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Household Economic Strategies and Healthcare-Seeking Behaviour in Rural Akoko Communities of Ondo State, Nigeria

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ABSTRACT
Household economic strategies has been identified as crucial in healthcare-seeking behaviour; yet little has been done to examine how household economic strategies predispose rural dwellers to healthcare challenges. Inspite of policies and programmes designed to improve healthcare-seeking behaviour of rural dwellers; they are yet to be secured health wise. This study investigated household production and consumption strategies and their implications for choice and utilization of healthcare resources. Through qualitative and descriptive ethnography, Key Informant Interview (KII), Focus Group Discussion (FGD) and the textual analysis of documents, our study seeks to establish that production and consumption strategies are principles that make household economic activities more tasking and complex; and also make economic relationships intricate in rural Akoko communities. It therefore limits available time to seek quality western healthcare, thus making people rely more on traditional healthcare and home remedies. Rural Akoko people preferred traditional healthcare and home remedies which allow them have more time for household economic activities. Rural Akoko people devoted more attention to work than healthcare. They seek western healthcare at advanced stages of illnesses, resulting in various health and healthcare insecurities. The production and consumption strategies adopted in the household economic system of rural Akoko communities have a strong influence in determining the choice and utilization of healthcare resources. The interface between household economic strategies and healthcare-seeking behaviour in rural communities therefore deserves more attention in order to aid the formulation of policy for health interventions. This will reduce health and healthcare insecurities in rural communities.
Keywords: Household, Economic, Strategies, Healthcare, Rural, Akoko

INTRODUCTION

Household economic strategies describes the style of action engaged in production and consumption at micro level of human organization; while

healthcare-seeking behaviour refers to actions taken by the individual to prevent and/or cure illness in a given social setting. Household economic strategies are characterized by cultural forces that influence actions taken to prevent and/or cure illnesses in rural communities.[1] In rural communities household members adopt several production and consumption strategies that is premised on allowing individual experience quality welfare that transcend good healthy living. These strategies embedded with customs, beliefs and values that are external to and coercive of individual. [2] Thus, these values, beliefs and customs serve as underlying structures that guide household economic relationship. Obviously, the effects of these cultural forces have made a large number of rural people opened to a variety of household economic insecurities that make them vulnerable to health and healthcare challenges. [3] This has adversely affected the well-being of rural dwellers by imposing low quality of life on them as 8% between 2011 and 2012, has life expectancy at birth falling from 51.6 in 2011 to 43.4 in 2012. [4]

World Health Organization reported that 70 percent rural dwellers experience critical health challenges that devoid of qualitative life.[5] About 70% of those living in rural areas do not seek proper healthcare facilities (that are essential for good living), as these facilities are also poorly utilized. [6] This has made the rural dwellers seek healthcare in various forms, some of which have affected their health status. Some of these effects include impaired productivity of able men and women in the community and increased rates of morbidity and mortality. This scenario is not in all ramifications exempt rural Akoko communities.

Akoko is predominantly situated in hilly and rocky areas of Ondo state, Nigeria. Akoko is an agrarian community that relies on subsistence production. Akoko topography makes household economic activities rigorous and stressful thereby necessitating the need to strategize. As reported by Okoli that this challenge has made rural Akoko dwellers derive impetus to device household economic strategies to adapt and cope with the environmental challenges.[7] Ondo State Health Survey reports on health care seeking incidence revealed that 45% morbidity and 32% mortality were directly attributed to the socio-economic correlates in the household. As also reported by Ondo State Health Survey that more than 70% of rural Akoko dwellers do not seek quality healthcare and 85 percent of the population rely on home remedies for health care and underutilize western health care facilities (that can enhance quality

health).[8] The reliance on home remedies and underutilization of health care facilities in rural Akoko communities has been socially constructed by Okoli as "uncivilized" "unscientific" and "dangerous" or at least in need of sustainable intervention and continual monitoring.[9] The growing concern on improving health status of rural populace in the global south has spurred researches and interventions especially in the area of health care seeking as sound health is a fundamental requirement for living a socially and economically productive life.

Many programmes have been introduced by government, and other parties like non-governmental organization to enhance improved healthcare seeking behavior in rural communities. Inspite of health intervention programmes in rural areas, many rural populace is yet to be secured health-wise especially rural Akoko people. It is therefore indicative that these interventionist programmes have either not been effective or are misdirected in addressing the health and healthcare challenges among rural dwellers in Nigeria. Scholars affirmed that information on interface between household economic strategies and health care seeking behaviors will have more relevance to rural health care policy formulation if more empirical studies demonstrate its essential role in rural health care development. [10]

Thus, there has been considerable debate in the literature recently as to whether the mere provision of health services will lead to improved health care seeking.[11] Bassey argue that the mere existence of health services is not enough to lead to qualitative health care seeking.[12] Hence, as Fatimi once observed, since health care is a consistent choice of individuals, the factors that change peoples' perception of the available alternatives and their motivation to seek care need to be properly understood.[13] Derrick observed that, many studies ignored the social complexity resulting from household economic strategies when patterning health care-seeking behaviour. Derrick suggested that the outcome of the interface between the two needs to be taken seriously in programmes and interventions geared towards promoting health in a variety of contexts. [11]

Studies show that health care seeking behaviour is influenced by physical, socio-economic, psychological as well as organizational factor, while the influences which household economic strategies have on health care seeking have been given less attention. [14] Most studies on health care seeking behaviour in have been disease specific with little or no emphasis on socio-cultural variables. Therefore, limited knowledge is available on interface

between cultural context of household economic strategies and health care seeking. Moreover, there has been very limited ethnographic work in this area. [15] It is against this background that this study examined cultural context of household economic strategies and health care seeking in rural communities of Akoko, Ondo state, Nigeria.

Objective of the Study

1. To examines examine cultural strategies employed in both production and consumption in rural Akoko households with special attention paid to customs, values and beliefs associated with the practice.
2. To examine how the above cultural strategies influence therapeutic choice and utilization of health care resources.

THEORETICAL FRAMEWORK

Rational Choice Theory

This study adopts Rational Choice Theory (RCT) as its theoretical framework. The central explanation of this theory is a focus on individual rational action that helps to explain the aggregate behaviour in the society. According to this theory, the main task of sociologists is to focus on social system, but that such macro phenomena must be explained by examining the factors internal to them, which centers on behaviour of individuals at the micro level. Further, rational choice orientation posits that a person acts purposively towards a goal, with the goal and the actions shaped by values or preferences. Although rational choice theory recognizes that in the real world, people do not always behave rationally, but this makes little difference in the position of the theory. According to this theory, the implicit assumption is that the theoretical predictions will be substantively the same whether the actors act precisely according to rationality as conceived or deviate in the way that have been observed. Hence, given the theoretical orientation, it follows that the focus in terms of the micro-micro issue is the micro to macro linkage, or how the combination of individual actions bring about the behaviour of the system. On the whole, the argument of rational choice theory is the rational construction of social system from the lowest level of individual. That is knowledge of macro level is best understood from primacy of micro level. This is anchored on the fact that data are usually gathered at the individual level and then aggregated or composed to yield the system level. Among other reasons for favoring a

focus on the individual level is that this is where "interventions" are ordinarily made to create social change through such "interventions".

Utilizing the rational choice theory in our study, both household economic strategies and healthcare seeking behavior are purposively geared towards a goal, with the goal and the actions shaped by values or preferences. To gain adequate understanding on how to improve and promote rural health care, it is highly essential to understand the household economic strategies which constitute predisposing factors that influence action of individual or group on health care. The knowledge of interface between household economic strategies and healthcare seeking behaviour at micro level will aid policy formulation for health care intervention at macro-level.

Study Area

Akoko is situated in North Eastern part of Ondo State, Nigeria. Located in an upland elevation with a hilly settlement, it shares its northern and eastern boundaries with Kogi and Edo states respectively and western boundaries with Ekiti state. Akoko is the largest community in Ondo state with 17km wide and 35km long. Akoko lies on the latitudinal range of between $7^0 46^0$n and $7^0 52^0$n and on the longitudinal range between $3^0 85^0$e and $3^0 89^0$e to the north of Kogi. Akoko community is made up of a collection of small towns. The population is estimated to be approximately 509,113 but that number is continually being adjusted due to the high levels of in and out migration for work abroad. Two-thirds of the populations live in rural areas of Akoko community. The largest town is Ikare-Akoko. Akoko takes a large percentage of the local governments in Ondo state. Out of the present 18 Local Government Councils it takes four Local Government Areas (LGAs), viz Akoko North-west, Akoko North-East, Akoko South-West, Akoko South-East. Akoko comprises about 40 small towns, predominantly situated in rocky areas of Ondo state. The rocky terrain nevertheless, may have helped the region to become a melting pot of sorts with different cultures coming from the north, eastern and southern Yoruba towns and beyond. Akoko became one of the few Yoruba clans with no distinctive local dialect of their own.

Akoko is an agrarian community that relies on subsistence production due to its topography. Each household cultivates a number of plots scattering over the mountainous landscape, the total area of land in production each year is fragmented and small, less than one-half hectare on average. They employ

the use of local agricultural implements, which require much physical exertion. In addition, rural communities in Akoko lack the economic power to revitalize their subsistence resources such as land and tools thereby putting considerable pressure on their health especially adult men and women who form the bulk of labour force. Their vegetation is characterized with dissident forestry which favours the growth of some crops and plants use for health care. The use of local agricultural implements often results in poor productive performance of rural Akoko communities as reflected in declining agricultural production and local manufacturing. As a result of this, economic resources are limited, a situation that leads to intense competition among household members. In addition, the economic situation in the households has made many Akoko men to migrate to urban area in search of better working condition and this has created a new household structural management that has left a few people with the burden of taking care of the household. This situation also has adverse effect on the health of many people thereby increasing morbidity and mortality rate in the community.

METHODS

The researcher conducted ethnographic studies in rural Akoko and employed qualitative methods. The research methods adopted were participant observation, in-depth interview and key informant interview. The rationale was to compensate for the deficiencies in any of the methods. Participants were purposively selected through snowballing. A total of 72 people (43 males, 29 females) were interviewed. The age range was 35 to 69 years. The rationale was that the people within this age range are mostly in their productive years. Participants were contacted by the researcher and given information about the study. The participants are males and females from respective households and health care providers. The people were chosen to provide information on study themes while health care practioners were selected to provide information on health status, profile, prevalent diseases and illnesses, patterns of healthcare and utilization of healthcare resources/facilities in the community. Prior to beginning the interviews, participants completed a consent form ensuring informed consent.

The researcher constructed the initial interview guide, which contained approximately forty-five questions, based on researcher review of literature and study themes/objectives. The interviews were conducted at locations

convenient to participants, such as their homes and work place. The interviews lasted between fifty minutes and three hours, averaging about ninety minutes. The question guide was not strictly followed in some cases as some circumstances often demanded for reflexivity. In some cases the researcher embarked on follow-up visits to some participants when it seemed difficult to get the required information in a single visit. Some participants invited the researcher for re-visitation when they perceived that they were still having some more information to give. Participants also consented to the recording of their interview and most of the fieldwork data were collected by taking copious amounts of field notes. The researcher audio-recorded interview sessions and then transcribe interviews with the assistance of a professional transcriptionists. Data collection and analyses occurred concurrently over 11 months.

The process of analysis began by doing open coding and microanalysis. This process entailed deep routine interaction with data generated from the field on a daily basis throughout research phases. Immediately after fieldwork sessions, all generated data were crosschecked and, where needed, further visits to sites were undertaken to fill certain gaps in the "raw" data collection. Both the data from the research field diary and notes were extrapolated with that retrieved from the electronic devices. Sorting of the data according to the research objectives involved the writing of study objectives on separate sheets of paper, which were referred to as "objective cards" (this enables the researcher to constantly check the cohesion of his findings in line with the aims and outputs of research – one could call this a "running point" of reference). Transcripts were imported into NVivo (verion10) and then analyzed for themes. We employed an iterative analysis approach in finalizing the code list to reflect a nuanced focus on the study themes. On the other hand, direct quotation of responses (that indicate participants/informants voices), which entails verbatim reporting of opinions, idioms, and proverbs that support important findings in the data were done. The direct quotations of informants were later translated into English for proper reporting.

RESULTS

Household Production Strategies and Health Care Seeking Behaviour

One of the production strategies in rural Akoko is the networking in recruiting labor for production. According to participants, it is meant to reduce stress and increase productivity in the household. A male participant who is an

artisan highlighted further, the purpose and importance of labour networking as he said; "it is a sort of relief system to increase efficiency of labour to boost production. It is also meant to strengthen kinship ties and to help indigent member to ascertain reliable means of survival because not every individual have the required means for productive endeavor". Networking in recruiting labour involves a cultural defined laid down principles which make the processes contractual and socio-economically interconnected. This labor arrangement is characterize with rules and regulations anchor on some beliefs which serve as checks and balances as narrated by a participant as follows.

> It involves labor arrangement between consenting parties, who have informally agreed to work together in rotation. The processes must go round among the consenting parties before the contract is terminated. It is a belief in this community that breaching the contract attracts a consequence. It is compulsory for someone to keep to the agreement otherwise incurs the wrath of ancestor. It is this belief that makes someone serious and law abiding in order to avoid being a victim.

Participants are more comfortable when their acts of networking are anchored on cultural rules and regulations. Samuel, a farmer, expressed his feeling as he said: "I do not entertain fear in any productive relationship as much as it involves rules and regulations accompanied by anticipated punishments". Another participant further pointed to the economic benefits of act of networking in recruiting labour for production purpose said, "It reduces my cost of production and strengthens my productivity and alleviates my anxiety in recruiting labour". Apart from the economic benefit, there is a cultural belief as highlighted by participants that reinforces the act especially when it involves farm production, "our culture frowns at lavish spending on production of food resources because such act does attract the spirit of devourers and bad harvest". I probed further asking for the implications of networking on health care seeking. Information gathered revealed that it creates pressure on one's time and energy, and the possibilities of having enough time to maintain ones health are almost hindered due to much work engagement. This makes them to seek for a more convenient alternative health

care to relieve them of any health challenge. Elder Joshua, a farmer who was one of the participants that shared their experience on implication of the act on health care seeking has this to say:

> I often engaged in various labour contracts in order to meet up with economic responsibilities ahead of me, it usually absorbs my time and energy. There was a time that I was not feeling fine that I needed to seek a proper medical attention, but because I have to redeem all the labours networking I had contracted. I began to manage myself by taking locally made herbal mixtures so that I would have time to work; because I must redeem all the outstanding contracts. Even when I feel any symptom, I do not have time to take proper care of myself. In most cases I do not have time to prevent myself from being falling sick. This often increases my chance of being fallen sick which I cannot ordinarily help-out.

From the above quotation, networking in labour for production limits time to take proper care of one's health and increases incidence of morbidity in the community. Taking locally made herbal concoctions and mixtures for both preventive and curative measures are very common among participants because they do not have sufficient time to consult western health care practitioners due to multiple work engagements. Female participants claimed that they are more affected due to their position in the household as evident from a participant as she said, "engaging myself in much labour work coupled with domestic chores do not allow me to have time to visit hospitals for health care and make me to rely on home remedies". In a Key informant interview with a western health practioners, he comment on rural Akoko peoples' attitude towards health care said:

> Most people in this community often fail to come for medical check-up as scheduled. Some of them will not take their drugs as prescribed. When you asked them why, they will tell you that they are very busy. At the end of the day, they will say the treatment is

> not okay. They are more concerned about their work than their health. They like embarking on selfcare which do not work for them in most cases. It even aggravates their condition. This has led to the death of many people in this community.

Gender allocation of roles and responsibilities in production activity constitutes another strategy. This strategy bothers mostly on agro-based production because 80% of rural Akoko populace engages in farming. This strategy is anchor on traditional belief and is patriarchally wired. It is characterized by a custom which ascribe cultivation of cash crop to men and cultivation of foods crops to women. It is anchored on a belief that men are the chief provider and women are to support the home. When asked what the implication on health care seeking was, it was gathered that this cultural strategy has a gender skewed effect on income generation and differentiated implication on financial strength between men and women in the household. It was revealed the practice makes men stand a better chance to conveniently seek for a qualitative healthcare and strengthen the reliance of women on men for healthcare financing.

> My husband produces cash crops that are liable to generate large income and I produce food crops that are mostly consumed at home; it is difficult for me to generate cash to replenish the loss strength. Sometimes ago, I felt sick and not financially okay and my husband was not around. I used herbal drink as first-aid thinking that it would relieve me till my husband will be around. After some days I realized I was not getting better rather, it grew worse and worse. I even collapsed before my husband came. My husband took me to hospital, when we got there, the health personnel in charge alleged him of delaying proper action on time.

Another production strategy is creating allowance for production in order to provide for one's kinsmen to complement their productive efforts for livelihood. This strategy is reinforced by cultural norm that make welfare

creation an obligation to one's kinsmen and guided by a belief that enforces a sanction. A participant highlighted the belief which guide the practice as he said, "I do make sure that I provide for my kinsmen in order to strengthen their welfare because anyone who fails to provide for his kinsmen incurs the wrath of ancestors. The fear of being a victim makes me conform to this act". This act of providing for one kinsman is fraught with some challenges as explained by a participant as he said, "I devote much time and energy on economic activities in order provide for my kinsmen. This affects the quantity of goods I offer for sale making my generated income low". When I asked for the implications on their health care seeking, participants indicated that it exerts coercive force on their expenses and make it difficult to maintain a proper health care. A participant like others shared his experience as he said.

> I am economically responsible to my kinsmen by providing for them. It is not normal to fail these responsibilities; nevertheless it expends on my income when am trying to meet-up. Even I find it difficult to take good care of myself because of responsibilities that have chocked me. If I have any health challenges, I do have a re-think and count the cost. I try to find means to get over any health challenge through any means that I know would not cost me much. At times I embark on faith healing when am short of cash.

Within the above strategy, providing for ones kinsmen for enhancing livelihood encourages subsistence production, which usually supports subsistence living. In most cases, production of cash crops is low, as focus is more on food crops to directly support subsistence. Few goods are often available for sales, thereby making their generated income to be relatively low because a large percentage would have been consumed at home. Most people in rural Akoko people are not salary earners, they generate most of their incomes through sale of economic goods in order to meet up their economic responsibilities. This often implicate on their ability to generate sufficient income to meet their needs. This usually has implication on their capability to reliably finance a health challenges and at times resulting to complications which sometimes lead to casualities.

> I am not a salary earner and a larger percentage of what I produce are consumed at home, only few are often available for me to offer sale and usually attracted low income, in most cases I find it difficult to generate sufficient funds to compensate for the stress and in larger extent to finance any potential ill-health. There was a time that my son felt sick I could not afford the drugs prescribed for him in the western hospital. I sought for a discharge and I took him home for home remedies. I started administering locally made drugs to him, eventually he later died.

The customs of conserving and preserving economic goods is another production strategy in rural Akoko. This strategy constitutes means of eliminating scarcity of food resources and also to adapt to the poor household economic condition. The act takes several forms including, putting harvested crops in barns and rearing of domestic animals which are meant to prepare for the future and also to cater for unanticipated expenses. When asked for the implication of that act on health care seeking, it was gathered that inspite of the benefits of the act; it is fraught with some health care challenges as explained by a participant.

> Anytime I conserve harvested crop into my barn it often affects the quantity offered for sale and reduce income I generated. The little amount generated can only take me for some periods. Anytime am having health challenges I often find it difficult to take prompt quality health care action because the conserved goods could not be converted to cash at short run to finance emergency. Most times I delay seeking quality care and will go for cheaper care to relieve me for some time before I will have enough cash for proper care.

Household Consumption Strategies and Healthcare Seeking Behaviour

One of the consumption strategies is the custom of instituting system of exchanging economic resources. In this practice economic goods are exchanged for goods among consenting parties; and there is a negotiation between parties as regards the measurement of goods to be exchanged in order to avoid negative reciprocity. A participant who is a hunter who highlighted the process in relation to his career explained, "If I kill two grasscutters, I will find a farmer that has yams that need meat. We will both agree on the tubers of yam to be exchanged with a grasscutter" The purpose and the benefits of the practice were highlighted by participants - is a way of coping with insufficiency and unlimited wants in the household. A participant like others who shared his experience said, "There is no way I can produce all what I want, I have to depend on some people for some needs. I am able to consume most economic goods impossible for me to produce without incurring any cost". This practice also bridges economic disparities among member in the household as explained by a participant, "It does not involve any cost, so everybody is bound to undergo the same process irrespective of your status". He further narrated the rules and regulations that subsumed in the contract to ensure compliance. "The culture stipulates that one should not breach any contract, it is a believed that defaulter's action attracts the wrath of ancestors". When asked if there are challenges and limitations in that practice, participants indicated some. A participant who is an artisan highlighted the challenges and limitations said, "the practice affects income generation as it does not attract cash and also very tasking and time-consuming to get someone that needed what one intend to exchange". I probed further asking for the implications on health care seeking. It was gathered that it creates a sort of inequality in capacity to maintain a quality health care. This made some of the victim to seek for home remedies as alternative to western health care to relieve them of any health challenge.

> The act of exchanging economic goods is very good because it makes one to have access to some things that one is not able to have ordinarily. But the process of looking for one to exchange with is very time-consuming. Also the process do not involve cash, it is not easily possible to generate cash for healthcare. Whenever a situation like this arises I embark on self care.

It is a customary norm in Akoko to consume some food for preventing and curing illnesses with little or no financial implication. This practice is anchored on the general belief that the money they suppose to use for healthcare will be used for other economic needs in the household. This act is instituted to minimize spending heavily on healthcare. This belief encourages them to use local food supplements for health purpose. A female participant shares her experience as she said: "I cook soup with "cotton wool" leaf which I use to consume for 3 days. This has proved efficient in treating my joint pains as well as other ailments in my body" Participants also indicated that there are many other things also consumed for healthcare. Information gathered reveals that the practice reduces the cost of healthcare and the stress involved in seeking care from health providers. A participant also shared her experience as she said:

> In most cases when I fall sick with a particular illness, instead of seeking care from healthcare providers I embark on consumption of some food supplements as alternative to seeking western healthcare. I have not been to hospital for health care for years. The cash I suppose to use to consult health providers will be use for other more appealing economic needs in the household.

The consumption of some foods for health care has reinforced the reliance of pregnant and nursing mothers on home remedies. The reliance has affected the degree of seeking western healthcare providers for both antenatal and postnatal care. This further has negative implication on health of pregnant and nursing mothers in rural Akoko communities. A western healthcare provider like others complained that many pregnant and nursing mothers die due to shortage of blood.

> Most pregnant and nursing mother are more concerned about consuming some foods in lieu of taking proper medicine for their antenatal and postnatal healthcare. Their ignorance has made them to ignore the advice given to them pertaining medical care. When we prescribed blood tonic for them many of them began to take some local foods

> as alternative. Some of them and their children die of shortage of blood. I can say this is one of those things that account for maternal and child morbidly and mortality in rural Akoko community.

The interview conducted with some western health practioners also revealed that rural Akoko people are more focused on their work than seeking healthcare and seek western healthcare only when illness is at advanced stage.

DISCUSSION

In this article, findings revealed that household economic strategies are anchored on kinship ideology characterized with cultural norms that validate the idea of hospitality among members of household. The cultural norm is instituted to cater for the welfare of household members. This further revealed that household economic interactions are complex, as production and consumption strategies depict cultural attributes influenced by customs, values and beliefs (which form its underlying structure) determine actions towards choice and utilization of health care resources. This is in line with Schultz and Fatimi assertion that socio-economic dynamics play a greater role influencing choice and utilization of healthcare resources. [15, 13]

The production strategies employ in the household economy subjects rural Akoko dwellers to socio-economic forces that strengthen their work engagement and reduce the available time to seek quality healthcare. Similarly, the consumptions strategies are characterized with values, customs and beliefs that strengthen the reliance on food remedies as a way to prevent and cure illnesses. This buttresses the assertion of Empery which indicate that culture influences health behavior as it spells out what constitutes an illness and pattern of health care.[2] This study shows that participants seek for a more convenient alternative healthcare that will allow them to have time for household economic endeavours. These results are similar to findings in previous studies that rural people were found to have a tendency to adopt various methods to manage their health to suit their purpose. [17,18]

The stages in the pathway of seeking health care are not always followed serially neither are they mutually exclusive among rural Akoko people. There are cases when an individual simultaneously seek home remedies and western health care. It is not uncommon for a person in rural Akoko to take enema with

herbal extracts early in the morning before visiting the hospital for treatment. This leads to fatalities in some instances. This finding is in line with Ajala assertion, that overlapping of pattern of healthcare can result into complications that can result into morbidly and mortality. [19] Rural Akoko people generally seek home remedies initially when they fall sick and turn to any other alternative care if they are not successful. This occurs regularly as local remedies might have failed to give the patient relief from the illness. This buttressed the assertion of Banti that hospital visits for health care is quite low, especially in the rural areas. Most of those who go to the hospital for health care do so at an advanced stage of the disease when the disease might have set in complications. [20]

This study revealed that rural Akoko people rely mostly on home remedies because it has affinities with household economy as well as their cultural belief pertaining to local etiology and management of illness. This study revealed that western healthcare facilities are not fully seek and utilize due to several limitations imposed by household economic strategies associated with socio-economic dynamics in the household. Seeking western healthcare only when their health condition worsens, and when effort to address the health problems proves unsuccessful, have negatively impacted on their health status. This explains why the presence of government does not have appreciable effect on health status of rural Akoko dwellers. [7]

CONCLUSION

The household economic strategies have strong influence in determining healthcare seeking behaviour- particularly the choice and utilization of healthcare resources in rural communities. Healthcare challenges in rural communities (especially in Akoko) are largely to remain the same and ever more endemic in future taking into consideration the various production and consumption strategies adopted in the household. Unless the government and NGOs recognize this, the quest for improved health and healthcare in rural communities may be a mere dream or illusion. To urgently bring these risks to bear upon modern scholarly consciousness and health systems analysis, there is a need for coordinated intervention and research, where the energies of both private and public institutions can engage with national policies, practices, legislative design, and the regional realities which often render these ineffective in the face of autonomous cultural trends and belief systems. Individual

healthcare seeking behaviour and the perception of health risk as a whole needs to be progressively attuned through public health education where all income and social levels have equal access to a knowledge which can ensure the improvement, empowerment and indeed the management of wellbeing.

There is a need to create an enabling environment to redress household economic practices (through production and consumption strategies) that impact negatively on healthcare seeking behaviour-especially on choice and utilization of health care resources. This will require mobilizing rural people through their respective local organizations and through mass media to bring about such change. There should be a coordinated effort to design behavioral health promotion campaigns to inform and educate the rural dwellers that the desirable healthcare-seeking behavior is to seek health care facilities for medical treatment by qualified healthcare providers.

Government should put in place a policy framework that can persuasively provide the basis for the reorientation of rural dwellers towards the use of available quality healthcare facilities when necessary. Sustainable attention should be paid to the customs, norms, values and beliefs that at play in interface between household economic strategies and healthcare-seeking behaviour. This deserves more attention for aiding health interventions policy formulation. Policy makers must understand the healthcare-seeking behavior and health use at the rural areas and give enough credence to these facts so that policies could be designed appropriately to reduce morbidity and mortality in rural communities.

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