Original Article

Health Seeking Behaviors and Utilization of Healthcare Services among Rural Dwellers in Under-Resourced Communities in Ghana

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Abstract

Background: The health seeking behavior of a community, group of people or individuals describes the actions taken in a bid to prevent, minimize or cure a disease condition as well as maintain good health status. The ways in which communities and individuals seek healthcare for their ailments determines the utilization of healthcare services. This contributes greatly to the overall health status of the community. It is against this background that this study was conducted to determine and assess the health seeking behaviors of rural dwellers in under-resourced communities.
Methods: A cross-sectional study was conducted using a semi-structured questionnaire administered to assess the utilization of healthcare services among rural dwellers in poorly resourced communities in the Bongo district. Multistage and simple random sampling procedures were employed to recruit participants for the study. Thirty (30) communities and two hundred and fifteen (215) houses were sampled. Overall, a sample size of four hundred and four (404) participants was interviewed.
Results: The study showed the health seeking behaviors of the participants. These included the treatment choices to healthcare, challenges faced in utilizing healthcare facilities, and the frequency of healthcare visitations among participants. About 44% of the respondents had an average household income less than US $400. The distance to the nearest healthcare facility was varied due to the scattered nature of their settlements. The choice of treatment method for ailments was found to be significantly associated ($p < 0.05$) with the household income, distance to healthcare center, occupation, and educational status. About 59% of males had attended healthcare facilities between one (1) to three (3) times within a year. The frequency of visits to healthcare facilities for care was found to be significantly associated ($p < 0.05$) with age, occupation, healthcare facility distance, income, and educational status of respondents. Majority (32%) of the respondents indicated the cost of services at the healthcare facilities as the major obstacle.
Conclusion and Recommendation: This study sought to bring out the health seeking behaviors of rural dwellers to trigger discussions and re-evaluation of health promotion and education policies and programmes to bring about improvement in health seeking among rural dwellers. It is imperative for duty-bearers to engage key stakeholders in rural communities in the design and implementation of healthcare programmes. The full utilization of the modern healthcare services by resource-poor communities requires a change in primitive health seeking behaviors. This demands a multifaceted approach in planning, stakeholder engagement, as well as the implementation of health education and behavior change interventions.

Key Words: Health seeking behavior, rural dwellers, herbal medicine, communities

Introduction

The health seeking behavior of a community, group of people or individuals describes the actions taken in a bid to prevent, minimize or cure a disease condition as well as maintain good health status. Tipping and Segall (1995) aptly defines health-seeking behavior as any action carried out by people who perceive to have a health condition to find an ideal solution. The ways in which communities and individuals seek

healthcare for their ailments determines the utilization of healthcare services. This eventually defines the health status of the entire population (Shaikh & Hatcher, 2005).

The ideals, values and attitudes of a community in relation to disease condition and health influence how the inhabitants utilize health services. The utilization of health services among rural dwellers is influenced by a multiplicity of factors that results in varied health outcomes and disease burden of communities. The fundamental basis on which good health could be achieved and maintained is to identify the factors that influence health-seeking behaviors of communities. Understanding human behavior is a complex issue that is traceable to the perceptions, attitudes and values of communities (Tipping & Segall, 1995). Social and physical environmental factors, religious belief and value placed on life (WHO, 2002; Omotosho, 2010) influence an individual's decision regarding the utilization of health services.

The practice and belief in the efficacy of herbal medicine in curing illnesses is high among rural dwellers in African countries which for several centuries been largely influenced by religious and cultural values and norms (Ojua et al. 2013). The Advancement in modern medicine, civilization and education has resulted in a magnificent changed the primitive beliefs and behaviors exhibited by rural dwellers towards the utilization of orthodox medicines and modern healthcare services (Ojua, 2000; Katung, 2001). Undoubtedly, perceptions held regarding health and illness are influenced socio-culturally. Income levels, social status, marital status, religious beliefs, quality healthcare delivery, level of education, cost of healthcare are among other factors that shapes the health-seeking behavior of communities and individuals (Omotosho, 2010).

Several studies conducted to assess the relationship between culture and health-seeking behavior of communities are premised on anthropology under the framework of social constructivism (Anyinam, 1987; Tsey, 1997; Twumasi, 1979). The understanding of people's culture is grounded in Anthropology. The patterns of behaviors exhibited by individuals are based on preconceived ideas, norms and values that affect how health and wellbeing is viewed (Winkelman, 2009). Rivers (1924) in a study asserts that, it is imperative to comprehend an individual's perception of illness before an attempt could be made to understand the observed actions or inactions regarding utilization of health services. Health-seeking behavior could be described in terms of a series of events and processes that involved a recognition of disease condition (diagnosis), identification of the causative factors (etiology), and prediction of course and outcome of the disease condition (prognosis) (Rivers, 1924; Sarfo, 2015). Anthropological understanding of the etiology and diagnosis of disease condition differs greatly with that of biomedical context, with the latter explaining the cause of disease within the context of germ theory, while anthropology further considers the social context of an individual in the understanding and explanation of a disease condition (Sarfo, 2015).

Culture alone cannot comprehensively explain or influence health services utilization among individuals and communities. In a study conducted by Jenkins et al (1996) to assess the role of traditional beliefs and the utilization of modern medical care, it was revealed that there was no significant correlation between beliefs held by individuals viz a viz the use of orthodox medicine. In another study conducted by Young and Garro (1994) to assess choice of health facilities visited, it emerged that even though the two communities shared similar norms, beliefs and attitudes regarding traditional and modern medical facilities. The most defining issues distinguishing the choices and utilization of health facilities between the communities were; the cost associated with healthcare, availability of facilities, and distance to health facilities among others (Young & Garro, 1994).

Indeed, the choice and patronage of any healthcare system largely depend on a myriad of factors including cultural beliefs, income levels, educational status, social status, age , gender, access to facilities, quality of service, availability and attitude of health workers among others (Ogunlesi & Olanrewaju, 2010: Thuan et al., 2008; Kiwanuka et al., 2008). A critical determining factor of health services utilization behavior is the health delivery system (Shaikh & Hatcher, 2005). In most developing countries including Ghana, the disease burden and health outcomes are greatly impacted by cost of health

care, illiteracy, poor healthcare funding, poor water and sanitation systems, cultural orientations, and knowledge of disease and wellbeing (Sarfo, 2015; WHO, 2008; Anyinam, 1987). Most studies conducted in regarding health-seeking behavior mainly concentrate on assessing the individual diseases such as Malaria, and infectious diseases (Tuberculosis, HIV/AIDS etc.). There is therefore limited knowledge regarding the general health-seeking behavior and utilization of healthcare services, as well as the challenges confronting rural dwellers and communities in the search for quality health services. The main purpose of this study was therefore to assess the factors influencing health care practices, access, choices, and challenges as well as the general health seeking behavior of rural dwellers in Bongo District in the Upper East Region of Ghana.

Methodology

Study Area

The study was carried out in Bongo district, one of the deprived districts in the Upper East Region of Ghana. The population of the District is estimated to be 90,818 people and an average of five (5) households in each house (Bongo District Assembly, 2014; GSS, 2012). Majority of the inhabitants are predominantly peasant farmers engaged in crop and animal production, fishing as well as petty traders (GSS, 2012). The delivery of health care services by the District Health Management Team (DHMT) is executed through a cluster of communities zoned into six (6) sub-districts. Health facilities in the district provide largely primary health care services and are mostly clinics, health centers, Community-Based Health Planning and Services (CHPS compounds), and a district hospital serving as the main referral health facility for the rest of the primary healthcare facilities in the Bongo District.

Study Design

A cross-sectional study was conducted between January and February 2018. A semi-structured questionnaire was administered to assess the utilization of healthcare services among rural dwellers poorly resourced communities. The interview questionnaire had several sections that included; demographic characteristics, choice of care, and challenges in healthcare utilization.

Sampling Technique and Sample Size

Multistage and simple random sampling procedures were employed to recruit participants for the study. Sampling was carried out in two phases. The first stage involved the sampling of communities while the second stage involved the selection of houses and households from each sampled community. The Bongo district is sub-divided into seven (7) area councils (Bongo central, valley zone, Balungu, Beo, Namoo, Zorko and Soe area councils). Random sampling was employed to select four (4) of the area councils. A random sampling of thirty- (30) communities as well as two hundred and fifteen (215) houses was conducted. The recruitment of participants at the household level was done hierarchically. That is, only the household head was interviewed from each household visited. In the absence of the household head, a spouse or eldest child of the family was interviewed instead. The decision to interview the household head was because at the household level, the decision to seek healthcare is largely made by the household head, an elder or matured and highly placed individual of the family and society. The sample size was determined using Cochran (1977) formula. A sample size of four hundred and four (404) participants was interviewed using a semi-structured interview questionnaire.

Data Analysis

Prior to data entry and analysis, each completed questionnaire was checked visually for completeness. The responses obtained from the administration of the questionnaire were entered into Microsoft Excel (2010). Data was exported to IBM SPSS version 22 (SPSS Inc., Chicago, IL, USA) and coded for statistical analysis. Descriptive statistics was employed to define and describe the responses. Pearson Chi-square test was used to test for associations among certain variables that influence health-seeking behaviours. A 5% level of significance and *P-value* less than 0.05 was considered significant.

Conceptual Framework

The health-seeking behavior of individuals, groups and communities are varied and largely influenced by a multiplicity of factors. The study was guided by Anderson's behavioral model (Anderson, 2008). This model has been applied in several studies (Kuuire et al., 2015; Riwanuka et al., 2008; Ahmed et al., 2008) conducted in

resource-poor communities to assess health seeking behaviors. The model asserts that access and utilization of health services is influenced by three main factors: Predisposing factors (socio-cultural characteristics), Enabling factors (resource availability), and Need factors (quest for solution to illness) (Anderson, 2008).

Figure 1 is a schematic illustration that shows the interconnections of the factors influencing health services utilization of individuals in resource-poor communities.

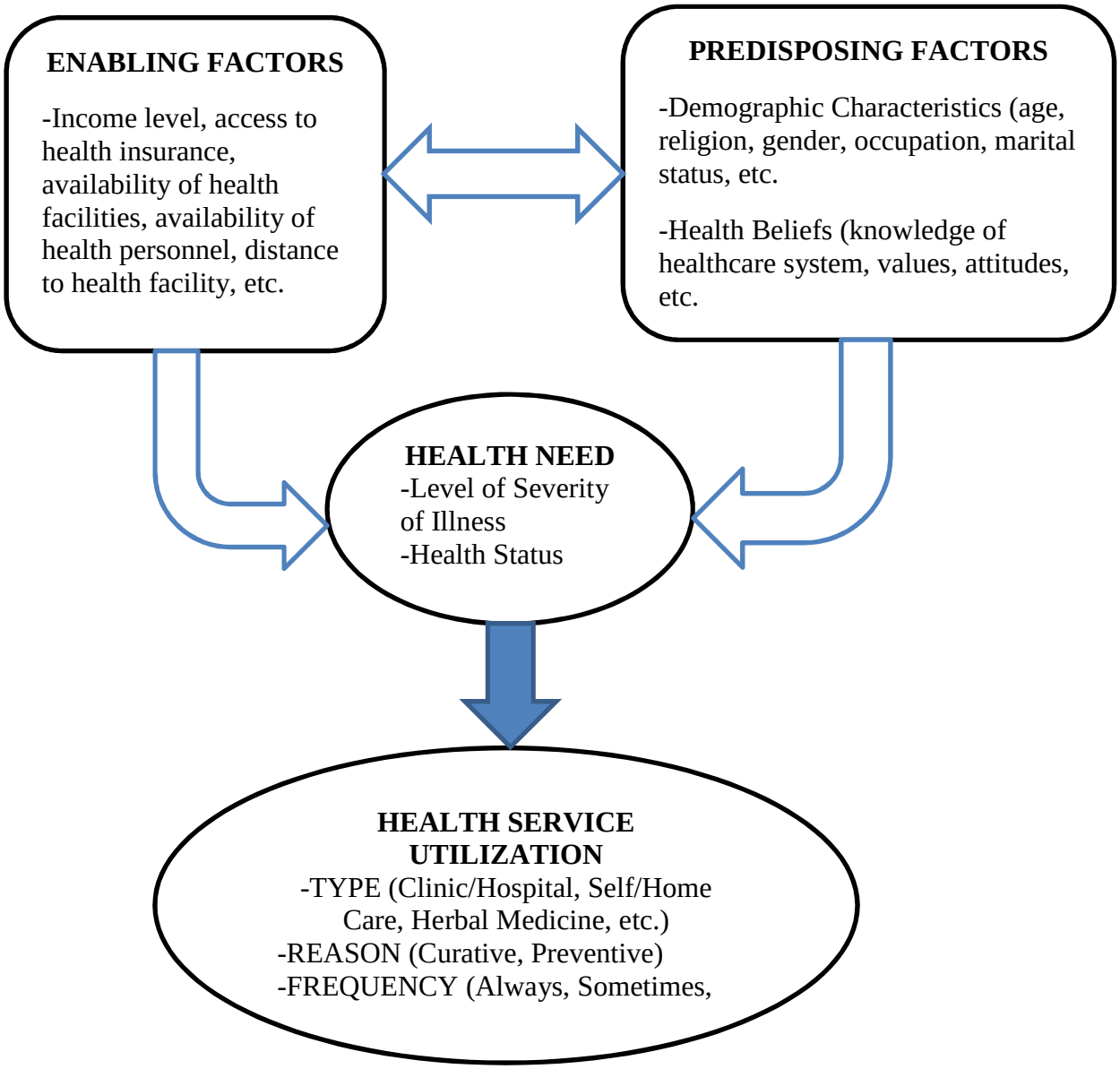

Figure 1: A conceptual framework on health services utilization based on Anderson's behavioral model.

Ethical Considerations

Permission to conduct the study was sought and granted by authorities of the District and community leaders of the study area. Participants consent was sought prior to their inclusion and participation in the study.

Results

Demographic Characteristics of Participants

Overall, 404 participants were interviewed with majority (73.8%) being males. The ages of the respondents were varied ranging from 18 years to greater than 55 years. The study participants belong to the major religions (Christianity, Islam and African Traditional Religion). Majority (57.7%) of the respondents were Christians. About 61% of the participants were farmers. About 44% of the respondents had an average household income less than US $400. The distance to the nearest healthcare facility was varied due to the scattered nature of their settlements. About 56% of the participants covered a distance greater than 2 km to get to a healthcare facility (Table 1).

Health seeking behavior of participants

Participants utilizes various treatment choices to reedy their ailments. Among the treatment choices included, the patronage of healthcare facilities (modern medicine), use of herbal medicines, purchase of over-the-counter-drugs (drug stores), and the patronage of the services of traditional healers. The choice of treatment method for ailments was significantly associated ($p < 0.05$) with the household income, distance to healthcare center, occupation, and educational status (Table 2).

Participants also reported various times they have visited healthcare facilities for treatment of their disease conditions. About 59% of males had attended healthcare facilities between one (1) to three (3) times within a year. The frequency of visits to healthcare facilities for care was found to be significantly associated ($p < 0.05$) with age, occupation, healthcare facility distance, income, and educational status of respondents (Table 3).

Challenges Faced by Respondents in Seeking Care from Healthcare Facilities

Participants revealed several challenges that inhibit their full utilization of the services of healthcare facilities. Majority (32%) of the respondents indicated the cost of services at the healthcare facilities as the major obstacle. This was commonly shared particularly by those who do not belong to the National Health Insurance Scheme or did not renew their membership with the scheme hence had to pay by cash, the full cost of all the services they required. In addition, about 26% of the respondents mentioned the problem of distance to healthcare facilities, 22% of respondents reported shortage of essential medicines, 13% of respondents mentioned inadequate staff, while 7% of the respondents indicated beliefs and cultural practices as the challenges to the utilization of the services of healthcare facilities in their communities (Fig. 2).

Discussion

Health seeking is an important behavioral issue that in recent time keen attention has been paid by individuals and communities. In rural communities and among rural dwellers, several treatment options are being utilized in a bid to finding solutions to their health challenges. The educational level of participants in this study has directly impacts on participants' awareness of good health behavior practices. It implies the more people are educated, the more they become aware of their health status and thus seek for remedy. In respect of the occupational status, the study showed that farming is what majority of the rural dwellers undertake as a source of their livelihood, with a few of them employed in formal jobs. Even though majority of the participants in the study engage themselves in farming activities, this is usually undertaken during the rainy season that lasts for only three (3) months in a year. It implies regular source of income is challenged by the short duration of farming activities and the absence of irrigation activities in the dry season.

Table 1: Socio-demographic characteristics of respondents

VARIABLE	FREQUENCY *(N=404)*	PERCENTAGE *(%)*
Age		
18-30 years	79	19.6
31-45 years	135	33.4
46-55 years	108	26.7
>55 years	82	20.3
Gender		
Male	298	73.8
Female	106	26.2
Marital Status		
Married	283	70.0
Unmarried	55	13.6
Divorced	31	7.7
Widowed	35	8.7
Religion		
Christian	233	57.7
Muslim	104	25.7
Traditional (ATR)	67	16.6
Educational level		
Primary	76	18.8
Secondary/Vocational	187	46.3
College/Polytechnic/University	99	24.5
Nil	42	10.4
Occupation		
Farmer	248	61.4
Trader	44	10.9
House wife	25	6.2
Public servant	81	20.0
Nil	6	1.5
Average annual household income		
US $50 - US $200	25	6.2
US $200 - US $400	181	44.8
>US $400	198	49.0
Distance to nearest health facility		
< 1 km	68	16.8
1 km - 2 km	109	27.0
>2 km	227	56.2

[n = number of respondents (frequency); % = percentage of respondents]

Table 2: Treatment choices of participants

VARIABLE	TYPES OF TREATMENT											
	Health facility (orthodox)		Self-administered herbal med.		Traditional healer		Over-the-counter (drug store)		No action taken		X^2	p-value
Age	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*		
18-30 years	33	41.8	12	15.2	11	13.9	11	13.9	12	15.2	401.0	<0.001
31- 45 years	41	30.4	23	17.0	16	11.9	24	17.8	31	23.0		
46 - 55 years	42	38.9	33	30.6	18	16.7	6	5.6	9	8.3		
>55 years	22	26.8	34	41.5	12	14.6	9	11.0	5	6.1		
Gender												
Male	105	35.2	87	29.2	34	11.4	32	10.7	40	13.4	37.8	<0.001
Female	62	58.5	11	10.4	6	5.7	23	21.7	4	3.8		
Religion												
Christian	123	52.8	41	17.6	9	3.9	37	15.9	23	9.9	209.0	<0.001
Muslim	55	52.9	11	10.6	3	2.9	13	12.5	22	21.2		
Traditional	96	38.7	62	25.0	50	20.2	22	8.9	18	7.3		
Occupational status												
Farmer	96	38.7	62	25.0	50	20.2	22	8.9	18	7.3	332.1	<0.001
Trader	15	34.1	6	13.6	6	13.6	10	22.7	7	15.9		
House wife	4	16.0	8	32.0	3	12.0	4	16.0	6	24.0		
Public servant	34	42.0	14	17.3	8	9.9	14	17.3	11	13.6		
Non	2	33.3	0	0.0	0	0.0	3	50.0	1	16.7		
Educational status												
Primary	26	34.2	19	25.0	4	5.3	15	19.7	12	15.8	372.4	<0.001
Secondary/voc.	112	59.9	24	12.8	10	5.3	28	15.0	13	7.0		
College/tertiary	72	72.7	7	7.1	2	2.0	13	13.1	5	5.1		
Non	7	16.7	11	26.2	20	47.6	3	7.1	1	2.4		
Distance to nearest health facility												
< 1 km	33	48.5	9	13.2	3	4.4	14	20.6	9	13.2	287.6	<0.001
1 km – 2 km	41	37.6	10	9.2	9	8.3	22	20.2	27	24.8		
> 2 km	95	41.9	65	28.6	13	5.7	26	5.7	28	12.3		
Annual average household income												
$50- $200	5	20.0	6	24.0	2	8.0	9	36.0	3	12.0	211.3	<0.001
$200- $400	88	48.6	38	21.0	7	3.9	33	18.2	15	8.3		
>$400	126	63.6	24	12.1	4	2.0	32	16.2	12	6.1		

Table 3: Health facility attendance of participants for the immediate past year

VARIABLE	FREQUENCY OF ATTENDANCE TO HEALTH FACILITIES									
	1 to 3 times		3 to 5 times		> 5 times		Nil		X^2	P-value
Age	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*		
18-30 years	40	50.6	11	13.9	0	0.0	28	35.4	187.2	<0.001
31- 45 years	83	61.5	32	23.7	5	3.7	15	11.1		
46 - 55 years	56	51.9	38	35.2	6	5.6	8	7.4		
>55 years	8	9.8	48	58.5	25	30.5	1	1.2		
Gender										
Male	176	59.1	76	25.5	8	2.7	38	12.8	7.08	0.07
Female	48	45.3	40	37.7	4	3.8	14	13.2		
Religion										
Christian	134	57.5	53	22.7	21	9.0	25	10.7	167.5	<0.001
Muslim	61	58.7	27	26.0	7	6.7	9	8.7		
Traditional	21	31.3	17	25.4	11	16.4	18	26.9		
Occupational status										
Farmer	132	53.4	78	31.6	10	4.0	27	10.9	309.3	<0.001
Trader	24	54.5	10	22.7	4	9.1	6	13.6		
House wife	11	44.0	4	16.0	1	4.0	9	36.0		
Public servant	66	81.5	8	9.9	2	2.5	5	6.2		
Non	2	33.3	0	0.0	0	0.0	4	66.7		
Educational status										
Primary	46	53.5	18	20.9	7	8.1	15	17.4	187.7	<0.001
Secondary/voc.	121	64.7	48	25.7	6	3.2	12	6.4		
College/tertiary	81	81.8	10	10.1	2	2.0	6	6.1		
Non	14	33.3	9	21.4	0	0.0	19	45.2		
Distance to nearest health facility										
< 1 km	12	17.6	43	63.2	9	13.2	4	5.9	246.8	<0.001
1 km – 2 km	87	79.1	15	13.6	1	0.9	7	6.4		
> 2 km	166	73.1	20	8.8	0	0.0	41	18.1		
Annual average household income										
$50- $200	9	36.0	1	4.0	0	0.0	15	60.0	167.3	<0.001
$200- $400	116	64.1	30	16.6	8	4.4	27	14.9		
>$400	121	61.1	60	30.3	7	3.5	10	5.1		

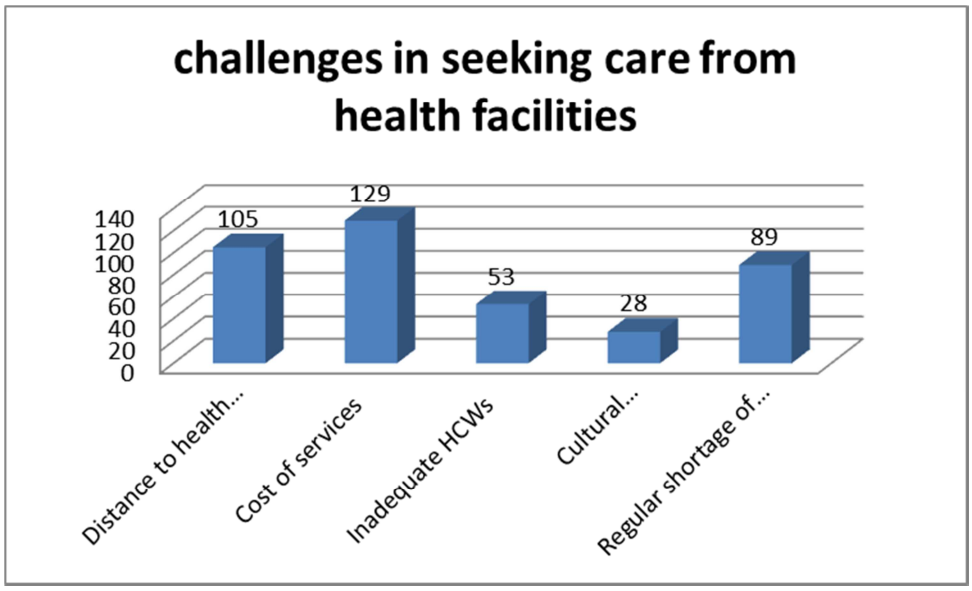

Figure 2: challenges in utilizing services of healthcare facilities

A regular and sustainable occupation somewhat guarantees good and regular flow of income and thus ensures good health seeking behavior. A secure source of income influences the treatment choice of respondents and promotes access to modern healthcare facilities and quality living among rural dwellers. This is corroborated by the findings of other studies in which it was reported that high-income earners and those with higher formal education patronize both orthodox and traditional medicines (Aniah 2015; Clement et al., 2007). This contrasts with the findings of Arye et al., 2007 and Birhan et al., 2011. Several studies have reported low income, easy access to services and efficacy of herbal medicines as reasons for the choice of treatment and use of medications (Birhan et al., 2011; Giday et al., 2007; Teklehaymanot and Giday, 2010).

Exposure to certain occupational disorders is largely reduced with good occupations (Omotosho, 2010). The study showed that there was a significant association ($p < 0.05$) between the various treatment options and variables such as occupational status, educational level, and distance to the nearest health facility as observed in a similar study by Anitha (2007). Cultural diversity brings along various beliefs and practices regarding the utilization of medicines in treating various disease disorders. The use of herbal medicines among rural dwellers and communities has been reported by other studies to be embedded in the cultural and religious beliefs and practices (Giday et al., 2007; Birhan et al., 2011; Teklehaymanot and Giday, 2010).

For complete comprehension of the health seeking behaviors of rural societies, it is imperative to assess the socio-cultural underpinnings of health seeking behaviours particularly in rural societies. The appreciation of modern or orthodox medicine in the treatment of disease conditions is largely influenced by the level of education, awareness, access to facilities and ability to pay for health services. This study has shown that rural dwellers walk long distances to access primary healthcare services due to the scattered nature of the settlements of the communities. The common mode of transport used by participants in this study are motor bikes, bicycles, and by foot, with the use of bicycles being the most commonest means of transport used by the participants. The Community-based Health Planning and Services (CHPS) compounds concept of ensuring access to primary healthcare services in rural communities is an important intervention that has bridged the gap between the rural and urban areas in terms of access to basic healthcare services. The CHPS compounds, which are sited in almost all communities, reduces to a large extend the travel distance of outpatients and promotes easy access

to trained health personnel. Majority of the participants were aware of the existence of these primary healthcare facilities and patronized their services. Notwithstanding, some participants in this study revealed certain constraints inhibiting them from fully patronising the services of the CHPS facilities in their localities which included, poor work attitudes of health personnel, shortage of essential medicines, the efficacy of treatment rendered, among others.

The study further showed that rural dwellers are confronted with several challenges in utilizing healthcare services. The inadequacy of health professionals in the CHPS facilities in most communities do not promote easy access to needed healthcare services. The availability of skilled medical practitioners in rural communities enhances the utilization of healthcare services as well as improvement in healthcare outcomes due to continuity of care (Mainous et al., 2001 and Starfied 1992). It is not a common practice for majority of rural dwellers to have personal doctors or health practitioners for medical attention. However, studies have reported that continuous access to healthcare practitioners play a key role in ensuring better access to health services compared to situations where there is no regular and permanent source and availability of healthcare practitioners (Lambrew, 1996 and Xu, 2002). Generally, the use of modern medicine and healthcare facilities among participants was high compared to patronage of traditional healers and herbal medicines as similarly reported in other studies (Pariyo, et al., 2009 and Odaga, 2004).

Conclusion and Recommendations

The study has revealed certain health seeking behaviors of inhabitants of the study area. It is imperative that these behavioural patterns in utilizing healthcare services are assessed and remedies designed to promote increased access and patronage of healthcare facilities. It is without doubt the role played by traditional herbal medicine particularly in rural communities and among rural dwellers. Regulation of the activities of traditional healers in communities by National regulatory authorities through routine monitoring and supervision would help to reduce the unlikely health implications of their activities. Behavior change in the seeking of healthcare among rural dwellers requires a full appreciation of the challenges and motivations associated with a particular society. The success of any plan or solution towards a change in health seeking behavior requires the full engagement and participation of the beneficiaries of such behavior change interventions from the onset through to the implementation and monitoring of the program.

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