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Utilization of Modern Health Care in Nkwanta District

by

John Henry Tettekpoe

The crest of the University of Ghana is centered on the page. It features a shield with a blue background and three golden stalks of grain at the top. Below the shield is a golden banner with a blue border, containing a blue emblem. The entire crest is set against a light blue circular background.

*Dissertation Submitted to the School of Public Health, in Partial
Fulfillment of the Requirements for the Award of Master of Public
Health (MPH) Degree.*

SCHOOL OF PUBLIC HEALTH

UNIVERSITY OF GHANA

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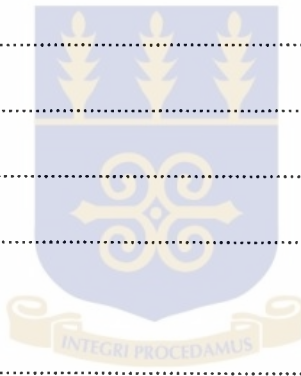
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Utilization of Modern Health Care in Nkwanta District.**M.P.H. Dissertation.****Abstract.**

The study focuses on the factors that influence utilization of modern health care, in a contemporary rural community of Nkwanta District, Volta Region, Ghana. The intention is to provide insight into understanding these factors in the light of the people's perception of health.

A sample size of three hundred and forty respondents were selected by simple random method. They were selected from one hundred and fifty-eight households, in twenty towns and villages within two subdistricts out of the five. We zoned one into north and south, and the other into east and west. The sample consists of one hundred and eighty-seven males and one hundred and fifty-three females within the ages of 20-80 years and above. The researcher and three trained research assistants used a structured interview schedule for the data collection. Data was analyzed in Epi Info 6, and Microsoft Excel, and results presented in simple percentages, frequency distributions, and cross tabulations. Two focus group discussions were held in two towns in twi, and was translated into English.

Findings indicated that majority 76.5% of the respondents utilized a modern health facility in the district the last time they were sick, with only 23.5%, using other sources such as self medication. Further, analysis of both the quantitative and qualitative data indicate that cost and distance are the two most important factors contributing to under-utilization of modern health service in the district. The study concluded that if hospital fees are reduced, deposits removed and the deplorable roads' conditions improved, utilization of modern health facilities in the district is likely to improve. Finally, it was suggested that further research, and more empirical testing remains to be done, in order to explore the link between willingness to pay and ability to pay, since this was the sentiment expressed by most of the respondents.

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My special complements go to the DDHS of Nkwanta district, in the person of Dr. John Koku Awoonor-Williams, who provided most of the financial and logistic support for the study,. *Akpe na wo!!!*. I also wish to record my sincere thanks to Messrs. Samuel Arhinful, Issaka Adamu and A.K Dzomeku all of the DHMT Nkwanta who volunteered to be my research assistants and tirelessly helped in collecting the data for this study. *Akpe na mia kataa!!!*. A special thanks to my colleagues of MPH 1996/97 programme. It would not have been the same without your support, fruitful academic exchanges and friendship. I owe special gratitude to Drs. Frank Nyonator the RDHS, Volta Region and Amuzu the SMO. (PH) also of the same region, for their timely directions and seful suggestions. *Akpe kaka!!!*.

John Henry Tettekpoe.

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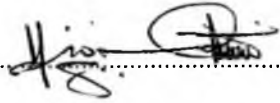
Dedication:

To my children, Anita, Robert and

Harriet, that their memories would live on.....

Declaration and Approval:

I John Henry Tettekpoe, do hereby declare that the work presented here was done by me through my own research while a student of the School of Public Health, University of Ghana, Legon, and that this same work has not been submitted anywhere for the same purpose.

Signed:.....

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Prelude :

"Two main groups of factors influence utilization: user characteristics and provider features.

However, they clearly interact and their separate influences are often difficult to distinguish.

Gilson 1988.



List of Abbreviations.

1. CFAF.Central African French Fracs.
2. MOH.Ministry of Health.
3. CHAG.Christian Health Association of Ghana.
4. MCH/FP.....Maternal and Child Health /Family Planning.
5. OPD.Out-patients Department.
6. ODA.Overseas Development Agency
7. DHMT.District Health Management Team.
8. WHO.World Health Organization.
9. OSA.Omnibus Service Authority.
10. GPRTU.....Ghana Private Road Transport Union.
11. KVIP.Kumasi Ventilated Improved Pit.
12. EHO.Environmental Health Officers.
13. EHA.Environmental Health Assistants.
14. DDHS.....District Director of Health Services.
15. NGO.Non Governmental Organization
16. D&C.Dilatation and Curettage.
17. FGD.Focus Group Discussion.
18. SMO; PH..... Senior Medical Officer; Public Health.
19. MPH.Master of Public Health.
20. Kms.....Kilometers.
21. PHC.Primary Health Care.

Chapter One.

1.1. Introduction.

Health care utilization has been defined simply as the number of consultations [1]. However, it can also be described as the number of visits to the hospital or clinic (orthodox) to seek assistance for cure of an ailment or illness one is suffering from, or to any other facility.

A lot of factors can influence use of health care [2]. In recent times, this has drawn the attention of many researchers. They have examined how and why such factors have influence on use of health care.

For example, some believe that distance from health facilities, attitude of staff and the availability of alternate source treatment influence the user. Others, are of the view that cost of service, quality of service, successes of previous treatments, and the perception of the cause of the illness all determine which type of health care individuals seek. Waddington and Enyimayew, working in the Ashanti -Akim district and in Volta Region of Ghana, found an immediate and rapid decline in outpatient numbers in rural and urban health facilities when the user-fee was introduced in Ghana in 1985[1].

In Niger, Weaver also found that the introduction of user-fees affected patients. He argued that user fees discouraged people from seeking care in three ways: 1) patients avoid seeking care at public hospitals, 2) patients delay seeking care from public hospitals and make fewer visits, 3) patients

seek care from alternative public and private facilities"[3].

Gilson, is of the view that provider characteristics, as well as user characteristics such as socioeconomic, age, sex, previous treatment success and perceived cause of illness are important factors [4].

In one of such studies in Pahou, Benin, Kanji, showed how the utilization rates with an average treatment cost of three hundred and seventy-five (375) CFAF were quite low, with 0.6% visits per person per year [5].

Individual behaviour influences health care utilization. Therefore, the question one would wish to ask is why don't the people of Nkwanta district seek treatment in the health care facilities available in the district? Therefore, in an attempt to examine factors that affect utilization of modern health care in the Nkwanta district of the Volta Region, it behooves us to discuss the types of health care institutions that exist in the country, and then narrow it down to our area of study. It is believed that by doing this, we can explain how, and why they use these facilities or not.

Modern or orthodox health care can be grouped into government and private institutions. The Ministry of Health (MOH) represents the government sector. The private sector is largely under the Christian Health Association of Ghana (CHAG). A few institutions are owned by private individuals and large industrial establishments. In general, health care services are provided through a network of clinics, health posts/centres, maternity homes, hospitals in both public and private sectors.

Although these have been provided, and efforts to supply these facilities with both human and material resources have been put in place, total coverage and access to health services remains low [6].

Nkwanta District, has four mission clinics, one referral centre, i.e., Nkwanta Health Centre, (which operates as a district hospital), five health centres/posts, eight MCH/FP Clinics, three private clinics and forty outreach clinics [7].

According to the district profile, these have not been utilized to their capacity over the years. (See Appendix a.). Level B facilities, which are supposed to cater for an average of between 1-30 out- patients daily, have failed to achieve that level of coverage. Similarly, level C facilities which aim for between 31-90 out- patients daily, have failed to achieve this level of coverage.

Furthermore, they have not achieved the targeted average bed occupancy rate of 50 in- patients at level C facility over the years, and average daily admission of 9-20 remains unrealized.

This study therefore seeks to explore the factors that contribute to low utilization of modern health care facilities in the Nkwanta district.

1.2. The Research Problem.

As stated earlier, Nkwanta district has health facilities which are equipped with modern medical equipment and other logistics necessary for the provision of efficient and effective health care .

Despite this, OPD attendance in most of these health facilities still remains very low over the years [8].

For example, OPD attendance at St. Joseph's clinic declined from 15,008 to 10,038 between 1994 and 1996.

Also, the district hospital, sees an average of 38 patients daily. At the Brewaniase Health Post for instance, they saw only 87 patients at the OPD in 1994 instead of the expected target of 12,000. (See appendix a).

The key question then is why this low turn out? A number of reasons may be advanced. The culture of the people, their beliefs and taboos may be the basis, that prevent them from seeking health care at modern health facilities.

They may also perceive illness as caused by supernatural causes [9]. Low level of education, and other endogenous and exogenous factors such as poverty which has a positive correlation to level of education, may also influence choice, and above all, the length of time patients spend at the service points before receiving attention. Early researchers into this phenomenon have found that some of the factors listed above may contribute to under use of modern health care [1,4,9].

1.3. Rationale for the Study.

Health care utilization and for that matter under-utilization has been a problem to service providers

the world over. In Ghana, studies such as that of Waddington and Enyimayew, Senah, Asenso-Okyere and Anyinam to mention a few, have shown that utilization of modern health care will improve if conducive

Atmosphere is created side by side the provision of facilities. Thus, our interest in studying modern health care utilization in this rural community would help us understand why although services abound, yet, the would be users eschew them, in other words, do not avail themselves to the use of these services as expected by the providers.

In doing the above, it is hoped that we would be adding to the existing body of knowledge in health care utilization, in Ghana, and the world at large. It is also hoped that, the study will help policy makers to redefine their roles and priorities to suit prospective, or would be users of the service they provide.

1.4 Objectives.

The broad objective is to examine the factors that influence the use of modern health care in Nkwanta district. In this regard the following factors are postulated to affect hospital utilization:

1. Distance.
2. Cost.
3. Time spent.

1.5. Methods.

This is a descriptive cross-sectional type of study. To collect data for the study, two research strategies were used. First, an interview schedule was used by three well-trained research assistants and the principal investigator who is a MPH resident.

The total of 340 respondents from 158 households in 20 villages selected from two 2 subdistricts, and from the population of 134,895, were interviewed. All these were done, using the simple random sampling technique. The results were analyzed in EPI INFO 6 and Microsoft Excel, using simple percentages and cross tabulations.

An interview schedule containing nineteen close ended, and eleven open-ended questions was used. Initially, two sub-districts were sampled by simple random technique out of the five in the district. One of these was zoned into north and south, and the other into east and west. By another simple random sampling method, each researcher was assigned to a zone. The sampling of five towns and villages followed this for each zone. The result was that twenty towns and villages were finally selected as the research zones. The researchers therefore interviewed between seventy-three and one hundred respondents in each of these zones during the data collection period.

The four researchers used five days to collect all the data. The results were that one hundred respondents were interviewed in the southern zone, ninety-one in the northern zone, seventy-six in the eastern zone and seventy-three in the western zone.

Finally, the research instrument was pretested at Kabitey, a village in the eastern zone of the district, about 48 kilometers from the district capital (Nkwanta). Further correction and adjustments were made to the questions.

Also, 2 separate focus group discussions (FGD) were conducted in 2 selected villages. One at a village 1.5 kilometers away from the district hospital, and the other at a village 65 kilometers away from the district hospital. These were held at Krontang in the southern zone, and Tinjase in the northern zone of the district.

Chiefs and elders of each of these communities were contacted, and by the use of a key informants, eight each of adult males and females of varying ages between 28 and 80 years were selected for the FGD which was held in Twi language and later translated into English.

Although, records from the District Health Management Team (DHMT) also provided some additional information, it was not used in the analysis. However, it provided a sense of direction and must be acknowledged.

1.6. Limitations.

In an attempt to select the appropriate method, certain deficiencies were realized. For instance it was realized that the tool been use, (an interview schedule) may introduce some kind of bias (that is interviewer bias) in its attempt to address the many factors which influence use of modern health

care. Thus, other tools such as a self administered questionnaire, which could elicit responses without that bias could be used. However, this could not be possible, given the high rate of illiteracy in the district. Besides, questionnaires have their own limitations, and probably cannot expose certain confounding factors we are interested in exploring.

Further, the sample size and the method used to select the respondents at the final interview point may suggest some flaws. This is because the researchers may decide to simplify their work by interviewing too many people from a single household, thus portraying only the view of a few of the study population. However, this was taken care of, by educating the research assistants on its effect on the findings, thus was entreated to refrain from it. The result is evident from the large number of households interviewed as stated earlier.

Finally, only two FGD's are not sufficient enough, to buttress the quantitative data in a study of this type. But it must be said that time and financial constraints, could not make it possible to do more than that. Nevertheless, it is hoped that the method used so far will bring up some findings about the topic under research.

1.7. Literature Review.

Other dimensions of utilization were seen in Waddington and Enyimayew's study in the Ashanti Akim district. These defined utilization simply as number of consultation. They realized that utilization levels fell from 4581 consultations to 1095 within six months period in 1985, and that was

after the introduction of user charges. Both quantitative and qualitative data showed marked reduction in the number of consultations at government health facilities. They concluded that user-charges are determinants to which health care system one would use when sick. See Waddington and Enyimayew [1]. The above finding was not different from what Kanji found in Mozambique. He realized that there was a dramatic decline in monthly consultations from 3000 in December 1986 to 1000 in June 1987, when the Bamako initiative was implemented in that country. Interest in user fees at a public hospital is tempered, however, by concern that user fees discouraged people from seeking care [5].

In the same vein, Weaver, indicated that higher prices can have three effects on utilization of hospital care:- i. patients will delay seeking care from public hospitals, or make fewer visits, ii. patients will avoid seeking care at public hospitals, and iii. patients will seek care from alternative public and private facilities [3].

Frankish , also presents evidence that price increases reduced the number of hospital out-patients visits [10]. However, early demand studies found that utilization is unrelated to the price of care, but more recent studies found that utilization is significantly related to price, and that the effects are larger for lower income households concluded Weaver [3].

Really, much has been said about which factors influence the utilization of modern health care.

Today, these multiple factors can be seen operating at all levels of our social life. Most Ghanaians today are suffering from what Nyame, called 'apecuniocis,' (lack of money)[11]. Thus, as observed by earlier researchers into the problem of utilization, people's health seeking behaviour depends by and large on their ability to pay, nearness to facility and others such as staff attitude and so on. Kunnes, observed that, the payment of hospital fees is not only a health hazard but also a psychological barrier to health care.

Hospital fees are, he argues, a road block to good health and makes mockery of health care as a right rather than a privilege; it makes the service increasingly a luxury to the majority who are also the poorest [12].

In a study in Cicia Fiji, Andy observed that people who live closer to health facilities will visit the facility with their illnesses as opposed to those living far away from the health facility. He recommended, that satellite clinics should be opened in those vicinities farther away from health centres, or local residents be trained to provide appropriate first aid [13]. This implies that distance or physical accessibility to the facility is a determinant factor for utilization.

This position was supported by Carpentier et al., in a similar study in Bobo-Dioulasso, Burkina Faso. They discovered that, the choice to select either traditional or modern treatment or even self medication, depend by and large on the patient's educational level, religion, type of illness or symptoms, proximity, cost, time spent at the facility, previous treatment success rate and above all

preference. They found for example, that nearly all the patients (89% of the 280 subjects) visited dispensers who were less than 5 kilometers from their homes.

Also, they reported that more people will see the traditional healer for treatment because in their study the total cost of treatment per an episode of illness amounted to US\$10. Thus, people will always go for the cheapest. This implies that cost of service and distance can deter people from seeking care at modern health facilities thus negating the Primary Health Care's (PHC's) goal of, health for all by the year 2000. They concluded that for all symptoms combined, 23% were treated by traditional medicine only, 52% by modern medicine only, and 14% by self medication only [2].

Chapter Two.

2.1. Research Setting.

2.1.0. Background to the Study.

The study was conducted in the Nkwanta district of the Volta Region in Ghana. Nkwanta district is the largest in the Volta Region, and was carved out of Kete-Krachi district in 1988. It is situated in the northern most part of the Volta Region. The district assembly is the highest political authority at the local level.

2.1.1. Size and Location.

It is a fairly a large district with a total surface area of 3,863 square kilometers. The district is located in the north-eastern part of the Volta Region between latitude 7.30 and 8.45 degrees north and longitude 0.10 and 0.45 degrees east. By the above description, the district shares common boundaries with Kete-Krachi district on the west, the Republic of Togo in the east, the Kedjebi district in the south and the Nanumba district in the north. (See Figure 1).

2.1.2. Physical Characteristics.

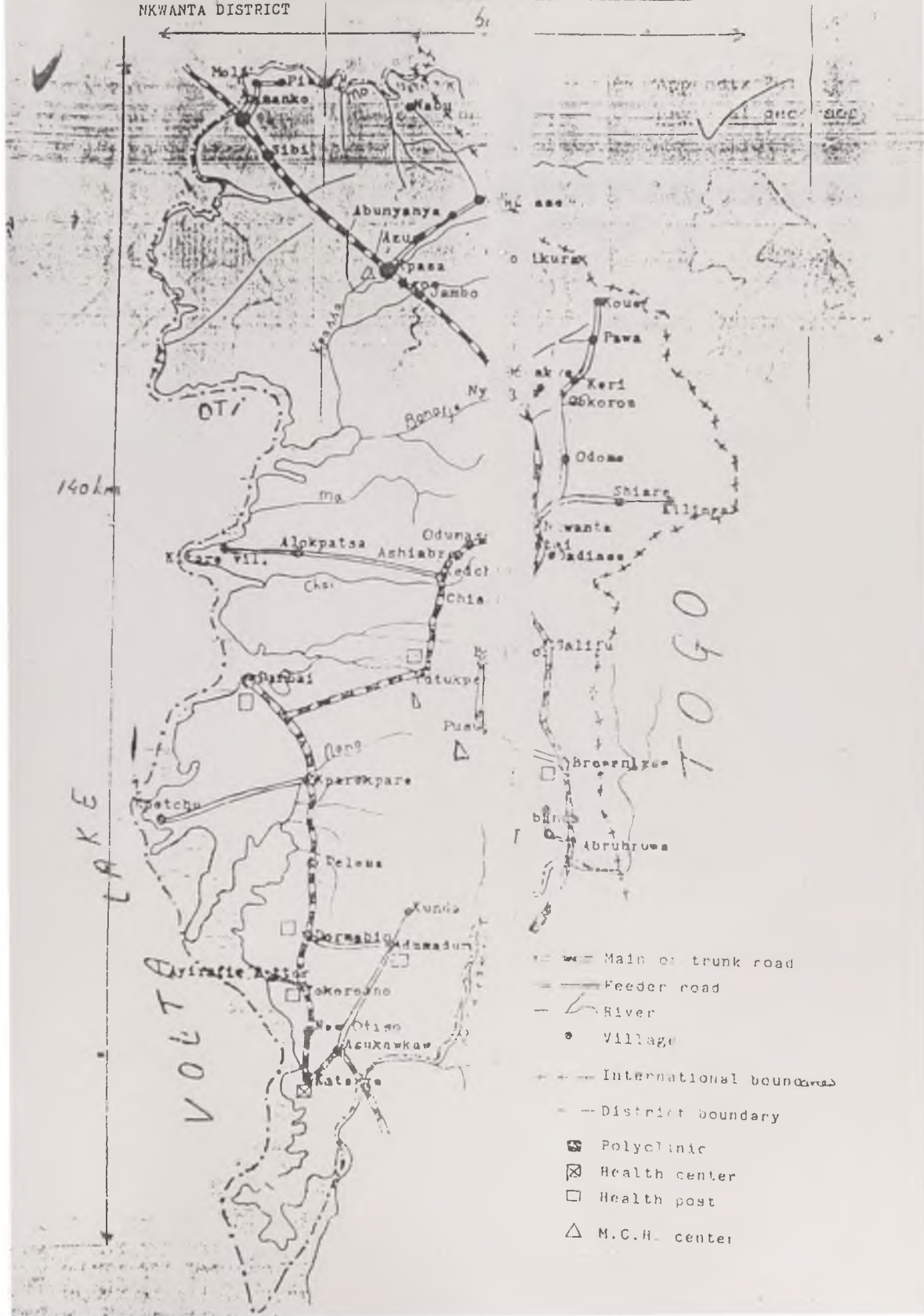
The physical characteristics of the district include climate, physiography, vegetation, and geology.

Climate :- Generally, the district is characterized by a tropical climate with dry and humid weather condition in the northern and southern zones. Monthly temperatures range between 24 to 28 degrees Celsius. The rainfall pattern is seasonal just like in any part of the country, with prolong rainy season bias during May to August.

Appendix 2a
NKWANTA DISTRICT

Nkwanta district

Administrative.

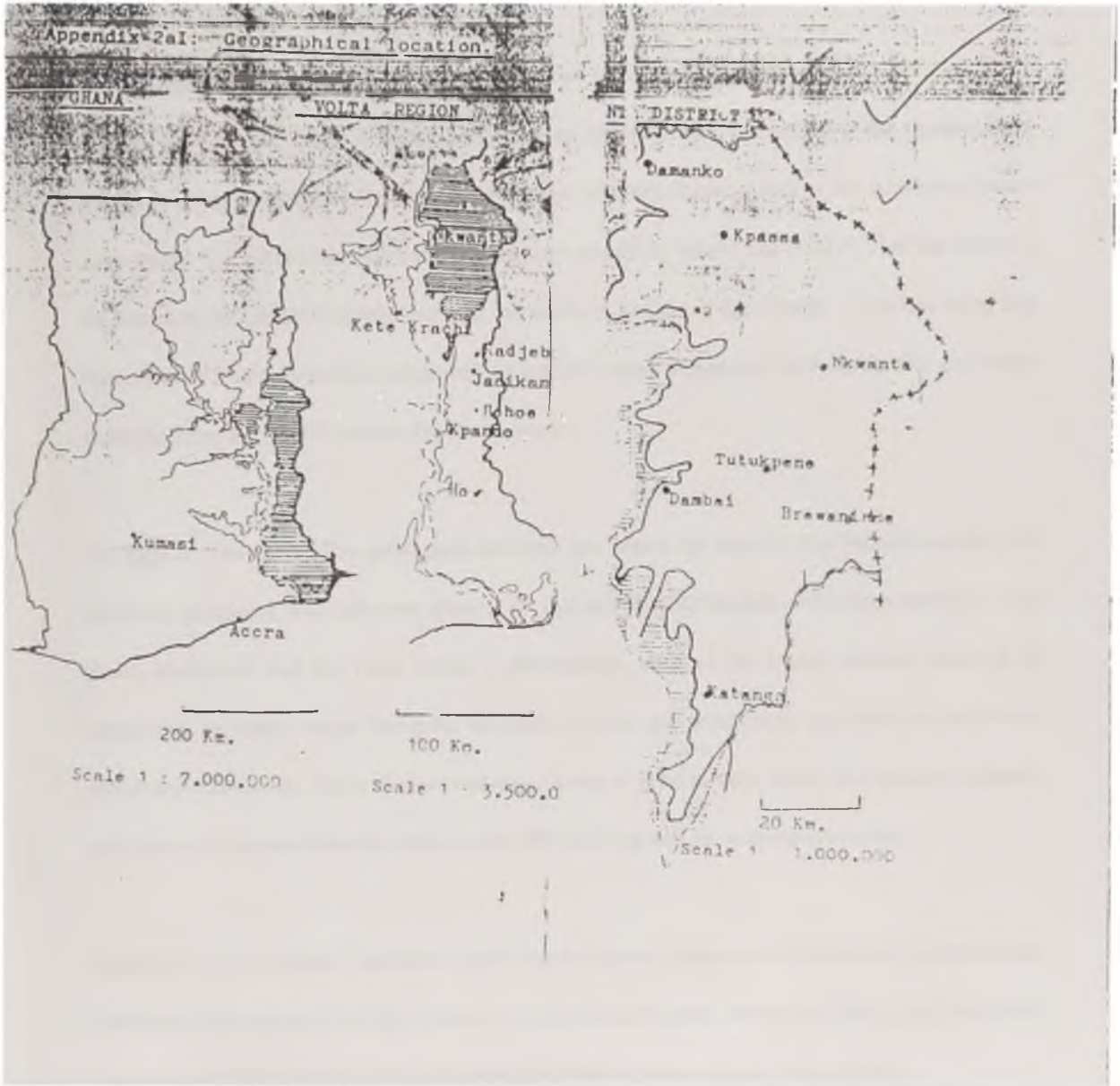


140 km

LAKE
VOLTA

- - - Main or trunk road
- - - Feeder road
- - - River
- Village
- - - International boundary
- - - District boundary
- ⊠ Polyclinic
- ⊞ Health center
- Health post
- △ M.C.H. center

TOGO



The rains in the district start around March and gather momentum around May and June, reaching its peak levels in September, and start reducing to almost zero levels in November.

Physiography:- There are two physiographic zones in the district, these are :-

A mountainous zone lying along the south-eastern section of the district and in the north-eastern direction along the border areas with the Republic of Togo, forming part of the Akuapim-Buém-Togo range. The other is the flat and low lying belt occupying almost one third (1/3) of the district's surface area and predominantly found in the northern section of the district. This low lying belt forms part of a land formation commonly called the interior expansive Voltarian basin, and varies in height from 100 to 200 meters above sea level.

Geology :- Out of the five geological domains into which the country has been classified, The district is associated with only two, these are:- Precambrian mobile belt , Voltarian system, i.e. the Buém formation and the Togo series. Unfortunately, none of the known mineral deposits of significant economic value like gold, diamond, bauxite and manganese are found in the above-mentioned formations. There are however many kinds of good pottery, bricks and tile clays, shale's and slates of various siliceous rocks suitable for building and for making ornaments.

Drainage :- The physical formation in the district has to a great extent influenced the source and direction of the natural drainage system. Rivers such as Kpassa, Bonakye, Sabu, Chai, Nano and Asukawkaw take their source from the stretch of the Akwapim-Buém-Togo ranges.

Most of these fall sharply from the hills and meander through the low lying lands of the district before finally terminating in the Oti River.

Apart from these rivers, there are numerous small streams scattered all over the entire district, serving as sources of domestic water supply for majority of the people since there is no pipe borne water.

Vegetation :- The vegetation of the district is about 30% forest, 50% guinea savannah woodland, 18% savannah woodland and 2% riverian or gallery forests. The forest zone is found mainly at the eastern border areas along the stretch of the Akwapim-Togo range. The savannah woodland areas can be found between the real grassland savannah and the lake at certain parts and lying roughly at the middle zone of the district. The grassland savannah is found mainly along the Volta Lake and Oti River and extends about 20kms. towards the east from the lake around the north-western corner of the district.

The forest provide timber wood and also provide fertile land for the cultivation of tree crops such as cocoa and cola nuts. Other natural resources that are supported by the vegetation especially in the savannah woodland include shea butter.

2.2. Population, the people and their socio-demographic characteristics.

The district has a population of 134,895 as projected at December 1995. Below is the breakdown of the population on sub-district basis:

Table 2.1. Population Distribution by Sub-District.

Name of Sub-District.	No. Of Village	Population
Brewaniase	29	19,525
Nkwanta	38	34,686
Kpassa	61	43,977
Tutukpene	38	10,567
Damanko	27	26,135
Total	0	134,895

The population of Nkwanta District is ethnically heterogenous. Among the many ethnic or tribal groupings in the district, five are dominant and they constitute the indigenous population of the district. These are the Ntrubo in the southern sector, centred around Brewaniase. The Challa around Odomi, the Adele in the Western and Southern sectors around Tutukpene, the Dadiase the Chiase and the Atwode in the east, with Shiare as their traditional centre.

The Kokomba constitute another major groupings in the district and are found in the northern sector of the district. Apart from the above major ethnic groupings, there are several minor settler groups among which the Ewe and the Akan dominate. Majority of the people live in farm villages with population of less than 300 persons per village; and are sparsely distributed.

This pattern to a large extent has been dictated by the major economic activities in the district which is peasant farming based on land rotation. By this method, people prefer living in smaller communities widely separated from one another.

2.3. Religion.

Most religions exist in the district, however, Christianity is growing rapidly and has almost dominate. the religious scene. Both the orthodox and the Pentecostal are on the increase. The Islamic religion also exists, but can be found mainly in the Kpassa and Nkwanta townships. However, these form only 1/3 of the population. The remaining 2/3 are predominantly traditionalists.

2.4. Economic activities.

The main occupations in the district are farming, fishing and trading. There is a number of peasant farming going on in the district. Cash crops such as coffee, cocoa, yam, sheanuts and groundnuts are produced on a medium scale. Citrus fruits, palm nuts, maize, cocoyam, rice and beans are also produced for domestic consumption, and in some cases for commercial purposes. Those living along the streams and rivers, fish from these, and may sell some of their catch, thus increasing the protein production in the district.

The commercial centres in the district are Nkwanta, Kpassa, Brewaniase, Damanko and Sibi.

Public and civil servants form a small portion of the population in the district. There is a Commercial Bank, which serves the whole community as well as paying the salaries of workers in the district.

Also, there is an Agricultural Development Bank Loan Office. This serves as a channel for giving loans to farmers who have formed a Cooperative Union in the district.

The main trunk road passes the district from Accra through Hohoe, Jasikan, Kedjebi and through the district capital which is Nkwanta township . It continues to Kpassa through Damanko, and to the northern region after crossing the Oti river at Damanko. The main transport system in the district is public transport; City Line, OSA and those run by the GPRTU.

There is only one Post Office in the district and it is located in the district capital. Most of the departments in the district use the Motorola system. About six of such departments, including the District Health Management Team (DHMT), use this type of communication.

There are eight large and five small markets in the district. The large ones are located at Kpassa, Nkwanta, Damanko, Sibi, Brewaniase, Bonache, Kacheibi and Kabiti. The small ones can be found at Tutukpene, Kue, Pawa, Tinjase and Pusupu. Until recently, the district assembly put up some few sheds for the traders at Nkwanta. The rest do their selling in the open air, these are always at the mercy of the weather.

Market days vary. Nkwanta's is Monday, Kabiti's, Wednesdays, and Pawa's Thursdays. For Brewaniase and Kacheibi it is Friday and Bonache and Keri are Saturday and Sunday respectively.

2.5. Education.

The district has been divided into five circuits each with a circuit officer for effective supervision. There are a number of schools in the district. These include twenty-five kindergartens, ninety-one primary schools, thirty-nine junior secondary schools, and three senior secondary schools. These have varying numbers of enrolled student. See table below.

Table 2.2. NKWANTA SCHOOLS AND THEIR ENROLLMENT.

School	Number	No. of Enrollment
Kindergarten	25	2750
Primary Schools	91	19185
Junior Secondary Schools	39	4775
Senior Secondary Schools	3	1380
Total	158	28,090

(Source: District Profile 1996).

2.6. Environmental hygiene.

The approved public toilets in the district are woefully inadequate to meet the increasing demand of the growing population. Sanitation in the district is the sole responsibility of the district assembly. Three new toilets were built in the district in 1996. These are public septic tanks, each located in Kpassa, Nkwanta and Damanko.

Table 2.3.

TOILET FACILITIES

TYPE OF TOILET	NO. IN USE
Septic Tank	4
Water Closet	21
Improved Pit	15
Communal KVIP	1
Private KVIP	30
Mozambique	3
Pit Latrine	123
TOTAL	194

(Source: same as above).

The land stretching from Bonakye to Damanko is so porous that when pit latrines are constructed, they collapse during the rainy season. Due to this, the affected communities feel reluctant to construct pit latrines. They have therefore turned to defecating everywhere especially in the nearby bushes, dubbed “free-ranging”. This they do with the view that their pigs will feed on their faeces. However, with cognisance of the consequence of indiscriminate defecation, there are plans to help these communities have proper and sustainable places of convenience.

There is no slaughter house in the district. Instead, there is an old slaughter slab. Even though environmental health officers (EHO) and the district veterinary surgeon do pre/post mortem inspections, and animals are slaughtered under their supervision, the wholesomeness of the meat sold to the people leaves much to be desired.

In all, there are about six meat shops in the district. Animals slaughtered for human consumption are cattle, sheep, goats and pigs (mostly the local pigs). Food hygiene is taught to the food vendors through hygiene education. And sanitary laws are enforced through the EHO's and other agencies for example the district assembly. All vendors are subjected to medical examination annually, this is to ensure that the food vendors are healthy enough to sell food to the larger consuming public, without causing disease outbreak.

Potable water supply has been the felt need of many of the communities in the district. The main sources of supply of water in the communities are from rivers, streams, ponds boreholes, hand-dug wells, and sometimes rain catchment during the rainy season.

The most important source of water supply in the district is the hand-dug well. Most of these more often than not dry up quickly when the dry season sets in, that is from November to March each year. When this happens, the affected communities collect surface sources of water such as from rivers, streams and ponds. These water sources are often infested with copepods of *dracunculus medinensis* which transmits dracunculiasis (guinea worm disease). Also some of the streams are infested with the water snails (*bulinus globus*) that cause *schistosoma haematobium* (bilharzia). Therefore, the problem of inadequate supply of water in the district has led to high prevalence of guinea worm and bilharzia.

Table 2.4.**Water Supply System in Nkwanta District**

No.	Water	Number
1.	Hand dug wells	200
2.	Boreholes	61
3.	Streams	16
4.	River	1
5.	Rain water catchment from roofs	16
6.	Springs	2

2.7. Health institutions.

There are a lot of efforts on behalf of the new District Director of Health Services (DDHS) to upgrade the health centre to a district hospital. This has been achieved partially, and as at now, a small operating theatre has been set up to receive referrals from the sub-district. Below is a table of health facilities in the district.

Table 2. 5.**District Health Facilities and Their Location.**

LOCATION	TYPE OF INSTITUTION	STATUS
NKWANTA	1. St. Joseph's Clinic	Mission
	2. Nkwanta Health Centre	Government
	3. MCH/FP Centre	-do-
BREWANIASE	1. Brewaniase Health Post	-do-
	2. Obanda Fame Clinic/FP	Mission
	3. Pusupu MCH/FP	-do-
TUTKPENE	1. Health Post MCH/FP	Government
KECHEIBI	1. Health Post MCH/FP	-do-
KPASSA	1. Church of Pentecost clinic	Mission
	2. Kpassa Health Centre (newly built)	Government (NGO)
	3. Private Maternity Home	Private
DAMANKO	1. Damanko Health Centre (newly built)	Government (NGO)

(Source: District Profile 1996).

The district has two senior medical officers, and one is the district director of health services. One medical assistant, two principal nursing officers, two senior nursing officers and four public health nurses. There are seventeen community health nurses, four staff- midwives and ten enrolled nurses. The rest are two executive officers, fifteen field labourers, three drivers, two typists, two leprosy control officers and two epidemiology staff. Morbidity and mortality patterns in the district are similar to what pertains in most districts of the country. Malaria is the commonest cause of illness in

the district , recording as much as 1474 cases in 1996.

This was followed by worms infestations with 390 cases. Similarly, malaria is the greatest cause of death in the district, recording as much as 22 deaths in 1996, followed by anaemia and measles each of which recorded 3 deaths respectively.

Table 2.6.

MORBIDITY AND MORTALITY PATTERN IN THE DISTRICT.

NO	DISEASE	# OF CASES	# OF DEATHS
1.	MALARIA	1474	22
2.	ANAEMIA	186	3
3.	MEASLES	56	3
4.	WORM INFESTATION	390	-
5.	URTI	186	-
6.	SNAKE BITE	104	1
7.	PREG. RELATED DISEASE	101	
8.	UTI	77	-
9.	MALNUTRITION	43	1
10.	JAUNDICE	34	-
11.	ACCIDENTS	26	-
12.	BURNS	6	2
13.	D & C.	5	2
14.	HEART FAILURE	1	1
	TOTAL	2689	35

(Source: District Profile 1996).



Chapter Three.

3.0. *Analysis of data.*

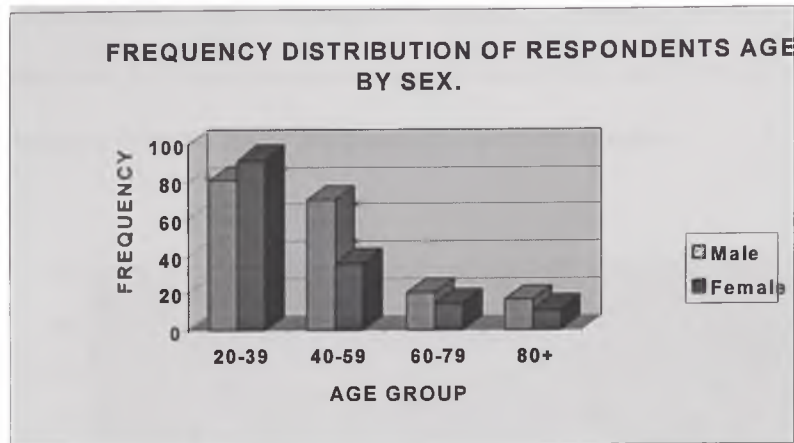
3.1. Characteristics of respondents.

Fifty five percent of the respondents were males and forty five percent were females.

Figure 3.0 :Frequency distribution of respondents by sex



Forty three percent of the male respondents are in the age group of 20-39 years, 37.3%, are of 40-59 years, 10.7% are 60-79 years, 8.6% falls within the 80 years and above group. Sixty percent of the female respondents are of age 20-39 years, while thirty-six 23.5% are 40-59, and 9.2%, and 7.2% falls within the age groups of 60-79, and 80 and above, respectively.

Figure 3.1.

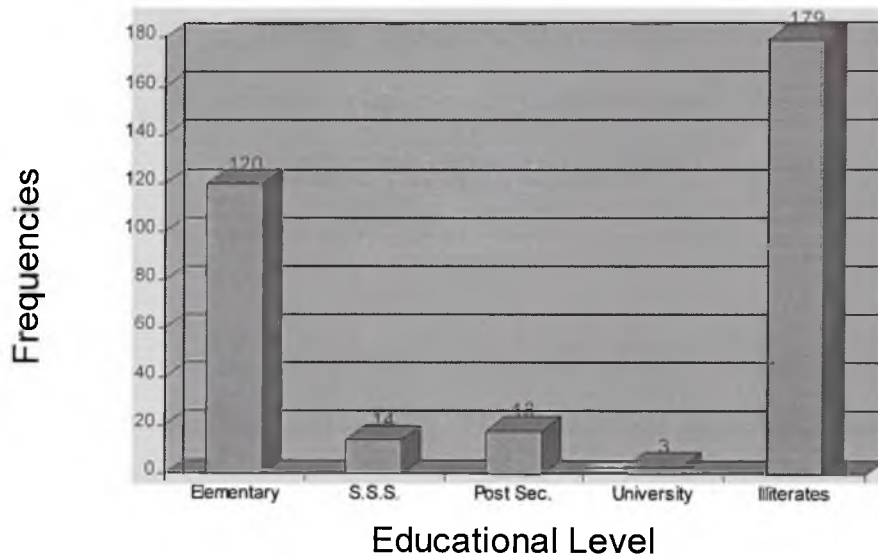
Religion:- Table 3.0. shows the distribution of by religion. Most respondents are either Christians or Traditionalists. The Moslems constitute 12% of the population. The data indicated that 55%, are Christians, that is orthodox and Pentecostal, 30% are traditionalists, in other words pagans .The Moslems constitute only 12.1%, and 2.9% do not belong to any religious denomination.

Table 3.0. Frequency and Percentage Distribution of Respondents Religion.

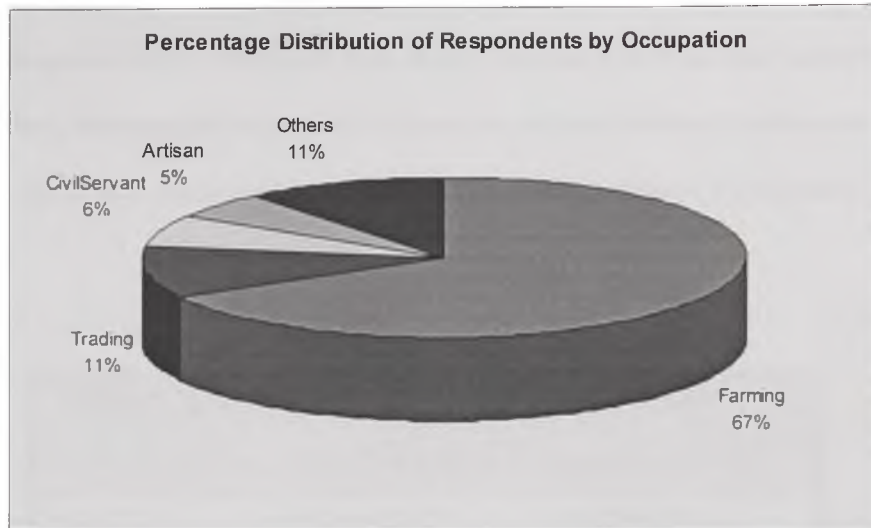
RELIGION	FREQUENCY	PERCENTAGE
Christians	187	55%
Traditionalists	102	30%
Moslems	41	12%
Others	10	3%
Total	340	100

Education:- Fifty three percent of the respondents A total of one hundred and seventy-nine (52.6%) respondents have not had any formal education, 0.9% went to University, 5.3% attended school to the post secondary level, 4.1% went to senior secondary school (SSS) and 37.1% primary level.

Figure 3.2. Frequency Distribution of Respondents Level of Education.



Occupation:- Sixty seven of the respondents are engaged in peasant farming, 10.6% are traders, 6.8% are civil servants, 5.2% are artisans and the remaining 10.8% are either housewives or unemployed.

Figure 3.3.

Marital Status:- Most respondents are married. Eighty-three percent are married and are living with their spouses. Only 10.9% are single, 2.7% of them are divorced, and 3.2% widows and widowers.

Table 3.1.

FREQUENCY AND PERCENTAGE DISTRIBUTION OF RESPONDENTS MARITAL STATUS		
Marital Status	Frequency	Percentage
Married	283	83.2
Single	37	10.9
Divorced	9	2.7
Widowed	11	3.2
Total	340	100

3.2. Respondents who fell sick during the past year.

All the one hundred and eighty-seven males and one hundred and fifty-three females interviewed said either their spouse, child or themselves, have fallen sick at one time or the other during the past one year. By this, the respondent then qualifies to become a subject of the study. In the same vein, these same number of respondents sought treatment to help cure their respective conditions.

Table 3.2 .

FREQUENCY AND PERCENTAGE DISTRIBUTION OF TYPES OF FACILITY UTILISED BY RESPONDENTS.		
FACILITY	FREQUENCY	PERCENTAGE
Hospital	128	37.6
Clinic	132	38.8
Herbalists	13	3.9
Spiritualists	2	0.6
At a shrine	2	0.6
Self Medication	63	18.5
TOTAL	340	100

3.3. Factors Influencing Utilization.

3.3.1. Reason for Choice.

Nineteen percent chose the facility because it is the nearest, 13.5% because it is the cheapest, 5% maintained that it is the only one available, that is easily accessible, 23% because quality and 40%, because of the illness.

On the other hand, about 89% of those who went to a modern health facility said it is very expensive. This is an indication that the people consider other sources of treatment as less expensive, for which reason they resorted to it's use. In a nut-shell, they will only go to hospital or a clinic, when attempts on other sources have failed.

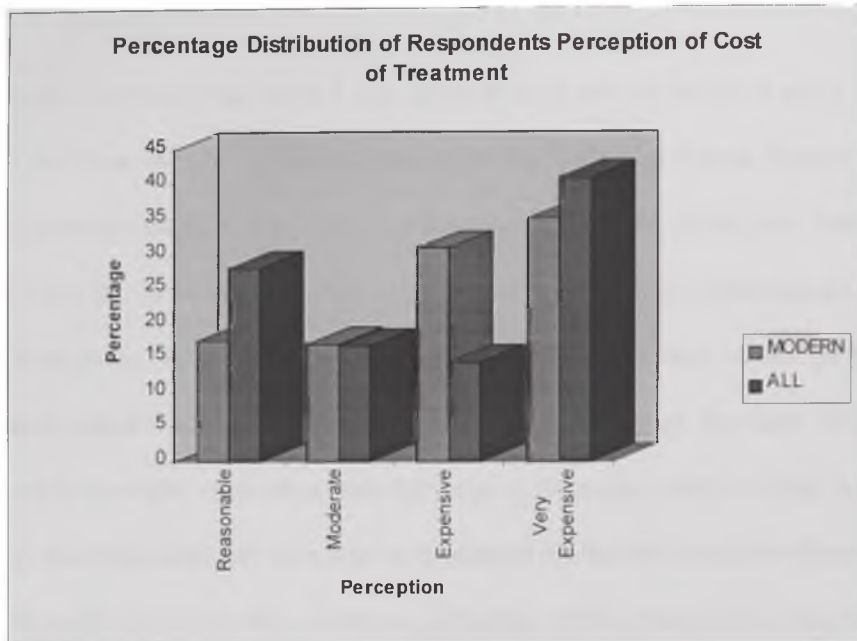
In the same vein, as much as twenty nine percent of those who went to a modern health facility, contended that they went there because of quality of service, opposed to only 12.5% of those who utilized other facilities. Again, of the number that utilized modern health facility, 50.4% said they did so because of the illness afflicting them, while less than 20% of those who utilized other facility claimed they made that choice because of the illness. Implicit in the above exposition, is that many will go to a modern health facility or a more reliable source of treatment, if they perceive their illness as one that really needs to be taken there. Thus most of the respondents that went to hospital/clinic, did so because their problems were mainly surgical such as hernia.

Table 3.3. Frequency and Percentage Distribution of Reasons for choice of Facility.

RESPONDENTS REASON FOR CHOOSING PARTICULAR FACILITY.										
FACILITY	NEAREST		CHEAPEST		QUALITY		ILLNESS		AVAILABLE	
	#	%	#	%	#	%	#	%	#	%
Hospital	11	3.2	2	0.6	46	13.5	68	20	1	0.3
Clinic	34	10	3	0.9	30	8.8	63	18.5	2	0.6
Herbalist	5	1.5	4	1.2	-	-	3	0.9	1	0.3
Spiritualist	-	-	-	-	-	-	2	0.6	-	-
Shrine	2	0.6	-	-	-	-	-	-	-	-
Self Med.	13	3.8	37	10.9	-	-	-	-	13	3.8
TOTAL	65	19.1	46	13.5	76	22.4	136	40.2	17	5

3.3.2. Cost of Service.

Seventy five percent of the respondents that utilized a modern health facility went there with surgical problem. Only 24.6% were medical cases. On the whole, respondents who sought treatment for both medical and surgical cases in any of the facilities listed above paid ₵90,000.00 and ₵25,000.00 respectively on the average. About 41% stated that the amount paid in either respect is very expensive; 14.4% said it is expensive. However, 16.5% of them said it is moderate, and 27.9% claim it is reasonable. The above exposition is so, because respondents were asked to take into account their level of income to justify their position. But for those who went to a modern health facility, 35% said it is very expensive, while 30.8% claim it is expensive.

Figure 3.4

Given the above, the total number of those who went to a modern health facility and claimed the cost of service at these facilities are unbearable constitute 65.8%, as against 34.2% who said the opposite.

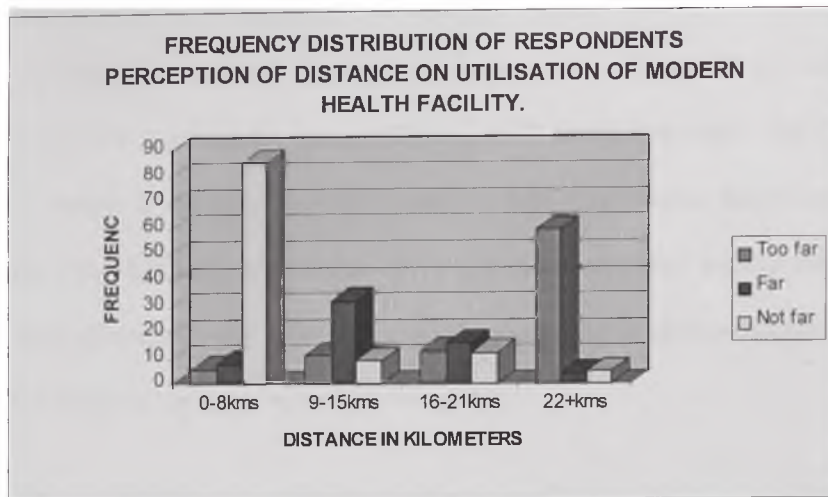
3.3.3. Distance From Facility.

As already stated, 19.1% of the respondents noted that their choice of treatment was influenced by distance. They said they went to the facility because it was very near. See table 3.3.

However, for those respondents who went to a modern health facility, the data indicate that those

living above 8 kilometers radius constitute 61.9% of the total number, and the remaining 38.1%. For the former, 83 said the facility is too far, but 52 and 26, said it is far and not far respectively.

In the same vein, for those living within 8 kms, as much as 85 said it is not far, 8 said it is far, and 6 said its too far. From the above, it can be deduced that the distribution is even, because while the total of 85 respondents living within 8 kms said the distance is not far, 83 of them living beyond 8kms said it is too far. On other hand, while only 6 of those living within 8 kms said the facility is too far 5, of those living beyond 8 kms said it is not far. Finally, it was observed that the frequency declined steadily with distance in those who said 'not far', in all the groups. See chart. This position was buttressed by the eighty respondents that did not go to the modern health facility. As much as 83.8% of them maintained that they did not go to the hospital or clinic because of the distance. These claim that, the roads are in deplorable conditions preventing vehicles from plying them frequently, except on market days. For these reasons, they prefer using facilities that are easily accessible to them. Thus it can be said that the nearer the facility, the better it is used.

Figure 3.5. Influence of distance on utilization of modern health care.**3.3.4. Time spent at facility.**

Most of the respondents who went to hospital contended that they spent between one to three hours at the service points before receiving attention. Seventy one percent said they spent between two hours before being attended to, and one hour on the average before collecting their drugs. However, an average of 25.5% fumed that they spent untold hours at both points before they received attention, and are not happy.

Table 3.4.

PERCENTAGE DISTRIBUTION OF TIME SPENT BY RESPONDENTS AT MODERN FACILITIES				
TIME SPENT	< 1 HOUR	ABOUT 3 HRS.	> 3 HOURS	TOTAL
Before consultation	35	36.9	28.1	100
Before collecting drugs	56.2	23.5	23.5	100

Finally, apart from 18.5%, the majority i.e., 81.5% of the respondents maintained that the time spent at the facility can never deter them from using these facilities whenever they have the need for it. As such, when the question was asked, "do you think there are other things that will make you seek treatment from other sources (not a modern health facility)?" , 62.6% responded "YES", and 37.4% replied "NO". As to why the former will seek treatment from other sources, they claim it is mainly due to poverty. This they claim prevents them because they cannot afford the high cost of hospital fees. "As farmers, although we may have some produce to sell, it becomes impossible to do that, just because of the nature of our roads" stated one respondent.

They concluded that long distance to health facilities coupled with persistent bad weather, and the insistence of hospital authorities to collect large sums of money as 'deposits' before treatment is commenced, are factors that deter them from using these facilities.

Chapter Four.

Discussion of Data

4.0. Introduction.

The problem of disparities between regions in the availability of health care institutions is compounded by significant under utilization of available services. Out-patient attendances at MOH institutions fell from 10-11 million in 1973, to about 3.7 million in 1992..... although the cash and carry system led to a more rationale indenting of drugs and user-fees, "cost sharing" was to reduce government burden for health care, it also resulted in low out-patients attendance. In sum, total coverage and hence access to health service remains low. Service simply does not reach or is inaccessible to a large proportion of the population in need [14].

This study was embarked upon to investigate factors influencing the utilization of modern health facilities in Nkwanta district. The findings revealed that out of the three hundred and forty respondents interviewed, as many as 76.5% used a modern health facility when they were sick. This is an indication that more people use modern health facilities. The appropriate interpretation of the data therefore, would be, there is no under utilization of modern health facilities in the district.

However, such conclusion could be elusive given the fact that quantitative data alone cannot explain a social phenomena that is due to behaviour. For it has been established that achieving constancy is necessary in explaining causation. Mills noted that the best method by which comparativists can determine causation and explain phenomena in the social milieu, is by using his method of agreement [15].

Reason for choice.

It was realized that most of the respondents went to these facilities mainly because of their perception of their illness. For example, one hundred and thirty-six said they went there because they realized that is the appropriate place to seek treatment for the illness afflicting them. Again, seventy-six said they went to hospital or clinic because of quality. On the contrary, none of those who used other sources of treatment said they went there because of quality, and only five of them claimed they used those facilities because of the illness. Rather, majority of them went either because it was the nearest, the cheapest or the only one available. One participant in the focus group discussion at Krontang remarked, "I suffered from boil only four days ago, but I did not go to hospital because I wasn't having money. I used herbs to cure it, although I know the hospital is the best" Another FGD participant at Tinjase supported the above view and said, "One thing that prevents me from going to hospital each time I am sick is poverty. It is difficult to get money these days, you will not know when you will fall sick; but when sickness comes, the doctor will ask for big money".

In fact, it has been established in the literature that utilization of modern health care declined to disheartening levels between the late 1980s and early 1990s. Among the host of reasons assigned to this is the cost of treatment (user charges) introduced in 1985 [1., 3., 5,].

The above presupposes that attempts by successive governments to introduce equity into the health care delivery system was compromised by the introduction of user-fees. This brings to bare what the psychologist call approach-avoidance [16], meaning factors within and without contribute immensely to the choice of people. An example will be the desire for one to undergo herniorrhaphy, yet he cannot

afford the exorbitant hospital fees and as such, the deposit.

Cost of Service.

Majority of the respondents went to the hospital with surgical problem. At least, 68.7% were there because of hernia, intestinal obstruction, typhoid perforation, ruptured ectopic gestation and obstructed labour to mention a few. Usually, these arrive in hospital in critical condition, and surgery thus becomes the only method for saving their lives. Therefore it was realized that an average amount of ₵90,000.00 were paid for treatment if surgery is to be done. This amount, the respondents claimed to be too expensive. Sixty seven percent of the respondents who used modern facility claimed that it is very expensive given their level of income. In fact they argued that there is no point in putting up the facility and yet make the service unbearable for the would be users. It must be reiterated here that Kunnes observed that “the payment of hospital fees is not only a health hazard but also a psychological barrier to health care. Hospital fees are, he argues, a road block to good health and makes mockery of health care as a right rather than privilege, it makes the service increasingly luxury to the majority who are also the poorest”[12]. It has been well documented that majority of Ghanaians are living below the poverty line. Gross domestic product is below \$500, and the monthly income of the average Ghanaian is as low as \$35 [17]. For this reason, poverty abound in most of our communities especially in a rural communities. As such, Nkwanta, where most people are peasant farmers cannot be left out.

Nyame reiterated that, “most Ghanaians today are suffering from apecuniosis” (lack of money) [11].

Waddington and Enyimyew also observed that the most common scenario was that the consumer

favoured the drug store or the drug peddlers instead of government facility, because they are cheaper. They presented what one farmer described to be the widespread trend since the introduction of user-fees thus:- "I have changed my preference since fees were introduced because formerly, I used to go to the clinic to cure all my ailments when hospital charges were then about ₵5.00.

Since the introduction of the new high charges, the clinic card costs about ₵40.00 to ₵50.00. When your finances are not sound you cannot go there. This prevents me from going there, ₵500.00 or ₵600.00 is too much for me. I buy from those selling aspirin - phenacetin - codeine or codeine on the streets.

You will be Ok with only ₵20.00, lamented the old farmer"[1]. At Tinjase, the story was not different. Two participants stated that "You will be asked to pay ₵500.00 for card each time you went to hospital at Nkwanta. Besides, the charges are too much, and if they will admit you, they will ask for big money sometimes as much as ₵150,000.00 as deposit, before you are treated." Another participant retorted in twi, "Dokita se mi ni bia mekor, dabi mintumi nkor no saa. Na se yare no bekumi a, se na ma wu nono". Literally, it mean, "doctor (referring to me), if I do not have money how can I go?. Therefore, if it is an illness that will kill me, then I will die." Suffice it to say that in situations such as this, the patient is left with options such as home remedy.

Although Anyinam[18] claimed that home remedy is part of the medical system, and was supported by Kleinman [19], and Tarimo [20], it is not the best, given the magnitude of its subsequent complications. Really, cost of service has posed a lot of hindrance to the health sector in recent

times. Attempts by the PNDC government to make the health service delivery system in the country sustainable and equitable by the introduction of user fee, failed because the people are too poor, and thus cannot afford to share the cost of health service. As a result, health services, although available in the district under study, could not be used by majority of the people due to financial constraints. The trend is that people will eschew modern health facilities and resort to the use of more affordable sources of treatment albeit harmful.

To conclude, it must be reiterated that in one study, it was found that out-patients numbers declined immediately and rapidly when user-fee was introduced in the Volta Region with rural facilities being the worst affected [1].

Therefore, Nkwanta, like any other rural community in Volta Region have the problem of under utilization of its health facilities. The research findings indicated that, this is so because of the high cost of hospital fees, coupled with the demand of large sums of money as deposit. The issue is not peculiar to that district alone, but the whole nation and the world at large, especially in developing countries.

Distance.

The next issues that come to fore is the poor road network in the district, which is further compounded by the prolonged bad weather thus leading to the reluctance of vehicle drivers to ply the routes.

The study revealed that distance from health facilities is a strong determinant for utilization. It was observed that respondents patronized facilities closer to them in time and space. Thus as much as 83.8% of the respondents who never went to a modern facility said it was so because of the distance. This position is clear given the number of respondents who said the facility they went to was very near to them because they were living within 8 kms radius. In contrast, as many as 135 of them who live from 9-22 kms and beyond claimed the distance is too far.

Distance as a factor influencing utilization of health service has been the domain of some researchers, including WHO. These observed that the nearer the facility the better its patronage. Thus the PHC concept states that facilities should be sited within 8 kms radius for communities.

It must be said that although there are facilities which are under utilized in the district, one cannot also deny the fact that the district is so large that such facilities could become physically inaccessible to the majority of the people, given the sparse distribution of the population in the district [8].

It was for this reason that majority of the respondents who used the health facilities said they did so because of the illness. Explicitly, one would have thought that presence, means accessibility. This may be erroneous, because as much as 62% of those who used the hospital or clinics live quite a distance away from those facilities. And for those who could not go to hospital or clinic, it is even much higher, (78.6%). Carpentier et. al, observed that, "In practical terms, the two most important factors which determine the choice between traditional and modern medicine are proximity and cost, which are closely related to the income and education level of the patient"[2].

They reported that nearly all the patients (89%) visited a dispensary which was less than 5 km from their homes. On the other hand, the majority (59%) of those who saw a traditional practitioner chose one who lived within 5 km of their homes.

To buttress this position, Andy found in a study done on Cicia, an island of Fiji, that almost 50% the people sought medical care in the local health centre, and most of these lived close by. He concluded that it appears necessary to provide care for those in a more distant villages, either by opening satellite clinics visited by a medical assistant several times a month, or by training a local resident to provide appropriate first aid [13].

Others such Waddington and Enyimayew [1], saw accessibility as a factor coupled with lack of transport and high transport fares. "Our roads are bad, and is one way. From here to Kpassa is about 30km. Therefore if one falls sick suddenly, it becomes difficult; its only God that is saving us" (Participant at Tinjase).

To conclude, it must be reiterated that almost all the respondents complained bitterly of the distance to health facilities. At Shiare for example, the community reported that their only problem is their inaccessibility to Nkwanta, given the bad landscape of their settlement. Thus all they want is a health centre in their locality. This demand was not different from what pertains at Kue, Keri, Alokpacha, and Tinjase, to mention a few.

Time Spent at Facility.

Although other researchers found time spent at facility as a factor, this research did not find same. Except 15%, the majority of the respondents reiterated that the time spent at the facilities will in no way deter them from seeking help the next time they are in need. However, the former complained bitterly that one thing they abhor most is favouritism.

They complained that it is annoying and even irritating to be the first person to go to hospital with the view of being seen early, only to realize that those who came late are being attended to, while you wait in vain. "Sometimes, 'big men' keep going to and fro the doctor's consulting room, and one doubts what they go in there to do", lamented one respondent. The general perception of these respondents is that the "first come, first served tenets should be strictly applied, except in emergencies.

The focus group discussion also yielded similar results. At Tinjase for instance, two participants reported:- (1) Yes, it has happened to me before. Once my wife was sick and I took her to St. Joseph's Clinic, in fact we wasted a lot of time without been called, rather they were calling those who came later.

When I complained the white lady was angry with me, and the nurses also started insulting me. From thence, I vowed not to go there again. (2) I also once sent my son to Nkwanta Hospital, I was delayed so much that the child started vomiting. When I approached the nurses to find out why this delay, and to tell them what is happening to the child, they started shouting on me. In fact I was

disappointed, thus decided not to go there again.

Apparently, these are few expositions which depicts one's emotional response to frustration. In such circumstance, one is only reacting as a rational being. It must be said that a lot of these occur daily in the hospitals and clinics especially the big ones, and this turns people away to other facilities.

However, it is apparent in this study that, notwithstanding all the insolent and dehumanizing behaviour from health providers, most people will still return to these facilities for assistance should the need arise. In this regard, it would be necessary for service providers to minimize the level of favouritism and abide by the 'first come first served principle'. It is believed that when this is done, more and more people will use the modern health facilities provided them.

4.1. Suggestions and Recommendations.

With reference to the research findings, the researcher wishes to mention some of the suggestions and recommendation made by the respondents and those conceived by himself. These are made first and foremost to the DHMT, the District Assembly, and second, to the Volta Regional Health

Administration and finally, to Policy Planners of the Ministry of Health. That:- To improve utilization, poverty must be reduced, in that more avenues should be created for people to get something to do (work) so as to get money to pay for hospital bills when sick because illness is inevitable.

Another way to state it, will be to improve the people's purchasing power, to make them more able to face the crises of sickness, or to reduce hospital fees to meet the pocket of the rural poor who are the most vulnerable to diseases given the deprived manner in which they live. Being peasant farmers, their level of income may not be sufficient enough to meet the increasing demand. As a matter of urgency, the deposit system should be scrapped immediately, so as to encourage would be users of these facilities to do so without further remorse. Mention must be made also of the deplorable road condition in the district, which is a strong factor.

It would be necessary to improve the road network and conditions so as to make them passable. In fact, it must be emphasized that the condition of roads in the district is so deplorable that urgent attention must be given to them. If this is done, it is believed that the problem would have been solved. In sum, the most important issues therefore, is to improve the road conditions, reduce hospital fees and remove deposits.

4.2. Conclusion.

This study was designed to examine factors contributing to utilization of modern health care in the Nkwanta district in the Volta Region. The findings indicated that most people interviewed went to modern health facility either near or distant from their homes when sick. This finding as already stated is elusive, because almost all the respondents complained bitterly about two main things that prevent them from going to the hospitals and clinics. However, it was realized that even those who went to clinic and hospital did so because of their perception of their illness. They went to the facilities nearer to them because it was moderate.

This suggests that choice is so much influenced by perception. By and large, respondents believe that if health facilities are far, but physically accessible, yet the cost of treatment is still prohibitive, there is no way they would not patronize them.

Thus a reduction in hospital fees would go a long way to invert the trend of utilization observed in the district. "Inferentially, the decline in poorer areas is due to severe inability to pay. In the light of these observation the introduction of hospital fees could be regarded as not fulfilling the equity criteria.

A point worthy of note is that both the rich and the poor indicate their willingness to pay for health services albeit at a very moderate cost. However, this opens up other areas of research. Further exploration needs to be done into whether willingness to pay means ability to pay considering the socio-economic status of the rural poor.

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Appendix a.

OUT-PATIENTS RETURNS NKWANTA DISTRICT 1994-1996.									
	1994			1995			1996		
Health Facility	Annual	Ave.Dly	Dly %	Annual	Ave.Dly	Dly. %	Annual	Ave.Dly	Dly. %
Nkwanta H/C	1,700	5	8.4	3,655	10	18.6	14,059	39	43
St.Josephs Clinic	15,008	41	74.3	12,243	10	62.3	10,038	28	31
Pentecost Clinic	2,979	8	14.7	2,751	8	14	1,267	3	3.9
Tutukpene H/C	424	1	2	384	1	1.9	311	1	0.9
Fame Clinic	-	-	-	167	<1	0.8	1,058	3	3.3
Brewaniase H/C	87	<1	0.4	436	1	2.2	486	1	1.5
Damanko H/C	-	-	-	-	-	-	2,389	7	7.4
Kpassa H/C	-	-	-	-	-	-	1,896	5	6
Kecheibi H/C	-	-	-	-	-	-	575	2	1.8
TOTAL	20,198	55	-	19,636	57	-	32,079	89	-

(Source: District Profile 1996)

Appendix b.**INTERVIEW SCHEDULE.****TOPIC:** Utilization of Modern Health Care In Nkwanta District.

PROTOCOL: Salutation, we are a team of researchers from Nkwanta, interested in the use of modern health care in the district. We will be grateful if you could spare us some minutes. We are going to ask you certain questions to enable us gather certain information we need for appropriate action. We assure you that all information given will be treated as confidential.

Thank you.

SECTION A:**Background Information.**

19. Age:
- a. 20-39 []
 - b. 40-59 []
 - c. 60-79 []
 - d. 80+ []
20. Sex:
- a. Male []
 - b. Female []
21. Present Resident.....
22. Religion
- a. Christian []
 - b. Moslem []
 - c. Traditional []
 - d. Others specify[]

23. Languages spoken.....
24. Level of Education:
- a. Elementary up to JSS. []
 - b. S.S.S. []
 - c. Post Secondary []
 - d. University []
 - e. Others specify []
25. Present Occupation:
- a. Civil Servant []
 - b. Farming []
 - c. Trading []
 - d. Artisan []
 - e. Others specify []
8. Marital Status:
- a. Married []
 - b. Single []
 - c. Divorced []
 - d. Widowed []

SECTION B:**Factors Influencing utilization.**

9. Have you, or any of your family members, been sick during the past one year?
- a. Yes []
 - b. No []

10. If yes, did you seek treatment ?
- a. Yes []
 - b. No []
11. If yes, where did you go for treatment ?
- a. Hospital []
 - b. Clinic []
 - c. Herbalist []
 - d. Spiritualist []
 - e. At a Shrine []
 - f. Self Medication []
 - g. Others specify.....
12. Why did you choose that treatment ?
- a. It's the nearest []
 - b. It's the cheapest []
 - c. It's the only one available []
 - d. Because of quality []
 - e. Because of the illness []
13. What was the illness ?
14. How much did you pay for treatment ?.....

15. In your opinion, taking into consideration the level of your income, how would you consider the charges at the facility you went to ?
- a. Reasonable []
 - b. Moderate []
 - c. Expensive []
 - d. Very Expensive []
16. Did the money paid commensurate the treatment received?
- a. Yes []
 - b. No []
17. If yes, how ?, if no why ?.....
.....
18. How far is your home/house from the nearest health facility in the district ?
- a. 0-8km []
 - b. 9-15km []
 - c. 16-21km []
 - d. 22 and above []
19. How would you consider the distance ?
- a. Too far []
 - b. Far []
 - c. Not far []

20. By what means of transport does you get to the health facility nearer to you when sick ?
- a. Lorry []
 - b. Bicycle []
 - c. By foot []
 - d. Others specify []
21. How much do you pay for transportation to and fro the health facility, if you were to go by public transport ?
22. How will you consider the time spent at a health facility you have ever been ?
- a. Before seeing the doctor ?
 - i. Less than 1 hour. []
 - ii. About 3 hours []
 - iii. Above 3 hours []
 - b. Before collecting drugs ?
 - i. Less than 1 hour []
 - ii. About 3 hours []
 - iii. Above 3 hours []
23. In your opinion, will the time spent at the facility deter you from seeking help next time you are sick ?
- a. Yes []
 - b. No []

24. If yes, why ?.....
.....
25. Do you think there are other things that will make you seek treatment from other sources (not at a modern health facility)?
- a. Yes []
- b. No []
26. If yes, explain your reasons.....
.....
27. Do you have any suggestion that can lead to the improvement of utilization of modern health facilities in the district ?
- a. Yes []
- b. No []
28. If yes, please, make them.....
29. Are there other things, that will make you go to the hospital or clinic , each time you and the members of your family are sick ?
- What are they
30. What are your perception about the attitude of the staff at the health facility you have ever been?

Thank you for co-operation.

Appendix c.**FOCUS GROUP DISCUSSION GUIDE.**

Topic: Perception of factors influencing utilization of modern health care in Nkwanta district.

Warm-up and introduction.

We are researchers from Nkwanta and are interested in the utilization of modern health care in the district. We want to have discussions with you, to enable us gather information on the above topic. Therefore, we shall be grateful if you would spare us some of your time for the discussion to commence. We also assure you of total confidentiality, thus you are entreated to feel free and make your contributions as possible.

Thank you.

SECTION A.

1. How long have you been staying in this area ?
2. What do you know about modern health care ?

Probe:

- What are they ?
 - Where are they ?
 - How different are they ?
 - How useful are they ?
3. Mention some other health cares, apart from modern health care that you know.

4. Have any of you been sick in the past 12 months ?

Probe:

- Can you tell us what illness it was ?
- Did you seek treatment ?

5. Where did you go for treatment ?

6. What are some of the reasons that make you take that decision ?

SECTION B.

7. In your opinion, is the health facility [specify what is in the area where the discussion is taking place, e.g., Hospital, Clinic or MCH/FP Clinic etc.] closer or farther away from your house ?

8. How much do you pay for transport to the nearest hospital, or for how long do you walk before getting to the nearest facility ?

9. What are some of the reasons why you will not go to hospital or clinic when you are sick ?

Probe:

- Probe each response further.

10. If you are given the chance to tell your community about modern health care, what precisely will you tell them, and what are some of the reasons why you will say that ?

Thank you very much for audience.