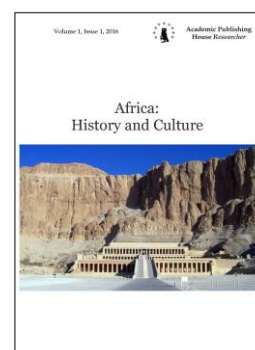


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Orthodox Health Seeking Behaviour in the New Juaben Municipality of Ghana: Disparities in Patients' Socioeconomic Status

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Abstract

An individual's decision to seek help from a particular health system is influenced by many factors, which are both intrinsic and extrinsic. The aim of this study was to examine socioeconomic factors as predictors of help-seeking, using the people of the New Juaben Municipality as a case study. Using a cross-sectional survey, data was collected using standardised questionnaire: Socioeconomic Factors and Health Seeking Behaviour (SFHSB) Questionnaire from a cross section of the population of the municipality on the determinants of intentions of seeking help. Data was analyzed using independent t-test. Results indicated that for this population, the intention of seeking hinged on proximate determinants like affordability, accessibility and acceptability of the provision of healthcare. Results further revealed that availability of finances did not necessarily determine where to seek help. A belief in a particular health system played a significant role and that the use of churches and other spiritual centres was very prominent as was the use of orthodox health system. Testimonies of previous users also played a major role in the future patronage of health services.

Keywords: Ghana, New Juaben municipality, orthodox health seeking behaviour, patients, socioeconomic status.

Introduction

Socioeconomic status (SES) is a combination of factors including income, level of education, social status and occupation. It is therefore a way of looking at how individuals or families fit into society using economic and social measures that have been shown to impact individuals' health and well-being. Socioeconomic status and health are closely related, and SES can often have effects on a person's health seeking behaviour due to differences in ability to access health care as well as dietary and other lifestyle choices that are associated with both finances and education. Socioeconomic status has long been noted to be a cause of health disparities among populations (Gwatkin, 2000). Both income and wealth are significant predictors of the likelihood to develop a chronic condition (Uzochukwu, & Onwujekwe, 2004); however, SES plays an even greater role in

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the functional ability of an individual, once they have already been diagnosed with a chronic condition like hypertension or a disabling condition like stroke (Ostrove, Adler, Kuppermann & Washington, 2000).

Socioeconomic status has been implicated to influence the health seeking behaviour of all manner of persons, irrespective of geographical location or racial background. Tipping and Segall (2005) have demonstrated that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables, which include sex, age, the social status, the type of illness, access to services and perceived quality of the service. Health seeking behaviour is thus influenced by the living standards, level of education, family size and income (Ankrah, 2004). Other studies (Gorman, & Sivaganesan, 2007; Matthews, Räikkönen, Gallo, & Kuller, 2008; Mbugua, Bloom, & Segall, 2005) have also demonstrated that socioeconomic variables have a very significant role on individuals' choice of healthcare and these appear in many forms. These include the care received by patients either at home or at hospitals (Anarfi, 1992; Anarfi, 1994), cost-benefit analysis as well as the direct and indirect cost of treating a patient (Ainsworth, & Over, 1994), evaluations of the cost of intervention programmes (Asamoah-Adu, Weir, Pappoe, Kanlisi, Neequaye & Lamptey, 1994) and the economic consequences of disease condition on families (Barnett, & Blaikie, 1992).

Socioeconomic statuses are critical factors that influence the utilization of health care services among many societies (Haddad, & Fournier, 2006). Poor people and people in the lower socioeconomic ladder seek assistance of religious healers, practitioners of folk medicine, home remedies and over-the-counter medications. They believe that alternative health practices are less costly and end in the reduction of symptoms. Anderson and Armstead (2005) believe that people from higher socioeconomic background tend to utilize orthodox medicine more than paying visits to traditional healers. These research methodologies laid a lot of emphasis on socioeconomic factors that influence health seeking behaviour but not much attention was paid to perception of efficacy of treatment and accessibility, all of which influence health seeking behaviour. Other findings by Ryan (2008), on health seeking for cardiovascular disorders have shown that the decision to seek health at a particular facility is not necessarily dependent on socioeconomic factors. Ryan (2008) found that health seeking behaviour is dependent on a combination of factors like belief in the aetiology of the disorder and the length of the illness are some of the determinants that result in whether one would seek help from an orthodox, spiritual or the traditional healthcare system. Most of the respondents in the research engaged in multiple health seeking behaviours, and that cut across social economic status.

Svab and Zaletel-Kragelj (2007) looked at the SES and racial and ethnic differences of a sample of 9744 men and women aged 51 to 61 who were suffering from cardiovascular disorders. The findings of this study showed that SES did not play a large role in the prevalence of disease; however, SES played a significant role in the functional health status of individuals once they had been diagnosed with hypertension, stroke, and arthritis. Lower SES is related to access to health care. Individuals who are of lower SES are less likely to get the necessary treatment, and are less likely to get treatment at earlier stages of the disease. The problem with the methodology of this study was that participants of this study were mainly those in the middle class without recourse to those at the lower socioeconomic level. According to Ward, Mertens and Thomas (2004), there may be structural barriers such as lack of health insurance, lack of financial support, geographical distance to treatment facilities, and access to transportation that prevent individuals from getting the care they need. For such groups of people, visits to traditional healers are more probable. Though this research looked at people from the lower socioeconomic background, there was no mention of belief systems which influenced the decision to seek help from a particular healthcare provider.

Cooper et al. (2007), in a study on cardiovascular disorders found that though socioeconomic factors influence health seeking behaviour to some extent, factors like culture and belief systems of the people cannot be ignored since cultures differ. Swanepoel (2008) posits that home remedy and non-traditional healers serve as substitute product that are used more by rural dwellers than others, because of the retention of the African tradition. While urban and other town residents were exposed to this culture and socialization, their higher level of education, access to more information and financial resources account for resocialization and re-adaptation to traditional medical care utilization. The researchers failed to take into consideration the level of acceptability

and the belief in the efficacy of treatment of orthodox medicine for which reason the rural dwellers sought help from non-traditional healers, but not necessarily socioeconomic factors.

Bourn and McGrowder (2009) have however showed that where cultural practices are more pervasive, one's status in terms of level of education, marital status, income and social standing have no effect on the health seeking behaviour of the people. While it has been established that higher rates of consultation for cardiovascular disorders are associated with a range of socioeconomic factors, the precise relationship between these factors and frequent attendance is unknown (Carr-Hill, Rice, & Roland, 2006). There has been considerable research to assess the impact of cost recovery in the form of cost of healthcare on health care seeking behaviour of people (Mbugua et al., 2005; Hussei, & Mujinja, 1997). In Kenya, Mbugua et al. (2005) put it that there was a drop of 42% in attendance for curative services in fee-charging Kibwezi health centres while in Tanzania, there was 50% decline in use of out patients' facilities after the introduction of user fees (Hussei, & Mujinja, 1997). However, there is no existing information on how user fees affect healthcare seeking in Ghana for diagnosis and treatment of cardiovascular disorders. Studies have also investigated the impact of user fees on the demand for particular types of services and there appear to be no studies on its effect on the cardiovascular conditions under study. Other studies have examined health seeking behaviour in African communities but there were no conclusive findings on the link between socioeconomic status and health seeking behaviour (Shea, & Swinkels, 2004; Sentell, & Halpin, 2006).

Low literacy and lack of awareness about services, schemes and entitlements, poverty, and cultural factors are among the crucial factors that determine the health-seeking behaviour in the state (Prasad, 2009). Recent surveys by Iyalomhe (2007) reveal that the continuing deficiencies in the awareness, treatment and control of hypertension were closely associated with certain socioeconomic factors. They concluded that in many cases, failure to achieve BP goals may be attributable to the poverty of patients' knowledge, perception, attitudes and life-style practices (Hennis, Wu, Nemesure, & Leske, 2002; Mari, Ukai, & Yamamoto, 2006). Iyalomhe, Omogbai and Ozolua (2008) showed that distance to health facilities was found to be an important factor associated with decrease in healthcare demand for cardiovascular disorders. This finding revealed that distance has significantly large and negative effect on health seeking behaviour for cardiovascular disorders. This suggests that the probability of seeking healthcare for cardiovascular disorders would increase significantly if accessibility were easier. The studies, however, focused only on economic factors that influenced the health seeking behaviour of the people, without taking into consideration other factors relating to their culture and belief systems that have profound influence on people's health seeking behaviour.

Matthews et al. (2008) in a study among people suffering from cardiovascular disorders showed that for each extra 1 km travelled to the health facility unit, usage for the facility fell by approximately 1 %, and the poor were more willing to pay a higher price to reduce the time. Deininger and Mpuga (2003) found user fees to be particularly important in determining access to health services, particularly for the poor. Verpoorte, Choi and Kim (2005), examined socioeconomic factors and health seeking behaviour for cardiovascular disorders and found the poor are more likely to use traditional medicine. Ahorlu, Dunyo, Afari, Koram, and Nkrumah (1997) showed that traditional medicine is not always more expensive than conventional medicine. Survey respondents in Ghana reported that the cost of malaria treatment at a health clinic ranged from ₵1,900 to ₵3,000 [US\$1.30 to US\$2.00 in 1997], treatment at home using drugs bought from pharmacies or health care workers ranged between ₵200 and ₵1,000 [US\$0.10 to US\$0.70], and treatment by a herbalist was virtually free.

Method

Study design and area

A cross-sectional survey method was used to carry out this study. The study was undertaken in the New Juaben Municipal area (see Figure 1). The New Juaben Municipality falls within the Eastern Region of Ghana. The Municipality covers an estimated area of 110 square kilometres constituting 0.57% of the total land area of the Eastern Region. The Municipality shares boundaries with East-Akim Municipal on the North-East, Akuapem North District on the East and South and Suhum-Krabo-Coaltar District on the West. Koforidua, which is 85 kilometres from the national capital Accra, serves both as the municipal and regional capital.

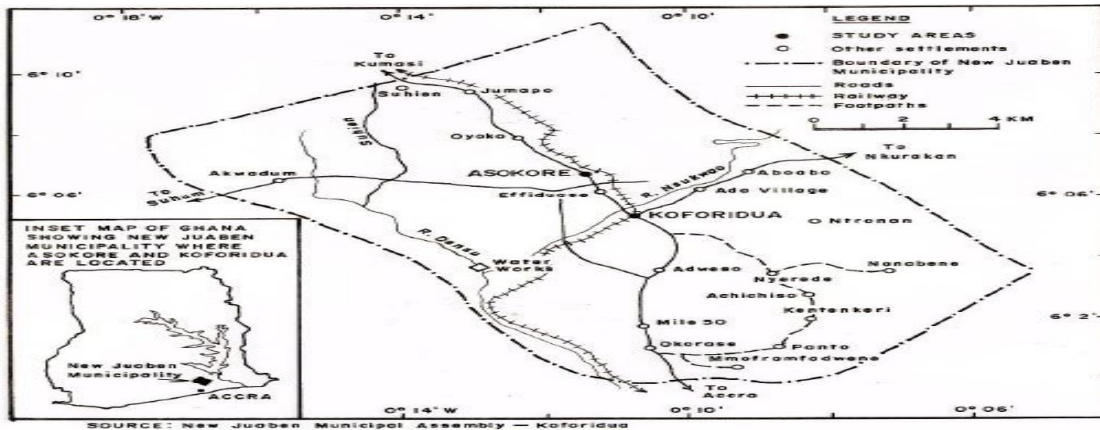


Fig. 1. A map of New Juaben

Population and Participants

The 2010 national housing and population census figures released by the Ghana Statistical Service indicate that the municipality has a population of 147,528, with a growth rate of 2.6 %. Females are the dominant group and constitute 51.5 % and males 48.5 % of the population. According to the 2010 Census, people under 15 years constitute 35% of the population; those between 15-64 years constitute 60 % while those above 65 % years constitute 5 % of the population. This signifies that New Juaben Municipality has a fairly young population with a dependency ratio of 64.7 per 100 persons in the 15-64 age groups (Ghana Statistical Service, 2012).

Procedure

Ethical approval for the study was obtained from the Department of Psychology, University of Ghana. Informed consent forms were then given to study participants, who read and signed before taking part in the study. For those who could not read and write, the informed consent was read to them to their understanding before they consented to take part in the study. Participants were people of different ethnic and professional backgrounds and were also aged 18 years and above. On the days of data collection, the researcher, with research assistants met participants at previously approved destinations. Data collection started after each participant had completed the consent form. They were asked to drop the completed forms in a box provided at vantage points. Research assistants were at hand to provide assistance to anyone that needed one. To ensure anonymity, no form of identifier was on the questionnaire and the participants were informed that participation was voluntary and they could withdraw from the study at any stage as they wished. It took participants between 30 to 35 minutes to complete the questionnaire. Data collection for the study took a period of two months to complete. The participants for the study did not receive any form of inducement or reimbursement for their participation.

Data Analysis

The researchers used collected demographic details of participants in addition to their general socioeconomic elements and health seeking behaviours. The Socioeconomic Factors and Health Seeking Behaviour (SFHSB) Questionnaire which is a 21-item scale measured socioeconomic factors and health seeking behaviour. The categories were; i. cost of treatment, ii. Income levels, iii. Proximate determinants (affordability, accessibility and acceptability). The scores on the SFHSB were calculated by adding to respective items a 7- point Likert Scale for a total scale score (i.e., where 0 = "Don't Know", and 6 = "strongly agree"). The reliability statistics after pilot test recorded a Cronbach's Alpha of .799. Correlation Between Forms indicated a reliability of .577 while Spearman-Brown Coefficient indicated for both Equal Length and Unequal Length values of .732 and .732 respectively. Lastly, Guttman Split-Half Coefficient recorded a reliability value of .731.

The SFHSB was further subjected to principal component factor analysis after the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of only four coefficients of .3 and above. The Kaiser-Meyer-Okin measure of sampling adequacy was .624, meeting the commonly recommended value of .6 and above. The Barlett's Test of Sphericity reached statistical significance, ($\chi^2_{(21)} = 75.481, p = .000$). Finally, the communalities were all above .3 further

confirming that each item shared some common variance with other items. Given these overall indicators, factor analysis was deemed to be suitable with all 21 items. Principal components analysis was used because the primary purpose was to identify the factors underlying the power distance scale. Principal components analysis revealed the presence of one component with eigenvalue exceeding 1, explaining 39.114 % of the variance. All the factors loaded onto one component.

Results

The researcher hypothesized that people with high socioeconomic status are more likely to seek help from orthodox health system for the treatment of cardiovascular disorders as compared to those with low socioeconomic status, and this was examined employing the independent *t*-test. The test results on this hypothesis are presented in [Table 1](#).

Table 1. Independent t-test of Orthodox Health Seeking Behaviour among Patients with Low and High Socio-economic Status

Socioeconomic Status	N	Mean	Standard Deviation	<i>t</i>	<i>df</i>
Low Socioeconomic Status	453	70.543	14.465	2.800	556*
High Socioeconomic Status	105	65.962	17.636		

* $p < .01$.

Results presented in the above table revealed that the likelihood of seeking help from orthodox health system by participants with low socio-economic status ($M=70.543$, $SD=14.465$) was significantly higher than their counterparts with high socio-economic status ($M=65.962$, $SD=17.636$), $t_{(556)} = 2.800$, $p < .01$. The higher the mean, the more likely is the patient willing to seek healthcare from the orthodox health system, implying that patients with low socio-economic status likewise sought treatment at the orthodox health system as shown in [Table 1](#).

Discussion

The study found that affordability of the treatment is a very important component of accessibility: that is, financial accessibility influenced patients' health seeking behaviours. There were respondents who found hospital services to be cheaper than treatment from a traditional healer. Their reasons were that at the hospital, payment for services was one stop, but at the traditional centres, one had to pay in bits both in cash and kind. The cumulative effect of this is that one ends up paying more at the traditional centres than at the orthodox hospitals. Habtom and Ruys (2007) and Heinzerling, (2005) found similar explanations.

The cumulative cost of health care was that traditional treatments were much more expensive, took longer, and more often included inpatient treatment. These findings are different from previous reports of other authors, who had argued that, in Africa mainly poor and less educated people seek care from traditional healers because they offer treatment at lower cost and are easier to reach (Cook, & Zumla, 2008). However, it seems that people in the New Juaben know exactly where to seek help, their choice is not a chance decision (Leonard, 2000).

Limitations and Directions for Future Research

It is important to cautiously interpret the findings of this study, since several issues might have introduced some biases in the current study. First, the cross-sectional nature of the study meant that it is difficult to readily establish a cause-and-effect relationship, though it is agreed that cross-sectional studies have the advantage to study large groups of people at one point in time.

Secondly, only a section of residents of the New Juaben Municipality were included, therefore caution should be exercised when drawing conclusions and generalising them to other populations.

Despite these limitations, the present study has added current literature about socio-economic status and health seeking in the New Juaben of Ghana and highlights some very key elements within the context of the study. Future studies are required to find out if the cost of traditional medicine, which hitherto was regarded as very cheap, is now taking a toll on the finances of people seeking help.

Conclusion

The importance of why people seek medical care is undoubtedly critical in health policy planning. This study has revealed that health seeking behaviour is not a simple realisation of symptoms and people taking remedial actions of just going to any nearby health centre, hospital or herbalist. It rather involves going through a decision making processes. This study has broader implications for policy planners and implementers who take decisions that have direct bearing on the health and wellbeing of the people. The implication for policy makers is that there is the need for them to understand that provision of healthcare does not necessarily mean the availability of physical structures and equipment. Healthcare provision should be tailor-made to suit the economic capacities and needs of the potential consumers.

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Conflict of Interest

The authors declare that there was no conflict of interest.

References:

- Ahorlu, C. K., Dunyo, S. K., Afari, E.A., Koram, K.A., & Nkrumah, F. K. (1997). Malaria-related beliefs and behaviour in southern Ghana: Implications for treatment, prevention and control. *Tropical Medicine and International Health*, 2(5), 488-499.
- Ainsworth, M., & Over, M. (1994). AIDS and African Development. *World Bank Research Observer*, 9(2), 203-240.
- Anarfi, J. K. (August, 1994). The conditions and care of AIDS victims in Ghana - *AIDS sufferers and their relations*. Paper presented at Conference on Social Dimensions of AIDS Infection in Africa, Ado Ekiti, Nigeria.
- Anarfi, J. K. (December, 1992). *Coping with AIDS in Ghana: the AIDS sufferer, the household and the community*. Paper presented at Workshop on AIDS and Society, Kampala, Uganda.
- Anderson, N. B., & Armstead, C. A. (2005). Toward understanding the association of socioeconomic status and health: A new challenge for the biopsychosocial approach. *Psychosomatic Medicine*, 57, 213-225.
- Ankrah, E. M. (2004). AIDS and the social side of health. *Social Science and Medicine*, 32(9), 967-980.
- Asamoah-Adu, A., Weir, S., Pappoe, M., Kanlisi, N., Neequaye, A., & Lamptey, P. (1994). Evaluation of a targeted AIDS prevention intervention to increase condom use among prostitutes in Ghana. *AIDS*, 8(2), 239-246.
- Barnett, T., & Blaikie, P. (1992). *AIDS in Africa: It's present and future impact*. London: Belhaven Press.
- Bourne, P. A., & McGrowder, D. A. (2009). Rural health in Jamaica: Examining and refining the predictive factors of low health status of rural residents. *Rural and Remote Health*, 9(2), 11-16.
- Carr-Hill, R. A., Rice, N., & Roland, M. (2006). Socioeconomic determinants of rates of consultation in general practice based on the fourth national morbidity survey of general practices. *British Medical Journal*, 312, 1008-1013.
- Cook, G. C., & Zumla, A. I. (2008). *Traditional Medicine. Manson's Tropical Diseases*. W.B. Saunders Company: London.
- Cooper, R. S., Rotimi, C. N., Ataman, S., McGee, D., Osotimehin, B., Kadir, S., & Muna, W. (2007). The prevalence of hypertension in seven populations of West African origin. *American Journal of Public Health*, 87(2), 160-168.
- Deininger, K., & Mpuga, P. (2003). *Has The Abolition of Health User Fees Improved the Welfare of Vulnerable Groups? Evidence from Uganda*. Paper presented at UNHS Workshop, October, 2003, Kampala, Uganda
- Ghana Statistical Service (2012). *2010 Population and Housing Census*. Sakoa Press Limited.
- Gorman, B. K., & Sivaganesan, A. (2007). The role of social support and integration for understanding socioeconomic disparities in self-rated health and hypertension. *Social Science & Medicine*, 65, 958-975.

- Gwatkin, D. R. (2000) *Health inequalities and the health of the poor: What do we know? What can we do?* *Bulletin of the World Health Organization*, 78(1), 3-18.
- Habtom, G. K., & Ruys, P. (2007). The choice of a health care provider in Eritrea. *Health Policy*, 80, 202-217.
- Haddad S., & Fournier P. (2006). Quality, cost and utilization of health services in developing countries: a longitudinal study in Zaire. *Social Science & Medicine*, 40, 743-753.
- Heinzerling, L. M. (2005). Attitudes of traditional healers towards western medicine in rural Cameroon. *Tropical Doctor*, 35, 161-164.
- Hennis, A. Wu, S. Y. Nemesure, B. & Leske, M.C. (2002). Hypertension prevalence, control and survivorship in an Afro-Caribbean population. *Journal of Hypertension*, 20(12), 2363-2369.
- Hussei, A. K., & Mujinja, P. G. (1997). The effect of the introduction of user charges on previously freely provided health services in government health facilities in Tanzania. *East African Medical Journal*, 74, 751-752.
- Iyalomhe, G. B. S. (2007). Compliance to antihypertensive therapy. *Nigerian Clinical Review Journal*, 63, 12-16.
- Iyalomhe, G. B. S., Omogbai, E. K. I., & Ozolua, R. I. (2008). Electrolyte profiles in Nigerian patients with essential hypertension. *African Journal of Biotechnology*, 7(10), 1404-1408.
- Leonard, K. L. (2000). *Incentives in rural health care delivery: Cameroon. Africa's Changing markets for health and veterinary services*. London: Macmillan Publishers.
- Mari, H., Ukai, H., & Yamamoto, H. (2006). Current status of antihypertensive prescription and associated blood pressure control in Japan. *Hypertension Research in Social Sciences*, 53, 71-82.
- Matthews, K.A., Räikkönen, K., Gallo, L.C., & Kuller, L.H. (2008). Association between socioeconomic status and metabolic syndrome in women: Testing the Reserve Capacity Model. *Health Psychology*, 27, 576-583.
- Mbugua, K. J., Bloom, G. H., & Segall, M. M. (2005). Impact of user fees on vulnerable groups: The case of Kibwezi in rural Kenya. *Social Science & Medicine*, 41, 828-835.
- Ostrove, J. M., Adler, N. E., Kuppermann, M., & Washington, A. E. (2000). Objective and subjective assessments of socioeconomic status and their relationship to self-rated health in an ethnically diverse sample of pregnant women. *Health Psychology*, 19, 613-618.
- Prasad, G. (2009). *Urban health in Uttar Pradesh: Challenges and opportunities*. Retrieved on July, 16, 2016 at http://uhrc.in/downloads/Presentations/Gajraj_Prasad.pdf
- Ryan, G. W. (2008). What do sequential behaviour patterns suggest about the medical decision-making process? Modelling home case management of acute illness in a rural Cameroonian village. *Social Science & Medicine*, 46, 209-225.
- Sentell, T. L., & Halpin, H.A. (2006). Importance of adult literacy in understanding health disparities. *Journal of General Internal Medicine*, 8, 862-866.
- Shea, J. A., & Swinkels, C. A. (2004). Assessing health literacy in African American and Caucasian adults: Disparities in Rapid Estimate of Adult Literacy in Medicine (REALM) scores. *Family Medicine*, 8, 575-581.
- Svab, I., & Zaletel-Kragelj, L. (2007). Frequent attenders in general practice: A study from Slovenia. *Scandinavian Journal of Primary Health Care*, 11, 424-430.
- Swanepoel, A. S. P. (2008). The intervention effects of a Community-Based Hypertension Control Programme in two rural South African towns: The CORIS study. *South African Medical Journal*, 83(12), 885-891.
- Tipping, G., & Segall, M. (2005). *Healthcare Seeking Behavior in Developing Countries: An Annotated Bibliography and Literature Review. Development Bibliography*. Institute of Development Studies Sussex University.
- Uzochukwu, B. S. C., & Onwujekwe, O. E. (2004). Socio-economic differences and health seeking behaviour for the diagnosis and treatment of malaria: A case study of four local government areas operating the Bamako Initiative Programme in South-East Nigeria. *International Journal Equity Health*, 3(6). doi: 10.1186/1475-9276-3-6
- Verpoorte, R., Choi, Y. H., & Kim, H. K. (2005). Socioeconomic Factors and Health Seeking Behaviour. *Journal of Ethnopharmacology*, 100, 53-59.
- Ward, H., Mertens, T., & Thomas, C. (2004). Health seeking behaviour and the control of sexually transmitted disease. *Health Policy and planning*, 12, 19-28.