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**UTILIZATION OF HEALTH SERVICES:
THE CASE OF ASSIN DISTRICT**

BY

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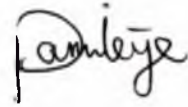
DEDICATION

This study is dedicated to God, my Maker.



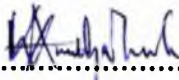
DECLARATION

I hereby declare that this dissertation is an original work produced by me from research undertaken under supervision.

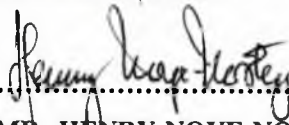


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LIST OF ABBREVIATIONS

CCA	-	Community Clinic Attendant
CWC	-	Child Welfare Clinic
DDHS	-	District Director of Health Services
DHMT	-	District Health Management Team
DMOH	-	District Medical Officer of Health
GIT	-	Gastro Intestinal Tract
FGD	-	Focus Group Discussion
JSS	-	Junior Secondary School
LAP	-	Lower Abdominal Pain
MA	-	Medical Assistant
MCH/FP	-	Maternal, Child Health/Family Planning
MIS	-	Management Information System
MOH	-	Ministry of Health
MTHS	-	Medium Term Health Strategy
OPD	-	Out Patients' Department
PHC		Primary Health Care
SDHT	-	Subdistrict Health Management Team
SMO	-	Senior Medical Officer
SPSS	-	Statistical Package for Social Sciences
SSS		Senior Secondary School
TMPs	-	Traditional Medical Practitioners
UNICEF	-	United Nations Children's Fund
WHO	-	World Health Organisation
WVI	-	World Vision International

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ABSTRACT

It is essential to recognize the relative importance of the various barriers to utilization if effective health services are to be delivered.

This study set out to find the factors leading to the observed underutilization in health facilities in the Assin District. It involved the administration of questionnaires to one-hundred household heads of selected communities of Assin District. Focus group discussions were also conducted with community members. In-depth interviews were carried out with service managers and opinion leaders. The data collected was processed and analysed manually and by SPSS computer programme.

The main finding was that the study population preferred hospital services for most of their health problems but financial constraints inhibited them from the use of formal health services in the district. Other service and community factors which contributed to low health service utilization were staff attitude, the existence of alternative forms of health care, socio-cultural factors and distance. Recommendations were made to policy makers (MOH), the District Assembly and the District Health Management Team. Some of the recommendations were:-

- 1. There should be a review of the user fees in the health facilities, especially in the district hospital by the Hospital Management, DHMT and District Assembly.**

2. **The District Assembly should identify Poverty Alleviation Programmes which are realistic and sustainable to help deprived communities.**
3. **Collaboration of the DHMT (MOH) with other sectors like the Ministry of Education was recommended for the implementation of comprehensive health education programmes targeted at the special needs of the study population.**
4. **Periodic Quality Assurance Programmes, with effective monitoring and evaluation were recommended to the DHMT; disciplinary measures were to be taken against erring staff in the discharge of their duties.**
5. **Periodic Supervision, Monitoring and Performance Appraisal of CCAs was recommended to enhance their work.**
6. **The District Assembly should advocate for the improvement of the Road Network in the District.**
7. **Finally the DHMT and District Assembly should encourage and ensure Community Participation in all health programmes for health and socio-economic development in the entire district.**

CHAPTER ONE

INTRODUCTION

Health is a fundamental human right. Hence WHO's call for "HEALTH FOR ALL" by the year 2000 (WHO's DECLARATION, ALMA ATA, 1978). Ghana and several other nations have adopted the Primary Health Care Concept as a means to reach the goal of Alma Ata.

Ghana's long term vision for growth and development, as captured in the document, GHANA VISION 2020, defines five main areas for priority attention in the medium to long term. These are: maximizing the healthy and productive lives of Ghanaians; fair distribution of the benefits of development; attainment of a national economic growth rate of 8%; reduction of the population growth rate from 3% to 2% and, the promotion of science and improved technology as tools for growth and development.

It is clear, therefore, that the government recognises good health as both a cause and a consequence of economic success. It is in this regard that government has as its prime responsibility, the development of strategies and the provision of five year programmes of work aimed at improving the longevity and quality of life of the population.

There has been some improvement in health status since independence in 1957. People now live longer and more children are surviving. According to MOH, Infant mortality rate was 133/1000 in 1957 and reduced to 66/1000 in 1996. Life Expectancy which was 45 years in 1957 increased to 55 years in 1996. The number of health facilities and health workers have increased by leaps and bounds since independence. The health sector also receives, on average about 8-10% of the total government budget.

Despite government's enormous investment of resources (Human, material and money) in the health sector, Ghanaians continue to suffer from a heavy burden of infectious diseases, malnutrition, poor reproductive health and non-communicable diseases. Relative to other countries, especially in East and Southern Africa, health status in Ghana is still poor. This is because the determinants of health or underlying causes for poor health have not improved significantly : sanitation coverage in the entire nation is 50% and the population growth rate remains at 3%. Female illiteracy is 42% and $\frac{1}{3}$ of the population fall under the poverty line. In addition to the above set backs in the health sector, access, quality and the utilization of primary health services are still too low.

To improve the health status, two main things ought to be done :

- i) Improve the determinants of health
- ii) Improve the performance of the health sector

The reforms taking place in the health sector via the current medium term health strategy, are meant primarily to improve the performance of the health sector.

The objectives of the reforms are:

- i) To improve quality of health services**
- ii) To make more efficient use of scarce health resources**
- iii) To increase access to health service and coverage of services**
- iv) To increase funding to the sector**
- v) To establish closer partnership and linkages**

The reforms have been specifically designed to address five (5) main systemic challenges facing the health sector with the ultimate aim of improving both the length and quality of life of the people of Ghana.

THE STUDY AREA

LOCATION

Assin District is one of the 12 districts in the Central Region of Ghana. It is bounded by Adansi East District (Ashanti Region) in the north, Birim South District (Eastern Region), Asikuma-Odoben-Brakwa and Ajumako-Enyan-Essiam in the east, Upper Denkyira and Twifo-Hemang/Lower Denkyira in the West and Abura-Asebu-Kwamankese and Mfantseman in the South. The District Capital is Assin Foso. With a surface area of 2,375 sq.km, Assin District is the largest district in the Region. It covers almost 25% of the region, which has a surface area of 9,826 sq. km.

NATURAL FEATURES

Assin district is situated in the wet semi-equatorial climatic region. The annual rainfall is between 125 to 200 cm which is twice the average for Ghana. The district has two peak seasons of rainfall, the main is from May to July and the minor in September to October. The original vegetation is moist, semi-deciduous rain forest. Some land is protected as forest reserve but a lot of the rain forest has disappeared and land has been turned into farm lands.

DEMOGRAPHIC BACKGROUND

With an annual population growth rate of 3.3%, the projected population of the district for the year 1998 is estimated as 191,000. This is the highest population in any district in the region, but given the large area it is one of the least densely populated districts in Central Region. The district is predominantly rural (85%). The breakdown of the district population by sub-district is as follows:-

Subdistrict	Population	Women in Fertile Age (WIFA)	Under 1 (Infants)
1. Assin Foso	69,267	13,853	2,771
2. Assin Bereku	27,377	5,475	1,095
3. Assin Kushea	10,863	2,173	435
4. Assin Praso	6,797	1,359	272
5. Assin Enyinabrim	18,425	3,685	737
6. Assin Manso	21,085	4,217	843
7. Fanti Nyankumasi	21,734	4,348	869
8. Assin Jakai	15,390	3,078	616
Total	190,938	38,188	7,638

The population is scattered over the district in small settlements. This sparse distribution of the population poses a great challenge to the health care delivery. How will these tiny settlements scattered all over the district be effectively reached with health services? Assin Foso, the administrative capital of the district is the largest town with about 15,000 inhabitants. Five other towns have between 2,000 and 5,000 inhabitants whilst 85% of the population live in villages with less than 2,000 inhabitants.

HISTORY AND TRADITION OF THE PEOPLE

The entire Assin people historically migrated from different parts of Ashanti as a result of inter-tribal wars that threatened the security and peace of the people.

The three traditional council areas have their defined areas of jurisdiction, properly documented and authenticated by law and tradition. Each has an internal administrative hierarchy that reflects its traditional sources of power, authority and line of communication, including enforcement of decisions.

The internal structure of the three traditional councils is basically the same. It is made up of Paramount Chiefs, Divisional Chiefs, and Sub-Chiefs. The Paramount Chief is the Head of the Traditional Council, who is immediately supported by his Divisional Chiefs. The latter controls a number of sub-chiefs, and serves as a link between the seat of the paramountcy and the communities, led by their sub-chiefs.

Each Divisional Chief has a Divisional Council made up of traditional rulers, and in some cases, non-traditional rulers as co-opted members of the Council. The inclusion of the latter group in certain cases, is to allow their specialized knowledge, experience and statesmanship, bear on the deliberations of the Council to enhance the quality of discussions and decisions taken.

These Divisional Councils have additional responsibility to deliberate on development issues affecting the welfare of the people within their area of jurisdiction, on specific issues like health care, sanitation, family and land disputes.

The traditional areas have their queenmothers who are involved in mobilizing the women for development.

FESTIVALS AND TABOOS

The only recognizable cultural event is the celebration of the Tutu Festival, which comes on in November every year. This is common to all the Traditional Council Areas. This event is normally preceded by "Afahye Kesee," which lasts for one week between November and December. The festive mood of the people is used as an opportunity to resolve outstanding conflicts between individuals or groups.

As a typical rural district, the Assins have a number of taboos, some being beneficial, others not.

For instance, for many years throughout the entire Assin community women were restrained from crossing the River Ochi (on Saturdays) which is one of the important rivers that runs across the district. This particular restriction was found incompatible with their farming activities, which provided their main economic support for livelihood. This practice made it impossible for pregnant women in labour to receive prompt medical attention if they had to be sent across the river. The present paramouncies

have scrapped this obsolete custom, in view of the social and economic considerations. These reforms augur well for the health and vitality of mother and child in the district.

RELIGION

The people are mostly Christians made up of Methodists, Catholics, Presbyterians, Pentecostals and other Spiritual Churches. There are also Moslems, a few Pagans, and Fetish Priests.

MAIN ECONOMIC ACTIVITIES

Most people are engaged in farming. The abundant rainfall makes cocoa and palm nut cultivation attractive and the district is one of the main producers. Cassava, plantain, cocoyam and citrus fruits are produced both for local consumption and for sale to the markets in Accra and other towns. Many farmers supplement their income by hunting, palm wine tapping, akpeteshie distilling and other industries. Many women are engaged in selling food products and trading activities. Animal husbandry, rearing goats, sheep and chicken are also common. There are few small scale industrial activities such as mining, lumbering and saw milling taking place in the district.

COMMUNICATION/UTILITIES

The Cape Coast-Kumasi trunk road was completed at the end of 1993. This has improved accessibility to the district from other parts of the country such as the Western, Ashanti and Eastern Regions. The feeder roads into various parts of the district are not tarred and many are in deplorable state. Many branch roads to the rural communities become unmotorable during the rainy seasons, thus making outreach services inaccessible to such communities in these periods. A pontoon and a recently constructed bridge at Twifo Praso has improved the accessibility to the Western part of the district i.e. the Awisam zone. The Accra-Takoradi railway line passes through the district and there are several railway stations within the district. Telephones were re-established at the end of 1994. A commercial communication centre and the post office provide communication services to the public.

Power supply from the National grid is available only in the southern part of the district and mainly in the towns along the main trunk roads. The power supply, however is irregular and often fluctuates in intensity. The main sources of water supply are harvested rain water, hand-dug wells and boreholes. The Dawumako water project which is to supply pipe borne water to the district is still uncompleted. Sanitary facilities for both liquid and solid waste disposal are also inadequate in most parts of the district. This makes sanitation in the district generally poor.

EDUCATION

There are eighty-five pre-schools, one hundred and seventy five primary schools, eighty-six junior secondary schools, seven senior secondary schools and one teachers' training institute.

HEALTH SERVICE

Health care in Assin District is delivered at three main levels.

Level A

This is the health care at the community level in the villages. This level has 39 functional community clinics manned by 76 Community Clinic Attendants. Eighty traditional birth attendants are active and 200 are yet to be trained. The district has 63 licensed chemical drug sellers and 6 homeopathic practitioners. There is however no established contact between the district Ministry of Health staff and the traditional healers, herbalists, spiritualists and homeopathic practitioners.

Level B

The district has 7 health posts in 7 of its subdistricts. In Foso subdistrict, health services are provided by staff from the district MOH office and the Catholic Hospital.

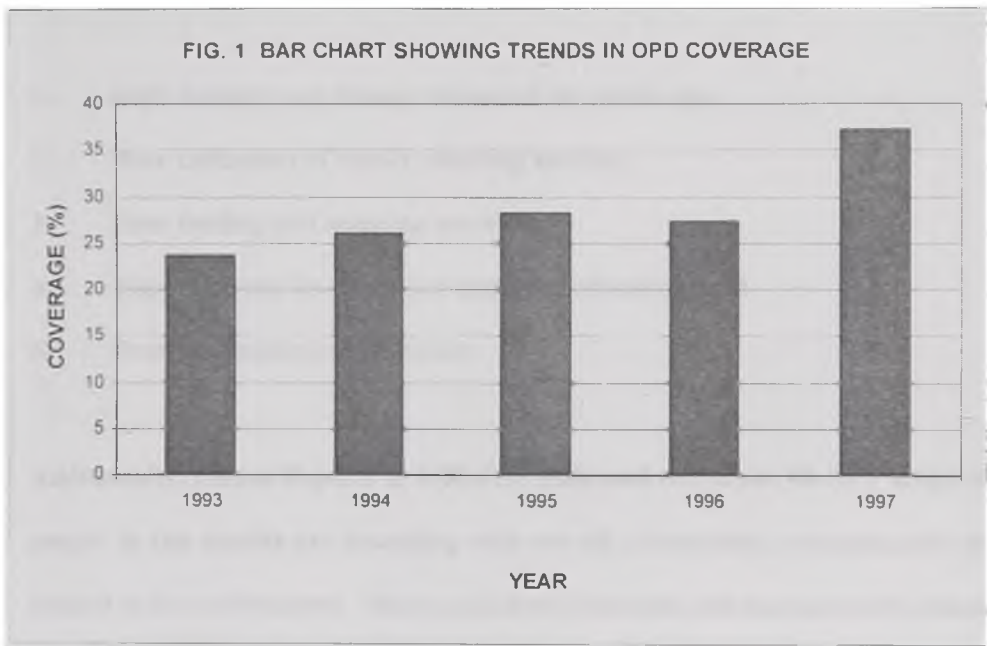
Level C

St. Francis Xavier Hospital with 106 beds, serves as the district hospital. Its catchment area goes beyond Assin district; many patients come from neighbouring districts. It is therefore expected that the OPD coverage would be higher than the values obtained over the years.

THE PROBLEM

According to the Annual Report of the Assin District (1997), there is underutilization of health services at all the levels of health care delivery in the district. As health planners and providers, the District Health Management Team has as its target, an *attendance per capita of approximately 100% in its health facilities. This means that on average, every person in the district is expected to have at least one contact with a health worker in a year. From the management information system in the health facilities, this expectation has not been realized.

The *OPD coverage, the total number of OPD registrants in the year per catchment population, which was also expected to be about 100% was only 37.2% in 1997. As shown by Figure 1 below, the trends in OPD coverage in Assin district (1993-97) though, rising steadily is still below expectation. (*See Appendix I for formulae for calculation of OPD Coverage and Attendance per capita).



Source : Annual Report, Assin District 1997.

The questions being posed are: Are people not getting ill? Are community members not satisfied with the preventive health services?

A cross sectional nutritional survey carried out by the DHMT in 1996 showed a prevalence rate of malnutrition (weight for age) of 27%. Chronic malnutrition was more prevalent than the acute type and stunting (Height for age) was 30%, a little more than the national figure of 28%. Some risk factors identified were:-

- 1. High fertility rate among women of the fertile age.**
- 2. Poor utilization of family planning services**
- 3. Poor feeding and weaning practices**
- 4. High illiteracy level and low maternal education; and**
- 5. Poor environmental sanitation**

Additionally, annual Reports of 1993-1997 indicated that about 60-70% of the diseases people in the district are grappling with are all preventable, communicable diseases related to the environment. Silent epidemics of chronic non-communicable diseases are also prevalent.

In a bid to mitigate the burden of disease and other health problems in the district, the DHMT explains that all its efforts to involve the communities in health programmes have proved futile. Reports indicated that community leaders (Chiefs), representatives (Health Committees) and members have on several occasions been invited to health durbars and other fora arranged specifically to address the observed underlying causes of poor health. It is surprising to note that in some cases, even the chiefs did not turn up, let alone the community members. The community members and their representatives have been described as apathetic as far as participation in health care activities are concerned.

This study envisages to gain insight into the reasons for the low utilization of health services in the Assin District. The findings from the study would enable the DHMT to develop appropriate strategies to address the problem. Wastage and inefficient use of health resources would be reduced. Ultimately, the length and quality of life of the people would be improved through a reduction in the risks of morbidity and mortality of the populace. Productivity would increase leading to economic growth.

CHAPTER TWO

LITERATURE REVIEW

The utilization of health services has been widely investigated in countries in the developed world by a host of researchers from disciplines including medical sociology, medical geography and health planning (Bailey, W. and Phillips, D.R. 1990).

Perhaps the first attempt to analyze the geographic variation of the per capita utilization of hospital services was reported in 1856 by William A. Guy who noted that the annual per capita rates for hospitalization in King's Hospital varied from 325/1000 population in the Parish of Saint Mary-Le Strand to 1/1000 in the district of Marylebone. Based on these observations, Guy hypothesized that the explanation for the variation in use rates between the two areas was related to behavioural characteristics of the populations, specifically to "expensive acts of self-indulgence" (Clark, J.D. 1990).

In the developing countries, however, studies of utilization of health services are few as illustrated by important reviews of health and the urban poor by Harpham et al,1988.

There have been many attempts in the social sciences and the broad fields of community medicine and Public Health to apply models to describe, determine and predict health services utilization (Phillips, D.R. 1990).

The majority of models have been concerned with specifying variables determining whether usage will occur and influencing its frequency. Many of the earlier models depict that underutilization is the main problem in social services, and that this should be a concern for health planners and providers who wish to optimize the use of facilities for their intended population. However, it is interesting to note that later models appear to regard underutilization as less important (Phillips, D.R. 1990).

In health and other social services, a number of models have been employed in an attempt to identify those variables which 'predispose' or 'enable' utilization, with the explicit intention of reducing any barriers identified. One of the earliest of such models is the health belief model (HBM). This model stresses the existence of a state of psychological readiness to act, whereby a person believes himself to be susceptible to a disease that could have serious effects but that can somehow be prevented or ameliorated by action on his part (Rosenstock, 1960). In addition to a psychological state of readiness to act, the environmental and cognitive elements of behaviour are also emphasized : barriers such as costs, distance, inconvenient service hours and the like should be reduced, whilst reminders from physicians or the media can serve as triggers to behaviour.

A model by Anderson (1968), refined by Aday et al, (1980) has emphasized family life-cycle and behavioural determinants of utilization. Gross, (1972) also developed a model which describes the major determinants of health care utilization. All these models recognize groups of factors influencing utilization : those which may enhance or predispose and those that will frustrate utilization inspite of predisposition to use.

Knowledge of above factors would enable health planners to fashion out appropriate strategies to help improve utilization of health services.

A number of discrete but often inter-related variables appear to influence health care utilization. Some are service-related characteristics : type, size, location, cost and quality; others are community-wide such as transport or the availability of financial support; yet others may be personal or family-related : age, sex, income, social status, family size, mobility and religion (Phillips, D.R. 1990).

Many studies in medical sociology have attempted to identify the effects of specific variables and provide a useful basis for classifying the determinants of health care (Mechanic 1968, 1979; Tuckett 1976; Kohn and White 1976; Cockerham 1978). However, this is very difficult to achieve precisely since variables are often closely related. Habib and Vaughan (1986) have pointed out the need to highlight certain variables in most utilization studies. This is because utilization is the outcome of many complex visible and invisible interactions of numerous factors, past and contemporary, which act at different stages and often in different directions. Habib and Vaughan assert that it is practically impossible in most utilization studies to observe the whole process in detail, noting that few utilization studies can be sufficiently comprehensive to encompass all possible factors that can play a part in the process.

It has been observed by some researchers that factors affecting utilization of health services show certain variations in developed and developing countries. The most distinctive feature of health care that impinges on utilization in many Third World Settings is probably the existence of pluralistic health care systems. People often have in theory, a wide choice of types of therapies to utilize (although cost and distance may rule some out). Options may be used in preference to one another, sequentially or concurrently so utilization patterns may appear very complex. Stock (1987) noted in his study that alternatives to institutional care serves the vast majority of needs in his study population in Kano State, Nigeria, and that the relative importance of these alternatives rises rapidly as distance from a western-type facility increases. Apart from distance, the cost and intermittent availability of western type care make people choose alternative forms of care. Stock further stated that whilst such unofficial but publicly popular sources of care may be important in many developed countries, they tend to be more so in most Third World Societies.

The beliefs of individuals and groups about the behaviour they should undertake for any given condition can be crucial in determining utilization. In a study in Sri-Lanka, which has a wide range of cosmopolitan and traditional sources of care, Wolffers (1988) investigated the choice of therapies with regard to eight different complaints. He noted that for the simplest case of 'fever and cough,' there are many ranges of therapy options. He further observed that in both the suburban and rural setting self-medication played an important role, however it was of greater significance in the latter. When a child fell ill, or for other acute complaints, people in the study were more prepared to use cosmopolitan medicine (public or private) in either setting. For a snake

bite or a fracture, people seem to prefer emergency help from acknowledged experts.

The situation is no different in Ghana. There is the co-existence of scientific and traditional medical systems. Twumasi, P.A. (1975) conducted an extensive study in Ghana which was mainly devoted to the investigation of this common phenomenon in developing countries. One interesting finding of this study is the differences in perception of disease causation of the scientific medical and the traditional medical practitioners. The scientific medical practitioner does not seek super-natural causes but employs the germ theory vis-a vis scientific method in his curative practices whereas the traditional medical practitioner holds a supernatural assumption about 'reality' from which his thinking proceeds. Thus all therapeutic measures the latter employs are associated with elements of magico-religious acts and concepts.

Understanding and interpretation of the causes of disease was mentioned by Senah (1997) as a factor determining health seeking behaviour. In his study about the perception and use of pharmaceuticals in a village in Ghana, he observed that diseases were classified by the Ga according to the perceived causes - natural or supernatural. Five main causes were recognized, the therapy sought being dependent on the causes identified. In her classification of supernaturally caused diseases among the same group, Mullings (1984) identified a sixth category which she termed "demon sickness." Fink (1990) also noted a similar concept among the Dormaa of Ghana.

Numerous studies of health care utilization have recognized the importance of geographical factors in the use of health care generally, and Primary Health Care in particular. A number of these studies have identified a negative relationship between distance and utilization of health services generally. In a Nigerian study on health care behaviour, Stock (1987) found that at a distance of 5 kilometres from a dispensary, per capita utilization fell to less than one third of the zero kilometre rate.

In economic studies, low household income has often been identified as a barrier to the use of modern health services even when these are publicly provided. However, even economically oriented studies have frequently acknowledged the related issue of physical accessibility. Distance to health care has also been cited as a major variable influencing utilization in Iraq and many other settings (Habib O.S., Vaughan, J.P. 1986, Gesler, W. 1979, Morrill, R.L., Earickson, R.J. and Rees, P. 1970).

Bailey, W. and Phillips, D.R. (1990) conducted a study focusing on the influence of distance, transport and accessibility on the use of health services in Jamaica. They observed that most respondents were not using their nearest facilities for varying reasons which included, for poorer respondents, need to attend frequently distant public facilities and for wealthier respondents, loyalty to old family doctors and the use of company-related doctors. It is interesting to note that in places where walking distance is short, more use has been made of clinics.

The issue of how the 'quality' of a service affects utilization is complex. 'Quality can include many facets : physical, attitudinal and socio-economic. High quality medical care is often considered to be that which involves an objective test such as an x-ray, blood analysis etc. (Donabedian, 1980). However, it also depends on many other physical and administrative attributes of the facility - space, comfort, cleanliness, seating arrangements and 'convenience' of opening hours. Finally, an evaluation of quality of service must take into account the level of professional care, availability of medicines and the affective behaviour of staff and ancillary workers to patients (Ben Sira 1976; Phillips 1981b). There is also an intangible aspect of quality associated with whether a service is being provided by the public sector or privately, as there are many inherent beliefs or images relating to care from each sector.

According to Akin et al. (1985) the quality issue is one of the most neglected demand issues in Primary Health Care and probably in all health care utilization.

An important factor patients passionately attach great importance to and which influences their choice of health care is the behaviour of service providers towards them. Mwabu (1986) noted that the majority of patients in his Kenyan study sought health care from outside the 'free' government health care systems due to the poor attitude of health care providers, among many other reasons. Indeed, it sometimes seems that improved quality of care and presentation of care can be more important than improving both economic and physical accessibility, as research in Guatemala and Chile suggest.

One other factor that influences health service utilization, is the cost of services. An extensive review of the literature on service utilization found that once people realize that a family member is seriously ill, they will take on almost any expense to get the help they consider appropriate (Thaddeus and Maine, 1990). However, the rising costs of medical care in many developing countries place it effectively beyond the reach of many people (Maine, D. 1991).

An aspect of public experience of health care delivery system that has been studied is "waiting time." Long waiting time has been identified as a factor that limits acceptability and utilization of health services. There is however, little empirical evidence on the actual time spent in health institutions by the public in developing countries. In a study on "waiting time," Banisaiye et al. found that community (public) perception of waiting time is greater than expected; staff perception of the time spent in the clinic was considerably less than the actual waiting time. Similar discrepancies between staff and patient perception of time cost was reported by Mirley et al. (1979) from Indonesia.

Besides economic, socio-demographic and 'geographical' factors, McKinlay (1972) identified socio-cultural factors as being of major influence in the use of health services. Researchers in the area of safe motherhood have also identified that certain cultural attitudes and practices, like perceptions of women's roles, block the ability of women to get care for themselves, hence impeding their use of available health services (Leslie and Gupta, 1989). In some cases decisions about where to seek care are often made by the husband, mother-in-law or other relations (Thaddeus and Maine 1990).

A study by Kumekpor et al, on the underutilization of supervised delivery service in Ghana was undertaken in 1992. This national study indicated that despite the sustained efforts by the MCH/FP Division of the MOH of Ghana to improve coverage of supervised delivery, the service continues to be underutilized due to obstacles such as inappropriate service provider attitudes, long waiting time, high cost of service and distance to be covered. In a study by Sekyi-Appiah K. (1996), to identify the factors contributing to the gap between antenatal and supervised delivery coverage, he observed that the high cost of service, wrong provider attitude, long distance from formal facilities, easy access to untrained birth attendants, socio-cultural and religious factors were contributing to the low supervised delivery coverage in the Birim South District. It is believed that the present study would elucidate the factors underlying the low utilization of health services in the Assin District and enable health planners to develop appropriate strategies to address this all-important issue.

CHAPTER THREE

OBJECTIVES AND RESEARCH METHODOLOGY

The literature reviewed has clearly indicated the myriads of inter-related factors that influence utilization of health services. Extensive work has been done, especially in developed countries, investigating how personal or family-related variables such as age, sex, income and social status influence health service utilization.

A number of studies have also been conducted to identify the effect of service-related characteristics and community-wide issues on people's use of health services. It was observed that not much has been done specifically in developing countries, on people's perceptions of health problems and quality of care and how these influence utilization of health services.

The present study thus concentrated mainly on how community members perceive local health problems and the quality of care they receive in the health facilities and how these affect their use of health services in the district. An attempt was also made to identify the service and community factors that influence utilization of health services.

OBJECTIVES

MAIN OBJECTIVE

To explain the apparent low utilization of health services in the Assin District.

SPECIFIC OBJECTIVES

- 1. To identify the common health problems of the district from the communities' perspectives.**
- 2. To determine the local perceptions of these health problems.**
- 3. To identify the service and community factors that influence the utilization of health services**

RESEARCH METHODOLOGY

STUDY TYPE

The study is descriptive and exploratory in nature. Thus the techniques employed to achieve the research objectives consisted of the collection and collation of qualitative data.

VARIABLES

The dependent variable studied was the utilization of health services. The independent variables were: quality of health services as operationalized through adequacy of drug supply and health personnel, cost of service, waiting time, attitude of workers and other service factors, physical accessibility to facilities and cultural belief, where beliefs about the causes and treatment of diseases of community members were explored. Background variables included age, sex, occupation, marital status, educational level and religion.

DATA COLLECTION TECHNIQUES AND TOOLS

Data collection techniques used were questionnaire administration, scheduled individual/group interviews and focus group discussions.

QUESTIONNAIRE ADMINISTRATION

A questionnaire was administered to 100 household heads in 3 selected communities of the district. It was used to determine their background characteristics, their perception of health problems, the underlying reasons why they do not utilize health services provided in the district, and the contribution of service factors to the problem.

SCHEDULED INTERVIEWS

Interviews were used mainly to explore the contribution of service factors to the problem of underutilization of health facilities in the district. They were conducted on the District Medical Officer of Health, The Senior Medical Officer and the Matron of the District Hospital, two (2) Subdistrict Heads and two (2) Community Clinic Attendants.

OTHERS

Others interviewed were the Chaplain of the District Hospital, the Chief of the capital town (Kontihene of Afutuakwa Traditional Area) four (4) teachers and four (4) Assemblymen.

FOCUS GROUP DISCUSSIONS

Two (2) focus group discussions were conducted in two (2) of the 3 selected communities. The groups consisted of men in one, and women in the other. Each group was as homogeneous as possible, consisting of 6-10 adults who were all parents.

TOOLS

Data collection tools were questionnaires for household heads, scheduled individual/group interview for the DMOH, SMO, the Hospital Matron, two Subdistrict Heads, two Community Clinic Attendants, the Hospital Chaplain, the Chief of the capital town, four teachers and four Assemblymen (See Appendices II, III and IV for data collection tools).

Information was obtained from the following sources:

- (a) Annual Report, Assin District Health Management Team.
- (b) Annual Report, Assin District Maternal, Child Health and Family Planning Unit.
- (c) Report from the Management of District Hospital.
- (d) Reports from Subdistrict Heads.

PRETEST

Questionnaires were pretested in three (3) communities; Assin Foso, Bereku and Jakai. Corrections made included closing some open ended questions, rephrasing ambiguous ones, omitting redundant questions and adding omitted ones.

SAMPLING TECHNIQUE

Multi-stage sampling was used to select the respondents for this study. The district was first stratified into the existing eight (8) subdistricts. Each of the subdistricts is made of communities ranging from 5 to 56. These communities are scattered over a large area by virtue of the vast size of the Assin District. Data collection was envisaged to be cumbersome and time consuming. Hence the subdistricts were clustered into three (3) groups, a group each in the north, central and southern parts of the district. All the subdistricts in each of the (3) groups were numbered, mixed together and given equal chance of being selected through a simple random sampling method. One subdistrict was thus selected from each cluster. Similarly, three communities were selected from each subdistrict. In each of the selected communities, houses were randomly selected and in each house, a household head, irrespective of sex was also selected randomly for interview. The service managers, community clinic attendants and opinion leaders were selected by purposive sampling.

SAMPLE SIZE

Being an exploratory study, the sample size needs to be large enough to reflect important variations in the population, but small enough to allow for intensive study methods. By virtue of the available resources (time, manpower, money and transport) the feasible sample size for the survey was fixed at 100.

DATA COLLECTION

Before the research took off in the communities, permission was sought from the Regional Director of Health Services, the DDHS, the District Assembly, the chiefs and elders of the various communities after meeting with them to explain the purpose of the research. Clearance was also sought from the various Subdistrict Heads. The actual field work commenced on July 27 and ended on August 13, 1998. Four (4) research assistants, comprising of two teachers and two disease control field technicians were trained in questionnaire administration. They were taught amongst other things to record what exactly the respondents said, guard against omissions and not to be judgemental of answers given by respondents. The research assistants were supervised periodically. Administered questionnaires were checked for completeness and consistency, coded, packaged into a well labelled envelope and stored. Data from the questionnaire were later entered into the computer via D-base and analysed using SPSS computer programme.

Scheduled interviews were conducted on the DDHS, SMO, Hospital Matron, Subdistrict Heads, Two CCAs, the Hospital Chaplain and other opinion leaders comprising teachers, assemblyman and the chief of the town. Two FGDs were done for a group of men and women in two chosen communities. The findings were transcribed using the notes and recordings made. Analysis was done manually.

ETHICAL CONSIDERATIONS

Ethical issues were not overlooked in the planning and implementation of the research work. Selected respondents were only interviewed after gaining their permission. Confidentiality was ensured. There were no names on questionnaires.

LIMITATIONS OF THE STUDY

The selected sample would have been more representative of the entire district population if more than 100 people had been used. It would have been ideal if respondents had been selected from more than three (3) communities in each of the subdistricts. The desired selection could not be effected due to time and financial constraints.

Respondent Bias: The element of respondent bias cannot be claimed to have been ruled out completely, however, because of the assurance from interviewers about the confidentiality of the data, and the intended use of findings to improve health services in the entire district, it is hoped that their responses were genuine.

CHAPTER FOUR

FINDINGS AND DISCUSSION

The study set out to determine and explain the apparent low utilization of health services in the Assin District. The questions posed to gain insight into the peculiar factors contributing to facility underutilization were:

- What are the common health problems and the local perceptions of these problems?
- How do community members' perceive the quality of care provided in the health facilities?

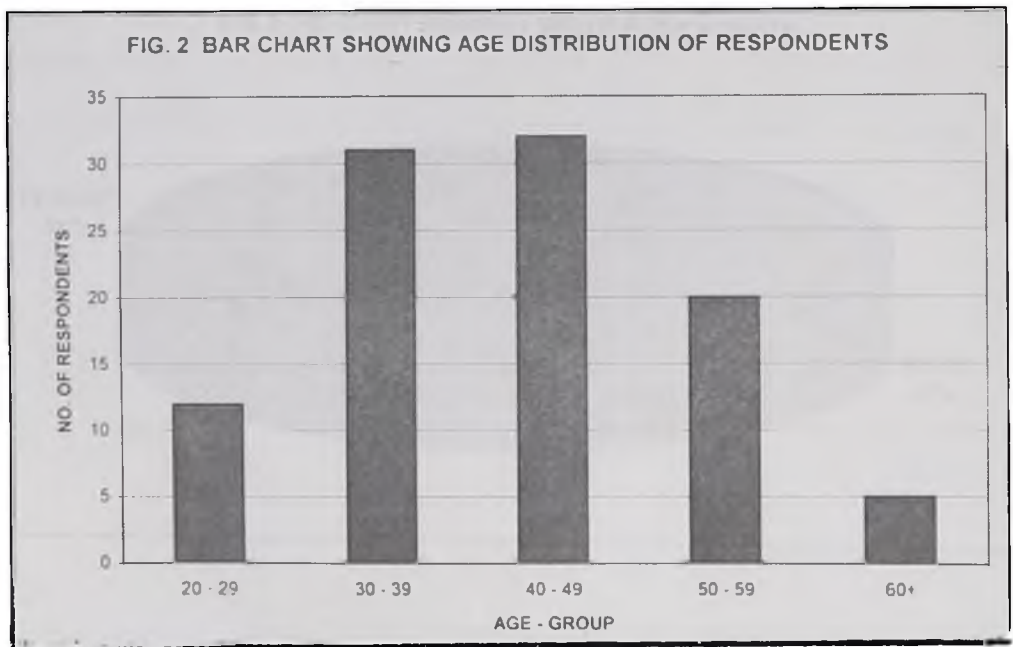
In pursuance of these objectives, a community survey was conducted in which 100 respondents were interviewed. The interview covered the various socio-demographic characteristics of respondents - age, sex, educational, marital and occupational background, and perceptions and attitudes towards various illnesses and therapies. The questionnaire also covered the major sub-themes of the objective of the study (See Appendix II).

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

A variety of studies concentrated on how socio-demographic factors influence the use of health services. The present study thus focused on the perception of respondents of disease causation and how it influences utilization.

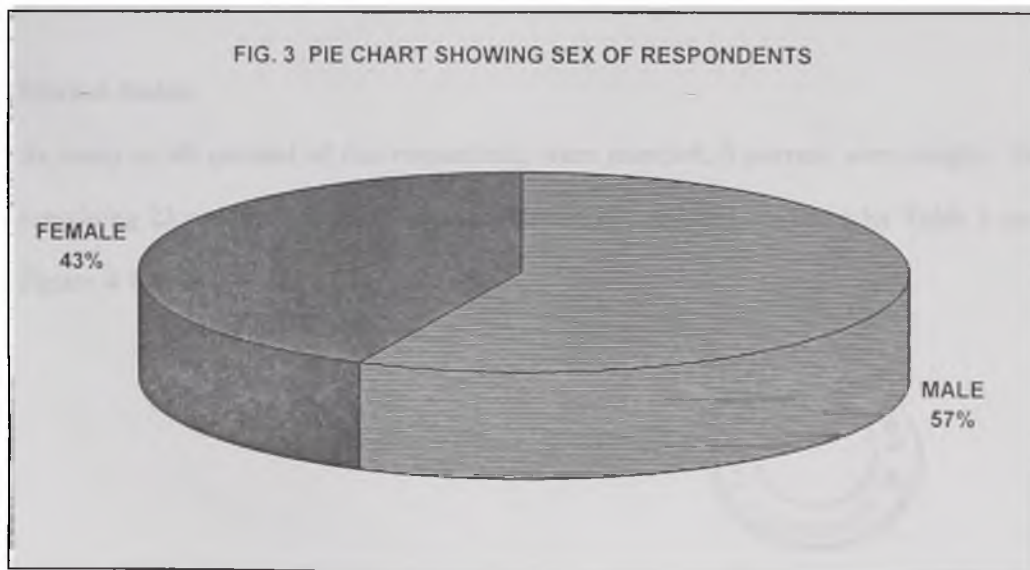
Age and Sex

In this study, the majority of respondents (63%) fell within the 30-49 age range. Only a few of the respondents (5%) were 60 years and above. The figure below shows the age distribution of respondents.



The ages of the respondents indicated that they were matured enough to be knowledgeable about health problems in their communities.

In terms of sex, 57 percent of respondents were males and 43 percent, females as shown by figure 3 below. This is not in harmony with the national figures which were 51% females and 49% males (Population Census, Ghana Statistical Services 1984).



The research assistants were all males; this finding could therefore be due to researcher bias. It could also be that household heads were invariably men.

Occupation

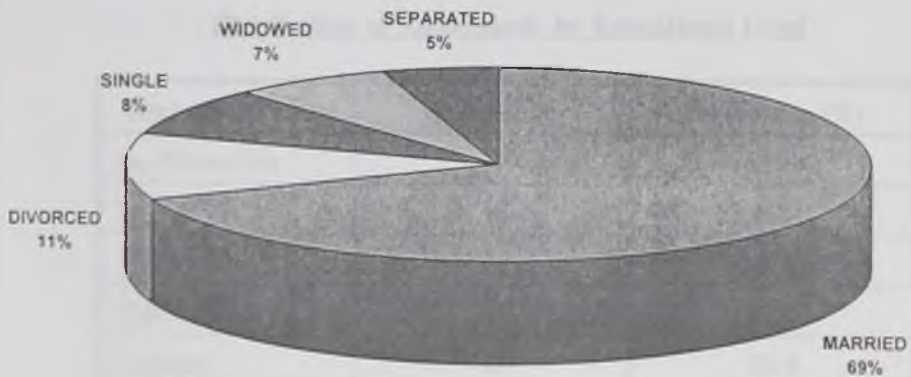
Knowledge of respondents' occupation was important in this study. This is because one's occupation determines one's income which is believed to influence health seeking behaviour. More than half (54%) of the respondents were farmers. Eighteen percent were unemployed and 16 percent were petty traders. This finding confirms the DHMT's report (1996) that the majority of people in the district are peasant farmers and petty traders; the former, having no regular source of income except at harvest times which may be yearly or twice yearly.

Marital Status

As many as 69 percent of the respondents were married, 8 percent were single; the remaining 23 percent being separated, divorced or widowed as shown by Table 1 and Figure 4 below.

Table 1**Distribution of Respondents by Marital Status**

Marital Status	Frequency	Percentage (%)
Married	69	69.0
Divorced	11	11.0
Single	8	8.0
Widowed	7	7.0
Separated	5	5.0
Total	100	100.0

FIG. 4 PIE CHART SHOWING MARITAL STATUS OF RESPONDENTS

The majority of respondents said they were married. Since most of the respondents were males, it could be that they said they were married in order to avoid shame. In the Ghanaian culture, unmarried men are usually regarded as irresponsible.

Level of Education

The level of education of respondents was sought for a number of reasons. Education has been observed to have an important influence on the knowledge of both when to use health services and how to use them effectively; as a variable, the effects of education are strongly linked to those of income and socio-economic status.

In this study, 21 percent of the respondents had had no education whilst 13 percent had furthered their education to tertiary level. Those who had had up to JSS/Middle schooling were in the majority, forming 41% percent of the respondents as shown in Table 2.

Table 2

Distribution of Respondents by Educational Level

Educational Level	Frequency	Percentage (%)
No Education	21	21.0
Primary	8	8.0
JSS/Middle	41	41.0
SSS/Secondary	17	17.0
Tertiary	13	13.0
Total	100	100.0

It is an expectation that increasing levels of education would enhance people's opportunity to use formal services, however this study showed that other factors, mainly economic in nature marred this opportunity.

Religion

Religion is a further variable that appears to have considerable influence on utilization. Sometimes, membership of certain cultural religious groups can be associated with access to superior or inferior health care.

Data collected from this study showed that as many as 84 percent of the respondents were christians, 7 percent being moslems and 6 percent did not belong to any religious group. The minority (3%) practised Traditional African Religion.

According to Senah, K.A. (1997), avowed christians easily resort to traditional therapeutic systems in the event of illnesses whose etiologies are perceived as metaphysical.

Respondents' Work and Health Service Utilization

The main objective of this study was to explain the low utilization of health services in the Assin District. Respondents were therefore asked whether their work affected their utilization of health services. The nature of work of respondents did not seem to affect their decision to utilize health services. Ninety-two percent explained that their work in no way affected their utilization of health services. They considered their health a priority and believed that they needed to be healthy in order to be productive. Most of the respondents said; "Health first" - "How can I work when I am ill"?

The minority (8%), whose work affected their utilization said they got too busy at work to enable them find time to seek health care. These were mainly traders.

Respondents' Perception of Disease Causation

People's perception of the etiology of disease is believed to influence their health seeking behaviour. Respondents in this study were asked about their beliefs regarding disease causation generally.

The majority of the respondents believed very strongly that the environment (69%), Germs (77%), Human agent (57%) and Spirits (59%) are causative agents of diseases. Eleven percent (11%) were not sure of the agents that cause diseases in our environment.

It is interesting to note that respondents believed strongly in the Germ Theory as well as in the supernatural causation of disease. Respondents also believed in the multiple causation of disease. Their belief was that certain diseases are initially caused by germs but with time "enemies" get involved to worsen cases supernaturally. This belief of respondents clearly explains why they "shop" for health especially where diseases are chronic.

Respondents' perceptions about the etiology of disease are further highlighted by the following statements made by some of the participants during the focus group discussion.

'We have ourselves to blame for the diseases our children get. Most diseases are from the environment; from heat and cold, instead of making our children wear protective clothing, we do not, it is our own fault.'

'The diarrhoea we get is from the water we drink, it is contaminated because people defaecate indiscriminately around our streams; flies are also problematic, they contaminate our food.'

'As for malaria (Ebum), it is the starchy food we eat, mainly cassava; we also toil in the sun all day on our farms, just for our daily bread, Madam, it is a pity.'

Local Perceptions of Common Health Problems

In the study, respondents in the survey, participants of the FGDs and interviewees were all asked to describe the common health problems of children, men and women in their communities. It was believed that their knowledge of the prevailing diseases in various groups in their communities would explain their utilization behaviour further.

Common Health Problems of Children

The common health problems of children cited were Measles (64), Convulsion (46), Malaria (44) and Diarrhoea (34). Others mentioned were Anaemia, Asthma and Acute Respiratory infections.

Perceived Causes

Malaria and measles were invariably said to be caused by heat from the sun - malaria and from within the body - measles. It was also believed that dirty surroundings could cause malaria and measles. Only a few people associated Malaria with mosquitoes.

Diarrhoea and Anaemia were said to be food and/or water related, whereas the respiratory infections were connected with climatic changes. In almost all the groups, phlegm was mentioned as the cause of convulsions.

Treatment sought for Health Problems

In children, the treatment sought for health problems were mainly at the orthodox health facilities as would be seen in Table 3. For almost all the communicable diseases like Malaria, Measles and Diarrhoea, the children were taken to the hospital. It is interesting to note that 19 responses were in favour of ¹chemical shops for convulsing children. The respondents indicated that their choices were due to distance, cost of service in hospital and also convenience.

Common Health Problems of Men

In men the diseases mentioned included Hernia (64), Waist Pains (18), Gonorrhoea (12) and Haemorrhoids (3). A few respondents cited Malaria.

Perceived Causes

Hernia was said to be caused by Phlegm. All but 7 of those who responded mentioned phlegm as the cause of Hernia. The minority, (7 respondents) cited heavy lifting. Waist pains were attributed to phlegm and hard work as in farming, their major occupation. Haemorrhoids were said to be due to food; mainly starchy food. Interestingly, the common sites for haemorrhoids indicated were; the eyes, waist, joints and head. Gonorrhoea was said to be sexually transmitted.

¹ *Chemical shops are licensed shops that sell 'over the counter' drugs.*

Treatment sought for Health Problems

Hernia was the major health problem of men in the district. This is not surprising since most of the respondents were farmers. The cause was attributed to phlegm in most cases and hard work in a few. By virtue of the perception of the respondents regarding the cause, the remedy was herbal treatment, to rid the groins of the "troublesome" phlegm. The few who mentioned hard work/heavy lifting as the cause of hernia, were knowledgeable that surgical intervention was required, however, they all mentioned that for surgery in the district hospital, one required a total of 400,000 cedis; 200,000 cedis to be provided immediately as deposit. Respondents bitterly complained that it was practically impossible for them to find the required amount hence they lived with their "trouble." One respondent was prepared to 'nurse' his problem (Hernia) and any other health problem until death ended it all, since he said he could not ever afford the hospital bills of the "so called Mission Hospital," St. Francis Xavier Hospital, which is the district hospital.

The treatment for waist pains and haemorrhoids were herbal. Men with Gonorrhoea went for treatment at the Disease Control Unit of the District MOH Office. A few sought treatment in chemical shops, others used herbs. For Malaria they went to the hospital when severe or to the chemical shop when the attack was minor.

Common Health Problems of Women

The common gynaecological diseases cited were Dysmenorrhoea, Leucorrhoea, Uterine Fibroids, Breast Cancer, Severe L.A.P., Waist Pains, Gonorrhoea and Malaria. All the conditions mentioned were perceived as common "diseases" affecting women. A few respondents cited jaundice.

In the focus group discussion with women in Bereku, the local names of the various conditions were mentioned - Dysmenorrhoea was referred to as "Bode" or "Enidane;" Leucorrhoea was popularly called "Odeepua," Gonorrhoea was "Babaso" and Malaria was either referred to as "feber" or "Ebun."

One participant stated : "Even though dysmenorrhoea is a common disease of women, it can cause serious complications. It can even lead to cessation of menstrual flow! Dysmenorrhoea is associated with a condition called "Oseakwan" (tubal blockage) which can lead to infertility."

Perceived Causes

Dysmenorrhoea and uterine fibroids were attributed to "clotted" or "wasted" blood in the female reproductive tract. Breast cancer was mainly associated with coins women put in their brassières. One respondent attributed breast cancer to curses. Waist pains were attributed to hard work and L.A.P. were said to be due to the numerous "secret" abortions the young girls caused. Leucorrhoea was said to be caused by sugary foods. Gonorrhoea was attributed to sex with multiple partners culminating in a "sore" in the lower abdomen.

Treatment sought for Health problems

With the gynaecological disorders, treatment was mainly traditional. By virtue of the causes described earlier, the women perceived that herbal treatment was the best choice. Herbs were either used vaginally as "pessaries" or rectally through enema. The reproductive disorders like fibroids were seriously treated for fear of infertility - a catastrophe in a rural woman, due to their characteristic pronatalistic ideas. Apart from the use of herbs, spiritual help was sought where necessary.

According to one FGD participant in the women's group, Gonorrhoea is a sore in the lower abdomen and is contracted by promiscuous men and women - "Gonorrhoea is a sore; being a sore it requires herbal treatment, "hot" herbs, for effective cure"!

One important finding in this study is the fact that respondents have a fair idea of the major health problems that plague the district. The diseases they mentioned were in conformity with the top ten diseases prevalent in the district as provided by the Management Information System of the district MOH Office (see Appendix 1). The problem identified was with their perception of the causes of some of the diseases. The cause of Malaria (which according to the MIS is the commonest of all communicable diseases) was not known by many of the respondents. Health education needs to be intensified and extended to all areas in the district.

To further explore their health seeking behaviour, respondents were asked where they sought help for specific health problems.

HEALTH SEEKING BEHAVIOUR

Twumasi (1975) deduced from observations in his study that the success of traditional medicine lies in its psychotherapy. The traditional medical practitioner is often recognized and held in high esteem in the traditional society because he is regarded as the intermediary between the spiritual world and the people. In many instances, the anxiety levels of the clients were reduced upon seeing the traditional medical practitioner who understood them as persons. Twumasi also identified that the traditional medical practitioner often assumed the responsibility of an advisor and advised clients on personal as well as on the specifics of the illness which was the object of the consultation. Twumasi further explained that, the traditional medical practitioner, being familiar with the cultural traditions, fears and wishes of his clientele, utilized such knowledge in his curative practices, in a form of psychotherapy with a strong element of suggestion in his act.

In this study the majority of respondents (80-93%) preferred the Hospital or Health Post for most of their health problems, mainly communicable diseases. This is because of their belief in the germ theory and the efficacy of orthodox treatment for above diseases.

The fact that communicable diseases constituted the bulk of disease problems in the district is not surprising, for, environmental sanitation was poor in the entire district and community participation was virtually an unknown concept, as far as community members were concerned.

Guinea worm infestation was one disease for which traditional cure was sought significantly. A number of reasons were given for the above choices.

Reasons for Choice of Healthcare

The Hospital was cited as their first choice by virtue of the fact that health providers in orthodox health facilities have been specifically trained to give effective therapy for all manner of diseases. However, the cost of services was mentioned as the major obstacle preventing them from utilizing the hospital.

Chemical shops were usually used for minor ailments or where due to financial constraints one may not have adequate money for transport to the hospital as well as user fees. Their drugs were referred to as "low cost" and effective. In the FGD with women, one participant said : "Madam, we all know the worth of hospitals but we cannot afford the hospital bills! Hospitals are good because patients are examined and effectively treated with injections and other potent drugs but we are poor farmers and the bills are very expensive. Imagine two of my children getting ill simultaneously. What can I do if I cannot afford the bills? I will just walk into a chemical shop, buy "pala" (paracetamol) and that is that."

Traditional healers/herbalists were said to have good knowledge of herbs as well as powerful and efficacious pharmaceuticals. They were described as highly efficient in the treatment of sickle cell disease, haemorrhoids, commonly called piles and waist pains. Some of the traditional healers were said to be excellent bone-setters, able to handle serious orthopaedic problems that trained surgeons cannot manage.

Interview with opinion leaders and health managers revealed that the district has numerous alternative health care practitioners like homeopathic practitioners, herbalists, spiritualists and traditional healers. These practitioners compete with orthodox health providers through attractive advertisements and reasonable modes of payment of user fees. The health managers believed that one's choice of care in such circumstances was mainly dependent upon one's income, nature of illness and past experience.

The respondents who saw traditionalists had trust and confidence in them. Their anxieties were usually allayed. They were also happy with the unhurried process of questioning as well as the enquiries made about their illnesses and associated symptoms.

They preferred being spoken to in the language' and concepts they were familiar with and which they could accept.

The FGD with men in Jakai community revealed that the hospital was the preferred form of care but usually herbs were tried at home first. One of the participants said:

‘We have certain herbs that are good for some diseases so we try them at home first. We go to the hospital or this nearby clinic when our conditions worsen. I must admit that most often than not, we delay unduly and get to the hospital moribund; why so? It is all because of lack of money?’

The help of spiritualists were sought where "satanic diseases" (humhum yaree) were involved or as an additional cure where orthodox therapy failed to treat the disease completely.

According to an opinion leader interviewed, (Hospital Chaplain), the people of Assin add spiritual dimensions to certain diseases, especially chronic ones; this he believed influenced their choice of health care. He also revealed that relatives were more willing to give loans to needy individuals when health care was being sought in alternative health facilities than in orthodox health facilities.

Drug peddlers were chosen mainly for convenience. These were said to provide their services at peoples' doorsteps. They made themselves available exactly when and where they were needed. They captured their clients on market days, at lorry parks and in their homes. Their persuasive talks and good bargains lured people to them.

Due to the "cash and carry" system and the high user fees, some respondents were forced to fall on "quacks" as they called them. They found the orthodox health facilities highly unaffordable and the alternative forms of health care, reasonable.

Schouten (1996), in her study on health seeking behaviour, in the Assin District, observed that the choice of health care depended on:

1. The severity of the disease (minor or major)
2. Whether the disease was acute or chronic and
3. The efficacy of treatment from respondents' own previous experience or experience of relatives.

Her findings revealed that homeopathic clinics were people's choice for chronic diseases whilst chemical shops were resorted to for minor ailments.

The findings from this study confirmed the choice of health care for minor ailments. However, in this study, respondents sought spiritual healing for chronic diseases in cases where initial care from orthodox health services failed.

This study also identified that the main determinant of one's choice of health care was one's financial status.

In his book, "Money be Man," Senah, K.A. (1997) indicated that health is increasingly being seen as something which costs money; health is basically buying medicines. Hence without money man is nothing. Interestingly, the general sentiments expressed by all the people in the study confirmed his assertions. Table 3 below shows the diseases and the various forms of health care sought.

Table 3

***Responses indicating Choice of Health Care for Named Diseases**

Disease	Hospital/ Health Post	Chemical Shop	Traditional Healer/ Herbalist	Drug Peddler	Total
Neonatal Tetanus	93	-	7	-	100
Measles	92	1	16	1	110
A.R.I.	86	8	5	4	103
Schistosomiasis	86	2	11	1	100
Onchocerciasis	85	1	11	4	101
Diarrhoeal Diseases	74	19	7	-	100
Malaria	84	23	2	-	109
Skin Diseases	84	5	6	7	102
GIT	81	7	8	4	100
Convulsions	80	19	4	-	103
Guinea Worm	54	3	38	5	100

**A few respondents provided more than one response*

The table indicates that for most diseases, health care in the hospital or health post was preferred. In the case of guinea worm, as many as (38) responses were in favour of Traditional Healers or Herbalists.

According to the Annual Report of the district (1996), Guinea Worm is an endemic disease in the area (Fanti Nyankumasi subdistrict). There is therefore an on-going Guinea Worm Eradication Programme (GWEP) which is donor-driven. This indicated that the disease had been effectively controlled and virtually eliminated, hence their aim of eradication. Is this target achievable? How realistic is this target since a reasonable number of the respondents, some of whom had the disease, cited traditional healers as the preferred form of care. Are the patients being effectively treated traditionally? What about health education? How effective is it in the district?

A situational analysis done prior to this study indicated the absolute absence of pipe-borne water in the entire district. Sources of water are mainly rivers, streams, ponds, boreholes, hand-dug wells and harvested rain water. Some of the streams are known to be contaminated with infected copepods. There is work to be done with regards to water-supply in the district if water-related diseases are to be controlled or eradicated.

SERVICE FACTORS

Cost of Service

Many authors have stressed the importance of economic factors such as prices, costs and income on utilization decisions and this is particularly so in Third World Countries such as Philippines, Indonesia and Kenya (Bailey, W. and Phillips, D.R. 1990).

High costs of delivery service are a special barrier to the use of health services. High service charges are known to reduce the use of services especially in the rural areas; most consumers prefer places where services rendered are cheaper, Waddington and Enyimayew (1989).

This study found out from the respondents, their perception of the cost of orthodox health services in order to determine whether it was one of the factors causing underutilization of health services in the district as have been proven by studies in other districts.

Table 4

Distribution of Respondents by Perception of Service Costs

Cost of Service	Frequency	Percentage (%)
Very expensive, cannot afford	47	47.0
Very expensive, manages to pay	39	39.0
Moderate/Affordable	14	14.0
Cheap	0	0.0
Total	100	100.0

As shown by table 4, 47 percent of respondents found the cost of services in the orthodox health facilities very expensive and unaffordable. Thirty-nine percent expressed similar sentiments, however they sought loans from friends and relations to enable them pay their hospital fees. Only 14 percent thought the fees were moderate and none of the respondents thought the fees were cheap.

This economic issue was further probed. This yielded interesting findings. Respondents were asked whether the cost of services affected their choice of health care. Fifty one percent indicated that the cost of health care was a major determinant of the choice of health care. Forty-nine said the cost of services did not exclusively determine their choice of health care. Both categories of respondents had explanations. Those who answered in the affirmative explained that despite their preference for hospital services, the high costs deterred them from utilizing hospitals when necessary.

They were forced by circumstances, mainly financial constraints, to fall on options which might not be their hearts' desire. The 49 percent who answered negatively had these explanations. Most of them also found the cost of services high, but for fear of death or other unwanted sequelae of diseases, they usually borrowed money from friends and relations to go to the hospital. The few respondents (14%) who could afford service costs utilized the hospital without any deterrents.

Findings from the FGDs indicated that even though people preferred hospital-based care, the user fees inhibited their use of the facility especially the 'cash and carry' system. Both the men and women groups found the cost of care in the district hospital unbearable.

In the FGD with men, one participant stated;

'Your question about our perception of user fees is a very good one. Madam, you see the health post over there, we, the people of Jakai built it ourselves. It was not built by the government ("Aban"). It is ironical that something we did in our own interest has turned out against us. The charges are unbearable so we cannot afford to go there. Instead we bypass it and go to drug stores where we can use less than 1,000 cedis to buy drugs we need. We know we have to go to hospital, but imagine, if I am ill and I have only 2,000 cedis, how do I manage?'

Interesting findings also came up from interviews with the opinion leaders. There were rumours that due to the exorbitant charges at the district hospital, convalescing patients absconded from the hospital when possible. Relations of in-patients who died were said to abscond, leaving their dead bodies in the hospital mortuary. They did not see why they were asked to pay high fees for "something" they had lost. This is incredible, for Ghanaians are known to treat "the dead" better than the living for fear of being haunted by the dead or as a way of showing off, hence the popular Ghanaian saying in Akan, "Ebusua do fun" literally meaning "relatives love dead bodies."

Another revelation, from the interview with health managers/providers was that relations often saw doctors caring for their sick ones privately, requesting their discharge from hospital prematurely for fear of high, unaffordable fees. A prominent person in the capital town once requested that his wife who was on admission be discharged prematurely. Upon enquiry, he confided in the doctor-in-charge that if the wife was kept in the hospital for a fortnight or more; he would be disgraced since he might not be able to afford her bills. He was thus prepared to take his wife home and nurse her until she fully recovered. The researcher had wanted to investigate some of the rumours, but time did not permit this to be carried out extensively.

PHYSICAL ACCESSIBILITY (DISTANCE)

Physical accessibility was another factor investigated to identify whether it influenced health care behaviour tremendously by virtue of the vastness of the district, the poor road network and the scattered communities all over the district in tiny settlements.

Physical distance naturally acts as a barrier to utilization in almost any sort of facility for good practical reasons. The effects of distance would vary in different circumstances: where there is a good road network or cheap public transport, its effects will be less severe than in areas where public or private transport is not available.

Distance also expresses itself as time - the time (and costs) of travel, which may well differ among facilities. It is implicit in the above that the effects of distance will vary in severity from one family to another depending on factors like their physical mobility, their financial and other resources. The effects of distance will also vary from community to community by virtue of the available community resources which influence the ease with which members of the community can use services, Phillips, D.R. (1990).

The effect of distance and utilization of health services have been of major interest for medical geographers. Most studies have identified a negative relationship between distance and utilization Phillips (1986b); Stock (1987). Some of these studies have shown that this relationship may vary according to illness and that it is not necessarily always negative or constant.

Takyi et al (1993) in a study of factors influencing utilization of health services in the Gomoa district of Ghana, observed that people resorted to unorthodox methods of treatment when the distance to the nearest health service centre was far. In this study, as many as 69 percent of the respondents were of the opinion that the health facilities in the district were not far. Almost the same percentage, 15 and 16 percent of respondents considered the distance to the health facilities where they normally sought health care as very far and far respectively.

The DHMT, SDHTs and the Management of the district hospital were all of the opinion that health facilities in the district were poorly sited. The district hospital and five (5) of the health posts are all along the Cape Coast-Kumasi trunk road in the district. Only two (2) of the health posts and the thirty nine (39) MOH Community Clinics are within various communities. The health planners/providers of the district therefore thought that distance to health facilities was a major deterrent to utilization of health facilities and had made recommendations for more facilities to be built close to the people. This was expressed in all reports in the district and several suggestions forwarded to improve geographical accessibility. These included the expansion of services through the building of more clinics, increasing health care coverage by increasing outreach clinics and the need for a mobile clinic, though its cost-effectiveness was queried.

The opinion leaders interviewed together with the CCAs and MAs in charge of the health posts all thought distance was one problem influencing utilization. It is important to note that the maldistribution of the health facilities in the district is a fact and was observed during this study. However, the respondents in this study were of the view that distance, though one of the factors affecting utilization, was not a major one. They did not perceive it as an unsurmountable problem. They were of the view that provided one had money for transport and the hospital fees, the problem of distance became non-existent. To them the problem was, and still is, money to pay for the high user fees. In their opinion distance became a problem only when disease struck around midnight. With regards to distance their plea was for the feeder roads (which are all in deplorable states) to be repaired.

EXPERIENCE IN A HEALTH FACILITY

To prepare respondents and enable them recall past or present experiences in the health facilities, it was enquired whether they had visited any health facility in the year.

Asked whether respondents had visited any orthodox health facility in the year, 55 percent answered in the affirmative and 45 percent in the negative. The majority of respondents (42%) who had visited the health facility in the year, walked, while 13 respondents went by some means of transport.

One area investigated was their perception of the quality of care in the orthodox health facilities.

QUALITY OF CARE

Determining respondents' perception on service factors like quality of care was of uttermost importance in this study. It was expected that quality of care in the health facilities would either promote or inhibit utilization hence questions were posed to elicit the opinion of respondents regarding quality since it is multi-faceted. some of the facets were : waiting time, staff attitude, span of service, drug availability and privacy.

WAITING TIME

Respondents who had visited the health facilities this year could easily recall the waiting time, though not accurately. Twenty-five percent spent less than an hour, 46 percent spent between one and three hours and 29 percent were unduly delayed for over three hours. Respondents shared their views with regards to waiting time at the district hospital. According to them, one is not delayed if he/she was to see a Medical Assistant. Those who needed to see doctors (whom they referred to as specialists) were unduly delayed. It was learnt that patients with minor ailments were seen by MAs whereas Medical Officers saw those with serious medical problems. Those who had to go to the laboratory were highly discontented with the delay there.

Both FGD findings confirmed this undue delay at the laboratory. The interview with the hospital matron provided the cause for the delay. According to the Hospital Matron, the hospital requires laboratory technicians and certain equipment in order to function efficiently. The need for an anaesthetist and more nurses was also expressed.

The DHMT could act as an advocate of the district hospital for staff to be seconded from the MOH to the district hospital (Mission Hospital) via the Regional Health Administration. Increasing the staffing levels would help reduce the waiting time to some extent.

Questions were posed in the survey, FGDs and the interviews regarding staff attitude, to identify if it was a factor in health care underutilization observed in the district.

STAFF ATTITUDE

Individuals in all the various groups interviewed were initially hesitant in responding to questions posed on staff attitude. This is not surprising. Respondents did not want to seem to be reporting health workers in the district to the researcher. Diplomacy was therefore of uttermost importance in eliciting responses about the attitude of health providers.

Good rapport established at the initial stages eventually proved helpful. It is therefore believed that the responses given were real. Almost half of the respondents (49%) described doctors as very cordial. Two percent however said some doctors were unfriendly. Respondents, here may be referring to doctors who did not have enough time to talk to them or examine them satisfactorily. These doctors could have treated them hurriedly hence labelled unfriendly.

Nurses and records staff were similarly labelled. Some were said to be friendly, others harsh. Most patients said they did not go to the laboratory. The few who did expressed their dissatisfaction. There were rumours of illegal fees especially where patients needed transfusion and had to look for donors. Preferential treatment at the laboratory was also mentioned. Clients expressed genuine dissatisfaction in connection with the laboratory of the district hospital. Their dissatisfaction was mainly over the delays. This complaint was genuine as indicated in the interview with the Hospital Matron.

Staff attitude is one facet of quality of care which is usually investigated in utilization studies. In a study by Dovlo, D. et al.(1992) to determine the factors contributing to client dissatisfaction with services in government health facilities, it was found that 92.9 percent of respondents were content with staff attitude. The few (21) who complained, all said staff were rude.

In this study, staff attitude was identified as one of the factors that deterred respondents from utilizing health services. Thirty respondents were affected by staff attitude. The majority of these respondents (21) have thus decided not to utilize certain facilities for fear of being mishandled by health workers. The others, (9) have decided to fall on chemical shops or local herbs. Some of the respondents (37) said, no matter what the attitude of staff was, for want of good health they would utilize health services in future. Other respondents were indifferent.

Very interesting results were obtained during the FGDs. The women described the attitude of staff in the district health facilities as reasonable. According to the women, the attitude of service providers towards clients depended on the providers' mood for the day as well as the way they the clients presented themselves or behaved at the hospital.

The statements below were from one participant:

'some of us are too bush - Abena Kesewa, no response; Abena Kesewa, no response! Even when people are called at the records section, they do not respond! Some of us behave like typical villagers; they deserve the insults showered on them or the harsh attitude they encounter. Others do not buy their prescribed drugs and return to the hospital moribund. What do they expect but insults? Generally, staff attitude depends on who you meet and how you behave at the hospital. At times when you are fortunate you would meet "angles." When luck is not on your side some frustrated nurses (who may not be happy with their salaries) will vent their anger on you.'

Another participant had a pathetic story. According to her some nurses do not perceive emergencies as such. This woman had already had five (5) children and once reported at the district hospital in labour with the sixth child. On arrival she said the midwife received her, gave her a bed and after examining her, stated that she would deliver in the following two hours. The parturient, though she said she was in excruciating pain, was virtually neglected by the midwife. Being an unusual experience, the woman said she sensed she required the intervention of an obstetrician. According to her the midwife delayed unduly in drawing the attention of the obstetrician. She sadly revealed that she had surgery eventually and lost the baby too. Five years had passed but the "pains" were still felt, pains from the nasty experience with a midwife.

Though the men generally described the attitude of health providers as cordial, they also cited an incident where the former midwife in-charge of the health post behaved rather inhumanly. She was said to have refused to attend to a woman in labour simply because she was a non-attendant and had no identity card. This woman delivered herself in a bush near the Health post. Eye witnesses were highly provoked by the incident. The village health committee which was then functional took the matter up and had the problem solved to their satisfaction. By these two incidents, what the clientele wish to tell the health providers in the district is that emergencies should be handled as emergencies!

DRUG AVAILABILITY

Drug availability in a health facility is another factor which determines the quality of care in that facility. Asked about the availability of drugs in the health facilities, respondents indicated that this was excellent. According to them, the district hospital always had prescribed drugs. More than half of the respondents (68%) commended the district hospital regarding their drugs. The remaining 32 percent said drug availability was reasonable. Interviews conducted with the DDHS, SMO, CCAs and opinion leaders confirmed that the district hospital has an excellent stock of essential drugs due to assistance they receive from UNICEF in the running of the District Medical Store - a Bamako Initiative Project. Those who said the drug availability was reasonable added that the money one had on him/her determined the drugs dispensed. One received drugs worth one's money on hand.

The question is, how effective would one's treatment be if drugs received are such that treatment is partial? Partial treatment is dangerous thus the Medical Officers' judgement is essential in this regard.

Respondents were asked of their general opinion regarding privacy, span of services and working hours in the health facilities. They were of the opinion that privacy (64%) and working hours (48%) were reasonable, however they wanted the span of services improved in the district hospital as well as the health posts.

Assessing and improving the quality of care was until recently a low priority for policy-makers in developing countries. In Ghana, quality of care has been the main theme of MOH thrust since 1989 (Dovlo, D. et al., 1992). To ensure good quality care a checklist was prepared by a special committee for use in all health institutions to monitor the quality of care.

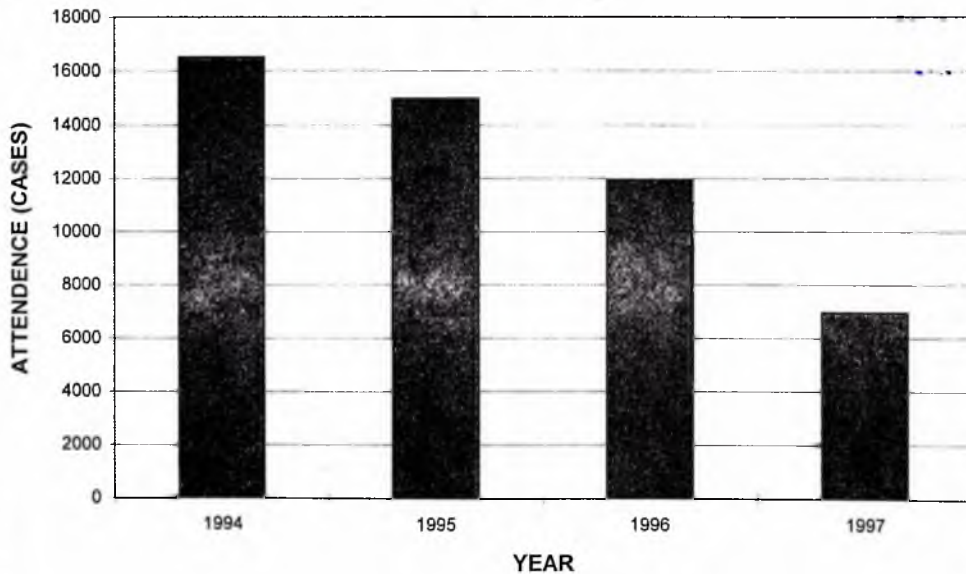
In the Assin District, two phases of a quality assurance programme had been implemented prior to this study. Interviews with the health managers revealed that they saw the need for such programmes to improve quality of care and possibly utilization. These programmes however, are yet to be evaluated. This study has showed that there is considerable room for improvement.

UTILIZATION OF COMMUNITY CLINICS

MOH has established community clinics in rural areas to bring health care as close as possible to the populace. These clinics are manned by community clinic attendants selected by village representatives (village health committees, if any) and trained by health providers at the district level.

The attendants are given basic medical training to enable them treat minor ailments. Their work is supervised by the DHMT. Attendance in these level A clinics used to be satisfactory. A review of records indicated a decline in utilization of these clinics as shown by the trends below (Fig. 5).

FIG. 5 BAR CHART SHOWING UTILIZATION TRENDS IN COMMUNITY CLINICS



The study investigated why there is a decline in utilization of the community clinics. In the survey, 74.5 percent of the respondents cited financial constraints as the main reason for non-utilization of the community clinics. Nine percent said that the clinics were poorly equipped, village-based health facilities where no proper examinations of patients were done. The others (9.1%) had no tangible responses to give to explain the observed low utilization. Respondents preferred to be managed by doctors and not men like themselves, of the same calibre, who have had minimal training and lacked medical expertise whilst 7.3 percent said they did not utilize community clinics due to the attitude of CCAs and the nature of their illness.

Interviews with CCAs indicated that community members had difficulty paying the user fees hence resorted to herbs which they referred to as "bush allowance." Also community members have no regard for CCAs since they are ordinary community members and not adequately trained for the job. The community members wanted to be treated by doctors or in their absence Medical Assistants. They wanted to be thoroughly examined - inspection, palpation and auscultation. They wanted to be given injections or attractive pharmaceuticals in capsules (antibiotics). Finally some community members were not happy with how the CCAs managed them, giving them paracetamol, chloroquine and haematinics for every complaint. Community members had no genuine trust or confidence in the CCAs. Lastly due to their poor remuneration (25% of their proceeds) the CCAs usually left the Clinics to farm to make ends meet. They were therefore often not found at the clinics. It was an arrangement that community members would help them (CCAs) on their farms whilst they saw patients but this was not being done. The CCAs thought they were poorly motivated by the

DHMT; they perceived their supervision by the DHMT as weak. They called for regular workshops, performance appraisal periodically and incentives. They were of the opinion that their standards had fallen hence the low utilization of their services. They would want the MAs or Medical Officers to visit their clinics periodically to see patients since the community members yearn to be managed by doctors. Their request was : "we want to see doctors."

The above contributions from the CCAs themselves are valuable. Their supervision and monitoring should be improved by the DHMT to improve utilization of their clinics.

ASSESSMENT OF PREVENTIVE HEALTH SERVICES

Curative, preventive and promotive health services are organized in all district health systems nationwide. Due to the observed underutilization of health services in the district, it was expected that preventive services would be reinforced through integrated services organized during outreach clinics. By virtue of the vast size of the district, it was also an expectation that outreach points would be established in most, if not all the deprived areas in the district. The district has 120 outreach points altogether. Are all these outreach points effectively reached with health services? In this study an attempt was made to assess the extent of home visiting and quality of health education as perceived by the respondents. Respondents were asked whether health providers visited them in their communities and the activities they undertook during those visits.

Sixty percent of the respondents said no health workers visited them in their communities whilst 31 percent spoke of being visited. Nine respondents had no idea whether health workers did visit them or not.

Those who had been visited (31%) said the visits had been either monthly, quarterly or twice in a year. Most respondents said the health visits were purposely for child welfare clinics. A few (24%) indicated that the visits were carried out for health education purposes. Messages for the health education were mainly on environmental sanitation, food and nutrition and AIDS. Very few respondents (19%) said the messages were on family planning. Respondents had not heard of community participation.

This study revealed that communities around the static health facilities were hardly visited by health workers. The latter rather moved out to distant communities and expected the nearby communities to come for care in the static facility. Since the facilities are not being utilized, people who live around static facilities miss both curative and preventive health services. Charity is said to begin at home. It is essential that communities which have static clinics within them should also benefit from preventive services.

Family planning coverage in the district is low, (8.4%); according to reports from the MCH/FP Unit. It was therefore expected that health education would be reinforced in this area, however the study did not show this. Health Education in several areas of health is imperative in the district. It is also essential for communities to be made aware that they need to get involved in decisions concerning their health care. This is the

essence of community participation which respondents did not know about. The DHMT has a task ahead together with the management of the district hospital. They need to find ways of involving the communities in decisions concerning their health.

CAUSES OF UNDERUTILIZATION

It is important to recognize that utilization is the outcome of many complex interactions among many variables and factors, visible and hidden, which act at different stages. Various models have attempted to assess the concurrent operation of such variables. Mckinlay (1972), attempted to identify such groups of variables in his discussion of approaches and problems in the study of the use of services. He identified groups of variables which he noted had major influence in the use of medical services. These were:-

1. Economic
2. Socio-demographic
3. Geographical
4. Socio-cultural and
5. Organizational or Delivery-System

This study set out to explore specifically how people's perception of health problems and quality of care provided in health facilities might affect utilization.

Respondents among several other questions were asked to state all factors that inhibited their desire to use health services. They were also asked to express their honest opinion of the contributory factors leading to the low utilization of services in the district. Table 5 shows the responses elicited.

Table 5

***Reasons for Underutilization of Health Services**

Factors Inhibiting Utilization	Frequency	Percentage (%)
Financial Constraints	86	65.6
Attitude of Staff	17	13.1
Ignorance	10	7.6
Existence of alternative Health Care	7	5.3
Socio-Cultural Factors	6	4.6
Distance	5	3.8
Total	131	100.0

**A few respondents gave more than one reason hence the 131 responses.*

It is obvious from this study that the major deterrent is economic in nature. Respondents preferred hospital services for most of their ailments, however they were forced to fall on other forms of health care. Poverty was extreme, as observed in the district. Farming was the main occupation. People had no regular income. Jobs were hard to come by and user fees in the hospital were described as high. How best can this situation be remedied?

Respondents in this study were not happy with the "cash and carry" system; they wished they could pay user fees in instalments, however some clients who were given this opportunity abused it hence the hospital management withdrew the favour. There is a task ahead. It lies in the domain of the DHMT, District Assembly, ²Management of the District Hospital and probably Policy-makers at the national level. The problem is an economic one. It is mainly due to inflation and extreme poverty in the district (Assin is the second-poorest district in central region, next to Twifo-Praso). What can be done about the user fees?

RESPONDENTS' VIEW OF DISTRICT HEALTH SERVICES

Respondents' general view of the health services provided in the district were sought. Sixty percent were happy with the services and 35 percent were of the opinion that certain aspects of health services in the district needed improvement. Five percent were indifferent on the topic.

A number of changes were requested. Respondents wanted the "cash and carry" system of payment in particular to be reviewed and phased out. They pleaded for reduction in user fees especially in the district hospital, St. Francis Xavier Hospital. A number of respondents were 'crying' for a Government Hospital to compete with, as they said "the so called" Mission Hospital, a supposedly Mission, non profiting, health institution whose user fees they found rather exorbitant. They called for health managers to find

² *Management of the District Hospital (Mission Hospital) are: The Spanish Congregation of Hospitaller Sisters of the Sacred Heart of Jesus.*

ways of checking negative staff attitude. The need for electricity and water were expressed for the health posts. Comments from two women, a nursing and an expectant mother would further highlight their perception of the problem of lack of water and electricity in the health posts.

The nursing mother reported :

‘We need light in the health post. When we go for weighing (CWC) the nurses economize the vaccines due to lack of proper refrigeration. They only have a kind of fridge which they said uses kerosine; I think it is inefficient!’

This came from the expectant mother :

‘We need light, here in Bereku Health Post. We deliver more or less in darkness. Madam, if I have only one source of light at home, when labour calls, do I go with it? What about the people at home? We also need water!’

The FGD with men in Jakai subdistrict revealed similar needs. An interview with the Midwife-in-charge of the health post later revealed that a benefactor - a native of the village, based in the United States of America, had just met one need. She had provided them with a generator.

Other needs expressed by respondents were staff accommodation and an increase in staff strength. Most respondents called for the extension of the good health services to the remotest areas of the district. Health education and home visiting were to be reinforced. The respondents believed that if these issues were adequately addressed and above all, user fees were reasonably reduced, they would utilize health services as much as we expect.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

It is a *de facto*, practical recognition that health care resources in many Third World Countries are both inequitably distributed and inefficiently applied. Ghana is no exception. There is uneven urban-rural distribution of health care facilities. Through PHC, some attempts have been made to adjust such inequalities. Attempts have been made to extend access to health care and coverage of services. The number of health facilities and health workers have increased considerably since independence (1957). Despite these reasonable improvements over the last 40 years, utilization of primary health services is still observed to be low. In the Assin district there is underutilization of services at all levels of health care delivery - district, subdistrict and community levels. Health Planners in the district (DHMT, SDHT and Hospital Management) not definite of the factors contributing to this observed underutilization, embarked on long and short term strategies to address this problem. New service points were created, integrated services were also rendered during outreach clinics, workshops and other quality assurance programmes were carried out to improve the quality of care in the facilities generally and staff attitude in particular.

This study focused on identifying the factors contributing to the observed underutilization of health services in the district. The main objective of the study was to explore and describe the factors leading to the low utilization of health services in the district. The main areas explored were:

- 1. The common health problems of the district.**
- 2. The local perceptions of these health problems and**
- 3. Perception of the community members regarding the quality of care given in health facilities in the district.**

The most important finding of this study was that most people in the communities that were studied, preferred hospital services for most of their illnesses, however, financial constraints deterred them from utilizing health facilities of their choice.

Poverty was identified as a major problem thus the paucity of financial resources was their major constraint as far as utilization of health services was concerned. Other constraints that influenced utilization included staff attitude, the existence of alternative forms of health care, socio-cultural factors such as people's beliefs and distance.

RECOMMENDATIONS

To the Ministry of Health (Policy-Makers)

Major concern: Poor people cannot afford cost of services

Solution: Removing financial barriers to access

Recommendation:

- **User Fees**

- Differential charges could be instituted for different types of health facilities; fees could be graduated to ensure that those at the lower levels pay less.

- **Exemptions**

- Special exemptions could be designed for deprived districts.
- Exemptions may focus on the socially disadvantaged.
- Access to exemptions could be increased or widened to cover more people; children, pregnant women, the aged and unemployed.
- Exemptions by disease categories could be considered further.

To the District Assembly

The health of people is a pre-requisite for socio-economic development.

- 1. The District Assembly should identify realistic and sustainable poverty alleviation programmes to help deprived communities - communities could be assisted financially to establish small-scale cottage industries and plantations of palm and cocoa which flourish in the district.**
- 2. The District Assembly should advocate for the improvement of the road net work in the district through its parliamentarians.**
- 3. The Assembly should take active part in Health Education activities in the district.**
- 4. Financial and logistic support should be offered to the DHMT in carrying out health education programmes.**
- 5. Vehicles from the assembly should be released for use by health personnel in their outreach services.**
- 6. NGOs like the 31st Women's Group could help women in the communities to establish income-generating activities.**

7. **The Assembly should work hard at getting pipe-borne water to the district to reduce the endemicity of water-related diseases like Guinea-worm Infestation.**

To the DHMT

1. **The DHMT, in conjunction with the district assembly and management of the district hospital should meet and review the user fees in the district hospital. This should be taken as a matter of urgency. NGOs like WVI may be helpful in this endeavour.**
2. **A comprehensive health education programme should be drawn up and implemented in the district to address the special unmet needs of the communities.**
3. **The target should be the entire community members - women, children and men. In this regard talks should be given in schools, workplaces, churches and fora where the populace would be reached.**

Advantage should be taken of durbars and social gatherings for health education purposes. Further talks should be given in all health facilities, outreach clinics and during home visits.

4. **The messages should be simple, culturally acceptable and suitable to their needs. The causes of various diseases ought to be explained and preventive measures emphasized.**
5. **Collaboration with Ministries of Education, and Information is imperative. Information Services Department may also be helpful.**
6. **The importance of home visiting cannot be over-emphasized. Community Health Nurses in the district must be supervised in this all-important preventive exercise.**
7. **The district is very big and staff strength is grossly inadequate. Requests should be made to the Regional Health Administration for the posting of more staff to the district.**
8. **To boost staff morale, special allowances like hardship allowance should be given for unpopular work locations. Extra-duty allowances should not be neglected. Staff in rural areas should be considered as well for refresher courses.**
9. **The District Assembly should be contacted to assist with money from the common fund to provide staff accommodation in existing facilities which lack adequate accommodation facilities.**

10. **Refresher courses, performance appraisal, periodic supervision and monitoring of CCAs is imperative.**
11. **On-going quality assurance programmes would be essential. Health providers who persistently misbehave towards clients must be disciplined by the appropriate authority.**
12. **Community participation is required throughout the district. The DHMT and District Assembly should mobilize the various communities of the district, encourage and ensure their full participation in decisions concerning their health as well as the planning and implementation of all health programmes in the district.**
13. **Courses should be organized for chemical sellers to make them aware of their limitations. Supervision of these sellers would be helpful.**
14. **The DHMT should pay attention to the identification and distribution of traditional medical practitioners in the district for effective supervision of their activities.**

REFERENCES

1. Aday, L.A., Anderson, R. (1974) A framework for the study of access to medical care. *Health Services Research* 9: 208-20.
2. Aday, L.A., Anderson, R., Fleming, G.V. (1980) *Health care in the US: equitable for whom?* Beverly Hills, CA, Sage.
3. Akin, J.S., Guilkey, D.K., Griffin, C.C. Popkin, B.M. (1985) *The demand for primary health services in the Third World.* Totowa, NJ, Rowman and Allanheld.
4. Anderson, R. (1968) A behavioural model of families' use of health services. Report no. 25. Chicago, IL, Centre for Health Administration Studies, University of Chicago.
5. Bailey, W., Phillips, D.R. (1990) Spatial patterns of use of health services in the Kingston metropolitan area, Jamaica. *Social Science and Medicine* 30 (1): 1-12.
6. Banisaiye, A. et al., (1986) Waiting Time and Its Impact on Service Acceptability and Coverage at An MCH Clinic at Lagos, Nigeria. *Journal of Tropical Paediatrics*, 32: 158-61.

7. **Ben Sira, Z. (1976) The function of the Professional's affective behaviour in client satisfaction: a revised approach to social interaction theory. Journal of Health and Social Behaviour 17: 3-11.**
8. **Clark, J.D. (1990) Variation in Michigan Hospital use Rates: Do Physician And Hospital Characteristics Provide The Explanation? Social Science and Medicine. 30 (1): 67-82.**
9. **Cockerham, W.C. (1978) Medical Sociology. Englewood Cliffs, NJ, Prentice-Hall.**
10. **Donabedian, A. (1980) The definition of quality and approaches to its assessment, vol. I. Ann Arbor, MI, Health Administration Press.**
11. **Dovlo, D., Boahene, A., Ntow, S., Attipoe, D., Ankrah, V., Matemera, B. (1992) What Does the Public Want From Us? A study of User Satisfaction with Services in Government Health Facilities in the Eastern Region, Ghana. Eastern Region Research Team, Ghana.**
12. **Ebrahim, G.J., Ranken, J.P. (ed) (1988). Primary Health Care: Reorienting organizational support. London, Macmillan Education Limited.**
13. **Fink, H. (1990) Religion, Disease and Healing in Ghana: A case study of Traditional Dormaa Medicine. Muenchen: Trickster Wissenschaft.**

14. Gesler, W. (1979) **Illness and Health Practitioner use in Calabar, Nigeria. Social Science and Medicine 13D, 23-30.**
15. Ghana, Ministry of Health, (1996) **Health Sector 5 year Programme of work. August 1996, Accra.**
16. Ghana, Ministry of Health, (1993-1997) **Annual Reports of the Assin District Health Management Team. (MOH), Assin Foso, Central Region.**
17. Ghana Statistical Service, (1984) **Ghana Population Census Report. Accra: Government Printer.**
18. Good, C.M. (1987a) **Ethnomedical Systems in Africa: patterns of traditional medicine in rural and urban Kenya. New York, Guilford Press.**
- Gross, P.F. (1972) **Urban Health disorders, Spatial analysis and the economics of health facility location. International Journal of Health Services, 2: 63 - 84.**
19. Habib, O.S. and Vaughan, J.P. (1986). **The determinants of health services utilization in Southern Iraq: a household interview survey. International Journal of Epidemiology. (15) 395-403.**
20. Harpham, T., Lusty, T., Vaughan, P. (eds) (1988). **In the Shadow of the city: Community health and the urban poor. Oxford, Oxford University Press.**

21. Joseph, A.E., Phillips, D.R. (1984). **Accessibility and Utilization: geographical perspectives on health care delivery.** London, Harper and Row.
22. Kohn, R., White, K.L. (1976). **Health Care: An International Study.** Oxford, Oxford University Press
23. Kumekpor, K.B., Richardson, N. (1992): **Underutilization of Supervised Delivery Services. The Socio-Cultural Context of Pregnancy, Delivery and Postnatal Care in Ghana, Preliminary Report No.1.**
24. Leslie, J. and Gupta, S. (1989). **Utilization of Formal Services for Maternal Nutrition and Health Care.** International Centre for Research on Women, Washington D.C.
25. Maine, D. (1991). **Safe Motherhood Programmes. Options and Issues.** New York: Columbia University.
26. Mckinlay, J.B. (1972). **Some approaches and problems in the study of the use of services.** *Journal of Health and Social Behaviour* 13: 115-52.
27. Mechanic, D. (1968). **Medical Sociology: a selective view.** New York, Free Press; London, Collier - Macmillan.

28. **Mechanic, D. (1979). Correlates of Physician utilization. Journal of Health and Social Behaviour 20: 387-96.**
29. **Morrill, R.L., Earickson, R.T. and Rees, P. (1970). Factors influencing distance travelled to hospitals. Economic Geography 46: 161 - 71.**
30. **Mullings, L. (1984) Therapy, Ideology and Social Change: Mental Healing in Urban Ghana. Berkeley: University of California Press.**
31. **Mwabu, G.M. (1986) Health care decisions at the household level: results of a rural health survey in Kenya. Social Science and Medicine (3): 315 - 19**
32. **Nakajima, H. (1995) Health begins in the family. World Health. Interview with Director General. WHO. Geneva.**
33. **Phillips, D.R. (1981b) Contemporary issues in the geography of health care. Norwich, Norfolk, Geography Books.**
34. **Phillips, D.R. (1986b) The Demand for and Utilization of Health Services. In: Pacione, M. (ed) Medical Geography: Progress and Prospect. London, Croom Helm: 200-47.**

35. **Phillips, D.R. (1990) Health and Health Care in the Third World. Essex, Longman Group.**
36. **Ramesh, A., Hyma, B. (1981) Traditional Indian medicine in practice in an Indian metropolitan city. Social Science and Medicine 15D: 69-81.**
37. **Rosenstock, I.M. (1960) What research on Motivation suggests for public health. American Journal of Public Health 50: 295-302.**
38. **Sekyi-Appiah, K. (1996) Factors contributing to low supervised delivery coverage in the Birim South District. Eastern Region, Ghana.**
39. **Senah, K.A. (1997) Money be man. The popularity of medicines in a rural Ghanaian community. Amsterdam: Het Spinhuis.**
40. **Schouten, M. (1996) Why people use services provided by licensed chemical sellers Preliminary Report. Assin District, Central Region, Ghana.**
41. **Stock, R. (1987) Understanding health care behaviour: a model, together with evidence from Nigeria. In: Akhtar, R. (ed) Health and disease in tropical Africa. London, Harwood : 279-92.**
42. **Takyi, C.N. et al. (1993) A study into factors influencing utilization of health services in Gomoa district. Ministry of Health, Central Region. Ghana.**

43. Thaddeus, S., Maine, D. (1990) **Too Far To Walk: Maternal Mortality In Context.** New York. Columbia University Centre for Population and Family Health.
44. Tuckett, D. (ed) (1976) **Becoming a Patient.** In: Tuckett, D. (ed) **An introduction to medical sociology.** London. Tavistock: 159-89.
45. Twumasi, P.A. (1975) **Medical Systems in Ghana: A study in Medical Sociology** Tema. Ghana Publishing Corporation.
46. Waddington, C.J., Enyimayew, K.A.: ⁽¹⁹⁸⁹⁾ **A price to pay part 1: The impact of user charges in Ashanti - Akim district Ghana.** **International Journal of Health Planning and Management.** 4: 17-47.
47. Wolfers, I. (1988) **Illness behaviour in Sri Lanka: results of a survey in two Sinhalese communities.** **Social Science and Medicine** 27 (5): 545-52.
48. Wong, E.L., Popkin, B.M., Guilkey, D.K. Akin, J.S. (1987) **Accessibility, quality of care and prenatal care use in the Philippines.** **Social Science and Medicine** 24 (11): 927-44.

APPENDIX I

APPENDIX I**FORMULAE FOR OPD COVERAGE AND
ATTENDANCE PER CAPITA**

$$1. \text{ OPD Coverage} = \frac{\text{Number of OPD New Attendances}}{\text{Total Catchment Population}}$$

$$2. \text{ Attendance Per Capita} = \frac{\text{Total Attendances (PHC New \& Re-attendance \& Home Visits + CCA Attendance)}}{\text{Total Catchment Population}}$$

OPD COVERAGE TRENDS ASSIN DISTRICT
1993 - 1997

Medical Care

Year	1993	1994	1995	1996	1997
Coverage %	23.7	26.0	28.2	27.4	37.2

Institutional OPD Coverage Trends (%)

FACILITIES	Y E A R				
	1993	1994	1995	1996	1997
Catholic Hospital	38.3	38.0	44.0	42.8	59.3
Bereku Health Post	9.4	7.3	8.0	8.3	13.7
Kushea Health Post	18.3	21.1	28.5	37.8	50.6
Praso Health Post	45.9	44.9	45.1	49.6	47.7
Enyinabrim Health Post	11.8	14.4	19.7	10.4	23.6
Fanti Nyankumasi Health Post	15.9	14.7	14.9	13.9	25.4
Jakai Health Post	9.8	15.3	16.4	11.4	18.6
Manso Health Post	8.6	19.4	17.2	15.7	20.7

TOP TEN CAUSES OF ADMISSION IN CHILDREN

NO.	DISEASE	FREQUENCY	PERCENTAGE
1	Malaria	561	39.8
2	Anaemia	416	29.5
3	Other Diarrhoeal Diseases	117	8.3
4	Pneumonia	117	8.3
5	Hernia	42	3.0
6	Meningitis	37	2.6
7	Cholera/Typhoid/Enteric	31	2.2
8	Malnutrition	30	2.1
9	Hepatitis	30	2.1
10	Accidents/Trauma	29	2.1
	TOTAL	1,409	100.0

Source : Annual Report, Assin District, 1996

TOP TEN CAUSES OF ADMISSION IN (ADULTS)

NO.	DISEASE	FREQUENCY	PERCENTAGE
1	Hernia	435	39.7
2	Accident/Trauma	186	17.0
3	Tuberculosis	98	8.9
4	Pneumonia	85	7.7
5	Other Diarrhoeal Diseases	66	6.0
6	Malaria	65	5.9
7	Anaemia	51	4.6
8	Hepatitis	39	3.5
9	Cholera/Typhoid/Enteric	36	3.2
10	Psychiatric	32	2.9
	TOTAL	1,093	100.0

Source : Annual Report, Assin District, 1996

TOP TEN OPD REPORTED CAUSES OF MORBIDITY (1996)

NO.	DISEASE	FREQUENCY	PERCENTAGE
1	Malaria	14,941	41.8
2	Skin Diseases	5,649	15.8
3	Upper Respiratory Infection	3,565	10.0
4	Accidents e.g. Fracture, Burns	1,911	5.3
5	Gastro-intestinal Disorders	1,774	4.9
6	Other Diarrhoeal Diseases	1,736	4.8
7	Gynaecological Disorders	1,620	4.5
8	Bites and Minor Trauma	1,529	4.2
9	Intestinal Worms	1,480	4.1
10	Rheumatism/Joint Pains	1,463	4.0
	TOTAL	35,760	100.0

Source : Annual Report, Assin District, 1996

TOP TEN OPD REPORTED CAUSES OF MORBIDITY (1997)

NO.	DISEASE	FREQUENCY	PERCENTAGE
1	Malaria	18,920	47.8
2	Upper Respiratory Infection	4,703	11.9
3	Skin Diseases	4,572	11.5
4	Other Diarrhoeal Diseases	2,172	5.5
5	Gastro-Intestinal Disorders	1,999	5.1
6	Bites and Minor Trauma	1,759	4.4
7	Gynaecological Disorders	1,644	4.2
8	Accidents e.g. Fracture, Burns	1,507	3.8
9	Rheumatism/Joint Pains	1,236	3.1
10	Anaemia	1,071	2.7
	TOTAL	39,583	100.0

Source : Annual Report, Assin District, 1997

APPENDIX II

APPENDIX II**QUESTIONNAIRE FOR IDENTIFYING FACTORS THAT INFLUENCE
UTILIZATION OF HEALTH SERVICES IN THE ASSIN DISTRICT**

INTRODUCTION: This questionnaire is intended to elicit the factors which affect utilization of health services in this district. Information given at any level in this research will be treated confidentially.

Name of Subdistrict/Community:.....

Name of Interviewer:.....

Questionnaire No.:.....

Interviewee's House No.:.....

Date..... Starting Time:..... Time Ended:.....

BACKGROUND INFORMATION:

1. Age:..... 2. Sex: M [] F []

3. Occupation:

- (a) Farmer []
 (b) Trader []
 (c) Teacher []
 (d) Driver []
 (e) Other(Specify).....

4. Marital Status:

- (a) No/Single []
 (b) Yes but separated []
 (c) Yes but Widowed []
 (d) Divorced []
 (e) Married []

5. What is your level of Education?

- (a) No Education (illiterate) []
 (b) Primary School (1 - 6) []
 (c) JSS/Middle []
 (d) SSS/Secondary School []
 (e) Post Secondary []

6. What is your Religion?

- (a) Christian []
 (b) Moslem []
 (c) Traditional Religion []
 (d) Other (Specify).....

7. Does your work affect your utilization of health services?

Yes [] No []

8. My belief in the causation of diseases by the undermentioned agents is:

Causes	Very Strong	Strong	Moderate	Weak	Other
By the Environment					
By Germs					
By Somebody					
Spiritual Origin					

9. What Common health problems affect Children in this community?

Diseases	Cause	Treatment

10. What common health problems affect men here?

Diseases	Cause	Treatment

11. What about Women?

Diseases	Cause	Treatment

12(a) If a child is ill with the following conditions where do you go for care?

Condition	Hospital/ Health Post	Chemical Shop	Traditional Healer/ Herbalist	Spiritualist
Malaria				
Acute Respiratory Infection				
Diarrhoeal Diseases				
Measles				
Convulsions				
Neonatal Tetanus				
Skin Diseases				

12(b) What are the reasons for your choice?

Choice of Health Care	Reasons
Hospital/Health Post	
Chemical Shop	
Traditional Healer/Herbalist	
Spiritualist	
Drug Peddler	

13(a) Generally, if you are ill, where do you go? Indicate where you or others go for health care with the following conditions.

Condition	Hospital/ Health Post	Chemical Shop	Traditional Healer/ Herbalist	Spiritualist	Self Medication
Malaria					
GIT Disorders					
Guinea Worm					
Onchocerciasis					
Schistosomiasis					

13(b) Give reasons for your choice.

.....

COST OF SERVICE

14(a) What do you think about hospital/health post charges?

- (a) Very expensive and cannot afford []
- (b) Very expensive but manages to pay []
- (c) Moderate/Affordable []
- (b) Cheap []

14(b) Does the cost of service in any way affect your choice of health care?

Yes [] No []

Please explain:

PHYSICAL ACCESSIBILITY TO FACILITY

15(a) How far do you consider the distance from your community to the nearest health post?

- (a) Very far []
 (b) Far []
 (c) Not far []

15(b) Have you visited the health post for treatment this year?

Yes [] No []

If No, skip to question 20a.

16. If yes, by what means did you get to the Health facility?

- (a) By Foot []
 (b) By Vehicle []
 (c) By Bicycle []
 (d) Other (Specify).....

17. If by vehicle, how regular are they?

- (a) Readily available []
 (b) Have to wait for a while []
 (c) Have to wait for a long time []

WAITING TIME

18. How long did you spend at the Health post?

- (a) A short time, less than an hour []
 (b) A considerable length of time, 1-3 hours []
 (c) A very long time, more than 3 hours []
 (d) Other (Specify)

STAFF ATTITUDE

19(a) What do you think about the attitude of the following categories of health workers?

	Very Cordial	Cordial	Not Friendly
Doctor			
Nurse			
Record Staff			
Laboratory Technician			

19(b) Does the attitude of health workers affect your desire to utilize services provided?

- Yes, Always []
- Yes, Sometimes []
- No []

20. What are some of the factors which inhibit your desire to seek treatment at the hospital?

21. What is your opinion about the following in the health facilities in this community?

	Very Good	Reasonable	Needs to be Improved
Privacy			
Span of Service			
Drugs/Supplies Availability			
Working Hours			

22(a) It has been observed that community clinics are not being used. Is this observation correct?

- Yes []
- No []
- Don't know []

22(b) If yes, why do people not go?.....

23(a) Do Health Providers from any facility visit your community?

- Yes []
- No []
- Don't know []

If No, skip to question 28.

23(b) If yes, how often.

- Weekly []
- Monthly []
- Quarterly []
- Not at all []
- Other (Specify)

24(a) What health programme do they organize when they visit the community?

- (a) Health Education []
- (b) Child Welfare Clinic []
- (c) Family Planning Services []
- (d) Medical Care []
- (e) Other (Specify).....

24(b) When was the last time Health Education was conducted in this community?

.....

25. What were the messages on?

- (a) Environmental Sanitation []
- (b) Family Planning []
- (c) Food and Nutrition []
- (d) Community Participation []
- (e) Other (Specify).....

26. Do you usually understand the Health Education messages given by Health Providers?

Yes [] No []

27. If yes, how useful are the Health Education messages?

- (a) Very Useful []
- (b) Useful []
- (c) Not Useful []
- (d) Other (Specify).....

28. Generally, how do you view health services provided in this district?

.....

29. Are there any changes you would want in orthodox health care provision? Name them:

- 1.....
- 2.....
- 3.....
- 4.....

30. What in your honest opinion contributes to the low utilization of health services in this community?.....

.....

APPENDIX III

APPENDIX III
INTERVIEW SCHEDULE (OPINION LEADERS)

Purpose: To identify factors affecting Utilization of Health Services in the Assin District.

Introduction: This interview is intended to elicit the factors which affect Utilization of Health Services in the Assin District. Information obtained will be treated confidentially.

Name of Subdistrict/Community:.....

Name of Interviewer:.....

Interviewee's House Number:.....

Date: Starting Time:..... Time Ended:.....

1. What are the Common Health Problems affecting Children, Men and Women in this community?
2. Where do people in this community seek health care?
Explore about all forms of health care:
 - Traditional Healers
 - Orthodox Health facility
 - Herbalists
 - Spiritualist
 - Drug Peddlers
3. It has been observed that community clinics are not being used. Is this observation correct: If so, why?
4. How do you view health services provided in this community?
 - (a) Medical Care
 - (b) Immunizations
 - (c) Health Education
 - (d) Environmental Sanitation
5. What about the quality of care provided? Explore the following:
 - i. Cost of service
 - ii. Physical Access of Health Facility
 - iii. Attitude of Health Providers
 - iv. Waiting Time
 - v. Availability of Drugs/Supplies
 - vi. Privacy
 - vii. Range of Services
 - viii. Socio-Cultural Factors
 - ix. Other Factors
6. What do you think are some of the factors that contribute to the low utilization of health services?
7. How can we improve upon the services provided in this district?

Thank you

INTERVIEW SCHEDULE (HEALTH PROVIDERS/MANAGERS)
(DDHS, SDHT, SMO, PNO, CCAs)

Purpose of Interview:- To find out Factors Affecting Utilization of Health Services in the Assin District.

Health Facility:.....

Respondent:.....

Name of Interviewer:.....

Date:.....

Starting Time:.....

Time Ended:.....

1. What in your opinion accounts for the low coverage of the health services? Explore the following;

- Physical, Financial Accessibility
- Attitude of Staff
- Availability of alternative health care
- Socio-Cultural Factors
- Range of Health Services
- Working Hours
- Adequacy of Health Facilities
- Staff strength.

2. A review of available records indicated that:

- Over the past five (5) years, OPD coverage % (Medical Care) is low.
- Low Family Planning Coverage
- Low Post Natal Care Coverage
- Unsatisfactory Supervised Delivery coverage
- Decline in utilization of Community Clinics.

What is being done about the low coverage of the various health services.

3. Generally how would you rank the quality of care in health facilities in the District.

4. Do you think certain areas need to be improved. If so, which areas?

5. Can you make some recommendations for improvement.

Thank you.

APPENDIX IV

APPENDIX IV**QUESTIONNAIRE GUIDE FOR FGDS WITH COMMUNITY MEMBERS**

FGD FORMAT: Introduce yourself and explain the purpose of your visit. The participants should be 6-12 in number. The group should be homogeneous and seating arrangements should be circular. You may commence the discussion with an introductory statement like we are here today as already announced to exchange ideas with you on factors affecting Utilization of Health Services in the Assin District.

- Allow the discussion to flow freely
- Be sure to control dominant members
- Encourage everybody present to talk
- Guide the discussion into areas related to the subject.

Name of Facilitator:.....

Name of Recorder:.....

Village:.....

Community Group:.....

Date:.....

FOCUS GROUP DISCUSSION GUIDE

PURPOSE: To find out Factors Affecting Utilization of health services in the Assin District in order to make appropriate recommendations to address the issue.

TOPIC: Low Utilization of Health Services in the Assin District.

Name of Facilitator:.....

Name of Recorder:.....

Village:.....

Community Group:.....

Date:.....

Time:.....

QUESTIONS

1. What common health problems affect children in this community?
1
2. What in your opinion are the causes?
3. What forms of treatment do you seek for above health problems
 - Ask about Malaria, Respiratory Tract Infection, Measles and Diarrhoea.
4. What about the common health problems that affect women?
 - What are the causes and treatment sought?
5. And Men?
 - Conditions, Causes, Treatment are to be elicited.
6. What are the health facilities available in this community?
7. Which one(s) do you prefer and why?
8. Where do you seek treatment for chronic diseases (Diseases which take more than 2-4 weeks to cure) and Why?
9. What is your view about Hospital/Health Post charges?
10. What do you think about the attitude of health workers in this district?
11. What do you think about the siting of health facilities in this community?
12. What are some of the factors which deter you from seeking health care in a Hospital/Health Post/Community Clinic?
13. Do health providers organize any health programmes in this community?
 - What are these programmes
 - How useful are they
14. How do you view health services provided in this district?
15. Are there any changes you would want in orthodox health care provision?
16. What factors do you think contribute to the low utilization of health services in this community?