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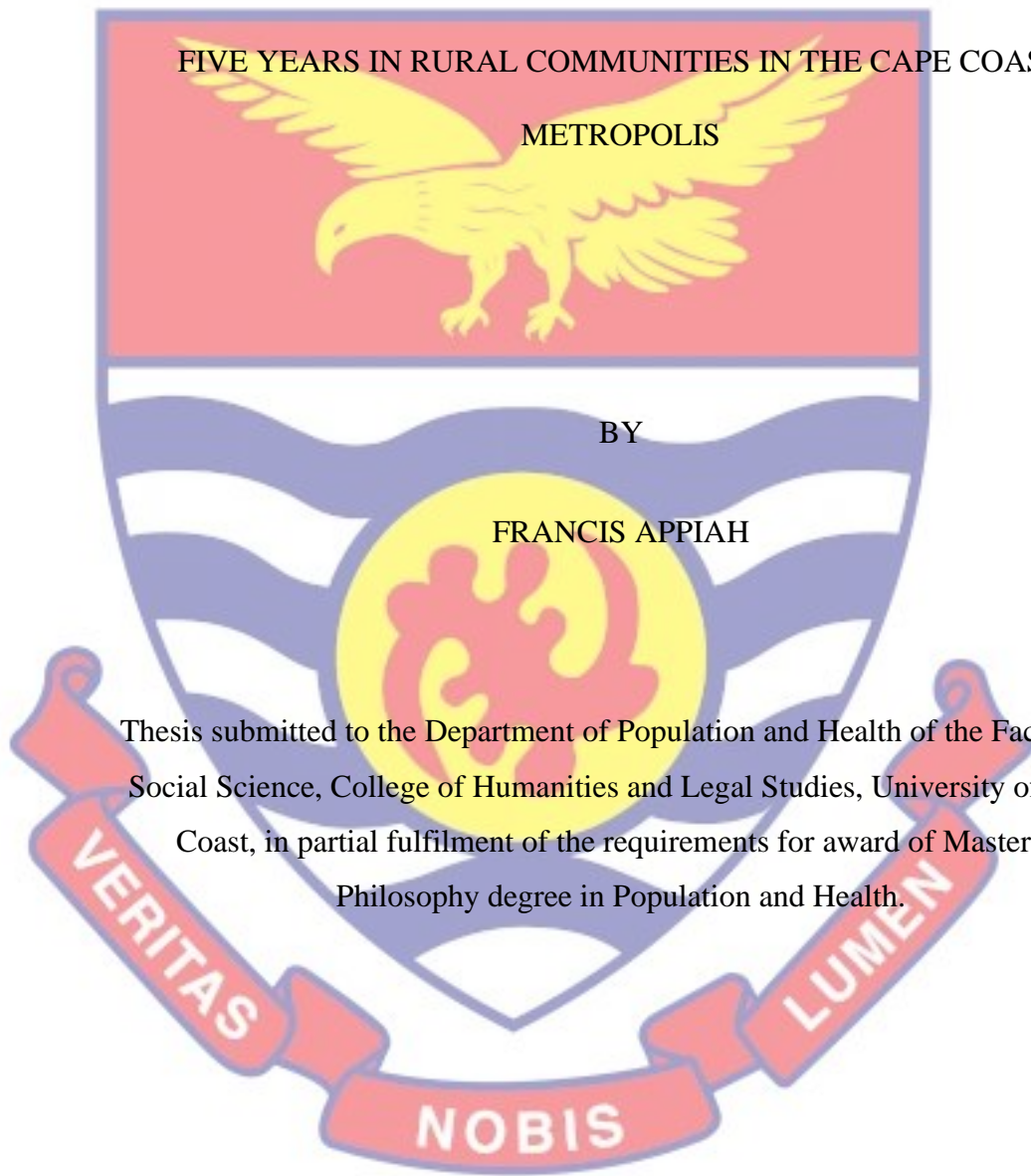
MOTHERS' HEALTH-SEEKING BEHAVIOUR FOR CHILDREN UNDER-
FIVE YEARS IN RURAL COMMUNITIES IN THE CAPE COAST

METROPOLIS

BY

FRANCIS APPIAH

This thesis submitted to the Department of Population and Health of the Faculty of Social Science, College of Humanities and Legal Studies, University of Cape Coast, in partial fulfilment of the requirements for award of Master of Philosophy degree in Population and Health.



MARCH 2017

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature:..... Date:.....

Name: Francis Appiah

Supervisor's Declaration

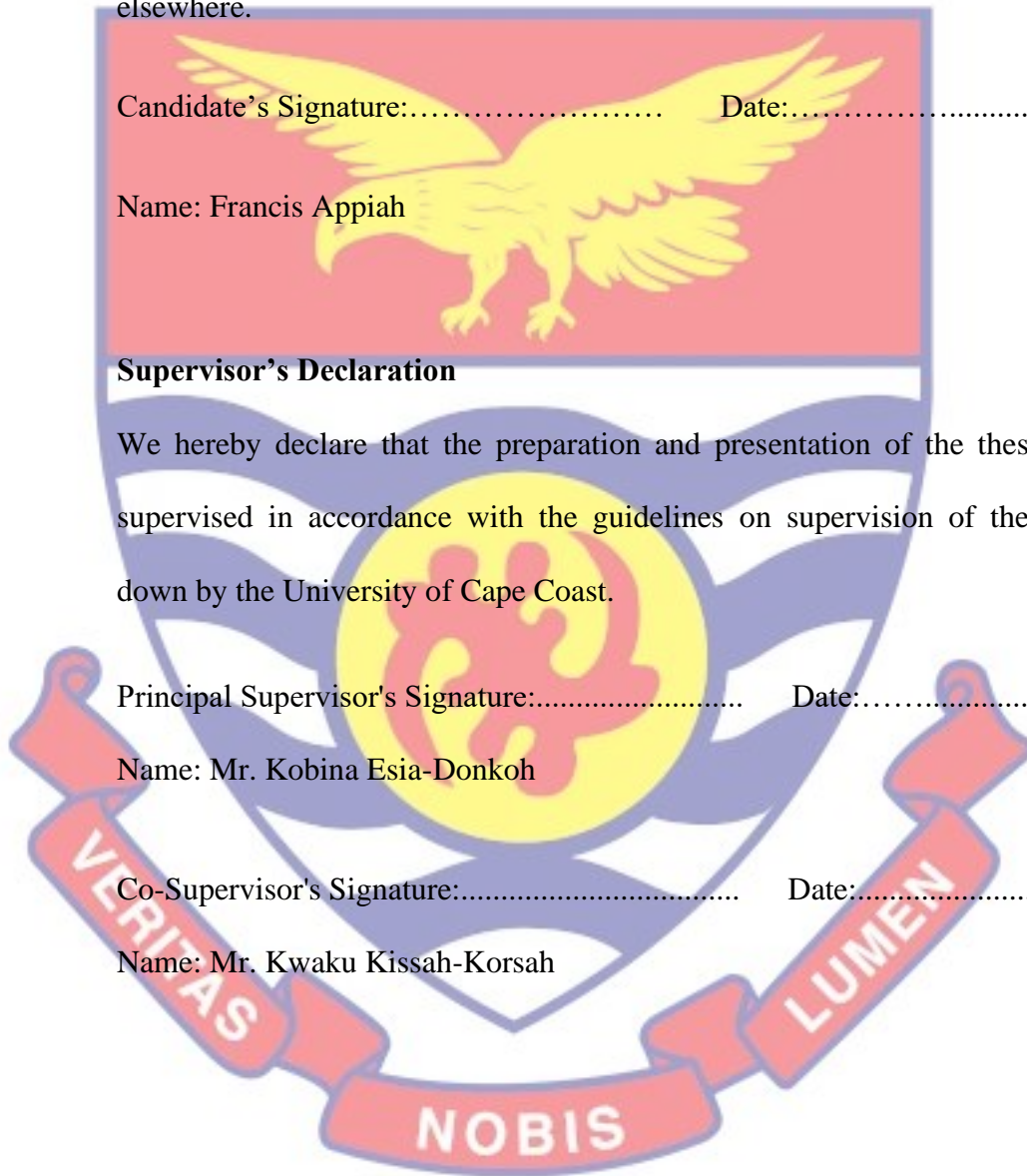
We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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ABSTRACT

This study was conducted to investigate mothers' health-seeking behaviour for children under-five years in rural communities in the Cape Coast Metropolis. Specifically, the study looked at mothers' perception of childhood illness; motivations and challenges to health-seeking behaviour.

The study employed a qualitative approach. Guided by the adapted planned behaviour theory, 42 mothers were purposively selected and interviewed. Thirty mothers from five communities within five kilometers radius to healthcare facility and 12 mothers from two communities outside five kilometers radius to healthcare facility were chosen. The analysis was presented with text and quotations. The results of the study showed that malaria was common among all the selected communities. It was noted that respondents' level of education influenced their perception of childhood illness while subscription to health insurance motivated respondents to seek health care regardless of their background characteristics. Decisions on time to initiate action and where to seek health care were affected by the respondents' religion, poor communication was stated by low income earners while unavailability of health facility was mentioned as a challenge to health-seeking. It is recommended that the Cape Coast Metropolitan Health Directorate should organise refresher courses for health workers in the Metropolis to enhance their communication skills. Also, further studies need to be done on religion and mothers' health-seeking decision making.

KEY WORDS

Cape Coast Metropolis

Children

Health-seeking behaviour

Mothers

Rural communities

Under-five

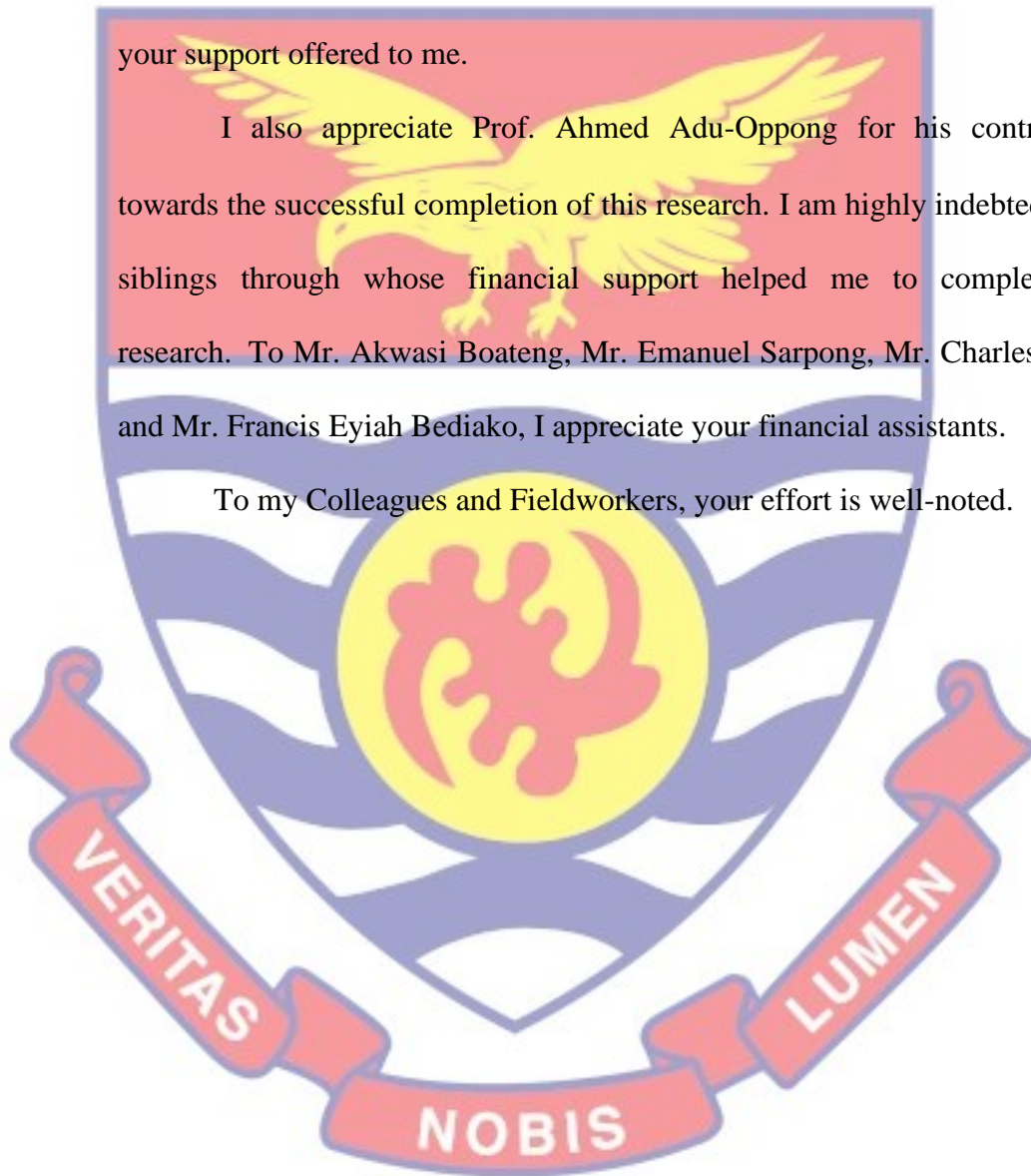


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DEDICATION

To Dora Abena-Adoma.



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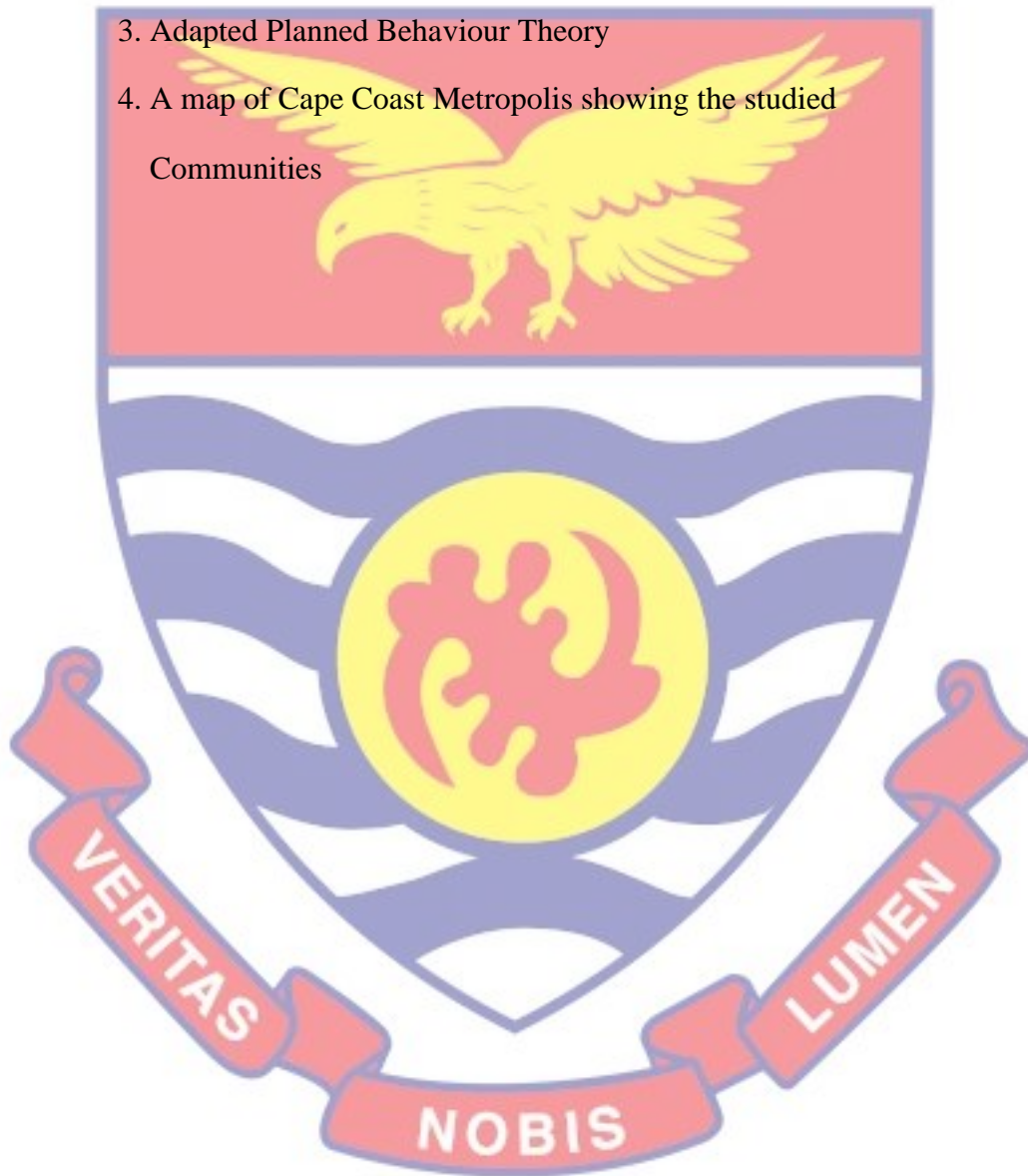
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LIST OF ABBREVIATIONS

ANC	Ante Natal Care
CHPS	Community-based Health Planning and Services
ENC	Essential New-born Care
GH	Ghana
HBM	Health Belief Model
MDG	Millennium Development Goal
MoH	Ministry of Health
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
PBT	Planned Behaviour Theory
PHC	Primary Health Care
PMT	Protection Motivation Theory
RCH	Reproductive and Health Centers
SDG	Sustainable Development Goal
TRA	Theory of Reasoned Action
UCC-IRB	University of Cape Coast-Institutional Review Board
UN	United Nations
UNICEF	United Nations International Children's Fund
UN-IGME	United Nations Inter-Agency Group for Child Mortality Estimate
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the Study

The global picture relating to under-five mortality rate has been a concern. According to the United Nations Inter-Agency Group for Child Mortality Estimate (UN-IGME) 2014 report, the world witnessed 233 million under-five mortality between 1990 and 2013 (UN-IGME, 2014). Although efforts have been made by global communities over the last three decades to reduce under-five deaths, evidence shows that 17, 000 children under age five die each day (UN-IGME, 2014). Nearly, half of all deaths of children under five is recorded among five selected countries located in sub-Saharan Africa and Southern Asia. For instance, India (21%) and Nigeria (13%) together constitute over a third of all under-five global deaths (UN-IGME, 2014). Available data also show that some countries including Democratic Republic of Congo, Nigeria and Ghana recorded 119, 117 and 62 per 1000 live births respectively as at 2013 (UN-IGME, 2014). This partly explains why these countries failed to meet Millennium Development Goal (MDG) 4. As a result, the global communities developed integrated strategies to conceptualise the Sustainable Development Goals (SDGs) with the view to minimise under-five deaths (SDGs) (Leadership Council of the Sustainable Development Solutions Network, 2014; Lui et al., 2015).

Most under-five deaths have been attributed to pre-term birth complications (17%), pneumonia (15%), intrapartum-related complications (11%), diarrhoea (9%) and malaria (7%). These, however, are preventable (UN-IGME, 2014). Scaling up investments into strategies that can boost

prompt health-seeking behaviour and utilisation of health care among mothers have been recognised by the World Health Organisation (WHO) and the United Nations International Children's Fund (UNICEF) as an effective child survival strategy that can aid to reduce excess morbidity and mortality (Chandwani & Pandor, 2015). Consequently, for the past decade, public health attention has been paid to factors that obstruct health-seeking and utilisation of health care in pursuance of solution to global health challenges, especially, child mortality (Morris, James, Laws & Eldemire-Shearer, 2011; Sreeramareddy, Sathyanarayana & Kumar, 2012; Chandwani & Pandor, 2015).

Health-seeking behaviour evolved from a term referred to as 'illness behaviour'; a concept introduced in the 1920's by Sigerist (Sirri, Fava & Sonino, 2013). Sigerist expressed that individuals do not necessarily attribute their illness to biomedical factors alone but view their illness, sicknesses or any disorder to be the results of both psychological and social factors. As a result, societal roles and responsibilities were assigned to sick persons (Sirri, Fava & Sonino, 2013). The concept did not gain much popularity until 1948 when a complex behaviour where those who really needed medical attention refused while those who did not need medical advice sought it, after the introduction of the National Health Service (Calnan, 1987; Hardey, 1998). This called for the need to explore how people reacted to illnesses (Mechanic, 1979).

Studies have shown that a mother's ability to take prompt action to seek health care is influenced by several factors including the locations of health care facility, health care providers' attitudes, individual health needs

and other social forces (Jalal & Shah, 2011; Ferdous, Das, Ahmed et al., 2013; Chomat, Solomons, Montenegro, Crowley & Bermudez; 2014). Evidence from an ethnographic study in Italy corroborates the observed attitude of Pakistan mothers' low ante and post-natal health care utilisation. In their studies, Jalal & Shah (2011) noticed that financial constraints limited 40 percent of women from the utilisation of Ante Natal Care (ANC). Similarly, evidence from Vietnam also indicates that, aside women belonging to ethnic minority and inability to meet user-fees, inequity in health-seeking and utilisation among mothers was created due to healthcare providers' behaviours (Malqvist, Phuong, Hoa & Thomsen, 2012).

Health-seeking behaviour is dynamic as one moves from one geographical area to another. Chomat, et al. (2014) observed that the background characteristics of mothers affected their health-seeking behaviour. Chomat and his colleagues realised that mothers who had low socio-economic status, including poor education, lived in abject poverty, inability to speak the Spanish, and another language was the reason why only a few mothers (13%) delivered at hospitals. A cross-sectional household-based health survey conducted by Long, Zhang, Xu, Tang & Hemminki (2010) among ten western rural provinces of China in 2003 and 2008 also showed that women who reported in health care facilities to deliver rose from 45 to 80 percent. From the studies, they realised that a possible factor associated with higher usage of health care facility among mothers was as a result of the Chinese New Co-operative Medical System that served as financial protection.

Again, when mothers are able to identify childhood sickness at the onset, they can seek prompt health care for their children under-five provided

they have few or no challenges (Ferdous et al., 2013; Chandwani & Pandor, 2015). This therefore implies that, mothers' knowledge on the signs and symptoms associated with childhood illness is essential in the health-seeking process (Sreeramareddy, Shankar, Sreekumaran, Subba, Joshi & Ramachandran, 2006). Evidence from Nepal supported that, aside wealth status and mothers' education, knowledge of symptoms and the perceived severity of illness were the predictors of health-seeking behaviour (Sreeramareddy et al., 2006).

Caregiving role in most traditional African settings, is reserved as a mother's responsibility. Thus, mothers are, in the real sense, caretakers of children especially children who are sick. Thus, they occupy a central point in child health outcome (Tolhurst, Amekudzi, Nyonator, Squire & Theobald, 2008; Pandalangat, 2011). On the other hand, the decision concerning where, when and what period a mother seeks health care for her children is influenced by a number of factors. These include husbands, relatives and societal influences. Through socialisation, the female internalises that her decisions relating to health care utilisation are subordinate to those of her husband, the family and society (Sen, 2012).

Societal norms, expectations and gender issues that revolve around caregiving role partially separate men from getting involved in child health care issues (Jorosi-Tshiamo, Mogobe & Mokotedi, 2013). Nonetheless, women usually relate to the male counterparts during decisions that touch on health care utilisation for their children. Therefore, decisions about child health interventions tend to be a function of the mother and her surroundings (Tolhurst et al., 2008).

It has been established that mothers' background characteristics as well as health facility factors influence mothers' health-seeking behaviour (Tolhurst & Nyonator, 2006; Dako-Gyeke, Aikins, Aryeetey, Mccough & Adongo, 2013; Aggrey & Yaw Appiah, 2014). For instance, women who lack economic support face difficulties in accessing health care for children. They concluded that income status and a subscription to insurance influenced health-seeking behaviour (Tolhurst & Nyonator, 2006).

A Zambian-based study realised that, there was a disparity in health care utilisation among urban and rural dwellers due to travel distance (Kyei, Campbell & Gabrysch, 2012). Kyei and his colleagues recognised that, among 88 percent of mothers living in the rural places located within 15 kilometres distance to ANC facility, only nine percent of the mothers had access to ANC facility that provided optimum level of health care. They also noticed that, the odds of attending the approved four or more ANC visits reduced by almost 20 percent for each 10 km increase in distance. This suggests that proximity to a health care facility is crucial in determining the utilisation of health service.

It is a common knowledge that urban folks have easy access to transport which is mostly not the case among rural dwellers. At the same time, health care facilities and providers including doctors, nurses, pharmacists and midwives that provide various health care services for children under-five in Ghana are not evenly distributed which disfavours the rural folks (Dixon, Tenkorang, Luginaah, Kuire & Boateng, 2013). These resource gaps presuppose that mothers living in rural communities without health care facility have to walk for longer distance before they can access health care for their children under-five.

Meanwhile, studies have shown that, accessibility to health care is challenged when patients walk for longer distance to a healthcare facility in developing countries (Noor, Zurovac, Hay, Ochola & Snow, 2003; Muhammed, Umeh, Nasir & Suleiman, 2013). Similarly, in Ghana, the location of the facility as well as the distance mothers have to cover to get to the facility affect health-seeking behaviour (van den Boom, Nsowah-Nuamah & Overbosch, 2004; Adu-Gyamfi & Adei, 2013; Krumkamp, Sarpong, Kreuels, Ehlkes et al., 2013). Therefore, it is noteworthy to assess mothers' health-seeking behaviour for children under-five in rural communities in the Cape Coast Metropolis.

Problem Statement

Under-five mortality recorded in Ghana is still high. It slowly declined from 128 to 78 per 1000 live births from 1990, to 2013, showing a 2.1 percent annual rate reduction (UN-IGME, 2014). Further estimates by the UN-IGME report (2014) show that more males die than females among children under five years in Ghana. Under five mortality declined from 136 deaths per 1000 live births in 1990 to 84 deaths per 1000 live births in 2013 among males while the females experienced a decline from 131 to 74 deaths per 1000 live births between 1990 and 2013 (UN-IGME, 2014).

Ghana has implemented several strategies which together aimed at equal health care accessibility, prompt health care seeking and reduction of self-care treatment in order to reduce under-five mortality. These include: Under Five Child Health Strategy (Ministry of Health (MoH), 2014); National Health Policy (MoH, 2007); National Health Insurance Scheme (NHIS)

(National Health Insurance Authority (NHIA), 2010) and New-Born Policy (MoH, 2014). In spite of these measures, self-care among mothers prevails in most communities (Ghana Statistical Service (GSS), 2011) while under-five mortality is still high (UN-IGME, 2014).

The WHO and UNICEF have, therefore, advised that children should be taken to health care facility immediately following the onset of signs and symptoms in order to reduce excessive morbidity and mortality (Chandwani & Pandor, 2015; Aigbokhaode, Isah & Isara, 2015). However, a nationwide survey by Ghana Statistical Service (2011) revealed that some mothers still kept children at home without seeking appropriate health care when children suffered from malaria. Their results indicated that more than 48 percent of the mothers kept their male children at home (not taken anywhere) while about 23 percent sought care for their male children from a government hospital. For mothers with female children, more than 52 percent said that they did not take their children anywhere with only a little over 14 percent, indicated that they sought care from a government hospital. This observation illustrates the poor health-seeking behaviour for mothers with children under-five years in Ghana.

The Cape Coast Metropolis faced a similar challenge of high under-five mortality. The Metropolis experienced 228 under five deaths in 2010, and 209 in 2011 and 235 in 2012 (Cape Coast Metropolitan Health Directorate, 2015). Though under-five mortality in the Metropolis is high and unstable, the majority of the deaths occurred in the Cape Coast Teaching Hospital. The facility serves as a referral centre and as such, receives childhood morbidity cases (Cape Coast Metropolitan Health Directorate, 2015). What factors influence health-seeking behaviour for mothers staying in rural communities

in the Cape Coast Metropolis? Aside this, how do mothers' perception of childhood illness, as well as other challenges mothers face influence the health care of their children in the rural communities in the Metropolis? Since mothers' health-seeking behaviour is related to incidence, prevalence and complications of diseases, early recognition of signs and symptoms of childhood illness, reporting to health care facility and adherence to treatment can reduce morbidity and mortality (Hausmann-Mueala, Muela Ribera & Nyamongo, 2003; Inche Zainal Abidin, Sutan & Shamsuddin, 2014). For instance, most diseases that affect children in the metropolis such as malaria, are preventable (Cape Coast Metropolitan Assembly, 2014; UN-IGME, 2014). However, delaying in seeking treatment or indiscriminate use of medications by caregivers rapidly increase the parasite burden; hence, rendering treatment ineffective and increasing fatalities (WHO, 2010; Bruxvoort, Goodman, Kachur, Schellenberg, 2014).

Again, quantitative studies which concentrate less on mothers with children under-five dominate health-seeking behaviour and health care utilisation studies in Ghana (Danso-Appiah et al., 2010; Avorti, Beke & Abekah-Nkrumah, 2011; Adu-Gyamfi & Abane, 2013; Nketiah-Amponsah, Senadza & Arthur, 2013; Krumkamp et al., 2013; Acquah et al., 2015). Few qualitative studies done also focused on the influence of cost recovery on health care utilisation (Asenso-Okyere, Anum, Osei-Akoto & Adokonu, 1998) and socio-cultural interpretations of pregnancy threats on health-seeking behaviour among pregnant women in urban Accra (Darko-Gyeke, Aikins, Aryeetey, Mccough & Adongo, 2013). Little is known about mothers' health-seeking behaviour for their children under-five in the rural communities in the

Cape Coast Metropolis. This study contributes to this research gap and explores mothers' health-seeking behaviour for children under five years in rural communities in the Cape Coast Metropolis.

Objectives of the study

The main objective of the study was to assess the health-seeking behaviour of mothers for children under-five years among rural communities in the Cape Coast Metropolis. Specifically, the study strives to:

1. assess the perceptions of mothers with children under-five years about childhood illness;
2. analyse factors that motivate health-seeking practices for children under-five years by their mothers; and
3. examine the challenges to health-seeking practices for children under-five years by their mothers.

Research Questions

1. What are the perception of mothers with children under-five about childhood illness?
2. What are the motivational factors to health-seeking practices?
3. What are the challenges to health-seeking practices?

Motivation of the Study

It has been established that children from rural communities mostly have a greater risk to infections and severe diseases such as diarrhea, malaria, fever and acute respiratory illnesses (ARI) and children in Ghana are not exception (United Nations International Children's Fund (UNICEF), 2012).

This therefore threatens the survivals of children under-five. Meanwhile, reduction in under-five mortality and improving the health of children under-five has been a global health concern (Leadership Council of the Sustainable Development Solutions Network, 2014; Lui et al., 2015). Most mothers with children under-five, especially from rural communities, due to poor social and environmental factors such as poor road network, irregular transportation system, unavailability of health facilities and health staff challenge mothers' timely arrival to healthcare facilities for their children under-five to be treated (WHO, 2009; Gelaw et al., 2014). Meanwhile, mothers and families have greater responsibility in child healthcare management as enshrined in the Integrated Management of Childhood Illnesses' policy draft (WHO, 2005). These factors among other things have motivated the need to investigate health-seeking practices of mothers in the rural communities in the Cape Coast metropolis.

Significance of the Study

For the past two decades, social scientists and epidemiologists have emphasised that studies about health-seeking behaviour and utilisation of health services will provide good understanding about factors which may have policy implications (Sreeramareddy, Sathyanarayana & Kumar, 2012). This study would, therefore, provide relevant information to contribute to policy decisions and practices, at least, in the Cape Coast Metropolis.

The study will also serve as a platform and stimulate further research into mothers' health-seeking practices. Again, it will provide additional

literature to existing ones for students, researchers, institutions and other related organisations.

Organisation of the Study

This study is organised into five chapters. Chapter One consists of the background to the study, the problem statement, the study objectives, research questions, motivation of the study as well as the significance of the study. Chapter Two deals with the review of relevant literature. This is covered under the following sub-topics: evolution of health-seeking behaviour studies, the concept of health-seeking behaviour, under-five child health policies, mothers' perception of childhood illness, motivational factors to health-seeking, challenges to health-seeking, theoretical and conceptual framework for the studies. Chapter Three highlights the methodological approaches used. It focuses on the study area characteristics, philosophical and research design, target population, sampling and sampling size, study instrument, pre-test, source of data, data collection, data management and analysis as well as ethical considerations.

Chapter Four consists of the findings and discussions. The chapter describes and discusses issues such as the demographic background of mothers; perception of childhood illness, motivations to health-seeking and challenges to health-seeking. The last chapter covers the conclusion, summary of major findings and recommendations of the study.

CHAPTER TWO

REVIEW OF RELEVANT LITERATURE

Introduction

This chapter reviews literature relevant to the study. It first presents the evolution of health-seeking behaviour, the concept of health-seeking behaviour, under-five policies in Ghana, epidemiology of under-five deaths in the Cape Coast Metropolis and mothers' perception of childhood illness. It further discusses motivations to health-seeking as well as the challenges to health-seeking practices. The chapter also discusses the theoretical and conceptual framework that guides the study.

Evolution of Health-Seeking Behaviour

Illness behaviour was a concept introduced in 1920 by Sigerist to explain the clinical phenomenon about the perception of people regarding factors that cause diseases. Sigerist was of the view that every sickness, ailment or any disorder cannot be attributed only to pathophysiological mechanisms but includes both psychological and social dimensions (Sirri, Fava & Sonino, 2013). Dealing with sickness and ailments is context specific and varies as one moves from an area to the other. Around the 1920s, Sigerist observed that within every society, there exists specific social status accompanied by specific privileges and obligations apportioned to sick persons (Sirri, Fava & Sonino, 2013).

After some decades, Talcott Parson picked and developed the writings of Sigerist. He, initiated 'the sick role' concept to further explain the civil liberties sick persons were to enjoy, including exemption from normal responsibilities and social duties (Parsons, 1951; Fava & Sonino, 2013). The

sick role concept further explained obligations sick persons were to fulfil. Among the obligations were that sick persons are to make conscious effort to recover within a given period by seeking appropriate health care from qualified personnel and complying with standards and prescriptions as a way to recovery. Sickness was, however, seen as a threat to the activities and functions of the society because the sick could not engage in productive work, hence, impeding societal functioning and progress (Parsons, 1951; Fava & Sonino, 2013).

Around 1960, Mechanic and Volkart (1960) explored several ways individuals reacted to physical and biomedical symptoms as well as the psychosocial and cultural factors that influenced those reactions. Mechanic and Volkart, therefore, defined illness behaviour as the ways by which given symptoms may be differently perceived, evaluated and acted upon by diverse kinds of persons in a society.

Mechanic (1995), subsequently, came out with a new specification and conceptualisation of illness behaviour and operationalised it as the divergent ways people respond to bodily indications, how internal conditions and symptoms are monitored, defined and interpreted and how people draw attributions, embark on remedial actions and make use of several sources of informal and formal care (Mechanic, 1995; Sirri, Fava & Sonino, 2013). After the work of Mechanic, several areas have been researched and developed including illness perception, health-seeking behaviour, delay in seeking treatment, treatment adherence and frequent utilisation of medical facilities (Sirri, Fava & Sonino, 2013).

Concept of Health-Seeking Behaviour

The term 'health-seeking behaviour' is complex to define. No consensus has been reached by experts interested in the health system and illness behaviour research on a single definition (Wade & Halligan, 2004; Klemenc-Ketis & Kersnik, 2014; Ferdous et al., 2013; Chandwani & Pandor, 2015). Therefore, the concept has been left open but defined in many contextual forms across disciplines.

However, a systematic review conducted by Grundy & Annear (2010) demonstrates that health-seeking behaviour studies predominantly view illness behaviour as a whole and tend to focus particularly, on individual motivating factors of illness perception and health beliefs. This means that an individual's ability to recognise sickness and respond to the sickness identified should be part of the underlying basis in conceptualising or defining the concept of health-seeking behaviour.

From the sociological point of view, the health-seeking behaviour is a summation of an individual's illness behaviour that is influenced by the individual self, the disease in question, and the availability and accessibility of health services. The interaction of these factors intersects to produce health-seeking behaviour (Cummings, Becker & Maile, 1980; Kroeger, 1983). Operationally, mothers' health-seeking behaviour can, therefore, be constructed as a summation of their personal needs, social forces, healthcare providers' behaviour and the geographical location of services (Ferdous et al., 2013; Chandwani & Pandor, 2015). This, therefore, means that, in evaluating mother's health-seeking behaviour for their children under five years, the

mothers' socio-demographic as well as the environmental factors should be taken into consideration.

Health-seeking behaviour has been expanded by other researchers. For instance, Wade and Halligan (2004) and Klemenc-Ketis and Kersnik (2013) define health-seeking behaviour as an action undertaken by individuals who perceive themselves as having a health problem or to be ill for the purpose of finding an appropriate remedy. Also, Pradham (2013) conceptualised health-seeking behaviour as the ability of respondents to identify sickness and the ways to counteract it. This definition highlighted perceived health needs and individuals' ability to respond to an identified disease as an important element in health-seeking.

However, the key argument is that it projects only those who are sick to be in need of health care and excludes those who are not sick or desire to maintain good health in the health-seeking processes. That is, it rejects individuals who seek health care not because they are sick but as a way of protecting themselves from anticipated danger including regular check-ups and immunisation.

Because of the flaws in the above definitions, Maneze, DiGiacomo, Salamonson, Descaller and Davidson (2015) included individuals who are not sick but are enthusiastic to maintain their positive well-being and good health status in the health-seeking process. They, therefore, defined health-seeking behaviour as intended actions individuals put up to care for, maintain, and uphold his or her health, regardless of updated health status (Maneze et al., 2015).

Health-seeking behaviour has been conceptualised in various ways based on research focus, domains and variables measured in studies. Focusing on patients points of view, Assefa et al. (2008) operationalised health-seeking behaviour as mother's response to signs and symptoms of illness to reduce severity, complication or even death, after mothers have noticed signs and symptoms of illness and have taken an action by visiting either a health facility or at least community health worker.

Over time, researchers have also added other related concepts like health care utilisation and help-seeking behaviour to the concept of health-seeking behaviour and concurrently represent both concepts with a single definition. For instance, Shafiq, Shaikh & Kumar, (2011) combining health-seeking behaviour and health-service-utilisation define these two concepts as the basis of perceived anticipation and perceived effectiveness of the health services that encompass availability of essential medicines at primary health care (PHC) level and affordability of prescribed medicines as major determinants.

Other studies also used the concept of health-seeking behaviour as a composite term by incorporating health-seeking behaviour with other concepts such as help-seeking behaviour and health care utilisation without necessarily establishing a clear difference between them (Dako-Gyeke, 2013; Pradham, 2013). The concept is used in such studies to refer to the aspects of individuals' efforts for taking steps towards addressing perceived ill-health or to visit a health care facility after recognising a disease or after the onset of a condition (Dako-Gyeke, 2013). Grundy and Anneras (2010), however, argued that distinction needs to be done to separate health-seeking behaviour, health

care seeking and utilisation, and help-seeking behaviour and other related concepts since each concept may have a unique feature and focus.

From the above, it can be deduced that though health-seeking behaviour has passed through several conceptualisations, certain key components including sensitivity and responsiveness to illness remain unchanged. Based on Kroeger (1983), Grundy & Annear (2010), Ferdous et al. (2013), Chandwani & Pandor (2015) and Maneze et al. (2015) perspectives, in the context of this study, mothers' health-seeking behaviour for their children under-five years shall operationally be defined as mothers' ability to be sensitive to childhood illness (including mothers' capability to recognise childhood illness) and their responsiveness to the illness identified (including mothers' capability to take actions by seeking care) or effort undertaken to seek preventive health care.

Under-Five Child Health Care Policies in Ghana

The 1992 Constitution of the Republic of Ghana serves as the legal framework to cater for and ensure that the needs and wants of vulnerable groups including children living in the country are met. It categorically states that the 'state shall enact appropriate laws to ensure the protection and promotion of all other basic human rights and freedoms, including the rights of the disabled, the elderly, children and other vulnerable groups in the development processes' (The Republic of Ghana, 1992, p37).

The Ministry of Health, also developed a strategic policy in 2007 referred to as the National Health Policy dubbed "Creating Wealth through Health" to simultaneously serve as a policy framework that would stimulate

economic growth and also as a basis for developing further health sector priorities to shape the health of the nation. The objective was to add to the socio-economic development and wealth creation by promoting health and vitality, guaranteeing access to quality health, population and nutrition services for the populace living in Ghana, and promoting the development of local industry (MoH, 2007). Under the policy mission, factors that influence quality of health was viewed across social, economic and environmental domains and not merely absence of sicknesses. Therefore, the policy sought a paradigm shift from all facets of living that are detrimental to one's health to the most preferred healthy way of living to ensure a healthy population. This policy is instrumental as far as the health of Ghanaian children is concerned because children are the most vulnerable to malnutrition and environmental health problems.

To further scale up strategies towards achieving the MDG Four that sought a two-third reduction in child mortality, Ghana, through the Ministry of Health and other policy makers and implementers launched the 'Under-five Child health Strategy' to cover the period of 2007 to 2015 (MoH, 2007). The main goal of the Policy was to reduce child mortality from 111 per 1000 live births to 40 per 1000 live births from 2006 to 2015 respectively (MoH, 2007). This Policy, viewed as an integrated approach, pooled salient strategies and interventions that were geared towards the quality health of children from conception to childbirth (under-five). Thus, the policy, holistically, took every factor that could ensure the survival of children through their life cycle into consideration. The policy areas were maternal and child health, immunisation, proper feeding, malaria, HIV and AIDS and their integration.

Ghana, through the Ministry of Health and other development partners, also developed the 'National Newborn Health Strategy and Action Plan' in 2013 to respond to the slow decline in neonatal deaths since neonatal deaths constituted a higher proportion of under-five mortality in Ghana (MoH, 2014). The goal of the policy was to add to the reduction of neonatal mortality rate from 32 per 1000 live births to 21 per 1000 live births from 2011 to 2018 respectively and to contribute to the decline of institutional neonatal mortality rate by at least 35 percent by 2018 (MoH, 2014). The policy has made a significant contribution towards a reduction in under-five mortality in Ghana. For instance, under-five mortality rate fell from 111 per 1,000 livebirths to 60 per 1,000 livebirths from 2008 to 2014 (Ghana Statistical Service, Ghana Health Service & ICF International, 2015).

The National Newborn Health Strategy and Action Plan look at the health of the children preceding birth and focuses on four main domains: basic essential newborn care, management of adverse intrapartum events, care of the preterm or low-birth-weight or growth-restricted baby and management of neonatal infections or sick newborns. The National Newborn Health Strategy and Action Plan was principally towards preventive care from birth to the end of the first week of delivery. Care that needs to be given to newborns based on the Policy are eye care, immunisation, vitamin K administration, cord care, quality birth practice and others (MoH, 2014).

Despite the implementation of these strategies, low maternal health care utilisation persisted. This led to the introduction of the Free Maternal Health Policy in 2004 (Ministry of Health of Ghana, 2004). The policy was directed at making delivery care free to mothers from conception to delivery.

The goal of the policy was to improve financial and geographic access to quality delivery care services. The services covered by this policy included normal deliveries, assisted deliveries including caesarean section and management of medical and surgical complications arising out of deliveries (Ministry of Health of Ghana, 2004; Witter, Adjei, Armar-Klemesu & Graham 2009).

The Policy made a significant contribution to the health of mothers and newborns by improving access to skilled delivery care. For instance, maternal mortality ratio fell from 376 to 325 per 100,000 live births between 2005 and 2010 (WHO, UNICEF, UNFPA, the World Bank & the United Nations Population Division, 2014) while childhood mortality also declined from 50 to 19 per 1000 (GSS, GHS & ICF International, 2015). Also, the number of women receiving antenatal care from a skilled provider increased from 95 percent in 2008 to 97 percent in 2014 while births occurring in a health care facility also increased from 57 percent in 2008 to 73 percent in 2014. Again, births attended by skilled providers also increased from 59 percent in 2008 to 74 percent in 2014 (Ghana Statistical Service, Ghana Health Service & ICF International, 2015). In addition, it led to the reduction of out-of-pocket payment among mothers in accessing maternal health services. However, the Policy was faced with administrative and financial challenges (Witter, Adjei, Armar-Klemesu & Graham 2009). Also, some of the private health care facilities ceased providing free services to mothers due to late payment of claims (Witter, Adjei, Armar-Klemesu & Graham, 2009).

Epidemiology of Under-Five Mortality in the Cape Coast Metropolis

Under-five mortality rate, denoting the probability of dying between birth and the fifth birthday, is a basic indicator of a country's socio-economic situation that depicts the quality of life (Ghana Statistical Service, Ghana Health Service & ICF International, 2015). Table 1 presents estimates for under-five mortality recorded in the Cape Coast Metropolis between 2010 and 2014. The Metropolis experienced 228 under-five deaths in 2010. This slightly declined to 209 in 2011 and rose up again to 235 in 2012. The metropolis further recorded 220 under-five deaths but this sharply declined to 85 deaths in 2014 (Table 1) (Cape Coast Metropolitan Health Directorate, 2015).

Table 1- *Children under-five deaths recorded in the Cape Coast Metro*

YEAR	TEACHING HOSPITAL	METRO HOSPITAL	UCC HOSPITAL	TOTAL
2010	142	80	6	228
2011	148	57	4	209
2012	179	55	1	235
2013	191	24	5	220
2014	68	11	6	85
TOTAL	728	227	22	977

Source: Cape Coast Metropolitan Health Directorate (2015)

The under-five deaths recorded in the metropolis is not evenly distributed as far as the facility-type deaths occurred is concerned (Figure 1). The Cape Coast Teaching Hospital has been recording the highest under-five deaths in the metropolis. For instance, the facility experienced 142 deaths out of the 228 total under-five deaths recorded in the metropolis in 2010 (Cape

Coast Metropolitan Health Directorate, 2015). This persisted and in 2014, the facility still recorded more than half (68 out of 85 deaths) of under-five deaths recorded in the metropolis (Figure 1) (Cape Coast Metropolitan Health Directorate, 2015).

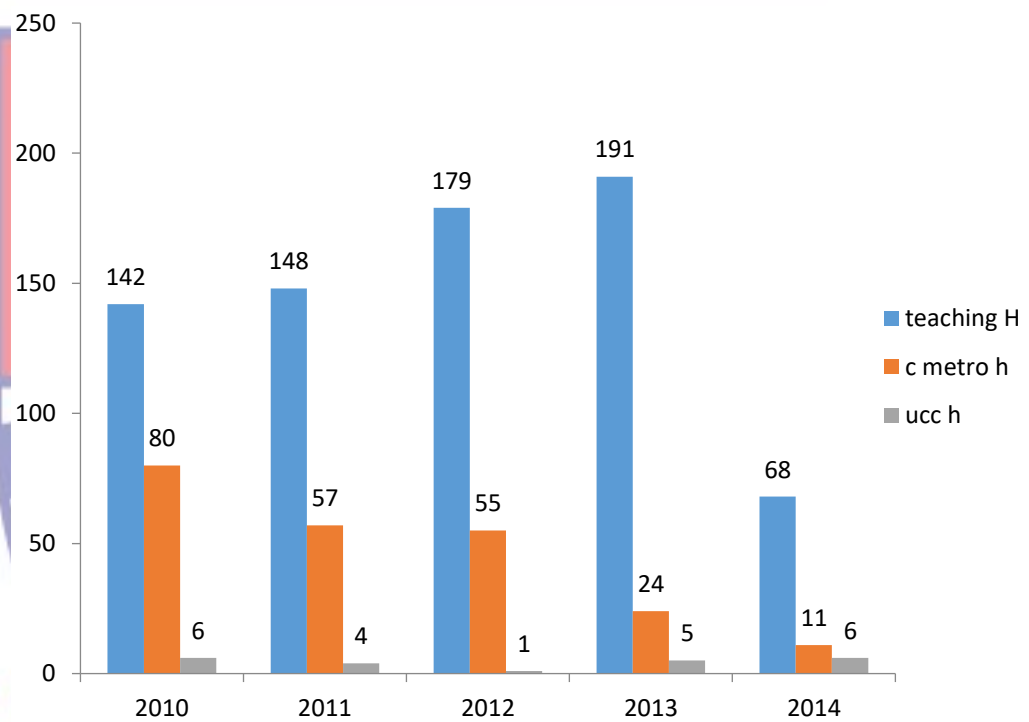


Figure 1: Distribution of under-five deaths by facility-type in the Cape Coast Metro

Source: Cape Coast Metropolitan Health Directorate (2015)

Mothers' Perception of Childhood Illness

Socio-behavioural models such as the health belief model (HBM) (Hochbaum, 1958; Becker & Maimam, 1975; Munro, Lewin, Swart & Volmink, 2007; Glanz, Rimer & Viswanath, 2008) and protection motivation theory (PMT) (Bandura, 1997; Floyd, Prentice-Dunn & Rogers, 2000; MacDonell et al., 2013) explain that individual perceptions constitute agents of behaviour change and influences health-seeking behaviour. These theories

acknowledge the influence of 'perceived vulnerability and severity' on health-seeking behaviour and have been widely applied to perceptions and the likelihood of health behaviours. For instance, the PMT was effective in studying tobacco use in Chinese Youth (MacDonell et al., 2013), the adoption and usage of protective technologies (Chenoweth, Minch & Gattiker, 2009) injury prevention, political issues, environmental concerns and protecting oneself (Floyd, Prentice-Dunn & Rogers, 2000). Again, Kroeger's explanatory model (1983) also conceptualised health-seeking behaviour as how individuals label and interpret particular signs and symptoms of sickness and factored these interpretations into household decision-making process based on experiences, norms and expectations and choice of an acceptable treatment option to deal with sickness (Kroeger, 1983; Prosser, 2007).

Empirical findings have also shown that how individuals perceive and interpret causes, signs and symptoms, as well as their belief about their susceptibility to sickness influence their sources of seeking health care and preventive practices (Flores, 2000; Murguia, Zea, Reisen & Peterson, 2000; Iroegbu, 2005; Westerlund, 2006; Vaughn, Jacquez & Baker, 2009; Nyabwari & Kagema, 2014; White, 2015). A wide array of factors including socio-cultural beliefs induces individual's judgement about health beliefs, perceptions and treatment options (Vaughn, Jacquez & Baker, 2009).

Although culture modifies individuals' subjective assessment, individuals' attribution about their health influence their intention towards seeking health care (Vaughn, Jacquez & Baker, 2009). Earlier studies (Flores, 2000; Murguia, Zea, Reisen & Peterson, 2000) concluded that individuals' attribution about causes of disease affect their course of action taken which is

affected by their geographical setting and racial background. These studies revealed that, mostly, western populations attributed causes of disease to scientific sources whilst African patients usually linked it to spiritual or social causes.

In sub-Saharan Africa, it is a general perception that being healthy also includes having a good standing with the community and society (Iroegbu, 2005; White, 2015). Iroegbu (2005) further reiterates that being healthy in African traditional contexts reflects individuals' ability to conform and live to the expectations of the values and norms of the societal traditions. White (2015) also adds that the constellation of a healthy person in Africa goes beyond the quality of life for the living but rather includes ancestral influence. The interpretation is that when the ancestors are healthy, they can also protect the living. A wider range of evidences have shown a link between causes of illness and belief systems in Africa (Westerlund, 2006; Nyabwari & Kagema, 2014). For instance, Westerlund (2006) observed that most people in African communities hold that disease is caused by the attacks from evil or bad spirits while others attributed causes of disease to ancestral manipulations. That is, they believe that when one is at fault with the ancestors, he or she could be punished with diseases (Westerlund 2006).

Similarly, Olupona (2004) acknowledged that people attribute sicknesses to their adversaries who possess evil spirits. That is, they believe that those who possess evil spirits could inflict sicknesses on others who disrespect or disobey them through spell casting and invocation. Again, Agbo and Chukwuemenam (2011) noticed that only 36.1 percent knew that lymphatic filariasis was caused by mosquito bites in Benue State, Nigeria.

Obinna (2012) also reasoned that it is a belief among certain traditional African communities that certain type of sicknesses such as barrenness and infertility may be transmitted via witchcraft and other unforeseen spirits. Nyabwari and Kagema (2014), after pooling evidence on beliefs systems and attribution of causes of illness, concluded that attributing misfortunes, accidents, conflicts, deaths, sickness and failures to witchcraft and bad spirits still persist in African communities.

In Ghana, after exploring cultural traditions and the implications for medical treatment, Bonsu (2014) concluded that individuals attributed illnesses to various causes. In the study, a traditional female priest indicated that some of the illness were not "hospital illness" implying that they are caused by unseen spirits. The informant further added that, the only way such disease could be treated is by reversing the curse. Another interviewee said that diseases can be caused by either malfunctioning of an organ or anger of God, deities, gods and goddess, ancestors, witchcraft, sorcerers and evil men.

Again, White (2015) also noticed that among the Akan communities in Ghana, it is believed that invocation of curses with name of river deities or spirits against an offender or enemies may also lead to sickness. He added that the belief among Traditional and Faith Healers is that a community may be infected with a disease or be punished with the strange disease if they flout taboos in that society. This shows that people still hold that disease is not caused by pathogens alone but include several factors that cannot be explained scientifically.

Consequently, the role and involvement of diviners, spiritual healers and herbalist are acknowledged in managing or treating sickness in some

African communities (van Anandel, Myren & van Onselen, 2012; White, 2015). A cross-sectional survey conducted by Asante et al. (2010) to investigate community perceptions of malaria and malaria treatment behaviour in a rural district of Ghana after the introduction of Artemisinin Combination Therapy (ACT) revealed that, the respondents depended on home management for malaria cases by either using herbs, left over drugs earlier used to treat same conditions or resorted to peddlers or chemical shops for drugs. They observed that respondents considered hospital as an option when home management failed. In their study, the respondents attributed malaria to mosquito bite.

In Ghana, after exploring the beliefs, knowledge and perceptions about pregnancy and delivery and care seeking behaviour among pregnant women in Ghana, Darko-Gyeke et al. (2013) realised that mothers combined public and private formal healthcare facilities as well as utilised both the orthodox and traditional health care services.

Health-seeking that can yield good results is dependent on early recognition of signs and symptoms (Ferdous et al., 2013; Chandwani & Pandor, 2015). Mothers' ability to detect signs and symptoms of illness is at the core of effective caregiving. Since children cannot communicate what they feel to mothers, it makes early detection and recognition cumbersome if not impossible (Galvez, Modeste, Lee, Betancourt & Wilkins, 2002). For instance, Galvez et al. (2002) inquired from Peruvian mothers about their knowledge level on signs and symptoms depicting onset of pneumonia. They noticed that even though respondents' rapid breathing was an indicator of an onset of pneumonia, that alone could not be a sure sign that the child had pneumonia.

Again, Ul-Haq, Durrani, Kumar & Durrani (2015) observed a poor knowledge about signs and symptoms of childhood illness among mothers in Pakistan. Using diarrhoea and Acute Respiratory Infections (ARI) as a proxy for childhood illness, they observed that, just a few (27%) of the respondents indicated that feverish condition was a serious symptom of childhood illness.

Though the study observed a lower knowledge about symptoms of childhood illness among the respondents, however, majority of the mothers (90.1%) sought appropriate care for children.

Another factor which determines health-seeking behaviour is about how individuals perceive themselves about their susceptibility to sicknesses (El Bcheraoui et al., 2015). Although it has been established that when mothers have to walk for longer distance, they find it difficult to seek health care for their children under-five. However, when the condition is life-threatening, the impact of distance becomes insignificant (El Bcheraoui et al., 2015). El Bcheraoui et al. (2015) realised that hypertensive and diabetic patients' health-seeking behaviour in Saudi Arabia, concerning the type of clinic visited and distance travelled to last clinic visit were not associated with diagnosis or treatment of hypertension or control of blood pressure because the patients considered the severity of their condition.

Motivation to Health-Seeking Practices

Several factors motivate mothers to seek timely health care for their children under-five years. For order of presentation, in this review, these factors shall be captured under three broad domains: demographic characteristics, socio-economic, and institutional factors.

Demographic Background Factors

Socio-behavioural models such as the health belief model (HBM) (Hochbaum, 1958; Becker & Maimam, 1975; Munro, Lewin, Swart & Volmink, 2007), the protection motivation theory (Bandura, 1997) and the planned behaviour theory (Ajzen, 1991; Tlou, 2009; Fishbein & Ajzen, 2010) stress on demographic background of individuals as a determinant and modifier of health-seeking behaviour. Again, the Anderson's three phase health care utilisation model consists of predisposing factors such as sex, age, occupation and education which affect health care utilisation (Andersen, 1968; Prosser, 2007).

Several evidence have shown that individuals' demographic characteristics account for higher health care utilisation (Danso-Appiah, De Vlas, Bosompem & Habbema, 2004; Taffa & Chepngeno, 2005; Assefa et al., 2008; Abose, Woldie & Ololo, 2010; Doku, Neupane & Doku, 2012; Rahman, Nakamura, Seino & Kizuki, 2012; Birmeta, Dibaba, Woldeyohannes, 2013; Singh, Kumar & Kumar, 2013; Selemani et al., 2014; Fenny et al., 2015; Kananura et al., 2016). In India, Singh, Rai, Alagarajan & Singh (2012) observed that the demographic factors were influential on mothers' health-seeking behaviour. From their observation, it became evident that there was significant difference in the use of selected maternal health care utilisation by educational attainment, economic status and region of residence. Thus, Muslim women and women belonging to selected castes, tribes and other backward classes were less likely to avail themselves for safe delivery services. Additionally, they found a higher maternal health care utilisation among adolescent women from the Southern region in India.

Another Indian-based study revealed that children's background characteristics, in some instance, have been observed to have motivated mothers to seek prompt health care (Chandwani and Pandor, 2015). In India, after investigating health-seeking behaviour for 405 mothers, Chandwani & Pandor (2015) found that male children were given much attention compared to the female children. They noticed that more than 68 percent of the male respondents were sent to public health care facility for treatment compared to 42 percent of the female respondents. This can be explained by the cultural orientation where there is high preference for a male child.

In Ethiopia, Assefa et al. (2008) also found that differences existed in health-seeking behaviour among mothers residing in the urban and rural areas. After comparing health-seeking behaviour of mothers for children suffering from fever, acute respiratory infections (ARI) and other illness two weeks preceding their survey, they found out that out of the 47 mothers living in urban residents, 87.2 percent said they took their children to health care facilities whilst only 12.8 percent said that they did not seek care from health care facilities. A possible explanation to this could be due to distance since mothers in urban areas can reach health care facilities after a few kilometres walk.

Another Ethiopian-based study also revealed that the age of the mothers influenced their health-seeking behaviour (Abosse, Woldie & Ololo, 2010). They realised that maternal age was a significant factor in the utilisation of ANC service in Ethiopia. Again, they noticed that mothers living with less than three children in a household were eight times more likely to

utilise ANC services compared to those living with five or more children in a household.

Over a time, Birmeta, Dibaba, Woldeyohannes (2013) also noticed that factors accounting for higher health care utilisation in Ethiopia included women's parity, literacy status, average monthly family income, media exposure, where to give birth and distance to health institutions (Birmeta, Dibaba & Woldeyohannes, 2013). The background characteristics of women are important factors which influence health-seeking. For example, families with higher wealth status can afford medication and transport cost compared to their counterparts with low wealth status.

Earlier studies in Ghana conducted by Danso-Appiah, De Vlas, Bosompem, and Habbema (2004) showed that women were more likely to seek health care than men. The reason to this could be due to differences in gender roles and expectations where women in the Ghanaian context are socialised to be soft and cautious about their bodies.

Factors associated with reproductive health care utilisation among Ghanaian women were also investigated by Doku and colleagues who identified that most mothers (96.5%) attended ANC but about 42.7 percent did attend usually after the first trimester while 36.5 percent delivered without the help of a trained health care personnel (Doku, Neupane & Doku, 2012). They further noticed that subscription to insurance influenced mothers' ANC attendance.

Fenny et al. (2015) also sampled 365 adults and children who reported ill of malaria from the three ecological zones (Coastal, Forest and Savannah zones) in Ghana and investigated their care seeking behaviour under the

operation of the National Health Insurance Scheme in Ghana. They identified that income status and subscription to insurance influenced health-seeking behaviour. The reviewed studies have shown that subscription to insurance influences health-seeking behaviour.

Socio-Economic Factors

The Anderson's three phase health care utilisation model, with the enabling factors capturing individual or family resources consisting of wealth status and ownership of insurance, as well as community resources including access to health care facilities and availability of support (social capital), draws the attention to the socio-economic variables and behavioural change relationship (Anderson, 1968). Bronfenbrenner's (1979) bio-ecological model also expanded the argument that health behaviour is a result of the interaction between factors clustered around historical, social, economic, political and environmental domain (Bronfenbrenner, 1979).

However, socio-behavioural theories such as the theory of reason action (TRA) (Ajzen, 1991), theory of planned behaviour (TPB) (Fishbein & Ajzen, 2010), health belief model (HBM) (Hochbaum, 1958; Glanz, Rimer & Viswanath, 2008) and protection motivation theory (PMT) (MacDonell et al., 2013) explain that one's relative ease or difficulty to seek healthcare is affected by his or her perceived benefits and barriers that are being modified by his or her socio-economic status such as availability of income to afford medical bills and transport cost.

Several studies have also noticed that the socio-economic factors also motivate mothers to seek health care (Blanchet, Fink & Osei-Akoto, 2012; Doku, Neupane & Doku, 2012; Ohashi, Higuchi, Labeeb, Mohamed, Chiang

& Aoyama, 2014; Acquah et al., 2015; Fenny, Asante, Enemark & Hansen, 2015). For instance, subscription to insurance motivates mothers to seek health care on the basis that, the insurance shall serve as a financial protection against health care cost (Blanchet, Fink & Osei-Akoto, 2012; Doku, Neupane & Doku, 2012; Fenny, Asante, Enemark & Hansen, 2015). Blanchet, Fink & Osei-Akoto (2012) assessed the influence of insurance on health-seeking behaviour of women in Ghana. The study found out that women who have subscribed to the insurance were more likely to obtain prescriptions, visit clinics and seek health care from formal health institutions when they were sick. Similarly, Acquah, Koomson, Ekumah & Osei-Kufour (2015) also noticed that subscription to insurance positively influenced health-seeking behaviour in Ghana.

Aside subscription to insurance, another way the socio-economic factors acting as motivations to health-seeking behaviour is through social support and fringe benefit mothers obtain from husbands and relatives (Ohashi et al., 2014). Mothers' access to benefits either in cash or kind from partners or relatives facilitates their health-seeking behaviour (Ohashi et al., 2014).

Institutional Factors

The health belief model (Hachbaum, 1958), theory of reason action (Ajzen, 1991), planned behaviour model (Fishbein & Ajzen, 2010) and protection motivation theory (MacDonell et al., 2013) summarised that, individuals can seek health care when they are efficacious to execute the intended behaviour coupled with limited or no barrier. These theories argued that self-efficacy (which denotes an individuals' pre-defined belief that one

can successfully perform the recommended action) is a key determinant of behaviour change (Bandura, 1997).

Young health care utilisation model (1981) also stressed that the belief about the efficacy of treatment influences individuals' choice and satisfaction to treatment. The model further explained that individuals' evaluation of the cost of health services, the availability of those services and other logistics determine healthcare utilisation. In a similar manner, the bio-ecological model by Bronfenbrenner (1979) also explained that factors that operate at the macro level including the availability of equipment and other logistics increase health care utilisation.

Findings have shown that health-seeking behaviour is affected by a wide range of institutional factors (Kruk, Paczkowski, Mbaruku, de Pinho & Galea, 2009; Alrubaiee & Alkaa'ida, 2011; Sreeramareddy, Sathyanarayana & Harsha Kumar, 2012; Ramez, 2012). In India, it was noted that wealthiest mothers had the higher probability of utilising private healthcare facility for treatment of both diarrhoea and fever or cough (Sreeramareddy, Sathyanarayana & Harsha Kumar, 2012). For instance, for the treatment of diarrhoea, the authors noticed that women belonging to richest households had higher odds of taking their children to a private health care provider as compared to women from poorest households. They also noticed an association between wealth status and place of treatment for fever or a cough. It was also evident that mothers switched to private health care providers for treating fever and cough because they held that, at the private health centres, enough drugs were given to them (Sreeramareddy, Sathyanarayana & Harsha Kumar, 2012).

A population-based discrete choice experiment study conducted by Kruk et al. (2009) in rural western Tanzania to estimate women's preferences for place of delivery concluded that place of delivery was influenced by facility-related factors such as distance, cost, type of provider, the attitude of provider, drugs and equipment as well as free transport. In their study, they realised that, the women's intention to choose and utilise a facility was influenced by a facility associated with respectful provider and availability of drugs and medical equipment.

Owing to the fact that patients are the primary recipient of services delivered by health care facility, the Ghana Health Service Patient Charter (2002) spelt out that, health care delivery should be sensitive to patients' socio-cultural and religious backgrounds and that services should be patient-centred where the dignity and value of patients should be the key towards health care delivery. Patients always strive for the quality of care. However, what is considered as 'quality of service' is context specific and differs from a person to the other. From patients' point of view, health care delivery and service is said to be quality when health care providers show respect, empathy, and concern as well exhibit professionalism at work (Tang, Luo, Fang, & Zhang, 2013; Amin & Nasharuddin, 2013). Undoubtedly, when the services received by patients are perceived to be of high quality, it affects their satisfaction and utilisation of health care. For instance, Alrubaiee & Alkaa'ida (2011) and Ramez (2012) noticed that satisfaction to services increases when patients conceive that the services they receive is of high quality.

From the reviewed studies, it was noted that several factors embedded in mothers' background characteristics, socio-economic and institutional

factors motivate mothers to seek health care. However, majority of the studies were quantitative biased and therefore failed to explore the views of mothers. This study shall incorporate the demographic factors that motivate mothers to seek health care by using qualitative approach to explore the phenomenon.

Challenges to Health-Seeking Practices

Mothers' timely reception to health care for their children under-five can be challenged by several factors as explained by the 'Three Delays' model (Thaddeus & Maine, 1994). The health care utilisation model (Anderson, 1968) and bio-ecological model (Bronfenbrenner, 1979) explained that individuals' demographic background including education, occupation, age and sex can inhibit health care utilisation. Individual-based theories such as the health belief model (HBM) (Hochbaum, 1958; Becker & Maimam, 1975; Munro, Lewin, Swart & Volmink, 2007), protection motivation theory (Bandura, 1997) and planned behaviour theory (Ajzen, 1991; Tlou, 2009; Fishbein & Ajzen, 2010) stressed that change in behaviour can be inhibited by a person's demographic characteristics.

Studies have also shown that individuals' demographic background also inhibit their health-seeking behaviour (Basu, 1996; Tolhurst & Nyonator, 2006; Yigzaw, Yibrie & Kebede, 2004; Allendorf, 2007; Mekonnen & Asrese, 2014; Chandwani & Pandor, 2015). The living arrangement of mothers is a key factor to consider as far as mothers' health-seeking behaviour is concerned in Ghana (Tolhurst & Nyonator, 2006). The reason is that mothers' health-seeking decision-making on the amount to spend, where and when to seek

health care is affected by their husbands, parents and relatives (Tolhurst & Nyongator, 2006).

Mothers' autonomy is very important as it influences the bargaining power of the women concerning child health care decision-making (Anwar, Shoaib & Javed, 2013). Meanwhile, studies have observed that mothers' ability to make decisions or determine events concerning their lives can be affected by their educational level, income status, employment status and other socio-demographic factors (Yigzaw, Yibrie & Kebede, 2004; Allendorf, 2007; Mekonnen & Asrese, 2014). The argument is that mothers who have little education cannot seek higher paid jobs and become highly dependent on the partner for survival and this further affects their household bargaining power. In most countries within sub-Saharan Africa, women have the poor educational background, limited decision-making power, scanty resources and are confronted with health service skewed towards the men (Basu, 1996; Mekonnen & Asrese, 2014).

Again, Needham, Foster, Tomlinson, & Godfrey-Faussett (2001) noticed that women were more likely to delay to seek treatment, particularly if their education level was low in Zambia. Similarly, Chandwani and Pandor (2015) noticed that there was a disparity in health-seeking with regards to the sex of the child in India. They noted that, among children who fell sick, few of the male respondents (16.5%) received preventive treatment as compared to a significant proportion of the female respondents (42%).

Household decision-making and distribution of resources can be influenced by individuals' subjective norms and perceived behavioural control surrounding the behaviour as argued by the theory of reasoned action (TRA)

(Ajzen, 1991) and theory of planned behaviour (TPB) (Ajzen, 1991; Tlou, 2009; Fishbein & Azjen, 2010). Thaddeus and Maine (1994) also argued that timely reception to health care can be interrupted by both "first delay" and "second delay". They explained the former as the delay at the household decision-making and the latter as the potential constraints and barriers that may inhibit identification and reaching the healthcare facility. In both delays, they acknowledged the influence of socio-economic factors as determinants of health care utilisation (Thaddeus & Maine, 1994; Kijugu, 2009).

In a similar manner, studies have identified several socio-economic factors as a challenge to health-seeking behaviour (Asenso-Okyere, Anum, Osei-Akoto & Adokonu, 1998; Danso-Appiah et al., 2004; Yakong, 2008; Sharkey, Chopra, Jackson, Winch & Minkovitz, 2011; Dako-Gyeke, Aikins, Aryeetey, Mccough & Adongo, 2013). A key area that serves as a challenge to seeking health care is the delay in health-seeking decision-making. Health care is one critical area where the head of a household is required to take decisions as to where care must be sought because they must provide the financial resources (Pradham, 2013). Pradham (2013) realised that mothers only made decisions when the heads of the family or the husbands die in India (Pradham, 2013).

Nyakato & Rwabukwali (2013) observed that the men were influential and occupied higher positions on ownership of family resources in Uganda. They further noticed that when the men were not at home, the women were less likely to use family resources to seek health care for their children. This could be due to marital union that gives room for power sharing and structural

allocation and ownership of resources within the household which disfavours the women in the societies

Similarly, Sharkey, Chopra, Jackson, Winch & Minkovitz (2011) observed that mothers face strong opposition from their husbands and relatives that affect their health-seeking behaviour in South Africa. This could partly be due to gender roles that reserved decision making as masculine activity. Also, Yakong (2008) argued that mothers adhere to partners and relatives' decisions in a society so that they can be recognised and praised as submissive people.

Moreover, evidence by Mekonnen & Asrese (2014) revealed that 61.2 percent of the mothers said that they played a joint role with their husbands and relatives in decisions involving their health in Ethiopia. They also noticed that 58.8 percent and 60.1 percent of the mothers respectively asserted that large purchases and visits to family, friends and relatives was decided by their husbands alone.

However, in some cases, health-seeking decision making tends to be a collaborative responsibility of both the head of the household and the mother or between households and their extended families (Danso-Appiah et al., 2004). Danso-Appiah et al. (2004) found that majority of the decisions to utilise an existing health care was taken by either the father or the mother. They noticed that the decision to request for healthcare was made mostly by mothers (86.3%).

Health-seeking behaviour is also affected by other economic cost such as travel time due to long distance and location of a facility (Prosser, 2007; Kiwanuka, Ekirapa, Peterson, 2008; Rutherford, Mulholland & Hill, 2010; Schoeps et al., 2011; Blanford et al., 2012; Kyei, Campbell & Gabrysch, 2012;

Adu-Gyamfi & Abane, 2013). Although travel distance has continuously remained a mediating factor that either enhances or inhibits individuals' access to essential healthcare (Kiwanuka, Ekirapa, Peterson, 2008; Schoeps et al., 2011). However, Rutherford, Mulholland & Hill (2010) highlighted that distance must be treated with caution. This is because, they found no clear evidence existed that explicitly explained direct link between mere physical distance and health care accessibility in their systematic review. They, therefore, suggested that travel time, for instance, must be used instead of mere physical distance.

Nonetheless, this assertion is subject to debate because findings in Zambia show that, the physical distance led to disparities to ANC utilisation among urban and rural dwellers (Kyei, Campbell & Gabrysch, 2012). In the same vein, after investigating the effect of distances on the utilisation of hospitals, maternity and integrated health centres in Niger, Blanford et al. (2012) realised that physical distance affected health care utilisation. Also, physical distance to a facility remained a determinant of health care utilisation in Burkina Faso and Ghana (Schoeps et al., 2011; Adu-Gyamfi & Adjei, 2013) This therefore makes the argument inconclusive since this evidence found physical distance to be a significant determinant to health-seeking behaviour.

Financial constraints is also a determinant that influences health-seeking behaviour. The argument is that, when the household is financially handicapped, they cannot afford hospital bills and transport cost (Taffa & Chepngeno, 2005). In Kenya, Taffa and his colleague noticed that lack of finance (49.6%) was the main reason given by mothers for failure to

seek health care outside the home among mothers living in Nairobi slums in Kenya.

In a similar manner, studies in Ghana found lack of access to funds to be a key determinant to health-seeking behaviour (Asenso-Okyere, Anum, Osei-Akoto & Adokonu, 1998; Dako-Gyeke et al. (2013). In both studies, they realised that patient's inability to afford user-fees served as a challenge to health-seeking behaviour. This implies that, without access to funds, mothers might face some challenges in seeking health care for their children under-five.

Thaddeus and Maine (1994) discussed that a "third delay" to healthcare utilisation could arise due to inadequate referral system, unavailability of equipment, drugs, supplies and other logistics, and insufficient trained and skilled staff (Thaddeus & Maine, 1994; Kijugu, 2009). The health care utilisation model (Young, 1981) also explains that individuals' evaluation of the cost of health services, efficacy in treatment, the availability of those services and other logistics also determine healthcare utilisation. Bronfenbrenner (1979) bio-ecological model also adds that other factors that operate at the macro level including policies, institutional (unavailability of equipment and other logistics) and environmental factors can inhibit healthcare utilisation.

Studies have shown that health-seeking behaviour is also affected by institutional factors including health care providers' attitude, availability of drugs and equipment (Yakong, 2008; Mrisho et al., 2009; Sharkey, Chopra, Jackson, Winch & Minkovitz, 2011; Sreeramareddy, Sathyanarayana & Harsha Kumar, 2012; Afolabi, Dorapale, Irinoye & Adegoke, 2013; Ohashi,

Higuchi, Labeeb, Mohamed, Chiang & Aoyama, 2014; Nyongesa, Onyango and Kakaipatient 2014; Acqua, Koomson, Ekumah & Osei-Kufour, 2015). For instance, Mrisho et al. (2009) observed that most women delivered at home due to walking distance to the healthcare facilities, fear of caesarean section and absence of privacy

Similarly, in Kenya, Nyongesa, Onyango & Kakaipatient (2014) noticed that over 28 percent and 15 percent of the respondents disagreed and strongly disagreed respectively that they understood the instructions given to them on medications. Also, they noticed that the respondents were not satisfied with services received and cited waiting time, attitude of the providers, availability of drugs and services, affordability of the services, level of staffing and level of cleanliness as their reasons for being dissatisfied with services received.

In a similar manner in Nigeria, students also expressed their dissatisfaction with services received and further commented that encountering negative attitudes like long waiting time and disrespectful healthcare providers obstructed them from using such a facility (Afolabi, Daropale & Adegoke, 2013).

Again, long waiting time and delay in seeking health care have been identified to affect satisfaction to service and overall health-seeking behaviour in Ghana (Aggrey & Yaw Appiah, 2014). Aggrey & Yaw Appiah (2014) noticed that 54 percent of their respondents were dissatisfied with services received due to delay in seeing a doctor, undergoing laboratory test and accessing healthcare entirely in the Kumasi Metropolis. The studies reviewed

have pointed that several health facility-based factors can negatively influence mothers health-seeking behaviour.

Theoretical Frameworks for the Study

The study is underpinned by the Planned Behaviour Theory (PBT) developed by Azjen in 1985 and the 'Three Delays' model developed by Thaddeus and Maine in 1994. The main purpose of PBT was to predict and understand individual's behaviour (Azjen, 1991; Tlou, 2009).

According to the PBT, an individual's behaviour can be predicted by intention reflecting on his or her readiness to perform a behaviour. However, the intention is predicted by attitude towards the behaviour, subjective norms, and perceived behavioural control (Ajzen, 1991). Attitudes depend on behavioural beliefs about possible outcomes of the behaviour and assessment of the outcome (Fishbein & Ajzen, 2010). Fishbein & Ajzen (2010) defined subjective norms as individual's perception about whether or not referents (example, husbands, relatives and friends) think a person should perform a behaviour. Perceived behavioural control was also explained as the extent to which an individual believes that he or she is able or have the control to perform a given behaviour (Fishbein & Ajzen, 2010).

This theory has been applied to explain and predict health-related behaviour. However, it has been observed that attitude, which was a major construct in the theory, has been found to be weakly correlated to behaviour (Bechtel & Churchman, 2002; Winter & Koger, 2004). Again, the theory assumes that people think about the outcome of a behaviour before they act.

Meanwhile, not every action including involuntary action is based on rational choice including involuntary action (Abrahamse & Steg, 2011).

Mothers' intentions to seek health care for their children under-five years can be predicted with this theory. Mothers may be motivated to seek health care for their children if they have a positive attitude towards seeking health care; if there are favourable subjective norms and favourable perceived behavioural control (reflecting on financial capability and limited barriers that obstruct health-seeking) (Ajzen, 1991; Nisbet & Gick, 2008).

The 'Three Delays' model was developed by Maine and Thaddeus in 1994 to serve as a framework to analyse delays embedded within individual decision making, geographical accessibility or infrastructure-related factors. These factors affect uptake of maternal health services and patterns of maternal mortality in general among developing countries (Thaddeus & Maine, 1994). The model has been applied to health-seeking behaviour of pregnant women in Banke District, Nepal (Chhetri, 2015).

The model analysed maternal mortality as dependent on these three delays. The model is based on the assumption that, from the onset of obstetric complication to the outcome, there are several factors that coincide with a woman's chances of getting swift and quality treatment which are termed as delay factors (Kijugu, 2009).

The model organised the delays into three main phases. These are: phase one (delay in deciding to seek health care), phase two (delay in identifying and reaching medical care) and phase three (delay that arises from receiving sufficient and appropriate care). According to the model, maternal

deaths occur as results of the combination of the phases or independent phase (Thaddeus & Maine, 1994; Kijugu, 2009).

The first phase which focuses on delay associated with the decision to seek care on time is influenced by perceived or actual barriers and constraints. These can be socio-economic, cultural, political, and perceived quality of care (Thaddeus & Maine, 1994; Kijugu, 2009).

The second phase explains the potential constraints and barriers that may inhibit identification and reaching the health care facility. These include geographical distribution of health facilities, distance from home to the facility, availability of transport and income to finance cost of transport (Thaddeus & Maine, 1994; Kijugu, 2009).

The third phase consists of delays associated with the provision and reception of adequate, appropriate and timely quality care. Factors identified under this phase are; adequacy of referral system, availability of equipment, drugs, supplies and others logistics, and sufficient trained and skilled staff (Thaddeus & Maine, 1994; Kijugu, 2009). The third phase of the model has been used to specify facility-level barriers to maternal health care (Knight, Self & Kennedy, 2013).

Mothers' health-seeking behaviour can be inhibited by these three main factors. At the decision-making processes, mothers can only seek health care for their children under-five promptly if they are able to overcome challenges that revolve around health-seeking decision-making processes. For instance, mothers may not be able to seek prompt health care if their husbands and relatives do not approve of the decision. Another challenge may arise when mothers have to travel for long distances in reaching a healthcare facility.

Financial constraints and poor road and irregular transport accessibility influence health-seeking behaviour. Again, mothers may feel reluctant to seek healthcare when health care provision at the facility is delayed or poorly provided. These affect quality of service and reduce mothers' satisfaction, and by extension, utilisation of healthcare.

The conceptual framework which guides the study is the adapted Planned Behaviour Theory (PBT) (Ajzen, 1991 cited in AL Ziadat, 2015) (Figure 3). The framework consists of four independent interrelated factors: Socio-demographic background of mothers; perception of childhood illness; significant others' influence on health-seeking decision-making; and the three accessibilities (financial accessibility; availability of health care; and geographical accessibility) (Figure 3). These independent variables separately or jointly operate through the three core construct of PBT (attitude, subjective norm and perceived behavioural control) to predict mothers' health-seeking behaviour for their children under-five (Figure 3).

Mothers' socio-demographic background include age, level of education, income status, religion, ethnicity and marital status which influence their health-seeking behaviour for their children. The perception of childhood illness also signifies how mothers conceive and interpret childhood illnesses. Mothers will seek prompt health care for their children if they conceive illness to be severe or otherwise (Figure 3). The influence of significant others on health-seeking decision making also explains husbands and relative's influence on child health's decision making. Mothers can receive timely healthcare for their children under-five if they encounter no challenges in

health-seeking decision making such as decision on where, when and an amount to spend (Figure 3).

The financial accessibility specifies availability of funds and insurance to cater for medical bill and other health care cost while availability of health care also denotes the presence of health care facility, logistics and personnel.

The geographical accessibility also explains the distance mothers have to walk to a health care facility (Figure 3). It is anticipated that, with a shorter distance, available health care facilities and providers and enough funds, mothers can seek timely health care.

Based on the overwhelming evidence supporting that significant others (Sharkey et al., 2011; Ferdous et al., 2013; Ohashi et al., 2014), the socio-demographic background (Selemani et al., 2014; Fenny et al., 2015; Kananura et al., 2016), facility factors (Alrubaiee & Alkaa'ida, 2011; Ramez, 2012), distance (van den Boom, Nsowah-Nuamah & Overbosch, 2003; Adu-Gyamfi & Adei, 2013; Krumkamp, Sarpong, Kreuels, Ehlkes et al., 2013) and individuals' perception about illnesses (Vaughn, Jacquez & Baker, 2009; Nyabari & Kagema, 2014; White, 2015) are determinants to health-seeking and utilisation of health care, the model shall be useful to this study. It provided the basis for assessing and analysing mothers' health-seeking behaviour for children under-five from a broader view. Below is a diagrammatical illustration of the conceptual framework.

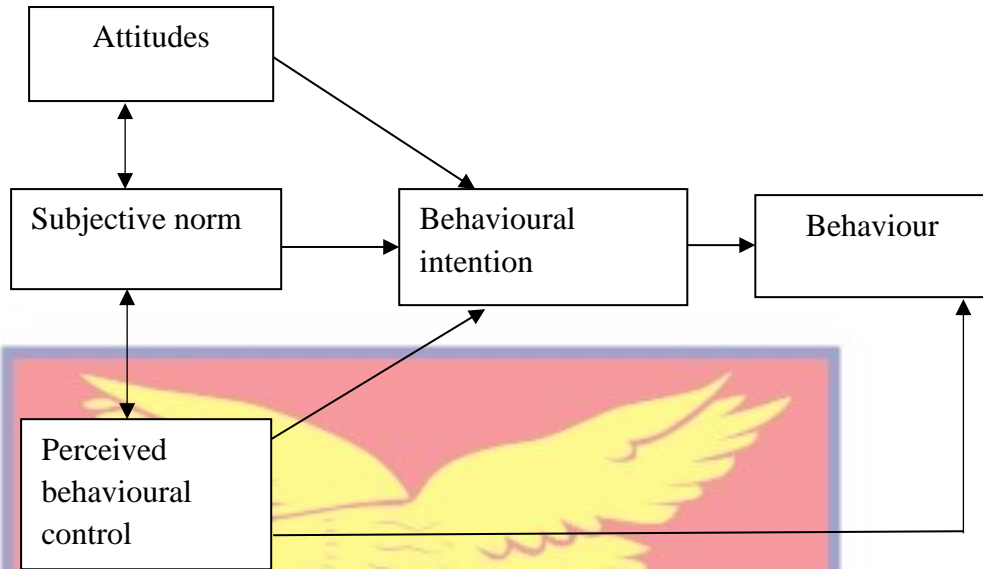


Figure 2: Planned Behaviour Theory

Source: Ajzen (1991) cited in AL Ziadat (2015)

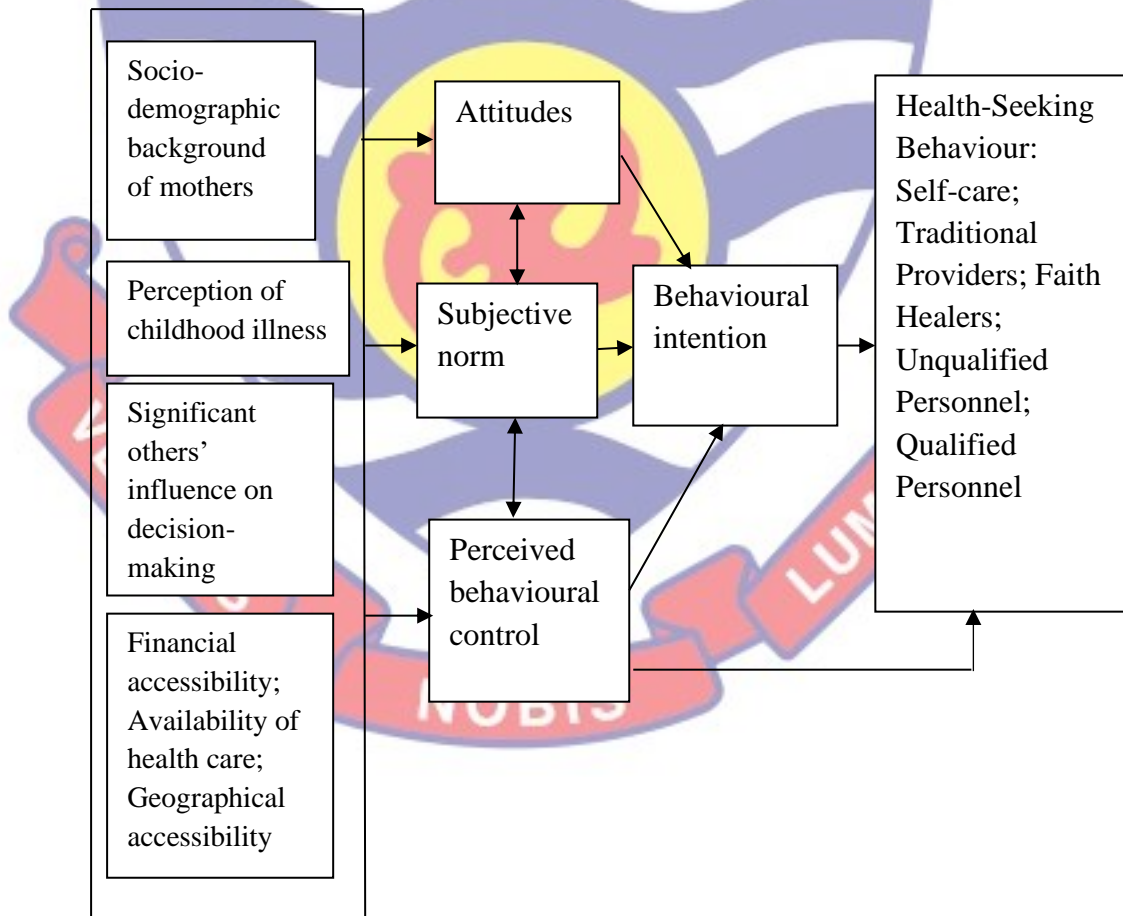


Figure 3: Adapted Planned Behaviour Theory

Source: Ajzen (1991) cited in AL Ziadat (2015)

CHAPTER THREE

METHODOLOGY

Introduction

This chapter deals with the processes that were involved in collecting and analysing the data as well as presentation of the findings. It comprises the description of study area, study design, target population, sampling and sample size, and study instrument. Other issues covered in this chapter include; pre-test of the instrument, source of data, data collection, data management, data analysis and ethical consideration.

Study Area Characteristics

The study was conducted in the Cape Coast Metropolis in the Central Region of Ghana. The Metropolis is found on longitude $1^{\circ} 15^{\circ}W$ and latitude $5^{\circ} 06^{\circ}N$ and bounded to the south by the Gulf of Guinea, to the west by the Komenda-Edina-Eguafo-Abrem Municipality, to the east by the Abura Asebu Kwamankese District and to the north by the Twifo Heman Lower Denkyira District (Figure 4). The Metropolis consists of 84 communities. The Metropolis stretches over a total land area of about 122 square kilometres (Ghana Statistical Service (GSS), 2013).

The population size stands at 169, 894 consisting of 82, 810 males (48.7%) and 87, 084 females (51.3%) as at 2010. Of the total population, 17, 539 are children under age five (0-59 months) comprising 8,859 (50.5%) males and 8,680 (49.5%) females implying male dominance over the females at birth to 59 months. Three-quarters (130, 348) of the population live in urban areas (GSS, 2013).

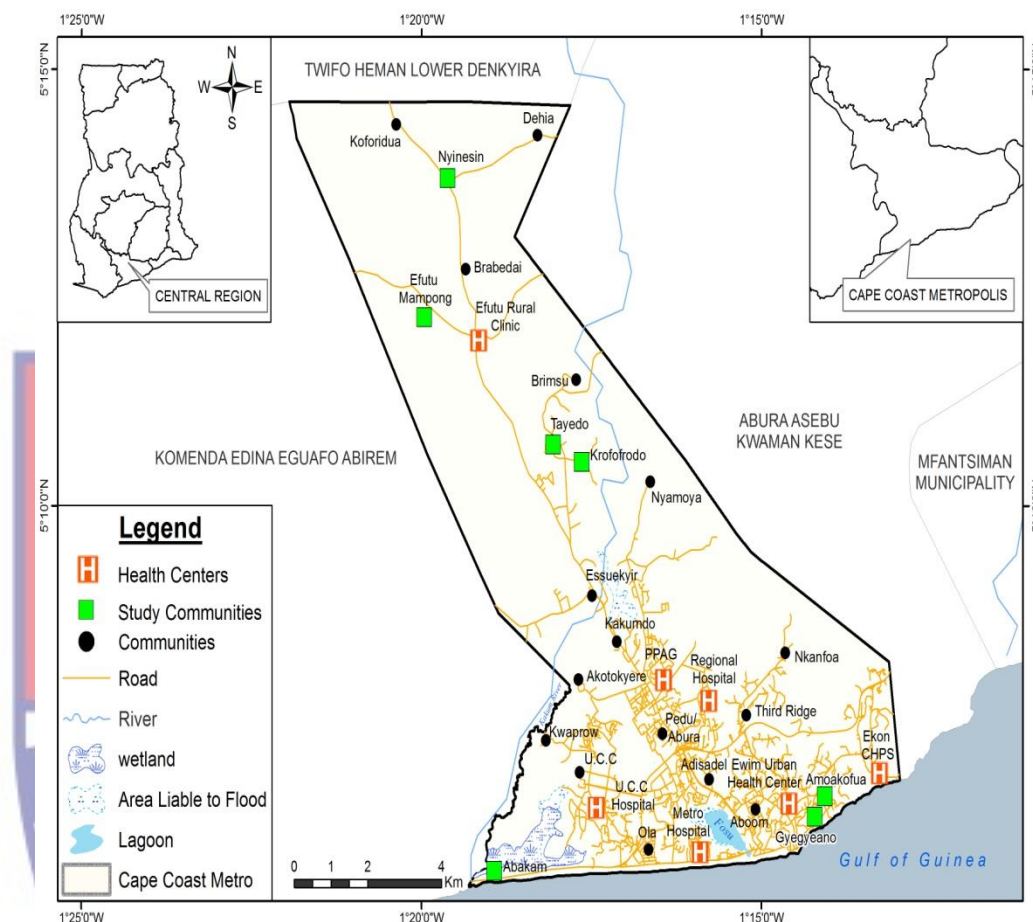


Figure 4: A map of Cape Coast Metropolis showing the studied communities
 Source: GIS Unit, Dept. of Geography & Regional Planning, UCC. (2016).

The Cape Coast Metropolis has 33 health facilities comprising; one teaching hospital, two other hospitals, eight health centres, 15 clinics, five Community-Based Health Planning and Services (CHPS) Compounds, one maternity home and one healing home (Table 2).

The Metropolis has 24 medical doctors and 418 nurses. The doctor-patient ratio for the Metropolis was 1:6,634 in 2013 while the nurse-patient ratio in the same year was 1:380. In addition, there are 67 trained traditional birth attendants (TBAs) and 82 community-based surveillance volunteers (Ministry of Finance and Economic Planning, 2015).

The top ten Out-Patient Department (OPD) cases in the Metropolis were malaria, upper respiratory tract infection (URTI), skin disease, anaemia, hypertension, acute eye infection, rheumatism and other joint pains, diarrhoea disease, diabetes mellitus and intestinal worms (Cape Coast Metropolitan Assembly, 2014).

The Metropolis is grouped under five (5) health care zones according to the distribution of health facilities for health administration purposes. These are: the Reproductive and Health Centres (RCH) health care zone, University of Cape Coast (UCC) health care zone, Ewim health care zone, Adisadel health care zone and Efutu health care zone (Metropolitan Health Directorate, 2016).

Table 2- *Health Care Facilities in the Cape Coast Metropolis*

Facility type	Number
Teaching Hospital	1
Hospital	2
Health Centre	8
Clinic	15
CHPS	5
Maternity Home	1
Healing Home	1
Total	33

Source: Fieldwork, Appiah (2016)

Study Design

The study adopted a qualitative research design. The philosophical perspective of the study is the interpretive perspective. The interpretive explains that reality is socially constructed and that the individual's interaction with his or her experiences and environment constructs what is perception, knowledge and reality (Cavana, Delahaye & Sekaran, 2001; Andrade, 2009). In the context of this study, mothers' health-seeking behaviour, which is socially constructed, can be explained with their interaction with the illnesses of their children and the social and environmental factors that promote or challenge health care utilisation.

Target Population

The target population for this study were mothers with children under five years (0-59 months). A mother in this study is a caregiver who lives with children under-five. This population with children under five years (0-59 months) were targeted because they are the primary caregivers for children under five years in Ghana (Ahorlu, Koram & Weiss, 2007; Tolhurst et al., 2008).

Sampling and Sample Size

Purposive sampling technique was employed to select respondents for the study. Since the total number of the targeted population were not known, this technique aided to identify and select manageable but information-rich mothers with experience about the phenomenon of interest (Patton, 2002; Creswell & Plano Clark, 2011). Therefore, the technique helped to select mothers who were most qualified for the study.

The first criterion was to select mothers from rural communities with no health care facility. Arguably, mothers who are closer to health care facilities tend to utilise health care more than those further away due to distance (Kiwanuka, Ekirapa, Peterson et al., 2008; Schoeps et al., 2011; Campbell & Gabrysch, 2012). The second criterion was to include only mothers who stayed with at least a male child or female child or both who was under age five. The purpose for these three categories of respondents was to assess variation in health-seeking behaviour with regard to the sexes of the children under-five (Taffa & Chepngeno, 2005; Chandwani & Pandor, 2015).

Studies have shown that, accessibility to health care is a challenge when patients are to walk for about a 5 kilometer radius to a healthcare facility in Ghana (van den Boom, Nsowah-Nuamah & Overbosch 2004; Adu-Gyamfi & Adei, 2013). However, communities closer to a health care facility have higher tendency to utilise health care (Aqua et al., 2015). Within each health care zone, the study categorised communities without health care facility but located within five kilometre radius to a health care facility under "Community A" while communities without health care facility located beyond five kilometer radius to a health care facility were classified under "Community B" (Table 3).

Five communities were purposively selected from "Community A" across the five health care zones while two communities were also chosen from "Community B". In total, 7 communities namely Abakam, Amoakofua, Krofofrodo, Tayedo, Gyegyeano, Efutu-Mampong and Nyinesin were selected (Figure 4). The reason for selecting communities in "Community A and B" categories of communities was to examine variation in health care utilisation

with regards to distance (van den Boom, Nsowah-Nuamah & Overbosch 2004; Adu-Gyamfi & Adei, 2013; Aqua et al., 2015).

It has been established that interviewing at least six respondents from a community with manageable population could offer an in-depth information needed for robust analysis (Guest, Bunce & Johnson, 2006). Therefore, six respondents were purposively selected from each community. The respondents comprised two mothers who lived with one under-five male child; two mothers who lived with one female under-five child; and two mothers who lived with one male and one female under-five children. In all, 42 mothers were selected and interviewed (Table 3).

Table 3- Sample size by 5 health care zone in the Cape Coast Metropolis

Health care zones	Selected Com. at 'A'	Selected Com. at 'B'	No. of mothers selected /zone
UCC	1	-	6
RCH	1	-	6
Ewim	1	-	6
Adisadel	1	1	12
Efutu	1	1	12
Total	5	2	42

Source: Fieldwork, Appiah (2016)

Study Instrument

The research instrument used for this study was the in-depth interview (IDI) guide. The IDI guide consisted of five sections. The first section looked at the socio-demographic background of mothers: mothers' age, occupation, income level, ethnicity, place of residence and marital status. The second section focused on the perceptions of childhood illness that influenced mothers' health-seeking behaviour. The section three assessed mothers' views about the influence of significant others on health-seeking decision-making while the fourth section elicited the factors that motivated mothers' health-seeking behaviour. The last section dealt with challenges to health-seeking and how to address them.

Pre-Test

The in-depth interview guide was pre-tested at Elmina, a town located in the Komenda-Edina-Eguafo-Abrem Municipality. The town was selected because it exhibits similar characteristics to the study area. For instance, malaria, diarrhoea and anaemia are among childhood sicknesses in Elmina. These sicknesses are among the top ten OPD cases in Elmina (Komenda-Edina-Eguafo-Abrem Municipal Assembly, 2014). Again, health care facilities in the Elmina township are not fairly distributed and are concentrated at the core of the town.

Two suburbs located 5 kilometre radius and beyond 5 kilometres radius from a healthcare facility within the Elmina Township were selected. Three mothers who lived with a male child, a female child and a male and

female children under-five years old were selected from each suburb. In all, 6 mothers were interviewed with the instrument.

Four Field Assistants consisting of three (3) males and a female were trained to pre-test the instrument. After the pre-test, some of the questions on the research instrument were well sequenced. Misplaced questions were re-arranged and clarifications were made on some of the questions that seemed ambiguous.

Source of Data

The study made use of primary data obtained from mothers with children under-five years. The data captured information on mothers' demographic background, perception of childhood illness, motivations to health-seeking and challenges to health-seeking.

Data Collection

The data collection lasted for 21 days (three weeks). Activities that went into the data collection were training of field assistants, community entry process and fieldwork. The selection of the field assistants was based on experience in qualitative data gathering and one's ability to speak any one of the two main Akan languages; that is, Twi and Fante. Four assistants were selected, consisting of three (3) males and one (1) female. The assistants were first degree graduates from the University of Cape Coast. The field assistants were trained on the study instrument.

Seven days were used for the community entry processes. The research team visited each community and met the leaders and other influential people in each community. The team briefed the leaders in each community about the

purpose of the study. Subsequently, a meeting was organised with the mothers available at each community to also brief them about the study. The selected mothers were asked to propose a period they would be available for the interview to be conducted. Based on their proposed time frame, a data collection plan was developed indicating date and venues for each interview (Table 4).

Thirteen (13) days were used for the actual data gathering. Based on the data collection plan, the data collection started at Abakam (a community within 5 kilometres radius to health care facility and within UCC healthcare zone) and ended at Nyinesin (a community outside 5 kilometres radius to a health care facility and within Efutu healthcare zone). The selected respondents consented to participate freely. Each signed or thumbprinted a written consent form to indicate that they had freely chosen to participate in the study. With respect to those who could not read, the field assistants read the informed consent form to them in the language they best understood.

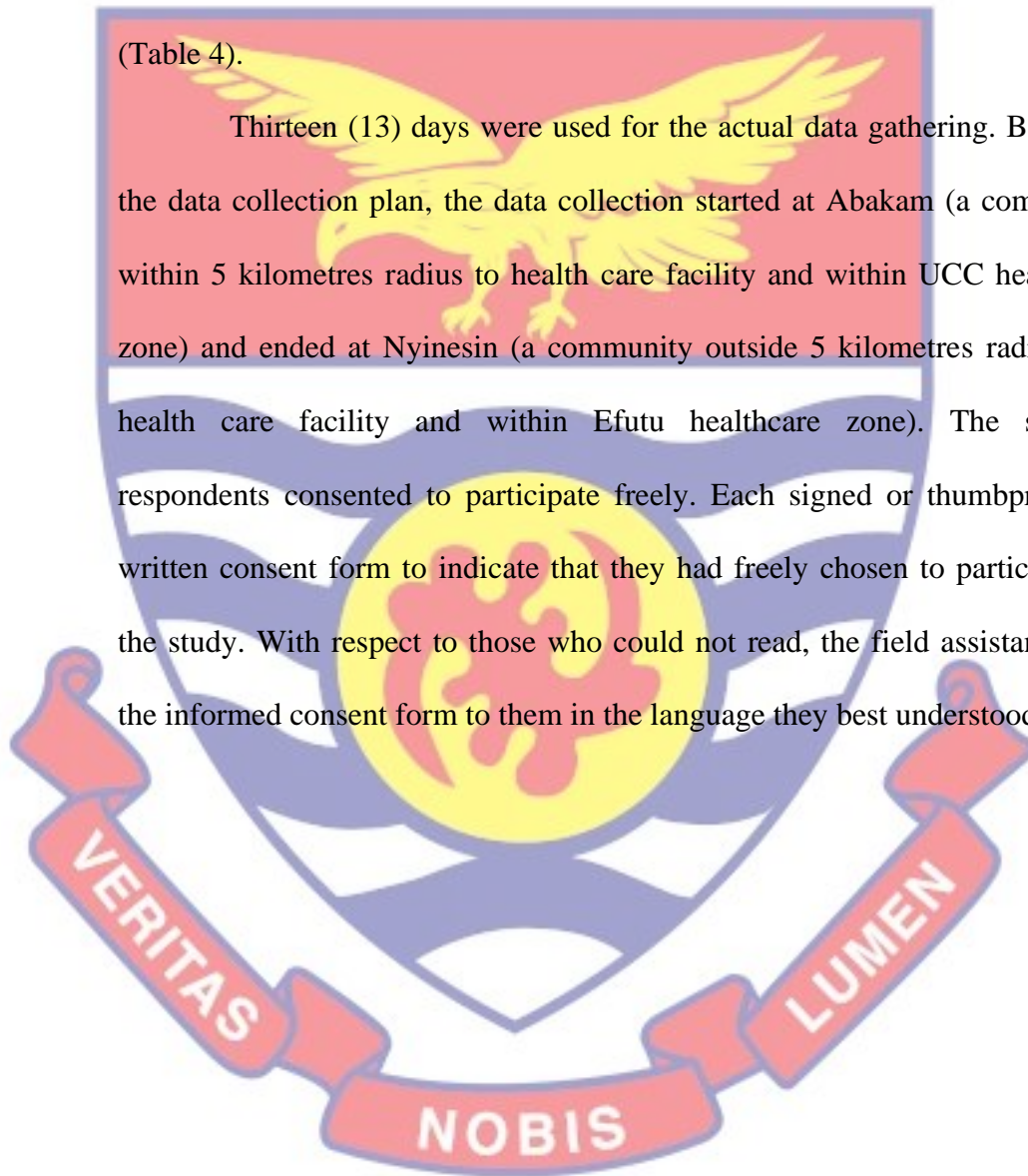


Table 4- *Data Collection Plan*

Number	Area	Date	Venue
1	UCC zone	11th March	Home
2	RCH zone	14-15th March	Home
3	Adisadel zone	16-17 March	Home
4	Efutu zone	18 & 21st March	Home
5	Ewim zone	22-23rd March	Home
6	Adisadel zone	24-25th March	Home
7	Efutu zone	28-29th March	Home

Source: Fieldwork, Appiah (2016).

Data Management

After each day's interviews, the recorded interviews as well as the field notes were kept confidential. Averagely, an interview lasted for 50 minutes. Two male assistants experienced in transcription and qualitative data analysis transcribed the interviews. Forty-two data files were created with each data file for one mother containing every information gathered about her.

The assistants systematically read the transcripts independently. They generated themes and subthemes and assigned codes to them. The assistants finally merged the codes they developed into a combined set of codes. In case there were difference in coding, they discussed it and upon reaching consensus selected the best one that helped to reduce biases in coding (Stauss & Corbin, 1998; Thomas, 2006). The recorded interviews and the soft-copy version of the transcription were stored from a third party access using 'my locked box', while the field notebooks were also kept out of sight.

Data Analysis

The data were analysed manually, guided by an inductive content analysis approach. The approach, which involves thorough reading of data before analyses (Thomas, 2006), helped the study to identify the major themes as well as sub-themes that emerged. First of all, the recorded interviews were transcribed. The transcripts were studied and subsequently, organised into four main sections similar to the sections in the instrument.

Secondly, general themes that emerged were developed. After that, sub-themes were created and assigned codes. Both similar and different views and experiences on the subject were identified under sub-themes to aid comparison. Finally, quotations were used to support the views raised by the respondents.

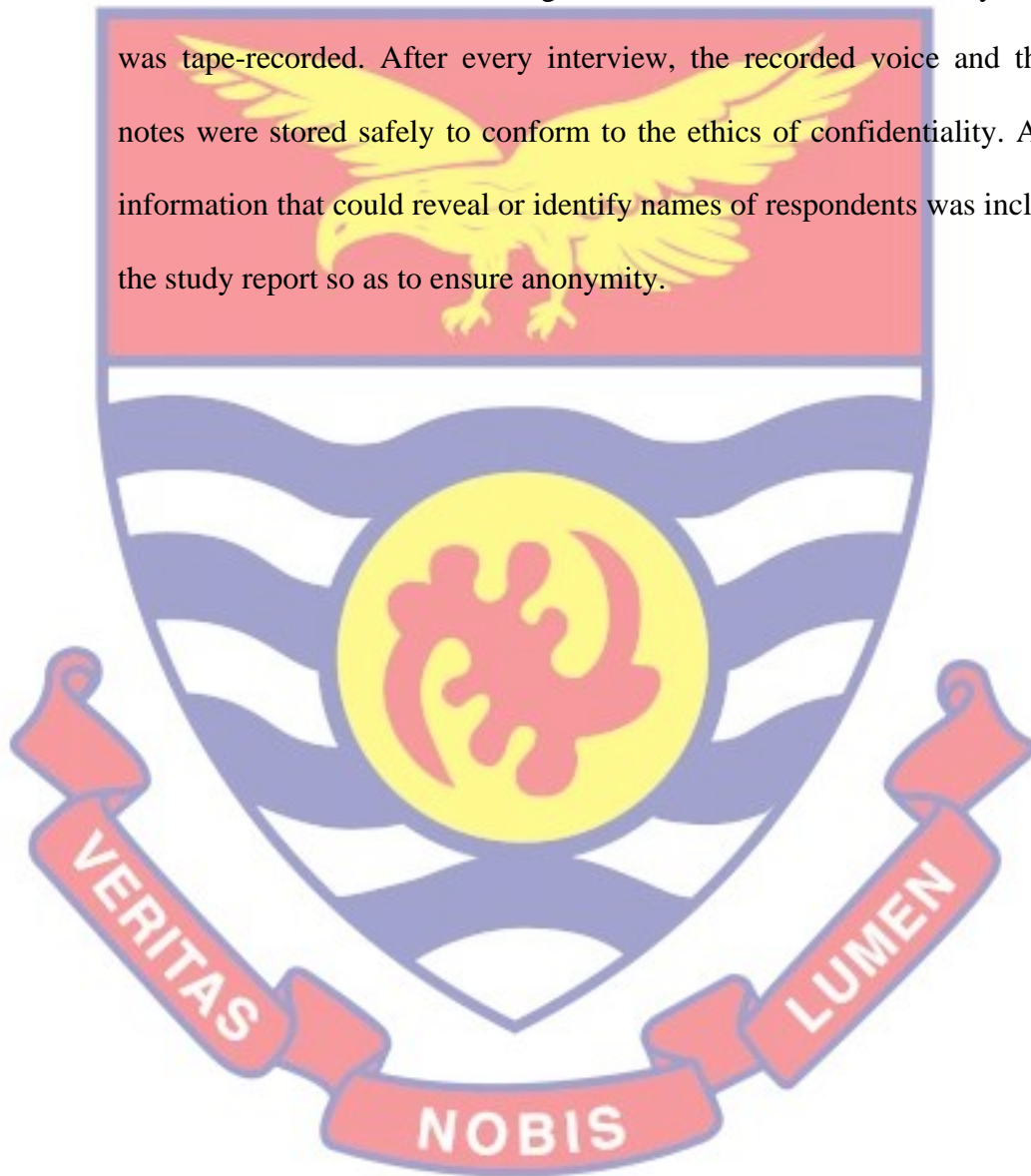
Ethical Considerations

The following ethical guidelines were followed to be consistent with all ethical standards required to conduct a research. Firstly, copies of the research proposal were submitted to the University of Cape Coast's Institutional Review Board (UCC-IRB) for assessment and clearance. After that, permission was sought from the Cape Coast Metropolitan Health Directorate to carry out the study in the selected communities.

Again, to ensure free informed consent and participation in the recruitment processes, the respondents were briefed about the purpose of the studies. Permission was sought from partners (husbands) of the mothers who consented to participate in the studies. Also, before any interview took place, mothers who could read in English were given a written consent form to read

and freely decide to participate in the study by signing. On the other hand, those who could not read the informed consent form, had it read to them in the language they best understood before participation. Those who consented thumb-printed.

Further, consent was sought from the mothers before every interview was tape-recorded. After every interview, the recorded voice and the field notes were stored safely to conform to the ethics of confidentiality. Also, no information that could reveal or identify names of respondents was included in the study report so as to ensure anonymity.



CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents the findings and discussions of the results of the study. It describes the demographic background of the respondents, analyses and discusses perceptions of childhood illness, motivations and challenges that affect health-seeking behaviour.

Demographic Characteristics of Respondents

Age, marital status, religion, ethnicity, level of education, place of residence, the number of children under-five mothers live with, living arrangement, occupation, and income earned per month constituted the demographic characteristics of the respondents (Table 5). Half (50%) of the respondents were within the group of 20-29 years. Additionally, 21 percent were within age 30-34. This implies that most of them were in the active age group who can engaged in various economic activities to earn enough income to support the daily needs of their children (Abosse, Woldie & Ololo, 2010; Rahman, Nakamura, Seino & Kizuki, 2012).

It was observed that 78 percent were married. This implies that married mothers would have the privilege to enjoy the resources of their husbands thereby having enough resources to cater for their children's healthcare needs (Nyakato & Rwabukwali, 2013; Ohashi et al., 2014). Again, it was noticed that over 66 percent were Christians. Mothers' religious affiliation affects their health-seeking decision making and health-seeking (Singh et al., 2012). The reason is that religious values influence individual's perceptions of disease

while household responsibilities and functions are also affected by religious values (Singh et al., 2012).

The majority (85%) of the respondents were Akans. Mothers' ethnic background influences their health-seeking decision-making since gender roles such as who decide on daily purchases are been shaped by ethnic background (Singh et al., 2012; Sen, 2014). It was also noticed that most (66%) of them had completed junior high school (JHS). This implies that most mothers could not be engaged in a higher paid job to earn enough income to fund their child's healthcare expenses. With regard to the number of children they lived with, about 67 percent of the respondents lived with one child under-five years (Table 5).

Participants' occupation was classified into four groups consisting of not working, primary occupation (such as farming), secondary occupation (such as oil processing and other manufacturing activities) and tertiary occupation (such as petty trading and other sales activities). Majority (58%) of the respondents were engaged in tertiary economic activities (Table 5). This implies that most mothers might not have strong financial base to cater for the daily healthcare needs of their children since income status depend on ones' occupation (Taffa & Chepngeno, 2005).

The results also showed that 52 percent of the respondents earned less than US \$ 21.2 income monthly (Table 5). This indicates that most mothers cannot finance the cost of medication and other user-fees on the basis that, their ability to afford the cost of care and other healthcare expenditure shall depend on their financial standing (Birmeta, Dibaba, Woldeyohannes, 2013).

Table 5- Demographic Background of the Respondents

Demographic characteristics	Frequency	Percent (%)
Age		
20-24	10	24
25-29	11	26
30-34	9	21
35-39	7	17
40-44	5	12
Marital status		
Never married	8	19
Married	33	78
Separated	1	3
Religion		
Christian	28	66.7
Muslim	10	23.8
No religion	4	9.5
Level of education		
No education	7	17
Primary	2	5
JHS	28	66
SHS	5	12
Place of residence		
Community A	30	71
Community B	12	29

Table 5 continued

Ethnicity		
Akan	36	85
Mole/Dagbani	2	5
Ewe	4	10
Number of children under-five lived with		
1	28	66.7
2	14	33.3
Living arrangement		
I stay with nuclear family	8	19
I stay with extended family	34	81
Occupation		
Not working	8	19
Primary	4	10
Secondary	5	12
Tertiary	25	59
Monthly Earnings (US\$)		
0-20.9	22	52
21.2-42.2	4	10
42.3-63.3	6	14
63.4-84.5	6	14
84.6-105.7	0	0
105.8 and above	4	10
Total	42	100

Source: Fieldwork, Appiah (2016).

Thematic Framework

The study took a thorough reading of the transcripts to aid identify the basic themes that emerged from the transcripts. Base on that, themes and subthemes that emerged were captured under the key issues (Table 6).

Table 6- *Thematic Framework*

Key issues	Themes	Sub themes
Perception of childhood illness	Perceived common childhood illnesses	1. Malaria. 2. Nsempuama (rashes), cough diarrhea, esoro (convulsion), Ahonhon (swelling) and chicken pox.
	Causes of childhood illness	1. Belief systems. 2. Exposure to the sun. 3. Scientific factors.
Motivations to health-seeking practices	Susceptibility to childhood illness	1. Exposure to pathogens/vectors. 2. Nutrition/genetic factors. 3. Every child is at risk.
	Easy access to funds	1. Having a valid insurance 2. Funds to pay for transport cost

Table 6 continued

	Closeness to health facility	<ol style="list-style-type: none"> 1. Closer to health facility. 2. Access to regular transport.
	Access to varied services	<ol style="list-style-type: none"> 1. Access to various services.
Challenges to health-seeking practices	Delaying in decision making	<ol style="list-style-type: none"> 1. Decision on timing of initiating healthcare. 2. Decision on where to seek healthcare. 3. Decisions on child's healthcare expenditure.
	Delay in reaching health facility	<ol style="list-style-type: none"> 1. Unavailability of health facility. 2. Lack of funds to pay for transportation cost. 3. Difficulty with access to transportation system. 4. Location of health facility.
	Delay in receiving adequate medical care	<ol style="list-style-type: none"> 1. Insufficient provision of drugs 2. Poor communication of health staff. 3. Queuing at health facility.

Source: Fieldwork, Appiah (2016).

Perception of Childhood Illness

Mothers' perception about childhood illnesses influence their health-seeking behaviour (Kroeger, 1983). In this study, the main issues analysed under mothers' perception of childhood illnesses were: perceived common childhood illness, perceived causes of childhood illnesses and perceived susceptibility to childhood illnesses.

Perceived Common Childhood Illnesses

Most of the respondents mentioned that malaria was the commonest disease that affected children under-five years in their respective communities. For instance, 80 percent of the respondents who lived in Community 'A' category of communities and 92 percent who lived in Community 'B' category of communities perceived that malaria was the commonest childhood illness. Other common illnesses mentioned included; fever, catarrh, stomach ache, measles, headache, and cholera. A mother from Community 'A' category of communities had this to say:

"...No one can talk about childhood diseases without mentioning malaria. In fact, malaria is highly endemic in this community. Malaria is everywhere. Even last week Wednesday, malaria attacked three children in this house. Also, yesterday, a child from that house [pointing towards a blue building] was attacked seriously and nearly died due to malaria. Children in this community suffer from malaria a lot". (Mother with a male child under-five, 34 years, Comm. A)

In a similar manner, a mother from Community 'B' category of communities also had this to say:

"In this community,...apart from malaria, I may not know the other diseases that attack children....My brother, malaria is worrying us a lot in this community". (Mother with a male child under-five, 23 years, Comm. B)

Again, about 62 percent of the respondents, consisting of 57.7 percent of the mothers from Community 'A' category of communities and 42.3 percent of the mothers from Community 'B' category of communities, also mentioned other diseases such as "nsempuama" (rashes), cough, diarrhoea, "esoro" (convulsion), "ahonhon" (swelling) and chicken pox that attacked children under-five years. For instance, a mother from Community 'A' category of communities had this to say:

"Children in this community suffer a lot from diarrhoea and cough. At times too "nsempuama" [rashes] is common in this community. It is like rashes and it affects children in this community mostly during the dry season. Another common one is "esoro" [convulsion]...Mostly, when "esoro" [convulsion] attacks children, their neck become stiff".
(Mother with a female child under-five, 34 years, Comm. A)

To corroborate this, a mother from Community 'B' category of communities had this to say:

"In this community it is chicken pox...The whole issue is chicken pox! The disease is everywhere and it affects every child in this community...Last two months, that boy [referring to her male child playing at the extreme corner of the house] was affected. During the raining season too, "ahonhon" [swelling] is often experienced

Sometimes too diarrhoea and cough are common...'. (Mother with a male child under-five, 21 years, Comm. B)

The study noticed that, malaria was the common illnesses that affects children under-five among both communities. This implies that children from both Community 'A' and 'B' category of communities will suffer from similar childhood illness. This results agree with the Cape Coast Metropolitan Assembly's (CCMA) (2014) report which indicated that, malaria is the topmost disease in the Metropolis.

Perceived Causes of Childhood Illnesses

Varied opinions were shared to explain the causes of these childhood illnesses. Some of the perceptions of the respondents were based on their beliefs. For instance, 60 percent of respondents perceived that witchcraft was the main cause of childhood illnesses. This perception was held in both Community 'A' and 'B' category of communities studied and consistent with earlier studies (Olupona, 2004; Westerlund, 2006; Obinna, 2012; Nyabwari & Kagemu, 2014). A mother from Community 'A' category of communities had these to say:

"Some of the sicknesses like "esoro" [convulsion], epilepsy and other strange ones are mostly caused by "anyen" [witchcraft]. When you are carrying pregnancy and insult or quarrel with others, those with bad spirit can transmit such disease unto the unborn child. You might not know the kind of spirit the person you quarrel with possess so it is advisable to avoid quarrelling during pregnancy". (Mother with a male child under-five, 36 years, JHS completed, Comm. A)

In the same vein, a mother from Community 'B' category of communities also indicated that:

"It is not good to always eat in public when you are carrying pregnancy because bad spirits are always hovering around and they can infect your food with sickness. Also when you are carrying pregnancy, it is good to watch your mouth since when you offend someone who possess evil spirit, the person can do anything to you and the unborn child". (Mother with both male and female child under-five, 23 years, JHS completed, Comm. B)

The results have indicated that, mothers from both Community 'A' and 'B' category of communities hold similar perception that witchcraft and bad spirit could cause childhood illnesses. The results are consistent with findings by Bonsu (2014) and White (2015) who noticed that in Ghana, it is believed that bad spirit and invocation of curses in the name of river deities leads to sickness.

Another 48 percent of the respondents were of the view that excessive exposure to the sun also leads to childhood illnesses. The respondents held that children who will be exposed to the sun during the day especially when the sun is scorching, are more likely to fall sick. This perception was held in both Community 'A' and 'B' category of communities studied. It was observed that, out of the 48 percent of the respondents who held this view, most (75%) of them were those who completed Junior High School (JHS). A mother from Community 'A' category of communities had these to say:

"My child likes roaming in the sun. He walks bear-chested and play throughout the day in the sun and that is why he normally suffers

from fever. I have heard that the sun carriers particles which are not good for our health. But children nowadays don't abide by their parents' advice and do whatever pleases them. Especially this boy [referring to her child]...I have warned him on several times not to play in the sun but he refuses to take whatever I say''. (Mother with a male child under-

five, 21 years, JHS completed, Comm. A)

Similarly, a mother from Community 'B' category of communities also indicated that:

'When children come into contact with the sun for long period during the day is not good. Especially after 12 pm where the sun is scorching and the heat is at its peak, when you allow your child to play in it, he will mostly suffer from fever''. (Mother with a female child under-five, 36 years, JHS completed, Comm. B)

There were other views that indicated that scientific factors were the causes of childhood illnesses. Factors such as exposure to pathogens, poor nutrition, and poor ventilation were perceived by 36 percent of the respondents as causes of childhood sicknesses. Among the 36 percent of the respondents who held this view, most (90%) of them were those who completed Senior High School (SHS). Some of them from Community 'A' category of communities had these to say:

'Look at how we have built our houses, no space for air circulation making rooms always hot so why shouldn't they suffer from fever and headache...people from far throw refuse into the gutters. This pollutes us and there is always pungent smell all over when the wind blows. Others also defecate along the coast. All these breed diseases''.

(Mother with both sexes under-five, 39 years, completed SHS completed, Comm. A)

“As I indicated earlier, the stagnant water around us breed mosquitoes and when they bite children, they fall sick in few days. Also, because children mostly put anything into their mouth, they mostly swallow germs and that also leads to sickness”. (Mother with a male child under-five, 25 years, SHS completed, Comm. A)

Similar perception were held by some of the mothers from Community ‘B’ category of communities, and one of them indicated that:

“Most of the sicknesses occur as a result of poor nutrition. Some mothers will give only gari and sugar for their children to eat. My children sometimes eat gari without adding anything to it in my absence and I think that is why they also fall sick”. (Mother with a female child under-five, 26 years, SHS completed, Comm. B)

Comparatively, across groups (thus mothers from both Community ‘A’ and ‘B’ category of communities), it was noticed that the mothers had similar perception about factors that cause childhood illnesses. However, within groups, it was observed that some of the mothers attributed childhood illness to scientific factors whilst others also attributed it to belief systems. This could partly be explained by the differences in the level of education. Based on Kroeger’s expositions, it can be concluded that, education improves one’s level of thinking about factors that can lead to childhood illnesses which then leads to adopting a healthy lifestyle that could prevent childhood illnesses (Kroeger, 1983).

Perceived Susceptibility to Childhood Illnesses

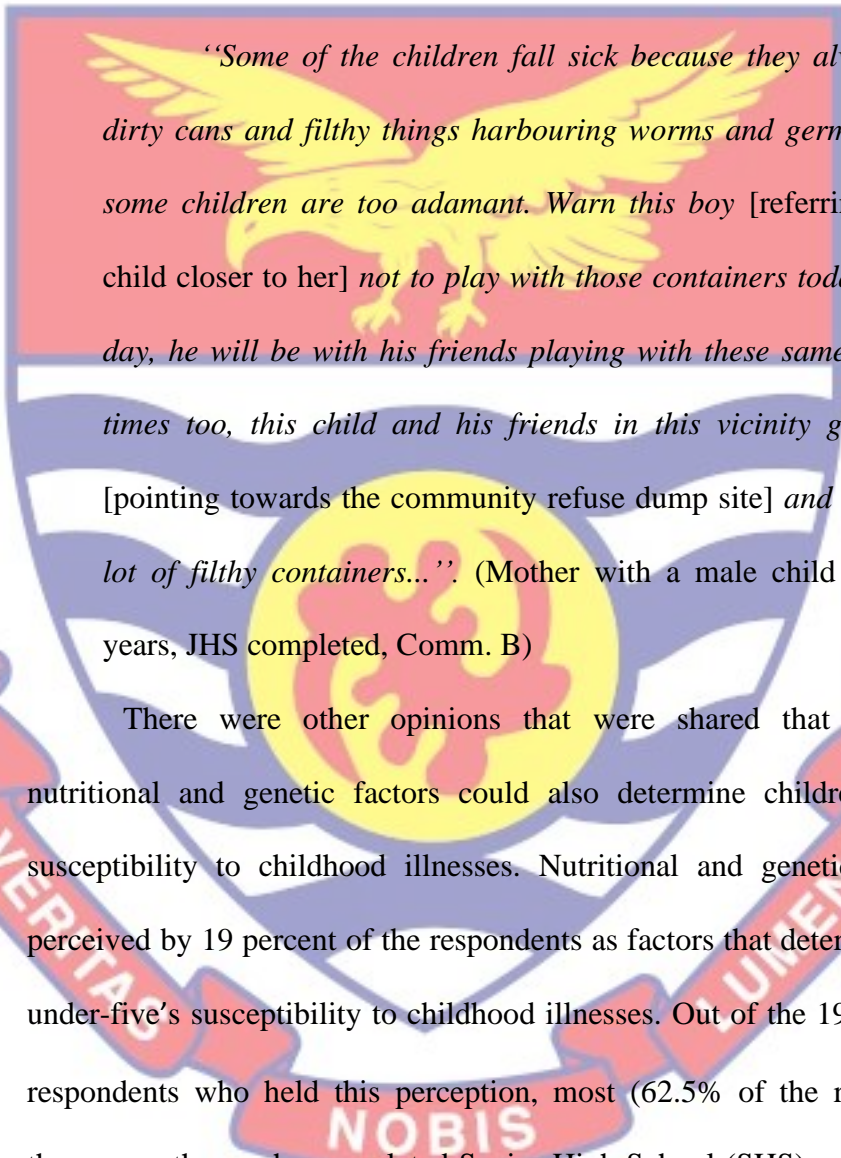
Over a half (76% of the respondents) were of the view that, exposure to pathogens/vectors determine children under-fives' susceptibility to childhood illnesses which is consistent with earlier results (Chukwuemenam, 2011). For instance, 69 percent of these respondents who lived in Community 'A' category of communities and 31 percent of these respondents who lived in Community 'B' category of communities perceived that children under-five coming into contact with pathogens/vectors such as germs, worms, flies, and mosquitoes, determined a child's susceptibility to sicknesses. This view was held in all the communities studied. Some of the mothers from Community 'A' category of communities got these to say:

"...because we are somehow closer to the sea, children in this area go to the shore regularly to play. Look at what I was just talking about [pointing towards a group of children playing along the shore]. For most of the shores are cleaned but on our part, ours is so so polluted with waste and effluents. So when the children go there to play in the sand, their nails become dirty and infected with small small worms...I think that is why they are prone to diarrhoea". (Mother with a female child under-five, 30 years, Primary Education, Comm. A)

"I think those that are exposed to mosquitoes will suffer from malaria...Children in this community fall sick due to the frequent mosquito bites. Look at where we live...our land is not good so with a little rain, the place becomes stagnated and flooded. At the far end of this community is also marshy which breeds mosquitoes. In fact, we need help. Because we don't have enough money, we have not been able

to spray the environment. There are a lot of stagnant waters in this community that breeds mosquitoes”. (Mother with both male and female child under-five, 39 years, SHS completed, Comm. A)

To corroborate this, a mother from Community ‘B’ category of communities also had these to say:



“Some of the children fall sick because they always play with dirty cans and filthy things harbouring worms and germs. My brother, some children are too adamant. Warn this boy [referring to her male child closer to her] not to play with those containers today and the next day, he will be with his friends playing with these same dirty cans. At times too, this child and his friends in this vicinity go to that area [pointing towards the community refuse dump site] and gather a whole lot of filthy containers...”. (Mother with a male child under-five, 24 years, JHS completed, Comm. B)

There were other opinions that were shared that indicated that nutritional and genetic factors could also determine children under-fives' susceptibility to childhood illnesses. Nutritional and genetic factors were perceived by 19 percent of the respondents as factors that determined children under-five's susceptibility to childhood illnesses. Out of the 19 percent of the respondents who held this perception, most (62.5% of the respondents) of them were those who completed Senior High School (SHS) as a mother from Community ‘A’ category of communities said:

“I will say it's as a result of poor eating habit. Their so called school feeding programme is killing the children. Every day, they serve them rice and stew; rice and stew! rice and oil! oil! throughout the term.

Instead of them to even change their diet like adding "bredze ampesi" [a local meal] to their menu, oho! Always, it is rice! rice! rice! throughout that are too starchy. Adding to that, they also eat toffees and other sugary things at school''. (Mother with a male child, 25 years, SHS completed, Comm. A)

To confirm this, a mother from Community 'B' category of communities also shared that:

"Some of the children who are younger may have a strong immune system than the aged so even if mosquitoes bite them, because of the strong immune system, they may not develop that disease...Yes, some of the children, with the slightest thing, they will fall sick. Also, an outbreak of a particular sickness can occur in an area but some of the children will never be affected because of their immune system''.

(Mother with a female child, 26 years, SHS completed, Comm. B)

The study noticed that, while respondents with SHS cited genetic and nutritional factor as determinants of a child's susceptibility to illnesses, about 10 percent of the respondents with no education perceived that every child is at risk of contracting any childhood illness regardless of the child's sex or age composition and a mother from Community 'A' category of communities got these to say:

"I can't tell, all of a while, you will realise that the child's body has become warm and then malaria will follow. Sickness can attack anybody, whether young or not, male or female''. (Mother with a male child, 42 years, No Education, Comm. A)

To confirm this, a mother from Community 'B' category of communities also indicated that:

“Oh, as for that one I cannot tell whether the male or the female will develop it. And I don't have any reason behind such things. Both of them can contract either stomach problems or fever”. (Mother

with male and female children under-five, 34 years, No Education, Comm. B)

The results point to the fact that, there were no difference in perception about factors that could increase or reduce a child's chance to childhood illness among mothers across both Community 'A' and 'B' category of communities. However, there were variation concerning perceived susceptibility to childhood illnesses within mothers from Community 'A' and 'B' category of communities and this could partly be explained by the differences in respondents' level of education. The reason is that individuals' level of education improves one's level of thinking and overall assessment of illness perceptions thereby making quality health care decisions (Singh et al., 2012; Sen, 2014). In his planned behaviour theory, Ajzen also postulated that behaviour change depends on attitudes reflecting on individuals' subjective assessment of an event (Ajzen, 1991). Based on the Ajzen's explanations, it can be deduced that the educated mothers may have positive attitudes and intentions to seek prompt curative or preventive healthcare for their children under-five (Ajzen, 1991; Fishbein & Ajzen, 2010).

Motivations to Health-Seeking Practices

The study observed that the main factors that promote health-seeking in the study community are easy access to funds, nearness to health care facilities and perceived quality of health care delivery at the health facility.

Easy Access to Funds for Health Care

Generally, it was observed that respondents who had easy access to funds were more likely to utilise health care whenever their children under-five fell sick irrespective of distance to the health facility. Funds are needed to pay transport fares, pay for treatment especially if one does not have a valid health insurance, and purchase of drugs.

The study observed that those who had valid insurance, utilised health care for their children more often than those who did not. For instance, a little above 83 percent of the respondents were of the view that, having a valid insurance encourages them to seek prompt health care for their children and it is consistent with earlier findings in Ghana (Doku, Neupane & Doku, 2012; Fenny et al., 2015). This view was held in all the communities studied. A mother from Community 'A' category of communities who was able to seek timely healthcare for her child under-five due to valid insurance had this to say:

“I think what makes health care easily accessible is the insurance. In fact, nowadays, the insurance is our biggest hope. If your child is sick, as a mother, you may not be able to eat until the child recovers. With the insurance, any moment the child falls sick, I just walk in for treatment. Oh, [broke into laughter], I paid something before they

issued the card to me so I should utilise it''. (Mother with both male and female child under-five, 28 years, JHS completed, Tertiary occupation, US \$ 21.2 monthly, Comm. A)

Similarly, some mothers from Community 'B' category of communities solidly expressed that they were more likely to utilise healthcare for their children under-five due to the health insurance that serves as financial protection and one of them had this to say:

'Insurance helps me a lot though it is unable to cater for most of the drugs. Unexpectedly, your child can fall sick. When you go without insurance under such unexpected situation, they will require a huge deposit before they will attend to you. But with the insurance, you will just join the queue''. (Mother with a female child under-five, 30 years, No Education, Tertiary occupation, US \$ 16.93 monthly, Comm. B)

The results pointed that, having access to valid insurance motivated mothers from both Community 'A' and 'B' category of communities to seek healthcare for their children under-five. This is consistent with findings by Long et al. (2010) that identified that the Chinese New Co-operative Medical System was able to raise healthcare utilisation. It also confirms findings by Blanchet, Fink & Osei-Akoto (2010) who noticed that subscription to the national Health Insurance Scheme (NHIS) improved accessibility and utilisation of health-care services in Ghana. Ajzen conceptualised that individuals can exhibit certain behaviour provided they have relative ease (perceived behavioural control) to do so, such as availability of funds (Ajzen, 1991). Therefore, premised on Azjen's propositions, it can be argued that the insurance will serve as financial protection especially during unforeseen

contingencies such as a period when mothers have no income to finance their medical cost while removing the financial barrier associated with health care utilisation such as medical bills and other user-fees (Ajzen, 1991; Fishbein & Ajzen, 2010)

There were other views that indicated that, funds to pay for transport cost also motivated mothers to utilise health care for their children under-five. Funds to pay for transport cost were mentioned by closed to 36 percent of the respondents as a factor that encourages them to seek timely health care for their children under-five. Out of the about 36 percent of the respondents who held this view, most (93.3% of the respondents) of them were married mothers, and a mother from Community 'A' category of communities indicated that:

“Nowadays the cost of transport has increased so when you move from here [referring to her community] to UCC [referring to UCC Hospital] with a taxi, you will pay almost GH ¢ 2. The GH ¢ 2 (Equivalent to US \$ 0.42) should not be a problem because the health of the child surpasses GH ¢ 2...When you have money to pay for the cost of transport, you will not stay at home for the child to die because of GH ¢ 2”. (Mother with a male child under-five, 21 years, Married, Comm. A)

To reaffirm this, a mother from Community 'B' category of communities had this to say:

“All that matters when your child falls sick is to have something on you. When your child falls sick and there are enough money, transportation and other things that may require money will never be

your problem’. (Mother with a female child under-five, 26 years, Married, Comm. B)

The results is in line with findings by Taffa & Chepngeno (2005) which indicated that lack of funds was the reason given by mothers for failure to seek healthcare outside their home among mothers living in Nairobi slums in Kenya. Again, the marital status of mothers is an important variable that influences their health-seeking behaviour on the basis that, married mothers might have the privilege to enjoy the resource of their husbands thereby having enough resources to cater for their children's health care cost and other needs (Nyakato & Rwabukwali, 2013; Ohashi et al., 2014). Also, based on Ajzen's suggestions, it can be concluded that married mothers, having access to their husbands' resources, would be more probable to utilise health care for their children under-five as compared to their counterparts (Ajzen, 1991).

Closeness to Health Facility

Generally, it was observed that respondents who were nearer to health facility were more probable to seek health care whenever their children under-five fell sick. When health care facility is closer to mothers, mothers can reach health facility within a few walking distance, especially those with access to regular transport system, as compared to their counterparts who are not close to health facility.

The study noticed that, respondents who were closer to health facility had a higher tendency to utilise health facility than those that were not. Over 83 percent of the respondents from Community 'A' category of communities shared that they were able to seek health care for their children because it took

them few minutes to reach a health facility. The following were some of the views of the respondents:

“They mostly go to UCC or Central hospital. I also go there as well. You know, the facility [referring to UCC Hospital] is closer to us. We just cross the road, pick a taxi that charges 1.80 pesewas and in few minutes, we are there”. (Mother with a male child under-five, 21 years, JHS completed, Comm. A)

“In this community, we are surrounded by three main health care facilities; Ewim, Central and Macro hospital. But most mothers visit Ewim and Macro than Central. From here to Macro or Ewim is very close than Central. For instance, with Macro, I will just take about some minutes to walk to taxi station and in a few minutes, we will reach there”. (Mother with a male child under-five, 25 years, SHS completed, Comm. A)

However, since Community ‘B’ category of communities was far from healthcare facilities as compared to Community ‘A’ category of communities, most of the respondents from Community ‘B’ category of communities shared that, they borrowed drugs from their neighbours as first aid to manage their children's illness at the onset of the illnesses and seek care the next day. Some of them had these to say:

In this community what I know is that they mostly give children drugs borrowed from friends. If the condition remains the same, then they take action the next day. I also do same when my child falls sick to avoid losing excessive water. (Mother with a male child under-five, 23 years, JHS Completed, Comm B)

*When he begins to show signs, I mostly give him first aid...
(Break into laughter)...first aid borrowed from a colleague nursing
mother. So if the condition remains the same, then I send him to Efutu
clinic. Oh, what I know is that, for most mothers, they mostly don't send
their children to health centre immediately after recognising the signs.*

*They usually give first aid and if it fails, then they send them to the
health centre the next day. (Mother with a female child under-five, 26
years, No Education, Comm B)*

The results confirm findings by Kyei, Campbell & Gabrysch, (2012),
Blanford et al. (2012), Krumkamp et al. (2013) and Adu-Gyamfi & Adjei
(2015). However, it was identified that only respondents who live in
Community 'A' category of communities indicated that short travelling
distance and easy access to transport were motivating factors to health-
seeking. The location of the Community 'A' category of communities could
be a possible reason since they were within 5 kilometre radius to healthcare
facility which is somehow closer to a healthcare facility than Community 'B'
which was beyond 5 kilometre radius to healthcare facility. Therefore, it is
probable for respondents within Community 'A' category of communities to
reach healthcare facilities within few walking or travelling distance (Gelaw et
al., 2014; El Bcheraoui et al., 2015).

There were other views that indicated that, access to regular
transportation system also motivated mothers to utilise health care for their
children under-five. About 54 percent of the respondents from Community 'A'
category of communities were of the view that, when they have access to
regular transportation system, they can reach health facility within the shortest

time as well as save them from walking for over a longer distance in accessing health facility. Out of the 54 percent who held this view, most (58% of the respondents) of them were those who earned US \$ 63.5 and above monthly.

The following were some of the views of the respondents:

‘In this community, mothers are able to seek health care due to easy access to transport...When your child falls sick, all that you need is to step out from your house and you will get a taxi to anywhere’.

(Mother with a female child under-five, 34 years, US \$ 63.5 monthly, Comm. A)

‘I visit the UCC Hospital...it is easy to get a car and you can just stand along the main road and you will get a car to that place’.

(Mother with both male and female child under-five, 23years, US \$ 105.8 monthly, Comm. A)

However, it was evident that mothers from Community ‘B’ category of communities had less access to transport system. However, some of them said that they walk to a nearby community or roadside where they can have access to transport system when their children under-five fall sick since the health of their children under-five were of most important to them. They were of the view that, unanticipated issues like death could occur if they failed to seek healthcare when their children fall sick. Some of them had these to say:

Oh, when your child is sick, you cannot allow him or her to die, that is why I sent my child to Efutu clinic, though that day, I walked from here to Efutu junction before I had a car to Efutu (Referring to Efutu clinic). Though that day, I was in serious financial crises. (Mother with a male child under-five, 30 years, US \$ 42.2 per month, Comm B)

In this community, the situation we are in is worse so when your child falls sick and you do not take a concrete stand, you may lose your child. The only way that encourages us to seek healthcare is due to the fact that, if you sit in the house without doing anything, the child may die. Brother, you look at the situation we are in now; and I hope you took notice of the road to this community...when they fall sick, we walked to that junction to pick a taxi to Efutu...that is the only way out...because of the nature of our road, most taxi don't come here. (Mother with a female child under-five, 42 years, US \$21.1 per month, Comm B)

The results have pointed that mothers from Community 'A' category of communities were likely to seek healthcare for their children under-five due to short travelling distance whereas mothers from Community 'B' category of communities walked to a nearby community where they can have access to transport. This observation could partly be explained by the differences in proximity to healthcare facilities (Adu-Gyamfi & Adjei, 2013; Blanford et al., 2012). The findings confirm the results by Blanford et al. (2012) which indicated that physical distance affected healthcare utilisation in Niger.

Also, most mothers who indicated that easy access to transport motivated them to seek healthcare for their children were higher income earners. This confirms the findings by Fenny et al. (2015) which indicated that income status influence health-seeking behaviour in Ghana. Indeed, having enough funds would grant mothers financial control to utilise health care on the basis that, if mothers could afford the cost of transport, they can reach health facility within a few minutes (Birmeta, Dibaba & Woldeyohannes,

2013). Therefore, when mothers have available funds to pay for transport cost coupled with regular transportation system, they will have relative ease to seek health care whenever their children fall sick, as postulated by the planned behaviour theory (Ajzen, 1991).

Access to Varied Service

In the present study, it was observed that the respondents were more likely to utilise health care for their children under-five when they have access to varied services. Mothers may be required to undertake scanning, laboratory, X-ray and other tests in the course of seeking treatment for their children and it is cumbersome to undertake a laboratory or X-ray service at one facility and move to the other facility with the results for treatment. In this study, it was noticed that over 21 percent of the respondents, comprising 78 percent of the respondents from community 'A' category of communities and 22 percent of the respondents from Community 'B' category of communities, were of the view that when a health facility provided varied services, it encouraged them to utilise health care when their children fell sick which is consistent with earlier findings (Alrubaiee & Alkaa'ida, 2011; Ramez, 2012). This view was shared by respondents who earned US \$ 63.5 and above income monthly. A mother from Community 'A' category of communities had this to say:

“... So to avoid all those inconveniencies, I go to those centres like Central, Adisadel or Dr Holbrook [A private health care facility] where I will have access to all the things I need. When you go to Holbrook [A private healthcare facility] or UCC [referring to UCC Hospital] you can get access to a whole lot of services such as X-ray,

blood testing, eye care and scanning service’. (Mother with a female child under-five, 26 years, SHS completed, US \$ 105.8, Comm. B)

Similarly, a mother from Community ‘B’ category of communities also indicated that:

“...I will not go there but rather go to Central [Referring to the Metro Hospital] or UCC [Referring to the UCC Hospital]. These places have a lot of equipment so you can have access to a lot of services. When you go there, wherever the sickness is hidden, they can see and give you proper drugs”. (Mother with a male child under-five, 22 years, JHS completed, US \$ 63.5, Comm. A)

The results indicated that access to varied services motivated mothers from both Community ‘A’ and ‘B’ category of communities to utilise healthcare. This results confirm earlier studies that indicated that women in rural western Tanzania were able to utilise health care due to access to services and equipment (Kruk et al., 2009). Again, the perceived behaviour control in Ajzen’s planned behaviour theory draws the attention to the fact that, without available funds, mothers might not be able to utilise health care even if there are available health facilities. The reason is that, funds are needed to pay for the cost of using services such as X-ray and scanning services, especially when one does not have a valid insurance. Possibly, mothers with higher income status may have financial control to utilise various health services, compared to low-income earners (Ajzen, 1991; Fishbein & Ajzen, 2010). This could explain why some of the respondents who earned higher income were more likely to utilise health care due to access to funds to pay for

the cost associated with varied services (Taffa & Chepngeno, 2005; Fenny et al., 2015).

Challenges to Health-Seeking Behaviour

The study observed that the main factors that serve as a challenge to health-seeking in the study communities are: delay in decision making, delay in reaching health facility and delay in receiving adequate medical care at the health facility.

Delay in Decision Making

Generally, it was observed that respondents were less likely to receive timely health care for their children under-five due to the delay in decision making on child health care issues. Mothers have to depend on husbands and relatives' approval on a number of child health care decisions such as decision on timing of initiating health care, amount to spend and where to seek healthcare that restricted their timely reception to health care, known as the 'first delay' (Thaddeus & Maine, 1994).

It was observed that respondents had challenges with decisions associated with timing of initiating health care for their children. It was realised that 38 percent of the respondents were of the view that husbands and relatives interfered with their decisions on time to initiate health care, especially when husbands and relatives considered the sickness as mild condition, which delayed their timely reception to health care for their children under-five. This view was held in all the communities studied. Out of 38 percent who held this view, most (56.3% of the respondents) of them were

Muslims. A mother from Community 'A' category of communities had this to say:

"The last time my child fell sick, it was a skin rash so my mother told me to visit a drugstore for antibiotics...It was not so severe...so my mother helped me with everything I did. My husband is always not at home during the day. Because of the nature of his work, he leaves home early and comes late but my mother has been always around. With my mother, once she is at home, she will tell me to do this or that... since she is older than me, she has more experience in child health issues so she mostly advise me on what to do and I take whatever she says...I listen to her...". (Mother with a male child under-five, 28 years, Muslim, Living with extended family, Married, Comm. A)

Similarly, a mother from Community 'B' category of communities indicated that:

"As I already told you, we are staying in the same room so who else should I decide with...He is also the head of the family and the children belong to him as well and not me alone...". (Mother with a male child under-five, 25 years, Muslim, Living with extended family, Married, Comm. B)

This finding is consistent with a study by Singh et al. (2012) in India. The explanation to this could be due to religious values that reserve decision making as masculine. Thaddeus and Maine's assumptions underlying delaying in seeking health care could also explain why some of the respondents were unable to seek timely health care for their children since delay to seek health

care can be interrupted at the household decision-making level (Thaddeus & Maine, 1994).

There were other opinions that indicated that, mothers were unable to seek timely health care for their children due to delays concerning decision-making on where to seek health care. Over 33 percent of the respondents shared that, in addition to their husbands, either father-in-law or landlord decided on where to seek health care. These views were held in all the communities studied. It was also noticed that, out of the 33 percent of the respondents who held this view, most (64% of the respondents) of them were Muslims. A mother from Community 'A' category of communities who shared that decision-making functions are males' responsibility had these to say:

“For this community, most of the decisions are made by husbands and men. They are the head and it is not right for a woman to be making decisions while the man is around. It is insubordination and disrespect to do that. When people get to know that a mother is the decision maker, the man will lose his dignity and respect in this community. Why should a man sit down for the woman to decide? Such a woman may be something else!”. (Mother with a male child under-five, 25 years, Married, Muslim, Comm. A)

Similarly, a mother from Community 'B' category of communities who recounted that delaying in child's health-seeking decision making obstructed her timely reception to healthcare for her child under-five had this to say:

‘In my case, when my children fall sick, the decision is made by my husband. Hmm, the children are his biological children. In the absence of my husband, my landlord stands in and does whatever my husband will do for me. He is the one whom, after my husband, I discuss every issue with’. (Mother with a female child under-five, 22 years,

Married, Muslim, Comm. B)

The results are consistent with findings in South Africa (Sharkey et al., 2011). In most African communities, women adhered to husbands’ advice and decisions to avoid being labelled as insubordinate and disrespectful wives in society (Tolhurst & Nyonator, 2006; Yakong, 2008). Again, Ajzen’s planned behaviour theory propositions can explain this phenomenon on the basis that individuals assess whether their intended behaviour shall be supported by their referents (subjective norms) such as husbands and relatives before putting up a behaviour (Ajzen, 1991; Fishbein, & Ajzen, 2010).

Again, there were other views that indicated that, respondents had challenges with the decisions on child’s health care expenditure. Over 52 percent of the respondents shared that husbands and relatives interfered with their decisions on child health care expenses that affected their timely reception of health care for their children. This view was held in all the communities studied. It was also noticed that, out of the 52 percent of the respondents who held this view, most (68.2% of the respondents) of them were those who earned below US\$ 44.8 income monthly. A mother from Community ‘A’ category of communities had this to say:

‘He is the head so in terms of money for transport, feeding and any cost, he decides alone. At times he would even prompt me that the

child is sick and so something should be done about it when he recognises the signs earlier than me’. (Mother with a female child under-five, 25 years, JHS completed, US\$ 0 monthly, Comm. A)

To validate this, a mother from Community ‘B’ category of communities indicated that:

“On an amount to spend on food and drugs it has been the father. The children belong to him so if they are sick, it is his responsibility to provide money for that. At times too, when he is not at home and the need arise, we discuss everything on phone’. (Mother with a male child under-five, 25 years, Primary Education, US\$ 19.1 monthly, Comm. B)

This result is consistent with the findings by Pradham (2013) in India. The respondents’ inability to participate in household decision-making on child healthcare expenditure was also noticed among Ethiopian mothers (Mekonnen & Asrese, 2014). It also confirms the results by Nyakato & Rwabukwali (2013) who realised that, rural Ugandan women were unable to sell a family property like a goat to take a sick child to hospital and rather wait for the husband’s approval. The results highlight the importance of mothers’ autonomy on their bargaining power concerning child health care decision-making (Anwar, Shoaib & Javed, 2013). However, to be autonomous is influenced by income status and other socio-demographic factors since mothers who have little education and low income become dependent on the partner for survival and further affect their household bargaining power (Yigzaw, Yibrie & Kebede, 2004; Allendorf, 2007; Mekonnen & Asrese, 2014). Therefore, it can be concluded that, mothers who were unable to make

decisions on the amount to spend might not be able to seek prompt health care for their children as argued by the 'Three Delays' model (Thaddeus & Maine, 1994).

Delay in Reaching Health Facility

The study observed that respondents were less likely to receive prompt health care for their children under-five due to the delays in reaching health facility. Timely reception to health care can be interrupted by delays such as financial constraints, non-existence of health care facilities and transportation difficulties that inhibit identification and reaching health care facility, termed as the 'second delay' (Thaddeus & Maine, 1994).

Generally, it was evident that unavailability of health facility limited mothers' ability to seek swift health care for their children under-five. It was observed that, closed to 93 percent of the respondents comprising 67 percent mothers from Community 'A' category of communities and 33 percent of the mothers from Community 'B' category of communities were of the view that they were unable to seek timely health care for their children under-five since there were no health facilities in their communities. For instance, some mothers who live in Community 'A' category of communities had this to say:

"Because there is no health centre in this community, if you need anything, you have to travel to Efutu which is very disturbing. Even when you need a common paracetamol tablet, you have to travel through that poor road to Efutu. It is a big problem". (Mother with female child under-five, 36 years, Secondary Occupation, US \$ 14.8 monthly, Comm. A)

“Almost all the healthcare facilities are around Tantri, UCC, Abura and Pedu area. They have neglected us as if we are not part of the metro. Also most of the service like lab and scan, they will direct you to Adisadel. If you want to buy any drug, you have to travel to either Abura, Kotokuraba or Tantri. In this community we are so deprive of everything”. (Mother with both male and female child, 24 years, Tertiary Occupation, US \$ 74.2 monthly, Comm. A)

In the same vein, a mother who live in Community 'B' category of communities indicated that:

“...because there is no health centre or even a drug store in this community, we suffer a lot. When your child falls sick you have to always travel and if we were to have a clinic here, there wouldn't be travelling issues. Also, even if you need just a tablet, that one too you have to travel, my brother, we are suffering a lot”. (Mother with a male child under five, 30 years, Primary Occupation, US \$ 0 monthly, Comm.

B)

The findings indicated that nonexistence of health facility was a challenged to health-seeking among mothers from both Community 'A' and 'B' category of communities. The results corroborate study findings in Ghana by Adu-Gyamfi & Abane (2013) and Acquah et al. (2015). Indeed, the nonexistence of health care facility should be a problem to inhabitants of both Community 'A' and 'B' category of communities because most of the communities did not have a facility at all nor a single drug store. As established by Thaddeus and Maine, (1994), unavailability of health care facilities also inhibits access to timely reception of health care. Based on their

expositions, it can be concluded that, unless mothers travel to the next community with health care facilities, the health needs of their children under-five years may not be met.

There were other opinions that indicated that, mothers who lack funds to pay for the cost of transport were less likely to receive timely health care for their children compared to those who have. Funds are needed to pay for cost of transport, especially when health facility is far from mothers' place of residence. It was observed that, 76 percent of the respondents said that, they were unable to seek prompt health care for their children due to unavailability of funds to pay for transportation. This view was held in all the communities studied. Again, it was observed that, out of the 76 percent of the respondents who held this view, most (78% of the respondents) of them were those who earned below US \$ 63.6 income monthly. Some of the mothers from Community 'A' category of communities got these to say:

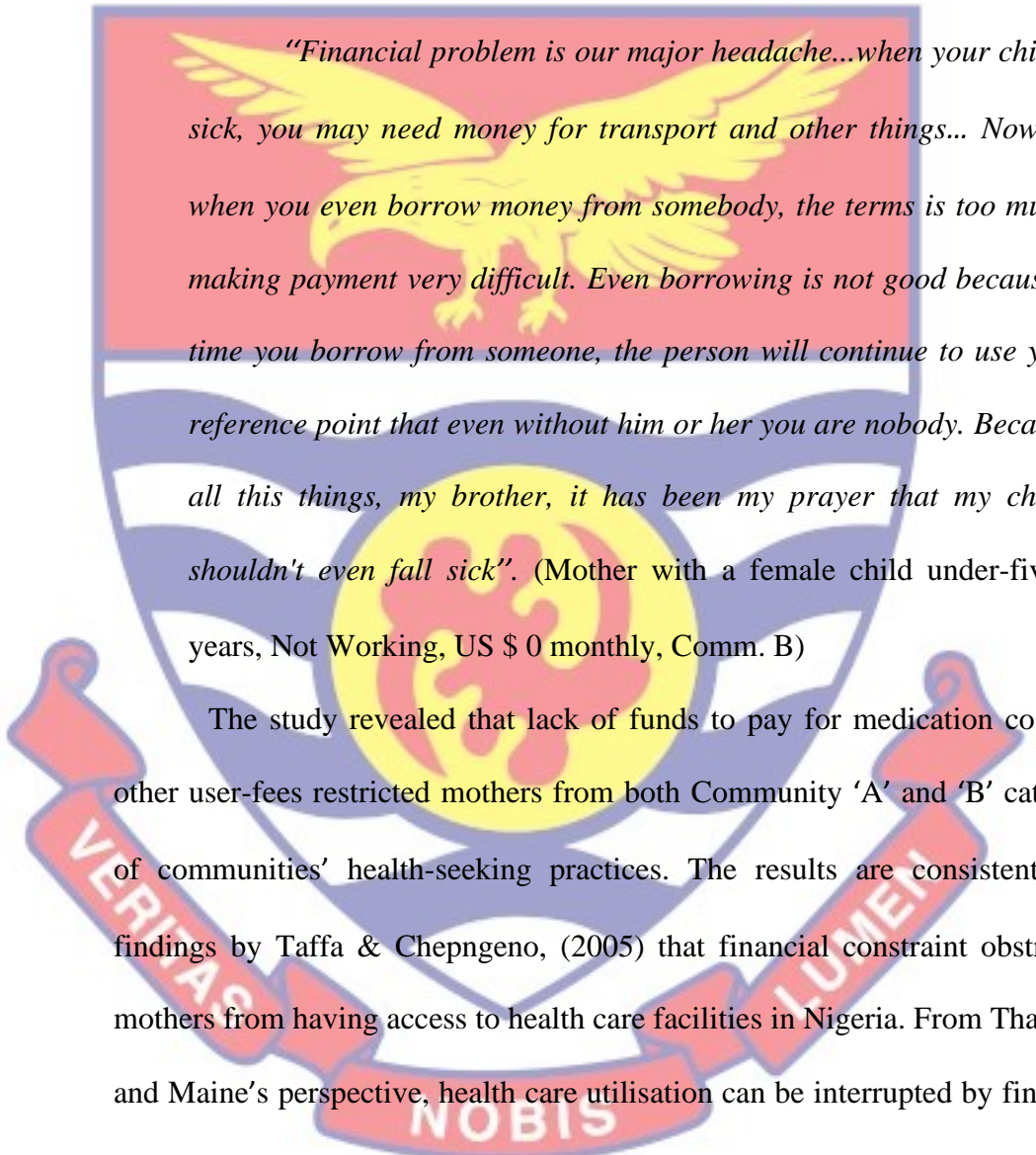
“In this community, our major concern is financial problem. Though you may have insurance, you still need to have some money on you for transportation. You need money for transportation and others. Can the card [referring to the health insurance card] pay the transport cost for you? The insurance is nothing. For me when my child is sick and I don't have money, I have to borrow money from somewhere else”.

(Mother with both male and female children under-five, 21 years old, Tertiary occupation, US \$ 42.4 monthly, Comm. A)

“When your child falls sick, one of our challenges is the means to be able to send him or her to the hospital. At times, things become so difficult to the extent that, the family cannot even afford breakfast. And

when your child falls sick, you need money for transport and other things. My brother it is not easy'. (Mother with a male child under-five, 32 years, Tertiary occupation, US \$ 21.2 monthly, Comm. A)

To confirm this, a mother from Community 'B' category of communities also indicated that:



"Financial problem is our major headache...when your child fall sick, you may need money for transport and other things... Nowadays when you even borrow money from somebody, the terms is too much so making payment very difficult. Even borrowing is not good because any time you borrow from someone, the person will continue to use you as reference point that even without him or her you are nobody. Because of all this things, my brother, it has been my prayer that my children shouldn't even fall sick". (Mother with a female child under-five, 21 years, Not Working, US \$ 0 monthly, Comm. B)

The study revealed that lack of funds to pay for medication cost and other user-fees restricted mothers from both Community 'A' and 'B' category of communities' health-seeking practices. The results are consistent with findings by Taffa & Chepngeno, (2005) that financial constraint obstructed mothers from having access to health care facilities in Nigeria. From Thaddeus and Maine's perspective, health care utilisation can be interrupted by financial availability on the basis that, mothers may need income to finance their transport cost in the course of accessing health care (Thaddeus & Maine, 1994). Therefore, it can be concluded that, low income earners might not be able to utilise health care for their children as compared to their counterparts with high income status (Thaddeus & Maine, 1994).

There were other views that indicated that respondents who had difficulty with access to transportation system were less likely to utilise health care for their children compared to those who were not. The results are consistent with earlier findings (Noor, Zurovac, Hay, Ochola & Snow, 2003; Kyei, Campbell & Gabrysch, 2012; Muhammed, Umeh, Nasir & Suleiman, 2013). Mothers, especially those living in distant communities, cannot reach a health facility within the shortest possible time when they have irregular transportation system. For instance, almost 92 percent of the respondents that were basically respondents from Community 'B' category of communities were of the view that, their accessibility to health care facilities was challenged due to difficulty in getting a means of transport to a health facility.

Some of them said:

“You know there are no commercial vans that run in the metro at reduced cost unlike other cities like Accra and Kumasi. You imagine where we are living. At times it is difficult to get a car to Efutu [Referring to Efutu Clinic]. Last time I heard on Ahomka FM that a child from the next community nearly died because there were no means of transport to take her to the hospital”. (Mother with a female child under-five, 28 years, JHS, US \$ 21.2 monthly, Comm. B)

“The last time she fell sick, the only thing I faced was transportation difficulties. I kept on waiting and waiting for several hours before a taxi appeared in a scene. In this metro, wherever you want to go, you have to use taxi which is expensive. Also, the number of vehicles in the metro are not enough”. (Mother with a female child under-five, 34 years, Primary Education, US \$ 0 monthly, Comm. B)

There were other views which indicated that the location of the health facility restricted mothers' timely access to health care for their children. A quarter (25% of the respondents) of the respondents who live in Community 'B' category of communities said that they were unable to reach health facilities on time due to the location of health care facility. The results are consistent with previous findings in Ghana (Krumkamp et al., 2013). They shared that, some of the health care facilities are not located alongside the road so one has to walk or hire a vehicle after reaching the transport station to a health care facility which is tiresome, as some of them said:

“With Efutu Clinic, when you reach Efutu community, you have to hire a taxi to the clinic or walk if you have no money which is disturbing. But Adisadel or Holbrook [referring to a private healthcare facility] is located on the roadside so you won't border yourself to hire a car again”. (Mother with a female under-five, 28 years, JHS, US \$ 10.6 monthly, Comm. B)

“Efutu or Brimsu clinic is unlike Zongo clinic or even Essuekyir. With Zongo or Essuekyir clinic, you can just alight at the roadside and take a few minutes' walk to the clinic. But with Efutu, you have to hire a taxi to the facility when you reach Efutu station. Those who don't have money have to walk for a longer distance before you can reach the facility”. (Mother with a female child under-five, 34 years, Primary Education, US \$ 0 monthly, Comm. B)

Thaddeus and Maine argued that, difficulty in identifying and reaching a health facility can inhibit mothers' health-seeking process (Thaddeus &

Maine, 1994). The current study noticed that difficulties in getting access to transport was a factor that inhibited respondents to seek health care residing in Community 'B' category of communities. Based on Thaddeus and Maine explanations, it can be concluded that without serving mothers with a regular means of transport, their timely reception to health care for their children under-five would be impeded (Thaddeus & Maine, 1994).

Delay in Receiving Adequate Medical Care

Generally, in this study, it was noted that respondents were less likely to receive timely health care for their children under-five due to the delays in receiving adequate medical care. Timely reception to health care can be challenged when health care is poorly delivered to mothers such as; insufficient provision of drugs, long waiting time and poor communication of health care providers, referred to as the 'third delay' (Thaddeus & Maine, 1994).

It was observed that insufficient provision of drugs inhibited mothers' timely reception to health care for their children under-five. Providing quality health care to patients is important to raise their satisfaction to health services received (Ghana Health Service, 2002; Tang, Luo, Fang & Zhang, 2013). In this study, it was noticed that over 90 percent of the respondents were of the view that, insufficient provision of drugs was a constraint they faced at the health facility. Accordingly, respondents exhibited feelings of discomfort when few or no drugs were given and perceived such conditions as a total deviation from what they knew from the past. For instance, 71 percent of these respondents who live in Community 'A' category of communities and 29

percent of these respondents who live in Community 'B' category of communities said that insufficient provision of drugs was another challenge. This view was held in all the communities studied and a mother from Community 'A' category of communities had this to say:

‘This is not how things were done in the past...Brofoyedur, Brofoyeduro, [referring to a clinic at Brofoyedur], that place I haven't been given 'para' before. I had wanted to inform the Assemblyman over there to report them. Since time immemorial, they add 'para' to any prescription; but at Brofoyeduro clinic things are different. Even the one going [pointing hands towards her female child], was sent to that clinic yesterday but they never gave us just a single tablet’. (Mother with both male and female child under-five, 39 years, JHS completed, US \$ 105.9 monthly, Comm. A)

In a similar manner, a mother from Community 'B' category of communities also indicated that:

‘When some mothers visit Zongo clinic, they complain that they don't give an injection, they don't give drugs and other stuff to children but rather pack dozens of 'para' 'para' for you alone and because of that mothers don't go there at all. I will also not go there because of what I have heard’. (Mother with a female child under-five, 34 years, No Education, US \$ 0 monthly, Comm. B)

This study observed that mothers from both Community 'A' and 'B' category of communities were less likely to receive utilise health care as a results of insufficient provision of drugs. The findings confirm a similar study by Afolabi, Daropale, Irinoye & Adegoke (2013) which noticed that students

expressed their dissatisfaction about service received due to poor attitude of healthcare providers and shortage of prescribed medicines in Nigeria. Indeed, perceived quality of care reflecting on the availability or provision of drugs is an important factor that influences mothers' health-seeking behaviour in that, when few drugs are given to mothers, it creates a feeling of discomfort which subsequently affects their satisfaction to services and utilisation (Thaddeus & Maine, 1994). Based on Thaddeus and Maine expositions, it can be concluded that, mothers may quit such a healthcare facility that gives few drugs (Thaddeus & Maine, 1994).

There were other views which indicated that mothers were less likely to utilise health care for their children under-five due to poor communication of healthcare providers. It was observed that almost 62 percent of the respondents mentioned that, health care providers attitude of poor communication was another constraints to their health-seeking practices. According to some of the respondents, the manner in which some of the health workers spoke to them was not commendable. Therefore, some of the mothers decided not to utilise facilities where their providers exhibit poor communication. This view was held in all the communities studied. It was also observed that, this view was held by the respondents who earned below US \$ 63.6 income monthly. These were some of the views of the respondents from Community 'A' category of communities:

‘Hmm, my brother, some of these small small nurses, they don't respect at all. When we go there, the way they speak to us is not good at all. Because of that, I have stopped visiting that facility. We went there for a test and we never knew the lab test was to be done twice so after

doing my first test, we went home. The next day when we went there, the laboratory technician and other nurses were so furious because they mentioned my child's name on several occasion but couldn't find my child to conduct the second test...because of that, I have stopped going there and rather chosen Sanford or Central hospital''. (Mother with a

male child under-five, 40 years, JHS completed, Not Working, US \$ 0 monthly, Comm. A)

“There is a certain boy at Zongo clinic, he doesn't respect patient at all. One day my child fell sick and when we got there, that boy was the only staff left...he instructed us to sit and wait for a while. It took us several minutes without being attended to so I asked him why he is still recording something while patients are waiting without being attended to. In a frowned face, he told us that he will be attending to us not until he is done...This became an exchange of words. He added that, if I was the one sick, he will never attend to me...I don't know why he behave like that or maybe is it because I don't have money that is why he treated me like that?” (Mother with a male child under-five, 42 years,

No Education, Primary occupation, US \$ 10.6 monthly, Comm. A)

Similar views were shared by mothers from Community 'B' category of communities and one of them indicated that:

“One day how a particular nurse spoke to me was not nice at all and I reported the issue to the Senior Nurse. Ewim oo!! Ewim!! It was Ewim [referring to Ewim health centre] that such an incident happened. It will be better for me to seek healthcare elsewhere than to fall into the hands of someone who doesn't respect because my brother it is painful!!

Someone who doesn't behave well can do anything that can affect your child so it will be better to seek healthcare from other clinics compared to such a facility.' (Mother with a female child under-five, 32 years, JHS completed, Tertiary Occupation, US \$ 53 monthly, Comm. B)

The present study identified that some of the health staff exhibited poor communication towards the respondents from both Community 'A' and 'B' category of communities which is least expected of health care providers in Ghana (Ghana Health Service, 2002). As enshrined in the Ghana Health Service Patient Charter, it is expected of health care providers to exhibit positive attitude towards clients (Ghana Health Service, 2002). This result also confirms findings by Afolabi, Daropale, Irinoye & Adegoke (2013) which noticed that 20 percent of their respondents recounted poor attitude of health care providers as their reason for avoiding using health care services in Nigeria. Arguably, this can affect mothers' health care utilisation behaviour since no mother would want to receive health care from disrespectful health care providers (Thaddeus and Maine, 1994).

There were other views that indicated that mothers who queued for long period at the health facilities were less likely to receive prompt health care for their children under-five compared to their counterparts who were not. It was observed that about 62 percent of the respondents were of the view that they could not receive timely health care for their children under-five due to long wait arising from constant queuing. This view was held in all the communities studied. It was also noticed that this view was shared by the respondents who earned below US \$ 42.4 income monthly. A mother from Community 'A' category of communities indicated that:

“The only problem mothers in this community face are that we spend a lot of time when we visit UCC hospital. You know the type of job we do here that most sell gari and watermelon along the road so if you spend all the time at the hospital, you will lose money. When you visit UCC [referring to UCC Hospital], especially Mondays and Thursdays, it will take considerable time before they [referring to the nurses] will send your child’s folder to the consulting room. Last week Monday I nearly left the facility due to this same queuing.” (Mother with both male and female child, 26 years, Tertiary occupation, US \$ 31.8 monthly, Comm. A)

To confirm this, a mother from Community ‘B’ category of communities also had this to say:

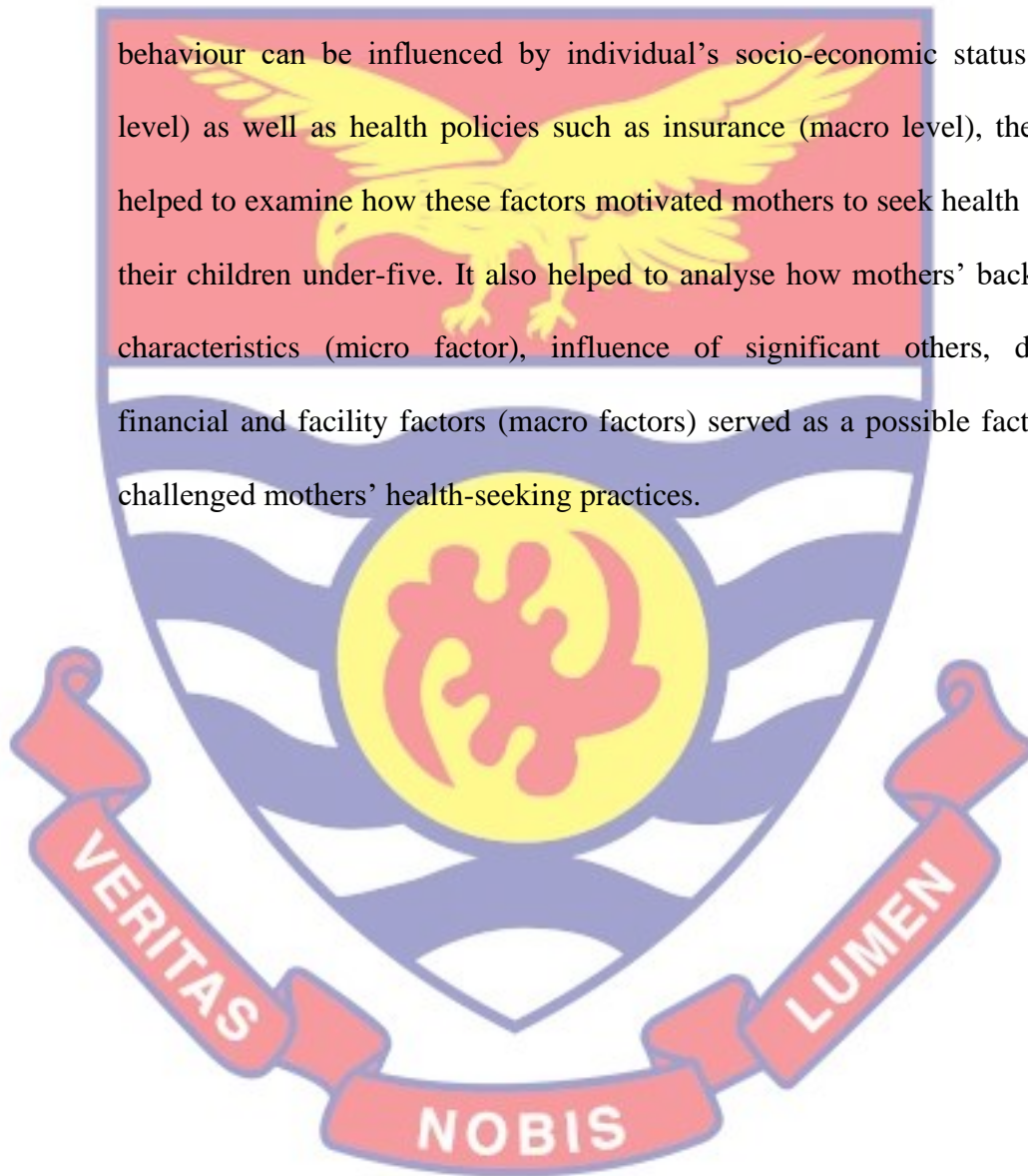
“The last time I went to Efutu clinic, I spent a lot of time over there...I went there around 8 am and came home around 3 pm. In fact, I will quickly move to Macro the next time I anticipate such a delay...Things move faster at Macro because it is a private facility.”

(Mother with a male child under-five, 40 years, Primary Occupation, US \$ 10.6 monthly, Comm. B)

The results indicated that mothers from both Community ‘A’ and ‘B’ category of communities shared similar views that poor attitude of health staff restrict their timely access to healthcare. The findings is consistent with previous results in Nigeria where respondents expressed long waiting time as an obstacle to their utilisation of healthcare facility (Afolabi, Daropale, Irinoye & Adegoke, 2013). As acknowledged by Thaddeus & Maine, indeed, delay can also occur at the facility on the basis that, when mothers are supposed to

queue for longer period, it will restrain their timely access to services (Thaddeus & Maine, 1994).

The adapted planned behaviour theory (Figure 2) was useful to the study in that, it helped to assess how mothers' perceptions about childhood illness influence their health-seeking practices. Again, since health-seeking behaviour can be influenced by individual's socio-economic status (micro level) as well as health policies such as insurance (macro level), the model helped to examine how these factors motivated mothers to seek health care for their children under-five. It also helped to analyse how mothers' background characteristics (micro factor), influence of significant others, distance, financial and facility factors (macro factors) served as a possible factors that challenged mothers' health-seeking practices.



CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter presents the summary, conclusions and recommendations of the study. It first summarizes the entire work and then presents the key findings of the study. The chapter also captures conclusions and recommendations of the study.

Summary

The study investigated mothers' health-seeking behaviour for children under-five years in rural communities in the Cape Coast Metropolis. Specifically, the study assessed the perceptions of mothers with children under-five years about childhood illness, analysed factors that motivate health-seeking among mothers for children under five years and examined the challenges to health-seeking practices for children under-five years by their mothers.

Three main research questions were formulated for the study. They were:

1. What are the perception of mothers with children under-five about childhood illness?
2. What are the motivational factors that influence health-seeking?
3. What are the challenges to health-seeking?

The planned behavioral theory and the 'Three Delays' model served as the main theoretical basis of the study and an adapted planned behaviour

theory served as a conceptual framework for the study. The study employed a qualitative design.

The study focused on seven communities consisting of five communities within five kilometer radius to a healthcare facility and two communities beyond five kilometer radius to a healthcare facility. Six respondents were purposively selected from each community comprising two mothers who lived with one under-five male child, two mothers who lived with one female under-five child and two mothers who lived with one male and one female under-five children. In all, 42 mothers were selected and interviewed.

Summary of Major Findings

Firstly, it was observed that some of the respondents, predominantly mothers who had completed JHS, perceived that excessive contact with the sun could cause childhood illnesses. It was also evident that some of the respondents, mostly mothers who had completed SHS, perceived that malnutrition, poor ventilation, and pathogens could cause childhood illnesses. The present study also found that some of the respondents, mostly mothers who had completed SHS, perceived that poor nutrition and genetic factors could increase a child's chance to illnesses while some of the respondents without education perceived that any child is at risk of illnesses.

It was noticed that, having a valid insurance motivated most mothers to utilise health care. It was also evident that some of the respondents, basically married mothers, shared that having funds to pay for transport cost motivated them to utilise health care. Again, nearness to a health facility were shared by

the respondents who predominantly lived in Community 'A' category of communities as motivation to prompt health-seeking. Also access to regular transportation system was mentioned by some of the respondents who basically lived in Community 'A' category of communities and earned US \$ 63.5 and above as motivation to health-seeking.

Again, it was observed that, respondents who were mostly Muslims could not decide on when and where to seek health care for their children. It was also observed that some of the respondents mostly mothers who earned below US \$ 42.3 could not take decisions on an amount to spend. It was also evident that, regardless of the respondents' background characteristics, most of the respondents could not receive timely health care for their children due to unavailability of health facility.

Furthermore, it was observed that some of the respondents who lived in Community 'B' category of communities had difficulty with access to transportation system. Finally, it was noticed that some of the respondents who earned below US \$ 63.5 income and below US \$ 42.3 income could not receive timely health care for their children due to poor communication of some of the nurses and queuing for long period of time respectively.

Conclusions

Based on the key findings, a number of conclusions were made.

Firstly, the study observed no variation among mothers from both Community 'A' and 'B' category of communities with regards to health-seeking practices and sex of the child. Also, the respondents, based on their level of education, attributed the perceived causes and susceptibility of childhood illness to belief

systems and scientific factors which has strengthened prior knowledge about the relationship between education, perception and health care utilisation. Therefore, it can be concluded that, there is a possibility for mothers with higher education to seek curative and preventive health care or adopt a healthy lifestyle to reduce their child's chance to illness.

Again, the respondents unanimously endorsing the National Health Insurance Scheme (NHIS) as a motivating factor to health-seeking has highlighted the essence of encouraging mothers who have not yet subscribed or renewed their membership to the scheme to do so to reduce financial challenges to health care utilisation. Also, married mothers having enough funds to pay for health care cost have pointed to how significant others can impact mothers' health-seeking behaviour and therefore, married mothers might be more probable to utilise health care compared to their counterparts.

Again, respondents' place of residence and income status were found to be influencing factor on mothers' health-seeking and that respondents were able to access health care due to closeness to a health facility and available funds. Therefore, it can be deduced that unless mothers who are far from health facility are served with health post or travel for long distance which is cumbersome, they might be less probable to seek prompt health care.

The study also unravelled that some of the respondents particularly Muslims and those with low income were unable to participate on a number of child health seeking decision making which led to a delay in receiving timely healthcare for their children under-five. This has highlighted the essence of using diverse avenues to empower mothers so that they can be autonomous and have a say on child health care decision making functions while there is

the need to explore the underlying religious values that restrict mothers to participate in decision making processes.

Another challenge respondents solidly expressed was unavailability of health facilities and indeed, without health facilities, mothers might not be able to seek health care for their children even if they have enough funds and valid insurance. Again, access to transport restricted mothers' timely health-seeking for their children and that, without serving study communities with a regular sources of transport, mothers might not be able to utilise health care for their children. Also the attitude of some of the nurses exhibiting poor communication is least expected of health staff in Ghana and therefore, possible avenues must be used to minimise such behaviours.

Recommendations

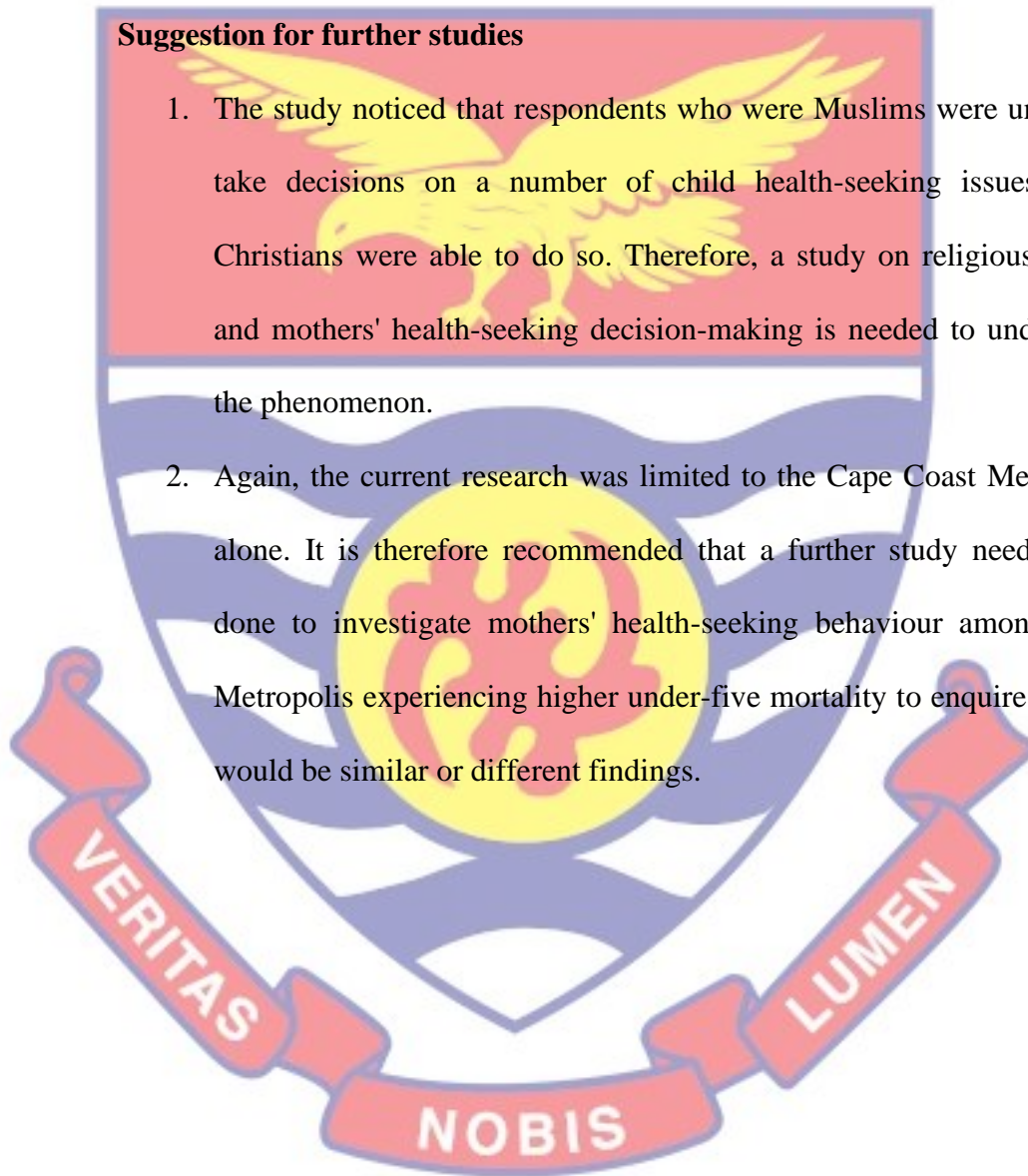
Based on the major findings and conclusions the study arrived at the following recommendations.

1. The Cape Coast Metropolitan Health Directorate should serve studied communities with Community-based Health Planning and Services (CHPS) compounds staffed with adequate health personnel because lack of health facilities was mostly raised by the mothers as a basic factor affecting their ability to seek health care for their children.
2. Owing to the negative attitude of some of the health care providers, the Cape Coast Metropolitan Health Directorate should intensify refresher courses organised to target nurses to shape their communication and interpersonal skills.

3. The National Health Insurance Authorities of the Cape Coast Metropolis should intensify their education and promotion programs to persuade mothers to subscribe and renew their membership to the scheme.

Suggestion for further studies

1. The study noticed that respondents who were Muslims were unable to take decisions on a number of child health-seeking issues while Christians were able to do so. Therefore, a study on religious values and mothers' health-seeking decision-making is needed to understand the phenomenon.
2. Again, the current research was limited to the Cape Coast Metropolis alone. It is therefore recommended that a further study needs to be done to investigate mothers' health-seeking behaviour among other Metropolis experiencing higher under-five mortality to enquire if there would be similar or different findings.



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APPENDIX A

UNIVERSITY OF CAPE COAST
COLLEGE OF HUMANITIES AND LEGAL STUDIES
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF POPULATION AND HEALTH

RESEARCH TOPIC: Mothers' health-seeking behaviour for children under five years in rural communities in the Cape Coast Metropolis

AN IN-DEPTH INTERVIEW GUIDE

Preamble:

This study seeks information about mothers' health-seeking behaviour for their children under-five years. The information is required for purely academic purposes and nothing else. Information provided will be accorded the maximum confidentiality it deserves.

You are also free to discontinue your participation at any stage of the study.

You are however recommended for agreeing to participate in the study.

Kindly be candid with your responses.

Locality name..... Household No.

Time of interview [Begins]..... [Ended].....

Date..... Number of visit.....

Section I: Socio-demographic background of mothers

As a way of starting our conversation, I want to know certain basic things about you by seeking your responses to the following questions.

1.1 Age of the mother (In completed years)

1.2 Completed education

1.3 Number of Children ever born. [Probe for number of children surviving]

1.4 Ethnicity

1.5 Religion

1.6 Marital status

1.7 Place of residence

1.8 Do you live with only your nuclear family? [Probe: who else she live with]

1.9 Regular Occupation

1.10 How much do you earn on a monthly basis?

Section II: Mothers perception of childhood illness

At this section, I want you to share your views about illnesses which affect children under five years.

2.1 To begin with, can you describe illness your child has suffered from for the past 6 months?

Probe [How often do such illness occurs and why; is the occurrence associated with seasonality]

Probe [Do you think such illness mentioned deserves healthcare specialist; should be treated at home and why]

Probe [What do you think are the causes of such illness and why]

Probe [Among your children, which of them do you think stands the greater risk of contracting the illness mentioned at question 2.1 and why]

Probe [What signs and symptoms do you think indicate onset of the illnesses mentioned in question 2.1]

Probe [Do you think visiting a healthcare facility at the first sign of illness mentioned is helpful and why]

Probe [When (time) do you think is good to initiate action after knowing that your child is ill and why]

Probe [Do you think seeking healthcare from multiple sources when your child faces the illness mentioned at question 2.1 is helpful and why]

Probe [Do you think practising good hygiene can prevent the illness mentioned at question 2.1 and why]

Probe [What other practices do you think can adopt to prevent the illness mentioned at question 2.1]

Probe [Do you think you go through challenges like financial, stress and emotional traumas, etc., due the illness the child suffered and why]

2.2 For the past two weeks, have your (named) child suffered any illness?

Probe [Do You think such illness mentioned deserves healthcare specialist and why]

Probe [Do You think such illness should be treated at home and why]

Probe [What do you think was the cause of that sickness and why]

Probe [What signs and symptoms do you look up for when your child under five contracted the illness mentioned]

Probe [Do you visit a healthcare care facility at the first sign of illness mentioned above and why]

Probe [Where did you seek healthcare and why did you choose that place as source of healthcare]

Probe [The last time your child falls sick, do you visit more than one source in seeking health-care for the child and why]

Probe [Do you think if you practise good hygiene can prevent the illness mentioned at question 2.2 and why]

Probe [What other things can you do to prevent the illness mentioned at question 2.2]

Probe [What problems did you go through as a result of the illness your child contracted]

Section III: Influence of significant others on health-seeking decision-making

At this section, I want you to share your views on the husband, relatives and other members who influence your health-seeking decision-making when your children under five years fall sick.

3.1 To begin our discussion, who influence your decision to seek health-care for your child under five?

Probe [How often and why]

3.2 How do such a person (s) influenced your decision?

Probe [Decisions about where to seek healthcare, why, how often]

Probe [Decisions about when to initiate care, why, and how often]

Probe [Decisions about amount to spend on food, transport, etc., why and how often]

3.3 The last time your child under five falls sick, who influenced your decision?

Probe [Where to seek healthcare, why]

Probe [When to initiate care, why]

Probe [Amount to spend on food, drugs, transport, etc, why]

Probe [In the absence of the decision maker, are you able to make decisions when your child falls sick, how often and why]

3.4 Who influence your decision to seek health-care for your child under-five during referral cases?

Probe [how often and why]

3.5 How do such a person (s) influenced your decision during referral cases?

Probe [Decisions about where to seek healthcare, why, how often]

Probe [Decisions about when to initiate care, why, and how often]

Probe [Decisions about amount to spend on food, transport, etc., why and how often]

3.6 Do You receive health information?

Probe [The message provider; channel; type of information; how often they receive the message; usefulness of the message in decision making]

Section IV: Motivations to health-seeking

At this section, I humbly want you to share your views about factors that motivate you to seek healthcare for your child under five.

4.1 Please, first of all, where do You visit when your child under-five falls sick?

Probe [Ask for more sources]

4.2 Why do you prefer this facility?

Probe [Distance very close; drugs are cheap, staff very friendly, short waiting time, quality of care received, previous experience with the provider, NHIS, etc.,]

Probe [What about your comment on the service received]

4.2 The last time your child under five fell sick, where did you go for treatment?

Probe [Ask for reasons about choice of place and how often]

Probe [Ask in relation to distance, health-care provider factors, healthcare facility factors, quality of care received, previous experience with the provider, NHIS, etc]

4.3. Will you still seek health-care from that place when your child under five falls sick again?

Probe [Ask for the specific reasons]

Section V: Barriers to health-seeking

Lastly, please I want you to share your views on factors that can impede you in seeking healthcare for your child under five.

5.1 To commence our conversation, can you share your views about barriers you encountered before when seeking healthcare for your child?

Probe [Ask the treatment received from healthcare provider and number of hours spent at the facility]

Probe [Ask further in relation to distance, health-care provider factors, healthcare facility factors, quality of care received, previous experience with the provider, NHIS, etc. if the reasons given are not enough]

5.2 The last time your child falls sick, what barriers did you encountered in seeking healthcare for your child?

Probe [Ask the treatment received from healthcare provider; number of hours spent at the facility; etc]

Probe [Ask further in relation to distance, healthcare provider attitude, healthcare facility factors, quality of care received, previous experience with the provider, NHIS, etc. if the reasons given are not enough]

5.3 Will you seek healthcare for your child from that facility when such barriers are still not being addressed?

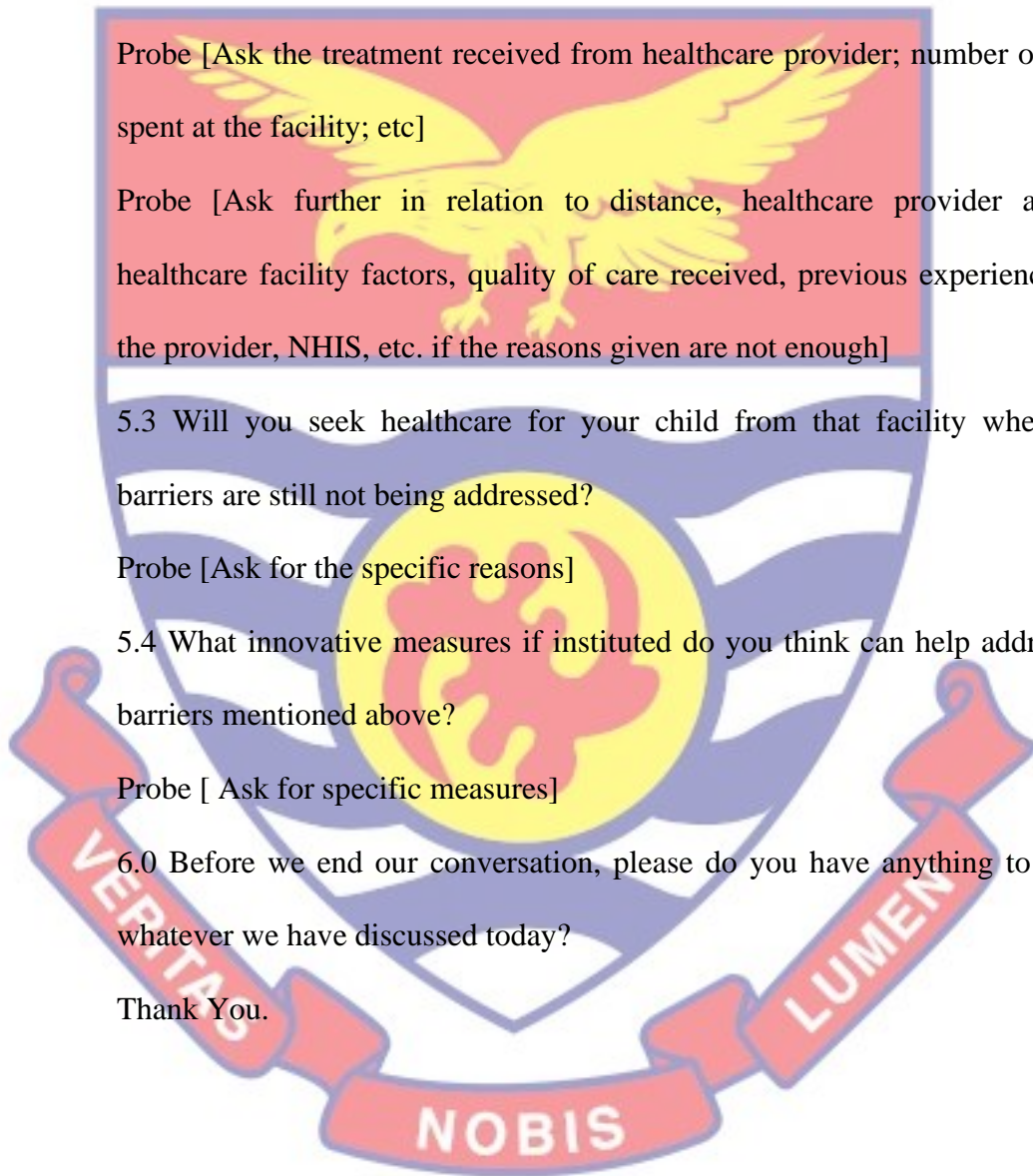
Probe [Ask for the specific reasons]

5.4 What innovative measures if instituted do you think can help address the barriers mentioned above?

Probe [Ask for specific measures]

6.0 Before we end our conversation, please do you have anything to add to whatever we have discussed today?

Thank You.



APPENDIX B
UNIVERSITY OF CAPE COAST
INSTITUTIONAL REVIEW BOARD
INFORMED CONSENT FORM

Title: Mothers' health-seeking behaviour for children under five years in rural communities in the Cape Coast Metropolis

Principal Investigator: Francis Appiah

Address: University of Cape Coast

College of Humanities and Legal Studies

Faculty of Social Science

Department of Population and Health

Cape Coast

General Information about Research

The main objective of this study is to assess the mothers' health seeking behaviour for children under five years in rural communities in the Cape Coast Metropolis. Due to longer travelling distance, unavailability of healthcare facility or providers, mothers in the rural communities may not be able to access healthcare for their children or may do so with difficulties. As a result of this, under-five mortality rate for the Cape Coast Metropolis has remained high and unstable for the past four years. The trend further shows that the Cape Coast Regional Hospital (a referral centre for the surrounding communities) has seen a higher under-five mortality rate, compared with the other healthcare facilities in the metropolis. Therefore, this study would want to identify where mothers seek health care, their understanding of childhood illness, the factors that motivate mothers to seek healthcare as well as barriers

that prevent mothers from seeking healthcare for their children under five years. As such, an in-depth interview guide shall be used to gather data for the study. It is expected that each interview section shall last for about 40-60 minutes. Mothers (informants) would be expected to answer questions relating to their child health. Informed consent would be sought from the participants before they would be included in the study.

Procedures

To find answers to some of these questions, we invite you to take part in this research project. If you accept, you will be required to: participate in an interview that would be conducted by Field Assistants. You are being invited to take part in this study because we feel that your experience as a mother who has taken care of your child(ren) under five years can contribute much to this discussion. The type of questions that are likely to be asked are: what are the causes, signs and symptoms of childhood illness? where do you seek health care when you are ill? who are the decision makers when your child(ren) under five years falls sick? and what are the factors that motivate or obstruct you when seeking healthcare for your child(ren)?

If you do not wish to answer any of the questions posed during the interview, you may say so and the interviewer will move on to the next question. The interview will take place in your home, and no one else but the interviewer will be present. The information recorded is considered confidential, and no one else except Francis Appiah, Kuffour Marthin, Edward Kyereme, Jane Araba Amponsah and Agnes Appiah will have access to your survey.

The expected duration of the interview is about 40-60minutes.

Possible Risks and Discomforts

There would be no realistic predictable risks or discomforts to the participants.

Possible Benefits

Mothers in the rural communities in the Cape Coast Metropolis through this study would gain a better understanding of factors that can cause childhood illness as well as signs and symptoms associated with childhood illness. The research would also serve as a guide to the mothers in rural communities in the Cape Coast Metropolis, outlining the various ways in which husbands, relatives (significant-others) influence their child health outcomes through their involvement in health seeking decision-making processes. The study would be of benefit to the Cape Coast Metropolitan Health Directorate, Non-Governmental Organisations, Policy Makers and Health Planners for best policy and planning practices.

Confidentiality

The information you give in this interview will be kept safe and used later in the study analysis but you are assured that, we will protect information about you to the best of our ability. The recorded interview, as well as the transcription, would be kept safe with the aid of 'mylockbox app' to prevent unauthorised people from having access to the data and only the researcher would have access to it. You will not be named in any reports.

Compensation

There is no compensation package either in cash or kind offered for participation.

Voluntary Participation and Right to Leave the Research

Your participation is solely voluntary and you can choose to exit from participation at any point in time when you feel uncomfortable with the questions being asked without any penalty.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (*name of research*) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent

ETHICAL CLEARANCE LETTER

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 03321-33172/3 / 0207355653/ 0244207814 C/O Directorate of Research, Innovation and Consultancy

E-MAIL: irb@ucc.edu.gh

OUR REF: UCC/IRB/A/06

YOUR REF:

31TH MAY, 2016

Mr. Francis Appiah
Department of Population and Health
University Cape Coast

Dear Mr. Appiah,

ETHICAL CLEARANCE –ID NO: (UCCIRB/CHLS/2016/02)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for implementation of your research protocol titled: **“Mothers’ health-seeking behaviour for children under five years in rural communities in the Cape Coast Metropolis.”**

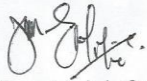
This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,


for (Samuel Asiedu Owusu)
ADMINISTRATOR

cc: The Chairman, UCCIRB

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST
Date: 21-05-16