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Health-seeking behaviour among Ghanaian urban residents: A quantitative exploratory case study

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Abstract

Health seeking behaviour is important for personal and social reasons, and several health problems can be adequately treated if they are reported early for appropriate health intervention. We examined the health-seeking behaviour of residents of a suburb in the capital of Ghana, the point in ill-health that they seek healthcare, their first point of call for healthcare, and the determinants of choice of first point of call. Simple random sampling was used to select 316 eligible respondents. Quantitative data were collected with questionnaire and analysed with IBM SPSS version 22. Descriptive statistics and Logistic regression were used to interpret the findings at 95% confidence intervals. Most respondents (50.6%) sought healthcare days to months after their first experience with ill-health, 15.5% sought healthcare when they were severely ill, and about 34% sought healthcare immediately they experienced ill-health. Most of the respondents' (54.2%) first point of call for healthcare was self-medication with herbal sources or faith-based healing, and 45.8% sought attention from orthodox sources. Males were 1.97 times more likely than females; married individuals were 2.33 times more likely than the unmarried; and health insurance holders were 1.55 times more likely than the uninsured to use orthodox outfits as first point of call for healthcare. Healthcare stakeholders and policy makers need to intensify education on the need to seek orthodox healthcare in ill-health, encourage increased enrolment on the national health insurance scheme and strengthen social support systems that encourage good health-seeking behaviours.

Keywords: Ghana, greater Accra region, health-seeking behaviour, residents

Introduction

The desire of every individual is to stay healthy and live a long life, thus, healthy life- a necessity of quality life is persistently pursued throughout one's life journey (Agrawal & Patel, 2016; Campbell & Roland, 1996; Pillai, Nallavalli & Immaculate, 2019). Health seeking behaviour is important for personal and social reasons (Agrawal & Patel, 2016; Pillai, Nallavalli & Immaculate, 2019). Several health problems can be adequately treated if they are reported early for appropriate health intervention (Gæde *et al*., 2008; Shapiro & Taylor, 2002). Hence, delays in seeking appropriate health solution after noticing symptoms for most diseases especially, fatal illnesses such as cancers, can be detrimental (George & Fleming, 2004; White *et al*., 2011). Thus, health-seeking behaviours clearly have implications for the state of health for individuals and the entire health system of a country (Volpp, 2016).

Health is defined as a "complete state of physical, mental and social wellbeing beyond the absence of disease or disability" (WHO, 2014). The state of people's health is related to their health-seeking behaviours (Agrawal & Patel, 2016). Health-seeking behaviour as defined by Lepine and Nestour (2013) is the likelihood that people will seek healthcare when ill, and or the propensity to choose a particular healthcare provider and healthcare system.

Empirical evidence suggests that the decision of people to seek health interventions for ailments is influenced by a range of complex demand and supply characteristics (Victoor, Delnoij, Friele, & Rademakers, 2012), which include socio-demographic, economic and healthcare-related factors (Agrawal & Patel, 2016; Asibey, Dankwah & Agyemang, 2019; Pillai *et al*., 2019). These factors can also be grouped broadly as psychological (e.g., cognitive, and emotional) and contextual (e.g., health-service, and sociodemographic related). Ghanaian urban dwellers are confronted with these factors among others, and since the decision to seek health is the result of the combined forces of social and family pressures (Pillai *et al*., 2019), this study was aimed at exploring the health-seeking behaviours, the time of deciding to seek healthcare interventions and the first point of call for healthcare among Ghanaian urban dwellers. It is hoped that the findings would enable an empirical basis for formulating effective contextual-based behavioural change educational programmes to improve the health-seeking behaviours among urban dwellers in Ghana.

Ghana- a low-middle-income country is confronted with a significant burden of preventable and curable illnesses coupled with high unmet healthcare needs. The country's morbidity and mortality profiles are significantly characterized by several infectious diseases like lower respiratory tract infections, malaria, cholera, among others (CDC, 2016; Fenny, *et al*., 2015). Also, there is high rate of non-communicable diseases such as heart-related problems (IHME, 2015), diabetes, cancers, and mental health problems (see Darkwa, 2011; Gatimu, *et al*., 2016; Kratzer, 2012). Hence, the country is confronted with double burden of disease.

Many people have health conditions that affect the quality of their life however, they fail to seek health interventions, or they delay in seeking treatment (Yaacob, Mokti & Muhammad, 2019). For instance, it is estimated that treatment gap in depression ranged from about 30% to 60% (Bristow & Patten, 2002; Fernandez et al., 2007), suggesting that the treatment and health-seeking gap remains high (Roskar, *et al*., 2017). Several health authorities and practitioners in various media discussions and health sensitization programmes have constantly called upon Ghanaians to seek timely treatment to avoid complications and untimely death. Despite these calls, people still delay in seeking healthcare. This late health-seeking behaviour could be attributed to several factors ranging from perceived attitudes of health professional, economic conditions of the individual, socio-demographic factors to behavioural factors.

Although several studies have examined the determinants of health-seeking behaviour globally (Agrawal & Patel, 2016; Ngangbam & Roy, 2019; Pillai *et al*., 2019; Yousaf, *et al*., 2015), literature on the topic in Ghana is limited (Abor, *et al*., 2011; Asampong, Dwuma-Badu, Stephens, Srigboh, Neitzel & Basu and Fobil, 2015; Asibey *et al*., 2019; Nuhu, 2018). The few studies in Ghana have been conducted

among specific occupations and from a qualitative perspective (see Asampong, *et al.*, 2015), others have relied mainly on the Ghana Demographic and Health Survey (GDHS) data (see Abor, *et al.*, 2011; Tettey, *et al.*, 2019). This study therefore sought to gather first-hand information on health-seeking behaviours among urban dwellers using quantitative method and responded to calls to conduct studies on the subject with an urban-based population (Chilale, Silungwe, Gondwe & Masulani-Mwale, 2017).

Korle Gonno, the study area, is one of the electoral areas under Ablekuma South sub-Metro of Accra Metropolitan Assembly and it is classified entirely as urban (Ghana Statistical Service, 2014), however, accident, violence, homicide, and suicide account for 12.0% of all deaths while other causes constitute 88.0% of deaths in the Metropolis (Ghana Statistical Service, 2014). This suggests that there is a high prevalence of preventable and curable health conditions among people residing in the area. Thus, this study examined the health-seeking behaviour of residents of Korle Gonno, the point in their illness at which they seek healthcare, their first point of call for healthcare, and the determinants of choice of first point of call for healthcare.

Theoretical Review

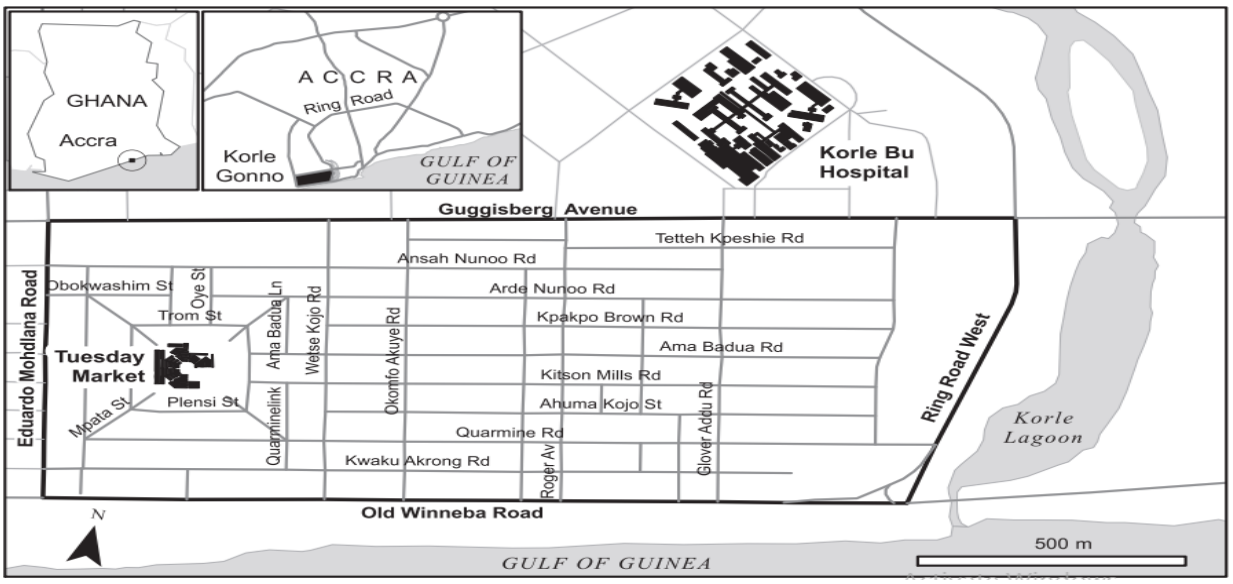
The study has the Health Belief Model (HBM) as its theoretical pivot (Jegede, 1998). Thus, in explaining the findings, the HBM comes into focus. The HBM allows for understanding and prediction of health-related behaviors regarding healthcare decisions and pursuit of health care. The HBM theorizes that health-related behaviors are conditional on a person's awareness of four crucial and vital fields, namely: the enormity of thinkable illness, susceptibility to the illness, returns of embarking on a disruptive or defensive action to thwart the incidence of the illness, and the obstacles to embarking on the act. Hence, the premise here is that health-seeking behaviors are inspired by a variety of subconscious variables and established modalities and standards that inhibit health-seeking behaviors of a group of people. The HBM suggests that individuals are faced with alternative acts but would naturally decide on the one apparent to be most beneficial (Munro *et al.*, 2007). Consequently, community members' health-seeking decisions and actions would be the subsequent effect of knowledge on types and availability of healthcare, the gains and significance placed on these healthcare facilities, the perceived severity of the effects of their morbidities, the beholding of mortalities associated with illnesses in communities, belief in the avoidance of self-medication and patronage of other unorthodox outfits for healthcare as the right course of action, and the social and economic consequences of seeking healthcare from orthodox and formal healthcare facilities.

Methodology

Study Area

The study was conducted in Korle Gonno - a major indigenous Ga community located at the heart of Accra. It covers an area of 15.1km^2. The Sub Metro has an estimated population of 257,543 with 22,751 houses and 69,401 households (Ghana Statistical Service, 2014; AMA, 2020). The major source of income for the residents is fishing and fish mongering. Apart from its central location with sea views, it also has a variety of employment centres such as banks, fuel stations, educational institutions, hotels, hospitals, and supermarkets (see Figure 3.1).

Figure 1: Study Area (Korle Gonno)



Source: Adopted from Arguello et al. (2013)

Study Population, Sampling and Sample Size

The target population for the study were persons aged 18 years or more who had been living in the area for not less than 2 years. Thus, residents younger than 18 years with less than 2 years of residence were not selected for inclusion in the study. This was to appropriately capture the pattern of health-seeking behaviour of adult residents in the area. Utilizing the existing enumeration system available by the Ghana Statistical Service (GSS) and the Accra Metropolitan Authority (AMA), simple random sampling technique was employed to select eligible respondents. By this probability sampling, equal chance was given to all eligible participants, to avoid bias in the findings of the study, and to allow for generalization of findings among the residents of the study area. For the purposes of standardization and stronger statistical power, the sample size was determined using Cochran (1977) formula. Thus, a sample size of three hundred and sixteen (316) was appropriately used for the study, which took into account a 10% non-response rate.

Data Collection Method and Instrument

We employed questionnaire to collect the required data for the study. The questionnaire collected data on the socio-demographic characteristics of participants, frequently experienced illnesses, reasons for seeking healthcare, first point of call for medical interventions, determinants of first point of call, and the stage in ill-health at which people decide to seek health interventions. The questionnaires were administered to participants in their homes on weekends and at their convenience by the second and third authors. The data collection period was 6 weeks.

Ethical Consideration

Before the start of the study, ethical approval was obtained from the Ethics Committee of Humanities, University of Ghana with the study protocol. Though the study did not have any serious ethical issues to contend with, participants were provided with written informed consent which were read to them before they agreed to participate in the study. Following information and explanation on the rationale, purpose, procedures, confidentiality, participation and rights, risks, and benefits, voluntary, and right to withdrawal at any point without prejudice to participants, participants were given the opportunity choose between signing or thumb- printing the written consent form before their involvement in the study. Permission was also sought from participants to publish the findings of the study. This was done

by asking participants to also sign or thumbprint another portion on the written informed consent form.

Data Management and 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 IBM SPSS version 22 (SPSS Inc., Chicago, IL, USA) and coded for statistical analysis. Descriptive statistics were used to define and describe the responses. Logistic regression was conducted to ascertain factors associated with health seeking behaviours of adult in the Korle-Gonno area. Results were presented in odds ratios and at 95% confidence intervals.

Results

Socio-demographic Characteristics of Participants

About 67% of the respondents were males and 33% were females. Many of the respondents (about 46.0%) were married, about 28.0% had never married before, and the remaining about (27.0%) were either widowed or divorced. It is worth noting that 66.5% of the population sampled have health insurance.

Table 1: Socio-demographic Characteristics of Respondents

Characteristics		**Frequency**	**Percentage (%)**
Gender:	Male	211	66.8
	Female	105	33.2
Age (in years):	18 - 25	66	20.9
	26 - 33	110	34.8
	34 - 41	95	30.1
	42 and older	45	14.2
Education:	No formal education	65	20.6
	Primary	95	30.1
	Secondary (JHS/SHS)	100	31.6
	Tertiary	56	17.7
Marital Status:	Never married before	87	27.5
	Married	144	45.6
	Divorced	65	20.6
	Widowed	20	6.3
Religious affiliation:	Christian	169	53.5
	Islam	105	33.2
	Tradition	41	13
	No affiliation	1	0.3
Occupational status:	Formally employed	74	23.4
	Self-employed	154	48.7
	Unemployed	71	22.5
	Student	10	3.2
	Retired	7	2.2

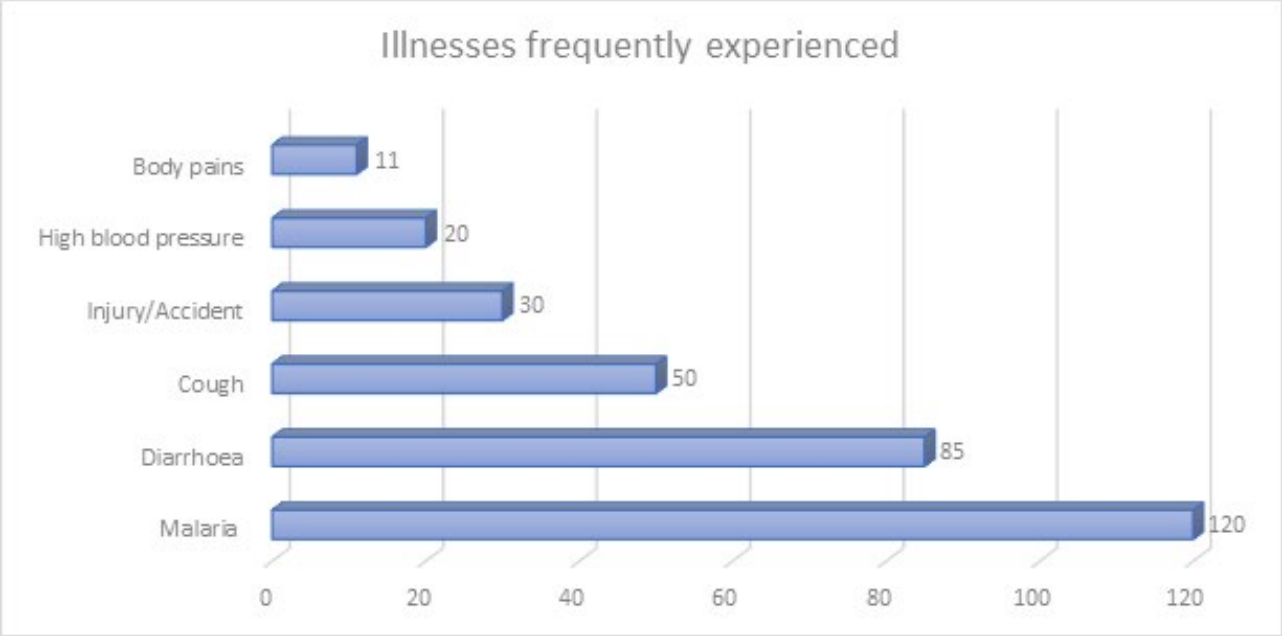
Health insurance status:	Insured	210	66.5
	Not insured	106	33.5

n = 316

Illnesses Frequently Experienced by Participants

Figure 2 shows the illnesses that the respondents normally experience. The common illnesses include malaria, diarrhoea, cough, injury/accidents, body pains. While most reported suffering one of the listed illnesses, a few stated they experience two or more.

Fig 2: Illnesses frequently experienced



n = 316

Stage in Ill-health at Which Respondents Seek Help for Health Problems

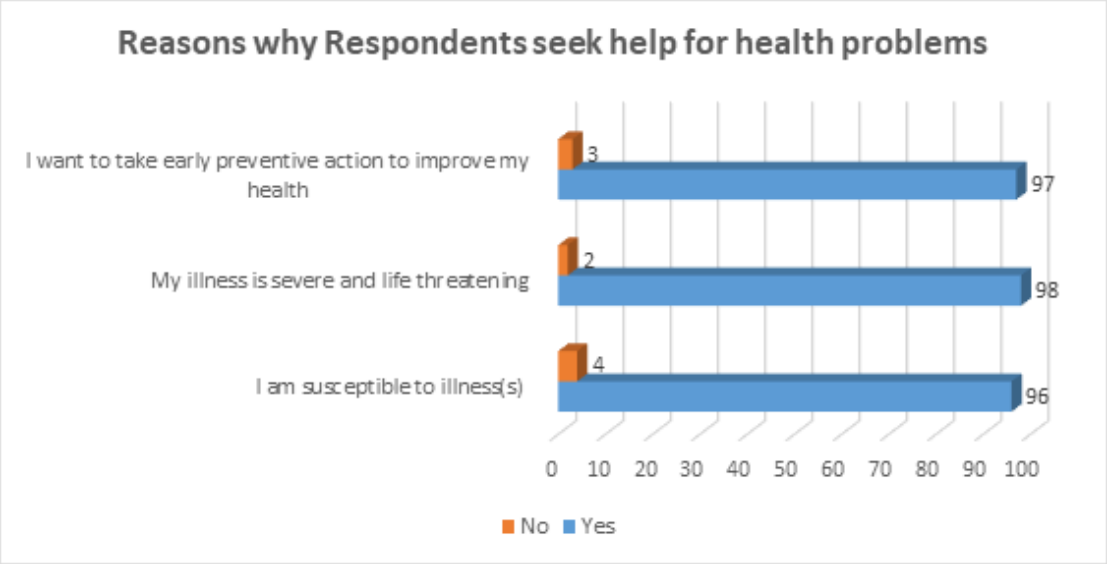
Almost 34% (107) of respondents indicated that they sought help immediately they experienced symptoms of illness, 40.2% (127) of respondents sought help days or weeks after when their symptoms persisted, 10.4% (33) sought help months later with symptoms present and 15.5% (49) only sought help for their illnesses when they were severely ill and could not do anything by themselves.

Table 2: Stage in ill-health at which Respondents seek help for health problems

Seek help:	**Frequency**	**Percentage (%)**
Immediately	107	33.9
Days after	91	28.8
Weeks after	36	11.4
Months after	33	10.4
When I am very ill and cannot do anything	49	15.5

n = 316

Fig 3: Reasons why Respondents Seek Help for Health Problems



Points of Call for Health Problems

Participants indicated Self-medication (142: 44.9%), Traditional/ Herbal medicine (20: 6.3%), Licensed Chemical/Drug Stores (62: 19.6%), Formal Hospitals and Clinics (107: 33.9%), and Religious/Faith-based Healing (49: 15.5%) as the points of call for their health problems.

Table 3: Points of Call for Health problems and First point of call for healthcare		
Points of call	**Yes**	**No**
Self-medication/treatment	142 (44.9 %)	174 (55.1%)
Traditional/herbal medicine	20 (6.3%)	296 (93.7%)
Drug stores/licensed chemical sellers	62 (19.6%)	254 (80.4%)
Formal healthcare avenues (hospitals/clinics)	107(33.9%)	209 (66.1%)
Faith/religious-based healing	49 (15.5%)	267 (84.5%)
First point of call for healthcare		
First point of call	**Frequency**	**Percentage (%)**
Self-medication/herbal treatment	142	44.94
Formal healthcare avenues (hospitals/clinics)	94	29.75
Licensed chemical/drug stores	51	16.14
Faith/religious based healing	29	9.20

First Point of Call for Healthcare

The first point of call for healthcare for about 45% (142) respondents is self-medication or traditional/ herbal treatment; Clinics/Hospitals (94: 30%), Licensed Chemical/Drug Stores (51: 16%), and Faith/ Religious-Based Healing (29: 9.2%)

4.4 Determinants of First Point of Call for Healthcare

Table 4 presents results from two different models that predict the odds of an individual using self-medication or formal health care as the first point of call for seeking healthcare. The Odds Ratios (OR) for gender, age, education, religious affiliation, health insurance status, and the behavioural factors are not statistically significant. However, results of the determinants of formal healthcare as the first point of call for seeking healthcare reveals that gender significantly influences the use of formal healthcare

services as the first point of call. Males are 1.97 times more likely to first go to hospitals or clinics when ill, compared to females.

Examining educational level as a determinant of formal healthcare as the first point of call for healthcare, gave different outcomes at the various education levels. While primary and secondary education levels do not significantly influence the decision to first contact formal healthcare facilities when ill, tertiary education level strongly affects this decision. Table 4 shows that those with tertiary education are almost 4 times more likely to first attend hospitals or clinics when ill compared to those who have no tertiary education. Marital status also demonstrated to be a critical determinant of the use of formal healthcare services as the first point of call for seeking healthcare. It is observed that those married are 2.33 times more likely to seek formal healthcare services first when ill than the unmarried. This suggests that the unmarried are less likely to first attend hospitals or clinics when ill. Health insurance status shows to have a strong influence on the decision to use formal health centres as the first point of call when ill. Compared to people who have no health insurance, those who have health insurance are 1.55 times more likely to use formal healthcare services as their first point of call when they fall sick.

However, the outcome shows that age, religious affiliation, and the behavioural factors of participants do not determine the likelihood that patients would employ formal healthcare services as their initial point of contact to cater for their health needs.

Table 4: Odds Ratios for seeking different types of health care as First Point of Call

	Type of health sought			
Characteristic	**Self-Medication**		**Formal health care**	
	OR	CI	OR	CI
Gender				
Female	Ref			
Male	0.68	0.76-1.72	1.97**	0.45-2.1
Age				
18-25	Ref			
26-33	0.67	0.7-1.86	1.32	0.9-1.8
34-41	0.83	0.59-1.5	1.55	0.9-1.2
42 +	0.51	0.4-1.7	1.78	0.5-1.5
Education				
None	Ref			
Primary	1.66	0.67-1.6	0.79	0.4-1.3
Secondary	1.36	0.5-1.2	1.18	0.6-1.6
Tertiary	0.61	0.7-1.65	3.97**	0.3-1.5
Religion				
No Religion	Ref			
Christianity	1.32	0.6-1.01	1.51	0.3-1.1
Islamic	1.28	0.8-1.25	1.59	0.6-1.5
Marital Status				
Not Married	Ref			
Married	0.82	0.99-1.2	2.33**	0.8-1.4
Insurance Status				
uninsured	Ref			
insured	0.64	1.2-1.7	1.55**	0.9-1.7

***, **, significant at 1%, and 5% respectively

Discussion

The quest for good health is an important aspect of all human societies, thus, religious/health institution is one of the most prominent institutions of all cultures around the world. Studies on health-seeking behaviours of societies are therefore crucial as they provide empirical basis for policy formulation on effective means of assisting individuals to stay healthy and contribute their quota meaningfully to the attainment of societal goals.

The present study revealed malaria, diarrhoea, cough, injury/accidents, and body pains as the health problems experienced by respondents in descending order (see figure 2). A study in a suburb in the Accra Metropolis also indicated similar ailments with qualitative methodology (Asampong *et al*., 2015). These indicate that as a country, Ghana still struggles with communicable diseases, especially in the urban capital, thus serious attention must be paid to them to avoid related complications and subsequent deaths.

Regarding the health seeking behaviour of respondents in managing these health conditions, almost 34% of respondents indicated that they sought help immediately they experienced symptoms of illness, 40.2% sought help days or weeks after their symptoms persisted, 10.4% sought help months later with symptoms present and 15.5% only sought help for their illnesses when they were severely ill and could not do anything by themselves. This portrays that most respondents hold 'present-oriented' health-seeking behaviours, that is, their present health condition is a major determinant of seeking healthcare, and only 34% hold 'future-oriented health seeking behaviour, implying that their health-seeking is based on prevention of future consequences of their present health condition. Delays in seeking appropriate health solution after noticing symptoms for most diseases especially, severe ones, can be fatal to the individual concerned (George & Fleming, 2004; White et al., 2011), as found to be the case for most of the respondents in this study. Respondents also indicated that they would seek health-related help for 3 main reasons namely: having life threatening illness, preventing illness, and perceiving to be susceptible to illnesses (figure 3).

Study respondents patronised both alternative and complimentary and orthodox medical sources for their healthcare problems. However, the first point of call for health problems by the majority of respondents (about 54%) was unorthodox (table 3). Implying that self-medication with herbal means and religious and faith-based healing were very prevalent as the first point of call for treatment of ailments among respondents. This finding indicates that most of urban dwellers in Ghana subscribe to complementary and alternative medical sources as their first point of call. This is not surprising as other studies have revealed similar findings (Abubakar *et al*., 2013; Assad *et al*., 2015). Individuals seek health from formal and informal systems of healthcare with the aim of resolving their health problems or conditions (Cornally & McCarthy, 2011; Yousaf et al., 2015). The preference of one of these sources as first point of call for healthcare problems over the other may also be due to the perceived benefits associated with each (Chilale *et al*., 2017). These benefits are usually related cost, proximity, and past-experience with the source (Asampong *et al*., 2015; George, 2007).

It is interesting to note from this study that, gender, age, education, religious affiliation, health insurance status, and the behavioural factors of respondents did not determine the tendency that a participants would choose self-medication as the first point of call for his or her ailments (see table 4). On the other hand, determinants of formal healthcare facilities as the first point of call for seeking healthcare revealed that gender significantly influenced the use of formal healthcare services as the first point of call with males being 1.97 times more likely to first go to hospitals or clinics when ill, compared to females. This implies that females are less likely to opt for formal healthcare services as their first point of call when ill, which is a deviation of what is found in relevant literature (Johnson *et al*., 2012).

Examining education as a determinant of formal healthcare as the first point of call for healthcare, gave different outcomes at the various educational levels. While primary and secondary education levels did not significantly influence the decision to first contact formal health centres in ill-health, tertiary

education level strongly affected this decision. Respondents with tertiary education were almost 4 times more likely to first attend hospitals or clinics when ill compared to those who had no tertiary education. This finding is contrary to findings of previous studies (Mackenzie et al. 2006; Roskar *et al*. 2017; Doherty & Kartalova-O'Doherty, 2010). Usually, males are uncomfortable discussing their health problems with other people due to the culture of masculinity and are more prone to self-stigma (Johnson *et al*., 2012). The outcome of this study may be because the study area is urban and has received increased campaign and advocacy for a change in males' attitudes towards seeking formal healthcare for their health problems.

Marital status was demonstrated to be a critical determinant of the use of formal healthcare services as the first point of call for seeking healthcare. It was observed that those married were 2.33 times more likely to seek formal healthcare services first when ill than the unmarried. This finding is consistent with findings of earlier studies (Agrawal & Patel, 2017; Doherty & Kartalova-O'Doherty, 2010) that concluded that marital status is a major determinant of healthcare-seeking behaviour. This may be due to the support and encouragement that married couples offer to each other in times of ill-health. This finding also highlights the importance of social support mechanisms in promoting health-seeking behaviour among people.

Health insurance status showed a strong influence on the decision to use formal health facilities as the first point of call for ill-health. Compared to individuals who had no health insurance, with health insurance were 1.55 times more likely to use formal healthcare services as their first point of call when they fall ill. This finding is also similar to those of other studies (Asampong et al., 2015; Asibey *et al.,* 2019; Ngangbam & Roy, 2019). These studies identified cost of inpatient healthcare service as a barrier to seeking formal healthcare. Thus, individuals with active health insurance and appreciable levels of income are less confronted with cost barriers when they seek formal healthcare (Agrawal & Patel, 2016; Asibey *et al*., 2019; Kim *et al*., 2016). This further increases their confidence in their ability to pay for some critical medical services such as medications. In other jurisdictions, heavy workload of health workers due to insufficient human resource, and inadequate funding support from government contribute to non-patronage of health services provided by public health facilities (Hyzam *et al*, 2020). In this study, age, religious affiliation, and the behavioural factors of respondents did not determine the likelihood of utilizing formal healthcare services as the initial point of contact to meet health needs.

In conclusion, we stress on the fact that the paradigm to disease causation of Ghanaians is two-fold – the physical and supernatural worlds. Thus, generally, most Ghanaians subscribe to plural medical systems without any sense of contradiction. This calls for scientific integration of both systems in environments where the use of CAM is inevitable like the Ghanaian situation. However, with evidence of orthodox medical system being scientifically superior to traditional/alternative and complementary medical systems, the findings of this study should contribute to putting in place effective policies on sensitization of Ghanaians and other sub-Saharan dwellers with similar health-seeking behaviours to modify their health-seeking behaviours towards orthodox medical systems in the face of technological and comprehensive healthcare, taking into consideration the elimination of financial bottlenecks. Future research may also focus on both rural and urban populations with both quantitative and qualitative methodologies.

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