



**International Journal of TROPICAL DISEASE  
& Health**  
2(2): 62-71, 2012



SCIENCEDOMAIN *international*  
[www.sciencedomain.org](http://www.sciencedomain.org)

---

## **Health-Seeking Behavior of Rural Dwellers in Southern Nigeria: Implications for Healthcare Professionals**

**Godfrey B.S. Iyalomhe<sup>1\*</sup> and Sarah I. Iyalomhe<sup>2</sup>**

<sup>1</sup>*Department of Pharmacology & Therapeutics, College of Medicine,  
Ambrose Alli University, Ekpoma, Nigeria.*

<sup>2</sup>*Department of Public Health and Primary Healthcare, Central Hospital, Auchi, Nigeria.*

**Review Article**

**Received 27<sup>th</sup> October 2011**  
**Accepted 24<sup>th</sup> January 2012**  
**Online Ready 4<sup>th</sup> March 2012**

---

### **ABSTRACT**

The Nigerian rural people demonstrate undesirable health-seeking behavior because of their cosmological and nosological notions which ascribe etiology of diseases and ill-health to entities far beyond the realm of the stethoscope. The present review is therefore solicited to enhance the health status of rural dwellers by providing potentially useful guidance that will enhance the knowledge of healthcare professionals with respect to the peculiar health-seeking behavior of rural dwellers so as to promote good patient-physician interaction and to provide empirical basis for rational health policy formulation. A manual literature and internet (Google, Medline, Embase, HINARI and Cochrane data bases) search showed that in a pluralistic medical milieu in which the rural dwellers find themselves, the decision to seek healthcare, where to do this and the form of care perceived as appropriate are all influenced by a multiplicity of factors relating to the person, the facility and the socio-cultural environment.

Primarily, religious beliefs, use of Traditional African Medicine (TAM) and patients' perception of reality influence health-seeking behavior. In order to adequately and successfully manage the Nigerian rural patients, the healthcare provider must pay attention to patients' impression of illness and underpinning health beliefs during consultation, in therapeutics and in handling evolving complications of TAM and ethical dilemmas. Improvement of rural infrastructure and behavioral health promotion campaigns among the rural people together with rational health policy formulation and regulation of TAM practice, are imperative.

---

\*Corresponding author: Email: [goddyiyalo@yahoo.com](mailto:goddyiyalo@yahoo.com);

*Keywords: Health-seeking behavior, rural dwellers, Nigeria, healthcare professionals.*

## **1. INTRODUCTION**

Health is the main aspect of human life. Although a healthy life is the desire of everyone, the reality is that everyone is not healthy. An essential aspect of preserving health is to identify the factors that enable or prevent people from making healthy choices in either their life-style or their use of medical care and treatment, the underlying assumption being that behavior is best understood in terms of an individual's perception of their social environment (Tipping and Segall, 1995). Sheeram and Abraham (1996) categorized the range of behaviors that has been examined using health belief model into three broad areas: preventive health behavior, sick role behavior and clinic use. In this type of model, individual beliefs offer the link between socialization and behavior. When individuals make decisions in relation to their health, they weigh up the potential risks or benefits of a particular behavior. They do so in a way that is influenced by their immediate physical environment, social rootedness, life-style, religious belief and their whole outlook on life generally (Norman and Bennet, 1996; WHO, 2002; Orubuloye, 2003). Thus various authors (Fabrega, 1973; Tanahashi, 1978; Egunjobi, 1983; Aregbeyen 1992; Orubuloye 1992; Ademuwagun, 1998) have noted that in a pluralistic medical milieu in which the rural dwellers find themselves, the decision to seek care, where to do this and the form of care perceived as appropriate are all influenced by a multiplicity of factors relating to the person, the facility and the socio-cultural environment. According to Tanahashi (1978), the level of functionality of a health facility or service may be measured by the degree to which it is accessible, affordable, acceptable and available to its potential users. Other relevant socio-cultural factors which affect the perception of health and wellbeing include religion, availability of relatives in the hospital or connection with hospital staff, family decision, marital status, position in the family, educational status and also very importantly the nature of the illness (Omotosho, 2010).

The polarisation of Nigerian society into a large rural sector and a small urban component provides a basis for the inadequate provision of infrastructure. For instance, over 65% of Nigerian population who live in the rural areas are most neglected and deprived of modern healthcare services as well as other modern infrastructural necessities that are essential to the maintenance and promotion of good health (Olujimi, 2006; Ewhrudjakpor, 2008; Omotosho, 2010). This situation is unfortunate as the majority of the nation's population who produce the nation's food needs including valuable export crops reside in the infra-structurally underserved area. In some areas where medical facilities exist, they are not sufficiently patronized to promote the sustenance of the healthcare services because of the undesirable health-seeking behavior of rural dwellers (Olujimi, 2006). It is in this unhealthy state of affairs that the present review is designed to enhance the health status of rural dwellers by improving the knowledge of healthcare professionals with respect to the peculiar health-seeking behavior of this category of people. This understanding will assist the healthcare providers during consultation, in therapeutics; in handling complications of TAM and evolving ethical dilemmas as well as provide empirical basis for proper and rational health policy formulation for rural dwellers, particularly in Nigeria.

## **2. HEALTH-SEEKING BEHAVIOR**

Community ideas and attitudes toward health and illness affect the way they utilize health services. This is because these ideas and attitudes provide ideological basis for the healthcare system (WHO, 2002; Omotosho, 2010). In Nigeria, and in many developing countries, the factors that commonly affect the way rural dwellers shop for health include.

### **2.1 Religious Beliefs**

Everywhere, the quest for health easily shades into issues of morality and religion because the latter plays a significant aspect of social life. The rural populace has cosmological and nosological notions which ascribe etiology of diseases and ill-health to entities far beyond the realm of the stethoscope. They believe that the doctor knows all and can cure all provided the right conditions are fulfilled. Hence, treatment of diseases classified as “common” or “ordinary” is diffused using either traditional or allopathic medicines while those classified as “severe” or “extraordinary” usually require special (traditional) attention (Olujimi, 2006; Ewhrudjakpor, 2007; Omotosho, 2010).

The basic explanatory theory is that in serious illness, there is an underpinning of the supernatural. The most frequently evoked agency is ancestor spirit anger. Ancestor spirits constitute part of the ordered structure of the African cosmology. Upsetting the ancestors produces a disturbance of this order and hence disharmony and illness. In African thought, all living things including man are linked in harmonious relationships with the gods and the spirits, so that reality consists in the relation not of man with things but of man with man and of all with the spirits. Such relationship is ascribed to vital forces which each entity generates. A state of health exists when there is perfect harmony between man and his environment. This belief is inherent in those who practice African Traditional Religion as well as in many Christians and Moslems (Mbiti, 1987; Ewhrudjakpor, 2008).

On the other hand, ill health and other misfortunes can result from a disturbance in the relationship between man and his social cum spiritual environment, or from forces directed by witches, wizards, sorcerers, evil spirits or angered ancestors because of infraction of totemic principles (Mbiti, 1987). The popular notion is that “people do not just suffer illness by chance” therefore, serious illness is believed to have its origin in a primary supernatural cause. There is no difficulty, however, in accepting biomedical explanations based on the presence of viruses, bacteria, parasites, cancer or high blood pressure; these are simply seen as secondary causes. The idea of primary causation provides an explanation as to why a particular individual, and not others in the group, is afflicted by these infectious agents (Kroeger, 1983; Twumasi, 1988).

### **2.2 Traditional African Medicine (TAM)**

Since tam has been with the rural dwellers for generations and also for the fact that orthodox medicine is often in short supply, their approach in times of ill health is first towards TAM. It is when this fails that they result to chemist shops or medicine vendors and then the hospital as a last resort (Katung, 2001). In TAM, divination (consulting the oracles), confession, ritual sacrifices, incantations and potions made from plant and animal parts are essential components of illness management (Sallah, 2007). These are aimed at restoring the patient to a harmonious relationship with his environment and/or counteract the effect of evil forces. In every instance where an illness is diagnosed to be due to ancestor spirit anger, there is

usually an antisocial act of commission or omission by the person who must usually confess the misdemeanor, followed by ritual sacrifices to appease the offended supernatural agency before he can be expected to recover (Badru, 2001). Confession, that is admission of guilt, is crucial for therapeutic success. In other words, although the illness is attributed to ancestor spirit anger, the trigger for this is the sin against moral laws committed by the afflicted person. It can, therefore, be said that ancestor spirit anger in TAM is a metaphor for emotional upheaval arising from guilt, anxiety and fear of ancestor spirit intervention in the minds of culturally socialized individuals. Such emotional torture can initiate a stress syndrome which may depress the immune system of the culprit making him more susceptible to serious illness than a devout member of the community (Okpako, 1991; Calhoun, 1992; Jegede and Onoja, 1994; Raikkonem et al., 1996; Sallah, 2007).

Since rural patients tend to shop around for healthcare depending on how they perceive ailments, their gender and position in the family, and their socioeconomic status (Kroeger, 1983; Olujimi, 2006), it is not uncommon nowadays to find that at the primary, secondary, and tertiary levels of healthcare, they secretly or openly combine traditional and allopathic medicines either sequentially or concurrently (Aregbeyen, 1992; Ewhrudjakpor, 2008; Iyalomhe, 2009a). Anecdotal reports abound about medical doctors who combine orthodox drugs with traditional remedies in collaboration with the traditional healers. This amounts to association with unqualified people which is a serious professional misconduct (Medical and Dental Council of Nigeria, 2004).

TAM practitioners claim they can successfully handle all manner of health problems. From febrile illness and infections such as malaria, tuberculosis, sexually transmitted diseases including HIV/AIDS; pains, aches and arthritis; convulsive disorders like febrile convulsions and epilepsy; hypertension, congestive heart failure and stroke; cough and asthma; diabetes mellitus and cancer; obstetric and gynecological problems including infertility; orthopedic problems like fractures to minor/major psychiatric disorders as well as various skin diseases. Other traditional healers specialize in medicines that empower one to commit crimes and escape safely, vanish in time of danger, assault or accident and to remedy witchcraft effects as well as bad luck. Other specialists undertake traditional surgical procedures such as male and female circumcision, ethnic or cultural body markings for identification or beautification purposes, tattooing, herbal skin incisions, bloodletting, uvulectomy and keratectomy. Hysterotomy is usually done to remove a fetus from a dead pregnant woman because many Nigerian traditions forbid the burial of the woman with the fetus (Tanahashi, 1978; Erinosh, 1989; Aregbeyen, 1992; Sallah, 2007; Iyalomhe, 2009a; Omotosho, 2010).

The roles of the Traditional Birth Attendants (TBAs) and Traditional Bone Setters (TBSs) in TAM are noteworthy. Between 60-80% of deliveries particularly in rural areas are taken by TBAs (frequently elderly women with no formal or medical education but whose forbears have coaxed the birth of generations of children) for reasons such as the good reputation of the TBA, personalized care, cheap fees and accessibility (Abioye-Kuteyi et al., 2001; Iyalomhe, 2009a). In the same vein, despite criticisms and supposed antagonism from orthodox medical practitioners, over 70% of Nigerians mainly in the rural areas, still rely on the TBS for primary fracture care because of the widespread belief that the TBS uses a traditional remote control means to hasten the reduction and healing of fractures (Onuminya, 2004). For example, he may deliberately fracture a fowl limb for sequential reduction and manipulation claiming that when the fowl's limb is set, the patient's fracture will be set as well (Iyalomhe, 2009a).

### **2.3 Denial of Reality**

Majority of the rural dwellers are at variance with reality when it comes to treatment of chronic diseases such as diabetes mellitus, bronchial asthma, hypertension, congestive heart failure, arthritis, epilepsy and schizophrenia. Because of repeated follow-up treatments and check-ups, they conclude wrongly that orthodox medicine does not have effective remedy for such diseases. Therefore, they opt for TAM (Olujimi, 2006; Omotosho, 2010). Whenever the rural dwellers envisage that treatment outcome may be unsuccessful e.g. during critical illnesses like terminal cancer, coma, tetanus, dementia and babies with congenital abnormalities, they usually discharge home such patients against medical advice. This may be a subtle way of practicing traditional euthanasia (Iyalomhe, 2009b). This is all the more reason why the practitioners must be compassionate, sensitive and constantly give reassurance even though the condition of the patient is poor. On a very serious note, practitioners must be wary of making prognostic statements concerning treatment outcomes or possible death because when events turn out to the contrary, they may be stigmatized. This is because the rural dwellers hardly accept the reality of failed treatment or death. Their firm belief is that doctors treat and make patients well (Atemie and Okaba, 1997; Ewhrudjakpor, 2007).

The acceptability of family planning methods especially Intra-Uterine Contraceptive Device (IUCD), Oral Contraceptives (OCs) and bilateral tubal ligation (BTL) among rural populace leaves much to be desired. Life-style modification in the management of such diseases like hypertension and diabetes mellitus are hard for the rural dwellers, hence the consequences of non-adherence must be carefully explained to them each time (Aregbeyen, 1992; Iyalomhe and Iyalomhe, 2010; Omotosho, 2010). There is a clear-cut gender bias in hospital treatment of diseases because more emphasis is laid on treatment of male children and adults, perhaps because they are believed to be home keepers (Erinosho, 1989).

## **3. IMPLICATIONS OF HEALTH-SEEKING BEHAVIOR FOR HEALTHCARE PROFESSIONALS**

The health-seeking behavior of the rural dwellers reveals the level of health/disease awareness in the rural community. Healthcare providers must pay more attention when dealing with this category of people. In particular, the following aspects must be emphasized.

### **3.1 Consultation**

Since the rural patient has been used to being told his/her problems by the traditional healers before complaining, he/she gets surprised, if not disappointed, when on getting to the clinic the doctor who is supposed to know all diseases asks for presenting complaints. To obviate this, we have learnt to start by saying to the rural patient "You have a fever" when the temperature is obviously high; or "You are sick!" Then, of course, he/she volunteers all the necessary information in the history taking. In taking drug history, you must assume that he/she may have taken many drugs by asking "Which drugs have you been taking?" You may be surprised that he/she may narrate a litany of drugs. If you ask "Have you been taking any drugs?", the obvious answer you may get is most likely to be "No, doctor", because he/she feels you may be offended that some native or other medicines have been used prior to clinic attendance (Iyalomhe, 2009a; Iyalomhe and Iyalomhe, 2010).

### **3.2 Therapeutics**

In TAM, in order to get greater effect, the rural patient increases dosage or frequency of usage of native medicines. Also, serious side effects like profuse diarrhea, dizziness or sudden collapse from orthostatic hypotension are interpreted to mean that the medicine is “powerful and efficacious” particularly when the patient survives the illness. Also one native medicine may be used to treat many disparate diseases quite unlike modern medicine (Okpako, 1991; Atemie and Okaba, 1997). Indeed, any medicament that has multiple efficacies has the potential for equally producing multiple adverse effects. This is all the more likely when in the case of herbal medication adherence to strict dosage regimen is not the common practice (Omogbai, 2009). Monitoring and documentation of the adverse effects of herbal medicines is not a routine practice. The healthcare professional should therefore take note of presenting symptoms of rural dwellers as these may be adverse effects of traditional medicines (Okpako, 1991). Patients should be advised to restrict themselves to either orthodox or traditional medicine at particular times.

The above phenomenon becomes a problem in therapeutics when the rural patient finds it difficult to adhere to treatment regimens. It is not surprising to find the rural patient taking a five-day course treatment in three days because he/she wants to get well faster. He/she may be taking 3 prescribed drugs sequentially instead of concurrently because he/she wants to keep the remaining drugs for future use or for the use of other relatives. Adverse events may not be reported because they are adjudged to mean that the drugs are very efficacious (Iyalomhe, 2009a). The WHO (2004) has noted that among users of herbal products, there is a widespread misconception that “natural” always means safe and that remedies of natural origin, unlike cosmopolitan medicines, are harmless and carry no risk. This notion is more deep-rooted among the poor and uneducated rural users of traditional medicines in developing countries (WHO, 2004; Omogbai, 2008).

Since it is known that rural patients are usually adherent because of the traditional healers’ warning of the consequences of non-adherence, we have found the principle very effective in getting patients to be adherent with treatment or life-style adjustments. For example, we make statements such as, “If you don’t finish this treatment, the sickness may come back”; “If you continue to smoke cigarette, the operation wound may not heal easily or you may get cancer or heart problem”; “If you continue to drink alcohol, you may have liver problem or suffer from erectile dysfunction;” “If you stop these antihypertensive drugs you may have a stroke”. In fact, patients enjoy hearing the statements and they usually comply (Thomson et al., 2001; Say and Thomson, 2003; Iyalomhe, 2007).

### **3.3 Complications from TAM**

While many of the practices of TBAs are positive in meeting the caring needs of women in the maternity cycle particularly in the local communities, they however, engage in some harmful practices detrimental to the mother and the baby in pregnancy, during and after labor e.g. lack of asepsis of material and equipment, applying dirty herbal preparations intra-vaginally in order to facilitate labor or accelerate placental delivery, cutting the cord with dirty local instruments or rubbing unsterile concoctions on it thus increasing the risk of tetanus infection. Some female circumcisers sometimes over-do the procedure and perform clitoridectomy (Abioye-Kuteyi et al., 2001). Other traditional surgeons generally have recourse to aseptic techniques. Profuse hemorrhage and infections are frequent complications (Asuni, 1979; Iyalomhe, 2009a).

The outcome of TBS treatment is good for closed fractures of the shaft of the humerus, ulna, radius and tibia but very poor for peri-articular and open fractures. Non-union, mal-union, infections (e.g. traumatic osteomyelitis, tetanus) and limb gangrene are common major complications (Onuminya, 2004).

It is a mere paradox that traditional healers' native surgical practices which have served to fill the gap left by inadequate modern health provision mostly in rural areas in Africa nay Nigeria, also harbor the risk of HIV/AIDS spread through inadvertent exposure to blood and blood products. Majority of the victims are unfortunately women, and children who may escape HIV infection from their mothers only to be infected by the unaware traditional healer. The WHO and other health agencies are concerned and reacting to the situation (Ana, 2001; Salako, 2007).

### **3.4 Ethical Dilemmas**

As already indicated, some rural patients refuse orthodox medical treatment for certain illnesses e.g. stroke, schizophrenia, fractures but would want excuse duty certificates to cover periods of absence from work after treatment with traditional medicine. Some want death certificates for patients who discharged against medical advice or relatives who died at home having refused hospital treatment outright. Should a doctor certify that which he has neither witnessed nor verified? To resolve the dilemma of issuance of excuse duty or death certificate in the above circumstances, we suggest that a doctor can direct members of the family to depose to an affidavit in a court of competent jurisdiction and proceed to birth/death registry to obtain a certificate and on the strength of this the doctor can issue that medical certificate which may be badly needed for official matters (Asuni, 1979; Iyalomhe, 2009b).

Dilemmas can also arise in relation to what the attitude of the doctor should be in a situation where there is conflict of claims between a patient's wish and his/her interest as seen by the doctor? For example, what should be done with a patient who needs to take an injection but refuses e.g. a stroke patient whose condition is widely believed by rural dwellers to be worsened by injections? Conversely, should a doctor succumb to the demand by a rural patient for an injection which, in the practitioner's view, is unnecessary though harmless? A good doctor-patient relationship and adequate explanation of the situation may resolve these dilemmas (Ademuwagun, 1998; Iyalomhe, 2009b). What should be the attitude of a doctor to a rural woman with obvious health problems who has 13 children but rejects family planning and pleads passionately with the doctor to help her achieve the 14<sup>th</sup> pregnancy so that she can have a traditional title? This patient needs sympathetic explanation that her health needs to be preserved above all.

The reality of surgical intervention in disease management is most of the time unacceptable if not abhorrent to the rural dwellers, particularly mutilative operations like mastectomy, hysterectomy, amputations and even Caesarean section. Some may prefer to die rather than undergo the operation claiming that none of their family members has done such before and that any dismemberment may affect them in the hereafter. A careful explanation to bring the patients to focus is essential here, making them realize that it is normal that certain events have to occur in some people at particular times in life and that surgical operations here have nothing to do with the hereafter.

#### **4. CONCLUSION AND RECOMMENDATIONS**

In order to adequately manage the rural patients, healthcare providers need to be more compassionate and caring so as to improve interpersonal relationships and communication. More also, they should possess integrity, creativity and sensitivity, paying close attention to patients impressions of illness and underpinning health beliefs. The physician-patient consultation can be one way of promoting understanding of patients' perceptions of illness and desirable health-seeking behavior. Overtly challenging the patients' health belief can result in non-adherence and treatment failure especially if the patients view a chronic illness such as hypertension or diabetes mellitus as an intermittent disease that requires ephemeral treatment (Iyalomhe and Iyalomhe, 2010). Exploration of these issues will result in effective disease management in rural areas and reduce ethical dilemmas.

A comprehensive healthcare system in Nigeria has to focus more on the 65% of rural people who are the poorest of the poor. There should be a coordinated effort to improve rural infrastructure and design behavioral health promotion campaigns to inform and educate the rural people that the desirable health-seeking behavior is to patronize health facilities for medical treatment by qualified healthcare providers (Tipping and Segall, 1995). Policy makers must understand health-seeking behavior and health use at the rural areas and give enough credence to these facts so that policies could be designed appropriately. The Federal Government of Nigeria should take a bold step to regulate the practice of TAM and establish a working relationship (cooperation or collaboration) between TAM practitioners and orthodox medical doctors, so that the comparative advantages that the two complementary health systems provide can be fully harnessed by Nigerians. Government should employ adequate health personnel in rural areas; embark on their continuing education and training, and provide them incentives not only to retain them but also to motivate them to deliver quality services.

#### **COMPETING INTERESTS**

Authors have declared that no competing interests exist.

#### **REFERENCES**

- Abioye-Kuteyi E.A., Elias S.O., Familusi A.P., Fakunle A., Akinfolayan, K. (2001). The role of traditional birth attendants in Atakumosa, Nigeria. *J. Royal Soc. Health*, 12(2), 119-124.
- Ademuwagun, Z.A. (1998). The challenge of the co-existence of orthodox and traditional medicine in Nigeria. *East Afric. Med. J.*, 53(1), 21-32.
- Ana, J.N.E. (2001). Native (traditional) surgical operations and the spread of HIV/AIDS in Africa. *B. M. J. (West Africa edition)*, 4(2), 40-44.
- Aregbeyen, J.B.O. (1992). *Healthcare Utilization in Nigerian Rural Communities: A Focus on Otuo Community and Environs in Edo State*. Nigerian Institute of Social and Economic Research (NISER) Monograph Services No. 3.
- Asuni, T. (1979). *The Dilemma of Traditional Healing with Special Reference to Nigeria*. Ibadan University Press, Ibadan, pp: 1-35.

- Atemie, J.D., Okaba, B.O. (1997). Socio-Cultural Context of Western and Indigenous Medical Practices in Africa. Osia International Publishers Ltd., Port Harcourt, pp: 32-46.
- Badru, F.I. (2001). Sociology of health and illness relations, in: Olurode, L., Soyombo, O. (Eds.), *Sociology of Health and Illness Relations*. John West Publications, Ikeja, pp: 326-355.
- Calhoun, D.A. (1992). Hypertension in blacks: socio-economic stress and sympathetic system activity. *Am. J. Med. Sci.*, 304(5), 306-311.
- Egunjobi, T.O. (1983). Characteristics of the healthcare resource production in Nigeria. *Canadian J. Afric. Studies*, 17(2), 142-149.
- Erinosho, O.A. (1989). Healthcare and Healthcare Services in Nigeria. Africa Development Foundation, Washington, pp: 1-25.
- Ewhrudjakpor, C. (2007). Conceptualizing Africans' perception of disease as distinct from Euro-American practice. *J. Soc. Policy Issues*, 4(3), 8-11.
- Ewhrudjakpor, C. (2008). Cultural factors blocking the utilization of orthodox medicine: A case study of Warri Area in Delta State of Nigeria. *Rev. Sociol.*, 14(1), 103-119.
- Fabrega, H. (1973). Towards a model of illness behavior. *Med. Care*, 2, 22-44.
- Iyalomhe, G.B.S. (2007). Compliance to antihypertensive therapy. *Niger. Clin. Rev. J.*, 63, 12-16.
- Iyalomhe, G.B.S. (2009a). The practice of traditional African medicine in Nigeria. *J. Afric. Traditions Development*, 1(2), 81-93.
- Iyalomhe, G.B.S. (2009b). Medical ethics and ethical dilemmas. *Niger. J. Med.*, 18(1), 8-16.
- Iyalomhe, G.B.S., Iyalomhe, S.I. (2010). Hypertension-related knowledge, attitudes and lifestyle practices among hypertensive patients in a sub-urban Nigerian community. *J. Public Health Epidemiol.*, 2(4), 71-77.
- Jegede, A.S., Onoja, A. (1994). Knowledge, attitudes, beliefs and practices related to yellow fever in Delta State of Nigeria. Monograph of study supported by the National Task Force on the Eradication of Yellow Fever in Nigeria; Federal Ministry of Health, Lagos.
- Katung, P.Y. (2001). Socioeconomic factors responsible for poor utilization of PHC services in rural community in Nigeria. *Niger. J. Med.*, 10, 28-29.
- Kroeger, A. (1983). Anthropological and socio-medical healthcare research in developing countries. *Soc. Sci. Med.*, 17, 147-161.
- Mbiti, Z.S. (1987). *African Religions and Philosophy*, McGraw-Hill, London, pp: 120-165.
- Medical and Dental Council of Nigeria Abuja (2004). Code of Medical Ethics in Nigeria, pp: 1-74.
- Norman, P., Bennet, P. (1996). Health locus of control, in: Cornner, M., Normans, P. (Eds.), *Predicting Health Behaviors: Research and Practice with Social Cognition Models*. Open University Press, Buckingham, pp, 197-225.
- Okpako, D.T. (1991). Traditional African medicine: theory and pharmacology explored. *TiPS*, 20, 482-485.
- Olujimi, J. (2006). Significant factors affecting patronage of health facilities by rural dwellers in Owo Region. Nigeria. *Soc. Sci.*, 1(3), 206-215.
- Omogbai, E.K.I. (2008). Functional guidelines for assessment of the toxicity and adverse effects of herbal medicines in a third world setting. *Ethnopharmacology*, 2, 41-55.

- Omotosho, O. (2010). Health-seeking behavior among the rural dwellers in Ekiti State, Nigeria. *Int. Multi-Disciplinary J.*, 4(2), 125-138.
- Onuminya, J.E. (2004). The role of the traditional bone setter in primary fracture care in Nigeria. *South Afric Med. J.* 94(8), 652-658.
- Orubuloye, I.O. (1992). The impact of family and budget structure on health. *Health Rev.*, 2, 189-210.
- Orubuloye, I. O. (2003). Disease, Illness and Society. Centre for Population and Health Resources, Ado-Ekiki, Nigeria, pp. 1-26.
- Raikkonen, K., Hantaten, A., Keltikangas-Jarviven, L. (1996). Feelings of exhaustion, emotional distress and pituitary adrenocortical hormones in borderline hypertension. *J. Hypertens.*, 14, 713-718.
- Salako, A.A. (2007). The HIV/AIDS epidemic in Nigeria and the need for regulation of tradomedical practice. *Niger. Clin. Rev. J.*, 64, 9-11.
- Sallah, E. (2007). Traditional medicine in Nigeria today. *The Herbal Doctor. J. Afric. Med.*, 1(2), 32-39.
- Say, S.E., Thomson, R. (2003). The importance of patient preferences in treatment decisions - challenge for doctors. *B. M. J.*, 327, 542-544.
- Sheeram, P., Abraham, A. (1996). The health belief model, in: Cornner, M., Norman, P. (Eds.), *Predicting Health Behaviors: Research and Practice with Social Cognition Models*, Open University Press, Buckingham, pp. 23-61.
- Tanahashi, T. (1978). Health Services Coverage and its Evaluation: *Bull., WHO. Geneva*, 56, 296-312.
- Thomson, R., Bowling, A., Moss, F. (2001). Engaging patients in decisions: a challenge to healthcare delivery and public health. *Quality Healthcare* 10, 11-16.
- Tipping, G., Segall, M. (1995). *Healthcare Seeking Behavior in Developing Countries: An Annotated Bibliography and Literature Review. Development Bibliography 2.* Institute of Development Studies Sussex University.
- Twumasi, P. (1988). *The Social Foundation of the Interplay Between Traditional and Modern Medicine.* Ghana Universities' Press, Accra, pp: 8-42.
- WHO. (2002). *The World Health Report 2000: Health System.* WHO Office, Geneva.
- WHO. (2004). *Guidelines on Safety and Monitoring of Herbal Medicines in Pharmacovigilance Systems*, 7148e.