"Where there is no Doctor": Determinants of Health-Related Practices among Rural People in Bayelsa State, Nigeria

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Abstract
The basic objective of the study is to investigate the factors that influence rural people's responses to illness in Bayelsa State. The Health Belief Model (HBM), and the sick role theory serve as the theoretical frameworks for this study. This qualitative study sampled 45 respondents drawn from three selected rural communities in Bayelsa State (Amatolo, Amurukeni, and Agorogbene) using a multi-stage sampling technique. Data for the study was collected through the qualitative tools of In-Depth Interview (IDI) and Focus Group Discussions (FGD). Collected data were analysed thematically using content analysis method. Findings from the study indicated rural people in Bayelsa State utilise traditional medicine as a result of their socio-cultural perception of illness. In addition to other probable reasons for rural people's response to illness is the invisible attacks (socio-cultural) which can lead to madness, blindness and other strange illnesses which only rural traditional doctors can treat. Lack of access to biomedical health facilities influences the pattern of the resort to healthcare services among rural dwellers in rural areas. Socio-economic status was implicated as having a direct impact on people's response to illness. Low-income earners are prone to negative responses to illness. Based on the findings of the study, it was recommended among others that harnessing and enhancing the skills of traditional healthcare practitioners to complement the orthodox healthcare settings will result in a more effective healthcare delivery system that will be beneficial to rural dwellers in Bayelsa State.

Keywords: Determinant of health, Rural people, Bayelsa State, Health Belief Model, Traditional medicine

Introduction
There is no doubt that mortality emanating from poor health are prevalent in rural areas due to a whole range of issues impacting on health status and the efficacy of health service interventions. While it is not possible to say what proportion of the excess mortality is due to the social determinants of health, one can be certain they play a major role. Lower incomes, lower levels of education and employment, and poorer access to health services are among the social determinants of poor health for people in rural and remote areas, who are also disadvantaged by a higher prevalence of common risk factors for health, such as higher rates of smoking and alcohol intake. Some studies 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 (Fabrega, 1973; Tanahashi, 1978; Egunjobi, 1983; Aregbeyen, 1992; Orubuloye, 1991; Ademuwagun, 1998). 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 or determine an individual's response to illness and perception of health and wellbeing include the type of illness, severity of illness, age, gender, level of education, economic ability, religious beliefs, family decision, marital status, availability, affordability, acceptability and accessibility (Omotosho 2010).

It is no gainsaying, however, that rural Nigeria remains the most neglected, and its people, the most deprived concerning the provision of modern health care services. Even in the few areas where medical facilities exist, such facilities are bedevilled by a lack of medical personnel, equipment, and inadequate supply of essential drugs. This, in the views of Aregbenyen (1992), has created an enabling environment for such rural dwellers to easily resort to traditional medical practice and spiritual healing homes as health response alternatives. Also, rural people lack other basic infrastructural necessities like potable water and the likes that are essential to the maintenance and promotion of good health. The outcome of these inadequacies is that the rural dwellers are subjected to a high incidence of morbidity and mortality resulting from the prevalence of preventable diseases, (UNAIDS, 1997).

It is estimated that 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 infrastructurally underserved rural areas.

It is also obvious that rural dwellers in the developing world have different notions and perceptions about the aetiology of disease and illness. Once a person assumes a sick role or becomes ill, it is observed that he/she strives to seek medical advice based on all available healthcare options like: visiting a public or private biomedical facility, or traditional health facility, self-medication, spiritual healing homes and the use of home remedies. Health seekers in Nigeria, especially the rural dwellers' determination to explore various treatment options is

predicated on several factors which include: the severity of the illness/symptoms of illness, socio-cultural influences, distance to the place of treatment, income, level of education, and cultural prescriptions among other factors. All these determine the choice of healthcare provider the patients use in such rural areas. However, very little research has been undertaken to identify the factors/determinants of rural dwellers' responses to illness in Bayelsa State. This has necessitated this research to investigate the factors that influence the health-seeking behaviour) among rural dwellers in Bayelsa State, Nigeria.

Theoretical Framework

The theoretical orientation of this study is the Health Belief Model (HBM). The Health Belief Model (HBM) suggests that the beliefs and attitudes of people are crucial determinants of what they call disease and their health-related actions, (Jegede 1998). The Health Belief Model (HBM) was developed in the early 1950s by some social scientists including Rosenstock, Kegeles and Hochbaum at the US Public Health Service, to understand the failure of people to adopt disease prevention strategies or screening tests for the early detection of disease (Croyle, 2005). Later in the 1970s and 1980s, the HBM was further developed by Rosenstock, to focus on the relationship between health behaviours, practices and utilization of health services. In recent years, the HBM has been revised to include general health motivation to distinguish illness. This is done by focusing on the attitudes and beliefs of individuals; HBM suggests that a person's belief in personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood that the person will adopt a given health-seeking behaviour (Croyle 2005).

The HBM attempts to predict health-related behaviour in terms of certain belief patterns. HBM has been applied to study all types of health behaviour. According to this model, a person's motivation to undertake a particular health behaviour can be divided into three main categories: individual perceptions, modifying behaviours, and the likelihood of action. Individual perceptions are factors that affect the perception of illness or disease; they deal with the importance of health to the individual, perceived susceptibility, and perceived severity. Modifying factors include demographic variables, perceived threat, and cues to action. The likelihood of action discusses factors in the probability of appropriate health behaviour; it is the

likelihood of taking the recommended preventive health action. The combination of these factors causes a response that often translates in action.

Taking a cue from the Health Belief Model (HBM), it is pertinent to note that rural dwellers health-seeking behaviour are predicated on choices and alternatives they are disposed to in their environment. Hence, the tendency to easily resort to traditional medicine, home remedies, traditional birth attendants (TBAs), self-medication, patent drug stores (chemist) and spiritual healing homes. In this regard, primary health care centres (if available), and general/specialist hospitals in the urban centres only become last resorts.

Materials and Methods

Study Designs

This descriptive survey was conducted in the rural areas of Bayelsa State. The target populations were a mainly adult male and female (18 years and above) residing within the study area. Given the nature of the study, three Local Government Areas, and three rural communities namely; Amatolo town in Southern Ijaw LGA, Amurukeni in Ogbia LGA, and Agorogbene town in Sagbama LGA were selected for the study.

Sample and Sampling Techniques

The sample size for this study consisted of 45 respondents who were selected through a multi-stage sampling technique of stratified, simple random and purposive sampling. The procedure began with the stratified sampling technique which was used to divide the state (Bayelsa State) into Three (3) Strata covering the three Senatorial Districts namely; Bayelsa Central Senatorial District, Bayelsa East Senatorial District, and Bayelsa West Senatorial District. Simple random sampling technique through the balloting method was further used in the second stage to select one local government area from each of the three Senatorial districts namely; Southern Ijaw Local Government Area for Bayelsa Central Senatorial District, Ogbia Local Government Area for Bayelsa East Senatorial District and Sagbama Local Government Area for Bayelsa West Senatorial District.

In the third stage, purposive sampling technique was applied in selecting one rural community each from the three (3) selected Local Government Areas viz: Amatolo in Southern Ijaw Local Government Area, Amurukeni in Ogbia Local Government Area and Agorogbene in Sagbama

Local Government Area respectively, based on remoteness geographically and poverty levels. Finally, the simple random sampling technique was used to select 45 respondents from the selected communities for the study.

Data Collection and Analysis

Primary data were collected using a qualitative method of data collection. Two qualitative approaches were adopted in this study; In-Depth Interview (IDI), and Focus Group Discussion (FGD). Questions that featured in the interview guides were divided into two parts. The first part centred on participants' background characteristics while the second part concentrated on the study's specific objectives. While thirty-nine (39) IDIs were conducted with participants in the selected rural communities (11 in each community), one FGD session consisting of four members was conducted in each community. The interview and Focus Group Discussion (FGD) sessions were conducted in an interactive, conversational manner to enable the participants to express themselves freely on the questions raised.

In analysing the data for this study, descriptive statistics was used to interpret data on the socio-demographic characteristics of respondents, qualitative data were sorted and analysed using content and thematic analysis.

Ethical Considerations

Bearing in mind that every social research is based on ethical issues, permission to carry out the study at the community level was sought from their respective community heads before respondents were briefed about the study and its expected benefits. They were also assured of their confidentiality. Thus, individual respondents gave their verbal consent before proceeding with the interview. The researcher also ensured that all ethical standards were observed as set by the National Health Research Ethics Code (NHREC).

Results

The socio-demographic characteristics of respondents in this study revealed that 51.9% were males while 48.1% were females. Age of participants ranged from 20 years to 60 years and above; the highest respondents (31.9%) were within the age bracket of 45 to 59 years. Also, more than half of the participants 51.8% were married compared to the 24.7% who were single

participants. The remaining were either divorced or widowered/widowed. Again, more than half of the respondents (52.1%) were Christians, while 31.6% identified with the African Traditional Religion. Others were affiliated with some other religions. With regards to educational status, the bulk of the participants (45.9%) had at least attended a primary school. 23.8% had no formal education, 21.8% had secondary education, while only 8.5% had tertiary education. The occupational status of the respondents also indicated that 30% of the participants are engaged in farming, while 29%, 14.8% and 16.8% were engaged in fishing, hunting and trading respectively. Only about 8.8% of the respondents were in forms of occupation not identified in this study. The income level of the participants revealed that about 40.6% of the participants earn a monthly income below N15,000. 29.8% earn between N16,000 and N30,000 monthly, while 20.1% and 9.5% of the respondents earn between N31,000, N49,000, N50,000 and above. Finally, while 62.2% of the participants were heads of their respective households, 37.8% were not.

Healthcare Practices among Rural Dwellers in Bayelsa State

The first objective of this study is to examine the health practices among the rural dwellers in Bayelsa state. Majority of the respondents from the three communities involved in the study alluded to the fact that traditional healthcare system is still extensively utilized in their respective communities and that it plays a dominant role in the diagnosis, management, and treatment of diverse illness episodes in the study areas. In an IDI conducted in Amatolo, one of the respondents stated thus:

> Traditional medicine has been part and parcel of our rural lifestyle and culture, we were born into it through the aid of traditional birth attendants (TBA's), when sick, we are attended to by the traditional healer or medicine man (buru owei) with the use of herbs from our community environment. We have home remedies which are handy to treat common ailments and it is less expensive, the practitioners are well known to us in the community which builds our confidence on the efficacy and genuineness of the herbs and practice. (IDI 45, Farmer, from Amatolo interviewed 25/4/2018).

Another participant in one of the Focus Group Discussion sessions in Agorogbene community gave impetus to the fact that traditional birth attendants play a vital role as traditional health practitioners in rural areas. According to her:

> Our women never had issues with childbirth, especially if they strictly adhere to the traditional therapeutic regime as instructed, and equally come for body massage.

> We do body massage to help pregnant women to be flexible in preparation for labour…we also do body massage for pregnant women to position and reposition a wrongly positioned foetus. (FGD 58, TBA, from Agorogbene interviewed 10/5/2018).

Concerning traditional bone setting activities in the study area, most of the participants attested to the fact that when a person within the community has a broken bone or bone/joint fracture, going to the Hospital for Orthopaedic treatment is a waste of time and money as the person stands the chances of going through amputation. One of the respondents put it thus:

> We have seen several cases of people with broken or fractured bones due to occupational or domestic accidents been taken to Hospitals in the Urban areas, who eventually came back with one leg or hand amputated and work with the aid of Crutches or Wheelchair. In contrast, Traditional Bone Setters would have treated such cases without amputation, using natural Herbal medicine and massage with herbal lubricants. (IDI 65, Community leader from Agorogbene, interviewed 18/5/2018.)

In a related development, during an In-Depth Interview with a respondent on the efficacy of Traditional Bone Setters in the study domain, he has this to say:

> My son was in the Nigeria Police Force (NPF) and was a member of the Escort team to the Executive Governor of Bayelsa State. While on duty one fateful day on a travel mission with the Governor, some vehicles in the convoy were involved in a fatal accident and my Son was a victim among others. He escaped death narrowly, but not without a badly battered leg with multiple bone fractures. He was rushed to an Orthopaedic hospital in Yenagoa the state capital, but he was later referred to a more standard Orthopaedic Department of a teaching hospital in Enugu. However, the last resort from the teaching hospital was to amputate the affected leg, I refused to sign the consent form, but instead signed against doctors' advice and took my Son to a famous Traditional Bone Setter in a neighbouring community in Bayelsa State. After a prolonged traditional medical treatment that lasted over a year and six months, my Son gradually recuperated and was healed. Although he is never the same again in terms of physical fitness because he limps while walking…but the joy is that he escaped amputation as prescribed by the Orthodox doctors in the hospital. All thanks to Traditional Bone Setters, and long live Traditional Medicine. (IDI 68, Fisherman from Amurukeni interviewed 28/5/2018).

Health Alternatives Available to Rural Dwellers in the Study Area

The second objective of the study is concerned with finding out the health alternatives that are available to rural dwellers in the study area. In an In-Depth Interview conducted in Agorogbene community, a respondent asserted that the only available alternative healthcare systems in contrast to the dominant traditional medical practice are the Primary Health Care (PHC) and

Patent Medicine Vendors (PMV). Other health facilities like the Federal Medical Centre, Yenagoa and the Niger Delta University Teaching Hospital, Okolobiri among others, are all situated in the urban areas which serve as referral centres during critical health situations for those that can afford the cost implication since there are no Cottage or General hospitals within the study area. In his words:

> We have a primary health care Centre in Agorogbene community built by SHELL oil company, however; it is not functional because there is only one community health worker in the PHC centre. We have made several appeals and request to the state commissioner for Health to send the appropriate number of medical personnel suitable to make the place functional but to no avail. We have one patent medicine store in this community, but patronage is relatively low. If an illness episode cannot be treated by traditional medical practitioners and sometimes over the counter drug application... then based on the availability of funds, the person is taken to a health facility in the urban areas for treatment" (IDI 31, Artisan from Agorogbene interviewed 15/5/2018)

Seeking medical care in clinics and other biomedical facilities including PHC centres, patent medicine vendors and faith healing were seen as alternative sources of seeking healthcare by various respondents in the study area as highlighted in the following excerpts from the three rural communities the study covered. This is based on a multiplicity of factors as narrated by various FGD respondents from the three communities. See the excerpts below:

Excerpt 1

> When my child was sick I applied home remedies but no improvement, I tried traditional medicine the situation deteriorated, a friend recommended some drugs from the patent medicine vendor which was purchased and administered, but the illness persisted, so finally I took the child to a hospital in the urban centres where the child was admitted for over a week before the child recovered. However, it impacted seriously on the family finances since am a peasant farmer. I don't pray for such experience again (FGD, 48 farmers, from Amatolo interviewed 29/4/2018

Excerpt 2

> The last time my wife was sick, we went and saw a traditional medical practitioner for treatment, but there was no improvement, so I took her to a faith healing tabernacle (Zion), fasting and prayer restored my wife's health (FGD, 52 fisherman from Agorogbene, interviewed 15/5/2018)

Excerpt 3

> It depends on the sickness: I will verify the symptoms and if it is something like fatigue, headache, general body pain, nasal congestion, or feverish condition... I will just go to the patent medicine vendor and explain to him and buy over-the-counter drugs as prescribed by the vendor, but when the condition persists then I will

> endeavour to go to the urban area to see a doctor (FGD, 45, Teacher, from Amurukeni, interviewed 3/6/2018

The responses from the excerpts reveal that beyond the traditional source of health care, some people are still interested in biomedical health care services irrespective of the fact that such services are marred with diverse shortcomings as attested to by some respondents.

Factors that Influence Rural Dwellers Response to Illness in the Study Area

The third objective of the study is to identify factors that influence rural dwellers' response in the study areas of Bayelsa State. There is a dearth of orthodox biomedical hospitals and clinics including qualified manpower in most of the rural areas in Bayelsa State. Rural dwellers are, therefore, encouraged to use unorthodox medical facilities due to multiple factors like affordability, acceptability, availability and accessibility.

Respondents/participants opined that the type of illness coupled with its severity are very significant factors that determine how rural dwellers respond to illness and the channel to follow. Some conditions, particularly those with mental health symptoms such as hallucinations or anxiety appear to be uniquely suited to traditional healing. An In-Depth Interview conducted in Amurukeni attested to this fact. According to a respondent:

> Some diseases and conditions are abnormal, take for instance someone who sleeps well and at midnight gets ill and starts screaming and calling out to people no one else can see, then we know that hospital cannot deal with this condition, so we take them to traditional healers who can see what the ill person can see (IDI, 55, Fisherman from Amurukeni Interviewed 28/05/2018).

In a related development, mother of a mentally ill girl from Amatolo has this to say:

> I decided to take my daughter to a traditional healer who knows the exact cause of the problem and how to appease the gods that are disturbing her. This is no hospital matter... It is spiritual and must be treated spiritually (IDI, 52, From Amatolo, interviewed 25/04/2018)

The responses from the respondents above reveal that cultural behaviour and belief system play a significant role in shaping the thought pattern and mindset of rural dwellers with regard to the aetiology of certain illnesses within their environment, which are anchored on superstition. In such instances, treatment is sought from spiritual healing homes and traditional healers who can interface with the spirit realm to proffer solutions to such strange illnesses that are beyond the physical dimension.

In a Focus Group Discussion session at Agorogbene, discussants alluded to the fact that the type of illness surely determines where to seek treatment as captured in the following extracts:

Excerpt 1

> I had a farmland boundary dispute with my neighbour, which was ruled in my favour by the village council. However, this did not go down well with my disgruntled neighbour who promised revenge. Two weeks after the ruling I was going to my farm since it was the beginning of the planting season. I got to the farm with my son and daughter, as we were about to start work, I felt something like a bullet hit my body and sent a shocking vibration on the left part of my body. I immediately fell to the ground shouting for help. I was taken to a hospital in the urban area and was diagnosed with a stroke. Around my abdomen region, I felt a sensation of a crawling movement inside of me. Scans were not able to reveal what was crawling in my abdomen, neither was the stroke getting any better, so after two months in the hospital, my husband and other family members decided to take me to a traditional healer who said that someone with an evil eye has sent spiritual bullet (Atamgba). After a session of incantation by the traditional doctor and pouring of libation and consultations with the supernatural, he placed his hand on my abdomen and extracted a living lizard out of my abdomen that brought an end to the crawling sensation. Sacrifices were made to appease the gods to turn away the evil eye from me before I was given some herbal roots to drink and bath with which ultimately led to my recovery from the stroke condition, and I have been able to resume my normal farming activities (FGD, 53, Farmer from Agorogbone interviewed 18/5/2018).

Excerpt 2

> I am a mother of three children and a trader from Amurukeni. Most nights when we are asleep, suddenly my fourteen years old daughter will scream for help from her sleep and be groaning as if under a weight. When I woke her up she would say a masquerade was chasing and flogging her in her dream, and she would complain of peppery feelings in parts of her body. On close examination we will discover thin incisions and stripes like marks in such parts of her body which was a frequent occurrence until we consulted a faith healer who conducted a deliverance session on her with anointing water and oil, the nightmare experience is now a thing of the past (FGD, 48, Trader from Amurukene interviewed 3/06/2018).

Excerpt 3

> In our community, it is a taboo to sleep (have carnal knowledge) with a woman in the forest. However, a young man from this community carried out the said act without the consent of the lady (rape) and threatened her to keep sealed lips or face his wroth, so she concealed the sexual transaction between them which was a taboo. Some months later the young man became very ill losing weight very fast and was pining away in silence. He was taken to so many hospitals for treatment but to no avail. He was finally taken to a spiritual healing home where his deeds of trespass were revealed, he later confessed as tradition demands, paid compensation to the girl's family, before purification and cleansing activities were carried out before he regained his health (FGD-65, from Agorogbne, interviewed 10/5/2018)

The above excerpts depict the fact that not all illness episodes are suitable for biomedical treatment. Thus, the type of illness determines the channel of treatment.

Another thematic factor that influences rural dwellers' responses to illness is economic consideration or the high cost of treatment or services and long distances to health facilities vis-a-vis the riverine terrain of the study area. The problem of distance to a biomedical health facility is aggravated by the high poverty levels in rural communities as captured in the IDI below:

Excerpt 2

> ... I am a retiree and pension payments are not regular and very meagre so travelling to a distant hospital in the urban area for treatment is totally out of the question for me (IDI, 73, Retired Teacher from Amatolo interviewed 29/4/2018)

Excerpt 2

> ... even to eat properly is a problem, as a disabled person I depend on goodwill from friends and family, so I make do with traditional medicine and spiritual healing that is available in the community" (IDI, 48, from Amatolo interviewed 29/ 04/2018)

Excerpt 3

> ... As a pregnant mother, I may not attempt long distances to seek healthcare without adequate means of transport which is non-existent here. We live from hand mouth as peasant here so the cost of transportation, buying of drugs, and admission fee we cannot afford (IDI, Trader from Amatolo interviewed 27/4/2018)

Excerpt 4

> I would have loved to go to the hospital if it were free, but there is nothing for free... So it is better to patronize the traditional healers since it is comparatively cheaper, available in my environment where you are sure of getting immediate and direct attention from the practitioners (IDI 42, Farmer, from Amurukeni interviewed 4/6/2018)

Excerpt 5

> ... my religious beliefs do not accept blood transfusion hence I prefer and patronize complementary and alternative medicine use in times illness compared to going to the hospital (IDI, 55, Religious leader from Amurukeni interviewed 5/6/2018)

Excerpt 6

> ... my lean resources cannot be wasted in an urban hospital. I also heard that the nurses are very rude and insult patients and their relatives especially people who are not highly educated, and from the villages, so why will I waste my time going to a place that I will be dehumanized (IDI, 67, Retiree, from Amurukeni, interviewed 3/6/2018).

Excerpt 7

> The last time my uncle was admitted in the urban hospital for an undisclosed ailment, because of the high cost of fees charged we were left with no option than to sell a choice portion of the family land to the cushion the hospital bills before he was discharged (IDI, 26, a student from Agoregbene, interviewed 15/05/2018)

Excerpt 8

> As a graduate who is now enlightened, I prefer the hospital and biomedical treatment to traditional medicine because the personnel are trained and there are standardized procedures to follow compared to traditional medical practices that are shrouded in mystery and practitioners have no formal training, but practices in trial and error (IDI 35, Teacher from Agorgbene interviewed 15/5/2018)

Other relevant thematic factors include rural dwellers literacy level or level of education, age and gender including family decisions; all of these play significant roles in how rural dwellers in the study area respond to illness. Views from some participants in a Focus Group Discussion (FGD) session gave credence to the above. One of the participants stated thus:

> I am 80 years of age, I grew up in this community (Amurukeni) and I have spent almost all my life here, depending on traditional medicine for all my health needs, is it now that I am old that I will bother myself going for medical attention in the urban hospitals? No way!!! The gods of our land will continue to protect me till the day I join my ancestors (FGD, 80 Community Leader, from Amurukeni interviewed 28/05/2018)

In a related development, another participant in a Focus Group Discussion (FGD) has this to say about the role of the family in healthcare-seeking options:

> Family and kin groups have a key role to play when a member of my family is critically ill because my family has a name to protect in this community (Agorogbeni). An injury to one is an injury to all, so we do come together to find a solution to cure the sick member, and the decision on where to go will depend on the nature, cause and type of illness" (FGD, 48, a fisherman from Agorogbene interviewed 18/05/18)

Also, a pregnant participant in a Focus Group Discussion conducted in Amatolo Community, while commenting on government policy in the state (Bayelsa State Safe Motherhood Initiative) which pays a monthly stipend (₦3,000) to pregnant women who registered for ante-natal care with government hospitals in the state, has this to say:

> I cannot travel out of my community to any government hospital with my condition to register for ante-natal care because of ₦3000 which the state government promise to pay pregnant women on registration. The closest General Hospital is three communities away from my town, so transportation and feeding alone will take all the money considering our difficult terrain. Therefore, I prefer to patronize the traditional birth attendants in my town (FGD, 36, Housewife from Amatolo interviewed 29/04/2018)

Discussion of Findings

The findings of the study go in line with the objectives of the study and therefore shall be discussed in line with how they answered the research questions as follows:

On the first objective, it was discovered in the study that the traditional medical practice enjoys a wider acceptance than the orthodox medical practice in the rural areas of Bayelsa State. This may be as a result of the near non-existence of biomedical facilities in the rural areas. This finding is corroborated by the findings of Ewhrudjakpor and Ojie, (2005) which observed that there is a dearth of orthodox hospitals and qualified manpower in most of the rural areas in Nigeria. Consequently, natives are encouraged to patronise traditional medical facilities as they are also more readily available, accessible and affordable. Other findings from the study confirmed that traditional medicine plays a complementary role to the formal healthcare systems hence, there still exists a high prevalence in the use of traditional medicine in the rural areas of Bayelsa. This is in line with the World Health Organization (2002) report on traditional medicine which states that at least 80% of people in Africa use traditional medicine at some point in their lives, which implies that the efforts to improve healthcare access in Africa cannot ignore traditional healthcare systems.

The study also revealed that rural dwellers in Bayelsa State, in line with their cultural belief systems and practices, are more disposed to traditional medicine in the diagnoses, management and treatment of mental illness. This corroborates earlier findings of Jegede (1998) that perceptions of mental illness are associated with supernatural forces. This viewpoint agrees with the research findings of Global Health Action (2011) which reveals that in Africa, mental healthcare is largely provided by traditional healers and a very high number of patients with mental illness seek help from these indigenous healers.

Concerning the second findings of the study, Primary Healthcare Centres and Patent Medical Vendors (PMV) readily serve as the alternatives to traditional medical practice. This study revealed the important role that PHC plays in rural areas. This supports earlier assertions by Onwujekwe and Uzochukwu (2005) that the concern for lack of healthcare in the rural areas led to the Alma Ata Declaration by the World Health Organization (WHO) in 1978 of Primary

Healthcare (PHC) as the only viable strategy for providing health care to over 80% of the population of developing nations who reside in the rural areas.

Community health workers play a very significant role in healthcare delivery in the rural areas, hence the need for the Bayelsa State Government to recruit more of such health practitioners to bridge the existing gap in terms of bringing biomedical healthcare to the rural areas as established by the study. This finding is in tandem with an earlier study carried out by Musoke, Boynton, Butler (2014), which posited that the use of community health workers in healthcare service delivery is a strategy used in Uganda and other countries that serve as a community's initial point of contact for health because these CHWs are mandated to carry out community mobilization in terms of health awareness and sensitization campaigns, health education, and referral of patients to health facilities especially secondary and tertiary health facilities.

On the third objective, findings revealed that the type of illness a person is affected with has a great implication on the channel of care to adopt—orthodox or traditional. Illnesses that are viewed as having supernatural causation are channelled to traditional health practitioners and spiritual healers. Studies by Omotosho (2010) support the above findings which state that people resort to the use of herbal medication when the illness is believed to be caused by witchcraft or sorcery, or attributed to the wrath of ancestors and supernatural forces, and include illnesses such as mental illness, epilepsy, bewitching and spirit possession among others.

Economic ability undeniably is a major encumbrance in the quest for prompt and appropriate healthcare as captured in the study. Even when some participants expressed the desire to seek healthcare in the secondary and tertiary facilities in the urban areas, the study indicates that rural people who cannot pay for health services in the urban areas could not access such services. Even for traditional medicine, some illness episodes like bone healing and other specialized services, based on cost implication, do stratify frequency of usage which is determined by household income levels. A previous study by Taffa and Chepngeno (2005) gives credence to the above when they asserted that the ability to pay determines the use of health services and that lack of finances seriously affect healthcare seeking to the extent that even when the willingness to pay for services may be there, the means to do so may not be there, hence, resulting in negative health outcomes for such people.

Religious beliefs were also implicated as deciding factors concerning the pattern of seeking healthcare among the rural populace in the study area. This supports earlier studies by Omeire (2017) which posits that some religious sects like the Jehovah's Witnesses do not opt for blood transfusion even when life is in danger, and also those who belong to the Faith Tabernacle do not subscribe to the administration of orthodox medication because of their religious inclinations. Thus, it is obvious that the religious mindset plays a significant role in healthcare-seeking behaviour.

The study also highlighted the importance of education and literacy in the study area. Some respondents maintained that education has transformed their worldview and thought pattern in favour of the orthodox medical practice, hence, they would seek its usage at all cost. This aligned with Buor's (2003) observation that in rural Ghana, higher education results in higher utilization of health facilities. Moses (2002) also observed that higher education consistently correlates with modern family planning practices and contraceptive use and negotiation of these with a partner.

Age, gender and disability were also implicated as factors that determine people's response to illness in the study area. The aged, the disabled and pregnant women were less likely to seek healthcare outside their immediate environment based on the discomfort associated with such decisions and cost implications. The aged component of the study aligned with Fatima and Avan's (2002) observation that some patients including those that are disabled, aged, or pregnant may not attempt long distances to seek healthcare.

Conclusion

The study established a mixture of orthodox and traditional healthcare practices in the rural communities of Bayelsa State. The major reason the traditional healthcare practices still hold sway and gain more relevance is based on the fact that traditional medicine is easily accessible, acceptable and affordable to meet the rural dwellers' expectations compared to orthodox medicine; and the traditional medical practitioners who are well known in their respective communities go all out to satisfy their clients, in a bid to keep their reputation. Orthodox medicine, to a large extent, is beyond the reach of many rural dwellers due to the socio-cultural, environmental and economic factors.

The researcher discovered the untold narrative that the traditional healthcare practices of the rural dwellers of Bayelsa State are defined by their cultural orientation as evidenced in the way they look at the aetiology of illness from a natural and supernatural perspective, including but not limited to the traditional rites of cleansing and purification when taboos are breached.

The rural people of Bayelsa State are said to be mostly of low economic status, which has been seen to have a serious impact on their response to illness. The choice of what action to take, what health care channel to patronise during illness is determined, to a large extent, by one's economic status, and belief system of these rural communities.

Recommendations

Based on the findings, the following recommendations were made. Firstly, the Bayelsa State Government should build a synergy between orthodox medicine and traditional medicine by setting up a traditional medicine practitioners registration board, to formally register traditional medicine practitioners which include; (Traditional Birth Attendants (TBAs), Bone Setters, Herbalists, Diviners, and General Practitioners).

Secondly, the Bayelsa State Government in collaboration with the respective Local Government Area Councils should endeavour to establish functional Primary Healthcare Centres (PHC) in the rural areas to serve as the first resort for rural patients in terms of health-seeking. Also, regulatory agencies like the National Agency for Food and Drug Administration and Control (NAFDAC) and the Pharmaceutical Society of Nigeria (PSN) should be empowered and strengthened to effectively regulate the activities of Patent Medicine Vendors (PMV) in the rural areas of Bayelsa State.

Additionally, the Bayelsa State Government should endeavour to boost the local cum rural economies of the rural areas by way of helping these rural dwellers to form and register rural cooperatives that will benefit from Government agricultural and entrepreneurial soft loans to further enhance and empower their traditional livelihood coping mechanisms which are predominantly fishing and farming in a sustainable manner that will help them to escape the poverty trap that has served as an economic limitation in terms of their response to illness.

Finally, ambulatory services/Mobile Clinics (River craft ambulances/clinics) should be provided by the Bayelsa State Government and Multinational Oil Companies operating in the state as part

of their corporate social responsibility (CSR), in a bid to help evacuate rural patients in case of an emergency, and during referrals from the respective Primary Healthcare Centres (PHC) to secondary and tertiary healthcare facilities as the case may be. The mobile houseboat clinics will help tremendously in bringing biomedical healthcare to the doorstep of the rural people.

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