UNIVERSITY OF GHANA

DETERMINANTS OF PRIMARY HEALTHCARE UTILIZATION IN THE GOMOA EAST SUB-DISTRICT

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THIS LONG ESSAY IS SUBMITTED TO THE UNIVERSITY OF GHANA BUSINESS SCHOOL IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF BUSINESS ADMINISTRATION DEGREE (HEALTH SERVICES MANAGEMENT OPTION)

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DECLARATION

I, Mary Konneh-Archer, declare that this work is a product of my own research effort. It has not been presented either in part or whole by anyone for any academic award in this or any other university. All sources cited have been duly referenced; and I bear sole responsibility for any shortcoming herein.

……. ……...

MARY KONNEH-ARCHER
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DATE

CERTIFICATION

I certify that this long essay was supervised in accordance with procedures laid down by the University of Ghana.

……. **…….**

DR. LILY YARNEY **DATE**

(SUPERVISOR)

DEDICATION

This work is dedicated to Ernest Nti and Nathan Kwasi Amoakohene Nti- you both give me the reason to push the boundaries every day.

ACKNOWLEDGEMENT

My foremost acknowledgement goes to God Almighty for making the successful completion of this piece of work possible. Profound gratitude to my supervisor, Dr. Lily Yarney- I have learnt a lot from you within this period. Thanks for your insightful comments and supervision of this work. Mrs. Rachael Hanson-Garshon (the able Teaching Assistant) may God richly bless you for being there for me insofar as the progress of this work was concerned. My beloved parents, Mr. and Mrs. Paul and Perpetua Konneh-Archer, words cannot adequately express my gratitude to you. I am forever indebted to your wise parental tutelage all this while. I cannot forget to mention my siblings, Dr. Paul Kwesi Konneh-Archer and Ms. Perpetua Yaaba Konneh-Archer- I will choose you as siblings again if I have the chance to do so in the next world- love you to bits. To my in-laws, Lawyer Peter Nti and Mrs. Esther Nti,- you have both been good counsels to the success of my academic journey. To the people of Gomoa East sub district (Okyereko and Adawukwa), especially to Patricia Otubuah (in charge) and the Okyereko health centre, you are simply awesome- thanks for your instrumentality during the data collection phase of this study. To the management and staff of Sanford, thanks for the being supportive in diverse ways. To all my classmates in the MBA class (2017-2019), especially my MBA family, I am forever grateful for your advice. Though it was a challenging process, you were with me all the time.

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ABSTRACT

Primary health care is vital in the general health care system in every country. Therefore, it is highly imperative to provide facilities and services to enhance access to healthcare services to benefit all individuals independent of their location. The effective provision and implementation of these services will encourage the utilization of primary health care. The present study, therefore, is aimed to contribute to existing literature by examining the phenomenon in a rural community in the Central region- Gomoa East sub-district. The focus of this study is to identify the determinants of the utilization of primary healthcare; the perception, identification of the factors that influence the use of primary health care and the health seeking behaviours. This study used the mixed method approach which is a combination of both quantitative and qualitative research approaches. Data collection instruments employed included questionnaire and interviews. Sample sizes of 200 respondents from two communities (Okyereko and Adawukwa) were selected for the survey. The study has confirmed that the key factors that determine the utilization of health care in the sub district are mainly the accessibility to the health facility and the age of the person. On the contrary, the observation made from the findings on level of education and the average monthly income showed a non-significant role as determinants of the utilization primary health care. The health seeking behaviour of the people showed that 46% report to the health facility when they become ill, another 36% self-diagnosis and self-medicate.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Chapter Introduction

This chapter presents the focus and the relevance of the study. In this chapter, the background of the study, the problem statement and the specific objectives of the study are discussed. The identification of the scope of the research and the limitations encountered have been included in this chapter. The chapter is concluded with the significance of the research.

1.1 Research Background

The provision of primary health care is a crucial aspect of the general health care system in every nation. As stated in Alma Ata declaration, primary health care should be based on scientifically sound, practical and socially approved methods of health care delivery widely distributed to the inhabitants, both individuals and families in a community (World Health Organization &United Nations Children's Fund, 2018). The effective practice of primary health care is mainly dependent on the high involvement of these communities and a sustainable approach financially by the community and the government to maintain the spirit of self-reliance at every level of its development (Makaula, Bloch, Banda, Mbera, Mangani, de Sousa & Muula, 2012).

Globally, advanced countries such as the United Kingdom, United States of America, Japan, Germany, amongst many others have demonstrated high commitment to providing quality, reliable and sustainable primary health care. Currently, the Japanese healthcare system provides universal health coverage through both a fee-for-service system under governmental control and a free-access system(Yoshikawa, Bhattacharya & Vogt 1996). Under these systems, Japan has

maintained top-class global health indicators, including life expectancy at birth and infant mortality (Kaneko & Matsushima, 2017). Unfortunately, the capacity in the delivery of primary health care in the Low and Middle Income Countries (LMIC) in the world is lacking, resulting in poor health related outcomes. For example, an extensive study in northern India revealed that diagnoses were provided in only 36% of reported cases and only 12% of these diagnoses were right. Similar cases displaying poor diagnoses were also found in Paraguay, Tanzania and Indonesia (Bitton, Ratcliffe, Veillard, Kress, Barkley, Kimball & Bayona, 2017).

Okpokoro (2013), in his study mentioned that the uneven distribution of social determinants of health such as income, housing, healthy environment, employment as well as the limited accessibility, affordability and availability of essential health services has led to widening health inequities between the high and low socio economic communities in developing countries of which Ghana is no exception. For the past two decades, Ghana has been committed to a series of actions to boost access in delivery of health services and making financial reforms in compliance with the WHO's policy on Universal Health Coverage (UHC) aimed at pursing the well-being of all people health wise (Nyonator, Ofosu., Segbafah & d'Almeida, 2014). This is evident in the national budget released in 2017 showing an allocation of GHc 4,226.15 million out of the total budget of GHc 44,961.64 representing 9.4% to implement the activities of the health sector (Citizens' Budget, 2017). The development of a close-to-client health care delivery system, called the Community-based Health Planning and Services Strategy (CHPS) and the implementation of the National Health Insurance Scheme (NHIS) are nationwide projects by the Government of Ghana to bridge geographic barriers and provide financial protection respectively (Awoonor-Williams, Tindana, Dalinjong, Nartey & Akazili, 2016).

However, despite the efforts of government to make primary healthcare assessible to all, it has over the years encountered various major hurdles impeding the effective health care delivery Novignon and Nonvignon (2017) in their study discovered many challenges faced in the delivery of health care especially to the rural communities across the country. Inadequate health facilities, unwillingness of health personnel to work in rural areas, long travel distances to health facilities and the cost of health care services were identified as the major factors affecting the provision of primary health care. It is imperative to understand the attributes of the primary health delivery that is creating inefficiencies and its negative impact on the people in the community.

1.2 Statement of the Problem

The significance of a sturdy health care system cannot be overemphasized. According to Gocking (2005), the stability of a country's health care system underpins the state of its economy. This stands to reason that, the healthier a populace is, the better position it will be to engage in economic activities that will inure to the aggregate economic benefits of the country-aggregate health is positively related to the state of the economy (Amamoo, 2000). No wonder, governments invest a lot to accomplish sturdy health care system thereby bolstering accessibility and utilization of primary health care.

Unfortunately, however, governments' investment in primary health care alone does not fully determine the utilization of same (Hoyle, 2016). In most hinterlands in most African countries, for example, the levels of utilization of primary health care facilities remains problematic (Marc, 2012; Dunn & Mutti, 2004). This has triggered the need for studies into the health seeking behaviors of people in such hinterlands. However, most of these studies conducted on primary health care were conducted one the impact of the use of National Health Insurance Scheme (NHIS)as a determinant of primary health care utilization (Dixon & Schafer, 2014; Matsumura,

Uemura, Okamoto, Yamamoto, Yamaguchi, Yamakido & Schlemper, 2001; Addai, 2000). The problem with these studies is that, they limit the determinants of primary health care utilization to only NHIS to the exclusion of others. In Ghana, most of the related studies were mainly conducted on maternal healthcare utilization- which is on one level of analysis (Abor, Abekah-Nkrumah, Sakyi, Adjasi & Abor, 2011; Saeed, Oduro, Mills & Zhao, 2012). This therefore warrants a study that will broaden the level of analysis to other factors.

Studies that specifically focused on the determinants of primary health care were mostly conducted in foreign jurisdictions (Brettschneidera *et al.*, 2019) which presents a context gap for this study. More to it, the related studies were predominantly qualitative (Addia, 2000; Brettschneidera *et al,*. 2019; Abor *et al.*, 2011), none of the studies, so far, have been sighted using the mixed method approach. This presents a methodological gap for the present study. The present study, therefore, is aimed at contributing to existing literature by examining the phenomenon in a rural community in the Central region- Gomoa East sub-district, using a mixed method approach.

1.3 Research Objectives

The general objective of this study is to identify the determinants of the utilization of primary healthcare

Specific Objectives

- To assess the perception of the populace on primary healthcare.
- To identify the factors that influence the use of primary healthcare at Gomoa East sub district.
- To identify the health seeking behaviors of the sub district.

1.4 Research Question

The following questions serve a guideline to achieve the objects of the study.

- What are the perceptions of the populace on primary healthcare?
- What are the factors that influence the use of primary healthcare at Gomoa East sub district?
- How does the populace of Gomoa East district perceive primary health care?

1.5 Scope and Limitation of the study

This study explores the various factors influencing the utilization of primary health care and the kind of health facilities available to the community. Also, as part of the study, the identification of health seeking behaviours of the populace in the community will be examined. The study is limited to the factors affecting the provision of primary health care in rural communities specifically in the Gomoa East sub district of the country.

1.6 Significance of the Study

The study will highlight the availability and access of primary health facilities in the study area as a rural dwelling. The purpose of the study will reveal the factors inhibiting access to primary health facilities and services by the rural populace which is related to causative factors ranging from physical accessibility problems, low income levels, low technological issues, high illiteracy amongst others. This research will provide valuable information to the district health care authorities on the state of the delivery of primary health care. This will aid in the formation of health policies peculiar to the district.

1.7 Definitions of key terms

Primary healthcare: Primary health care is a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing (WHO, 2013). Additionally, primary health care involves the services and products which aim to address acute and episodic health conditions which also includes health promotion efforts. Primary healthcare is the first level of care.

Utilization: Health Care Utilization is the quantification or description of the use of services by persons for the purpose of preventing and curing health problems, promoting maintenance of health and well-being, or obtaining information about one's health status and prognosis. (Turner, 2013).

Determinants: The determinants refer to the factors which affects the nature and outcome of a service. The determinants of health care include:

the social and economic environment,

the physical environment, and

the person's individual characteristics and behaviours.

1.8 Chapter Outline

The research is in five chapters. Chapter one consists of the introduction to the study. Background of the study, problem statement, objectives of the study, research questions, scope, limitations and significance of the study are the main sub-topics of the first chapter. Chapter two

entails review of both theoretical and empirical literature that are relevant to this research. The methodology used in the research is captured in the third chapter. This chapter describes the research design, research setting, population, the sampling technique, sample size, sources of data, the analysis of the data and the ethical considerations.

Chapter four contains the presentation of data, key findings, analysis and discussion, whilst the last chapter finally summarizes the findings of this research, and conclude with recommendations for practitioners, policy, academia and the general public.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter describes what the determinants of healthcare utilization as well as delineates the theories that support and explain healthcare utilization. For the present study, the Gomoa East sub-district was the focal point of interest. The end part of this chapter presented scientific studies that have been done in Africa and other continents that have a bearing on this study. The final part of the chapter presents a conceptual framework based on the variables in the study and the expected relationships between them.

2.1 Definition of Concepts

This section outlines defining information from extant literature on the key variables under investigation in this study.

2.1.1 Primary Healthcare

The World Health Organization's vision for primary health care in the 21st century is to have universal coverage; that is, everyone having access to basic health care (WHO, 2012). According to Olayiwola and Adeleye (2005), primary healthcare is the essential healthcare that is based on socially acceptable, and scientifically sound methods that are made universally accessible to families and individuals in communities through the full participation of these individuals and at a cost the community can be maintain at every stage of development in the spirit of self-reliance and self-determination. The World Health Organization Report (2012) reports that, in the African region, primary healthcare utilization stands at 5-7%. This is woefully inadequate considering Africa's population.

2.1.2 Health Seeking Behaviour

This is defined as any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding appropriate remedy (Musinguzi, Anthierens, Nuwaha, Van Geertruyden, Wanyenze, & Bastiaens, 2018). There are several factors that will encourage or discourage help seeking behaviour according to extant literature. Musoke, Boynton, Butler, and Musoke (2014) reported that one of the key determinants of health seeking behaviour is the organization of the entire healthcare system- how the entire healthcare system is organized such as issues with the healthcare providers, quality of service, and proximity to the health care center are catered for.

Inappropriate health seeking behaviour has been linked to high morbidity, increased mortality and poorer health statistics (Mwase, 2015). There are studies that have found economic reasons why some respondents in certain economic statuses will prefer to engage in inappropriate health seeking behaviours such as self-medication and using traditional healers. In a Pakistani study by Rehman, Shaikh, and Ronis (2014) it was found that people from households whose income was below the minimum wage were less likely to visit the hospital when ill. While other respondents who had higher incomes were more willing to utilize the healthcare facilities available to them.

Abidin, Sutan and Shamsuddin (2014) assert that health seeking behaviour is directly related to disease incidence, prevalence and complications. They are quick to add that depending on the determinants of interest and their interactions, health seeking behaviour can be a complex outcome of these determinants and the interactions between them. In this Malaysian study, the researchers concluded that family support was a key determinant of health seeking behavours. Respondents in that study had appropriate health seeking behaviours when they had the support of their families, than when their families were not supportive of seeking health care.

Furthermore, Siddiqui, Siddiqui and Sohag (2011) aver that to improve health seeking behaviours in low economic countries, intensive education should be embarked on. Their conclusion was based on a study of permanent dwellers of 300 households of low and middle-income earning homes. The mean age of the participants was 38.27 years. The results showed that respondents were more willing to seek medical help from traditional healers than proper health facilities primarily because they did not have the money to visit these health centers. Some of these respondents also did not know about the availability of the health centers and for those who knew did not know of the full benefits of using the health centers. Therefore, the researchers concluded that education was the way to improve health seeking behaviours. Again, this education will also improve family support; because, then, the family members will be aware and will encourage sick family members to seek healthcare (Siddiqui, Siddiqui & Sohag, 2011).

Atwine, Hultsjö, Albin and Hjelm (2015) conducted a study in Uganda on health seeking behaviour among diabetics. This study employed qualitative measures such as focus group discussions and interviews with ten women and seven men between the ages of 39 through 79. The results showed that the respondents visited traditional healers with symptoms such as fatigue, polydipsia and decreased sensitivity in the limbs. The respondents also reported that western medications had less effect. The participants also reported that they did not know the sources of the extracts used in western medications and therefore had some form of mistrust for western drugs. The researchers concluded that health seeking behaviour was inconsistent because there was a switch between traditional healers and western medications. The participants still experienced medical complications. The solution the researchers proffered was increased education.

2.2 Determinants of Primary Healthcare Utilization

Generally, determinants of primary healthcare utilization are access, availability, accommodation and acceptability (Olayiwola & Adeleye, 2005). With respect to access, there are the 5As that explain the various accesses there are. Access represents the fit between the characteristics and the expectation of the community dwellers (clients) and providers

Factors that determine the use of primary health care have been a topic of study in recent times. On the African continent some factors have been empirically found as constant determinants of how and when primary healthcare is used. Abu-Mourad, Alegakis, Shashaa, Koutis, Lionis, and Philalithis (2008) assert some demographic characteristics such as marital status, age, living conditions, poor health and unemployment. Other determinants have been found to restrict utilization of primary healthcare are high cost of drugs and services, inadequate infrastructure at the primary healthcare facilities (Muhammed, Umeh, Nasir & Suleiman, 2013).

2.3.0 Theoretical Framework

This study adopted two major theories that explain utilization of healthcare services and health behaviour generally. Andersen and Newman (1973) theory of healthcare utilization basically explains why people use healthcare services with three major factors. Then there is the theory of planned behaviour propounded by Ajzen (1991). This theory also explains behaviour in terms of social norms, perceived behavioural control and behavioural intention. Both theories complement each other in the explanation of utilization of healthcare.

2.3.1 Healthcare Utilization Model (Andersen & Newman 1973)

This theory was developed by James G. Andersen. This model describes the factors that will motivate an individual to seek medical services or help. In effect the aim of the model is to show

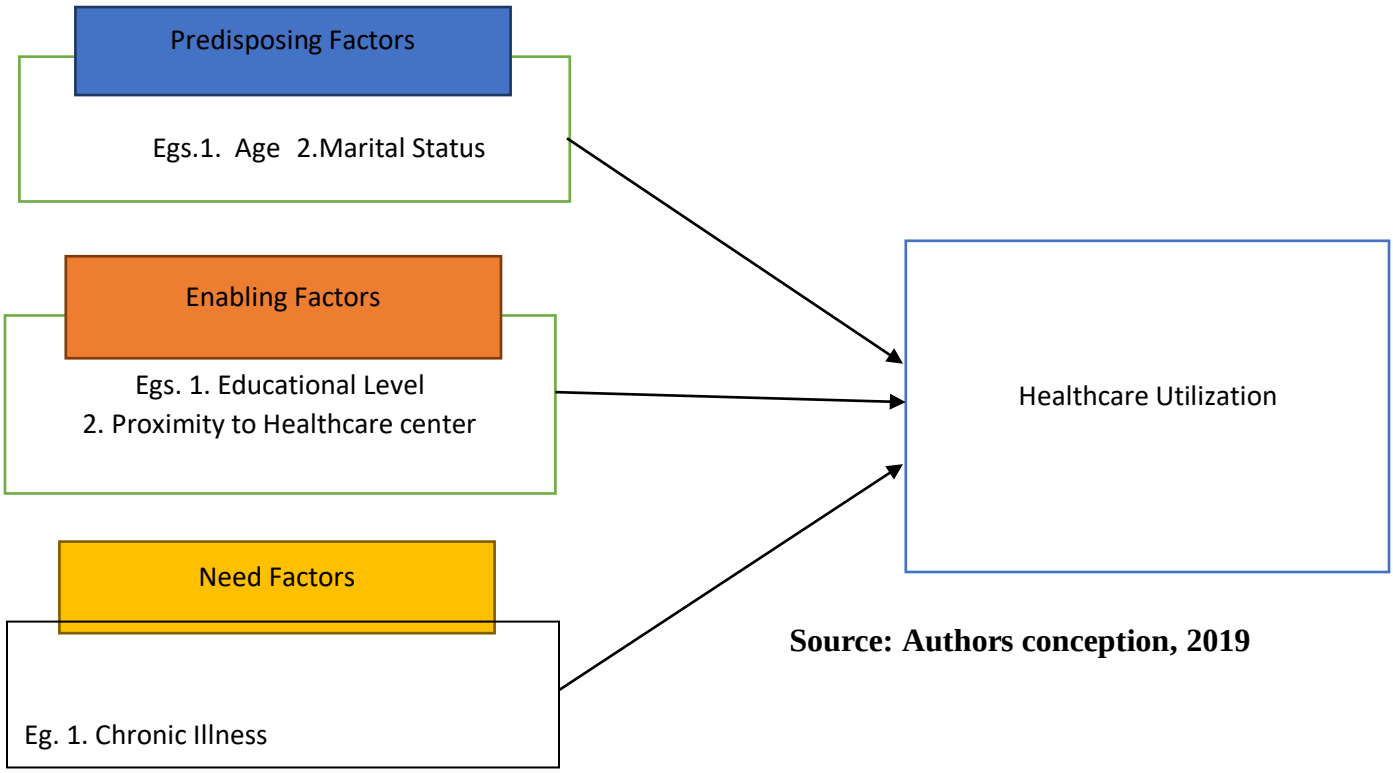
conditions that either impede or facilitate utilization of healthcare services. This theory states that an individual's access and usage of healthcare services are as a result of first, predisposing factors, second, enabling factors and lastly, need factors. These three group of factors together according to this theory give an indication of whether an individual will use the healthcare facilities available to him or not.

Andersen and Newman (1973) states that predisposing factors are socio-cultural features or demographics that exists before the individual's illness. These characteristics are social structure which are characteristics such as occupation, ethnicity, education, culture, and social interaction. Also, there is the health belief of the person, which encompasses the attitudes, knowledge and values that people have concerning healthcare services, infrastructure and systems. Lastly, demographic features such as age and gender make up the predisposing factors that will inhibit or encourage a person to use healthcare services.

The second factor that determines the utilization of health facilities is enabling factors. According to the healthcare utilization model (Andersen & Newman, 1973) enabling factors are the logistical aspects of getting healthcare. These factors could be personal, communal and other related factors. Personal or family factors encapsulates the means and knowledge about healthcare services, insurance, social interactions, travel, length and cost of travelling to receive healthcare, the extent and quality of social and familial relationships. There are community factors that also play a role under the enabling factors. These factors are availability of health facilities, and personnel, and the waiting time users have to endure to receive this care. There are other factors that could also determine the utilization of healthcare under enabling factors that could be genetic and psychological factors.

The last factor is the need factors. These represent the immediate reasons why people will use healthcare services. It is the need for healthcare that will motivate a person to seek healthcare. If all other factors are present, as in the person has some predisposing factors and enabling factors but has no need for healthcare, he or she is likely not to use the healthcare services available. How a person defines his or her sickness and assesses his or her need for healthcare determines whether he will obtain healthcare (Andersen, 1995). The need could also be perceived need and objective need. Perceived need helps explain why patients adhere to s treatment regimen, and also explain health seeking behaviour (Sutter, 2017).

Figure 2.1 Healthcare Utilization Model



Source: Authors conception, 2019

2.3.2 Theory of Planned Behaviour (Ajzen, 1991)

This theory states that beliefs about a particular behaviour predict the intention and eventually the actual behaviour (Ajzen 1991). This theory helps explain an important factor in predicting health behaviours – perceived behavioural control. This theory posits that in predicting behavioural intention, there are three major beliefs: attitudes, subjective norms, and perceived behavioural control. These together help predict if a person has the intention to behave in a certain way and will eventually behave that way.

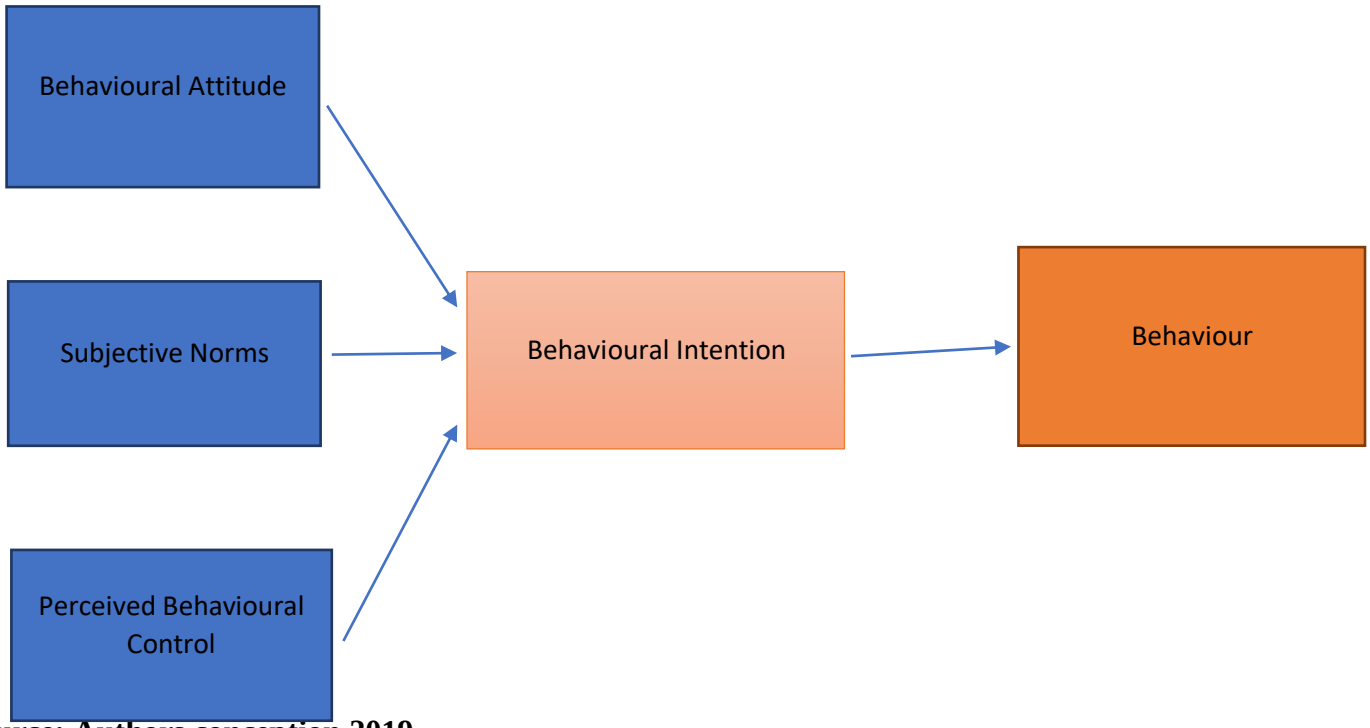
Attitudes are the individuals' perceived notion about the consequences of the behavior either positive or negative. This is where the behaviour is perceived to be good, bad or somewhere in between (Ajzen, 1991). For instance, a person's attitude towards healthcare in a religious culture where seeking any other medical help apart from divine healing may see seeking healthcare from a hospital as bad. This is because their religion may make such a behaviour look bad and religiously not right. In other words, attitudes represent the degree to which an individual has favourable or unfavourable evaluation of a particular behaviour. This evaluation is based on the outcomes of the behaviour.

Behavioural intention, another belief of the theory of planned action refers to the motivational features that influence a behaviour. The stronger the intention, the higher the likelihood that this behaviour will be eventually be performed. It is worthy of note that once the behaviour is under the person's volitional control the likelihood to perform it increases (Sutter, 2017). There is also subjective norms. This basically describes other people's evaluation and opinion about whether one behaviour is good or not. Whether other people approve or disapprove of a particular behaviour is what is termed as subjective norms. This is where the person in question has peers

and higher status people in his or her life who believe he or she should engage in the behaviour. Relating this to health behaviour and utilizing healthcare services, per this theory, a person will go to the hospital or clinic if he/she think his/her peers approve of that behaviour.

Perceived behavioural control refers to the ease or the difficulty with which a behaviour can be performed in the opinion of the person who will perform that behaviour. Perceived behavioural control is dependent on each situation. Therefore, depending on each situation a person may have varying perception of his level of control (Ajzen, 1991). Though perceived behavioural control may share some similarities with locus of control, that latter has more stable traits whereas perceived behavioural control changes based on the situation at hand (Sutter, 2017). It was the addition of this that shifted the theory from reasoned action to planned behaviour.

Figure 2.2 Theory of Planned Behaviour



Source: Authors conception 2019

2.4.0 Empirical Literature Review

This section outlines historical and current studies that have been carried out on determinants of healthcare utilization in diverse settings and draws the lines of distinction and similarity between those studies and the current research.

2.4.1 Distance as a determinant of primary healthcare utilization

Buor (2003) reports that, distance is the most important determinant to the utilization of primary healthcare. He sample was the Ahafo - Ano South district in the Bono Region of Ghana. In that sample which consisted of 400 respondents who were chosen by systematic random techniques, some face-to-face interviews were done in the course of the survey. There were also some questionnaires distributed as part of the data collection process. After regression model analysis the results showed that distance was the most important determinant of the use of primary healthcare in that district. While Bour (2003) described distance as the key determinant of primary healthcare utilization, Ress, Hawkesworth, Moore, Dondeh and Unger (2016) averred that though distance is key, transportation had more bearing on whether the community dwellers used the primary healthcare services available.

Early researchers such as Fredricksen (1964), Bailey and Philips (1990) also describe distance as being one of the foremost factors that prevent or encourage usage of primary healthcare. Bailey and Philips (1990) studied the Jamaican terrain with respect to distance, transportation and access to healthcare in Kingston, Jamaica. The fifty respondents in that study were asked about the kind of health facilities they visited, how frequent, their travels times from their homes to these centers, their modes of transportation to the health facilities and the frequency of their visitations to these healthcare facilities. Results show that for poorer respondents they visited facilities that were far because of less expensive services, while for richer or

highstatusrespondents, they travelled to long distance facilities in order to remain loyal to family doctors or because those facilities had the company doctors.

In the Nigerian setting, Awoyemi, Obayelu, and Opaluwa (2011) report that distance was a determining factor for the Nigerian respondents they studied in the utilization of healthcare facilities. The study covered 160 households and 60 primary healthcare facilities in the Kogi State of Nigeria. After analysis of data, the results proved that, besides household size, which influenced the frequency of a member of the household going to the clinic, distance between the household and the healthcare facility determined the rate at which members of the household visited the health facilities. The results further pointed out that, the proximity of the healthcare center to the households especially, poorer households, increased the rate of the utilization of the facility. The conclusion of the study on distance as a determinant to the utilization of primary healthcare was that utilization of primary healthcare facilities increased when it was in close proximity to the users.

2.4.2 Quality of healthcare as a determinant of utilization of primary healthcare

Quality of healthcare from studies has been known to be one of the reasons people will either use a healthcare facility or not. Findings from Haiti support this claim. Gage, Leslie, Bitton, Jerome, Joseph, Thermidor, and Kruk (2018) aver that quality of the healthcare service influenced the utilization of primary healthcare facilities. In the study, the researchers asserted that the quality of healthcare services was low while quality of infrastructure was around half the expected quality in Haiti. An interesting result in that study was that in rural areas the quality of the healthcare service delivered was more strongly associated with utilization than quality of infrastructure and inputs. The researchers opined that service delivery may have had a larger impact because it was a more comprehensible factor. Service delivery included factors such as

the wait time, availability of services, provider competence, duration of service, and adequate communication from the service provider- these were all composite of the entire care experience.

However, in the urban areas service quality and infrastructural quality was not a strong indicator as compared to quality of infrastructure and input as was the case in the rural areas. Gage, Leslie, Bitton, Jerome, Joseph, Thermidor, and Kruk (2018)

2.4.3 Education as a determinant of primary healthcare utilization

Generally, with higher education people are able to access and use primary healthcare more often. This is evidenced in a study by Tsawe and Susuman (2014) where women failed to use available maternal health care because they had no knowledge about maternal health care. Neither did the respondents know the importance of seeking maternal care. Therefore, the researchers suggested that as part of measures to increase the usage of healthcare services educational programs tailored at educating the women on the importance and benefits of seeking maternal healthcare should be included in media broadcasts especially in the rural areas.

A study by Geitona, Zavras, and Kyriopoulos (2007) studied found education non-significant in their study of determinants of primary health care usage and in Greece and therefore deleted it from their final model. Corroborating this finding is the research by Grimsmo and Siem (1984). The researchers did not find education as a significant determinant of primary healthcare utilization when it was taken together with other demographic features.

2.4.4 Access as determinant of primary healthcare utilization

Access to health care is defined as having timely use of personal health services to achieve the best possible health outcome (IOM, 1993). It is also described as gaining entry into health care system, getting access to sites of care where patients can receive needed services and finding

providers who meet the needs of patients. Simply one's initial contact with or use of service (AHRQ, 2017).

Dias, Severo and Barros (2008) aver that access to healthcare is as a result of complex determinants, however it is necessary that all people have access to healthcare. Access to healthcare has been found to be a key determinant of primary healthcare utilization (Ress, Hawkesworth, Moore, Dondeh, & Unger, 2016). These researchers focusing their study on the utilization of primary healthcare for children under five years report that

In the African setting a number of factors have together given or inhibited ease access of healthcare. In a South African study to investigate access and use of maternal health care services, it was revealed that women who had had secondary education, had to travel under 20km to access healthcare, and were not married had more access and therefore used maternal health care services more. Using a mixed method approach just as in this study, through qualitative interviews it came to light that the women did not use the maternal health care services available to them because of factors such as staff shortages and financial shortages (Tsawe, &Susuman, 2014).

Wandera, Kwagala, and Ntozi (2015) investigated the determinants of access to healthcare by older persons in Uganda and found that for older people, from poor households access to healthcare was reduced for them. The access to health care was also reduced for older people who had various degrees of difficulty walking. However, for older people who earned wages within the period of the study, their access to healthcare increased. The respondents with heart disease, diabetes, hypertension accessed health care more. The researchers concluded that in Uganda the most important determinants of access to health care were enabling factors such as household income and health needs factors such as severity of illness and difficulty with mobility

2.4.5 Age as a determinant of primary healthcare utilization.

The conclusion on this particular demographical characteristic – age has not been conclusive. There are studies that have found that age was a determinant to whether a person used primary healthcare or not yet, other studies have not found such a relationship between age and primary healthcare utilization.

Exavery (2011) found age to be a significant determinant of primary healthcare utilization in rural Ghana. Besides age having at least one chronic disease also influenced the use of primary healthcare facilities. According to the researcher, old age predisposes elderly people to some diseases and ailments (such as joint pains, predisposing them to having difficulty with lifting up objects), that require that they use primary healthcare facilities available to them. This therefore increases the likelihood that they will use primary healthcare services available more readily than younger people who may not have such conditions. Exavery (2011) labelled age as well as sex, marital status as predisposing factors.

However, a Jordanian study reported converse results. In that study age was not a determinant of primary healthcare usage. There was a sample size of 190 adults aged between 50 and older, with a mean age of 64.6years. The sample was selected from three different geographical locations. Participant's usage of primary healthcare facilities for the past one, six and twelve months were the dependent variables of interest. Participants were asked questions such as "did you visit your primary health care facility in the last month, or six months". Results showed that age was not a determinant of usage of primary healthcare facilities in their locality (Exavery, 2011).

In Korea, similar results to that which was found in Ghana was reported among older people who are 80 years and above. Age was found to be a determinant where the respondents were above 80

years, had no income and health insurance, were religious, living with others and had poor health status (Park, 2005).

2.4.6 Gender as a determinant of primary healthcare utilization.

Based on the biological difference between men and women, there may be some differences in their health risks and needs (Carretero, Calderón-Larrañaga, Poblador-Plou, & Prados-Torres, 2014). Generally, views and results based on empirical research has largely proved that women have a higher rate of primary healthcare usage than men. However, a few other studies have found either no difference or slightly higher usage among men. Women have been found to use healthcare facilities more than men (Redondo-Sendino, Guallar-Castillón, Banegas, & Rodríguez-Artalejo, 2006; Carretero, Calderon-Larranga, Poblador-Plou, Prados-Torress, 2014; Jørgensen, Andersen, Tjønneland, & Andersen, 2016).

Redondo-Sendino, Guallar-Castillón, Banegas, and Rodríguez-Artalejo (2006) studied morbidity and utilization of healthcare facilities and found that women as compared to men had higher utilization of healthcare facilities than men. The study was conducted with a sample of 3030 respondents who were non-institutionalized, 60 years and above. After considering some predisposing factors such as age, head-of-family status, marital status and educational level, it was evident after results were analyzed that women used healthcare facilities and services more than men.

In the study by Jørgensen, Andersen, Tjønneland, and Andersen (2016) again women had higher rates of primary healthcare utilization than men. One of the key questions of the study was the number of consultations respondents' wen to during the period under review. Results showed that women had an average of 4.1 while men had 2.8 consultations per year. Again Koskela,

Ryynanen and Soini (2010) corroborate the above findings with their Finnish study where women were more frequents users of primary healthcare facilities than men.

The study was done in Tampere, Finland on a primary healthcare facility. The researchers sampled 85 patients who were using that primary healthcare facility. They chose two groups, frequent attenders and persistent attenders. A respondent was considered a frequent attender if he or she visited the health center at least eight times in a year for at least three years out of four years follow-up years. After analysis of results, the most influential risk factor for being a frequent attender was being female, having a body mass index above 30, and irritable bowel syndrome. But the key indicator was being female.

Furthermore, in Turkey females were found to be more frequent users of primary healthcare than men. After studying one-hundred and fifty respondents on their utilization of both primary healthcare specialists and outpatient specialist, researchers concluded based on the results of the study that females used primary healthcare services more than men.

2.4.7 Income as a determinant of primary healthcare utilization.

There is the need for income in access or using primary healthcare. The cost of these services have been found in some studies to be a barrier to access and usage of primary healthcare (Olayiwola, & Adeleye, 2005). Income has also been found to determine whether primary healthcare facilities will be used or otherwise. In a Turkish study, income was found to be one of the important predictors to primary healthcare utilization. Alemi, Stempel, Koga, Smith, Danis, Baek, and Montgomery (2017) studied one hundred and fifty-five Afghan respondents and their usage of primary healthcare physicians and outpatient specialists. After multivariate regression analysis, results showed that respondents who earned a higher income used primary healthcare more often than respondents with a lower income level.

Moreover, Geitona, Zavras, and Kyriopoulos (2007) also reported that income was a strong predictor of primary healthcare usage. The researchers went further to explain that with respect to income as a determinant of primary healthcare usage, income became a determinant at the lower income levels. This study used a nationally stratified sample randomly selected by the researchers. The total sample size was 1819. The main aim of the study was to investigate some characteristics of the respondents and their utilization of primary healthcare utilization. In settings where there was general lower income, it showed that respondents failed to use the primary healthcare facilities and services available because they had financial constraints.

In China, income was also a determinant in the utilization of healthcare services. Zhang, Yu, He, and Wang (2018), studied status and determinants of healthcare utilization among older migrants into China. 13, 043 respondents were sampled for the study. The researchers considered, doctor visits, hospitalization, and local inpatient care as what made up utilization of primary healthcare. The results showed that income was one of the leading determinants of primary healthcare usage. It was also evident in that study that migrants who earned less than 3000 yuan were not so willing to visit a doctor when they were unwell but those with an income of more than 7000 yuan were willing to visit a doctor when they fell sick.

Another study also found income as a determinant of healthcare utilization. Baker and Lui (2006) asserted from their study that economic status had a relationship with utilization of primary healthcare usage. The researchers compared three rural clinics and the patients they attended to and their utilization of services and facilities available in these three Honduran villages. The results of the study showed that among these three villages, economic status could explain why the dwellers of these communities were either using or not using the services available to them in the clinics of interest in the study.

There is a study that found contrary finding with respect to income as a determinant of healthcare utilization. Geitona, Zavras, and Kyriopoulos (2007) in their Greek study found that income was not a significant determinant of healthcare utilization. The researchers asserted that this result could be a result of the insurance cover that gives free access to primary health care and even free laboratory and diagnostics services during their hospital stay.

2.5.0 Hypotheses

1. Age will have a positive relationship with the usage of healthcare.

2. Education will have a positive relationship with usage of healthcare.

3. Access will have a positive relationship with usage of healthcare.

4. Income will have a positive relationship with usage of healthcare.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

The approach and methodology adapted in the study have been defined in this chapter. This study highlights the importance of capturing the various elements (determinants) of primary healthcare utilization at the Gomoa East sub-district to know the state of healthcare delivery in the rural communities.

Also, in this chapter, a detailed description of the research design, research setting, sample size, sample technique, sources of data and the population from which the data was collected have been discussed. The ethical considerations observed during the sampling of the data have been outlined.

3.1 Research design

According to Yin (2003), a case study design can be used considering some four factors that includes the researcher's inability to manipulate the behavior of those involved in the study. The case study design adapted in this study has been proven valuable for research into health science. Due to its flexibility and rigor, it has led to the development of theories, evaluation of programs and the creation of interventions (Baxter & Jack 2008). This study was designed using the case study approach.

3.2 Research setting

The sub-district is located in the southern part of Gomoa East sub district in Central Region and situated between latitude 3014' North and 3035' North and longtitude 0016 West and 0042' West. Okyereko Health Centre is uniquely situated on Winneba-Accra road which shares boundaries on the North by Gomoa Potsin, South by Winneba, East by Atekyedo and West by Ansaful. It is 45 kilometers drive from Winneba roundabout. Moreover, the newly established Asebu CHPS compound situated on the Winneba-Swedru road, also shares boundaries on the north by Effutu Ansaful and on the South by Awombrew. The sub-district is located in the Gomoa East district in the Central Region of Ghana. Gomoa East District is one of the 17 districts in the Central Region of Ghana. Its capital is Gomoa Afransi. It has 24 towns with population of 207,071 with 108,748 females and 52,898 households (Gomoa East District Assembly [GEDA], 2015).

The major economic activity of the people is mainly agriculture which engages over 60% of the labour force in the sub district. However, a small percentage of the population engage in aqua-culture as a source of livelihood. The ecology of the district encourages the cultivation of crops such as cassava, maize, rice, pineapple, pawpaw, yam, plantain and vegetables. To a great extent, the farmers depend on the two major rainy seasons for irrigation and production of crops (GEDA, 2015).

In the district has a low level of education with 18.5% of the inhabitants representing 142,877 have only primary school education (Ghana Statistical Service, 2015b). The sub district has both private and public educational facilities with the public basic school been predominant. Currently, the sub-district has recorded a total of twelve (12) schools from which five (5) are public school and seven (7) private schools. Four (4) of the five (5) public schools such as

Oguaakrom/Nyakuadze D/A Primary/J.H.S school, Chapess D/A Primary, J.H.S school, Pomadze/Asebu D/A Primary/J.H.S school and Mpota/Mampong/Adawukwa D/A Primary/J.H.S school were built by the District Assembly of Gomoa East District. The remaining one (1) is Okyereko Methodist Primary/J.H.S school built by Methodist Church of Ghana. The schools are greatly contributing to the development of the sub-district.

According to the Gomoa East District Assembly report (2015), health care delivery in the district is at two levels, the community and sub-district levels. Okyereko Health Centre is the only health facility in the Sub-district endorsed by Ghana Health Service to render health services to the community members. Malaria is a major health problem in the sub-district. Possible factor leading to this situation is high breeding of mosquitoes because of the existence of rice farm, waterlogged areas and Ayensu river in the Sub-district precisely Gomoa Okyereko, GomoaAdawukwa,Gomoa Mampong and GomoaMpota community. Other factor such as poor accommodation and temporal structures exposes community members to mosquitoes which mostly lead to malaria.

There is a Herbal Clinic registered as Lucky Herbal Clinic which alternatively renders health service to client who prefers herbal treatment. This is however, not endorsed by Ghana Health Service. The herbal clinic is located at Gomoa Oguaakrom in the sub-district and attracts people across Ghana and neighbouring countries.

Figure 3.1 A map of the subdistrict

3.3 Research approach

This study used the mixed method approach which is a combination of both quantitative and qualitative research approach. From the work of Cresswell (2009), it is believed that the combination of methods provides a better understanding than using either the quantitative or qualitative method alone. Qualitative research is a method used in simplifying and managing data without destroying complexity and context (Atieno, 2009). The use of the qualitative approach allowed the evaluation of the complexity of the information gathered and ensured that the conclusion or findings will take into accounts a combination of the uniqueness and general factors. Also, the use of quantitative approach in the data gathering and its subsequent analysis provided a general understanding of the research problem which informed the direction of the qualitative interviews. Mixed method was used because this method of data collection and

analysis made it easy to check for validity and reliability of the survey data. The adoption of this method helped to deal with the weaknesses of both quantitative and qualitative methods when used alone.

3.4 Population

A research population is known as a well-defined collection of individuals or objects known to have similar characteristics (Ritchie, Lewis, Nicholls & Ormston, 2013). The population of the district according to the 2010 population and housing census is about 207,071. This figure consists of 47.5% males and 52.7% females at a growth rate of 2.5 (GEDA, 2016). This study generally targeted the people who reside in the district since they are the direct beneficiaries of the primary health care facilities and services provided. The population of the Okyereko and Adawukwa is 1228 and 819. The target population for the study excludes the population between 0-11 years which makes the population for both communities 1,166 and 761 respectively

3.5 Sampling technique

According to Singh and Masuku (2014), sampling technique describes method for the selection of individuals on which information are to be made. The research used purposive sampling technique which is a non-probability sampling technique for the collection of qualitative data. This non-probability technique was adapted for this study because it tends to focus on small samples and is intended to examine a real life phenomenon, not to make statistical inferences in relation to the wider population (Taherdoost, 2016). The researcher used purposive sampling technique to identify the individuals' capability to respond to the studies, effort to explore the factors, prospects and challenges of sustainable health practices.

The data collection was done in two folds. A pre-tested questionnaire used in the similar studies was used and divided into three sections: personal and socio-demographic information, factors influencing the use of primary healthcare and the identification of their health seeking behaviour. An unstructured questionnaire was used to assess the perception of the populace on primary healthcare. This included four open-ended questions.

3.6 Sample size

According to Shank and Cutchin (2010), a sample is the subset of a population that is used to represent the entire group of a whole. The researcher sampled two hundred (200) respondents from the two selected communities including seventy men (70), one hundred and thirty women (130). Also, twelve community members were interviewed six from each community. One nurse and two auxiliary staff from the health centre were also interviewed. The sample size was chosen to acquire a comprehensive information from the end users of the primary health care delivered and the providers of the health care.

3.7 Sources of data

They are un-interpreted materials on which a decision is to be based, and depend on facts which may include anything known to be true or exist (Slam, Mohajan & Datta, 2011).The two main sources of data used for the study was from primary and secondary sources. The primary data was collected directly from the respondents who reside in the study area. The data was directly retrieved from the inhabitants comprised of diverse respondents including women and men. Some of the respondents answered the questionnaires designed for the survey and others especially uneducated were interviewed in the gathering of the data.

The secondary data was, however, retrieved from previous studies that have been carried out in the Gomoa East District Assembly, Ghana Health Service, Ghana Statistical Service and other valid publications serving as the basis for comparison and analysis of the findings from this study.

3.8 Data analysis

The analysis of the obtained qualitative data is an imperative aspect of the research. The collected data after being cleaned and organized must be analyzed to reach a conclusion based on the aim of the study. The data received from conducting the interviews were evaluated based on the objectives and theme of this study using a thematic content analysis.The thematic analysis used in the study provides a flexible and useful research tool which can potentially provide a rich and detailed, yet complex account of data (Braun & Clarke 2006). The results from the primary data analysis were compared with the secondary data to provide a comprehensive analysis of the study. The quantitative analysis was done using the Statistical Package for Social Science (SPSS) version 20. Specifically, the Binary Logistic regression and Chi square were used to analyse data on the second and third objectives respectively.

3.9 Research Limitations

This study was, however, constrained by some limitations, which are well noted. Some of these challenges include the reluctance of the health care staff to provide clear and precise answers/information touching seemingly sensitive issues. Also, as a qualitative study of this nature would require audio recordings to capture even the manner and mood with which interviews responses are given. Some respondents may refuse this due to personal reasons.

With these limitations, however, the researcher employed all necessary, effective and efficient means to arrive at reliable findings for informed decision-making. This does not therefore make it inappropriate to generalize from its empirical findings.

3.10 Ethical Considerations

Ethics in research regards norms of conduct distinguishing between what is acceptable and what is not acceptable in research. Works or studies of other people used in this research have been duly acknowledged through proper citation. Data collected from the selected sample was kept confidential. The anonymity of the respondents was assured through the use of pseudonym.

CHAPTER FOUR

DISCUSSION OF STUDY FINDINGS

4.0 Introduction

This chapter focuses on the results and findings of the study. The study sought to access respondents' perceptions on primary healthcare, identify the various determinants that influence the usage of the primary health care, and to identify the health seeking behaviours of the people of the Gomoa-East sub district. Qualitative data in the form of responses from the interviews conducted were gathered from two communities- Okyereko and Adawukwa located in the sub district. The respondents also answered questionnaires designed for the survey. The researcher sampled two hundred (200) respondents from the two selected communities including seventy men (70), one hundred and thirty women (130). Also, twelve (12) community members were interviewed- six (6) from each community. One (1) nurse and two (2) auxiliary staff from the health centre were also interviewed. The presentations of the research results were done in accordance with the themes highlighting the research objectives. In this discussion, findings are triangulated with health care utilization reports and other relevant secondary data such as prior empirical and theoretical studies reviewed in chapter two.

Demographic characteristics of the respondents was obtained and presented below for the purpose of understanding the general outlook of the people in the community. The perception of the health care provided was discussed into details. The study further discussed the factors that influence the patronage of the primary health care facilities and the identification of the behaviour of the people in terms of seeking health care. Striking responses from the interviews that buttress the findings of the study are also presented in italics to contextualize the discussion.

4.1 Socio- demographic characteristics of respondents

Table 4.1 Analysis of distribution of respondents in the communities involved in this study

Communities	Frequency	Percentage(%)
Adawukwa	88	49.4
Okyereko	90	50.6

Source: Field Data (2019)

The participants were residents of Okyereko and Adawukwa located in the Gomoa East sub district. Eighty-Eight respondents (representing 49.4%) were surveyed at Adawukwa and ninety respondents (representing 50.6%) from Okyereko took part in the study. This is displayed in Table 4.1 above.

Table 4.2 Analysis of respondents' gender

Gender	Frequency	Percentage(%)
Male	50	28.1
Female	126	70.8

Source: Field Data (2019)

From Table 4.2 above, it can be observed that the number of female respondents form a larger percentage of the participants as compared the male respondent who took part in the study.

Table 4.3 Analysis of respondents' age

Age	Frequency	Percentage(%)
18-23	40	22.5
24-29	52	29.2
30-35	33	18.5
36-41	25	14.0
Above 40	27	15.2

Source: Field Data (2019)

In Table 4.3 above, combined respondents from both Okyereko and Adawukwa were within the following age ranges; 18-23 years - 22.5%, 24-29 years - 29.2%, 30-35 years - 18.5%, 36 – 41 years - 14.0% and above 40 years - 15.2%.

Table 4.4 Analysis of respondents' education level

Education levels	Frequency	Percentage(%)
None	27	15.2
Primary	44	24.7
Secondary	49	27.5
Tertiary	6	3.4
Other	47	26.4

Source: Field Data (2019)

From Table 4.4 above, number of respondents who have not had any form of formal education were 27 representing 15%, basic education 44 respondents representing 24.7%, secondary education 49 respondents representing 27.5% and tertiary education 6 respondents representing 3.4%

Table 4.5 Analysis of respondents' occupation

Occupation	Frequency	Percentage(%)
Formal	11	6.2
Self- employment	109	61.2
Informal	8	4.5
Unemployed	49	27.5

Source: Field Data (2019)

As shown in Table 4.5 above, majority of the respondents are self-employed 100 (61.2%), those found in the formal sector were 11 representing 6.2% whilst workers in the informal sector formed 8 representing 4.5%. The unemployed respondents were made up of 27.5% representing 49 of the respondents.

Table 4.6 Analysis of respondents' length of stay in the community

Length of stay	Frequency	Percentage(%)
1 - 3 years	30	16.9
7 - 9 years	28	15.8
4 - 6 years	29	16.4
Above10 years	90	50.8

Source: Field Data (2019)

Displayed in Table 4.6 above, is respondents' length of stay in the communities. It is seen that 90 representing 50.8% who have lived in the community for more than 10 years. The respondents who have stayed in the community within 1 - 3 years are 30 (16.9%), 7 - 9 years (15.8%) and 4 - 6 years (16.4%).

Table 4.7 Analysis of respondents' marital status

Marital Status	Frequency	Percentage(%)
Single	70	39.3
Married	93	52.2
Divorced	8	4.5
Widowed	5	2.8

Source: Field Data (2019)

Table 4.7 above shows 70 respondents (39.3%) were single, 93 respondents (52.2%) were married, 8 respondents (4.5%) were divorced and 5 respondents (2.8) were widowed.

Table 4.8 Analysis of respondents' average monthly income (AMI) of the respondents

AMI	Frequency	Percentage(%)
< 500	107	60.1
500 – 1000	28	15.7
1001 – 2000	2	1.1
>2000	2	1.1

Source: Field Data (2019)

On the monthly income of the respondents, Table 4.8 above shows that, 60.1% of them earn less than five hundred Ghana cedis with 15.7% earning between five hundred to one thousand Ghana Cedis. Again, 1.1% earn between one thousand and two thousand Ghana Cedis as shown in Table 4.8.

Table 4.9 Analysis of respondents' religion

Religion	Frequency	Percentage(%)
Christian	150	84.3
Traditionalist	10	5.6
Muslim	14	7.9

Source: Field Data (2019)

In Table 4.9 above, the dominant religion found in both communities was Christianity - 84% whereas Islam and traditional had 7.9% and 5.6% respectively.

Table 4.10 Analysis of respondents with and without NHIS registration

NHIS	Frequency	Percentage(%)
Yes	134	75.3
No	29	16.3

Source: Field Data (2019)

From the responses given, it is evident that a good number of the respondents depend highly on the National Health Insurance Scheme (NHIS) when seeking health care with 75.3% forming the majority and 16.3% confirming that they do not use NHIS. This is displayed in Table 4.10 above.

4.2 Objective One: Perception of primary healthcare

The perception is key determinant in the utilization of primary health care (Bakker, 2006). Perception of respondents were examined in this study under four sub-heading in order to have a comprehensive overview of the factors influencing the utilization of healthcare.

4.2.1 Understanding of primary health care

Under the present theme, the researcher assessed respondents understanding and their knowledge of primary health care to ascertain the level of awareness of primary health care delivery to the community. The analysis of the responses obtained from the survey established that the people lacked understanding of the nature of primary health care. From the responses of most of the interviewees, there is an indication of the lack of knowledge of primary health care. The present finding shows that, there is a lack of education and sensitization of primary health care amongst the community members. When the interviewer asked respondents' understanding of primary health care,

One female respondent replied:

> *" No please, I do not know."*

Another person responded:

> *"Please can you explain to me what primary healthcare is all about, because I do not know what it means."*

These responses confirm the research carried out by Siddiqui, Siddiqui and Sohag (2011) in low economic countries. Their results showed that respondents did not know about the availability of the primary health care centers and for those who knew did not know of the full benefits of using the health centers. It also stands to reason that, in such low economic area health education are usually on the low or even none-existent. Hence, they concluded that continuous education was the way to improve the understanding of primary health care (Siddiqui, *et al.*, 2011).

4.2.2 Patronage of health facility

There was a discovery on the patronage of primary health centre in the community. The respondents iterated that the primary healthcare facility is the immediate point of call when faced with health issues since it is located within the community. The proximity of the healthcare facility to the people within the community appear to encourage its frequent patronage. This finding in line with Bailey and Philips (1990) who described distance as being one of the foremost factors that discourage or encourage usage of primary healthcare. Their conclusion was that utilization of primary healthcare facilities increased when it was in close proximity to the users.

4.2.3 Perception of quality primary health care

From the study, most of the respondents confirmed that the services rendered at the health facility were of good quality. Andersen and Newman's (1973) in his model describes the factors that will motivate an individual to seek medical services or help. The enabling factors such as the delivery of quality health care form a basis of encouragement for inhabitants of the community to utilize the health facility.

A respondent informed:

> *"I am provided with the medication I need and the nurses advise me on how to remain healthy always."*

A respondent shared an experience saying:

> *"I was seriously ill one evening and was rushed to this facility. The swift response by the nurses at post was laudable. So, I will say that they provide quality emergency services and respond immediately to reported health.*"

Some attributed the provision of quality health care to the availability of medicine prescribed for them, the education given to them by the nurses, how early they are attended to when they report to the hospital and the attention given to pregnant women. Generally, the response from the inhabitants largely proves that the facility within Okyereko and Adawukwa provides some appreciable level of quality health care.

4.2.4 Choice between private and public health care

The researcher deduced from the responses given by the interviewees that they would prefer to visit the public health centre than to visit the private health centre. The choice was mostly as a result of economic reasons; many narrated that the services rendered at the private facility comes at an expensive cost due to their unwillingness to accept the National Health Insurance (NHIS) Card. Therefore, majority choose to patronize the public health facility in order to access the benefits of the NHIS.

One respondent said:

"They accept the National Health Insurance Card but the private clinics do not accept the card."

Male Respondent stated:

"The cost of treatment and medications are affordable in the public health facilities"

Income has also been found to determine whether primary healthcare facilities will be utilized or otherwise. This was highlighted in the work of Olayiwola and Adeleye (2005) who mentioned that the cost of health services has proven to be a barrier to access and usage of primary healthcare.

4.3 Objective Two: Factors influencing utilization of primary healthcare

Under the present objective, the researcher sought to determine the factors that influence the use primary healthcare facilities as well as the relationship between these factors and the utilization. The Chi square as displayed in Table 4.11 was used to determine the relationship. The Chi Square ($\chi 2 = 34.269$, $p(.024) < .05$) revealed a positive and significant relationship exists between the influencing factors and the utilization of primary healthcare facilities.

Table 4.11 Chi square showing the relationship among the factors influencing the utilization of primary healthcare

Variable		Primary Healthcare Utilization (n%)		$\chi 2$	p-value
		Yes	No		
PrimaryHealthcare Utilization	Yes	54	14	34.269	.024
	No	19	37		

Source: Field Data (2019) **n=121** **p<0.05**

4.3.1 Regression Analysis

The Binary Logistic regression was used to analyze the strength of the relationship between the individual factors (age, education, income, accessibility) and the level of utilization. The displayed information in Table 4.12 shows the responses of factors that affect their decision to use the health facility in the community. The distance of the health facility to the inhabitants plays a key role in the accessibility of the health facility. As many as 43 respondents out of 119 respondents (representing 36.2%) mentioned that the proximity of the facility influenced its utilization. Also, 30 respondents representing 25.2% out of the total number of respondents confirmed that the availability of the NHIS makes health care affordable, hence, the use of the

health care facility. The figures displayed under the average monthly income shows clearly that 76.6% of the respondent earn less than five hundred Ghana cedis in a month. Considering the cost in the provision of health care, this statistic shows the financial state of the people will not readily encourage them to seek treatment for their illnesses in order to escape the possible high cost of treatment. The NHIS has currently become one of the solutions to providing affordable health care to the rural folks. There were 11 respondents (9.2%) of the total responses data which depicts that the availability of the staff is not encouraging. Quality of health care provided at the facility is represented by 26 respondents (21.8%) who confirmed that the state of the provision of healthcare is influential in its utilization. About 9 respondents (7.6%) agree that the availability of logistics and drugs at the facility played an important role in their use of the health facility. The finding draws on the Healthcare Utilization Model by Anderson and Newman (1973). The model examined the factors that will allow individuals to access and use primary health care. Amongst these factors are the enabling factors; it encapsulates the available means (possession of insurance, financial wherewithal, and social interaction) with which one accesses healthcare as well as the level of knowledge (the extent and quality of the healthcare service, travel distance and cost travelling to receive healthcare) a person has about healthcare services- the availability or absence of these enabling factors encourage or discourage the utilization of primary healthcare. To fully assess the various determinants in the utilization of primary health care, the binary logistic regression and chi square tools were used.

Table 4.12: Binary Logistic Regression showing the strength of the relationship among the factors and the utilization of primary healthcare

Explanatory Variables	n(%)	Coefficient	Odd Ratio	95% C.I Lower – Upper
Age (years)				
18-23	24(19.5)	1.404	4.070	.741 – 22.362
24-29	35(28.2)	1.541	4.670	.876 – 24.911
30-35	22(17.7)	-.568	.567	.112 – 2.864
36-41	21(16.9)	1.587	4.890	1.067 – 22.37
>41(ref)	22(17.7)			
Total	**124(100)**			
Level of Education				
None	19(15.3)	.121	1.129	.237 – 5.370
Primary	33(26.6)	-.254	.776	.241 – 2.492
Secondary	35(28.2)	-1.549	.213	.057 - .789
Tertiary	5(4.1)	-.769	.464	.050 – 4.326
Other (ref)	32(25.8)			
Total	**124(100)**			
Marital Status	52(40.9)	.062	1.064	.641 – 7.281
Single	5(3.9)	-.113	.894	.946 – 5.361
Divorced	64(50.4)	.727	2.069	.293 – 9.110
Married	5(3.9)	.089	1.093	.621 – 3.480
Widowed	1(0.9)			
Other(ref)	**127(100)**			
Total				
Average Monthly Income				
< 500	95(76.6)	19.576	3.173	.049 – 1.689
500 – 1000	26(21.0)	20.056	5.131	.752 – 9.84
1001 - 2000	2(1.6)	20.077	5.239	1.321 – 2.563
>2000(ref)	1(0.8)			
Total	**124(100)**			
Accessibility				
Proximity	43(36.2)	-22.763	.962	.389 – 1.562
Availability of NHIS	30(25.2)	-21.747	.901	.719 – 4.563
Availability of Staff	11(9.2)	-21.584	.102	.222- .978
Quality Service	26(21.8)	-22.599	.305	2.541 – 5.832
Availability Logistics/ Drugs	8(6.7)	-23.269	.792	.625 – 1.974
Other(ref)	1(0.9)			
Total	**119(100)**			

Source: Field Data (2019) **C.I = Confidence Interval**

4.3.1.1 Accessibility of healthcare facility

Based on the Anderson and Newman model and the findings of the study, the accessibility of the healthcare facility is affected by some enabling factors. These factors are the proximity, provision of quality services, availability of NHIS, available of staff and availability of the health facility to the people in the community.

4.3.1.1.1 Proximity

From the results displayed in Table 4.12, 43 respondents out of 119 representing 36.2% of the number of respondents attributed their utilization of the healthcare facility to the travel distance of the facility. From the analysis the corresponding Odd Ratio indicates that, when a primary healthcare facility is in close proximity, users are 9 times more likely to utilize its services. Indeed, proximity had the highest percentages (36.2%) in terms of frequency giving an indication that the location of the facility is of prime concern to the inhabitants of the community. One may allude to emergency medical conditions as the reason why respondents cite proximity as a consideration for utilization of primary healthcare. This observation made in this study is in agreement with a similar study by Buor (2003) at Ahafo - Ano South district in the Bono Region of Ghana. Buor concluded after he conducted regression analysis that distance was the most important determinant of the use of primary healthcare in that district.

4.3.1.1.2 Provision of Quality Services

The number of participants who responded positively to provision of quality health care were 26 in number and is represented as 21.8%. The resulting value of the Odd Ratio shows that when there is provision of quality services in primary healthcare facilities, users are 3 times more likely to utilize the services. The participants agreed that the quality of health services provided at the facility to a higher extent encourages their use of the facility. Gage *et al.*, (2018) aver that

quality of the healthcare service influenced the utilization of primary healthcare facilities from their findings in Haiti. Therefore, their study supports the findings of this work.

4.3.1.1.3 Availability of NHIS

Out of the total number of respondents, 30 respondents attributed their utilization of the health facility to the availability of the NHIS services offered at the facility. This figure is expressed as 25.2%. From the analysis the corresponding Odd Ratio indicates that, when a there is availability of NHIS, respondents are 9 times more likely to utilize services of primary health care facilities. In the recent past, health care delivery in Ghana was based on the cash and carry system. This system dealt directly with making physical cash payment before health needs are attended to. The introduction of the NHIS in the year 2003 as a solution to curtail the cash and carry system nationwide and encouraged easy access to health care by Ghanaians (Ghana Health Service, 2003). The gradual shift from the cash and carry system to the NHIS approach of health care delivery has become linked to the increase in the utilization of health care facility across the country. The availability and access of the NHIS which is an enabling factor can influence the use of the health facility. Fortunately, the health facility in the Okyereko and Adawukwa communities provides the NHIS services. The availability of the NHIS services has influenced 25.2% of the respondents to use the health care facility when they are ill.

4.3.1.1.4 Availability of Staff

The results captured in the Table 4.3 shows 11 respondents out of 119 representing 9.2% of the number of respondents attributed their utilization of the healthcare facility to the availability of staff in the facility. Judging from the analysis the corresponding Odd Ratio indicates that, when a there is availability of staff, respondents are 1 time more likely to utilize services of primary health care facilities. The result gives an indication of a relatively poor delivery of services by the staff of the facility. This can be attributed to the longer waiting time respondents are

subjected to when the facility is visited. Limited availability of staff could result in longer duration of the service and improper communication of the staff to the respondents due to stress. All of these factors form a composite experience for the respondents. The issues may be due to the inadequate health staff to cater for the number of growing health needs reported at the facility. Currently, in Ghana the high staff to patient ratio (nurses 1:627, doctors 1:8431 and midwives 1:907) (Ghana Health Service, 2017). These gloomy statics accentuate the reason why non availability of the staff is a reason for consideration for respondents. In as much as the respondents are at the receiving end of the services provided, the staff strength is likely to be inadequate thereby putting some pressure on the staff to deliver, hence, the present finding.

4.3.1.1.5 Availability of logistics and drugs

The number of participants who responded positively to the availability of logistics and drugs were 8 in number and is represented as 6.7%. Judging from the analysis the corresponding Odd Ratio indicates that, when a there is availability of logistics and drugs, respondents are 7 times more likely to utilize services of primary health care facilities. This finding may have resulted because, most of the respondents would like to utilize the health facilities where NHIS is accepted. It is therefore likely that, when drugs are not available, one may feel that he/she will be given drug prescription to purchase on their own. Hence then present finding.

4.3.1.2 Age

As shown in Table 4.12, about 24 respondents representing 19.5 % are within the ages of 18 to 23 years. A total of 35 respondents which represents 28.2% mentioned that their ages fall within 24 to 29 years. Also, 22 respondents, approximately 17.7 % fall within the ages 30 to 35 years. A number of 21 participants which is 16.6% revealed that they lie between the ages of 36 to

41years. The remaining respondents who are 22 in number representing 17.7% are above 41 years of age,. The Anderson and Newman model categorizes age as part of the first factors which exist before the individual's illness. This they believe will inhibit or encourage a person in the utilization of healthcare services- they term it as a predisposing factor. Judging from the analysis the corresponding Odd Ratio indicates that, being between the ages range of 24 – 29 years, is 7 times more likely to influence respondents to utilize services of primary health care facilities. Averagely, in Ghana, individuals who complete their tertiary education fall within the ages of 24 to 29 years (Ministry of Education, 2012). It is believed that the individuals within this age group have had formal education, therefore have an appreciation of seeking health care at the facility hence the high patronage of the facility. Meanwhile, the individuals within the ages of 18 to 23 years may have limited exposure to higher education which can limit their level of appreciation for utilization of primary healthcare facility. Also, the use of primary healthcare facility by the 24-29 years and 30-35 years (5 times more likely to influence the use primary healthcare facilities among respondents) could be associated with pregnancy related situations. This may be attributed to the high number of female respondents (126) in the study as compared to the male respondents involved (50). This finding of this study goes contrary to the work of Exavery, (2011) who argued that the elderly more likely to use primary health care facility as compared to the younger individuals. This finding revealed the contrary.

4.3.1.3 Education

The displayed information in Table 4.12 shows the responses of factors that affect their decision to use the health facility in the community. The level of education of the inhabitants plays a key role in the use of the health facility. As many as 19 participants out of 124 respondents

representing 15.3% mentioned that they have no formal education. A total of 33 respondents representing 26.6% have only primary (Basic) level education whiles 35 respondents representing 28.2% have secondary (Senior High School) level of education. Also, 5 respondents which is 4.1% have attained tertiary level education. The combination of the percentages of the level of education of the respondents who have had at least basic education to the tertiary level of education are 59.8% of the total number of respondents. The uneducated respondents are 40.2% of the total number of respondents. The statistics shows the community has a high number of uneducated folks. The finding is not totally shocking as the communities (Okyereko and Adawukwa) are rural farming communities. Comparatively, folks in such communities lack education relative to city folks. On the contrary, the level of education in this study does not necessarily affect the utilization of health care in the communities. This is proven in the logistic regression Table 4.12 shows the total number of respondents who visit the facilities as 119. Meanwhile, the total number of respondents who responded under education were 124. This gives an indication that the uneducated respondents use the facility as much as the educated respondents. It suggests that, one's level of formal education is largely inconsequential to their patronage of health facility. This finding is in agreement with the research by Geitona, Zavras, and Kyriopoulos (2007) who found education non-significant in their study of determinants of primary health care usage.

4.3.1.4 Average Monthly Income

Most of the respondents (76.6%) representing 95 respondents earn less than 500 Ghana Cedis as average monthly income. About 26 respondents representing 21.0% earn between 500 to 1000 Ghana Cedis as income and 2 respondents expressed as 1.6% earn 1001 to 2000 Ghana cedis.

Also, 1 respondent out of the total number of 124 earns an average of more than 2000 Ghana Cedis a month. The results of the financial strength the respondents show that most if not all are economically handicapped. This under normal circumstances will be a major deterrent to the utilization of the health care facility in the community. Rather, 119 respondents out of 124 respondents confirmed their use of the facility. This can be linked to the availability of the NHIS provided at the health care facility. Geitona, Zavras, and Kyriopoulos (2007) in their Greek study found that income was not a significant determinant of healthcare utilization. The researchers asserted that this result could be a result of the insurance cover that gives free access to primary health care. The study of Geitona, Zavras, and Kyriopoulos confirms the findings of this study.

4.4 Objective Three: Health seeking behaviours

The health seeking behaviour of the respondents to the utilization is a significant determinant in the utilization of health care facilities. When asked if any of the respondents has sought for healthcare in the last two years, 63% of the respondents confirmed they have been ill. This reveals that a good number of people in the community are largely prone to falling ill from time to time. The Azen (1991) theory of planned behaviour states that beliefs about a particular behaviour predict the intention and eventually the actual behaviour. Azen posits that in predicting behavioural intention, there are three major beliefs: attitudes, subjective norms, and perceived behavioural control. The findings from this study will be linked to this established theory to further ascertain if it supports the theory or otherwise.

Table 4.13 Chi square showing behviours in detecting the cause(s) of illness among respondents

		What was making you sick? (Predictors)													
		Headache	Fever	Hyper-tension	Skin Disease	Anaemia	Joint Pains	Diarrhoea	UTI	Cold	Malaria	Cough	Total	χ^2	p
How did you detect the cause of your illness? (Observed)	Friend	3	2	0	1	1	1	1	0	0	0	0	9	85.48	.317
	Neighbour	0	1	1	0	0	1	0	0	0	0	0	5		
	Relative	0	0	0	0	0	0	0	0	0	1	0	1		
	HealthCenter	14	8	1	6	0	6	4	0	1	23	1	63		
	Spiritual Leader	0	1	0	0	0	0	0	0	1	3	0	5		
	Herbalist	0	0	0	0	0	0	1	0	0	2	0	3		
	Self - Diagnosis	16	5	0	2	0	5	2	1	2	14	3	49		
	Chemical Seller	0	1	0	0	0	1	0	0	0	0	0	2		
	Other	0	1	0	0	0	0	0	0	0	0	0	1		
	Total	33	19	2	9	1	14	8	1	4	43	4	138		

Source: Field Data (2019) UTI = Urinary Tract Infection **n = 138**

From the Table 4.13 four leading illnesses in the community from the responses is malaria with a total response of 43 respondents, headache is second with 33 respondents confirming it. The third illness is fever which was revealed by 19 respondents; and 14 respondents reported joint pains. The 63 respondents detected the causes of their illnesses at the health centre whiles 49 respondents claimed they detected the illness by themselves. The recorded number of respondents (14) with joint pains may be associated with musculo-skeletal issues which could be attributed to their farming activities due to the manual nature of the activities. The Chi square value of 85.48 shows that there is a positive relationship between the health seeking behaviour of the respondents and the detection of their illness. The high figures are oscillating between the diagnosis of malaria and headache. These have, therefore, become the focus of discussion. The number of people who were diagnosed at the health facility shows the behaviour of the people. This indicates that the health facility (63 respondents) is the first point of call when inhabitants become ill. However, a good number of the participants resorted to self-diagnosis (49 respondents) their ailment. This must be highly discouraged by developing strategies. More work needs to be done in the area of educating the people on health seeking behaviours in order to curb self-diagnosis and visit the health facility to avoid possible fatalities.

Table 4.14 Chi square showing respondents' mode of obtaining medication when unwell

		What was making you sick? (Predictors)													
		Headache	Fever	Hyper-tension	Skin Disease	Anaemia	Joint Pains	Diarrhoea	UTI	Cold	Malaria	Cough	Total	χ^2	p
Have you bought a drug without prescription? (Observed)	Yes	22	10	0	8	1	9	3	1	2	29	3	88	5.799	.832
	No	8	6	1	1	0	3	2	0	1	12	1	35		
	otal	30	16	1	9	1	12	5	1	3	41	4	123		

Source: Field Data (2019) **n = 123**

From Table 4.14 , 88 respondents out of a total of 123 respondents reported that they buy drugs without prescription when they experience signs of an illness. Of these figures, 2 respondents self-medicate when they have headaches and 29 respondents self-medicate when they experience symptoms of malaria. Also, for joint pains, 9 respondents were recorded and 10 people confirmed they self-medicate when they have symptoms of fever. These findings give room for concern since 72% of the total number affirmed self-medication as a health seeking behaviour. The possible attribution of this health seeking behaviour practiced by the people could be as a result of lack of proper education, the quality of healthcare provided at the facility and the number of health facilities located in the community. Indeed, there could be a health facility in the community which could be easily accessible. However, when the staff strength is inadequate or the facility cannot accommodate the growing number of sick persons, these people are likely to seek treatment on their own to escape the inconveniences associated with seeking health care in the facility. Hence the present finding.

Table 4.15 Chi square showing respondents' mode of seeking healthcare when unwell

		What was making you sick? (Predictors)													
		Headache	Fever	Hyper-tension	Skin Disease	Anaemia	Joint Pains	Diarrhoea	UTI	Cold	Malaria	Cough	Total	χ^2	p
What is your immediate action when you are unwell ?	SelfMedicate	16	12	1	2	0	6	3	0	2	16	3	61	53.66	.336
	Spiritual Healing	1	0	0	0	0	1	0	0	0	1	0	3		
	Herbal Preparation	0	1	0	0	0	3	1	0	1	2	0	8		
	Rest	4	3	1	3	0	1	0	0	0	4	1	17		
	VisitClinic	12	2	0	3	1	3	4	1	1	20	0	47		
	Other	0	0	0	1	0	0	0	0	0	0	0	1		
	Total	33	18	2	9	1	14	8	1	4	43	4	137		

Source: Field Data (2019) **n = 137**

Again, self-medication is prevalent in this table at a total of 61 respondents agreeing to the fact that they resort to self-medication when they are unwell. The health facility is visited by 47 respondents when they feel unwell. A total of 17 respondents replied that they rest when they are unwell. The use of spiritual healing was reported by 4 respondents and herbal preparations was reported by 8 respondents- these in the minority of immediate actions sought by the respondents. The Chi square value shows a positive relationship between the immediate action when unwell and the type of illness it is associated with.

Table 4.16 Chi square showing respondents' behaviours in staying healthy in the long term

		What was making you sick? (Predictors)													
		Headache	Fever	Hyper-tension	Skin Disease	Anaemia	Joint Pains	Diarrhoea	UTI	Cold	Malaria	Cough	Total	χ^2	p
What strategies do you adopt to live in good health ? (Observed)	Balanced Diet	16	8	1	3	1	3	2	0	3	20	3	60	5.799	.832
	Clean Drinking Water	6	6	1	0	0	3	3	0	1	8	1	29		
	Exercise	1	2	0	3	0	1	0	0	0	4	0	11		
	Enough Rest	0	1	0	0	0	1	1	0	0	2	0	5		
	Sleep in ITN	6	1	0	0	0	5	1	1	0	7	0	21		
	Avoid Alcohol	1	0	0	1	0	0	0	0	0	1	0	3		
	Avoid Smoking	2	0	0	0	0	0	1	0	0	0	0	3		
	Other	1	0	0	0	0	0	0	0	0	1	0	2		
	Total	33	18	2	7	1	13	8	1	4	43	4	134		

Source: Field Data (2019) ITN = Insecticide Treated Net **n = 134**

From table 4.16 ,60 respondents out of a total of 134 respondents revealed that the adoption of balance diet will allow them to live with good health. Also, 29 respondents attributed the good health to drinking clean water. A number of 21 respondents answered that sleeping in an ITN will ensure their good health. Additionally, 11 respondents agreed that exercising is the way to live a good healthy life. The chi square value (5.799) shows a positive relationship between the adopted strategies to live in good health and the type of illness it is associated with. There is a popular truism which states that what you eat reflects on your body. This statement affirms the responses given by the majority of the respondents. Also, it is known that the circulation of blood is imperative in the effective distribution of nutrients to every part of the body. Exercise has proven to facilitate this process hence a good strategy to ensure a good healthy life.

4.6 Summary

In summary, the key findings which responds to the three major objectives of the study have been established. From this study, it can be concluded that the three top factors the influence the use of the health facility are the proximity of the facility, the availability of quality health services and the availability of the NHIS services.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.0 Introduction

This chapter summarizes the principal findings from the study of the determinants in the utilization of primary health care in the Gomoa-East sub district. The approach or methodology employed for the study including the conclusion from the findings of the study were also captured in this chapter. An outline of the recommendations that will improve the utilization of the primary health care facility through the policies formulated by the government is written in this chapter.

5.1 Summary of the study

This study was carried out in two communities called Okyereko and Adawukwa located in the Gomoa East sub district in the Central region of Ghana. To establish the determinants of the utilization of primary health care in these communities, three main objectives were used. These specific objectives assessed the perception of the populace on primary health care, identified the factors that influenced the use of primary health care and identified the health seeking behaviours of the people. In total, sixteen respondents were interviewed. The researcher sampled two hundred (200) respondents including three (3) staff of the health facility for the study.

The study used the mixed method approach which is a combination of both quantitative and qualitative research approach. The data received from conducting the interviews and survey was evaluated based on the objectives and theme of this study using a thematic content analysis. The quantitative analysis of the data was done using the Statistical Package for Social Science (SPSS)

version 20. The Logistic regression and Chi square which are tools in the SPSS were used to analyze data on the second and third objectives respectively.

The findings of this study were categorized into three major parts according to the stated objectives. The level of perception of primary health care was assessed based on their knowledge, quality of service provided and patronage of the facility. The findings revealed the lack of education and sensitization of primary health care amongst the people in the community. A high number of respondents expressed some level of ignorance to the basic understanding of primary health care even though they patronize the facility. The findings under the factors that influence the utilization of the primary health care shows that accessibility and the age of the respondents were the major factors that contributed to the utilization of the facility. Meanwhile, the level of education and Income were found as non-significant to the utilization of the health care facility. The health seeking behaviour in the diagnosis of illnesses shows that an appreciable number of respondents get diagnosed at the health facility. Also, a valuable number of respondents resort to self-diagnosis. Majority of the respondents confessed that they bought drugs without prescription. As part of the health seeking behaviours of the respondents, most agreed to the fact that the regular practice of eating a balanced diet can promote good health.

From this study, it can be concluded that the three top factors influence the use of the health facility are the proximity of the facility, the availability of quality health services and the availability of the NHIS services. Also, the findings on perception shows that, lack of education and sensitization of primary health care in the community. The two prevalent health seeking behaviours of the respondents in the utilization of primary health care are attributed to their visit to the facility and the prediction of illnesses by themselves (self-diagnosis and self-medication).

5.2 Conclusion

The results from the study show that the basic perception of primary health care in the community is lacking. A great number of the respondents have little or no knowledge and understanding concerning the importance of primary health care. Also, the majority have concluded that they would prefer the public health care facility to the private health care facility due to the perception that the public health facility is affordable. This perception can be accepted based on the likelihood that the public health facility has the NHIS services available.

This study sought to determine the significant factors that affect the utilization of primary health care facility in the Gomoa East sub district. The study has confirmed that the key factors that determine the utilization of health care in the sub district are mainly the accessibility to the health facility and the age of the person. On the contrary, the observation made from the findings on level of education and the average monthly income showed a non-significant role as determinants of the utilization primary health care. This finding confirms and disproves the stated hypothesis in chapter two. The accessibility of the facility to the community folks and the age of the have been found to confirm the hypothesis. However, the level of education of the people and the average income were not confirmed by the hypothesis in this study.

The results from the study, draws our attention to the issue of self-medication and self-diagnosis as a major flaw in the health seeking behaviour of the community folks. Even though 46% report the health facility when they become ill, another 36% self-diagnose and self-medicate. This significant number of the participants diagnose the illness by themselves and this must be highly discouraged by developing strategies to curb this menace.

5.3 Recommendation

Although this study attempted to explore the factors that influence the utilization of healthcare facilities in the Gomoa East sub district as well as the health seeking behaviours of the people, some unique findings were made that can inhibit the utilization of these healthcare facilities. Hence, this section offers some recommendations to address challenges. The study suggest that the ministry of health intensify health education in the rural communities so as to increase the utilization of primary healthcare services. Also, the Government Ghana (GoG) should strengthen policies of construction of more primary healthcare facilities so as to bring access close to the door step of the people. As noted in this study, proximity of the health care facilities represents the key factor that influences utilization.

Again, since a nations' health is its wealth, the government should chart innovative policies that will encourage more corporations to set corporate social responsibility agenda on the issues of rural health education, augment existing primary healthcare facilities by constructing more especially in the rural communities, and sponsoring more health education among other things. These suggestions can ameliorate the present situation thereby increasing accessibility and increasing utilization. Finally, yet importantly, future researchers may expand on the number of communities to encapsulate other rural communities as this can bring corroborating or contrasting evidence to this study.

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APPENDIX

Questionnaire

Questionnaire #

Hello, I am an MBA student of the Public Administration and Health Service Management Department of the University of Ghana. I am conducting a survey concerning the determinants of primary health care utilization in the Gomoa East sub-district. I would be very thankful if you answer this questionnaire. Any personal information that you provide will not be kept confidential. Your participation is very valuable and help improve healthcare delivery in your community. This would not take more than ten minutes. Thank you

SECTION A

1.Age

☐ 18-23yrs ☐ 24-29yrs

☐ 30-35 ☐ 35-40yrs

☐ Above 40 years

2.Gender ☐ Male ☐ Female

3 . Place of residence…….

4. How long have you stayed in this community?

☐ 1-3 years ☐ 7-9 years

☐ 4-6 years ☐ Above 10 years

5.What is highest level of education

☐ None ☐ Secondary

☐ Primary ☐ Tertiary

☐ Other specify……

6. Marital Status

☐ Single ☐ Divorced

☐ Married ☐ Widowed

☐ Other specify……

7.What kind of employment are you in

☐ Formal ☐ Self-employed

☐ Informal ☐ Unemployed

8.What is your average monthly income

☐ Less than 500 ☐ 1001 – 200

☐ 500-1000 ☐ above 2000

9.What is your Religion?

☐ Christian ☐ Traditionalist

☐ Moslem Other Specify…….

10. Do you have NHIS? ☐ Yes ☐ No

Section B: Factors influencing primary health care utilization

11.Have you used any health facilities when sick

☐ Yes ☐ No

12. If Yes, what kind of health facility did you use?

☐ Hospital ☐ CHPS compound ☐ chemical shop

☐ Clinic ☐ Health Centre ☐ Other Specify …….

13.What factors influenced the use of this health facility (tick as many as you want)

☐ Proximity ☐ Availability of NHIS

☐ Availability of Staff ☐ Quality Service

☐ Availability of logistics and drug ☐ Other ☐ Specify

14. If No, how do you treat yourself when you fall sick

☐ Self-Medication ☐ Prayers/Healing service

☐ Traditional medicine ☐ Visiting the shrine

☐ Other Specify…….

15.How often do you attend a health facility when you fall sick

☐ Always ☐ Not often ☐ Never

☐ OFTEN ☐ ONCE

16. What are the reasons for not using a primary health care facility

☐ Longer waiting time ☐ Use of traditional medicine

☐ Long distance ☐ Lack of transport

☐ Religious belief ☐ Poor quality service

☐ High cost of service ☐ Other Specify……

17. Do you seek care at health facility when your NHIS is expired

☐ Yes ☐ No

SECTION B: Health Seeking behaviours of the populace

18. Have you been sick in the past two years

☐ Yes ☐ No

19 What was making you sick

☐ Headache ☐ fever ☐ Hypertension ☐ Acute respiratory disease

☐ Skin disease ☐ Anaemia ☐ Joint pains ☐ Diarrhea ☐ UTI,

☐ Cold ☐ Malaria ☐ Cough

20. How did you detect the cause of your illness

☐ Friend ☐ Neighbour ☐ Relative ☐ Health Centre ☐ Spiritual Leader ☐ Herbalist

☐ Self Diagnosis ☐ Chemical Seller ☐ Other ☐ Specify

21. Do you seek healthcare in case of acute illness

☐ Yes ☐ No

22.If yes what kind of healthcare facility do you attend

☐ Self-Medicate ☐ Health Centre ☐ Herbal medicine

☐ CHPS compound ☐ Chemical Shop ☐ Spiritual help

23. If No where do you to seek care……

24. Do you seek care at health facility when you NHIS is expired

☐Yes ☐ No

25.Have you bought a drug without prescription Y/N

26.What influence your choice to buy medications without prescription

…….

27. What kind of illness did you use the drug for

……..

28.What are the causes of ailments in the community (tick as many as you want)

☐Malnutrion ☐ Poor lifestyle habits☐ Poverty ☐ Promiscuity☐ Over Crowding

☐Pollution ☐ High cost of living ☐Spiritual Omen ☐Other Specify……..

29. What is the cause of your last sickness?

☐ Poor lifestyle habits☐Pollution☐Poverty ☐High cost of living

☐ Promiscuity☐Genetics☐Over Crowding☐Malnutrition☐Spiritual Omen

☐Other Specify……

30.What strategies do you adopt to live in good health

☐Balanced Diet ☐Clean drinking water ☐Exercise ☐Enough rest ☐Sleep in ITN

☐Avoid alcohol ☐Avoid Smoking ☐Other Specify……

31. Who makes decisions concerning health care in your household

☐You ☐ Family Member☐Your partner ☐ Parent

☐Other Specify……

32. What is your immediate action when you are unwell?

☐ Self-Medicate ☐Go for spiritual healing

☐Use herbal preparation ☐ Rest

☐ Visit the clinic ☐ Other Specify……

INTERVIEW GUIDE

Hello, I am an MBA student of the Public Administration and Health Service Management Department of the University of Ghana. I am conducting a survey concerning the determinants of primary health care utilization in the Gomoa East sub-district. This interview guide is designed to assess the perception of the community on primary healthcare. These answers are solely for academic questions and shall treated confidential

Age

Sex

Educational Status

Religion

1) What do you understand by primary healthcare?
2) Do you attend the health centre in the community?
3) What are your views of the quality of care at the Health Centre?
4) Would you prefer a private clinic to the public Health Centre?
5) What are your reasons?
6) Would you recommend PHC facility to anyone and why?

INTERVIEW GUIDE-STAFF

Hello, I am an MBA student of the Public Administration and Health Service Management Department of the University of Ghana. I am conducting a survey concerning the determinants of primary health care utilization in the Gomoa East sub-district. This interview guide is designed to assess the perception of the community on primary healthcare. These answers are solely for academic questions and shall treated confidential

Age

Sex

Educational status

Rank

1. What are the top ten diseases reported at your facility in order of magnitude?
2. What are the barriers that affect patronage of your services?
3. How does these barriers affect the health outcome of the patients?
4. What are the factors that causes patients dissatisfaction?
5. How do staff behave towards patients?
6. What can be done to improve quality of care at this facility?