
Widowed	37	10.7
Married	297	85.6
Family setting		
Monogamy	165	48.7
Polygamy	174	51.3
Religion		
Islam	337	97.1
Christianity	10	2.9

Variable	Frequency (n = 347)	Percentage (%)
Ethnicity		
Hausa	306	88.2
Fulani	27	7.8
Yoruba	13	3.7
Others	1	0.3
Duration of stay in current location		
10-30	109	31.4
31-50	93	26.8
51-70	106	30.5
71-90	39	11.3
Height		
150-155	43	12.4
156-160	103	29.7
161-165	128	36.9
166-170	69	19.9
171-175	4	1.2
Weight		
1-40	1	0.3
41-50	30	8.6
51-60	176	50.7
61-70	132	38.0
71-80	7	2.0
81-90	1	0.3
BMI		
<18.5	2	0.5
18.5 - <25	305	87.9
25 - <30	39	11.2
≥ 30	1	0.2

Table 1 shows that majority of the study subjects, 276 (79.6%) were within the ages of 65-75 years with only 2 (0.6%) greater than 100years and a larger proportion 286 (82.4%) where males with 61 (17.6%) being females. A total of 297 (85.6%) of the elderly were married with only 3 (0.9%) being single while majority, 337 (97.1%) were Muslims 306

(88.2%) and Hausa by tribe.

Table 2. Socio- economic characteristics of the respondents. contd.

Variable	Frequency (n = 347)	Percentage (%)
Level of education		
None	36	10.4
Qur'anic only	186	53.6
Primary	24	6.9
Secondary	63	18.2
Tertiary	38	11.0
Occupation		
Farming	135	39.0
Trading/Business	70	20.2
Vocational job	10	2.9
Not engage/Retired	128	37.0
Civil servant	3	0.9
Socio-economic class		
Upper class	3	0.9
Middle class	45	13.0
Lower class	299	86.2
Ownership of residence		
Owned by me	336	96.8
Rented	11	3.2
NHIS enrolment		
Yes	15	4.3
No	332	95.7

Table 2 shows that 186 (53.6%) of the respondents had Qur'anic education while only 38 (11.0%) had tertiary education. A total 135 (39%) of them were farmers some of them, 128 (37%) not engaged or are retired. Majority 332 (95.7%) were not registered under any Health insurance scheme.

Table 3. Medical History of respondents.

Variable	Frequency (n = 347)	Percentage (%)
Is there a health facility close to your residence		
Yes	339	97.7
No	8	2.3
Have you been hospitalized for any medical problem in your life		
Yes	150	43.2
No	197	56.8
Do you have any current medical problems		
Yes	325	93.7
No	22	6.3
*If yes, what are they?		
Fever	26	7.49
Musculoskeletal problems	243	70.03
Skin diseases	3	0.86
Hypertension	72	20.75
Diabetes	21	6.05
Asthma	4	1.15
Visual problem	76	21.90
Hearing problem	14	4.03
Sexual dysfunction	15	4.32
Peptic/gastric ulcer	25	7.20
Arthritis	9	2.59
Genito-urinary problems	5	1.44
Others	1	0.29
For how long have you been with the problem		
<10 years	159	47.9
10 – 30 years	168	50.6
31 – 50 years	3	0.9
51 – 70 years	2	0.6
Are you currently on any medication for that problem		
Yes	275	81.1
No	64	18.9

Multiple Responses Allowed

A total 339 (97.7%) of the respondent lived close to a health facility, 150 (43.2%) of them have been hospitalized before

325 (93.7%) had current medical problems, including musculoskeletal problems 243 (70.03%), hypertension 72 (20.75%) and visual problems 76 (21.9%) (Table 3).

Table 4. Health seeking behaviors of respondents.

Variable	Frequency (n = 347)	Percentage (%)
Source of treatment during illness		
Public Health facility	165	47.8
Private Health facility	10	2.9
Traditional healers	31	9.0
Home remedy/self-medication	138	40.0
Nurse/Dr visits home	1	0.3
Why did you make the choice of place treatment?		
I trust their treatment	172	49.9
Less expensive	139	40.3
Good attention	23	6.7
Less time wasting	11	3.2
Who determines where you obtain treatment when sick		
Myself	149	42.9
My husband/wife	31	8.9
Friends	4	1.2
Children	162	46.7
Others	1	.3
If you have been sick and went for treatment, how much did you pay the last time		
<10,000	273	79.1
10,000-30,000	60	17.4
31000 -50,000	10	2.9
51,000 - 70,000	1	.3
71,000 - 80,000	1	.3
Did you get any support while sick		
Yes	309	89.0
No	38	11.0
If yes what was the nature of the support (multiple response)		
Money	248	71.5
Food	122	35.2
Cloths	14	4.0
Drugs	100	28.8
Others	1	0.2

Among the respondents, 165 (47.8%) visited public health facilities during illness while only 138 (40.0%) preferred home remedy or self medication; about 149 (42.9%) of the respondents took decisions themselves on choice of place of

treatment, while in 162 (46.7%) the choice was made by their children. A total of 309 (89.0%) got support when sick, in the form of money [248 (71.5%)] and drugs [100 (28.8)] (Table 4).

Table 5. Association between Socio-demographic characteristics of the respondents and source of treatment during illness.

Variable	Sources of treatment during illness					^a Test statistic	p-value
	Public Health Facility	Private Health Facility	Traditional healers	Home Remedy/Self Medication	Nurses/Doctors visit		
Ages of the elderly							
65-75	145 (52.2%)	7 (2.6%)	16 (5.9%)	112 (41.0%)	138 (40.0%)	4.927	0.241
76-85	22 (43.1%)	2 (3.9%)	7 (13.5%)	20 (38.5%)	1 (0.4%)		
86 – 95	5 (31.2%)	0 (0.0%)	6 (37.5%)	5 (31.2%)	0 (0.0%)		
96 – 100	0 (0.0%)	0 (0.0%)	2 (100%)	0 (0.0%)	0 (0.0%)		
>100	0 (0.0%)	1 (50.0%)	31 (9.0%)	1 (50.0%)	1 (0.3%)		
Sex							
Male	137 (48.2%)	7 (2.5%)	19 (6.7%)	121 (42.6%)	0 (0.0%)	17.90	0.001
Female	28 (45.9%)	3 (4.9%)	12 (19.7%)	17 (27.9%)	1 (1.6%)		
Marital status							
Single	0 (0.0%)	0 (0.0%)	1 (33.3%)	2 (66.7%)	0 (0.0%)	17.66	0.344
Seperated	4 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)		
Divorced	4 (66.7%)	0 (0.0%)	1 (16.7%)	1 (16.7%)	0 (0.0%)		
Widowed	14 (37.8%)	3 (8.1%)	6 (16.2%)	14 (37.8%)	0 (.0%)		
Married	143 (48.5%)	7 (2.4%)	23 (7.8%)	121 (41.0%)	1 (0.3%)		
Family Setting							
Monogamous	70 (43.2%)	4 (2.5%)	7 (4.3%)	80 (49.4%)	1 (0.6%)	11.50	0.021
Polygamous	85 (51.2%)	6 (3.6%)	18 (10.8%)	57 (34.3%)	0 (.0%)		
Religion							
Islam	159 (47.6)	10 (3.0%)	30 (9.0%)	134 (40.1%)	1 (0.3%)	0.900	0.924
Christianity	6 (4.8)	0 (.0%)	1 (10.0%)	3 (30.0%)	0 (.0%)		
Ethnicity							
Hausa	137 (45.7%)	10 (3.3%)	27 (9%)	126 (42.0%)	0 (.0%)	23.216	0.026
Fulani	17 (63.0%)	0 (0.0%)	1 (3.7%)	8 (29.6%)	1 (3.7%)		
Yoruba	8 (61.5%)	0 (.0%)	3 (1.2%)	2 (15.4%)	0 (0.0%)		
Others	0 (.0%)	0 (.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)		
BMI							
<18.5	1 (50.0%)	0 (0.0%)	0 (0.0%)	1 (50.0%)	0 (0.0%)	15.87	0.81
18.5-24.9	142 (46.9%)	9 (3.0%)	30 (9.9%)	121 (39.9%)	1 (0.3%)		
25-29.9	21 (53.8%)	1 (2.6%)	1 (2.6%)	16 (41.0%)	0 (0.0%)		
Socio-economic status							
Upper class	2 (66.7%)	1 (33.3%)	0 (0.0%)	0 (0.0%)	0 (.0%)	44.63	0.000
						11.76	0.018

	Sources of treatment during illness					^a Test statistic	p-value
	Public Health Facility	Private Health Facility	Traditional healers	Home Remedy/Self Medication	Nurses/Doctors visit		
Middle class	29 (65.9%)	5 (11.4%)	0 (.0%)	9 (20.5%)	1 (2.3%)		
Lower class NHIS Enrolment	134 (45.0%)	4 (1.3%)	31 (10.4%)	129 (43.3%)	0 (.0%)		
Yes	11 (73.3%)	2 (13.3%)	0 (0.0%)	2 (13.3%)	0 (.0%)		
No	154 (46.7%)	8 (2.4%)	31 (9.4%)	136 (41.2%)	1 (0.3%)		

^aFischer exact test

There was statistically significant ($p = 0.001$) association between gender and source of treatment during illness, the proportion of males (48.2%) who accessed public health facility were significantly higher than that of females (45.9%). Similarly, type of family setting was also significantly ($p = 0.021$) associated with source of treatment as the proportion of those in polygamous set-up (51.2%) was higher than those in monogamous set up (43.2%).

There was statistical significantly ($p < 0.000$) associated

between respondents' socio-economic class and source of treatment during illness, the proportion (33.3%) of those in upper class who accessed private facility during illness was significantly higher than those of middle and lower class (11.4%) and (1.3%) respectively. Enrolment into NHIS was also significantly ($p = 0.018$) associated with source of treatment as the proportion (73.3%) of those with NHIS coverage accessed public health facility compared to (46.7%) with no such coverage (Table 5).

Table 6. Association between respondents' health problems and sources of treatment during illness.

Variable	Sources of treatment during illness					^a Test statistic	p-value
	Public Health Facility	Private Health Facility	Traditional healers	Home Remedy /Self Medication	Nurses/ Doctors visit		
Is there a health facility close to your residence?							
Yes	163 (48.4%)	10 (3.0%)	30 (8.9%)	133 (39.5%)	1 (0.3%)	4.55	0.482
No	2 (25.0%)	0 (0.0%)	1 (12.5%)	5 (62.5%)	0 (0.0%)		
Do you have any current medical problems?							
Yes	152 (46.9%)	10 (3.1%)	30 (9.3%)	131 (40.4%)	1 (0.3%)	2,24	0.710
No	13 (61.9%)	0 (0.6%)	1 (4.8%)	7 (33.3%)	0 (0.0%)		
Duration of health problem							
< 10 years	97 (43.3%)	5 (2.2%)	26 (11.6%)	96 (42.9%)	0 (0.0%)	11.86	0.011
>10 years	68 (56.2%)	5 (4.1%)	5 (4.1%)	42 (34.7%)	1 (0.8%)		

^aFischer exact test

Respondents' duration of health problem was found to be significantly ($p = 0.011$) associated with source of health facility for treatment, the proportion (56.2%) of those with

health problem for more than 10 years was significantly higher than those (43.3%) with the problem for less than years (Table 6).

Table 7. Binary Logistic regression.

Variables	aOR	95% Confidence Interval		p value
		Lower	Upper	
Age group	1.25	0.750	2.077	0.394
Gender	0.92	0.515	1.626	0.762
Duration of current health problem	0.56	0.352	0.887	0.014
Social class (Upper vs lower)	3.96	1.928	8.127	<0.000

aOR: adjusted odds ratio

In logistic regression model, duration of current problem, and socio-economic class were found to be the predictors of health seeking behavior. Respondents with health problems for more than 10years were approximately one time more likely to access health care than those with less than 10years (aOR = 0.56, CI = 0.352-0.887, $p = 0.014$). similarly, respondents in upper socio-economic class were approximately 4 times more likely to access health care than those in lower class (aOR = 3.96, CI = 1.928 – 8.127, $p = <0.000$). (Table 7).

4. Discussion

In this study, majority of the respondents (79.6%) were within the ages of 65-75years. In similar studies elsewhere, a greater majority of the respondents were between 60-70 years [20-22].

The majority, (97.7%) of our study subjects agreed to the availability of a health facility close to their residence. In a similar study, (69.5%) of the study subjects had health facilities located within 30 minutes walking distance from their residence [23]. This is very important if the objectives of United Nations decade for healthy ageing (2021-2030) and Universal Health Coverage are to be achieved amongst this vulnerable group.

A greater majority, (93.7%) of our study subjects admitted to being ill before the study. This is in tandem with other studies conducted in the rest of the world that have shown that most of the geriatric populations face various illnesses with varying prevalence [24-27]. Findings from our study showed that less than half, (47.8%) of the respondents used the public health facilities during illness. This result was however higher than the study conducted in southwest Ethiopia [28] and a household survey carried out in Nigeria [29] where only 45.6 and 31.2% visited the health facility during illness respectively. A higher figure of 84% attendance in health facilities was observed in a rural part of India [20]. In contrast to our findings, a similar study from Ghana [30] observed that more than two-thirds of their respondents reported not using any health facility during their last illness which favorably agrees with evidence from other similar studies [31, 32]. It is im-

portant to note that since these elderly persons are faced with multiple chronic problems, there is always the need to encourage them to visit health facilities from time to time.

One important finding of our study is that a greater proportion (48.7%) of our respondents had inappropriate health seeking behavior like visiting patent medicine vendors, chemist shops, and traditional healers or resorting to self-medication. This is in tandem with the finding from the study in Calabar, Nigeria, where 83.8% of the respondents relied on herbal medicines for the treatment of their ailments [33]. A similar study Delta state, Nigeria also observed inappropriate HSB amongst their respondents [34].

In this study, the commonest ailment reported by our respondents was musculo-skeletal problems. This finding is in agreement with similar studies conducted in many developing countries [24, 27, 29, 35-37]. However, in contrast to our findings, hypertension was the commonest ailment in other studies [20, 38, 39].

The presence of musculo-skeletal diseases amongst our study subjects may not be unrelated to the physiologic effect of aging on the component of the musculoskeletal system since aging is associated with significant losses of structural and functional properties of tendons, ligaments, bone, and cartilage [40].

A greater majority, (89%) of the respondents got support while they took ill mostly in form of money and drugs from family members and other persons around them. Anecdotal evidence has shown that the well knitted and entrenched extended family system in most parts of Nigeria makes everyone his brother's keeper thus facilitating help in times of need. Having trust and cost of the services rendered to the respondents were the commonest reasons for accessing the preferred choice of place of treatment. This is not surprising as a greater proportion, 86.2% of the study subjects belonged to the lower socio-economic class and this is more compounded by the fact that 95.7% of them were not enrolled for any health insurance scheme; not having any health insurance increases the probability of a low health seeking behavior. This finding is in agreement with other studies else where [24, 41, 42].

This underscores the need for governments at all levels to

hasten the establishment of community based health insurance scheme (CBHIS) that will enable many community members including the aged access affordable health care services considering the low budgeting for health care in Nigeria.

In this study, monogamous family setting, socio-economic status (high and middle) and duration of illness (<10 years) were associated with better health seeking behavior. This is in contrast with other studies where age (60-65 years), formal education, family support during illness were found to be associated with appropriate health seeking behavior by the elderly [29, 33, 43-45].

5. Conclusion

The study revealed that less than half, 47.8% of the study subjects utilized the services of public health facilities during illness and were propelled to do so due to the trust and cost of services. The commonest ailment experienced by the elderly in our study were musculo-skeletal problems and most of them, 89% got assistance during illness in forms of money and food since most of them belonged to the low socio-economic strata of the society. This underscores the need for governments at all levels to facilitate the commencement of the community based social health insurance and other social welfare schemes with provisions for the free care of the aged in the society.

6. Limitations of the Study

Some of the respondents inadvertently hoarded some information as they claimed that they wouldn't know if the information volunteered would be used against them. However their fears were allayed by engaging the community guide who cleared their doubts concerning any political undertone.

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Author Contributions

All the authors participated in all the phases of the study which include conceptualization of the study, protocol development, data collection, analysis and manuscript preparation and have all gone through the final manuscript.

Conflicts of Interest

The authors declare that they have no competing interests.

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