CHAPTER FOUR

MECHANIC'S AND SUCHMAN'S INTELLECTIONS OF HELP SEEKING AND STAGES OF ILLNESS BEHAVIOUR AS EXPONENTIALS OF EFFECTIVE UTILIZATION OF HEALTHCARE SERVICES IN NIGERIA

Nkanta, Nsikan Clement
Department of Sociology
Ritman University, Ikot Ekpene, Akwa Ibom State, Nigeria.
nsynkanta@yahoo.com,nsynkanta@gmail.com

Edidiong Anthony Ekoriko
Department of Sociology and Anthropology,
Akwa Ibom State University, Obio Akpa Campus

Oyebanji, Ademola Oyeleye
General Studies Department, Federal Polytechnic, Ukana
Essien Udim, Akwa Ibom State

INTRODUCTION

Health seeking behaviour is a manifestation of the propensity to stay healthy. According to the World Health Organization (1951), health is *"a complete state of physical, mental and social wellbeing and not merely the absence of disease or infirmity".* Implied in this definition is the fact that health is a utopia, in plain terms, an unattainable goal. It means that nobody is qualified to claim health. Predicated on this problematic nature of this definition, WHO (1986) effected an adjustment of this definition and presented health as, *"the extent to which an individual or group is able, to realize aspirations and satisfy needs, and on the other hand, to change or cope with the environment".* From this standpoint, health is seen as a resource for everyday transactions, instead of the object of living. This view objectifies social and personal resources as well as physical capabilities. Many scholars had also given their definitions of health for example; Pander (1987) quoted in Etobe (2005), described health as,

> *"The fulfillment of intrinsic and extrinsic possibilities through object-directed behaviour, effective self-care, and convivial relationships with others as well as adjusts to ensure reasonable flexibilities to achieve structural incorruptibility and congruence with the environment."*

Though this view seems a bit flexible, it has not been able to point to the extent to which it can be evaluated (Etobe, 2005). In another bold relief, health is painted as going beyond a specific status and oriented towards a resounding process of change indigenous to the various definitions of health from different people. In reacting to the scenario created by these definitions of health, one can safely conclude that health is a phenomenon that presents different impressions to different people or puts differently, society that an individual lives, creates an impression of health, and influences the conceptualization of health for example, an individual with rashes on the skin may be classified as unhealthy in a particular society, while in another society, such an individual is classified as healthy. Bar prejudice to the multiple views held on health, it could be regarded as a stage of life that an individual obviously functions maximally to the extent that the psychological and physical composition of an individual are logically and legitimately oriented to harnessing available opportunities and potentials for personal and communal benefits. The inspiration to satisfy the interest

of society in this perspective boldly emphasizes the desirability of a convivial environment as facilitating medium for appropriate health seeking behaviour. To attain this height demands that the rubrics and standard of health must be famously entrenched in the consciousness of society, to assess specific accomplishments, reactions and responsibilities. In doing this, care must be taken to prevent the weakness of cultures from dampening the actualization of these projections if such efforts are geared towards health as an asset with multiplier utility.

Health Seeking Behaviour Perspectives

Naturally Man exhibits different behaviour depending on the environmental objective components of the situation. Generally, an individual would exhibit positive behaviour in a promising situation and reacts correspondingly, if a contrary situation ensues. According to Nkanta (2019), in all societies the world over, a healthy population has the potentials to transform available resources for growth and development and in all contemporary societies, there are different methods of sensitizing the populace to the importance of health and procedures for avoiding the emergence of illness. Such messages could be delivered through the media, both the print and electronic. It should be noted that illness is repugnant to happiness, productivity, growth and development, in as much as the productivity of any society is a derivative of health, any imbalance in the body system is bound to cause a specific behaviour aimed at returning the body to a functional state that merits the social definition of health of such a society no matter the cost, provided the health of the individual is restored. Health is the goal of all societies and is only realized through the relevant behavioural architecture (Rabban 2011).

Given the sundry environments and experiences that man is continually exposed to, the sanctity of health seeking behaviour is described in recognition of the compelling influence of some variables in relation to realizing it. Behaviour that has to do with health requires an emancipated view, with adequate allowance to accommodate extraneous and innate capabilities necessary for the emergence of equilibrium between the health providers and seekers. According to Khadka and Ahikara (2022), taking decisions on seeking help varies from one person to another and depends on a variety of factors. Health seeking behaviour is a conscious human act that stems from the realization that the body is dysfunctional and requires treatment or cure (Iyalombe, 2011). This presupposes that such behaviour should show the natural willingness to get healed, It should reflect acknowledgement of the urgency of the situation, it should reflect actions in line with the available resources (in a situation where the cost of receiving treatment is beyond the reach of the sick), behaviour should indicate the preferred place for the treatment, the elected nature of the treatment, possible information on the cost, and payment regime (whether full or installmental) etc. It is prefaced by a decision directed by individual values and communal norms, expectations and the personal attributes of the health provider (Hubber, Knottnerus, Gran, Van der, Smith, 2011). Health seeking behaviour exposes the probable conditions that combine to produce a pattern of care seeking but remains adjustable (Olenja, 2003:12) quoted in Uche (2017).

Health seeking behaviour covers the attitude of the health seeker towards the health providers' doctors, nurses, herbalist, bonesetter, massager, diviners/fortune teller etc. In terms of adhering to instructions and showing respect and friendliness Ahmed, Tomson, Retzold & Kabir (2005), described it as any action or inaction undertaken by individuals who perceive themselves as having a health problem and deserving appropriate remedy. Linking health seeking behaviour with the level of development of a nation, it has opined that health seeking behaviour covers all the behaviour associated with establishing and maintaining a healthy physical and mental state, which in other words, is referred to as primary prevention. It describes behaviour that deals with any deviation from the healthy state, such as the control, prevention or reduction of impact and progression of an illness (Uche, 2017)

In the absence of any symptoms, realization of the importance of health, people put up frantic efforts to stay healthy. Such endeavors include taking certain types of food based on professional advice, regular and/or routine exercise to keep fit, abstinence from certain food and lifestyle and

reading health instruction literature and different other health boosting behaviours (Uchudi, 2011). This paper revealed that not all behaviours are commendable in relations to recovery from illness. While some health seeking behaviour are helpful and expedite recovery from illness, others are not, whereas they are all grouped under behaviour, this paper therefore defined health seeking behaviour as;

> *"the totality of behaviour exhibited by individual with the intention to prevent illness or recover from illness based on recognition of socio-cultural and economic implications of being overpowered by a state of health that introduces a state of life capable disrupting the potentials to live a self-sustaining life and promoting significant advancement of society.".*

According to Effiong, Kingdom and Wordu (2018), it demands a better balanced approach and broader perspective such as a comprehensive social model approach. It should be noted that the social model of health emphasizes the absence of illness as well as a state of general well-being associated with convoluted cultural, structural and other influences (Federal Ministry of Health, 2008; Ekong, 2006). Based on this awareness, many literature are focused on the actions taken to regain health on the arrival of symptoms, while those steps that do not facilitate recovery are down played, Though it is not possible to create a universally accepted category of these actions owing to certain socio-cultural differences, yet the frequency of behaviour and the attitude or interpretation of such behaviour in different cultures has made health seeking behaviour a popular issue (Sanders, 2011).

Various authorities have applied different theories and/or models to describe health seeking behaviour. Observably, a common strand that characterizes these submissions is that illness behaviour is a composite of two omnibus components; the personal and social. The personal component is an assemblage of actions and activities that must be carried out directly by the ill person, while the social component has to do with those actions and activities done by others, for example members of a household, extended family, clubs, communities and corporate bodies etc. The COVIC- 19 Pandemic was a critical experience and opportunity to judge the social component of health seeking behaviour of some societies. Societies that fail to provide or address the health challenges of her constituents do not have good health seeking behaviour as typified in, assessing health in the rural area through strenuous conditions and always compounded by various factors especially where chronic illness and disability that requires the effort of society to address are involved. Once the issue of health seeking behaviour among individuals, household and society is addressed dispassionately, there will be grave implication; illness of any kind must be efficiently managed no matter how minor they may appear to be as a sign of appropriate health seeking behaviour (Uche, 2017)

Mechanic's General Theory of Help Seeking Behaviour

This applies a social psychological approach to the study of illness behaviour. The theory aligns itself to the theoretical mythology of the looking glass self-concept, the definition of situation, the self process, the effect of group membership on health, and the effects of bureaucratization. Mechanic's general theory of help seeking places emphasizes on two principal themes namely: the perception or definition by an individual (or by the individual significant other's) of the situation at hand and the ability of the individual (or of the individual's significant other) to cope with the situation. He (Mechanic) employed the two variables to communicate why an individual is incapable to acknowledge a condition and refuse to allow it to alter his life, while another with a milder version of the same experience would exhibit thoroughgoing social and psychological disabilities. Here, Mechanic is of the view that variation in illness behaviour, which he defines as behaviour relevant *"any condition that causes or might usefully cause an individual to concern himself with his symptoms and seek help".* Principally, Mechanic's theory of help seeking facilitates an understanding of the behavioural process that ensues prior to searching for a care provider based on his condition. Mechanic in this view has escalated the Talcott Parson's (1951) analysis of illness behaviour through the inclusion of ill persons in the concept of help seekers. Two significant concerns birthed by this

explanation need to be addressed. To engender adequate understanding of the behaviour of an individual during illness, there is need for one to really appreciate the components of social, physical and psychological environment of the affected individual. Succinctly put, a better way to ask how an individual reacts to his illness is to ask how the experience started, that is the etiology of the illness should be ascertained (Suchman 1965). The second concern in studying illness behaviour has to do with ascertaining factors that promote variation in identifying the symptoms of the illness and linking these symptoms to illness and responding accordingly.

Determinants of Illness Behaviour

Arising from his analysis of illness behaviour Mechanic (1978), postulated specific factors that influence an individual's response to illness which he further classified into four main groups namely;

Group (a)
Those related to perception and conceptualization of the symptoms (visibility, recognisability or perceptual salience, and the extent to which the symptoms are perceived as serious). This to a tidy extent depends on the medical exposure and socio-cultural conventions of the individual. Those who had been socialized to a specific pattern of response would respond differently to a symptom than those who had not.

Group (b)
These are those that are concerned with the disruptive and persistent nature of the symptom. In other words, these are variables focused on the visible nature of the functional limitations caused by the illness symptoms. Under here, the level of impact the symptom creates on the family, job, social and related activities are considered, the frequency at which the deviant version of the symptom appears, the tolerance threshold of those frequently attacked, assess of the deviant signs and symptoms., available knowledge information and cultural assumptions and understanding of the person making the evaluation.

Group (c)
These ones are concerned with the competing needs of the individuals and the rational alternatives for understanding the observed disruptive symptoms. This group of factors includes the basic needs and the determination of their availability, as well as acknowledging the effects of their absence or denial.

Group (d)
This is also known as the residual group, it accommodates all effects of all non-social psychological factors. In addition to the four main groups Mechanic identified two additional levels of factors that determine illness behaviour namely

(i) Other -defined level and
(ii) The self -defined level.

The other-defined level refers to a situation in which other persons apart from the one that is ill, recognizes the ill person's symptoms and tries to classify the person according to the recognized symptom and recommend the attention of a professional. The ill person may reject the opinions as such, may only seek help under duress as commonly applied in psychotic and somatic cases etc. The self–defined level refers to a situation in which the ill person recognizes the symptoms and personally determines to seek help.

Evaluation of Suchman's Stages of Illness Behaviour
Suchman also presented his version of illness behaviour of an individual. He saw illness behaviour as. "The way in which symptoms are perceived, evaluated, and acted upon by a person who recognizes some pain, discomfort, or other signs of organic malfunction". The object of his analysis of illness

behaviour was identifying the trajectory in "seeking, finding and obtaining medical care'' and postulated a model that would demonstrate the behaviour of the individual from the perception and identification of the illness, to the time of recovery through the help of a professional health care provider. In the course of manifesting his model of illness behaviour, four outstanding elements which he regarded as propelling illness behaviour came to bear as: the content, the sequence, the spacing and the variability of illness behaviour. He integrated these four elements to formulate the following five concepts with which illness behaviour could be analyzed:

(i) Shopping - he used this to represent the process of seeking various places where medical attention can be accessed with the expectation and capacity of the ill person.
(ii) fragmentation - he used this concept to describe the process of receiving medical attention from different people for the same illness within the same location.
(iii) procrastination - this referred to the postponement of seeking care after identifying or recognizing symptoms.
(iv) Self-medication – the process of applying home remedies in person
(v) Discontinuity - the process of interrupting the treatment effort for sometimes based on certain reasons (Leya, Kageyama & Erviti-Erice 2021).

Applicability Suchman's Pattern of Decision Making during Illness

In analyzing how an individual takes decision during illness, Suchman postulated five stages as follows;

Stage of Symptom Experience

This stage reveals the realization that the organic functions when compromised, becomes abnormal. At this stage, three aspects of the symptoms must have manifested. Firstly, the individual must have been experiencing pain and uneasiness in the body. Secondly, there is consciousness of the fact the pain presages illness. Thirdly, there is a threatening emotional reaction to the symptom. Generally, the emergence of symptoms has always been treated as unimportant and incapable of precipitating harm until it threatens one's socialism– acceptable and gainful interaction with others.

Stage of Assumption of the Sick Role

This is the stage that the individual accepts that s/he is ill and deserves to seek medical attention from a healthcare professional. The ill person may at this stage demonstrate the readiness to regain health through self-medication, in addition to gathering information about the symptom from others. The ill person expects acknowledgement of his/her illness as well as the need to be assisted and exempted from duties by others. The promptings and efforts lay referrals are followed.

State of Looking For Medical Attention

At this state the lay referrals are suspended for professional attention. The knowledge of the ill person about the symptom is seen in this context as this would guide the source of professional care providers. This is a critical stage as the ill person may return to the lay referrals if the treatment at this point does not meet the expectation of the ill person.

Dependent - Patient Role

This is the stage the patient decides to comply with the instructions of the professional healthcare provider. According to Suchman, the ill person is not a patient until this stage at which he decides to transfer the control of the treatment process to the professional health care provider. Even when this decision has been made, the patient discontinues for several reasons including disparity in understanding the etiology of the illness. This requires a functional communication and relationship between the ill person and the professional health care provider. It requires the readiness of the ill person to comply with the treatment regimen in terms of frequency and /or regularity.

Recovery or Rehabilitation

This is a decisive stage in the treatment process. It summarizes the efforts of the professional healthcare provider and the ill person. At this point the ill person is discharged, asked to continue with the treatment or may discontinue on his/her own, or recommended for rehabilitation

Utilization of Health Services during Illness

Generally, there are two categories of health care: the Public or Population-oriented and the Private or Individual oriented. The two categories correspond to the two types of health services available: the public and private health services. Services Under the public health consist of: protection of air quality or pollution, immunization projects, water treatment, sanitation services etc. These services are public-oriented with little or no input from individuals. Private health services are oriented to the individuals and the individuals or representatives or sponsors supporters are expected to contribute towards. It should be pointed that most health services have to do with the private, and will be examined here, using the Andersen and Newman (1973) quoted in Wolinsky (1988) theoretical framework for the assessment of private health services because of it definition of health services utilization and provides an ideal type framework to health care researchers., as well as define health services into: types, purpose and unit for analysis. To measure health services according type, it could be discovered that there are long and short-term trends for the various health services like the hospitals, physicians, dentists, nurses, drugs, nursing homes etc. Previous studies identified individual determinants of utilization of health services are not the same (Sheeran and Abraham, 1996; Ng'ambi, Mangal, Philips, Colbourn, Mfutso-Bengo, Revil and Hallet, 2016)

From the perspective of purpose, the primary, secondary, tertiary and custodial care initiated by the Commission on Chronic Illness in the United States is examined. Traditionally, the primary, secondary, tertiary and the custodial represent perform different functions. The prevention of the outbreak of disease falls under the duties of primary health care. Primary Health care

> *"as defined by 1978 Alma Ata Declaration is "essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community and through their full participation and at a cost that individuals and communities in the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".*

It is the first tier of health care that provides the first contact to individuals, the family and the community. It helps to bring health care as close as possible to where people live and work. It constitutes the first element of continuing healthcare with a scientifically sound process. *"Scientifically sound"* Implies that all health practices and technologies, both orthodox and traditional shall be evaluated to determine their efficacy, safety and appropriateness (Etobe 2005).

Deducing from the above idea, a perfect guide has been volunteered to ease the suitability or otherwise of this theory in discussing, assessing health seeking behaviour in relation to the utilization and of health services. One critical question that begs for answer in this context is the capacity of our society to provide the needed health services with particular attention to scientific operations. According to the National Health Policy (1996), quoted in Etobe (2005), Primary Health Care has the duty of providing general health services at the health centers, Dispensaries, Maternity homes, Domiciliary Midwifery etc. and to be funded by the local government. In the contemporary economic situation in the country coupled with the poor attitude of the leaders to ensure conscientious and religious implementation of citizenry-oriented policy and programmes, the provision of the appropriate health care facilities for effective discharge of primary health services becomes an unrealizable dream and a corruption of health seeking behaviour.

Secondary Health Care

Health institutions that provide secondary health services are General and Cottage hospitals, Comprehensive health Centers etc. Services at this level are restorative, that is, it means to restore the individual to the state before the emergence of symptoms. Institutions under the secondary health care serve as referral centers to the primary health care centers. They provide services on departmental basis namely; the out-patient, in-patient, medical, surgery, pediatric and community services, laboratory, diagnostic, blood bank, physiotherapy rehabilitation.

Tertiary healthcare

In Nigeria, this is the third tier of the health care system. It consists of special institutions such as; specialists and teaching hospitals, health research institutions. They are concerned with specific cases and manned by medical experts in various fields. Here teamwork is the general norm. Special investigation that can be done here include brain scan, histology, barium meal, renal dialysis, anesthesia, salpingoscopy, hysterectomy, prostatectomy, laparotomy, oophorectomy, tracheostomy, electroconvulsive, nephrectomy, neuro-surgery, heart surgery.

The Custodial Care

This is concerned with the personal needs of individual patient and does not and the treatment of diseases in Nigeria, this department is not yet popular in her health care system. Inputs may be gathered from the agencies that offer services of this nature and such information could be transposed.

Unit of Analysis

Action in this direction can be done under three headings namely: Contact, Volume and Episode. The beauty of applying this pattern is that it would help to ascertain the characteristic of the individual and this may expose the individual to illness episode or the previous case was reported to health professional for the necessary medical attention. Studies have shown that individuals exposed themselves severally to illness at various time but refused to take the appropriate steps to healing. Similarly the characteristics of the delivery system including the disposition of the also contributes to frequency or otherwise of illness episodes.

Models for Assessing Health Services Utilization in Society

With the benefits of research done by scholars in the past, many models for assessing the utilization of health services had been developed namely: The demographic Model. Under this model variable commonly considered are age, sex, marital status as representative variables as symbols of physiological (age and sex) and life cycle (marital status, family size) states assuming that different levels of health, illness and the utilization of health services are connected with these different states. Demographic information equally aligns social attributes like the distinction of gender which may affect interaction in society.

Social Structural mode

This model presents variables such as education, occupation, ethnicity as affecting the level of utilization of health services as they influence construction of personality and lifestyle which the use of healthcare facilities is among.

Social Psychological Model

Characteristics largely considered in this category are the individual attitude and belief. This model collapses into the perceived susceptibility to disease or illness, the perceived seriousness of the disease or illness and the expected benefits of taking using the health services for recovery. The application of this model tends to indicate why people behave the way they do instead of trying to assess the use of health services based on the psychological promptings of the ill person.

The Family Resource Model

Components of this model are regular source of healthcare (private or public) health insurance coverage; under this model the ability of the family to afford healthcare services is emphasized. This model is microeconomic and focuses on the ability of the individual to pay for health services as frequently as he can pay for.

Community Resource Model
This is essentially a macroeconomic supply model. It concerns itself with the totality of health resources accessible within a particular area. The model moves the utilization of health services from the individual angle to the ability of the community to supply or provide the needed health services.

The Organizational Model
This model compares the use of health services by individuals in one healthcare delivery system with individuals of similar characteristics in another health care delivery system. This model focuses on the availability of different health care delivery like solo, partnership, group, or health maintenance organization as well as the nature of delivery system that is whether it is fee-for service, prepaid, salaried, location of treatment (private office, hospital or clinic) or the health workers who first on the patients ‘s contact list (physicians, nurses).

The System Model
This model illustrates how changes in one category of characteristics influence other characteristics through the whole healthcare system

The Health Belief Model
This is a famous model of assessing the utilization of health services. It emerged in the 1950‘s from the effort of social psychologists Hochbaum, Rosenstok and others who were worked in the US Public Health Service and different confronted similar health challenge between the 50’s and 60’S principally, the failure of the public to accept preventive drugs and screening tests for tuberculosis, Polio and asymptomatic diseases. The model is based on the Lewinian theory and proposes that an individual would take action against disease based on factors namely: the perceived susceptibility, perceived seriousness, perceived benefit and barrier to taking a particular action, the cues that motivate the action process in the individual. However, people could work closely to overcome the physical and sociological barriers within their communities through a holistic approach to their environment in the areas of health (Effiong and Ekpenyong 2017).

Is There A Swiss-Knife Model For Determining Health Services Utilization In Relation To Health Seeking Behaviour?

Health seeking behaviour of persons is a complex phenomenon that has defied a specific descriptive endeavor. This is not unconnected with heterogeneous socio-economic and cultural circumstances or characteristics of individuals, resultantly, many are found displaying different behavioural traits at various stages of their illness. In an attempt to regain health or prevent illness, one would expect the ill person to take maximum advantage of the professional health services available in the environment for example, though there are General Hospitals and Health Centers in each of the thirty-one local government areas of Akwa Ibom State, yet, experience revealed low traffic of ill persons to these facilities for treatment, and of the number of those that visit them, a greater percentage of them would only be prodded to do so, mostly when the illness had reached an avoidable critical stage. The study of help seeking behaviour through the intellectual lenses of Mechanic and Suchman’s models vis-a-vis the utilization of health services revealed that no single model is able to address the peculiarities of the Nigerian societies. The demographic, social structural, social psychological, family resource, community resource, organizational, health system model and the health Belief model have not taken notice of the state of insecurity, corruption, stigmatization, absence of basic infrastructure, incessant

strikes by health care providers, kidnapping, communal skirmishes, farmers and herders clashes as variables capable of influencing the use of health services. Again all the models cannot be used at the same in explaining utilization of health services issue in Nigeria. The situation in present Nigeria invites a home-made approach aimed at motivating the provision and utilization of health services during periods of illness.

CONCLUSION AND RECOMMENDATIONS

Behaviour during illness had for a long time constituted a sociological gordian knot among ill persons, health care providers in societies, and ignited a deluge of models and variegated theoretical dispositions among scholars. Granted these opinions, the series of behaviour commonly exhibited by ill persons within the tenure of illness had been susceptible to asymmetrical evaluations. This study revealed that with plenteous models in assessing the behaviour of persons during illness, no specific model for categorizing the behaviour had been entrenched and no specific model could aptly accommodate the Nigerian situation in recognition of her peculiar circumstances. Arising from these observations, this paper painstakingly undertook an appraisal of these issues through the prisms of Mechanic and Suchman's ideas of Help Seeking behaviour at various stages of illness vis-a-vis the efficacious utilization of health services in the Nigerian societies., propounded the "Motivational model", which is an embodiment of incentives to the ill person to avail him/herself of health services at his disposal, the professional healthcare providers, the host communities to health facilities, the governments and stakeholders in the provision and maintenance of healthcare and ancillary Amenities. The study made recommendations to change the narrative in the matter of ascertaining the commensurate utilization of health services as an aspect of health seeking behaviour as well as serve as a working tool for the formulation of healthcare policies in the country

i. Government and sundry stakeholders in the utilization of health services should inaugurate policies for free treatment packages for some illnesses. The packages should accommodate, feeding and free drugs to motivate the utilization of health services and a model for assessment of the utilization of health services by help seekers should be based on the extent of motivation at the disposal of the ill persons.
ii. Government should evolve and enforce strategies for promoting cordial relationship between the health services providers and the ill persons, and a model that seeks to ascertain the implementation of this cordial relationship applied in the course of assessing the utilization of health services.
iii. The National Database should be strengthened to synergize individual data with phone numbers, to replace the drudgery associated with documentation of ill persons at health facilities prior to actual meeting with the relevant health care providers, and a model of assessment in this perspective put in place'
iv. Reliable security at the healthcare facilities for both the personnel and the ill persons to address the burgeoning spate of kidnapping, banditry, communal clashes, vandalism, armed robbers, cultism etc. should constitute a model for assessing the extent of utilization of health services.
v. A model for entrenching the conscientiousness of partnership in the ownership of health services between the providers and the host communities should be in the psyche of the people for effective management and patronizing of the health services; Idea is that once the host communities see themselves as co-owners of such facilities, this would boast patronage.

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