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Factors Influencing Health Seeking Behaviour in Kwabre East District of Ashanti Region, Ghana

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Abstract

Quality of life changes over life span and health becomes one of the major concerns. What influences people to act variedly in connection to their health and the factors facilitating against the use of health services have been areas of interest to researchers. There is still a growing concern either on the 'end point' (utilisation of the formal system, or health care seeking behaviour) or those which emphasise the 'process' (illness response, or health seeking behaviour). But what informs people to decide on the type and source of health care poses greater challenge to most individuals: A situation which makes people become sceptical about their health decisions. Kwabre East District of Ashanti was used as a case in point in this study to examine the factors influencing health seeking behaviours and measures that can be used to improve upon people's health conditions. Ninety (90) questionnaires were distributed to the people in Kwabre East District of Ashanti.

Data was collected using questionnaires and interviews which were then coded and input into a statistical software package before analyses were made. Descriptive statistics and regression were employed in the analysis for easy understanding and reader comprehension. The study revealed that malaria is the most common illness affecting the people in the district. The health facilities commonly available in the district are hospitals and health centres. It was seen that members in the district mostly seek healthcare from hospitals and health centres and their reasons for provider choice was proximity. Again, a reasonable number of people having valid NHIS cards did not access healthcare with them.

Establishment of healthcare facilities in most communities cost of healthcare being very low, training of more healthcare professionals, and rehabilitation of road networks leading to healthcare facilities, availability of logistics and consumables at provider sites, and cooperation between health professionals & religious leaders are measures to improve upon health seeking behaviours of the people. The study concluded that even though one factor leads a person to go for a particular treatment, the people access health care simultaneously from all treatment centres.

Keywords: *Health Seeking, Healthcare Facilities, Health Seeking Behaviours, Quality of Life Changes*

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1.0 INTRODUCTION

The definition of Health or care seeking behaviour has been said to be any attempt or action one takes to get an appropriate remedy for themselves or for the patient, when they have health related problem or illness (Webair & Bin-Gouth, 2013). Health or care seeking behavior has been defined as any action taken by someone in order to find an appropriate remedy for themselves or for the person whom they take care of, when they have a health problem or illness (Webair & Bin-Gouth, 2013). According to Conner and Norman (1996a) certain developed "social cognition models" attempt to offer useful explanations to some of these behaviour patterns. Such models emanate from the matrix of demographic, social, emotional and cognitive factors, perceived symptoms, and access to care and personality (Conner and Norman, 1996b). They came out with these under the premise – human behaviour can better be appreciated in the point of view of an individual's social environment.

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The study was to find out why, where, when and how do people (patients) seek for health care. Why some people are reluctant to seek for health care and many others are the issues the study generally investigates. It further tries to find out the factors which negatively or positively affect the usage of medical and health services, notably, health care seeking behaviour. The emphasis would be on the process of seeking health care. Globally, culture and beliefs are some of the factors responsible for both health-seeking and healthcare seeking behaviours of people (Rogers, 2010). Schaefer (2004) also sees culture to contribute to differences in medical care. MacLean, *et al.* (1999) in their study "People who seek health care at emergency sessions" also cited cultural and social inequalities, opportunities to care issues, and the nature of signs being experienced as factors responsible for health-seeking behaviour.

El Kahi, *et al* (2012) conclude that formal healthcare seeking behaviour had nearly extinct; for psychological issues (3.3%), relational and social issues (1.8%), and issues related to substance use (5.1%). Schaefer (2004) is not different from Rogers and El Kahi. He writes that culture is a contributory factor to disparities in health care and also the definition of health. Abubakar, *et al.* (2013) state that some researches in Africa have dealt with the prime view of the primary causes of various diseases and their related health seeking behaviour.

The direction has broadly been on the description of socio-cultural indicators of health-seeking behaviour in the context of particular health situations. According to UN HABIT and Republic of Kenya (2005) a number exceeding 70% of respondents failed to access healthcare from public healthcare facilities. Although such facilities were not only closer to them but also less expensive compared to alternative health facilities in terms of time and cost; they were reluctant. However, Dill (2012) finds that since 2001 health services, including medicines, have been without user fees in Non-private Ugandan health facilities. The above notwithstanding hindrances emanating from geographical access, shortage of drugs, and a lack of social health insurance scheme compelled residents to access health care from the private sector and pay for it.

There has been a considerable attempt by Ghana to increase its access to health care. It thus plans to raise its percentage of people using trained health staff when ill from 30% to 50%. The above aim is difficult to achieve due to poverty in the villages, unavailability of trained health staff, and lack of professional health providers (Russel, 2008). People seek for healthcare base on certain factors. It is significant for decision makers to become aware of what really influences patients in their quest to seek for healthcare (Muriithi, 2013).

2.0 MATERIALS AND METHODS

The chapter two is on the review of literature on my research area. It reviews related literature on the research topic. It attempts to find out the existing contributions of previous writers – what they have said and the gaps that need further attention. It has been organised as follows. Healthcare provider choice, health, health seeking, healthcare seeking behaviour, health seeking behaviour, determinants of health seeking behaviours, perceived susceptibility to a health situation, perceived seriousness of a health condition, perceived importance of action taken and barriers to taking action in a health condition, cues for action, health seeking behaviour modification and the mass media, healthcare delivery system in Ghana, empirical review, theoretical perspective and framework for the study, and conclusion.

2.1 Healthcare Provider Choice

The significance of healthcare provider choice has been fueled by intense demand by patients. Choices made by the demand-driven patients are characterized by the interplay of certain factors. These factors may determine the willingness of the patient to choose, when to choose and how to choose to access health care. Therefore, the health seeking behaviors of patients are determined by a complex interchange between the healthcare providers and the customers (Victoor *et al.*, 2012).

The usage of health services in emerging developing countries is as being multifaceted compared to developed countries in considering the choices between diverse healthcare systems (Kroeger, 2003). Many developing countries still find it uneasy to achieve the millennium development goals (MDGs). A quick-paced and multifaceted effective way to training, mining knowledge, sharing knowledge and translating knowledge into effective and affordable

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interventions and strategies are essentials called for since several individuals base their health decision on the availability of information at their disposal. The situation is not different in Ghana as more information needs to be generated to meet the health needs of the individuals (Ghana E-Health Policy and Strategy, 2013)**.** This is evident in 2012 when the National Health Insurance Authority introduced capitation as a new provider payment system in Ashanti Region of Ghana. Many clients as well as healthcare providers resisted vehemently.

There is generally the need to rub in the necessary ingredients to improve coverage of the health interventions and to empower our populations to seek treatment and make proper lifestyle choices (Ghana E-Health Policy and Strategy, 2013). The determinants of the health seeking behavior of individuals are multifaceted and knowing the patterns interplaying on the use of health services in this context is important (Rosenstock, 2005; Trish & Psych, 2007).

2.2 Health

The World Health Organisation's definition for health suggests a state of an absolute social well-being, mental, and physical but not just the absence of illness (WHO,1948). The 'life span' approach to health admits people's health and disease as an accrual of conditions that initiate early life and risk throughout the period (Institute of Medicine, 1996). It is an evident reality that individuals in poor countries are susceptible to deadly diseases than those in rich countries (World Bank, 1993). For instance, high levels of maternal death continue to be a public health anxiety as the 2007 Ghana Maternal Health Survey report calculates a maternal death ratio of 580 deaths per 100,000 live births (GSS/GHS, 2009).

Many features may impact the feedback, including features of people and their capacity to utilize the resources they would need in their attempt to dealing with their negative health conditions. Primarily, the main determinants of Health can be viewed as the feedback of a complicated mixture of cultural, educational, social, economic, and political indicators (Kotecha, Patel, Shah, Katara, Madan, 2012; Falconer, 2010; Howson, Harrison, Law, 1996).

2.3 Health Seeking

In defining Health seeking, care must be taken as literature clearly shows a distinction between health seeking which highlights the wider process of inferring causation and choices regarding many of the non-visible processes that affect health and health seeking behavior. Healthcare seeking only accentuates the "end usage" of health services by individuals. In extensive positions, it only relates to access, health facility use, the mode in which individuals may react to their belief of ill health (Ahmed, Adams, Chowdhury, & Bhuiya, 2000; Mackian, Bedri, & Lovel, 2004, cited in Trish & Psych, 2007).

Tipping and Segall, (1995) in their study classified literature on health seeking behavior into two main blocks. First and foremost, there are certain researches that emphasise the 'end point' (utilization of the official way of proceeding, or *health care seeking behavior*); and secondly, those which emphasize on the 'process' (illness response, or *health seeking behavior*). Such investigations may explain act of seeking 'health' in their own familiarized context.

2.4 Health Care Seeking Behavior

Available evidence suggests that self-medication and care, attendance to traditional practitioners and unapproved health ways, still inflate the healthcare system. But greater emphasis has been laid to make individuals deem this as a thing necessary to be prevented, with the focusing of more efforts on encouraging people firstly accept the official channels in their health care seeking (Ahmed, *et al*, 2001). This is mainly evident in developing countries including Ghana. These research works in this area have often illustrated that the choice and the idea to use a peculiar clinical method is determined by a multiple effect of social and economic characteristics: sex, age, social status of women, type of illness, access to services and perceived quality of the service (Tipping & Segall, 1995). It is of a greater interest to this study to define what is meant by health seeking behaviours.

2.5 Health Seeking Behaviours

It is beneficial to define health seeking behaviour as "any activity undertaken by a person who believes he/she is not healthy, for the purpose of preventing disease or detecting disease in

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an asymptomatic stage" (Rosenstock, 2005). Health seeking behavior has also been defined as any activities assumed by folks who identify themselves to be having a health difficult or ill for the purpose of seeking proper therapy (Ward, Mertens, and Thomas, cited Olenja, 2003; Trish and Psych, 2007). This is normally defined as the process of illness response by Tipping & Segall (1995) and Health Systems Development Program (2004). This second classified studies are based on the elements that prevent individuals to make health related choices either their behavioral lifestyles or the usage of health care and treatment (Tipping & Segall 1995) This may result in illness behaviour, which can be defined as "any act undertaken by a patient, for the objective establishing the condition of his health and coming out with appropriate cure" The ill person will take a sick-role behaviour. This is the activity undertaken by those who consider themselves ill for the purpose of getting well" (Rosenstock, 2005). The healthcare provider is more significantly anxious with pre-diagnosed illness behaviour than post-diagnosed illness behaviour (Rosenstock, 2005). There is a peculiar interest in the study of what influences the behaviour of individuals to take action in relation to their health and what informs them in such decision making process.

2.6 Determinants of Health Seeking Behaviours

The seeking of Healthcare depends on a person's information of what might be measured as a medical signs and symptoms beside the cognizance of the probable bases of such signs and their latent severity, and specific information of the sorts and accessibility of therapy for such signs (Shaw *et al.*, 2008). Furthermore, a verdict to take a health directive is predisposed on the individual's inclination to behave, by his socio-cultural and individually determined beliefs about the effectiveness of substitute actions, by mental barriers to action, by relational impacts and by one or more critical signals incident which may aid in the triggering of a reaction (Rosenstock, 2005). Msiska *et al* (1997) recognize numerous factors of health seeking behavior in emerging and advanced countries, and classified them as degree of effect, type, the source of the problem, and the permissible duties of the patient, insight concerning origin of the disease or problem such as patient's age, patient's sex, patient's education and economic position, patient's social standing, patient's social capital and common referral points, service availability as well as the opinion of the value of curative options".

For instance, it is also suggested that the severity and nature of the symptoms may influence the delay in health care-seeking behavior (Dubois, 2006, Wilkinson, 2002). In their study, they intimated that those who had severe and unpleasant symptoms like genital sores had sought care early compared to those with symptoms such as vagina discharge. However, patterns in the use of detection and preventive healthcare services permit certain presentation about the association of personal characteristics such as education, income, gender and age with the use of healthcare services. Studies of users of free medical examinations, immunization, physicians' healthcare, and hospital services revealed that these services are mostly likely by the youth and people of average age, by females, by others who have relatively achieved better education and have higher income.

The socio-cultural and economic environment plays a major role for this care-seeking behavior. Higher socioeconomic groupings (defined in terms of gender, literacy, education, regular age educational and income level) have high probability of accessing medical and other hospital services although the relationships between income and utilization are becoming lesser (Borsky, P. N., and Sagen, O. K, 1959; Rosenstock, Derryberry, and Carriger, 1959; and Health Statistics From the U.S. National Health Survey, 1960 cited in Rosenstock, 2005). Not forgetting the factor of accessibility which includes processes of communications, means of transport, proximate facility, and duration of movement to closest facility. This has for centuries remained as a major challenge for the rural folks due to the remoteness of these areas; they frequently travel to get health services. Partly attributed to the issue of the causes of hindered access is the cultural practice of the areas in question (Hartigan, 2001).

2.6.1 Perceived Susceptibility to a Health Condition

Susceptibility to an illness condition may differ from individual to individual. One may critically deny the contraction of a certain health condition whiles the other might accept its probability of happening but to whom believing this possible occurence is less realistic and it will

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not happen to him. Adding to this, an individual may also exhibit a behaviour that he or she is in realistic danger of being affected by the ailment. To conclude, susceptibility relates to the subjective risks of illness condition contraction (Koos, 1954; Stoeckle, 1963; Zola, 1964; Freidson, 1961; Rosenstock, 2005).

2.6.2 Perceived Seriousness of a Health Condition

Personal conviction of individuals to the seriousness of a given health problem also vary from person to person in a period of time. The degree of responsiveness of seriousness may be viewed from both the measure of emotional stimuli arousal from the thinking about of a disease and ultimately by the types of challenges the person believes as a given health situation will bring upon him (Robbins, 1962). Health problem can be in terms of its clinical result and to some extent the spiritual beliefs in developing countries.

2.6.3 Perceived Benefits of Taking Action and Barriers to Taking Action in a Health Condition

Acceptance of likelihood to a health condition that is also seemed to be disastrous influences a person to take a course leading to an action. However, it does not necessarily define the special line of behaviour that is likely to be taken by the individual. The direction that the action will take is influenced by beliefs regarding the relative effectiveness of known available alternatives in reducing the disease threat to which the individual feels subjected. The individual's behavior is likely to rely on how beneficial he perceives the individual alternatives would accrue to his favor in his case. Emphatically, the individual's belief on the availability and efficacy of individual courses of action, and not sensationally the objectivity about the effectiveness of an action, predisposes what course he is like will take. (Sheeran and Abraham, 1996).

2.6.4 Cues for Action

Very important are the elements that play as triggers to beef up appropriate action. The extent of readiness fuels the effort to act as well as the perception of benefits providing a desirable pathway to action. Considering the health seeking arena, these triggers may be internal, for instance perception of the condition of the body or external such as the impact of media ((Becker et al, 1977; Rosenstock, 2005).

2.6.5 Illness behavior framework

Aside the models discussed above, Mechanic, (1962) proposed framework to explain illness behavior. Illness behavior as itinerate by Mechanic, (1986) reflects "the manner in which persons monitor their bodies, define and interpret their symptoms, take remedial actions, and utilize the health care system." Illness behavior as a relative process is directed by uncountable elements, including social and cultural differences, access to care issues, and the nature of the symptoms being experienced. Four classifications were fitted to provide incentive to the research into illness behavior (Mechanic, 1986; Maclean et al., 1999). These are: dispositional, Acquisitional (person-environment, i.e. learned differences in individual's responses to illness.), Familiar examples of acquisitional factors include variables such as symptom severity, culture, ethnicity, gender, age, marital status, insurance status, and other socio-demographic variables. Patient perception /decision making, and the influence of health care system factors: pressure of the health care structure on individual's illness behavior, in particular the operation of health care services. Integrated in this point of view are determinants such as access to care, distance to care site, and the nature and availability of providers. (Mechanic, 1986; Maclean et al, 1999).

In the presentation of these entire frameworks, it is evident that classifications and explanation of determinants of health seeking behavior highlighted are vibrant and multifaceted. However, aiming at investigating the approach that individuals in peculiar areas formulate ideas and choices relating to their plans of health seeking behavior, take on a frame that applauds the way in which individuals discover 'risks' associated to particular behaviors. In the present study these dynamic determinants would be examined in line of rural Ghanaian environment by means of measuring trigger activities meant to bring us to a specific end point. In view of this, some individuals may plainly a subject of cost and accessibility, for others a symptom severity or socio-

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cultural ethics may buttress any verdict they make in health care seeking. The individual is seemingly rational in decision making given the available information.
Since we are chiefly concerned with the health delivery systems, implicit understanding should be derived for service utilization and structural process of change, necessitating all-encompassing views than those mainstreamed by the health seeking behavior studies.

2.7 Health Seeking Behavior Modification and The Mass Media

Considering the customary difficulties in adjusting the judgments and behavior of adults, it is thought-provoking and noteworthy that effective efforts to change health behavior and health beliefs by sensitive formal request are possible especially to the young and middle age groups (Janis and Feshbach, 1953). This will spring from the role of the mass media in the health seeking behavior of individuals. The blending of mass media and communications tactics and stimulating techniques, using emotional appealing adverts bearing in mind a specified targeted groups of individuals, may handsomely yield extremely greater meaning to a number of hearts in modifying health beliefs and behavior, unlike the results that can be obtained with the practice of any one method. However, a skeptical stance must be taken concerning the probability that mass media would make a tool to alter instead of fortifying health beliefs/behaviours, specifically if the beliefs are intensely rooted (Rosenstock I M, 2005). According to Katz and Lazarsfeld, (1955), it is difficult to reach the illiterates through educational programmes than their counterparts in literate society.

2.8 Health Care Delivery System in Ghana

Delivery of Health services in Ghana is fashioned on the concept of Primary Health Care for all (Alma Atta Declaration of Health for all, 1977). A government-owned and managed hospital is at least located in the District capitals and qualified medical staff such as doctors, nurses, laboratory technicians, pharmacists, auxiliary nurses and other health support personnel are entrusted to deliver on health issues. The decentralized hospital structures in the districts are entrusted to deal with all health case except complicated and specialized ones which may be referred to the Referral Hospitals. The position of health centers in the sub areas cannot be overlooked. There is at least a health center located in the sub-districts and villages to cater for the health needs of the people. These centers are medical assistants and nurses who are normally in charge of the facility.

There is also the need to note the role of the private hospitals, clinics and licensed chemical seller or pharmacies in the district and sub-district. Individuals are expected to register with the National Health Insurance Scheme (NHIS) to benefit freely in their health care delivery. The National Health Insurance Scheme (NHIS) was inducted in 2005 with a mandate by The National Health Insurance Act 650 (2004). A Legislative Instrument, LI 1809 was alongside passed to provide the administrative and operational guidelines for its implementation. The purpose of the scheme was to solve the challenge of financial blockades to health care initiated by the 'Cash and Carry System' which requires instant out-of- pocket payment for health care at the point of service delivery such as hospitals, clinics and other medical centers.

Despite these great strides, Ghanaians continue to wallow in the effects of infectious diseases, malnutrition, non-communicable and communicable diseases, poor reproductive health, which goes a long way to affect their well-being and life expectancy. This condition has been generally connected to the fact that less attention is given to socio-economic, cultural and other factors that may impact on the health of individuals in the determination of ill health (Ghana Health Sector Gender Policy, 2009). It is in this light that this study is conducted into the identification of the factors of health seeking behavior of individuals and the utilization of health facilities in the country.

2.9 Empirical Review

Studies of health seeking behavior on tuberculosis (TB) recurrently exhibit that patients rarely select a state healthcare institution for treatment; they interrupt identification of illness and seldom finish the prolonged sequence of therapy basically, although TB is typically public health concern, as actual identification, cure and control mechanisms are imperative for the public at large (Lönnroth et al, 2001). Steen and Mazonde (1999) established in their study that

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95% of TB patients in Botswana attended a modern health delivery facility as a first stage. But, after beginning with modern cure, 47% at that point continued on to call on a traditional or faith healer too. They later concluded that "there is an increasing tendency to use modern medicine as a 'quick fix' solution, whereas traditional medicine is utilized for providing answers that may be asked about the meaning of the misfortune, and to deal with the 'real' causes of the illness." Patients stress the rank of social and cultural influences in backing up to their consequence of TB control.

Unfortunately, Steen and Mazonde (1999) were aggrieved due to the point that the term " health seeking behavior" is 'not recognized in commonly used books, notwithstanding that appropriate appreciation of health seeking behavior can possibly lessen interruption to diagnosis, advance treatment or cure compliance and expand health training approaches. Corresponding research by Pronyk et al. (2001) in South Africa indicated that TB patients attended public health facilities more out rightly than certain other conditions. Statistically, 72% patients initially went to a public hospital and clinic whiles only 15% visited a spiritual or traditional healer. 13% were attended to by private health provider. A substantial failure of formal clinical facilities to diagnose individuals with symptoms was detected.

Evidently, the result in the Philippines seems to be dissimilar. Only 29% of TB patients in their study of Auer et al (2000) visited first to a health delivery center, alongside 53% turning to a private doctor initially. Majority of patients (69%) had been edged by a family member to pursue medical guidance for their symptoms, whiles those who felt banished due to their TB condition postponed seeking medical help for a while. The researchers attribute that: "result oriented health seeking and fact seeking are controlled by the health system, community, family, and other personal issues" (Auer et al, 2000). TB patients visited private doctors over public health services, believing their services to be more well-mannered, effective, and more confidential.

In the study area of health seeking behavior and maternal health, a significant literature on the cultural, social and structural difficulties women face in various ways have been harnessed especially in the developing countries. Evans and Lambert, (1997; 1793) cited in MacKian, (2005) claim that women have more elusive elucidations in the definition of health which create impression on their health seeking behavior. Dako-Gyeke et al. (2013) in a study in Ghana revealed that perceived threats, which are often socio-cultural aroused women's concerns, lashing them to pursue multiple health care providers. Significantly, pregnant women health care seeking behaviors are chronological utilization of biomedical treatment and other methods of treatment by herbalists, traditional birth attendants, and spiritual healers, often disrupting the continuous use of expert health providers.

Again, this multiple use of health providers is anchored by a view that public health facility is suitable for only antenatal and emergency services (Dako-Gyeke et al. 2013). Researchers such as Bazzano et al. (2008)conducted a study in the Northern Ghana and predicted a significant high cultural value attachment giving birth at home, which unfortunately abruptly definethe negative opinions associated to hospital birth attendance with loss of status, loss of control over delivery process, or loss of secrecy during delivery. This supports Wallman and Baker (1996) analysis and a comprehensive itemization of the 'elements of livelihood' that are expected to upset women's capacity to access treatment.

They are; social status, social life, networks, actual money income, potential money income, autonomy and liability. These are argued to play later when a woman has evaluated how well, kind, shameful, private, feasible and suitable decisions are, within the physical infrastructure of that society and total resource will vary amongst women relative quantities, geographic scope and precise illness episode (Wallman and Baker 1996; MacKian, 2005).Traditional Birth Attendants (TBAs) in Ghana are renowned and patronized due to their high sympathyto socio-cultural norms coupled with their keen capacity to integrate psychosocial care into their services compared to modern health facilities (Bazzano et al. 2008).

A study of patients with Sexually Transmitted Infections in Ghana found that, 64% of them delayed for more than 4 weeks before seeking treatment at the clinic and another 61% had sought treatment elsewhere and 80% of the patients had sex whiles experiencing symptoms (Agambire &Clerk, 2013). Studying on older STI patients (i.e. those aged 45years and above), about 68% sought care late and the motives for delaying were: waiting for resolution (34%) and

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embarrassment or distress of attending the STI clinic (24%). Also in Uganda among STI clients, Bearinger et al., (2007) identified that 74% of clients (aged 50 years and above) deferred seeking health care for more than 4 weeks. The explanations mentioned were embarrassment (30%) and the social implication of been seen as STI clients (32%).In a study in Kenya by Fonck et al 2001 shows that, 41% of 471 patients attending an STI clinic waited for 4 weeks, and 23% delayed for more than 2 weeks before seeking care. They stated reasons like "attitude of staff, lack of privacy and clients' age as a major determinant of ability to seek care. Another study in Singapore showed that 73% waited for 4 week and 27% delayed for over 2 weeks before seeking care. Reasons for delay include: social stigmatization against sexual promiscuity, fear of public exposure, embarrassment, and lack of privacy (Leenars et al., 2003).

Similarly, a numerous of universal matters arise which are relevant in cases of health behavior. Rapley and Fruin (1999) studied on Diabetes Type 1. They outlined that, diabetic conditions frequently places demand in changes of lifestyle and attitude to health behaviors, and the easiness with which such alterations arise is contingent on the individual's self-efficacy and anticipations about results. Hjelm et al, (1999) cited MacKian, (2005) reemphasizes the significance of self-efficacy in health related behaviors and compliance. Also incorporated into their study is relativity of beliefs in cultural settings about health and illness. This clearly shows a health seeking behavior.

Finally, Stenström and Andersson (2000) conclude on a stimulating fact that individuals or patients, who have feeble knowledge in healthcare experts, have a high possibility to participate in risky behaviors in respect to their diabetic state. Hence, the "doctor-patient dynamic" is for a second time mentioned as central theme in health seeking behavior (MacKian, 2005).

2.10 Conclusion

Gaps in the provision and sustained use of health facility from qualified and traditional providers call for the need to make inquiries into the determinants of health seeking behavior in the clearer context. Literatures in these areas have not been harmonized to bring us to complete comprehension of the causal factors. Mackian (2003) states that many (86% of women in rural Bangladesh) access health care from non-trained personnel. Even though, the paper attempted to find out - from the untrained personnel – their knowledge in relationship to modern medicine; she, however, fails to find out why the people behave the way they do. Ten years after Mackian (2003), Webair & Bin-Gouth, (2013) stated that Health Seeking Behaviour learning sometimes describes patterns of behavior but failed to state the source of it. They are hence unable to offer significant recommendations. It is not only enough for such informative knowledge but the causal factors associated with it. The study will find out why people seek health care from untrained personnel and possible determinants that motivate them to decide on where to seek health care.

BPsych stated that people (Busia and Melindi district) with high level of education access healthcare from informal services but people without formal education (Samburu district) have a high possibility to use the formal system. He stated access issue, literacy, and education to be the possible causes. This work will find out factors in the study area which motivate people to use informal health care services. Hence, this study explores this in broader context which aimed at a specific end point.

2.11 Theoretical Perspectives

This aspect of the dissertation looks at concepts and theories that explain health seeking behaviour. Two major models which have been embraced are Pathway and Health Belief Models. A description of different procedures in decision making on health and the focus on the ways households take before using healthcare are what concern the pathway model (Dill, 2012). Nyamongo (2002) found in Kenya that there is relatively a long time observation of sickness before people could see professional advice. Health belief model hinges on people's perceptual views and subjective evaluation of health situations. BPsych (2007) asserts that such evaluation focuses on cost benefit analysis of ill-health situation. An alternative type of model relative to the health belief model is behavioural model. It attempts to make available some variables that affect health care seeking behaviour. Some of these variables are technology and norm; health service

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system; and individual characteristics. Schaefer (2004) attempts to use sociological perspectives (functionalism, conflict theory, interactionism, and labeling theory) to gain insight into sociological context shaping definitions of health and treatment of illness with regards to the following questions. Why is it that you may consider yourself sick or well when others do not agree? Who controls definitions of health and illness in our society? What are the consequences of viewing yourself (or being viewed) as ill or disabled?

Functionalists, such as Talcott Parsons, believe that individuals are supposed to perform various roles in society. Once an individual is said to be sick, he or she takes a social role. The sick role refers to societal expectations about the attitudes and behaviour of a person viewed as being sick. Parsons (1975) outlines that people considered sick are exempted from their normal, day-to-day responsibilities and generally do not suffer blame for their condition. Even though such people are obliged to try to get well, they disturb the smooth functioning of society (Schaefer, 2004).

The conflict theorists observe that medical profession has assumed a preeminent role in society. They have been given a considerable authority to affect the smooth functioning of other social institutions. For example, a student can be excused from school and an employee from work by a medical report. The officially approved monopoly of the right to define health and illness and to treat illness is a source of concern for conflict theorists (Schaefer, 2004). The above concern compel conflict theorists to use the term medicalisation of society; only to refer to the growing role of medicine as a major institution of social control (Conrad and Schneider, 1992; McKinlay and McKinlay, 1977; Zola, 1972, 1983) cited in Schaefer (2004). Conflict theorists emphasise that inequalities in health care resources have clear life-and-death consequences.

The interactionist approach to health is rooted in the relationship that exists between the patient and medical practitioner. The interactionists have a view that patients are not simply passive but often actively seek the services of health care practitioners. The compliance rate of patients to practitioners is also interested to the interactionist. Schaefer (2004) writes that some patients play an active role in health care by failing to follow a physician's advice. Labeling theory offers insights into why certain people are viewed as deviants or criminals whereas others whose behaviour is similar are not.

A suggestion made by Mechanic (1986) posits that at least dispositional, acquisitional, patient perception/decision making, and the influence of health care system factors may be used to study illness behaviour. Dwelling on acquisitional and health system factors, he explained that the former refers to person-environment interaction. Examples include symptom severity, culture, ethnicity, gender, age, marital status, insurance status, and other sociodemographic variables. While the latter (utilisation of health care services) concentrates on access to care issues, distance to care site, and the nature and availability of providers. Based on the above perspectives, the data to be collected shall be analysed to find out which factors really affect the health-seeking behaviour of the respondents in the study area.

2.12Theoretical Perspective

In the active areas of health care policy, restructuring, managed care, access and provision of health care information to the public, and the ever rising demand for health services, the individuals in charge of the planning for and implementing of health care services are accustomed to several critical and challenging issues (American Hospital Association, 1996). A recent profiling of individuals who seek various healthcare services and the type of factors that prompt such actions is necessary if health seeking behavior is needed to provide the essential information necessary to plan health care services for preventive, detective and treatment of illnesses (MacLean et al. 1999). Various interest of literature have always been focused on the multiple determinants of health seeking behavior of individuals, which have sort to model a pattern for these behaviors (Trish and Psych, 2007; MacLean et al. 1999; Suchman, 1965, cited in Mackian et al., 2004).

These models are classified and briefing has been made as follows; *Behavioral* models: (such as Anderson Behavioral Model (Anderson, 1968). This as one area of study can be itemized, in that a little extensive energy has been applied to the understanding of health seeking and illness behavior as a disposition of personal characteristics; such an area is explained by Kasl and Cobb, (1965) cited in Rosenstock, (2005) as "determinants affecting the perception of

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symptoms." Various researchers have attempted to coin personal and socio-cultural variables to the individual's likelihood of believing an occurrence as a symptom or to his method of treatment to a symptom (Rosenstock, 2005).

The classification is as follows: predisposing factors such as sex, age, occupation, education; religion, prior experience, attitudes to health services, health insurance and social network support, suggest that personal attributes may predispose individuals to seek care, enabling factors such as income, household materials; and triggers and barriers to care, which tend to be structural or organizational, such as health insurance coverage and having a regular source of care. Need factors, that is, perception of illness, sick days and service indicators (Hausmann-Muela et al., 2003; Pokhrel & Sauerborn, 2004). Indicators for health seeking and health service use are determined by socio-cultural, political and economic variables from the perspective of the individual and the community at large (Solomon, 2005). These Models normally only contribute a small proportion of the variance in health seeking behaviors. This is because of the undue-emphasis on rigid structural elements and refusal to consider psychosocial variable (Mechanic, 1979). *Psychosocial* models: (Pathwaysmodels Bedri 2001, Suchman, 1965, cited in Rosenstock, 2005), Social Cognition Models (Conner and Norman, 1996) and *Health Belief* Models (HBM), (Hochbaum, 1958; Becker, 1974 as cited in Pokhrel & Sauerborn, 2004 and Rosenstock, 2005).

These models were fitted most significantly, to offer rigorous explanation to health behavior and can immensely apply well to examining illness behavior and sick-role behavior (Anderson, 1968; Hochbaum,1958; Rosenstock., et al, 1965; Pokhrel & Sauerborn, 2004). The main elements in the models are drawn and adapted from general social-psychological theory, notably the work of Lewin, (1935) Cited in Basically, it dwells on: The psychological state of readiness to take specific action(susceptibility and severity) and, The extent to which a particular course of action is believed, on the whole, to be beneficial in reducing the threat (less barriers), (Rosenstock, 2005). Two key dimensions define whether a state of readiness to act exists. They include the degree to which an individual feels vulnerable or susceptible to a particular health condition and the extent to which he feels that contracting that condition would have serious consequences in his case.

Conner and Norman, (1996) in their social cognition model aimed at straightforward indicators to suggest particular behavior patterns. These are dependent on the combination of social, demographic, cognitive factors, emotional and perceived symptoms, personality and access to care (Conner and Norman, 1996). The baseline understanding is that behavior is properly appreciated by one's way of viewing things in his or her social setting (Ghana Health Systems Development Program, 2004). Health Belief Models rely on: 'threat perception' and 'behavioral evaluation' (Sheeran and Abraham, 1996 cited in Health Systems Development Program, 2004). Critiques suggest that the model (Health Belief Model) recognizes individuals as socio-economic choice makers, and being applied world health issues, such as sexual behavior, has not been able to deliver appropriate results and meaningful insights (Sheeran and Abraham, 1996). Health seeking behavior is not likely to be a one off secluded outcome. It revolves daily around society's, person's, or family's characteristics, that indeed the consequence of a changing blend of socio-cultural factors. The procedure of reacting to 'illness' or seeking health care encompasses various phases (Uzma et al, 1999 cited Mackian, 2005). Explaining it into a one off decision or action, or being understood from a single model of health seeking behavior will be deceptive and questionable (Mackian, 2005).

3.0 METHODOLOGY

3.1 Introduction

In this chapter the researcher looks at study setting, study design, study population, sampling and sample size, method of data collection, pre-test of research instrument, reliability, validity, data analysis, and ethical requirement.

3.2 Study Setting

The study was conducted within the Kwabre East District of Ashanti, Ghana. The District has 14 health facilities. There are 6 government hospitals, 7 private and 1 Mission hospital. The proximity of the District to the Kumasi Metropolis makes access to general and specialized health

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services easy. The following health facilities are available in the district. Kwabre District Hospital, Mamponteng Health Centre, Kenyase Health Centre, Aboaso Health Centre, Antoa Health Centre, Wonoo Health Centre, St. Joseph's Clinic, Joy Maternity Home, Maame Rose Maternity Home, Meduma Clinic, African Diaspora Clinic, Christ Our Hope Maternity Home, Adom Mmoroso Maternity Home, Cee Diagnostic, P.A. Diagnostic Centre, Right Care Hospital, Sharp Diagnostics Centre, Sammess Pharmacy, Sonolite Diagnostic Centre, St. James Diagnostic Centre, Royal Palace Maternity Home/Hospital, (NHIA Kwabre District, 2016). There are traditional centres people go for traditional medicine and healing in the district. Some of these centres are: Shesu Bone Healing Centre (Meduma), Ante Anane Traditional Centre (Mamponteng), Agya Dabo and Sofo Lamptey (Ntonso), Hajia Safura, Malam Illiasu (Aboaso), Nana Yamoa, Obaa Yaa – Power Power (Kasaam).

Religious groups (healing centres) available are Prophet Kofi Amponsah (New Asonomaso), Jesus Power Ministry -Columbus (Asenua), True Faith Turbanacle (Mamponteng), Obofo (Fawoade), Antoa Nsuo Nyamaa (Antoa). The common diseases available in the district are malaria, diarrhea, acute respiratory infection, skin diseases & ulcers, hypertension, home accidents and injuries, chicken pox, rheumatism and joint pains, acute eye infection, intestinal worms, and others (Kwabre East District Health Administration, 2013). Health personnel available in the district are as follows: doctors (2), nurses (58), others (126), (Kwabre East District Health Administration, 2014). The District has a youthful population with 40 percent below 15 years and 5 percent elderly persons; 60 years and older. Again, the population of Kwabre East District which is 115,556 is represented by 55,106 males, 60,450 females (Ghana Statistical Service, 2010 Census).

3.3 Study Design

A cross sectional research design was used to observe and describe the relationship between ill health and why people seek for health care at their chosen facilities. A cross sectional research design was used because the outcomes of the research can be analysed to create new theories for further detailed investigations. It is also fairly cheaper to use within a shortest time. Both quantitative and qualitative data were sought for the study. In the opinion of Naoum (2007) and Dawson (2002) three types of research are fundamentally used. These are Qualitative, Quantitative research types and mixed method. The quantitative approach according to Naoum (2007) is 'objective' in nature and makes inquiry into a social or human problem based on testing a hypothesis or a theory. The qualitative is however 'subjective' in nature and lays emphasis on meanings and experiences. To enable the researcher get appropriate responses, mixed method has been chosen.

3.4 Study Population

The Health System of Ghana is arranged in all the districts within the ten administrative regions of the country. The Ministry of Health ranks highest and it permeates through to the community level. The communities involve in this study are found in Kwabre East District of Ashanti Region. There are forty-two (42) communities within the district. The communities are mostly rural with few semi-urban communities lying in the eastern part of Ashanti Region. These communities are distinguished by their homogeneous (rural communities) and heterogeneous (semi-urban communities) nature. This characteristic gives a cross-sectional view of respondents. Members in the communities have access to public and private hospitals, public clinic, private clinic, public and private health centres and maternity homes, prayer camps, traditional healers, pharmacies, drug stores, and drug peddlers as potential health providers.

The population of Kwabre East District (KED) is 115,556 (KED Assembly, Planning Department, 2015). The target population for this study involves all residents within the Kwabre East District aged 18 and above who have lived in the community for more than six months. The basis for these criteria is that, persons who have lived within the district for more than six months are deemed to have a fair knowledge of the study area. Also, section forty-two of the 1992 constitution of the republic of Ghana considers persons aged 18 as matured enough to make informed decisions.

3.5 Sampling Technique and Selection of Participants

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Mugenda & Mugenda (2003) shares that sampling procedure refers to a systematic process of selecting individuals to represent the larger group from which they were selected. The sampling procedure was multistage. A two stage sampling technique was chosen. The primary stage adopted the stratified probability sampling techniques. It was used to select the respondents by categorizing them into three strata defined on the basis of three purposively selected communities. Saunders *et al* (2009) explains that if data cannot be collected from the entire population and statistical inferences must be made from the sample where the research requires face-to-face contact and the population of the study is geographically concentrated, then provided that the sampling frame which contains periodic patterns has relevant strata; stratified random sampling is recommended. The above criteria fully satisfy the research, hence the choice for stratified random sampling technique. Also, the technique has better comparison and hence representation across strata (Saunders, et al., 2009).

At the stage two, a systematic sampling technique was used to select three houses from the left side and three houses from the right side each of three communities with a common standpoint. The principal road/street was used to divide the chosen community into two halves (left and right sides).The researcher selected from every fifth house on each side of the road 5 respondents (male or female) from a household (one of whom was a head of household). Thus, one household head and any other 4 qualified members within a house. In all, six houses were selected from each stratum and this gave a total of 30 participants from the stratum. The three strata groupings therefore produced 90 participants from the communities. This ensured that samples from the three strata had been proportionally allocated. Fifteen members from three facilities were added up to 105 total sample size.

Thus, a total of 90 respondents were selected for the quantitative data and 15 respondents were selected purposively for the qualitative interviews. One health facility from each stratum, five respondents comprising a doctor/physician assistant, pharmacist, midwife, nurse, and biostatistician would be chosen from each facility within each stratum. The above stated personnel have been selected because they occupy key positions in the facility to have access to the intended information. Thus, they would be able to provide appropriate responses for the interviews.

3.6 Method of Data Collection

Mixed method approach was used throughout the study. The choice of questionnaires was based on the fact that respondents would get the opportunity to answer same questions. Again, more questionnaires can be administered in a day which will go a long way to reduce cost. Another advantage for using questionnaires is that they are self-administered for the literate respondents. It is capable of allowing volumes of information to be gathered from many of respondents in a shorter possible time and in a relatively cost effective way (Popper, 1959). Questionnaires were administered to collect primary data from selected respondents in the study communities. The information explored by the questionnaires were demographic characteristics of respondents, general information on health seeking behaviour, various health related problems in the district, type of healthcare services available in the district, factors determining health seeking behaviour in the district, and measures that can be put in place to improve upon peoples health seeking behaviours.

In-depth interviews were conducted to collect qualitative data from health professionals after the questionnaires had been administered. The information explored by the in-depth interviews was how people seek healthcare services; various types of diseases affecting the people in the community, how accessible are healthcare services in the district, why people seek healthcare services from non-biomedical sources, and measures that can improve upon health seeking behaviours in the district. A tape recording machine was used to record qualitative data which was later on analysed by themes. The reasons for selecting in-depth interview were the following. It enabled the researcher to get direct responses from the intended respondents. It has the potential to give the researcher the opportunity to further explain or redirect questions. This situation increased the accuracy of the data collected (Minter, 2003). In-depth interviews were used to collect data from the 15 health professionals.

3.6.1 Pre-Test of Research Instrument

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It is significant that the researcher pre-tests the research tool to be sure of its validity and reliability measures before the real collection of data for the study. The pre-test, was conducted among 30 community members who were not included in the actual study within the three strata. The aim was to help identify questions that sounded ambiguous or irrelevant and also to check the time spent by respondents in answering the questionnaires. The most commonly used type of internal consistency reliability; the Cronbach's co-efficient alpha was used to establish the reliability of questionnaire items.

The credibility of a research finding is anchored on two important testing principles. These are reliability and validity (Saunders et al, 2009). Testing ensures that the findings and evidence of a piece of research work can stand up to the closest scrutiny, and can be proven as being valid and reliable.

3.6.2 Reliability

Saunders *et al* (2009) defines reliability as "the extent to which your data collection techniques or analysis procedures will yield consistent findings". This study made good use of Cronbach's alpha in the test for reliability. Cronbach's alpha is the most popular measure of true reliability of a survey Hinton *et al*, (2005). To achieve this test, it is imperative that sources of information and empirical data be explicitly documented and referenced.

3.6.3 Validity

Validity, however, refers to whether the findings represent and reflect the true situations on the ground. This will ensure that the relationship between two variables is not a mere causal relationship as argued by Saunders *et al* (2009).

3.7 Data Analysis

Data collected was edited, encoded and analyzed, and presented in the form of statistical tables with the help of Statistical Package for Social Sciences (SPSS). The statistical analytic tools of percentages were used to provide a more comprehensive presentation for analysis and interpretation. The qualitative data were used in the form of comprehensive statements and analytical inferences. Relations were drawn as to whether a particular finding was supported by the reviewed literature or not.

3.8 Ethical Requirements

The study complied with the ethical requirements for research in accordance with the Helsinki declaration. Study participants were duly informed about the objective of the study and their voluntary participation for which they could redraw at any point in time. The consent of research participants were sought before enrollment. The confidentiality and anonymity of respondents were highly prioritized

4.0 RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents an in-depth analysis of the data obtained from the field. The data were processed using Statistical Package for Social Sciences (SPSS) and presented with tables before analyses were made. All the data used in this analysis was first-hand information collected from the sample of interest. The analyses consist of profile of respondents, descriptive statistics, regression, and analysis of variance (ANOVA) of the various determinants or factors related to the topic of interest. Ninety (**90**) questionnaires were distributed to the various respondents and **90** questionnaires representing 100% were returned and used in the quantitative analysis accordingly. Also, fifteen (**15**) respondents from health facilities were interviewed for open-ended views but responses from fifteen (**15**) representing 100% were used for the qualitative analysis.

4.2 Demographic Characteristics Of Respondents

4.2.1 Gender

Table 1: Gender

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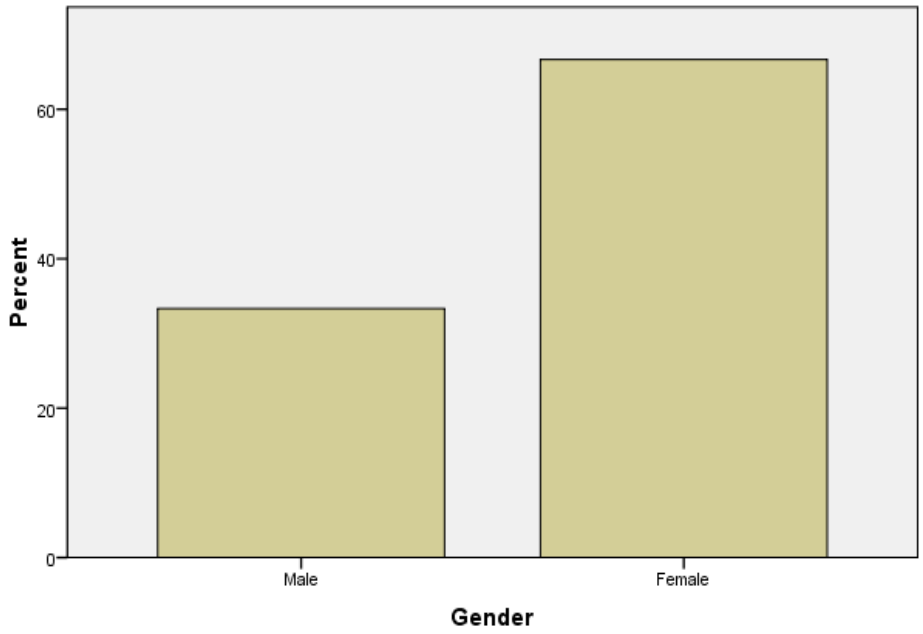
	Frequency	Percent	Cumulative Percent
Male	30	33.3	33.3
Female	60	66.7	100.0
Total	90	100.0	

Source: Field Data, 2016

Table 1 above shows that there are more females in the district than males. Out of the ninety respondents, 60 of them were females. This figure represents 66.7% of the respondents. This is a confirmation in the literature that "the population of Kwabre East District which is 115,556 is represented by 55,106 males, 60,450 females" (Ghana Statistical Service, 2010). The female percentage of the population according to the report was 52.3%.
The fig. 2 below shows the gender of the study population.

Figure 2: Gender



4.2.2 Age Group

The data shows that 40% of respondents have attained age between 18-22 years while 52.2% of the respondents did not exceed age 28. This is a clear manifestation that the population of the district has more youth than the elderly. This can be seen in Table 2 below. Again, there is a correlation between this and the population of the district given by Ghana Statistical Service. "The District has a youthful population with 40 percent below 15 years and 5 percent elderly persons; 60 years and older" (Ghana Statistical Service, 2010).

Table 2: Age Group

	Frequency	Percent	Cumulative Percent
18-22	36	40.0	40.0
23-28	11	12.2	52.2
29-60	38	42.2	94.4
61 and above	5	5.6	100.0
Total	90	100.0	

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Source: Field Data, 2016

4.2.3 Level of education and provider choice

To ascertain whether a person's educational level influences his or her provider choice, the two variables: education and provider choice were studied. Tables 3a and 3b respectively show that 50% of respondents had attained tertiary education and 75.6% of same had indicated biomedical centres as their provider choice. This confirms what Rosenstock (2005) said in the literature that people of higher education access healthcare from biomedical centres. Contrary to this view was what BPsych (2007) said as pertained situation in Kenya.

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Table 3a: Level of education

Level of education

	Frequency	Percent	Cumulative Percent
JHS	7	7.8	7.8
SHS	33	36.7	44.4
Tertiary	45	50.0	94.4
Other	5	5.6	100.0
Total	90	100.0	

Table 3b: Patient's provider choice
Which of the health care facilities do you normally seek health care from?

	Frequency	Percent	Cumulative Percent
Hospitals/Health Centres	68	75.6	75.6
Maternity Homes	20	22.2	97.8
Herbalists	2	2.2	100.0
Total	90	100.0	

4.2.4 Regular Monthly Source of Income and Estimated Monthly Income

A person's income has a direct relationship with the kind of healthcare he would seek. Even though the majority of respondents had regular monthly source of income, a significant number of the study participants representing 41.1 per cent did not have regular source of income. Table 4 below shows that a significant percentage of respondents (43.3%) receive or earn monthly income less than Gh¢ 100.00. This confirms in the reviewed literature that 44.4% of respondents had attained JHS and SHS education and are not engaged in any gainful employment.

Table 4: Estimated Monthly Income

	Frequency	Percent	Cumulative Percent
less than Ghc 100.00	39	43.3	43.3
between Ghc 100.00- Ghc 300.00	35	38.9	82.2
between Ghc 301.00- Ghc 500.00	3	3.3	85.6
between Ghc 501.00- Ghc 1,000	7	7.8	93.3
above Ghc 1,000.00	6	6.7	100.0
Total	90	100.0	

Source: Field Data, 2016

4.3 General Information on Health Seeking Behaviour
4.3.1 Health Information Seeking

The table 5 below shows the extent to which people seek for health information. This would determine whether respondents show interest in their health before, during and after falling sick. Eighty per cent (80%) of respondents were of the view that they had not sought information from their relatives or friends who have medical background.

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Table 5: Health advice from non-biomedical settings

	Frequency	Percent	Cumulative Percent
Yes	18	20.0	20.0
No	72	80.0	100.0
Total	90	100.0	

Source: Field Data, 2016

4.3.2 Seeking Healthcare from traditional healers and religious leaders

Respondents were asked whether they seek medical care from traditional healers and religious leaders. It was found that majority (80%) of respondents answered that they had not gone to traditional healers and religious leaders for health care. Thus low patronage of non-biomedical facilities might be due to low availability of such facilities in the district. The above response opposes what the health professionals said that most patients believe that their sicknesses were caused by curses and deity and attempt to seek care from such sources before attending hospitals.

Table 6: Types of health care facilities available in the community of residence?

	Frequency	Percent	Cumulative Percent
Hospitals/Health Centres	60	66.7	66.7
Maternity Homes	23	25.6	92.2
Native Doctors	2	2.2	94.4
Herbalists	4	4.4	98.9
Spiritualists	1	1.1	100.0
Total	90	100.0	

Source: Field Data, 2016

4.3.3 Home visit by doctors

Respondents were asked if their doctors had paid them visit in their homes in the past three months. It helped to ascertain if they had their own paid doctors who attend to them when sick or for review purposes. Most of the respondents (95.6%) stated that their doctors had not paid them visits in their homes. This suggests that most people in the study area do not have their own paid doctors. This confirms that the youthful population in the study area (43.3%) receives monthly income less than Gh¢ 100.00 and as such cannot pay doctors to take care of them in their homes when sick.

Table 7: Home visit by doctors

	Frequency	Percent	Cumulative Percent
Yes	4	4.4	4.4
No	86	95.6	100.0
Total	90	100.0	

Source: Field Data, 2016

4.3.4 Illness Treatment Seeking Behaviour

Respondents were asked if they often treat their illnesses on time. Responses indicated that most (81.1%) treat their illness on time. The respondents said that they sought for healthcare within 3-7 days at the onset of disease symptoms. Majority (44.4%) as shown in table 8 affirm that. This was confirmed during the qualitative interviews that patients seek for early treatments at health facilities even though they might have started self-medication. When

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respondents were asked where they go for treatment at the first step, most of them (as shown by Table 9) responded that they consult pharmacist without a prescription but in consultation with the pharmacist. This behaviour confirms what Steen and Mazonde (1999) established in their study that 95% of TB patients in Botswana attended a modern health delivery facility as a first stage.

Table 8: Number of days for seeking health care

	Frequency	Percent	Cumulative Percent
The same day	17	18.9	18.9
The next day	14	15.6	34.4
Two days later	9	10.0	44.4
3-7 days	40	44.4	88.9
More than seven days	10	11.1	100.0
Total	90	100.0	

Table 9: Where respondents go for treatment at the first step

	Frequency	Percent	Cumulative Percent
General practitioner's office, health centre emergency room, clinic, private or governmental hospital	32	35.6	35.6
Pharmacy without a prescription but consultation with the pharmacist	49	54.4	90.0
Pharmacist without a prescription	6	6.7	96.7
Others	3	3.3	100.0
Total	90	100.0	

Source: Field Data, 2016

4.4 Various Health Related Problems In The District

4.4.1 Type of illness commonly affecting the people

The study sought to find out the type of illnesses in the district that affect most people at the individual and community levels. At the individual and community levels, respondents were of the view that malaria and respiratory infections commonly affect the people. This opinion of the respondents was affirmed by majority of healthcare providers. Tables 15 and 16 show that malaria at the individual level (55.6%) and community level (70%) mostly affects the people followed by acute respiratory infection. This confirms what was said earlier in the study that "the common diseases available in the district are malaria, diarrhea, acute respiratory infections …" (Kwabre East District Health Administration, 2013). The opinion of respondents on diarrhea, however, contradicts what is in the literature as one of the common diseases affecting the people. At the individual level, only 2 persons representing 2.2% were of the view that diarrhea is a common disease in the district. Also at the community level, it was observed that only one person representing 1.1% was of the view that diarrhea is a common disease in the district.

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Table 10: Type of illness that commonly affect individuals

	Frequency	Percent	Cumulative Percent
Malaria	50	55.6	55.6
Diarrhea	2	2.2	57.8
Acute Respiratory Infections	25	27.8	85.6
Skin Diseases and Ulcers	12	13.3	98.9
Hypertension	1	1.1	100.0
Total	90	100.0	

Table 11: Type of illness that commonly affect the community

	Frequency	Percent	Cumulative Percent
Malaria	63	70.0	70.0
Diarrhea	1	1.1	71.1
Acute Respiratory Infections	19	21.1	92.2
Skin Diseases and Ulcers	1	1.1	93.3
Hypertension	6	6.7	100.0
Total	90	100.0	

Sources: Field Data, 2016

4.4.2 The causes of common illness affecting the people in the district

On the causes of common illness affecting the people in the study area, 44 of the respondents representing 48.9% indicated that insanitary environment was the cause. Others such as poor diet and eating habit, dusty environment were causes of the common illness affecting the people. This can be seen in table 12 below.

Table 12: Causes of illness

	Frequency	Percent	Cumulative Percent
Insanitary Environment	44	48.9	48.9
Poor Diet and Eating Habit	15	16.7	65.6
Dusty Environment	26	28.9	94.4
Excessive Heat	3	3.3	97.8
Poor Drinking Water	2	2.2	100.0
Total	90	100.0	

Source: Field Data, 2016

4.5 Types Of Healthcare Services Available In The District

Table 13: Healthcare facilities commonly available in the community

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	Frequency	Percent	Cumulative Percent
Hospitals/Health Centres	60	66.7	66.7
Maternity Homes	23	25.6	92.2
Native Doctors	2	2.2	94.4
Herbalists	4	4.4	98.9
Spiritualists	1	1.1	100.0
Total	90	100.0	

Source: Field Data, 2016

Table 14: Healthcare facilities commonly available in the district

	Frequency	Percent	Cumulative Percent
Hospitals/Health Centres	50	55.6	55.6
Maternity Homes	35	38.9	94.4
Native Doctors	2	2.2	96.7
Herbalists	1	1.1	97.8
Spiritualists	2	2.2	100.0
Total	90	100.0	

Source: Field Data, 2016

4.6 Factors Determing People's Health Seeking Behaviours In Kwabre East District

4.6.1 Reasons for provider choice

To determine the common factor that influences people's provider choice, respondents were asked to give reasons for their provider choice. The following variables: relationship, proximity, income, and better treatment were used. Most responded that they choose their providers because of proximity of such providers to their residences. Other respondents said that they chose such facilities because of better treatment.

4.6.2 Proximity of healthcare facilities to residents

The study sought to find out if proximity of healthcare facilities to the residents was a challenge to the people in their attempt to seeking for healthcare. It can be seen from Table 21 that 66.7% responded that hospitals/health centres are the closest facilities. This confirms their reasons for provider choice stated in 4.6.2. This is attributable to what is said in the literature by Msiska *et al* (1997) that … "availability of service" is a factor for health seeking behaviour.

4.6.3 Possession of NHIS cards by respondents

To find out whether or not income was a hindrance to people in their attempt to seeking for healthcare, respondents were asked if they have NHIS cards. This is because the object of such cards is to enable them access healthcare free without instant payment of fees. It can be seen from table 15 that 76 out of 90 respondents representing 84.4% responded that they had NHIS cards. This was also affirmed by health professionals that majority of patients access healthcare with their NHIS cards. It is interesting to know that 76.7% access healthcare with the cards. A reasonable percentage (7.7%) does not access healthcare with their valid NHIS cards.

Table 15: Possession of NHIS cards by respondent

	Frequency	Percent	Cumulative Percent
Yes	76	84.4	84.4
No	14	15.6	100.0
Total	90	100.0	

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Source: Field Data, 2016

4.6.4 Seeking healthcare from native doctors, herbalists, religious leaders, and traditional birth attendants

To find out why some people seek healthcare from sources such as native doctors, herbalists, religious leaders, and traditional birth attendants, respondents said because they had belief in spiritualism and its potency. People's beliefs and practices in their social context play significant roles here. Others were of the view that biomedicines do not completely cure the diseases but suppress them. Herbal medicine on the other hand cures diseases completely. The medical practitioners had a different view. They said that biomedical treatment is comparatively better than non-biomedical ones. Table 16 shows that a cumulative figure of 78.9% of respondents either agree or strongly agree to the statement that patients who access healthcare from biomedical centres are better treated than their counterparts in the non-biomedical centres. This confirms what Steen and Mazonde (1999) concluded in the literature that " there is an increasing tendency to use modern medicine as a 'quick fix' solution" to human illness.

Table 16: Herbal medicine cures faster than biomedicine

	Frequency	Percent	Cumulative Percent
Strongly Agree	28	31.1	31.1
Agree	43	47.8	78.9
Fairly Agree	9	10.0	88.9
Disagree	8	8.9	97.8
Strongly Disagree	2	2.2	100.0
Total	90	100.0	

Source: Field Data, 2016

4.7 Measures That Can Be Put In Place To Improve Upon The People's Health Seeking Behaviours
4.7.1 Establishment of healthcare facility in each community.

On a likert scale, respondents were asked to indicate their degree of acceptance of the possible factors that can improve upon the health seeking behaviours of the people in the district. It became apparent that 88.9% strongly agreed that healthcare facility should be established in each community. The cost of healthcare must be very low despite the nature of illness was also the view of others, whilst 61.1% opined that there should be improvement in the road networks in the district. Tables 17 and 18 below attest to the above facts. The health professionals however said that government should stock medicines in the regional medical stores; the NHIA should reimburse the facilities on NHIS claims as per the agreement and to provide logistics such as consumables to all facilities.

Table 17: Establishment of healthcare facilities in each community

	Frequency	Percent	Cumulative Percent
Strongly Agree	80	88.9	88.9
Agree	5	5.6	94.4
Disagree	4	4.4	98.9
Strongly Disagree	1	1.1	100.0
Total	90	100.0	

Table 18: Cost of health care must be very low despite the nature of illness

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	Frequency	Percent	Cumulative Percent
Strongly Agree	49	54.4	54.4
Agree	30	33.3	87.8
Disagree	9	10.0	97.8
Strongly Disagree	2	2.2	100.0
Total	90	100.0	

Table 19: Road networks leading to health care centres must be easily accessible

	Frequency	Percent	Cumulative Percent
Strongly Agree	55	61.1	61.1
Agree	34	37.8	98.9
Disagree	1	1.1	100.0
Total	90	100.0	

Sources: Field Data, 2016

4.7.2 Payment of realistic NHIS premiums by subscribers

Accessing the income ability of respondents to pay the existing NHIS premiums, respondents were asked if the authority should ensure that subscribers pay realistic premiums. Over forty-five per cent (45.6%) disagreed whilst 17.8% agreed. This is seen in table 20 below.

Table 20: Government should ensure that contributors pay realistic premiums towards the NHIS for appropriate service

	Frequency	Percent	Cumulative Percent
Strongly Agree	31	34.4	34.4
Agree	16	17.8	52.2
Disagree	41	45.6	97.8
Strongly Disagree	2	2.2	100.0
Total	90	100.0	

Source: Field Data, 2016

4.7.3 Training more healthcare professionals

From Table 21 below, it can be seen that 80% of respondents strongly agree that government should train more health professionals to work in the health institutions. This view was also suggested by the health professional in the selected sample.

Table 21: Training of more healthcare professionals

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	Frequency	Percent	Cumulative Percent
Strongly Agree	72	80.0	80.0
Agree	13	14.4	94.4
Disagree	4	4.4	98.9
Strongly Disagree	1	1.1	100.0
Total	90	100.0	

Source: Field Data, 2016

4.7.4 Seizure of licences of all non-biomedical practitioners

Assessing the views of respondents on the seizure of licences of all non-biomedical practitioners, respondents were of the view that the licences of the practitioners should not be ceased. Although 75.6% of the people access healthcare from biomedical side, 46.7% of respondents disagree that such licences should be ceased. In a related issue, Table 22 shows that 52.2% of respondents agree that government should assist non-biomedical practitioners to improve upon their practices. The stay of these traditional healers is what Steen and Mazonde (1999) concluded that …. "traditional medicine is utilized for providing answers that may be asked about the meaning of the misfortune, and to deal with the 'real' causes of the illness." In the qualitative interview, the health professionals suggested that there should be proper regulations on these non-biomedical practitioners by the government through the Metropolitan, Municipal, and District Assemblies. This confirms what Dako-Gyeke *et al.* (2013) said that " herbalist, traditional birth attendants, and spiritual healers, often disrupting the continuous use of experts health providers".

Table 22: Government should assist non-biomedical practitioners to improve upon their practices

	Frequency	Percent	Cumulative Percent
Strongly Agree	29	32.2	32.2
Agree	47	52.2	84.4
Disagree	5	5.6	90.0
Strongly Disagree	9	10.0	100.0
Total	90	100.0	

Source: Field Data, 2016

4.7.5 Logistics and consumables should be readily available in all health facilities.

To ascertain the extent to which healthcare practitioners get necessary logistics to work with, respondents were asked to indicate their level of agreement. Table 23 shows that 74.4% of respondents strongly agreed that logistics and consumables should be readily available in all health facilities.

Table 23: Availability of Logistics and consumables

	Frequency	Percent	Cumulative Percent
Strongly Agree	67	74.4	74.4
Agree	19	21.1	95.6
Disagree	2	2.2	97.8
Strongly Disagree	2	2.2	100.0
Total	90	100.0	

Source: Field Data, 2016

4.7.6 Reliability of Response

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The Cronbach's Alpha coefficient for the extent of occurrence of factors influencing health seeking behaviours as seen in Table 24 below is 0.678. Since this figure is greater than 0.5 (Goforth, 2015), the response provided is reliable and can be used and relied upon for this study. This test was carried out using Reliability Analysis of SPSS.

Table 24: Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
0.678	0.710	49

4.7.7 Regression Analyses of Factors Determining People's Health Seeking Behaviours

In statistical modeling, regression analysis is a statistical process for estimating the relationships among variables. More specifically, regression analysis helps one to understand how the typical value of the dependent variable changes when any one of the independent variable is varied, while the other independent variables are held fixed. The term "regression" was coined by Francis Galton in the nineteenth century to describe a biological phenomenon (Galton, 1885). Regression models involve the following variables:

- The unknown parameters, denoted as ß, which may represent a scaler or a vector.
- The independent variable , X
- The dependent variable Y

The regression model relates Y to a function of X and ß.

$$Y \approx f(X, ß)$$

In general, multiple regression procedures will estimate a linear equation of the form:

$$Y = ß_o + ß_1 X_1 + ß_2 X_2 + \ldots + ß_p X_p$$

The regression model was computed to check how well a regression model fits the data. The R measure can be considered to be one measure of the quality of prediction of the dependent variable. The regression analysis has been used in this research to predict the value of one variable on the basis of other variables (Keller & Warrack, 2004). If the R value is 0.5 or more, it means that the data has a high level of prediction. Since the R value of the data is 0.526, the data has a good level of prediction.

Table 25: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.526[a]	.277	.185	.453

Source: Field Data, 2016

The ANOVA is used to test whether the overall regression model is a good fit for the data. If the P value is less than 0.005 then the regression model is a good fit of the data. The data has 0.003 hence a very good fit for the research

Table 26: Anova

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ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	6.210	10	.621	3.020	.003[a]
	Residual	16.245	79	.206		
	Total	22.456	89			

Source: Field Data, 2016

5.0 CONCLUSIONS

5.1 Introduction

This chapter (chapter five) summarizes the issues addressed throughout the study. It begins with a summary of how the research objectives were achieved and concluded with the recommendations obtained from the research and directions for further research that can be conducted based on the conclusions and limitations of the study.

5.2 Summary Of Findings

This study which looks into the factors influencing health seeking behaviour in Kwabre East District of Ashanti Region, Ghana revealed the following. It confirmed the literature that there are more females 66.7% than males. The study revealed that the district has a youthful population where 40% fall within the range of 18 – 22 years. Again, it can be seen that the district has high literacy rate (94.4%) spreading across Junior High Schools, Senior High Schools and Tertiary levels. It has been found out that 70% of illnesses affecting the members in the district is malaria. It was seen that insanitary environment was the major cause of malaria. The health facilities commonly available in the district are hospitals and health centres. It was seen that members in the district mostly seek healthcare from hospitals and health centres and their reasons for provider choice is proximity. It was found out that 84.4% of people in the district possess NHIS cards and 76.7% out of 84.4% access healthcare with the NHIS cards.

It was seen that majority (78.9%) agree in various degrees that biomedicine heals effectively than non-biomedicines. With regards to measures to improve upon health seeking behaviour, it was found out that government should establish healthcare facilities in most communities, cost of healthcare must be very low, train more healthcare professionals, and road networks leading to healthcare facilities must be accessible. Again, it was found out that logistics and consumables should be readily available in all health centres. However, respondents disagreed that contributors should pay realistic premiums towards the NHIS. Again, they disagreed that government should cease the licences of non-biomedical practitioners. The study found out that most people of average education use biomedical treatments for healthcare but not traditional medicine at the onset of disease treatment.

5.3 Conclusion

The results of this study have shown that Malaria and Acute Respiratory Infections mostly affect the people in Kwabre East District of Ashanti. Again, the type of healthcare services available in the district is general consultation. The following were noted as factors influencing health seeking behaviour of the people in Kwabre East District of Ashanti: Belief, Cost, Proximity, Attitude & Behaviour, and Suggestion Ability. Primarily, the main determinants of Health can be viewed as the feedback of a complicated mixture of cultural, educational, social, economic, and political indicators. This, notwithstanding, it can be concluded that even though one factor leads a person to go for a particular source of treatment, the people access health care from all treatment centres.

5.4 Recommendations

In reference to the findings of this study, the following recommendations are being proposed to improving health seeking behaviours of people in Kwabre East District.

- There should be proper and intense education on how people in the study area must clean their environment and the reasons for that.

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- There should be at least one specialized hospital in the district.
- There should be education on dangers involved in self-medication.
- People should be sensitized enough to become aware of the causes of their illnesses and the appropriate way to prevent and or cure them.
- There should be cooperation between health professionals & religious healers.

5.5 Recommendations For Further Research

The factors influencing health seeking behaviours of people in Kwabre East District have been made manifest in this study. The researcher believes that this was only conducted in one district of Ashanti and with a smaller sample size; this means that, the work may have provided a tilted outcome. It would be very essential to conduct similar research to cover a wider range of districts with larger sample size within Ashanti Region. It can be seen that 84.4% responded that they had NHIS cards. It is worthy of note that 76.7% access healthcare with the cards. A reasonable percentage (7.7%) does not access healthcare with their NHIS cards.

A further study can therefore be conducted to find out why people who have valid NHIS cards do not access healthcare with it. Further studies can be done on the contribution of culture in disease acquisition and health seeking behaviour in contemporary societies. This research was not able to delve thoroughly into the role of culture in disease acquisition. This study however serves as an eye-opener and a stepping stone for a nationwide study.

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