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Health Seeking Behaviour among the Internally Displaced Persons in the North East Nigeria: Case Study of Tuberculosis Patients

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ABSTRACT

Over two million people are internally displaced in north-eastern Nigeria due to the complex humanitarian catastrophe. Overcrowded and unclean living conditions increase the risk of tuberculosis (TB) transmission, sickness, and death. The seeking behaviour of internally displaced persons (IDPs) in north-eastern Nigeria was explored to improve disease surveillance and response in IDP camps and host communities. In Adamawa, Gombe, and Yobe states, this qualitative study recruited tuberculosis patients from IDPs. The study selected 50 adult IDPs using purposive sampling. Participants were interviewed at relocation camps utilising open-ended in-depth questions. Finance predicted response speed and health care seeking. Most individuals use chemists or alternative treatment instead of hospitals except in emergencies. Internally displaced persons (IDPs) can get healthcare depending on proximity and transit difficulty and cost, according to the study. Internally displaced people (IDPs) were satisfied with free medical care, but hospitals' incapacity to prescribe and perform exams pushed them to private institutions. Free medications and education increase healthcare utilisation. Logistical difficulties must be addressed to improve IDP hospital treatment. Hospital wait times must be fixed.

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Introduction

The unprecedented humanitarian crisis in the North-eastern part of Nigeria resulting from ethno-religious disputes, tensions between Fulani herdsmen and farmers have resulted in people being displaced from their original settlements [1,2]. The Boko Haram sect, an insurgency group ravaging the country since the last decade, using extreme violence to instill fear into the general Nigerian populace has been identified as the cause of about 91.9 percent of the internal displacement in the Northern Nigeria, bringing to about 3.3 million displaced people in the country [3,4]. Furthermore, thousands of people are also displaced annually as a result of natural disasters including flooding in the North and West, erosion in the East, oil spillage and development projects in the Niger Delta (South-South) [5,6].

In line with the Guiding Principles on Internal Displacement, IDPs are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border [7]. The affected persons are subsequently caused to turn to relatives or absorbed by the ill maintained displacement camps where they face severe food insecurity and nutrition problems, health challenges, exploitations, child and gender-based violence, human trafficking, family separation and detention with no consideration of the rule of law, sexually transmitted diseases, education challenges, rape and prostitution among other things [8-10].

Forced displacement exposes IDPs to new hazards and accrued vulnerabilities, these dynamics result in greater risk of illness and death. The risk factors that work in synergy with displacement to promote communicable diseases include movement of mass populations and resettlement in temporary locations, overcrowding, economic and environmental degradation, poverty, inadequacy of safe water, poor sanitation and waste management, and poor access to healthcare [11]. Tuberculosis is one of the prevalent communicable diseases with 9 million new cases and nearly 1.5

million deaths yearly. The Internally Displaced Persons (IDPs), refugees and other crisis-affected individuals are particularly vulnerable to this disease due to poor nutrition status, poor living and working conditions, low education and awareness, and low health-care access [12]. Cases of tuberculosis were recorded among the IDPs in the North- East Nigeria. Considering the sensitivity of this disease in relation to the population index in the IDPs and the moral obligation of protecting other IDPs, this investigation was therefore carried out to study the health seeking behaviour of the tuberculosis patients among the internally displaced persons in the North-East Nigeria.

Methods

A qualitative approach was used to explore the shared experiences of displaced persons living in the re-settlement camps. Patients undergoing tuberculosis treatments, among the Internally Displaced Persons (IDPs) were recruited to participate in this study, as to access their health care seeking behavior. Three IDP camps situated in the North-East Nigeria; Adamawa state (Yola north, Yola south, Mubi south and Furfure LGAs), Gombe state (Akko, funakaye, yamaltu Deba and Kaltungo LGAs) and Yobe State (Damaturu, Nguru, potiskum and Fika LGAs) were selected for this study. The selection criteria for the participants of this study included; (i) IDPs aged 16 years and above (ii) Resident in the re-settlement IDP camps in any of the 12 LGAs evaluated, (iii) Patients, undergoing tuberculosis treatments at the period of this investigation and (iv) Displaced persons that consented to participate in all aspects of the data collection process of the study. In each of the camps, 50 adult IDPs that met up with the selection criteria were recruited to participate in the study.

Purposive sampling technique was employed to recruit a diverse sample and identify the widest range of experiences and opinions on the healthcare seeking behaviour among IDPs residing in the 12 LGAs evaluated. Study participants recruited included men and women, with tuberculosis (TB) who was diagnosed through the intervention exercises.

Open-ended in-depth interview of individual adult IDPs was conducted in their resettled camps, using a semi-structured interview guide. Trained Research Assistants who had a good understanding of the local language administered the questionnaires. Simultaneous recording of the interview conversation using an electronic audio recorder or equipment was done under the supervision of the lead consultant. All recordings were later transcribed into a written format and subjected to qualitative analysis. Main themes developed during the qualitative analysis were; response of the IDPs to the treatment of ailments, decision making towards health care seeking, access of IDPs to medical care, patients waiting period in the health facilities and satisfaction with the health care services received. Sub-themes were developed to give deeper insight into the situation surrounding each of the themes.

Results

Response of the IDPs to Treatment of Ailments

The Internally Displaced Persons (IDPs) in the selected facilities at Adamawa, Gombe and Yobe states of Nigeria where this investigation was conducted experienced a number of challenges which includes; overcrowding, inadequate feeding and deteriorating health conditions. This study focused on the health seeking behaviour of IDPs with attention on the case of tuberculosis which was observed as prevalent among the population. As gathered in this study, participants engaged diverse approach in obtaining care when they or any of their family members are sick. Factors that determine the choice of care facility used include their financial capacity, attitude and orientation to health management.

Finances Influence Health Seeking Behaviour

As gathered in this investigation, finance is a major determinant of the kind and quality of healthcare facility the participants use. The IDPs are mostly unprepared to finance themselves or their ward back to health.

"If I have little money, I usually take my family member to the dispensary close to us in the camp but when it is serious, we go to a bigger hospital in town (Yola North- Non-Patient 01, Adamawa state).

I usually find money to bring them to the hospital…. (Patient 01, Funkaye LGA, Gombe state).

Few were assisted by the friends or family members, while those who could not access fund in any other way initially took up any kind of available job to raise money before proceeding to chemist or hospital with the sick ward, the choice of which depends of the available cash at hand.

What I do is to seek assistance from friends and then go to the hospital to see the doctor (Patient 09, Yobe state).

"I usually get help from my parents. We usually go to the hospital to see the doctor" (Fufore, Patient 03, Adamawa state).

Some of the participants took advantage of the health care provision available in the camp in the case of sickness. This provision might not be readily available as indicated by some of the participants.

"I will go for labour to get money to take any of my children feeling unwell to the chemist. That is in situations where the volunteer workers do not show up…" (Fufore, Patient 02, Adamawa state).

Chemist then Hospital when Necessary

The most common pattern of health seeking behaviour in practice was firstly accessing care at the chemist through the attendants but in situations where the sickness persists they resorted to using hospital services.

We try as much as we can to go to the chemist at first. But if the sickness persists, we can now proceed to the hospital (Patient 05, Yobe state).

We begin with the chemist at first to see the chemist attendant (Patient 04, Funkaye, Gombe state).

"… But if it is urgent, I take them to the chemist first to collect drugs to relief the condition before proceeding to the hospital" (Yola North Patient 04, Adamawa state).

Many of the participants had regular chemist they patronise. Most people in this category as observed in Adamawa state perceived the chemist attendants as doctors.

"We usually go to Dr Isa's chemist to get drugs and lodge our complaints" (Yola North-Patient 10, Adamawa state).

We usually go to the chemist first to see a doctor called Yusuf…. (Yola North-Patient 08, Adamawa state).

"…we usually see a doctor at the chemist" (Yola North Patient 05, Adamawa state).
Whereas, in few instances some visit pharmacists who later refer them to the hospital if need be;
"…we get to see the pharmacists who administer drugs for us but in severe cases, he refers us to the hospital" (Yola North Patient 07, Adamawa state).
"… I first go to the chemist but if health condition is serious, I will be referred to the hospital for further diagnosis…" (Yola South, Patient 01, Adamawa state).

Seeking Care in the Hospital
Some of the participants directly accessed and utilize hospital care where they receive adequate medical attention. The use of these services was found associated with their nearness to dispensaries and health facilities.

We usually go to the hospital first when any member of the family is sick (Patient 06, Yobe state).

"When any of my family member is feeling unwell, we 'normally' take them to the hospital where we see the doctor…" (Fufore, Patient 04, Adamawa state).

We first go to the hospital to confirm the cause of the sickness (Patient, 04 Akko LGA, Gombe state).

Also, the free medical service received in the hospitals was a major factor which influenced their decisions, as indicated by the IDPs.

We usually come to the hospital for a medical check-up and because of the free treatment, the doctors help us due to our conditions as IDPs. They treat us well (Non-Patient 01, Yobe state).

Decisions on the health facility used were in accordance to the instructions earlier received in the IDP camp as narrated by some of the patients.

"...we usually go to the hospital due to the instructions given to camp residents…." (Yola North- Patient 02, Adamawa state).

Sometimes Drugs are not Available in the Hospitals
The IDPs who uses hospital services affirmed that doctors are usually available to attend to patients, subjecting them to necessary medical tests. However, 'drugs are not available in the hospitals. Hence, many had to revert to alternative means of getting drugs, which of course is 'chemists' as popularly patronised by many.

If any of my children is feeling feverish, I usually take them to the hospital first for a blood test but sometimes drugs are not available in the hospitals. The doctors are usually available (Fufore, Non-Patients 02, Adamawa state).

"I take my family to the hospital nearby but the major challenge is lack of drugs. You need to have money to buy drugs elsewhere or you continue to suffer without treatment" (Fufore, Non-Patients 01, Adamawa state).

Use of Traditional Medicine
The preference of some of the participants is traditional medicine, however those in this category only access hospital treatment when the traditional approach fails and the condition would have worsened over time.

We get to see the doctor in severe cases but we can go for traditional medicine in less severe cases (Non-Patient, 03 Akko LGA, Gombe state).

Decision Making towards Health Care Seeking
As regards decision making concerning health of the family, varying responses were gathered. Some, as the husband and man of the house were in charge of such decision making, and this was well acknowledged by the family members. In some situations, the eldest sons in the family or wives make such decision and, in few cases, extended family member.

Man of the House
Evidence gathered from the fathers, mothers and children who composed the participants in this investigation affirmed that fathers are in charge of the decision making on health and wellness in the family.

I am the one who give the final decision regarding any issue in my family (Yola North, Patient 03, Adamawa state).

I am the one who makes the final decision with regards to going to the hospital or anyone feeling unwell (Non-Patient, 01 Akko LGA, Gombe state).

I am the one responsible for taking the final decision regarding health of my family members (Patient 10, Yobe state)

Fathers also take decision as regards their own health:
I am the one who takes the final decision as far as my health condition is concerned (Yola South, Patient 01, Adamawa state).

I am the one who is responsible for taking decisions as it relates to my health (Patient, 02 Akko LGA, Gombe state).

It was also clearly acknowledged by the wives that husbands were in charge of decision making on health care seeking in the family.

My husband is the one who takes the final decision regarding health decision (Patient 07, Yobe state).

My husband is the one who takes the final decision anytime any family member is feeling unwell (Patient 04, Funkaye LGA, Gombe state).

My husband is the one who takes the final decision in cases concerning health and well-being of the family ((Yola North, Patient 05, Adamawa state).

Similarly, the children recognize this peculiar role of their fathers.

My father is the one who takes the overall decision concerning health issues (Patient 13, Yobe state).

My father is the one who usually takes the final decision (Fufore, Patient 03, Adamawa state).

It is our father who takes the final decision as it concerns health issues in the family (Patient 04, Funkaye LGA, Gombe state).

Joint Decision by the Family
In few instances, the family under coordinated by the father deliberates on the most suitable decision on the health of any member of the family.

"I am the one who takes the final decision after much deliberation with my family" (Fufore, Patient 01, Adamawa state).

My wife or I is in charge of taking the last decision on any health issues that may arise" (Yola North, Patient 01, Adamawa state).

The Wife Decides

Some participants clearly expressed that their wives are the decision maker in the family as pertains to health-related issues.

My wife Fatima is the one that takes the final decision. … (Yola North, Patient 02, Adamawa state)

It is my wife who usually takes decision on any health issues concerning my family because I am not usually around (Patient, 01 Akko LGA, Gombe state).

My wife is the one who takes the final decision as regards to health issues concerning us (Patient, 04 Akko LGA, Gombe state).

Especially when the husband is not available at the period a member of the family falls ill, the wife takes charge in healthcare decision making.

I always take the final decision about their state of health especially while my husband is away in Maiduguri but if he is around, he takes the final decision (Furore, Non-Patient 02, Adamawa state).

My mum is the one who takes the final decision especially when our father is away from here" (Yola North, Patient 08, Adamawa state).

The Male Child in the Family Decides

The mantle of leadership and decision making on health matters of the family falls on the eldest son. In other instances, the eldest son assumes this role when the father is not available to do so.

My father is the one who takes the final decision concerning our health and if he is not available, I am the next in charge (Patient, 02 Akko LGA, Gombe state).

Our eldest brother is the one who takes the final decision in any situation… (Yola North-Patient 07, Adamawa state).

My first born who is the most elderly amongst us is the one who takes the final decision regarding health issues (Patient 12, Yobe state).

However, the eldest son may not necessarily be the one to decide on the health issues of the family, as other male children readily takes charge.

A younger family male son takes the final decision in all cases (Fufore, Patient 05, Adamawa state).

It is my second son who usually takes the final decision if the need arise (Fufore, Patient 02, Adamawa state).

Other Member of the Family Decides

In few instances, other member of the family makes decision of the health seeking of the sick person in the family. Such includes the grandmother and aunt.

The decision is taken by our grandmother (Patient 03, Yobe state).

My aunt is the one who takes the final decision in any situation concerning our health (Yola North, Patient 10, Adamawa state).

Access of IDPs to Medical Care

Ease of accessing the health facilities as discussed by the participants was dependent on the nearness of their residence to the facility, cost of transportation and other possible challenges involved. While the waiting period in the hospital before having doctor's attention ranges with the time of arrival at the clinic and day of the week. These had been studied in relation with the rate of traffic of the people.

Nearness to Health Facilities

Some of the participants utilized the health facility in the IDP camp, or in close proximity to a facility and this gave them the privilege of assessing the care at their comfort, either day or night.

It is not so far. The health service is within the camp and we normally go on foot (Fufore, Patient 04, Adamawa state).

The hospital is very close because we can always go on foot and at any time even in the middle of the night (Fufore, Patient 01, Adamawa state).

It is not far at all even at night, we can always go on foot (Fufore, Patient 02, Adamawa state)

Some covered the distance of less than a kilometer and they easily access the hospital care on foot or under the cost of transportation of #50 or below.

It is not far. We pay N30 as transport fare to the hospital…. we usually go on foot unless in severe cases do we go on a vehicle (Yola North, Patient 08, Adamawa state).

It is easy for us to access the health service because we have a dispensary close to the house. We usually take a Keke-Napep and it costs N50 (Patient 04, Yobe state).

It is easy for us to access the health services as it cost us only fifty naira. It takes around 10 minutes to come on foot and 2 minutes on bike (Patient 05, Funakaye, Gombe state).

Although, some were fairly distant but still within 20 to 30 minutes on foot or with 200 naira or less when using commercial motor bike or keke Napep (tricycle)

It is easy for us to access health services because it is not too far. We convey ourselves using bike and it costs 200 naira (Patient 09, Funakaye, Gombe state).

It is easy for me to access the health service because it is close. It takes like 20-30 minutes to get to the hospital on foot. We sometimes use a keke Napep or a friend's car (Non-Patient 02, Yobe state).

It is very easy to access the health service for example, it takes 30 minutes to get there on foot but on Keke Napep, it takes around 5 minutes (Yola South, Patient 03, Adamawa state).

Perceived Stress in Accessing Hospital Care

The distance of about 1km and amount spent (100 naira) by some participants were in the same range with others who reported easy access to health facility, yet this category of people claimed they encountered difficulty in accessing care. The interviewer therefore suspects misleading information and exaggeration of the situation.

It is not easy for me to access the health services. The distance is up to a kilometre and I usually take a bike to come here (Patient 03, Akko, Gombe state).

It is not easy for us to come to the hospital due to the distance. It is around 1km and we come on Napep or we manage to come on foot sometimes (Non-Patient 01, Yobe state)

It is not easy for us to access the health service due to the long distance. If you take a bike, it will take you around 12 minutes. But on foot, it can take up to 30 minutes. We usually take a car and in some instance, we walk on foot (Patient 02, Yobe state).

Not Easy to Access Hospital Care

Many of the participants in this investigation travelled between 30minutes to 2 hours before accessing health care. This indicated the stress and difficulty they experience each time they want to access care at health facility. The cost of transportation could be as high as 500 naira.

It is very difficult for us to access the health centre. We pay around N500 to transport ourselves using keke-Napep (Yola North, Patient 02, Adamawa state).

The access to health services is not easy due to the distance. We usually need to go on a vehicle or bike. It can take up to 6km to get to the health centres (Patient 01, Akko, Gombe state).

Inability to Cope with the Transport Fees

Financial challenges to cope with the transport fee to and for the health facility was the predicament of some of the participants, especially those covering a fairly longer distance of up to 34km. Considering the cost implication and their state of health, accessing hospital care becomes a great ordeal to many.

Just like I said, due to our financial incapacity, we face a lot of challenges to access the health services. It is up to 34km and we usually go on a car (Patient 04, Funakaye, Gombe state).

Effect of Seasonal Variation on the Ease of Accessing Health Facility

However, seasonal changes were also reported to influence the accessibility to health services, as it is more challenging in the raining season.

Due to the raining season, it is not easy to come to the hospital. It takes up to an hour to get to the hospital and we usually board a car to get to the hospital (Fufore, Patient 05, Adamawa state).

Patients Waiting Period in the Health Facility

The waiting interval of patients before consultation with doctors or other health workers varies possibly with the health facilities, as some participants reported low traffic of patients in the facility they attended, hence they got prompt attention. Other participants reported the waiting interval of 15 to 30 minutes if there are fewer patients on the queue and up to an hour and thirty minutes when the patients are many.

Cases of Emergency

As the practice in all medical outlets, cases of emergency were granted express attention of the medical team and in such situations, protocols were waved so that such patient experience almost zero waiting period before obtaining care.

We usually see the doctor in time during emergency situations…. (Non-Patient 01, Akko, Gombe state).

When there is queue, it takes some time for us to see a doctor unless in case of emergency…. (Patient 01, Funakaye, Gombe state).

Short waiting Period

Majority enjoyed prompt attention of the health workers with an estimate of 5 - 10 minutes of waiting.

… without the queue, we spent only 5 minutes to see the doctor (Yola North, Patient 08, Adamawa state).

We don't take time to see the doctor. Sometimes it can take up to 5 minutes while sometimes it could be more (Patient 05, Funakaye, Gombe state).

Another set of participants reported the waiting period of less than 30 minutes before the consultations with the doctors.

If there is queue, it takes us around 30 minutes but in the absence of queue, it takes like 15-20 minutes (Patient 03, Funakaye, Gombe state).

It doesn't take long to see the doctor which is around 20 minutes (Yola North, Patient 03, Adamawa state).

It takes up to 30 minutes to see the doctor while if the queue is not much, we can spend just 15 minutes (Patient 02, Yobe state)

Longer waiting Period

Based on the estimation and experience of some, it takes between 1 to 5 hours waiting period before consulting a doctor in the health facilities they use.

It normally takes at maximum one hour thirty minutes to see the doctor (Patient 05, Yobe state).

It takes up to an hour to see the doctor or hospital attendant (Patient 01, Akko, Gombe state).

It takes us 1 hour to see the doctor if we go early. But when the queue is much, it takes over 2-3 hours (Yola North, Patient 07, Adamawa state).

Others experience an extremely long waiting period, mostly as a result of the high traffic of patients in the clinic.

It takes several hours like 3-4 hours to see the doctor due to the long queue (Yola North, Patient 06, Adamawa state).

It depends on the queue. It takes around 5 hours when the queue is much but when the queue is not much, we spent 5 minutes (Patient 08, Funakaye, Gombe state).

Time of Patient Arrival, Days of the Week and Season Influence the waiting Period

The waiting period of patients was dependent on their time of arrival at the health facility, since patients were attended to on a first come first serve basis. While the early risers spend about 30 minutes others could wait up to 2 or 3 hours before being attended to.

This depends on how early you came. Sometimes you can spend up-to 2-3 hours before seeing the doctor (Patient 14, Yobe state).

If you come on time, it doesn't take you up to 30 minutes but arriving late, you can spend up to an hour to see the health care workers (Patient 02, Akko, Gombe state).

The earlier you come, the easier it is to see the doctor….(Yola North, Patient 05, Adamawa state).

The waiting period also vary with days of the week. Participants reported the usual pattern of higher traffic of patients on Mondays and the waiting period to access care could be as high as 6 hours while an average of 30 minutes was reported on other days.

It takes us around 6hrs especially on Mondays when the queue is much but during other days we can spend around 30 minutes (Non-Patient 01, Yobe state).

The waiting time experienced was reported to be more during the raining season when the patients could wait the whole day without doctors' attention as a result of the higher number of people that access the health facility during this period.

"We don't waste any time before seeing the doctor unless during the rainy season where we experience much patient…" (Fufore, Patient 04, Adamawa state)

"Sometime it is easy to see the doctor but we may sometimes **wait till the next day to see the doctor**" (Fufore, Patient 05, Adamawa state).

However, the participants validated the efforts to reduce the waiting period in the hospital especially at the Centre for treatment of TB has been productive.

Sometimes it takes up to 2 hours to see the doctor but it has improved now especially the centre for treatment of TB (Patient 15, Yobe state).

Availability of Doctors

Reports gathered from the participants especially those from Yola North LGA of Adamawa state, the doctors were readily available to attend to patients during the day, but not always the case at night. This was revealed by the patients;

Doctors are usually available at the hospital…. (Yola North, Non-Patient 02, Adamawa state).

In the daytime, we see the doctor without any delay unlike at night. We sometimes don't get to see the doctor (Yola North, Non-Patient 01, Adamawa state)

Free Consultation

All the participants acknowledged the Governmental efforts in providing free healthcare services. Apart from the initial payment to obtain hospital cards and the subsequent purchase of drugs, no other expenses were incurred in the hospital.

There is no consultation fee paid to the doctor and that is a very good development especially for us who are poor and can't afford to pay the bills. We thank God for them considering our health as a priority (Yola South, Patient 01, Adamawa state).

… we don't have to pay for anything and we have been adequately attended to (Patient 04, Funakaye, Gombe state).

We don't pay for the services and that is a very good thing. We only have to obtain the hospital card (Non-Patient 02, Yobe state)

In addition to the free medical consultations received, there is evidence that the prescribed drugs were also dispensed freely except when the drugs are not available in the pharmacy.

"…we are encouraged because it helps people who cannot afford to pay for drugs" (Yola North, Patient 10).

The service is very good. The only time we spend is when the need arise to get drug from the chemist (Patient 03, Yobe state).

While majority only pay for the registration card in the clinic, few others especially from Adamawa state stated that even the card was issued freely;

Everything is free including the collection of card, test and treatment (Yola North, Patient 03, Adamawa state).

You don't have to pay to see the doctor. It is only payment for hospital card (Patient 08, Yobe state).

We don't pay for any services unless payment for card and if you are hospitalized (Patient 04, Akko, Gombe state).

Satisfaction with the Health Care Services Received

The participants expressed satisfaction and appreciation for the quality health care services they received without financial involvement of their part. Since it is possible that majority might not have access to such treatment on their own, due to their financial instability. The free services were noticed to encourage their use of health care services while many demonstrated improvements in their health since they had been accessing this hospital care.

Prompt Attention of the Medical Team

Satisfaction of some was based on the close attention the medical team paid to nurture them to health.

The services are very good and they pay attention to us very well (Patient 04, Akko, Gombe state).

The services here are far better than what is applicable in my village (Yola North, Non-Patient 03)

Medical Services brought Relief and Encouragement

Outcome of the effective treatment received even without going through the ordeal of raising hospital bills made the patients feel important and encouraged.

I like the services very well because it helps to relieve us especially due to our financial instability (Patient 01, Yobe state).

We are happy for this development since we are been helped especially when we can't afford it…. (Fufore, Patient 03)

We like the services very much because they save us from difficulty that will arise if we have to pay for the services (Patient 09, Funakaye, Gombe state).

Furthermore, they affirmed the competence of the medical personnel and efficacy of the treatments received. They seem to really know the worth and value of the treatment they got freely.

The services are okay because the doctors are effective and we are treated for free (Patient 01, Funakaye, Gombe state).

We like the services because we get to complain to the doctor without worrying about the financial involvement (Patient 07, Funakaye, Gombe state).

"…they quickly understand what our problems are and give the recommended advice" (Yola North, Patient 09).
Also, some were especially appreciative for the drugs received and others for their improved health since they have been using hospital services.

I am satisfied with the services because they are giving us drugs and it is okay (Patient 06, Funakaye, Gombe state).

…I sometimes use a bicycle to go to the hospital due to improvement in my health (Yola North, Patient 10).

Dissatisfaction Experienced with the use of Hospital Services
The participants registered their dissatisfaction with the lack of capacity of the Government hospitals to conduct adequate tests for patients when necessary, but rather refer the patients to private clinic.

The only challenge we have is when we go for test in the Government hospitals, they refer us to a private clinic to get tested (Non-Patient 02, Akko).

Discussion
Health seeking behaviour is the act of making a decision, whether or not to seek health care from qualified medical personnel when feeling unwell [13]. According to World Health health behaviours was regarded as all behaviours associated with establishing and retaining a healthy state, including aspects of dealing with any departure from that state [14,15]. The internally displaced persons (IDPs) in this investigation demonstrated diverse health seeking behaviour pattern in caring for their sick ones. Decision and action of the majority was largely dependent on their financial capability, and in most cases the IDPs are stranded financially and have no savings towards emergency. Similar observation was made in the study of who reported cost as an important barrier to health service access despite the high levels of care seeking among the IDPs studied. In this study, the family of the sick initially seeks financial assistance from friends or family and this corroborated the reliance and support IDPs obtained from friends and relatives as earlier documented [17,18]. However, in cases where no assistance was forthcoming participants resort to taking up any available job that could afford them quick cash to care for their sick ones. Whereas, possibility occur that desperate IDPs could be involved in risky or illegal dealings to raise the required fund, this may possibly give rise to hazardous behaviours (e.g. promiscuity and sexual and/or intra-household violence) as mostly documented among the displaced people (United Nations High Commission for [17]. Generally, the time spent in sourcing for fund have implications in delayed care seeking behaviour for the sick.

Chemist was the first point of call for majority when any member of their household falls sick; "If any of our family members is not feeling well we usually go to the chemist and if the sickness persists we may decide to go to the hospital". Possibly because of its nearness, low financial involvement or mild nature of the illness suffered, majority prefer to consult the chemist attendants who dispensed over the counter drugs to ease their conditions. This corroborated the report that in many developing countries, out-of-pocket expenditure is the most common form of health care financing and many households spend more than half of their income on medicines [19]. This preference of care seeking over hospital care could be associated with the challenges IDPs experienced in accessing medical services as reported to include damage to medical infrastructure, financial constraints, or due to unreasonable, even discriminatory, policies that frustrate IDPs' access to essential medical treatment [20].

On the other hand, some participants readily used hospital services; "I usually go to the clinic at first because they usually carry out test. We get to see the doctor in the clinic or hospital…" (Yola South Patient 03, Adamawa state). Reasons for this was their confidence in obtaining better medical care, knowledge of free hospital services and compliance to the instruction to use hospital care as was told in the camp. This was found in line as the right of IDPs to health as stated in the Guiding Principles which is meant to ensure that IDPs are provided, with essential medical services, beyond this, principle 19 requires states to provide wounded and sick IDPs with medical care, as well as psychological and social services, and to pay special attention to the health needs of women as well as to prevention of contagious and infectious diseases United Nations High Commissioner for [21,22]. Inspire of the care received in the hospital, participants were mostly responsible to sourcing for drugs; "……you need to have money to buy drugs elsewhere or you continue to suffer without treatment". Whereas, for the IDPs especially, access to essential medicines has been defined as a human right and is one of the targets of the Millennium Development Goals [19].

Few of the participants, particularly from Gombe state resorted to the use of alternative medicine in caring for the sick member of the family, and only access hospital care in severe cases. This decision could be possibly explained as bureaucratic problems such as long distances in travelling to the clinic or hospitals, very limited time, and non-inclusiveness of some medicines in the health insurance plan, and could be the reason for choice of the alternate care which is cheaper and easier. However, medical care seeking behaviour is found associated with the perceived severity of the illness, indicating that families give priority to children and perceived serious illnesses [23,24].

Just like the decision making in other family issues are mostly championed by men, such was also the case of health issues of the family as gathered in this study. This agreed with the report which align father's role to promotion of the health of the mother and children [25]. In some other instances, decision concerning health care seeking were jointly made by the family, and women as well takes charge especially when the men were not available to make such decisions, this explains the opinion of that fathering and mothering needs to be understood as constructions of shared responsibilities within the man-woman dyad [25]. However, some participants shared peculiar views; "My wife is the one who takes the final decision as regards to health issues concerning us". This exclusive right of women taking a lead role in the health seeking of the family is in contrast to the usual perception that African women have little participation in health care decisions [26]. While the level of enlightenment and if in health or medical profession could be suggested as the reasons for this position, factors earlier documented in favour of women autonomy in health seeking decision might be due to the fact that the more a husband is educated, the more he will accept gender equality and believe in equal participation in decision making, and women's independence in generating income, but the probability of the woman participating in health care decision making decreases as family size increases [27-29]. The mantle of leadership and

decision making on health matters of the family falls on the male child of the family, in most cases when the father is not around, according to a participant; "My first born who is the most elderly amongst us is the one who takes the final decision regarding health issues". This is synonymous to patriarchal family type described by Simmers (2004, page 278) in which the father or oldest male is the authority figure and this dominant male makes most health care decision for all family members.

Some of the IDPs easily accessed health care services due to their proximity to health care facilities, many accessed it by walking 20 minutes to 1 hour covering 1 to 6km, using #50 to #200 on transport. Others however covered as high as 34km spending up to #500 (equivalent $1.5) on transport, the situations were even more challenging during the raining season. The financial burden and stress involved discourages many from accessing health care. This is found in line with the report of the United Nations High Commission for that displaced persons may not be able to access available health care for a number of reasons, including discrimination, high user fees, insecure environments, long distances, or lack of affordable transport [17]. Older persons, as well as women and girls, also face additional obstacles in accessing health care. The waiting period of 5 to 10 minutes before consulting with doctor was mostly reported among the IDPs, in cases of high traffic which is usually the case on Mondays and during the raining season, it could last from 30minutes to 5hours, as stated by a participant; "the earlier you come, the easier it is to see the doctor…"

Generally, the IDPs interviewed expressed satisfaction and gratitude for the free and quality health care services received which a participant described as better than what is obtainable in his village. This indicate a step in the right direction towards coping with the health demands of IDPs as required by the United Nations High Commission for that National authorities carry primary responsibility for ensuring the highest attainable standard of health for everyone within their jurisdiction, including internally displaced persons [17].

Conclusion

Health seeking behaviour of tuberculosis patients among the internally displaced persons in the IDP camp at Adamawa, Gombe and Yobe states showed availability of finance as a major predictor to quick response and type of health care seeking behaviour. Majority prioritizes use of chemist or alternative cares and only resorted to of hospital services in severe cases.

Apart from the joint decisions on health issues in few instances, the type of family set up which could be patriarchal or matriarchal where the dominant male or female in the family respectively, takes decision on health issues. Also, ease of access of IDPs to healthcare facilities was found as dependent on its nearness, stress and cost of transportation involved in accessing care.

The waiting period before consulting a doctor in the hospital usually ranges from 5 to 10 minutes, and it depends on how early the patients arrives in cases of high traffic, which usually occur on Mondays and during the raining season.

The IDPs were satisfied with the free medical services enjoyed, but dissatisfied with the inability of hospitals provide drugs and conduct medical tests, but instead referring them to private hospitals.

Recommendation

There are possibilities that most IDPs were not aware of the free medical services offered or they simply pull back from using hospital facilities because of the associated cost of drugs that may not be supplied free. Therefore, ensuring full medical responsibilities including the drugs, and making awareness of such will enhance the rate of healthcare use.

Long distance and high cost of transportation discouraged the use of healthcare facilities. There is need to look into issues around logistic for the IDPs to enable them better access the hospital services. High traffic of patients was reported on Mondays and during the raining season. This results in longer waiting period of up to 5 hours, and a participant recounted his passing the night in the hospital before being able to consult the doctor. Special arrangement needs to be made to cope with these situations.

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