UNIVERSITY OF CAPE COAST

FACTORS INFLUENCING HEALTH SEEKING BEHAVIOUR OF FISHER FOLKS IN PRAMPRAM, GHANA

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BY

GODFRIED AGOE LARTEY

Thesis submitted to the Department of Health, Physical Education and Recreation of the Faculty of Education, University of Cape Coast, in partial fulfilment of the requirements for the award of Master of Philosophy Degree in Health Education

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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 signature …… Date: ……..

Name: Godfried Agoe Lartey

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 University of Cape Coast.

Principal Supervisor's Signature …….. Date: ……

Name: Dr. J. K. Ogah

Co-supervisor's Signature…… Date: ……

Name: Mr. F. S. Bediako

ABSTRACT

The study was carried out in Prampram in the Greater Accra region of Ghana to determine the factors which influence health seeking behaviour of fisher folks. To achieve this, a structured interview guide was used to gather data from 120 fisher folks in a face to face interview.

The data collected was grouped and analyzed according to the seven specific objectives of the study and frequencies and percentages used to describe the results. The results revealed that 99% of fisher folks are aware of health resources available to them and resources like clinics, nurses and drug stores are accessible to the majority of the respondents. It was also revealed that 87% of the fisher folks studied consider a factor like the attitude of health personnel whilst 76% consider the gender of health personnel and 76% also consider the costs involved when seeking health.

The general conclusion of the study was that fisher follks in Prampram are satisfied with their health seeking endeavours. Among the recommendations made were that healths providing agencies should increase the quantity and quality of health resources in deprived areas, and people living in such communities should be encouraged to register with health insurance schemes.

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DEDICATION

To my children; Lawrencia, Smiles and Malaika.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

Background to the Study

Naturally, every one becomes ill at one time in his or her life. Decisions taken by people to seek good health are very critical, since such decisions may affect health positively or negatively.

The health of every nation, according to Anderson (1985), is everybody's business but individually, everyone is responsible for his or her own health. Health is a personal issue and therefore each person should take care of him or herself so that he or she can be healthy. A healthy person should be able to perform daily tasks without undue fatigue, control his or her emotions, and be able to interact with people and the environment. This will satisfy the World Health Organization's (WHO) definition of health that "health is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity "(Payne and Hahn, 2002, p. 67)

When people are sick they become restless and resort to different means to seek health. Health seeking decisions, according to Hoover, Davis and Donatelle (1998), may be influenced by a variety of factors, and may be motivated by a complex interaction between values, beliefs and selected factors in the social environment.

To Neubeck and Neubeck (1979), health behaviour is highly correlated with the social class of a person and as one goes down the social structure, good health becomes less frequent. This leads to the assumption that people in a particular social group may put up similar health-seeking behaviour, although Bedworth and Bedworth (1992) think that each individual has the fundamental responsibility for his or her health.

From the above we can inferre that people in the same social class might put up similar health seeking behaviour .That is why Foster, Scott and Goldsmith (2006) revealed that Alaska fishermen may live a healthier health style than the general population in the United States of America. This might also be because Most Alaskan fishermen, like their counterparts in other parts of the world, can be expected to enjoy a diet high in fish, regular exercise, and fresh air. Additionally the general conclusions drawn after a study of Alaska fishermen, who we expect to put up similar health seeking behaviour, according to Foster et al (2006) are:

1. They are commercial fishermen whose options for both health care delivery and insurance are limited.
2. Alaska fishermen may have lower than average health care cost.
3. Health insurance options are difficult to find and vary by location.
4. Lack of health insurance is an increasing concern as the average age of the fisherman is gradually rising.
5. Fishermen find it difficult to pay for health care.
6. State and federal actions may address the problem but remain uncertain.
7. Affordable health care and insurance deserve to be national priorities.

Lungu and Huskein (2010) also described some fishing communities in Kenya that they lack clean drinking water and poor sanitation and hygiene due to the general isolation and remoteness of their locations .Such communities are prone to diseases like cholera, diarrhea dysentery and malaria People in these communities would be expected to put up similar health seeking behaviour.

Health seeking behaviours, according to Parker (1998), are also determined partly by information received from or offered by friends and family members based on common knowledge, which may often be wrong. Husbands, wives and siblings may suggest means of seeking health to influence a sick person's decision. To buttress this fact Bruce and Senior (1998) cited Sacks (1985), who reported that a woman's frequent complaint about her husband's unusual behaviour to a psychiatrist finally compelled the man to seek health.

Payne and Hahn (1998) are of the opinion that advertisements and commercials on televisions, radios, newspapers and magazines which are health related can also be factors which can influence a person's health seeking decision. It is however important to realize that the accessibility of the information, and how the person is able to analyze and understand it will have to be taken into consideration.

How early a person seeks health is another factor which according to Bedworth and Bedworth (1982) can lead to early recovery or otherwise. This may be influenced by ignorance, poverty, accessibility to health resources etc.

Ogah (2004) suggests that people in deprived communities often do not seek health care early not necessarily because of ignorance but because they cannot afford it. The issue of unaffordability of health-care may lead people to seek health from quack health practitioners, who in the opinion of Byrd (1986), often cause fatal delays for people suffering from some illnesses that could be cured by qualified health practitioners. Besides defrauding the sick people, these quacks cause the loss of lives in some instances.

Unaffordability of health-care may cause fatal delays in seeking health. It at times leads to self medication. This might involve buying of drugs off the counter (to avoid paying consultation fees to health practitioners), or using herbal medicine.

Graham and Monie (1995) indicate that some medicines sold in pharmacies and village stores can be very useful .Their concern however is that people sometimes use these drugs in a wrong way, so that they do more harm than good. To be helpful medicines must be prescribed by qualified medical personnel and used correctly.

Socio-cultural factors may also help to determine whether a sick person should visit a hospital, a fetish shrine, or self-medicate. Some people, depending on their faith, may decide to go to churches to seek health.

The heath policy of a nation, according to Baldwin (1985), may affect people's decisions on where and when to seek heath. In some societies there may be free income and health policy for the aged, pregnant women and children. Another factor which may influence a person's health seeking behaviour is his or her occupation. Thus according to Payne and Hahn (1989), whilst some people's

work schedule may delay seeking health, other people have to negotiate with managers and doctors whether an absence from work is legitimate.

Statement of the Problem

Even though there is wide-spread perception that fishermen are physically strong, each human being, according to Parker (1998), has the same basic design, though there are variations in body shapes. A close look at fishermen living along the coast of Ghana reveals poor housing, poor hygiene and poor nutrition, and due to the fact that fishermen are exposed to the scorching sun at sea and most often sleep in crowded rooms they may frequently fall sick. Sickness may cause death and these may have socio- economic impacts on the livelihoods of fishing communities. These might among other things threaten food security, as fishermen provide fish which is one of the cheapest sources of protein to the poor.

According to Lungu and Huskein (2010), the fishing industry, in Zambia, apart from providing food and nutrition security for the poor including the sick also provides many people with employment which serves as a source of income and, supports thousands of livelihoods. Fish contains a wide variety of nutrients that are essential for various body functions and processes which can help prevent weight loss and strengthen the immune system. Fish is easy to digest and provides valuable proteins and micro nutrients.

Bartlett and Begeron (2005) are of the view that fishing is a highly seasonal and dangerous occupation, but fishermen are by nature independent minded, self sufficient, hard working and skeptical. Fisher folks are mobile workers who at times stay away from home for very long periods being out at sea or on a lake,

and may have scanty or irregular meals, and might find it difficult to keep to any regular form of medication. They can be hard to reach because they often move from boat to boat and the assumption generally is that fisher men cannot afford modern health care but resort to self care and visits to traditional healers and unofficial medical channels. Most fishermen are small business persons who operate their own boats or are crew members who find it difficult, expensive and sometimes impossible to get insurance for health coverage.

Purpose of the Study

With reference to the assertion of Neubeck and Neubeck (1979) that health behaviour is highly correlated with the social class of a person, the study was to investigate factors which influence health seeking behaviours of fisher folks in Prampram. It was also meant to find out the awareness level of the fisher folks of the health resources available to them and seek out the factors which delay, enhance or prevent health seeking among fisher folks.

Research Questions

The study's specific research questions are:

1. What is the awareness level of fisher folks in Prampram of the health resources available to them?
2. How accessible are health resources to fisher folks in Prampram?
3. How affordable are health resources to fisher folks in Prampram?
4. Which health resources do fisher folks in Prampram prefer?
5. What factors do fisher folks in Prampram consider when they seek health?

6. How satisfied are fisher folks in Prampram with the health resources available to them?

7. How satisfied are fisher folks in Prampram with their health seeking endeavours?

Significance of the Study

The study was to find out the factors which influence health seeking behaviours among fisher folks.

It is hoped that the study would help health providing services such as the Ministry of Health, Ghana Medical Association, and Traditional Healers Association of Ghana in the provision and distribution of health resources in Ghana. It is also hoped that it would assist fisher folks in particular to improve upon their health seeking behaviour, making use of the health resources available to them. Finally the study would serve as a source of literature for people who need information on health seeking behaviour of fisher folks, particularly in Prampram.

Delimitations of the Study

Factors which influence health seeking are so many and diversified that it is difficult to find all of them in a single study. Therefore in terms of delimitations, the researcher delimited the sample size to 120 fisher folk. This was to enable the researcher reach out to all the respondents within the time constraint and to ensure speedy analysis of collected data of the study and report writing.

The study was also delimited to adult canoe fishermen living in Lower Town, Prampram. It was also delimitated to the wives of the fishermen studied, or their

(the fishermen's) close relatives. The Statistical Package for Social Sciences S.P.S.S. computer software was used to analyze the data

Limitations of the study

Some challenges encountered in carrying out the study were the difficulties most of the respondents faced in distinguishing between hospitals and clinics, and doctors and nurses. Some of the fisher folks were unwilling to be interviewed because they felt they should be motivated with money.

Definition of Terms

1.	Dangme-West District:	-	A district in the Greater Accra Region of Ghana.
2.	Health Seeking Behaviour:	-	Behaviour put up by people when they think they are sick.
3.	Deprived Community:	-	A community that lacks the basic things that are necessary for a pleasant life.
4.	Canoe Fishermen:	-	Fishermen who use canoe for fishing.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter reviews some of the related literature which deals with the variables selected for the related factors which influence health seeking behaviours. As suggested by Travers (1978) the review is to give the researcher an idea of what he wants to investigate and what has already been done, while helping to clarify his thinking. It is also to help the reviewer to familiarize himself with the issues and the problems of the field, and to discuss the researcher's own early impressions of the literature.

The review has been grouped under sub-headings. These include:

1. The concepts of health seeking,
2. Reasons why people seek health,
3. The influence of perceived causes of illness on health seeking behaviour,
4: the influence of health related-information on health seeking behaviour.
5. The influence of availability and accessibility of health resources on health seeking behaviour.
6. The influence of the status of health systems on health seeking behavior.
7. The influence of occupation on health seeking behaviour.
8. Financing health care.

9. Self medication.

10. Gender and access to health care.

11. Provision of health care by the private sector.

12. Access to health care facilities in Ghana.

13. Health systems organization in Ghana.

14. Health delivery system in Ghana.

15. Summary.

The Concept of Health Seeking

Concepts about health and how to achieve good health evolved over the centuries within the cultures as they developed. According to Bedworth and Bedworth (1992) it was not until inter-cultural communication came into being that knowledge about health, disease and medicine began to be interchanged. This supports Parker's (1970) assertion that until Roman medicine came under the influence of the Greeks, healing had consisted of traditional remedies in prayers to the gods.

Despite the fact that people have come to appreciate the concept of health and well being so much, today people in developed countries view illness as something out of the ordinary, which should quickly be cured by advanced medical services. However, Bryan (1993) laments that unfortunately people living in some areas of the world such as parts of the Philistines and parts of Africa, see

infections, illnesses and suffering as a way of life, and healthier existence is an unlikely dream.

This, according to Payne and Hahn (2002), obliged the W.H.O. to give a multifaceted definition of health that "health is a state of complete physical mental and social well being and not merely the absence of disease and infirmity". (Payne & Hahn ,2002, p. 67). This novel definition extends beyond the structure and function of our bodies to include feelings, values and reasons. Thus health has physical, social and mental dimensions.

Scholars have for a very long time been debating on the use of the term health seeking behaviour. Contributing to this debate, Mackian (2003) opines that health promoting programmes worldwide have long been premised on the idea that providing knowledge about causes of ill health and choices available will go a long way towards promoting a change in the individual's behaviour. There is however a growing recognition, in both developed and developing nations, that providing education and knowledge at the individual's level is not sufficient in itself to promote a change in behaviour. Other proposals have been that instead of using the term health seeking as a tool for describing how individuals engage with services, we need to move the debate to more fruitful areas by developing a tool for understanding how populations engage with health systems on health seeking Thus the need to study and understand how groups like farmers and fisher folks seek health, since the assumption is that people in the same social class tend to put up similar behaviour.

For instance Quah (2004) lamented that the municipal fisheries in the Philippines is a significant figure in the fisheries sector yet it remains one of the most marginalized sectors in agriculture, and fisher folks continue to be trapped in the web of poverty and disease. And Balisacan (2008) added that poverty affects a person's choice of and ability to utilize health systems. Poverty connotes a deprivation in standards, or the lack of the minimum entitlements of households in society which the government must seek to provide, either directly or indirectly. In the contest of human development however, poverty is defined as the sustained inability of a household to meet its minimum set of capabilities for human, physical, intellectual and psychological functions, or its minimum basic needs.

Thus poverty has been confirmed as major factor which affects the health seeking behavior of people who live at remote areas far away from clinics and hospitals.

Studies, according to Mackian (2003) have focused exclusively on the individual as a propulsive and decisive agent, and elsewhere there is a growing feeling that factors promoting good health seeking behaviours are not rooted solely in the individual, but they also have a more dynamic, collective and ,interactive element. Academics have therefore started to explore the way in which the local dynamics of communities have an influence over the well being of the inhabitants.

Each society is made up of individuals who might exhibit different health seeking behaviour .In a fishing community for instance Balisacan (2008) sees a heterogeneous society with a distinguished stratum of poverty. These groups can be identified based on the fishing gears they use. Socio-economic differentiations in such societies are evident not only in the gears (passive or active) and vessel (motorized or non-motorized, municipal or commercial) used but also on whether or not they have access to production capital , or whether or not they have other sources of income, or whether or not they have stable families Balisacan. (2008) therefore suggests to health care providers and donor organisations that it is very important to identify the particular groups of fisher folks who need assistance rather than channeling funds of poverty alleviation to the fishery sector or small fishery sub-sector as a whole.

'The fact that health seeking behaviour is not even mentioned in widely used medical textbooks perhaps reflects that many health seeking behaviour studies are presented in a manner which delivers no effective route forward. This results in an unfortunate loss for medical practice and health system development programmes, as proper understanding of health could reduce delay to diagnoses, improve treatment compliance and improve health promotion strategies in a variety of contexts'.(Mackian, 2003 p.35.).

Researchers have long been interested in what facilitates the use of health services and what influences people to behave differently in relation to health. To answer this, Hausmann-Muela and Riberah (2003) classified health seeking behaviour into knowledge, behavior and practice. These they saw as the most

frequently used studies in health seeking behaviour research. Knowledge is usually assessed to see how community knowledge corresponds to biomedical concepts. Typical questions include knowledge about causes and symptoms of the illness under study.

According to Good (1994) people's reported knowledge which deviates from biomedical concepts is usually termed 'beliefs'. .This distinction between 'knowledge' and 'beliefs' markedly deviates from the use of terms in psycho-social theory where 'beliefs' have a much broader meaning and include also beliefs concerning perceptions about one' self. Downie (1998) for instance mentioned the illustrative example where the belief that 'I am not good in sports' may restrict a person's readiness to engage in health exercise. Also beliefs about illness severity and susceptibility are seldom enquired. Enquiry about other types of knowledge tends to be highly neglected in Knowledge, Attitude and Practices (KAP) studies. Very little information is sought on knowledge about the health system (access, referral, opening hours, cost sharing scheme etc).

Attitudes form a more complicated issue, and despite their explicit inclusion in the study type, they are scarcely accounted for in KAP surveys. Attitude has been defined by Ribeaux and Poppleton (1978) as "a learned predisposition to think, feel or act in a particular way towards a given object or class of 'objects' .As such, attitudes result from a complex interaction of beliefs, feelings and values .They are important in designing promotion campaigns which aim to change attitudes, e.g. attitude towards condom use for prevention of AIDS. Attitudes may be inferred from a variety of statements and answers, but direct asking is usually

problematic since people often respond in terms of what they think is the "correct" answer. In particular, attitude towards traditional medicine might be hidden .In a survey, attitudes are therefore not easy to obtain. However attitudes are central to understanding behaviour, an element which is better acknowledged in cognitive models.

According to Yoder (1997) questions related to practicals in KAP surveys usually enquire about the use of preventive measures or different health care options. Normally hypothetical questions are asked (example what do you do if your child is ill?). They therefore hardly permit statements about actual practices .Rather they yield information on people's normative behaviours or what they know should be done (or they expect the interviewer wants to hear).In this sense, they check well on people's knowledge about practices, as heard in educational campaigns for example .However special caution must be given to deduction from KAP survey data about explaining health-seeking behaviour.

Above all KAP surveys yield highly descriptive data without providing an explanation for why people do what they do. Unfortunately many investigators who use KAP studies do use them, implicitly or explicitly, to explain health-seeking behaviour .Their studies are based on the underlying assumption that there is a direct relationship between knowledge and action. They assume that by changing knowledge, behaviour is automatically changed as well. To give an example, one might expect that if people recognize the signs and symptoms of let's say tuberculosis and if they know that TB can be treated by antibiotic drug regimens, they will act accordingly and attend a health facility. That this is overtly

over-simplistic becomes clear if one considers that there are many other factors which influence health-seeking behaviour .Although knowledge about an illness may be high, illness recognition during an actual episode is much less clear. In the example of TB, the typical symptom of incessant coughing leaves open a variety of other less serious illness, interpretations. Also not considered are motivational factors and stigma which may influence health-seeking behaviour. Neglected are other factors like treatment expectation, satisfaction with health care services ,decision making for health care, and external barriers (e. g .financial constraints, accessibility of health services).All these make it clear that knowledge is just one element in a broad array of factors which determine health-seeking behaviuor.

Having mentioned the limitations of KAP surveys it must be acknowledged that there are important advantages. On the whole, KAP surveys are very useful for assessing distribution of community knowledge in large-scale projects, example national surveys and for evaluating changes in knowledge after education and media campaigns.

‘They permit rapid assessments yielding quantitative data and are therefore a cheap way to gain quick insights into main knowledge data. Moreover , they are relatively easy to carry out ,and with some basic training in interview techniques ,any public health specialist can design a questionnaire and undertake a KAP survey .however the superficial and very knowledge oriented data they provide can clearly make them useful only as a part of an overall research strategy for studying health-seeking behaviour .(Lane, 1997.p.24). .

As a response to the limitation of KAP studies and their misuse for explaining health behaviour, anthropologists, according to Forster (1987) plead for the use of ethnographic studies. Traditional ethnographies carried out by anthropologists had, however, one big limitation to time. To describe culture, anthropologists usually spent years in the field, learning the language of the communities under study, living with them for long periods of time. Furthermore, their sophisticated language and their aim to contribute to advances in anthropological theory hardly matched with the expectations of public health specialists and epidemiologists. Already in the 1980s Foster (1987) noted that one of the problems in behavioural research was the failure to 'keep research simple' and criticized the tendency of many social science researchers to be so 'keen on conveying an impression of research sophistication that they overlook entirely the need to address the question of the ends for which the research is carried out'.

A compromise therefore was sought to bridge the two opinions in order to produce a more meaningful comprehension of community perspectives which helps understanding of health behaviour. Therefore in a collaborative work of applied anthropologists and public health specialists, the focus is on ethnographic studies (F.E.S.) with the primary aim of identifying local illness concepts and categories.

Studies by Garro (1998) showed that health and treatment seeking models from social psychology, anthropology, medical sociology and medical anthropology allow for considerable extension of the determinant factors for behaviour of KAP and FES studies. In public health however the most utilized models from social

psychology are the ‘Health Belief Models’, the ‘Theory of Reasoned Action’ and its later development into the ‘Theory of Planned Behaviour’. Most known from medical sociology and medical anthropology are, respectively, the Health Care Utilization or Socio-Behavioural Model and its diverse posterior variations and the Decision Making Model.

All these models contain associations of variables which are considered relevant for predicting health seeking behaviours .On the whole Garro (1998) added that ‘health seeking behaviour models as applied to public health mostly serve as catalogues of relevant variables that need to be considered in research design, rather than as behavioural models themselves’. The mainly statistical data obtained using these models permit the evaluation of relative weights of different factors in health behaviours (using of preventive or therapeutic measures, choice between different health resources, non-compliance with treatment, or the consequences of behaviour for delayed health seeking).

Tippings and Segal (1995) also classified health seeking behaviour into the “end point” (utilization of the formal system or health care seeking behaviour), and “process” (illness response, or health seeking behaviour).

Health Care Seeking Behavior (Utilization of the System)

According to Ahmed, Sobbani, Islam and Barakat (2002), there is often the tendency for studies to focus specifically on the act of seeking health care, although data are also gathered on self care, visits to more traditional healers and unofficial medical channels, these are often seen as something which should be

prevented, with the emphasis on encouraging people to opt first for the official channel. “Studies demonstrate that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to service and perceived quality of the service” (Tippings & Segal, 1995, p. 18.).

In mapping out the factors mentioned above, there are two broad streams. The first category is the type of barriers and determinants which lie between patterns and services, the divisions fall under geographical, social, economic, cultural and organizational factors.

Secondly, there are studies that attempt to categories the type of processes or pathways at work .Explaining these processes, Bedri (2001), developed a pathway to care model in her exploration of abnormal vaginal discharge in Sudan. She identified five stages where decisions are made, and delays may be introduced towards the adoption of modern care. Bedri (2001) suggests that there are four pathways that women may follow, from seeking modern medical care immediately, to complete denial and ignoring of symptoms .This approach offers an opportunity to identify key junctions where there may be a delay in seeking competent care and is therefore of potential relevance for policy development.

Why People Seek Health

According to Auckland (2002) the human body is a system and a balance of many muscular, neurological and biochemical processes. If the balance is disturbed, symptoms are noticed. Symptoms therefore are a body's ways of telling a person that he has a problem. Auckland (2002) adds that pain is a way the body

indicates to one that something is wrong with his or her body. Thus, to Anderson (1985), a person naturally becomes ill at one time or the other. Illness is thus a departure from normal health and it has no racial, sexual or age boundaries. It can be physical, mental and even social, and may sometimes cause death; these among other reasons force a sick person to seek health.

To Bryan (1993), illness is rampant these days because of our modern way of life. For instance, the digestive system was designed to cope with raw food long before humans discovered how to make fire and cook. The system could get nutrients from raw meat, leaves and fruits, but today we expect it to digest rich, spicy processed foods without a murmur or complaint. The results of these are the diarrhea, vomiting, constipation, indigestion and the cancers we experience today. These are some of the ways our digestive systems fight back.

Bryan (1993) adds that some of these sufferings and illnesses are warnings which if we ignore may cause death. This and other reasons may explain why Yeboah (2006) reported that malaria is hyper endemic in Ghana, yet many Ghanaians tend to ignore it when it starts to attack them and so it causes 22% deaths among Ghanaian children.

Sicknesses are so diverse and widespread these days that Donkor (2006) quoted a WHO (2005). report on mental health in 2001 which states that within a lifetime of society, 25 out of every 100 people are bound to suffer from one form of mental illness or the other, and that 1 out of every 100 people is bound to suffer from severe mental illness.

According to Hoover, Davis and Donatelle (1998), although scientific evidence shows that disease and death have always been part of human existence and people try to cope with them, disease at times brings untold hardships to individuals and whole families. Adult ill health for instance harms children more than the reverse implies since it may affect children both physically and psychologically. No wonder Parker (1998) asserts that within all cultures when someone is sick, his family members, friends and other relations get very worried. This, according to Gyekye (1984), is because in African cultures for instance, mutual help, collective responsibility and reciprocal obligations are regarded as important values. The extended nature of African families make it mandatory for brothers, sisters, cousins and nephews to see each other as members of the same family and are thus obliged to support one another in times of need. Gyekye (1984) explained that among Africans the family is seen as a unit and that when one speaks of the family in an African context one is referring not to the nuclear family consisting merely of husband, wife and children, but to blood relations who trace their descent from a common ancestor and who are held together by a sense of obligation to one another. These obligations include values such as solidarity, mutual helpfulness, interdependence and concern for the well-being of every individual member of society.

Bruce and Senior (1998) agree that when a person is sick, its effect may extend to his family, but they insist that it is the sufferer who feels the pain, and becomes restless and worried. Apart from the pain, sickness may cause death. No one enjoys pains, and only a few may wish death for themselves or for a member of

the family.This and other reasons might explain why people are "forced' to seek health when they are sick.

Sickness or death may bring untold hardship to a whole family. This may even extend to the community as a whole, depending on the role played by the departed person when he or she was alive. The death of Madam Hawa Yakubu Ogede, a former member of parliament in Ghana (she died on 21st March, 2007) for instance according to Adu and Daparten (2002), was a big blow to not only her family, but to the entire Bawku township (where she lived) ,since she was a mother, a philanthropist, role model and a political stalwart.

In support of the above, Frenchman, Kjellstrom and Murray (1992) opined that the death of a person who is the head of a household or a leader in a community may create economic, social and psychological problems for the family and or the community at large. No wonder. Glover (2007) reported that the death of Madam Yakubu was a great loss to her people because she organized several training workshops for women in soap making, tailoring and hairdressing and in addition, gave the people equipment and money to enable them to set up their own businesses.

Fortunately, Frenchman et al, (1992) assure us that not every episode of illness leads to suffering and death. This might account for why Werner (1985) is baffled as to why people should worry when they are sick. To him, people will get well when they are sick, without the need for medication, since the body has its own means of recovery. This may account for why some people do not seek health when they are sick. Despite these assurances the fact still remains that

health problems may cause death, and this may destroy a family unit or bring economic implications to a large population. Hence, people are forced to seek health when they are sick.

Some people, according to Abraham (1999) ,delay in seeking health because getting help for a personal problem is very difficult .Often when someone delays to seek help the reason may not be obvious to people around him. It can also be frustrating to family members and friends around him who want the person to get assistance. Depending on the problem and the person it involves, there might be a variety of reasons he might be reluctant to seek help.

According to Abraham (1999) it is not easy to talk about it even when you realize that you need help, when the problem is too upsetting or embarrassing to talk about .Some people find issues like phobias and sexual or medical concerns too uncomfortable to discuss, so they avoid seeking help. This can have a tremendous impact on their personal lives and the lives of their family. Once they overcome the initial discomfort of talking about the problem it can generally be treated. Helping the sufferer feel less about the problem and by not criticizing him and being judgmental, can often make it easier for him to seek care from a professional.

It might also happen that sometimes the problem is too overwhelming to tackle. Divorce, loss of a spouse or loved one and financial problems for instance can have such profound effect on people's lives that they can get discouraged. Often feelings of helplessness or hopelessness come into play and people might feel that

it is pointless to seek help. Trying to help them find that small ray of hope can often bring them in for treatment.

In some cases, some people cannot recognize that a problem exists. According to Maxwell (1991) conditions like dementia and psychosis, in which people lose touch with reality, may not be perceived by the individual .In these cases sometimes it is necessary for friends and family members to seek help for the person against his wishes. As these disorders can be life threatening, safety is always the most important issue when deciding if someone needs help.

Again, to Maxwell (1991), another common reason people do not seek help is denial. Such people ignore the problem and convince themselves that they are well. Alcoholism, eating disorders and addictive disorders are good examples. The person can convince him or herself that his or her substance use is not a problem until everything falls apart and he can no longer deny it .This can take a heavy toll on his family, job and personal life .Unfortunately it takes a disaster to occur before this person seeks help. Denial can be strong and it can be frustrating and painful for friends and family. Trying to force the individual into treatment against his or her will can sometimes even make the case worse.

Some people do not seek help because they want to solve the problem on their own. Often when they start handling the problem themselves they are able to cope with it but then the problem becomes too great for them to deal with. For some, accepting help at this stage means that they are weak in some way or they have failed. Emphasizing how long they have been able to cope, and how things have

become too difficult despite their efforts, can sometimes allow them to feel comfortable accepting help.

Decisions taken by people to seek or not to seek health when they are sick may in the end become a family or community problem, however to Merki and Merki (1991), caring for one's health is a personal responsibility. To this Webb (1991) adds that despite the support people get from loved ones when they are sick, individuals are responsible for their own health.

Influence of Perceived Causes of Illness on **Health Seeking Behaviour**

Knowing or suspecting the cause of sickness may influence what a person does to seek health. To Bruce and Senior (1998) however, apart from knowledge, one's recovery may depend on a perceived cause. A study reported by Parker (1999) showed how the conditions required explanations beyond the limits of available medical knowledge. Some respondents found the cause of their conditions in internal factors like not taking enough tea break, working too hard, health hazards and old age.

This is why Philips (1990) is of the view that in some parts of Africa the explanations of illness adhered to locally are of significance to health care delivery and utilization. Thus, in Africa beliefs count very much in explanations for causes of illnesses and these beliefs may determine whether the sufferer seeks health at a fetish shrine, or a spiritual church; consults a "mallam" or sees a medical doctor. "Explanation for causes of diseases in Africa includes deities who punish wrong doers; sorcerers who work for free or personal reasons, spirit possessions or the intrusion of an object into the body. Some of these are

sometimes referred to as magic". (Philips, 1990 p.8.). In such instances, pouring of libation, pacification of deities and drinking of herbal concoctions may be involved in a person's health seeking endeavour. In such cases, prophets and prophetesses are consulted or pastors are seen in spiritual churches and fasting and prayers might be resorted to as a cure for the sickness.

Anderson (1985) however does not really see the extent to which knowledge or perceived causes of episodes can affect a person's choice of health care. He therefore suggests that a sociological research needs to be conducted to examine ways in which sufferers attempt to explain and rationalize their conditions beyond existing and available medical knowledge.

On the issue of knowledge of the causes of diseases or symptoms, and sufferers attempt to rationalize the conditions, an old adage sums this up that, for lack of knowledge many people perish. Surgery in early breast cancer for instance can be curative if performed in good time. This however depends on the knowledge of the symptoms, what to do and where to go for treatment.

Influence of Health-Related Information on Health Seeking Behaviour

No one wishes to be sick. This is why people need to behave healthfully or live health promoting live Each person needs to have a quality level of physical, social and emotional well-being which will enable him to live effectively and enjoyably; and every individual should seek health when he or she thinks he or she is sick. Payne and Hahn (2000) stated that access to health-related information plays a very important role in seeking health, and added that

“to be informed, consumers and people must learn about services and products that can influence health’. Practitioners, manufacturers and sales personnel use a variety of approaches to get people to buy their products or use their services. Because health is at stake, when people “”buy into” these messages it helps a great deal.

A health seeker’s sources of information are as diverse as the number of people he or she knows, the number of people he or she sees, the number of publications he or she reads and the number of experts he or she sees or hears. No single agency or professional regulates the quality or quantity of health-related information a person receives, however the accuracy of information a person receives from a friend or family members may be questionable .Some family members may give biased information because they are participating in a pyramid- type sales organization that sells health products.

Many people spend much of every day watching television, listening to radios or reading newspapers. Because many advertisements are health-related these are significant sources of information. Other sources of health-related information are folklores. Because folklores are passed down from generation to generation, they are principal sources of information for some people. The accuracy of such information is however difficult to evaluate. People therefore should be careful when relying on its scientific soundness

Health care consumers also receive health-related information from health workers and their associates, who often act as health educators. Other sources are

on-line computer services, heath-related publications, health libraries and qualified health educators.

Anderson (1985) also confirmed that each of us needs information about health matters which can be obtained from different sources. These sources may include friends, newspapers, radio and television. To him (as reported earlier by Payne and Hahn (2002),) for some people folklore about health is the primary sources of health information. This type of information is often obtained from family members, neighbours and co-workers and is difficult to evaluate, but often the emotional support provided by the suppliers of this type of information is the best medicine for some people.

The advice Merki and Merki (1993) give to health seekers on how to handle health-related information is that "you make choices everyday that affect your health. You decide what to eat, whom to have for friends and which books to read. It is very necessary to carefully evaluate this information. A century's saying, according to Merki and Merki(1993) is "let the buyer beware." This phrase means that consumers have to watch out for goods and services which do not do what sellers claim they do. Some products are fake, and some sellers are not honest. The fact therefore is some people make a living out of selling useless products. Part of being a good consumer therefore is to know such people and avoiding them

Quacks sell worthless products and treatments for diseases and other health problems. They take advantage of people who are ill to make money, although this is against the law.

Quah (2004) sees a positive relationship between a person's educational level and health seeking behavior. In a study conducted in Singapore, he revealed that people with higher education are more likely to use modern medicine for self medication. His study also revealed that there is a positive association between knowledge or information on disease and the level of formal education. The higher the person's formal education, the more likely is he/she to have accurate information on health seeking.

The higher the level of knowledge of a disease, the more inclined will be a person to seek health, therefore people who are highly educated are exposed to a wider scope of written information on health matters by virtue of their access to information , which can not be got by less educated people.

When information is obtained on a subject of interest, an educated person is usually inclined to search for more. Educated people turn to be more inquisitive. They seek information not only from relevant literature but also from their own doctors when possible.

Payne and Hahn (1985) however warn that too often health-related information is based on knowledge that is wrong, in addition, family members and friends may provide information that they believe is in the best interest of the sick, instead of giving factual information. In support of this Seeley and Allison (2005) report that although the W.H.O guidelines suggest that continuous involvement of relatives, friends and community support personnel , unfortunately people who are mobile (like fisher folks} do not often have family and community members

to provide support due to the fact that they at times stay on the sea for weeks or months.

Seeley and Allison (2005) added that the high degree of mobility among fisher folks can affect health seeking behavior in the communities in which they reside. For instance in Uganda, fishing communities tend to lack any form of resilience to HIV/AIDS due to the lack of community initiative to offer advice, counseling support or health care. To buttress this, Salia (2006), reports the concern of the Ghana National Cardio-thoracic centre that, between November and March 2005, every other patient the centre had attended to reported back with complications owing to the use of food supplements and herbal preparations. According to the report, subsequent investigations on the patients (who were suffering from diabetes, kidney failures, hypertension and other heart diseases), revealed that those herbal preparations used by the patients were recommended to them by family members and friends. That is why Parker (1999) advises that some of the information received from family members and friends may sometimes be wrong, so there is the need for such information to be carefully analyzed.

Payne and Hahn (2002) believe that another source of health related information is advertisements and commercial broadcasts in televisions and radios, as well as in newspapers and magazines, and suggest that it is vital for people to be able to read and understand these advertisements critically. This is because some of the advertisements are so tantalizing that it needs expects to determine whether they are really genuine or fake, and some media experts regret that some of these advertisements are so well packaged and labeled to outwit even the vigilant mind;

so it will take the watchful eyes of professionals and experts from the Food And Drugs Board (in Ghana) to control these advertisements.

To buttress the above Merki and Merki (1993) add that 'advertising agents have tested which colours attract you, what kind of letters you like, what words you respond to. They have put together packages so they seem just like the things you need, whoever you are'. Some of these advertisements appear in televisions , magazines and newspapers and are often so satisfying that they seem like old friends, reliable and satisfying. These products mean to grab you at a level beyond health sense and they often succeed. It is therefore up to the consumer to sort through the words and decide what to buy or which services to use. Although this is not an easy task, Payne and Hahn (2002) advise that one should be informed, and carefully, since he or she is being emotionally manipulated.

One important way to inform one' self, according to Merki and Merki (1993) is to read labels of the products one buys. They add that although one may balk at the time and trouble involved, at the end one may be able to know which items or services are the best. This is because some food and drugs do not seem to be what they are. Ingredient labels are not always complete, and a term like 'natural' is used indiscriminately and 'fresh' and 'wholesome' are never literally true.

It is therefore not surprising that Salia (2006) reported the concern of the Ghana National Thoracic centre that some patients with hypertension and other heart problems were substituting their medications with food supplements or herbal preparations. Some of the said patients were said to be highly educated, yet they had easily been influenced by these well-packaged health related advertisements.

It is worth noting that, since wrong information may negatively influence health seeking behaviour, among strategies devised in Ghana by the ministry of health to improve disease control and quality of health, is an effort to improve access and management of health information. Another strategy is the Ghana News Agency report in 2006 that a temporary ban has been placed on the advertisements of drugs and herbs and any other product that makes claims for cure and management of any disease conditions. A committee has thus been set by the Food and Drugs Board to draw up modalities to ensure that advertisements for only approved products and scripts are broadcast, particularly on the radios and televisions.

Influence of Availability and Accessibility of Health Resources on Health Behaviour

Another factor which may influence a person's health seeking decision is the availability and accessibility of health care resources. The British Medical Officer's Association (2002) state that today we have medical specialists to take care of our needs and to help us live longer lives. Modern medical care has therefore helped to prolong the lives of some sick. This might account for Duodu's (2006) report that the average life expectancy of the Ghanaian is 55 years for men and 60 years for women.

Although presently there are a lot of health resources the world over, Green and Ottoson (1999) believe that adequate total supply of health resources does not guarantee accessibility. Other barriers like money, education, geography or language still keep many people from needed heath care resources. This is why

the United Fishermen of Alaska (2007) observed that a major advantage which other citizens living in the United States have over fisher folks, especially those in remote coastal communities, is access to health care services. Their observation is that , in the United States health services are concentrated in urban communities ,and access to health care by fisher folks is often over looked, but they think Alaska fishing families in particular deserve more attention from health services providers when it comes to access to health services

Furthermore the United Fishermen of Alaska lamented that all but a minuscule proportion of States residents are served with a road system to a choice of hospitals and other medical facilities, but in contrast, a survey of United Fishermen of Alaska indicates that 32% of its members live in communities without hospitals. The U. F.A also found out that many Alaska towns do not even have medical clinics, and in order to be nearer to the fisher grounds, Alaska fishermen are more likely to live in more remote areas where medical facilities are lacking than the general population. Some of these fishermen end up living at communities that are 20 miles from a hospital.

No wonder the United fishermen of Alaska (2007) noted that a major difference between urban dwellers and rural people, especially those in remote coastal communities is access to health care services. To the U. F. A., in the United States national arena a major difference between typical United States residents, especially those in remote coastal communities is access to health care services. To them, in the U.S. national arena access to health care is often confused with

access to health insurance, but they think that for Alaska families the problem begins with access to health insurance itself.

To Seeley and Allison (2005) access to HIV/AIDS. testing and treatment facilities may be difficult for mobile populations like fisher folks. Mobility, coupled with irregular working hours pose an even greater hindrance to adherence to treatment regimes. There is also a problem for poor mobile patients who cannot afford time off from wage earnings to attend appointments with health personnel because of the long wait for treatment in busy health centers.

Seeley and Allison (2005) reported a study in Uganda which found that the distance from hospital to the 21 fishing communities studied was up to 67 kilometers, and the journey could take up to 6 hours .A fisherman, according to the above source told researchers that 'I went to be tested but they said when I got there that it was the wrong day. I cannot fish for another day and I do not have 3000 shillings to go there again.' In addition the United Fishermen of Alaska (2007) lamented that Alaska fishermen are more likely to live in more remote areas where medical facilities are lacking than the general population.

So, for mobile workers and remote rural communities, the inequities in access to health services are a continuing part of life and issues of access to health care are just the latest among challenges for many such workers. Lungu and Huskein (2010) added that analysis from literature elsewhere in Africa show that fishing communities in Africa are hardly reached by health services, on the one hand because it is too costly, and on the other hand because of lack of efficient strategies to reach out to these often remote areas.

The ever growing population all over the world has placed a great burden on all governments in efforts to provide adequate supply and equal distribution of health resources. The government of Ghana for instance, according to Nyame (2006) outlined her commitments to the implementation of broad strategies towards:

1. Increasing the geographical and financial access to basic services.
2. Ensuring better quality of care in all health facilities and during outreach programmes.
3. Increasing overall resources in the health sector, equitably and efficiently.

Although governments all over the world have been trying to provide adequate health care systems for their citizens, wide gaps still remain. For example, physicians, dentists, nurses and other health workers although not adequate to cater for everybody, are generally concentrated in metropolitan areas. "This seems to be the trend in third world countries where the distribution is heavily biased against the rural areas. The physical access to health resources for most urban people is better than for rural people"(Philips 1990, p.64)

To buttress this, Nyame (2006) gave Ghana's doctors ; patient ratio at the end of 2005 as 1:1,000; and Owusu (2011) reports that statistics indicate that the doctor-patient ratio in Ghana in 2011 is 1:13,000, a figure far below the WHO global standard pegged at 1:5,000 These doctors, according to the report are mostly stationed in towns and cities. This situation has naturally been influenced not only by the availability of facilities and personnel, but also by the population density and transport available.

The problems of accessibility of health resources are therefore compounded in developing countries, according to Green and Ottoson (1999), by poorer transport and communication systems.

Some people are forced to bring family members sometimes over great distances by rudimentary and even primitive means of transport to receive basic or emergency health. In support of this Adeze (2006) laments that there is only one health centre which serves the people of the Tamping community in the Northern Region of Ghana; with a population of 2,600. The people of Tamping, who are predominantly farmers, are confronted with the problem of poor road network which makes it difficult for them to take pregnant women to the Tamale Teaching Hospital at the Regional capital for safe delivery.

Other constraints that influence the utilization of health resources include facility opening times and time at which individuals can reach a service point, taking into account the availability of transport and other commitments. Owing to these constraints some people may decide to seek health at the nearest provider of health care no matter the quality of services provided, be it a clinic, spiritual church, or at a hospital.Bard (1986) believes that though these people see the reason why they should seek health at some particular places (because of quality service), distance and other factors beyond their control prevent them from doing so.

Interestingly, Moslay and Woodland (1987) summed up the imbalances in the provision of health resources as social injustice. According to them, if we take social justice to mean the fair and even distribution of services and resources, then

the health sector is full of major injustices, both nationally and internationally. Some of these injustices are due to the limitation of resources but much of it is social, political and professional actions that deprive the poor."Examples of these are decisions by governments to build large teaching hospitals or referral centres which limit even further the resources available to the rural people" (Moslay and Woodland, 1987 p.19).

Another common example of the social injustice, according to Moslay and Woodland (1987) is that medical school admission policies perpetuate a cycle of well educated parents who provide a quality education for their children, thus giving them advantage over others, particularly those in rural schools, in gaining entry into a medical school. These decisions are made with clear intentions to maintain an existing imbalance between the urban and the rural, the poor, the powerful and the powerless.

Payne and Hahn (1985) complain that unfortunately at some places where people have access to facilities, doctors and other health workers may discourage them from seeking health care. This might partly explain why despite the fact that the 2000 Hospital fees Regulation (C.I. 1313, section 2) sate that "No fees other than cost of prescribed drugs respect of services rendered in a hospital to any person suffering from an illness particularly children, Rhule (2006) reports that many Ghanaian women do not send their malnourished children to the hospitals because many individuals are illegally collecting money from patients from whom they should not be doing so.

Apart from the attitude of personnel at the available health-care centres, the quality of personnel and equipment at the centres are other factors which may affect a person's decision to seek health at a particular health care centre This concern has been echoed by Modey (2006) that the country representative of Sight Saver's International (in Ghana), James Amervenah expressed regret that though 90% of blindness could be treated, people do not have access to properly equipped eye care centres.

Gender and Access to Health Care

Studies in health seeking behaviour according to Ojanugah and Gilbert (1992) mainly centre on the differences in access to health care between men and women due to gender inequalities .To a higher or lesser extent, inequalities exist in all societies and social classes, but in developing countries and among the poor, they are assumed to have a negative impact on women's health.

According to Kroeger (1998) men play a paramount role in determining the health needs of a woman. Since men are the decision makers and are in control of all the resources, they decide when and where a woman should seek health care. Kroeger(1998) added that women suffering from an illness report less frequently for health care seeking as compared to men. The low status of women prevents them from recognizing and voicing their concerns about health needs. Women are usually not allowed to visit a health care provider alone or to make the decision to spend money on health care. Thus women generally cannot access health care in emergency situations. This certainly has severe repercussions on health in particular and self-respect in general of the women and their children. Despite the

fact that women are often the primary care givers in the family, they have been deprived of the basic health information and holistic health services.

According to Sadiq and Mynck (2002),in Pakistan, having a subjugated position in the family, women and children need to seek the permission of head of the household or the men in the family to go to health services. Women are socially dependent on men and lack of economic control reinforces a woman's dependency. The community and the family as institutions have always undermined her prestige and recognition in the household care. The prevailing system of values preserves the segregation of sexes and confinement of the woman to her home. Education of women can bring respect, social liberty and decision making authority in household chores.

The effects of gender inequalities can be clearly seen when access of women to both preventive and therapeutic care is significantly lower compared to men. For example different studies show an increased number of men patients who attend medical services in areas where disease rates are equal for both sexes. In general, inequality in access is associated with the finding by Ojanugah and Gilbert (1992) that women have to overcome more obstacles to treatment. Another expression of sexism is the unequal treatment women receive from health personnel.

Doyal (1987) complained that in some cases the health providers attend to men and boys better than women and girls .This behaviour is the extreme consequence of sexism among physicians who tend to treat women's problems as less important, with the exception of reproductive health, an area which is increasingly medicalized .The often disrespectful treatment and the poor quality information

which women often receive lead both to poor comprehension of actions to take., and to unsatisfied women who abstain from health services.

According to Vlassoff (2000) , the technical paper on Gender and Health WHO (1997) proposes a series of factors which need to be taken into account in health seeking behaviour studies as well as in elaborating gender sensitive heath system responses. On the whole, compared to men women have limited access to cash money which is needed for coping with health costs. This applies particularly to remunerated work. As a basic division of labour, Bonilla and Rodriguez (1993) pointed out that women are mainly engaged in the private sphere while men are in the public sphere. Decisions which economically affect households are taken by the breadwinner who is mostly male, making women dependent on men for accessing health services for themselves and for their children .Mwenese (1993) therefore pointed to the paradox that while women as the care takers are the first in perceiving illness in the children, they often lack the means to act because they depend on the men who control funds.

Sadiq et al (2002) lamented that gender disparity has affected the health of the women in Pakistan by among other things putting an un-rewarding reproductive burden on them,resulting in early and excessive child-bearing.

Provision of Health Care: - By the Private Sector

According to Hansen and Berman (2010) it is conventional to define “private” providers as those who fall outside the direct control of government. Private ownership generally includes both for- profit and non-profit providers. For example, private ownership would include health care facilities owned by

individuals who seek to earn profit, clinics and hospitals owned by private employers, and those operated by religious missions and other non-governmental organizations (NGO's).

Naturally there are a number of grey areas which are adequately described by this definition. For instance, it is not clear where health services owned by public enterprises or parastatals (such as social security institutions, national petroleum companies or airlines) should fit into such a typology. The extent to which the behaviour of health services owned and operated by such organizations conforms more to a public or a private model will depend on the precise nature of their management and financing structures. For example, services provided in a hospital that is operated directly by social security funds, an organizational structure which is common in Latin America are usually, considered to be publicly-provided. In some countries, NGO's receive substantial operating subsidies from government, who owns the provider is therefore often considered to be the key characteristic implying behavioral differences. Thus, according to Bennet (1992), NGO's would typically belong to the private sector, while "private" wards in public hospitals are considered to be essentially public in character and behaviour.

Providers may be individual practitioners, group practitioners or facilities (e.g. clinics, hospitals, or other institutions). Exactly who provides health care services will depend on the particular country, but services are usually provided by doctors, paramedical health workers (e.g. clinical officers, registered medical practitioners, physiotherapists), or nurses. Although countries differ in their

training requirements for specific categories of health care provider, information on training differences is not readily available.

Researchers have accepted the categorization used in most resources and have assumed that cross-country comparisons are valid. This applies also to the definition of hospitals, which are typically defined in structural terms, such as the presence of some arbitrary number of beds (e.g. 10, 20 or 50). Significant numbers of private beds may be located in non-hospital in-patient facilities such as nursing or maternity homes.

Intermediate-level facilities not officially categorized as hospitals may provide inpatient services which do not appear in published data sources. National conventions regarding such definitions and their reporting do not typically appear in many data sources, making it difficult to achieve consistency in cross-country comparisons.

Pharmacies, to Bennett (1992) often play an important role in national health care systems, as providers of over-the-counter and prescription drugs, and in giving medical advice. Both controlled and over-the-counter drugs are often sold in informal setting as well, such as markets and kiosks. There is, however, virtually no official data on the provision of services in these settings.

Bennett (1992) added that a typology of health care providers should include services provided by traditional doctors or other healers. Again, information concerning the size of this sector tends to be scanty. National associations of traditional healers may exist, but their coverage of the sector is often incomplete.

Income

Although the relationship between income levels and composition of health expenditure is well established in a number of cross-sectional studies, according to Getzen and Poullier (1991), there is little work exploring the way in which the number of public and private health care providers vary with income. Existing conceptual frameworks which describe the growth of the private sector do not lead to clear predictions about evolution of the relative shares of the public and private sectors as income increases. This is partly because the relationship between the sizes of the two provision sectors is likely to depend on a host of other factors such as relative quantity, institutional features, payment systems, etc.

Berman and Rannan-Eliya (1993) review a number of demand and supply factors which are believed to affect the development of the private health sector. On the demand side this includes needs, prices, quality, the presence of risk sharing mechanisms such as private and social insurance, and the nature of the medical referral system.

The increase of urbanization and secondary school enrollment both have a significant and positive effect on the number of private physicians. The rate of urban population growth is however, negatively related to the number of private physicians. Urban areas are likely to have a higher concentration of high income individuals, and are more densely populated, both of which would be important demand-side influences. Urban formal sector employees are more likely to be covered by social or private health insurance .That is why Baker and Van der Gaag(1993) opined that the role of insurance in stimulating demand for private health care is an important area for further research .Where rates of urban

population growth are high, it may be relatively low income people who are moving to the cities with the consequence that demand for private services may not be very high.

Berman and Rannan-Eliya (1993) added that education is positively related to the demand for health services in general, and may increase the demand for higher quality private health services. The positive relationship between secondary school enrollment and the number of private physicians and for-profit beds is consistent with this story. The fact that total private beds include non-profit beds, which may be more likely to operate in rural areas and charge lower fees than for-profit facilities ,may explain why the education effect is diluted for this measure of the size of the private sector.

Getzen and Poullier (1993) opined that health and demographic transitions are likely to have an important effect on the growth of the private sector through the effect of patterns of morbidity and demand for different types of care, and overall ,an increase in the adult and elderly population may lead to an increased demand for health services. If this demand is satisfied through a relatively greater use of private providers, one would expect to see larger private health sectors in countries with longer life expectancy and lower proportion of children. Getzen and Poullier (1993) added that longer life expectancy is associated with a larger number of private physicians and of private hospital beds.

A number of health financing variables are associated with the private hospital bed variables. Generally a higher level of health spending is associated with a larger number of private beds. An extra dollar of health expenditure from the

findings of Getzen and Poullier(1993) seems to have a similar positive effect on the supply of private beds , regardless of whether the money comes from public or from private sources. The composition of financing also seems to be related to the total supply of private beds; other things equal, increasing the share of public expenditure is associated with an increase in private beds, while increasing the private share is associated with a decrease. Since these relationships are weak /nonexistent for-profit beds this suggests that the main influence of these financing variables is on the non-profit hospital sector.

As a country's income increases more resources are available to purchase health services of all types, including those provided in the health sector, so supply of private providers increases with income. This, according to Berman and Rannan-Eliya (1993) is significant, in that most developing countries devote a lot of policy attention to government roles in health care financing but little to the development of private provision in the health sector planning.

According to Mcintyre (1995) a wide range of health services are provided by the private sector in South Africa, including independent practitioners working in solo or in group practice (e. g. general practitioners, dentists, psychologist and physiotherapists), pharmacists at retail pharmacies, specialist doctors (who generally have consulting rooms in private hospitals,) private hospitals which employ nurses and other health professionals and ambulance services. Traditional healers are another important private provider in South Africa, although Mcintyre (1995) thinks it is very difficult to determine how many health professionals work in that sector due to data constraints.

Access to Health Facilities in Ghana

For a population of a little short of 23.5 million people, there are only 1439 health care facilities. A study by Van den Boom (2004) noted that access to these facilities has remained a problem. Medical facilities are not evenly distributed across the country, with most rural areas lacking basic facilities such as hospitals and clinics as well as doctors and nurses. The study further said that Ghanaians on the average live about 16km from a health care facility where they can consult a doctor, but half of the population lives within a 5 km radius. By the same token, the other half cannot consult a doctor within 5 km, which corresponds to a 1 hour walking distance, and one quarter even lives more than 15km from a facility where a doctor can be consulted. “The Government of Ghana embarked on a health sector reform in the early 1990s to improve the accessibility and quality of services. However, the health situation in Ghana is still far from satisfactory.” (Van del Boom, 2004 p.9) Many people in the country still rely on self-medication.

Projects to raise accessibility however are underway: the Minister of Health told Parliament in December 2007 “that the Ministry has established 176 health infrastructure projects within a period of five years. This includes 50 Planning Schemes (CHPS)”. (Ghana Parliament, 18 December 2007).

Common Diseases in Ghana

Communicable diseases

In 2008, malaria, a curable illness, continued to be the disease claiming the highest number of victims, followed by HIV/AIDS, diarrhoea, lower respiratory infection, and perinatal conditions.

'These five diseases account for 50% of all deaths in Ghana, and 68% of deaths among children under 14 years old; as a result Ghana still occupied the second place behind Sudan on the list of Guinea Worm infected countries' (the statesman, 26 January 2008)

Malaria

Comparable to many other African countries, malaria is the number one killer of Ghanaians .Reporting on malaria in Ghana, the WHO (2008) noted that "about 3 million of Ghana's 20 million population seek treatment for malaria each year. According to WHO, more people continue to develop resistance against chloroquine, which forms the first line of treatment of malaria. Therefore, "officials have decided to tackle the mosquito-borne disease by switching to the more expensive artesunate-amodiaquine as the first line of treatment". WHO said that in 2002, some 23.2 per cent of the people in Ghana had developed resistance to chloroquine. With the assistance of WHO, the government introduced a new artemisinin-based combination therapy which now costs US$1.30, compared to "the previous US$0.10 to treat a single case of malaria".

Tuberculosis

According to the Ghanaian Chronicle (2008) tuberculosis (TB) has long been among the six killer diseases listed by the ministry of health. Therefore Ghana is a member of the WHO's Directly Observed Treatment Short course (DOTS), which was implemented in 1994 countrywide. Treatment of Tuberculosis at health centres in the country is free, still Ghana recorded 697 TB related deaths in 2006. TB accounts for about 40 per cent of AIDS deaths in Africa. Experts, sector workers and traditional leaders in the country have called on the government to declare it an emergency disease in the country until solutions are found.

WHO (2008) show that compliance with effective treatment within a couple of weeks makes a previously infectious patient non-infectious**.** On the other hand, non-compliance with treatment may lead to persistence resurgence to TB and is regarded as chief cause of relapse and drug resistance. Non-compliance also results in increased morbidity and increased cost to TB control programmes. Due to the socio- economic situation of infected people in Ghana, non-compliance with treatment patterns occurs frequently. A quantitative review on treatment default at Effia-Nkwanta Regional (ENR) Hospital [in the Western region of Ghana] revealed that the defaulter rate in 2000 to 2001 was 13.9 per cent of all those who committed initially to treatment of TB. Financial difficulties were citied as the main reason for defaulting. Also, defaulters had poor knowledge about TB and reported lack of social support during treatment.

Treatment for viral hepatitis is, according to the Ghanaian Times (2007), is not covered by the National Health Insurance Scheme (NHIS). Accordingly, a

physician at the Korle –Bu teaching hospital in Ghana underscored the need to widen the National Health Insurance Scheme to cover Hepatitis B treatment in order to encourage people to know their status and seek treatment. The Ghana Hepatitis B foundation (GHBF), which mainly focuses on information dissemination on preventative measures and immunization, was formed a month prior to the physician's appeal. It also made its aim to get Hepatitis B on the list of illnesses covered by the National Health Insurance Scheme.

The GHBF said other hepatitis prevention measures in Ghana focus on the hepatitis B virus. Numerous researchers have proven the prevalence of the B virus in West Africa and Ghana in particular over a long period of time. The British Medical Journal (1971) concluded that "the increase in hepatitis in Accra since the second world war has accompanied the development of shanty towns with poor sanitation.' Despite the long history of Hepatitis in Ghana, larger initiatives to tackle the problem are relatively young. According to its own reports, GHBF (2008) started its operation in September 2007. The foundation also indicated that it is the only organization active against the disease on a permanent basis in the country .Its data shows that a vast majority of children was immunized in 2008.

Non-Communicable Diseases

According to the Ghana News Agency (GNA (2005) cardiovascular diseases (CVD) are becoming more and more dangerous in poor countries as well. The GNA added that these could be more dangerous in developing countries because "an important phenomenon of CVD in developing countries is the trend of complications occurring at younger ages'. Thus, stroke, cardiac failure and renal

failure further fuel the vicious cycle of ill-health and poverty. The reports indicate that conditions are not treated under the National Health Scheme.

Cancer

Reports from the International Atomic Energy Agency (2005) indicate that breast and cervical cancer are prevalent among Ghanaian women. Personnel shortages and a lack of awareness are huge problems, and cancer cases are mostly presented or treated in an advanced stage only.

Diabetes

A study on Ghana's Brong Ahafo Region revealed that diabetes is a major cause of adult disability and death in Ghana. The study, according to the Ghana Health Service (2008) said, recent studies and policy discussions strongly attribute the burden of diabetes to deficiencies in health systems, which include high medical costs, unavailability of drugs, poorly staffed and financed diabetes services and poor patient practices, chiefly biomedical non-compliance and healer shopping for ethno-medical treatments. It also stated poor patient practices to problematic cultural beliefs (such as spiritual casual theories) and poor knowledge of the clinical complexities of diabetes at health centres.

According to the Public Agenda (2007) the Ghana Diabetes Association (GBA) sources indicate that 'diabetes has been recognized as the cause of prolonged ill health in at least 2.2 million Ghanaians and threatens 50 per cent of all Ghanaian patients.' Intensive therapy directed at the control of blood glucose and blood pressure are the main containment approaches used in Ghana and many other

developing countries. Cost of therapy is included in the National Health Insurance Scheme (NHIS).

Kidney Disease

Acute and chronic renal failures as well as other kidney diseases, according to the GNA (2005) are not covered by the National Health Insurance Scheme.

Mental Health

WHO (2008) estimates that "of the 21.6 million people living in Ghana, 650,000 are suffering from a severe mental disorder and a further 2.166,000 are suffering from a moderate to mild mental disorder.' The treatment gap is 98 per cent of the total population expected to have a mental disorder. One of the reasons said to be making it difficult for mental health practice is the traditional stigma attached to mental health. The traditional healing of mentally ill patients in Ghana gives rise to disturbing trends. In Ghana, the proliferation of spiritual churches and other orthodox institutions have become threats to the patient's rights and appropriate treatment. The acting Medical Director of the Pantang Psychiatric Hospital, Dr. Anna Dzadey, "disclosed that more often, mental health patients are kept in police custody for a prolonged period of time without any legal reason, before being brought to the hospital for evaluation and treatment" (Public agenda, 7, April 2006)

The paper (above) also reported a complain by the African Commonwealth Human Rights Initiative (CHRI), that human rights violations in prayer camps are widespread in Ghana in the form of chaining, beatings, insults, denials of food

and lock-ups in crowded rooms. The report said that “Maj. Courage Quarshiegah (rtd)”, minister of health, has said his outfit was preparing various health bills which would become law, which would allow the country to regulate and monitor such practices.

Reproductive Health

Reproductive health remains a big issue in the health sector of Ghana. Despite the fact that neo- and antenatal care are covered by the national insurance scheme , ‘only 35 percent of all deliveries are attended to by a qualified medical practitioner, the remaining 75 percent of women either deliver at home or seek traditional help’ (Integrated Regional Information Network, IRIN, 5 August 2008).

According to a report on reproductive health and the reduction of maternal and infant mortality and morbidity, by the IRIN (2006) available statistics for Ghana “indicate that there are only 2,800 people working in the various health facilities in the country”.

While the IRIN reported progress in prenatal and antenatal care in early 2008 and that there has been success recorded through an “integrated approach of cost-effectiveness strategies combining immunization, infant and young child feeding, management of childhood illnesses and improved antenatal care however, in August of the same year, an article by the Ghanaian Chronicle said “the rates of maternal deaths is on the increase, owing to certain incidences beyond the control of those in charge.” The WHO (2009) estimates that “560 pregnant women will die out of every 100,000 that go into labour. It added that, for every 10,000 births

in the country, over 214 Ghanaian women die in the process of delivery .The reports also said that among rural communities in the hardest hit areas in the north of the country, the maternal death rate was 700 per 100,000 live births.

According to IRIN (2007), observers say that Ghana has one of Africa's most liberal abortion laws but because of lingering stigma, fear and misunderstanding, safe, affordable abortion laws remain virtually non-existent and unsafe abortion is a major cause of death.

Health Systems Organization in Ghana

According to Abekah-Nkrumah and Abor (2008) the health care system in Ghana is organized under four categories of delivery systems: public, private-for-profit, private-not-for-profit and traditional systems. Though the former three are mostly associated with healthcare delivery in Ghana, efforts are being made since 1995 to integrate traditional medicine into orthodox mainstream.

Political Administrative Structure of Health

The constitution of Ghana provides that "the state shall safeguard the health, safety and welfare of all persons in employment, and shall establish the basis for the full deployment of the creative potential of Ghanaians". The current nationwide health insurance scheme is based on the parliamentary bill "ACT 650 and LI 1809" (National Insurance Act, August 2003). The National Health Insurance Scheme was formally launched in December 2004.

According to the Ghana Health Service (2008) health administration in Ghana is divided into three administrative levels: the national, regional and district levels. It is further divided into five functional levels of national, regional,

districts, sub-districts and community levels. All levels of administration are organized as Budget and Management Centres (BMCs) or cost centres for the purpose of administering funds by the Government and other stakeholders. There are a total of 223 functional BMCs and 110 sub-districts BMCs. With the health quarters of Ghana Health Service (GHS) also managed as a BMC, there are 10 Regional Health Administrations, 8 Regional Hospitals, 110 Districts Health Administrations and 95 District hospitals. All of these run as BMCs.

The Ghana Health Services (GHS) is in charge of transport, equipment and infrastructure provision, delivers information and provides "support and guidance for the design and policies and strategies" to the Ghana Health Service Council. The activities of the various organs under the Ghana Health Service are coordinated and administered by the Ghana Health Service Council supervised by the Minister of Health. Its main duties are to implement and approved national policies for health delivery in the country, increase access to improved health services and to manage prudently resources available for the provision of health services. External contributors of the health service such as the National Health Insurance secretariat and the auditing offices and controlling services work directly with the council. The Health Ministry is responsible for policy planning processes and information management, particularly concerning the areas of financing, human resources and infrastructure.

Public Health Care System

The public health care system of Ghana is operated through the National Health Insurance Scheme, which Abekah-Nkrumah and Abor (2008) say permits the

operation of three types of insurance schemes, district-wide (public) mutual health insurance schemes in all the country's 110 districts, private mutual insurance schemes and private commercial insurance schemes. However, only the district-wide public (public) mutual health insurance schemes are financially supported by the NHIS.

The public health system faces a variety of obstacles, among them are shortages of personnel and funding, as well as unequal distribution of health workers in the country's regions. The country's most densely populated region, Western region, accommodates 10 per cent of the population but only 99 doctors. There are 91 doctors living in the Volta region and 33 in the Northern region, compared to 1238 public and private medical as well as dental practitioners in the Greater Accra Region.

Corruption seems to be another major problem in Ghana's public health care system: According to the Ghanaian Chronicle (2007) Transparency International (TI) in its 2006 Global Corruption report, has identified the health sector of Ghana as a corruption prone area with evidence of bribery and fraud across the breadth of medical services. This is said to have emanated from petty thievery and extortion, to massive distortions of health policy and funding, fed by payoffs to officials in the sector.

A study carried out in selected rural communities by the Ghana Health Service in 2006 revealed that other factors such as traditional beliefs, social stigma, poverty and illiteracy still stand in the way of proper health care in some places in Ghana including the Kassena District in the Northern Region .Some of the

respondents said that contributing money for illness yet to come was not appropriate as that in itself could invite more illness .Another study in the district hospital revealed that people with leprosy and tuberculosis defaulted treatments due to social stigma, lack of funds and/or the need to fend for themselves or others.

Private Health Care System

According to Abekah-Nkrumah and Abor (2008) treatment on private basis cost approximately US$10 per session, and the average income of Ghanaians was about $1.5 per day. They added that, whereas the missions (Christians and Muslims health services) treat the poor free of charge, most private medical practitioners such as herbalists, fetish priest and some orthodox private practitioners apply charges, the amount of which "vary widely".

The operation of private mutual insurance and private commercial insurance schemes are permitted by Ghana's National Health Insurance Scheme along with that of district-wide (public) mutual health insurance schemes, in order to give Ghanaians the opportunity to join a health insurance scheme of their choice.

A survey conducted by the Ecumenical Pharmaceutical Network (2005) found that "faith-based health services in Ghana provide approximately 40% of the available health care." It quotes a report by the Christian Health Association of Ghana (CHAG), according to which 'the church health care facilities in Ghana numbered 56 hospitals and 83 clinics at the time of research'

The larger religious organizations such as Catholic and Presbyterian churches offer their own orthodox medical insurance schemes, through which public

screening, vaccination, treatment and awareness programmes are organized. Particularly Christian organizations operate larger hospitals and clinics, mostly in rural areas and small towns and rarely, in regional capitals and urban centers. Christian healthcare delivery organizations which are recognized as such by the Government fall under the leadership of the Christian Health Association of Ghana. 45 to 60 per cent of the total operational revenues of the Christian faith based health sector come from subsidies from the government. According to CHAG, a precondition or access to this insurance scheme is the Christian faith; the scheme is thus open to Christian Ghanaians only.

Islamic organizations maintain a relatively low percentage of the private health care delivery in Ghana. Besides the Islamic Republic of Iran which runs a clinic in the country, another organization such as the Ahmadiyyah Muslim Mission of Ghana, organizes medical aid programmes and implements health care delivery projects such as free medical care on temporary basis.

Traditional Health Care

In Western countries, a common perception is that traditional medicine serves as an auxiliary to orthodox medicine. Traditional medicine however, overshadows orthodox medicines in many developing countries. “Traditional medicine”, according to WHO (2003) “refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illness or maintain well-being’. According to a 2003 WHO estimate, ‘in Africa up to 80% of the population uses traditional medicine

for primary health care'. Furthermore, Traditional practices such as homeopathy, naturopathy and osteopathy are already better integrated into Ghana's health system than in other African countries

According to Abekah-Nkrumah and Abor (2008) as of May 2007, the NHIS was yet to cover over half of its targeted people (coverage was estimated at 41 per cent, 30 May 2007). With often unaffordable cost of treatment, traditional medicine therefore still remains important in Ghana.

In Ghana, as in other countries, WHO is collaborating with the government to integrate this type of medicine into orthodox medicine. Studies have indicated that, in the two and half decades since the introduction of on the spot payment for health delivery, more than half of the country's patients have turned to traditional and self-medication.

A 2007 article by the news platform of the WHO on science and technology in developing countries ,Science Development Network, quotes a journalist arguing that "integrating traditional medicine into Ghana's healthcare system is essential to improving the delivery of health services in the country. Recognizing that with the challenges facing the country's health delivery, it can augment the system and play an important role. He said that with health workers' frequent strikes and their migration elsewhere in search of better pay, integrating traditional medicine into the NHIS would play a vital role. "The author suggests this burden could be lightened by Ghana's roughly 45,000 traditional healers, most of who are licensed through national practitioner associations. He noted, 'this type of medicine is culturally accepted and accessible to 80 per cent of Africans. In Ghana a large

proportion of the population relies on this type of healthcare, particularly in rural areas."(WHO, 2007, p. 75)

As much as the traditional medical practices augment the orthodox national healthcare services, they also present problems to government's efforts to offer universal healthcare in the country. Particularly challenging are those who mix orthodox and traditional medicine (i.e. herbal treatment and religious prayers). They are known in the country as healing churches. Many of these groups claiming to have spiritual powers for healing physical and mental illness eventually end up maltreating patients and abusing their rights. Meanwhile, a Ghana Health Service (2008) report mentions that Ghana Health Services (GHS) outreaches over the past few years have convinced some members of the Kpale (Xorse) Faith Church at Kpale, in the Ho Municipality of the Volta Region in the Eastern province of Ghana whose faith taught them to 'refuse orthodox medicine either for curative or preventive purpose", to change their attitude and "report at healthcare facilities and use prescribed drugs when sick.'

Health Care Finance and Expenditure

In a research report Asante (2006) said that the mode of budget allocation for health care in Ghana is that the pattern of allocation of the previous year is used as a guide for the current year's allocation. It has little bearing with the health needs of the population. Despite policy commitment to enhance the resource allocation formula to incorporate health needs and poverty and gender issues, only minor changes have been made, However, the government has recently changed its strategy in resource allocation by prioritizing a pro-poor and needs based

resource allocation in the health sector. The MOH ring -fences part of the health budget and lodges it with specific budget and management centres to protect critical services areas from the risk of under-funding .The risk-fencing is also used to ensure that resource allocation patterns reflect national poverty alleviation and equity commitments .A significant portion of the pro-poor funding strategy goes into ensuring that exemptions are paid for among other things 'material deliveries and guinea worm eradication in northern Ghana .However ,according to Asante (2006) , much of these efforts in 'resource allocation in the Ghanaian health sector remains inadequately reflected on the health needs of the population ,and to date ,only few indicators of needs are included in the allocation criteria .The funding of the insurance scheme is based on a system called 'cross-subsidization.' In this payment system ,the rich is supposed to subsidize for the poor ;the healthy subsidies for the sick and the economically active adults pay for children ,indigents and the aged [70 years and above through the social security and National Insurance trust [SSNIT],workers contribute 2.5 percent of their salaries. Additional funding comes from a 2.5 percent value added levy on selected goods and a minimum premium of 72,000 cedis per annum from informal workers, aside from these payments ,other consolidated funds are used to finance the scheme. Donations, grants, gifts and other voluntary contributions are also added to fund the scheme.

Insurance and Coverage

According to Asante (2006), with a health expenditure of USS 10 to 17 million dollars annually, part of which is subsidized by international donor initiatives ,the

main aim of the scheme is to provide basic health care for the country‘s poor. Being a new scheme with limited funds, it focuses on communicable diseases. An estimated 20 to 50 percent of inpatient admissions, and up to 50 percent of outpatient visits are cases of malaria.

According to the scheme, Ghanaians are supposed to pay an annual fee according to their income. Poor people contribute about USS10 annually, workers in the formal sector pay 2.5 percent of their social security contribution The government covers the aged ,indigent and children whose parents pay into the scheme .Financing comes through a 2.5 percent national health insurance levy on selected goods and services .It is also funded by the Highly Indebted Poor Countries Initiatives.

Three types of insurance schemes, as reported by Asante (2006) exist under the national health insurance scheme; A District-wide (public) mutual health insurance scheme through which the workers of the public sector directly pay a share of their wages into the health insurance system.; a ‘private’ mutual health insurance scheme through which subsistent farmers ,people working in the informal sector and unemployed people who were not formerly employed in the public sector are to pay their contribution; and a ‘Private commercial health Insurance scheme ‘through which those employed by larger companies and multi –national companies pay their contributions (Hepent, 30th May, 2007).

Within these Schemes, the Insurance Programme offers the following Benefit Packages; full OPD (out patient department) and admissions treatment (surgery and medical) cost including feeding ‘are catered for if listed on the scheme and.

Full payment for medicine if within the approved list. Payments for referrals are taken care of 'provided it is within inclusive list'.

Out of Pockets Payments

Abekah- Nkrumah and Abor (2008) report that in 2005 the percentage of expenditures paid out of pockets in Ghana amounted 79.1% of the total private expenditure on health, which forms 65.9 per cent of the country's total expenditure on health. Out of pocket payments therefore make up approximately 50 per cent of the combined public and private expenditures on health. The health system of Ghana, according to the report is still in a transitory process;-it is being transformed from the former 'cash and carry' system to the newly implemented insurance system. The system prior to the current one was based on a full cost recovery on pay- for- access basis. The aim of charging access fees was to recover 15per cent of the public sector operation cost. Though this aim was achieved there were always difficulties as costs of illnesses vary and the majority of the people could not afford treatment .Financial equity for the poor was always a problem. Though some exemptions were introduced, increasing public discontent called for its abolishment.

Health Delivery Structure in Ghana

According to Van del Boom G, & Nsowah K (2008) currently, the largest producer of health care services in Ghana is the government. The government health care facilities can be distinguished in four layers depending on the services offered at the facility: village or community health post, district clinics, regional hospitals and the two teaching hospitals.

The community health posts predominantly provide preventive or primary health care services; however, their curative treatment is limited due to the fact that they are mostly not staffed by doctors. Nurses and health workers provide first aid and referral cases to district hospitals, polyclinics, regional or tertiary hospitals, depending on the institution's proximity and the treatment required .Hospitals and polyclinics are the main providers of curative secondary and tertiary care. The polyclinics also serve as first points of contact of primary health care in urban areas and therefore provide a mixture of preventive and curative care and use the regional hospitals for referrals. The regional and teaching hospitals are usually perceived to be the providers of higher and highest quality respectively . The community health centres are staffed by nurses and midwives.

The regional levels according to Van del Boom(2008) ,offer mainly curative services, which are delivered at the regional hospital and public health centre of the regional hospitals. At the district level curative services are provided by the district hospitals. Many of the district hospitals are faith based hospitals collaborating with the government health institutions for health delivery. Traditional health attendants and traditional healers also receive recognition at the district and the sub-district levels and at the sub-district levels Public health services are provided by a District Health Management Team and the public health unit of the district hospitals.

At the sub-district levels both preventive and curative services are provided by the health centres as outreach services to the communities within their catchment areas. Basic curative and preventive services or minor ailments are treated at the

community and household level with the introduction of the community based Health Planning Service. As a result of government decentralization reforms of the health sector, health delivery is mainly operated at the 10 regional capitals.

The Status of Healing Systems on Health Seeking Behaviour

The status of a healing system is another factor which may influence health seeking behaviour. A Christian for instance would not like to be seen by fellow members of his church if he decides to seek health at a fetish shine. Likewise, the stigma attached to a health facility may be another factor. A negative perception deters a person from patronizing a particular healing centre. Thus, Vinorkor (2006) reports that although the Ghana government has a policy of not charging fees at the Accra Psychiatric Hospital, because of the stigma attached to mental illness in the country, most patients refuse to seek treatment there. So, embarrassment, fear of discovery or related concerns may prevent some sick people from seeking health at some health centres. People suffering from diseases like gonorrhea and syphilis are likely to behave in this way.

To Baldwin (1985) most people do not like being physically examined by what he term "strangers" particularly of the opposite sex. When it comes to the examination of the mouth, breast and the genital organs, females in particular are very careful with their choice of health care facilities Nonetheless to Fullerton (1997) the suddenness of accidents for instance at times does not give one the chance to decide where he or she may like to be sent to "in such a situation, the first aider is the first person who gives aid. In the case of small injuries, this is

usually a close friend, a member of the family or the nearest person. With serious accidents, causalities may be sent to the nearest health-care centre whether they (the casualties) like it or not" (Fullerton, 1997, p.164).

In cases of public health emergencies of international concern, the W H O (and other bodies) intervenes through its policy to prevent, protect, control and provide a public health response to the nation involved. In such cases, the country involved only has to notify the WHO 24 hours of all events which may constitute a public health emergency of international concern and any health measure in response. The world health organization upon request is obliged to provide technical assistance and mobilize international expert teams when needed, to respond to a country's public health risk. For instance when an outbreak of drug-resistant strains of tuberculoses were found in Latvia , reports from the British Medical Officers Association (2002) indicate that a partnership between the Red Cross and the WHO was designed to boost detection, infection, control and treatment.

There are many reasons why people decide to or not to seek health at particular health care centres. Some people, according to Bullough and Bullough (1980), prefer home health care. “This is because such people do not wish to be a burden on the family and friends; they also want their privacy, being treated in the comfort of their home.”(Bullough et al, 1980, p.35). Another reason assigned to this preference is that such people do not want other people performing personal chores for them and are embarrassed, ill at ease and anxious when sent away from

home to seek health. Preference for home care, however, depends on the willingness of the sick person to play sick role.

Influence of Occupation on Health Seeking Behavior

The mobility of fishermen and fish traders, which at times results in their long absence from home, may influence their health seeking behavior .To buttress this, Seeley and Allison (2005) sites a study in Thailand among 818 Thai, Khmer and Burmese origin which found that access to health care was difficult for fishermen not only when they were at sea, but also when they were in shore. Because they were at sea the fishermen do not know what services are available at places where they stay .The problem was even compounded for non Thai fishermen because of language and cultural barriers or their status as illegal workers in Thailand.

In addition to mobility and long absence of fisher folks from home, cash incomes in the context of poverty, gender inequality, easy availability to commercial sex in ports and landing stations, and a masculine culture that condones or encourages sexual encounters have been heighted as increasing vulnerability to HIV infection. This same life-style characteristics of fisher folks also affect their access to HIV treatment in particular and health care in general.

According to the British Medical Officers" Association (1991) it is essential for all institutions (including boarding schools) to have their own efficiently managed sanatoria staffed by trained personnel to, at least serve as first aid centres. This is because sudden illnesses and injuries which may occur at workplace need to be attended to immediately. That is why Dovor (2006) reports that a Deputy Minister of health in Ghana, Samuel Owusu, has called on heads of responsible

organizations to provide first aid training in their areas of ;jurisdiction. His concern is that because of our inability to provide first aid to victims of accidents and natural disasters, many lives are lost or injuries are aggravated before they are sent to hospitals.

Since every occupation has its own risks, it is important that medical personnel who can handle such peculiar health problems be attached to institutions for instance at football matches and other sports meets. Likewise, mining companies, oil producing industries and fishing harbours which have peculiar health hazards and accidents like burns and drowning are likely to occur there, need specialists to be always available to give immediate attention to victims.

Smook (2006), agree that some illnesses are occupation related and employers should assist employees in treating such sicknesses. He reports that back strain for instance are very common in occupations which involve sitting for long periods, for example office workers and drivers, he adds that many people who work with heavy weights are attuned to bending with a strained back when lifting, and most people in call centres have headsets, while many office typists who spend comparatively long hours on the phone, rely on the old crooked ways of grasping the receiver. A survey in the United States according to Smook, reported that more than a third of office workers who used a telephone for more than two hours a day and also used a computer suffered from lower back pain

Fishermen for instance may stay at sea for very long periods of time, which means meals may be scanty and irregular, and keeping to any form of medication will be hard. These may make fishermen prone to a disease like tuberculosis.

Therefore a life-style like that of fishermen that involves irregular meals and poor diet may impair the effectiveness of treatment of some diseases, and consumption of alcohol as part of that diet may be problematic.

For various reasons, some employers are interested in where their employees seek health. According to Baldwin (1985) some institutions and companies compel their employees to seek health at particular health centres to prevent the workers feigning sickness and the employers paying fictitious health bills. The Police, Armed Forces and Life Insurance Companies fall in this category. To Pantry (1995) however some employers show interest in where their employees should seek health because they (the employers) take the health of their workers serious. This is because it has now been realized that so many workers die due to not getting the necessary medical attention they need. He adds that far more people die yearly owing to their health having been harmed at work than are killed in accidents either at work or owing to work activities.

Institutions and companies have their own reasons for showing interest in the health of their employees. Some employers insist on deciding what constitute a health seeking illness and may not allow some of their employees to be absent or to report sick. For this, Payne and Hahn (2002) cite a study conducted in Staffordshire, which examined, among other issues, the importance of legitimate illness at work. According to the report, clerics, workers, managers and doctors have to negotiate whether a case of absence from work is legitimate.

As to what really constitutes a health seeking illness and should merit an excuse from duty, the British Medical Officers' Association (1991) suggest that in

the school environment for instance the school doctor should be responsible for all matters affecting health in the school. This includes not only the health of the students, but that of anyone who is in the school. Eg. teachers, domestics, clerks, maintenance staff and visitors to the school. The school doctor is obliged to treat injuries to visitors, for instance, or provide emergency care to members of visiting teams and report details of the patients to the patient's own doctor.

Financing Health Care

According to Philip (1990) research over a number of years has emphasized that many factors intervene to delay or prevent health resource utilization. Prominence among these is the existence of recognized need to use the facility, closely followed by the financial ability to use it (owing to charges in transport costs and the likes). Health cost is normally financed by the sufferer, but family members, friends and well-wishers may also contribute.

Nations all over the world through various policies try to finance health care for particular categories of the population, or cushion the general financial health burden of their people. This might be partly due to the fact that most governments recognize that a healthy population is a very great assert.

Besley and Kambur (1990) mentioned one of such polices introduced in the Philippines by the government in conjunction with the African Development Bank in which the Philippine government provided subsistent fishermen access to coastal resources to improve economic conditions in coastal communities through the provision of alternative sources of livelihood, credit ,technical and marketing assistance and strengthening social services in coastal communities

through the provision of effective education, health and nutrition services and the implementation of population control programmes.

It was therefore based on the above premises that the United Fishermen of Alaska (2007) suggested that health care for Alaska fishermen should make the list as a national priority in the national health care plan given that Alaska fishermen produce more than half of the nations sea foods, which is crucial to the nations balance of trade. This suggestion led to the creation of the Alaska Health Care Strategies Planning Council which advises the United States government on legislature on ways to provide quality health care and to help to reduce the cost of health care for Alaskans. The council, according to the United Fishermen of Alaska (2007) is tasked to develop a statewide plan which will identify short-term and long-term strategies to effectively address issues of access to, and cost and quality of health care for Alaskans.

Mccintyre (1995) reports that the main ways in which health is financed in South Africa are through private health insurance called (medical schemes) and through direct out of pocket payments. Membership of medical schemes is voluntary, in the sense that there is no law requiring individuals or groups to become members of medical schemes. However in reality membership is not entirely voluntary as contributing to a medical scheme is often a condition of service for formal sector employees. Medical schemes in South Africa are non profit associations, governed by Boards of Trustees who are expected to ensure that their scheme works in the best interest of its members. However day-to-day

management of most schemes is contracted out to large medical scheme administrator organizations, which are for-profit organizations.

‘In 2007, there were 122 registered medical schemes compared to 240. Medial schemes in 1990, over the decade and a half, there have been substantial consolidation of schemes with the number of registered schemes declining by about a third since the early 90s.’(Mcintyre, 1995)

Out of pocket payments in South Africa are primarily paid to private providers, although a small share of out of pocket payments is attributable to user fees in public hospitals. Medical scheme members make considerable out of pocket payments, they are expected to make co-payments in certain services (e.g. some schemes expect their members to pay 20% of the medicines for acute illnesses cost of prescription), and also have to make co-payments for services not covered by their schemes, or when their annual benefits have been used. Non -scheme members who choose to use private providers (such as general practitioners, retail pharmacies and traditional healers) have to pay for these services on out of pocket basis.

According to Baldwin (1985) the health policy of a nation may affect people's health seeking behaviour. Policies like free income and health policy for the aged, pregnant women and children, and health insurance schemes are introduced by some governments to cushion the health seeking costs of the vulnerable in some societies. These policies, according to Bullough and Bullough (1990) are mostly targeted at the poor, children, the aged and sufferers of some particular diseases.

According to Yeboah (2006), buruli, tuberculosis and leprosy are examples of these ulcer diseases.

As a general rule, it is the elderly in society who have such large medical costs that, to Bullough and Bullongh (1990) can wipe out a whole life time's savings. Indeed these costs are calculated three times higher for persons older than 65 years than for young persons

Talking about age and financing health care, Glied (2008) suggests that as expected, health care rises with age for both men and women. And for both men and women there is a pronounce difference in health spending from ages 30 to about 55.After about age 55, spending patterns of the two groups (sexes) begin to converge, and in late life spending for the upper ages accelerates much more quickly than among the lower ages.

Gilied (2008) talked about income and health financing..According to him, in most publicly financed health care systems, including Canada, incomes of individuals is related to health expenditure at appoint in time, and to health status. Explaining further, Gilied (2008) said that at any given age, lower income people are usually in worse health than are higher income people. This leads them (lower income people) to use more health care services. Secondly, lower in most countries, income people and higher income people may use health care differently, even under universal free health care.

Furthermore lower income people are more likely to use hospital services than higher income, people, and in most countries they spend more days when hospitalized. Conversely, in most countries higher income people are more likely

to see any doctor, use specialist services, and tend to have more specialists visits than do lower income people. On the average higher income people use the health systems more intensively, and use more costly health services than lower income people. And Bhuttacharya, (2006) adds that the optimum design of health care system financing cannot be isolated from the rest of the components of the economy of the nation. Public funds used to finance health care cannot be used to finance other purposes. Thus, if national health care rises, either taxes must be increased or other taxes must be cut. This problem according to Bhuttacharya (2006) is the acute case of health care spending because the health sector grows more rapidly than any other element of government budget. Moreover the relatively modest progressive impact of spending on health raises the risk that rising health care spending is displacing more progressive cases or in-kind transfer programmes.

Since governments and some non governmental organizations all over the world are struggling to finance national health care programmes in the face of economic difficulties ,the necessity to strategize so that financing health care services would not be too high for both individuals and nations arises .One of such strategies is in a report by Seeley and Allison (2005) that the United Kingdom Department for International Development (D.F.I.D.) supports the government of Gujarat (India) in targeting populations at risk (including fisher folks)with access to condoms and sexual health services.

In addition numerous non-governmental organizations, often working in partnership with fisher folks and socio-professional organizations, are providing

prevention advice and livelihood support programmes in Zambia that trains men who are too ill to fish in less physically demanding tasks such as tailoring. And in Uganda the government supports fisher folks in HIV care and prevention, whilst in Congo the government has released community centres to be used as a means of raising awareness of HIV/AIDS and to challenge existing norms of behavior that make people vulnerable.

That has been why since independence, successive governments in Ghana have tried to find such a way of financing health care services that the cost burden would not be too high for each individual. Thus, free health care services were introduced soon after independence, but this was found to be unsustainable in view of the increasing population and dwindling health services.

Rhule (2006) named some of the policies introduced as free basic care for children under 5 years, and the introduction of the cash and carry systems as a cost recovery measure with a view of making the health sector sustainable. The system led to low patronage of health services since most Ghanaian's could not afford to pay their health bills.

Being anxious about the health needs of Ghanaians and being mindful of the linkage between health and productivity as well as economic growth, the Ghanaian government, according to Abdul-Rahman (2006) made an attempt at the provision of affordable basic health care services by introducing Health Insurance as an alternative and a sustainable health financing regime. The National Health Insurance Scheme was introduced in 2003 by Act of parliament with a view of improving the financing and access to health care by Ghanaian's especially among

the poor and vulnerable. Under the N.H.I.S. regime, the rich, the healthy and the economically active subsidize the cost of health care for the poor, the sick, children and the aged respectively.Similarly, Yeboah (2006) reports that in addition to the above, as part of its commitments to continuously provide free health care service to paupers, children under 5 years and the aged as well as those who suffer from disease such as buruli ulcer, tuberculosis and leprosy the government also subsidises the cost of anti-retroviral drugs under different packages.

Despite the introduction of the National Health Insurance scheme the fact still stands that hospital costs have raised very sharply. This might affect a person's decision to seek health, and at a particular health care providing centre. The unavailability of funds may compound the problem by the time the sufferer is “forced' to seek health. This might explain why Ogah (2004) opines that people in deprived communities do not seek health care early not necessarily because of ignorance but because they cannot afford it.

Similarly Pereko (2005) adds that health care accessibility and affordability issues are now very expensive. Even herbal preparations which were cheap in the past have added value, and cost much to administer. Another factor worth noting, with regards to the issue of affordability of health care is that at times those we think are poor and cannot afford the cost of a particular health care may be having the means, but health care may not be their priority. It may therefore not be right to conclude that people who do not seek health care early or chose a particular health care facility are poor.

Explaining the above Ametepey (2002) cites the Ghana statistical service (2000) as giving the evidence of poverty for coastal area of Ghana as 26.8% and 46.3% respectively for urban and rural coastal areas. He again asserts that that "fisher folk, generally the assumptions are that are poor, but it is because they are often found migrating, and owing to their desire for mobility, they would probably want to invest into property that they can easily carry along with them, or abandon without any economic loss. They would therefore rather invest in boasts, fishing nets and motors than they would in durable houses, hence using their mere physical appearance and living room quarters as a measure of standard of living can be misleading (Ametepey, 2000, p.8)

Self Medication

Self-medication is another factor, which can influence health-seeking behaviour. According to Quah (1984), self medication referrers to the practice of keeping and, or using medicines without a physician's prescription or advice. Self care involves people taking care of themselves at home. This may involve injuries and headaches which people think they could handle at home without complications.

Self medication may also involve people using over-the counter medicines or keeping left-overs of physician's prescription or advice according to Merki and Merki (1987), now thousands of Americans are taking people more active role in their self-care, and many communities now offer self-care education courses. People through these courses, leice.arn how to monitor their own vital signs and illnesses, find out when to see the doctor and organize the right type of questions to ask the doctor.

According to Barba T, Shaikh and Hatcher, J (2007) cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers, particularly in rural communities. For instance advice of the elder woman in the house is very instrumental in most communities and can therefore not be ig nored. These factors may result in delay in treatment seeking and are more common amongst women, not only for their own health but especially for their children's illnesses.

To Insert and Roth (2000) there are several skills necessary for effective medical self-care These include observation of your own symptoms, knowing when to seek professional advice, the ability to self-react when appropriate and being able to develop a partnership with your physician. The good news for people who do self-medication is that, it has some benefits. According to Payne and Hahn (2002) the benefits of self-medication are:

1. They lower health-care costs both to the state and the individual.

2. They can be effective for particular conditions e.g. Common colds, home injuries and insect bites since these can easily be managed with self-care.

3…They enhance interest in health activities.

Despite the above benefits of self-medication Stein and Makonze(2005) have cautioned people who self-medicate to be very careful, since some medicines sold in village stores are of no value .Werner (1985) also insists that people do not need to panic and do self-medication when they are sick but do not have money to seek health. He is of the view that even in cases of more serious illness; it is the body that must overcome the disease, the medicine, he says, only helps. According to him, cleanliness, rest and nutritious food are still very important.

He added that much of the health-care does not and should not depend on use of medications. "Even if you live in an area where there are no modern medicines there is a great deal you can do to prevent and treat most common sicknesses if you know how"(Doruness,1995,p.23).

As to why he thinks people should not resort to self-medication, Werner (1985) sums up that if people simply learn to use water correctly, that alone can do more to prevent and cure illnesses than all the medicines they now used and mis-use. Therefore, if everyone living on farms and villages made the best use of water, the number of deaths especially of children could probably cut to half. This is because the main cause of death in children is diarrhea (severe dehydration) and one only has to give the casualty plenty of water, sugar, honey and salt. It would therefore be quite useful if parents in particular, sick people and close relations of sufferers who have this basic information could apply them in their homes.

Summary

Scientific evidence shows that disease and death have always been part of human existence. Sickness can be physical, mental and even social, and may cause pain and sometimes death, and sometimes bring untold hardships to individuals and a whole family. This brings tremendous socio-economic problems on the lively hoods of fisher folks. Food security is threatened, as food provides one of the cheapest sources of animal protein to the poor. Such social and economic problems may affect health seeking behaviour .Socio-economic indicators and the nature of illness, are the most pervasive determinants of health

care seeking behavior. Other factors like age, sex and quality of health services provided are however, also very important.

Since individuals are responsible for their health, decisions taken by people to seek health are personal; however friends and family members may influence a person's health seeking decision.

Other factors like health related advertisements, availability, accessibility and affordability of health resources can also influence a person's health seeking behaviour.

Funding of health care in Africa is most often done by 'out of pocket payments' made by low income people like farmers, traders and fishermen who face unusual obstacles when it comes to obtaining health care. It is however worth noting that in Africa heath services are generally provided by the state with support from private and donor agencies. '

Researchers have long been interested in what facilitates the use of health services, and what influences people to behave differently in relation to health. These had to correct the world wide premise on health promotion programs that providing knowledge about causes of ill health and choices available will .go a long way towards promoting a change in individual behavior. It has therefore now been generally accepted that health seeking behaviours are not to be solely focused on the individual but should include the decision of people to engage with particular medical channels and the provision of health care by the state or private entities. The late twentieth century has seen the rapid growth of both legitimate medical uses and the illicit non-medical abuse of an increasing number of drugs.

Other factors which serve as barriers and determinants to health seeking behaviours fall under geographical, social, economic, cultural and organizational.

Since one's relations show concern when one is sick and may influence a sick person's health seeking behaviour, it is regrettable that studies tend to focus only on the sufferer of illness. With studies on the fisherman for instance, it is necessary that both the fisherman and the fishing mummy should be studied, since invariably they belong to the same household and the fishing mummy is the fisherman's wife who counsels him and generally takes care of him.

There is a growing literature on health seeking behaviours and the determinants of health services utilization especially in the context of developing countries. The available literature presents similar factors responsible for shaping up health seeking behaviour and health service utilization in developing countries. These factors may be seen in various contexts: physical, socio-economic, cultural and political. Therefore the utilization of a health care system, public or private, formal or non-formal, may depend on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination. Status of women, economic and political, systems, environmental conditions disease patterns and the heath care system itself are other factors which also come into play.

Policy makers all over the world are trying to study and understand the drivers of health seeking behaviour of populations in an increasingly pluralistic health care system.All these studies are aimed at strategic policy formation to help direct health seeking and utilization behaviour, particularly in developing countries.

CHAPTER THREE

METHODOLOGY

This chapter discusses the methodology that was used in carrying out the study. It also describes the processes the researcher went through to arrive at the instruments that were used for collecting data for the study. The chapter is divided into 5 sections. These are: research design, population, sampling procedure and sample size, instruments, data collection and data analysis.

Research Design

The study was a descriptive study which looked into how socio-economic background, occupation, availability and accessibility of health care, and other factors influence health seeking behavior. This was in agreement with the observation of Moser and Kalton (1990) that a descriptive survey studies social conditions, relationships and behavior, and is simply to provide information, and what questions can be clarified.

Population

The target population for the study was fisher folks in Prampram, a fishing town in the Greater Accra Region of Ghana. Prampram, according to internet sources has a population of 7,000 and is located on the south of the Atlantic Ocean, an hour east of Accra. Traditionally, majority of the people of Prampram earn a living through fishing and small-scale agriculture. The indigenous local people are Ga-Dangbes.

The fishery practiced by the people of Prampram is entirely operated individuals in canoes with, the fishermen converging after working together as a group and sharing the profits.

Fishing is the main occupation among males while fish trading is mainly done by women. However some men derive a livelihood out of taking their fish to urban markets as fish traders, which is mainly a female occupancy.

Transporting and owning a shop in the fishing camps are often sources of livelihood mentioned. For female fish traders, additional sources of income include taking groceries, other food items or plastic wares, perfumes and clothes to fishing communities to sell while waiting for their supplies of fish.

Approximately there are about 2000 fisher folks in Prampram, including women. The fisher folks in Prampram migrate to other fishing communities in Tema, Apam and Winneba. Some even go as far as to neighboring countries like Togo, Benin and Ivory Coast and stay away for weeks, months or even years.

When it comes to education, fisher folks are among the sub populations with lower levels, particularly among women within fishing communities.

The population consisted of 120 fisher folks. The fisher folks were made up of fishermen and their wives or close relations who all work in the fishing industry. Out of the 120 fisher folks, there were 104 men and 16 women.

Majority of the fisher folks (55) were between the ages of 31 and 40 years and constituted 46%. About 32 of them were between 41 and 50 years, constituting 27

%, whilst 19 of them, constituting 16 % were between 20 and 30 years. Whilst 10 of them, constituting 8% were between 51 and 60 years, only 4 of the fisher folks, constituting 2% were between 61 and 70 years.

Sample and Sampling Procedures

Prampram, a fishing town in the Dangme West District of the Greater Accra Region was purposefully selected for this study because the indigenes portray very serious and intensive fishing activity and it is a close knitted society.

The convenient cluster sampling technique was chosen for the study. This sampling technique, according to Moser and Kalton (1990) is a process of sampling complete groups and tends to lower field costs in investigation. Each of the 925 houses (Ghana Statistical Service 2002) from the beach in the fishing community of the town was enumerated, and houses which were marked on each fifth count were chosen for the study. In addition, the simple random sampling procedure was used in selecting the fisher folks. First the names of fishermen in the houses enumerated were written separately on pieces of papers and folded. The names of the close-relation of the fishermen picked e.g. wife, sister, brother etc.) were also written on papers, folded and picked. Thus 60 fisher folks and 60 close-relations were randomly picked.

The above sampling procedures were carried out to give a total of 120 respondents. These sampling procedures were chosen because of limitation of finance and time. This is in support of the opinion of Philips (1990) that the sampling methods mentioned above are designed to ensure that adequate attention is paid to obtaining the most relevant data on the problem being studied. Frankel

and Wallen (1990) also added that simple random sampling increases the likelihood of representativeness, especially if one's sample is not very large.

The study of fisher folks was based on the suggestion by Ametepey (2002) that with the study of fishermen, the fishing mummy in particular should be studied, since invariably they belong to the same household. It is the fisherman's wife who counsels him and generally takes care of him. Quah (2oo4) also supports the idea of studying fisher folks in general (instead of studying only fisherman) because mothers ,wives and grandmothers do take upon themselves the tasks of looking after the health of their family members in a manner that is both consistent and is expected in their families.

Instruments

The instrument used for the study was an interview guide. The interview guide was designed for the fisher folks to make it easier for them to express themselves in a face-to-face interaction with the researcher in the local language, Ga-Dangme. The interview guide contained seven (7) sections: A-G. Section A-B was concerned with the research question on the awareness level of the fisher folks of the health resources available them, and how accessible these resources are to the fisher folks in Prampram. A list of resources was provided for the respondents to tick which of them they are aware are available in Prampram, and which of these resources are accessible to them.

Section C was to answer the research question on the affordability of health resources to fisher folks in Prampram. A list of health resources were provided

for the respondents to tick the ones which are affordable to them (respondents) in terms of financial cost, transport cost and cost in terms of time spent at a particular resource.

Section D addressed the resource question on the health resource preference of fisher folks in Prampram. A list of health resources was provided for the respondents to tick which of them they prefer in terms of financial cost, status of the health resource, distance and time spent at the resource.

Section E addressed the research question on the factors which fisher folks in Prampram consider when seeking health.

Lists of factors were provided for the respondents to tick which of them they consider when they are seeking health.

Section F addressed the research question on whether fisher folks in Prampram are satisfied with the health resources available to them. Respondents were required to tick out of the list provided, which of them they are satisfied with.

The last section on the interview guide, section G, addressed the research question on how satisfied fisher folks in Prampram are with their health seeking endeavours. Respondents were to answer Yes or No whether they are satisfied or not with the statements provided.

Personal interview was preferred to other techniques in gathering data from the fisher folks because most of them are of low educational background.

The questions for the interview guides were in English, but were administered in the local language;- Ga Dangme, to enable the respondents expresses themselves as well as they could. Room was made, when necessary for further

information to be given by the respondents, and issues to be clarified when necessary. This was in agreement with Moser and Kalton (1990), that personal interviews are widely used in collecting data in social research since they are conversations between the researcher and the respondents with a purpose of eliciting certain information from the respondents and questions can be clarified. The instrument was prepared by the researcher and validity was tested by the supervisor of the study.

Pilot Study

A pilot study was conducted to find out how the respondents are likely to react to the questions, how long the survey is likely to take, the estimated cost for the survey and how meaningful the questions will be to the average respondents. Thus, a small scale replica of the main survey was carried out twenty (20) fisher folks at Tema New Town, a fishing community in Tema. The analysis of the results of the pilot study proved 90% reliable. The results proved that interview guide can be relied on for the main study.

Data Collection

Data was collected from 120 fisher folks personally by the researcher over a period of three months. Interview guides were used to get information from the fisher folks in a face to face interview.

Data Analysis

The data collected was analyzed in accordance with the assertion of Moser and Kalton (1990) that since all one is doing is describing the features of the survey aggregate, part of what is called analysis is a matter of working out statistical

distributions, constructing diagrams and calculating simple measures like , percentages and frequencies . Thus, the responses from the interview were separately tallied into meaningful data for analysis in accordance with Moser and Kalton (1990) that categories must be meaningful in relation to the data.

Thus, the data was grouped in seven (7) main areas according to the sub-hypothesis of the study. Frequency and percentage distributions of the responses were calculated with the Statistical Package for Social Science computer software, and the results were presented in tables for each of the specific objectives of the study.

Descriptive Statistics in the form of percentages and frequency distributions were applied in this section of the study. They were calculated to help in describing the fisher folks and computations were made in terms of gender, age and level of education. The fisher folks were 120.Out of these 104 were men and 16 were women.

CHAPTER FOUR

RESULTS AND DISCUSSION

Results of the study are presented in this chapter. There are also discussions of findings based on objectives of the study.

Research Question 1

What is the awareness level of fisher folks in Prampram of the health resources available to them?

Table 1: Awareness level of availability of health resources to Fisher Folks in Prampram

Health Resource	Yes	%	No	%	Total	%
Community Health Centre	119	99	1	1	120	100
Traditional Birth Attendance	119	99	1	1	120	100
Nurses	118	98	2	2	120	100
Herbalists	118	98	2	2	120	100
Drug Stores	117	98	3	2	120	100
Spiritualists	116	97	4	3	120	100
Clinics	116	97	4	3	120	100
Maternity and Child Care	116	97	4	3	120	100
Counselors	113	96	7	4	120	100
Doctors	113	96	7	4	120	100
Nutritionists	79	55	41	45	120	100
Pharmacists	79	55	41	45	120	100
Hospitals	24	20	96	80	120	100
Physical Fitness Centre	24	20	96	80	120	100

Table 1 reveals that 99% of the fisher folks are aware of the availability of health resources in terms of Traditional Birth Attendants and Community Health Centres further more 98% of them acknowledge the availability of Nurses and Herbalists.

Apart from Physical Fitness Centres (20%) and Hospitals (20%) responses for all the other resources were above 50%. of the resources listed. Bedworth and

Bedworth (1982), opined that these days although governments the world over have been trying to provide adequate health care systems for their citizens, wide gaps still remain; but Sekri (2005) summed up the issue of availability of health resources in Africa that at the heart of Africa's health crises is a circle of the most vicious variety, perpetuating low supply of good quality care and low demand for such care, trapped within it are the poor. It is also worth noting that one of the respondents remarked that 'as for awareness of the health resources, we are so much aware of them that times, we even take a very long time to decide which ones to patronize'.

Research Question 2 How Accessible are Health Resources to Fisher Folks in Prampram

The Second Research Question sought to find out how accessible health resources are to fisher folks in Prampram in terms of language, finance, opening days and times, and distance.

Table 2: Accessibility of Health Resources to Fisher Folks in Prampram

Health resources	Yes	%	No	%	Total	%
Community Health Centre	117	97	3	3	120	100
Nurses	116	97	4	3	120	100
Maternity and Child	116	97	4	3	120	100
Herbalists	113	96	7	4	120	100
Traditional Birth Attendants	110	92	10	8	120	100
Spiritualists	110	92	10	87	120	100
Drug Stores	100	83	20	17	120	100
Clinics	100	83	20	17	120	100
Doctors	100	20	20	17	120	100
Clinics	100	83	20	17	120	100
Counselors	100	83	20	17	120	100
Pharmacists	76	63	44	37	120	100
Nutritionists	57	47	63	53	120	100
Hospitals	24	20	86	80	120	100

Table 2 explains how accessible health resources are to fisher folks in Prampram. According to the table, Community Health Nurses (97%), Nurses (98%) and Maternity and Child Care Centres (97%) are accessible to the respondents. The table further shows that distance does not necessarily hinder access to health resources to fisher folks in Prampram. Contrary to these Green and Ottoson (1999) still insist that adequate total supply of health resources does not guarantee

accessibility, since other barriers like money, education, geography or language still keep many people from health resources. More than 50% of the respondents say that they have access to Counselors, Clinics and Traditional Birth Attendants It is only hospitals (20%) which scored below 50%. In fact the accessibility level of majority of the health resources were above 60%. Therefore from the table it can be can inferred that health resources are accessible to fisher folks in Prampram. With accessibility to the community health centre in terms of distance, for instance, majority of the respondents said that 'we just walk there'. This might be because the centre is in the middle of the town, not far from most houses.

Research Question 3 How Affordable Are Health Resources To Fisher Folks In Prampram?

The third Research Question sought to find out how affordable health resources are to fisher folks in Prampram in terms of financial costs, transport and time spent at the resource.

Table 3: Affordability of Health Resources to Fisher folks in Prampram

Health Resources	Affordability in Terms Financial Cost				Affordability in Terms of Transport				Affordability in Terms of Time Spent at the Resource				Total	
	Yes	%	No	%	Yes	%	No	%	Yes	%	No	%	No.	%
Doctors	76	63	44	37	90	75	30	25	104	87	16	13	120	100
Nurses	105	87	15	13	115	95	5	5	116	96	4	4	120	100
Herbalist	117	97	3	3	111	92	9	8	110	9	10	8	120	100
Spiritualist	100	83	20	17	99	82	21	18	99	81	21	19	120	100
Pharmacist	67	55	53	45	79	65	41	35	84	70	36	30	120	100
Counsellors	94	77	26	23	88	72	32	23	91	75	29	25	120	100
Physical Fitness Centres	24	20	96	80	13	10	107	90	18	15	102	85	120	100
Nutritionist	63	52	57	48	66	44	54	45	75	53	45	37	120	100
Hospitals	40	33	80	67	38	32	82	68	42	35	78	67	120	100

Table 3 continued

Clinics	93	72	27	23	103	86	17	14	106	88	14	12	120	100
Maternity and Child Welfare Centres	110	91	10	9	118	99	2	1	120	100	0	0	120	100
Community Health Centres	112	95	8	5	118	99	2	1	120	100	0	0	120	100
Traditional Birth Attendants	109	91	11	9	110	92	10	8	110	92	10	8	120	100
Drug Stores	109	91	11	9	113	94	7	6	119	99	1	1	120	100

Table describes how affordable health resources are to fisher folks in Prampram. The description was made in accordance with the opinion of Philips (1990) that prominence among factors which delay or prevent health care utilization is the existence of recognized need to use the facility, closely followed by the financial ability to use it (owing to charges in transport costs and the likes) The table shows that responses for clinics (7%), physical fitness centres(20%) and hospitals (20%)are the only ones that are below 50% for affordability in terms of financial costs. With affordability in terms of transport costs, physical fitness centre 10%, hospital 10% and nutritionists 44% were the only resources which score below 50%.Likewise, with affordability in terms of time spent at the resource, hospitals (15%), physical fitness centres (15%) and herbalists (44%) scored below 50%.

Affordability for majority of the health resources listed are generally very high as shown from the table. This might partly be due to the concern by one of the respondents that, '.when I am sick I have no option than to find time and money to seek health'.

The level of affordability of health resources to fisher folks in Prampram being very high confirms the assertion of Ametepey (2002) that although the assumption is that fisher men are poor, it is because they are often found migrating and owing to their desire for mobility they would probably want to invest in property which they can easily carry along with them so that they can abandon without economic loss.

This also supports the concern of Sekri et al (2005) that since it is difficult for public systems in Africa to deliver health resources, people have no options but to pay for health care. They added that 60% of health care in Africa is financed this way, and this is the most expensive, least effective and least inclusive financing channel. It weighs heavily on households and forces many into a poverty trap. This type of health care financing is seen as an unpredictable catastrophic health expenditure.

Research Question 4

: **Which Health Resource Do Fisher Folks In Prampram Prefer?**

Table 4 shows the preferences of fisher folks in Prampram in terms of health resources.

The preferences were looked at in terms of financial costs, costs in terms of transport and time spent at the health resource.

Table 4: Preference of Health Resources of Fisher Folks in Prampram

Health Resources	Yes	%	No	%	Total	%
Community Health Centre	122	93	8	7	120	100
Maternity and Child Health Centre	105	93	5	7	120	100
Nurses	112	87	18	13	120	100
Herbalists	103	86	17	14	120	100
Clinics	93	82	27	18	120	100
Traditional Birth Attendants	98	82	22	18	120	100
Hospitals	24	20	96	80	120	100
Spiritualists	75	63	45	37	120	100
Counselors	72	61	48	39	120	100
Doctors	65	56	55	44	120	100
Nutritionists	62	52	58	48	120	100
Pharmacists	47	39	73	61	120	100
Physical Fitness Centre	24	20	96	80	120	100

The responses from the fisher folks indicate that with the exception of physical fitness centres 20%, pharmacists 39% and hospitals 20% more than 50% of the respondents patronize all the resources listed. The ranking of preferences are however community health centres 93%,, Nurses 87%, herbalists 86%, , clinics 82% and the Traditional Birth Attendants 82%..

This supports the view of Ahmed et al (2003) that the view is often that the desire health care seeking behaviour is for an individual to respond to an illness episode by first and foremost seeking help from an allopathic doctor, in a formally recognized health care setting, yet a consistent finding in many studies is that for many illnesses people will chose traditional healers, village homeopaths, or

untrained homeopaths above formerly trained practitioners or government facilities.

Research Question 5 What Factactors Do Fisher Folks In **Prampram Consider When they Seek Health?** :

The fifth Research Question is to find out the factors which fisher folks in Prampram consider when they seek health.

TABLE 5 : Factors considered by Fisher Folks when they are seeking Health.

Factors	Yes	%	No.	%	Total	%
Attitude Health Personnel	103	86	17	14	120	100
Gender of the Health	90	76	30	24	120	100
Financial Costs Involved	87	76	33	24	120	100
Opening Times	84	71	36	29	120	100
Status of the Health Centre	84	71	36	29	120	100
Opening Days	81	67	39	33	120	100
Times Spent at the Resource	77	64	43	36	120	100
Religion o the Health Centre	66	55	54	45	120	100
Nature o the Buildings	60	50	60	50	120	100

Table 5 indicates that 86% of fisher folks in Prampram consider the attitude of health personnel when seeking health. Consideration of the gender of the health personnel 76% and the financial costs involved when seeking health 76% followed. However 76% of the fisher folks responded that they consider the total

cost involved when seeking health, whilst 55% consider the religion of the health resource. These support the opinion of Bullough and Bullough (1990) that there are many reasons why people decide to or not to seek health at particular health centres.

Results from the table show that fisher folks in Prampram consider some factors when seeking health ,with factors like attitude of health personnel and the gender of health personnel ranking very high.

Research Question 6 . How Satisfied Are Fisher Folks.In Prampram with the health facilities available to them?

The sixth Research Question seeks to find out how satisfied fisher folks in Prampram are with the health resources available to them. This is presented in table 6.

Table 6: Satisfaction of Fisher Folks in Prampram with Health Resources Available

The Health Resources	Yes	%	No	%	Total	%
Satisfaction with the location of the resources	107	89	13	11	120	100
Satisfaction with opening days	102	85	18	15	120	100
Satisfaction with the number of facilities	85	71	35	29	120	100
Satisfaction with opening times	85	71	35	29	120	100
Satisfaction with drugs and prescription	81	68	39	32	120	100
Satisfaction with the number of health personnel	64	54	56	46	120	100
Satisfaction with the total cost involved in seeking health	51	49	69	51	120	100
Satisfaction with the quantity of health personnel	43	36	77	64	120	100

According to table 6 89% of the fisher folks are satisfied with the location of health facilities in Prampram whilst 85% are satisfied with the opening days. The responses further show that only 49% are satisfied with the total cost involved in seeking health. This supports the opinion of Bedworh and Bedworth (1982) that although governments the world over are making efforts to provide satisfactory health facilities for their citizens, wide gaps still exist.

Research Question 7 How Satisfied Are Fisher folks in Prampram with their Health Seeking Endeavours?

The last Research Question seeks to find out how satisfied fisher folks in Prampram are with their general health seeking endeavours. The results are presented in table 7.

Table 7: The satisfaction of fisher folks in Prampram with their health seeking endeavours

Satisfaction	Yes (%)	No (%)	Total (%)
Willingness to visit the same health centre	117 (98)	3 (2)	120 (100)
Recommends a health centre to others	119 (99)	1(1)	120 (100)
Recovers after seeking health	114 (95)	6(5)	120 (100)
Does not feel he has wasted his time after seeking health	80 (73)	12 (27)	120 (100)

According to table 7, 98% of the fisher folks visit the same health centre the next time they seek health. Furthermore 99% recommend health centres they visit to other people, whilst 73% say they do not feel they have wasted their time after seeking health. The general satisfaction sums up the belief of Bruce and Senior (1990) that even in cases of every serious illness, it is the body that must over come the disease, the medicine he says, only helps, so people do not have to panic when they are sick or do not have money to seek health.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The summary of findings, conclusions and recommendations of the study are presented in this chapter.

The study was done in Prampram in the Dangme West District of the Greater Accra Region. The target population was fisher folks in Prampram. The sample size was 120 fisher folks. An interview guide was designed to gather data from the fisher folks.

The interview guide was pre-tested at Tema New Town, a Fishing town in the Tema District in the Greater Accra Region over a two week period. Data was subsequently collected over a three month period and analyzed with the Computer Software, Statistical Package for Social Science (SPSS).

Availability of Health Resources to Fisher folks in Prampram

On the question whether health resources are available to fisher folks in Prampram, out of the 120 respondents 89 (74%) of them responded "yes". The 89 respondents who said "yes" were made up of 14 females and 65 males. The results indicate that there are more men fisher folks women. On the availability of Nurses, 118 (98%) of the fisher folks answered "yes".

The study also identified that a very high percentage of the respondents are aware of the availability of the health resources listed for them. For instance 119 (99%) of the fisher folks answered "yes" for Maternity and Child Health Care Centre and Traditional Healers, and 100% of the health workers responded 'yes" for Community Health Centre. .

The general agreement therefore was that fisher folks in Prampram are aware of the health resources that are available to them.

Accessibility of Health Resources

With regards to the accessibility of health resources to fisher folks, the study found out that generally the respondents agreed that they have access to health resources. For instance, general access to Doctors was 55%. The break down is 83% in terms of language, 58% in terms of financial cost, 48% in terms of personnel, 68% in terms of opening days and in times and 27% in terms of distance.

The study also identified that access to herbalist was on a very high side. General access to herbalist was 94% whilst general access to spiritualists was 92%.

Since there is no hospital in Prampram, general access to hospital was very low, 24%, but that of clinics on the other hand was 91%. Access to clinics in terms of language was 83%, in terms financial costs was 83%, in terms of personnel was 72%, in terms of opening days and times was 89% and in terns distance was 96%.

Affordability of Health Resources

The study found out that 75% of the fisher folks agreed that generally health resources are affordable to fisher folks.

From the study, the health resources which respondents said are highly affordable are Nurses (94%); the nurses, the breakdown is: – affordability in terms of financial cost, 88%, transport cost 96%, and transport to the resource

97%; and for Maternity and Child Health Centre affordability in terms of financial cost is 95%, in terms of transport is 99% and in terms of time spent at the resource is 100%.

Furthermore, general affordability of Traditional Birth Attendants was 92% for fisher folks, 92% for health workers and clinics respectively, 85% for folks and 60% for health workers.

Factors Considered by Fisher folks when Seeking Health

The findings further indicated that more than 50% of the fisher folks consider some factors when they are seeking health. The factor which scored the highest percentage with the responses from the fishermen was "attitude of the health personnel" (87%),Gender of the health personnel" was the next factor which the fisher folks consider, followed by "attitude of the health personnel" (87%), opening times (71%), statues of the centre(68%), time spent at the resource and opening days (64%) respectively, and the religion attached to the health centre, 55% followed in that order.

Preference of Health Resources

Respondents had a high agreement that there are some health resources they prefer to others when they are seeking health. The general agreement that fisher folks have preferences when it comes to health resources was 72% for fisher folks and 71% for health workers. According to the study, the health resources which are most preferred by the fisher folks are Nurses(93%) and Maternity and Child Health (66%0, Drug Stores (90%0 and Herbalist (88%) , Preference for Clinics 96%) and Doctors (91%) were also high.

Preference for Nurses in terms of financial cost was 65%, in terms of transport cost was 72%, and in terms time spent at the resource was 64%; whilst preference for Doctors in terms of financial cost was 76%, in terms of time spent at the resource was 64%.

Satisfaction of Fisher Folks with Health Resources Available to Them

Respondents highly agreed that they are satisfied with the health resources available to them. Satisfaction with the location of health facilities 89%, satisfaction with Opening Days and times 85%, satisfaction with the numbers of health facilities 71% and satisfaction with time spent at the facilities 70% were some of the responses from the fisher folks.

Satisfaction with Health Seeking Endeavour

The results indicated that 99% of the fisher folks recommend the health facilities they visited earlier to other people. This shows that they appreciate the service rendered to them at the said centre. Fisher folks 96% of the respondents said they are willing to re-visit the centre where they last sought health while 96% claim they recover after seeking health.

To sum it up, 73% feel they do not waste their money and time when they seek health at the health resource available to them. The general aggregate of general satisfaction of health seeking among the respondent is 82%.

Conclusions

Based on the findings the following conclusions are drawn.

1. With respect to the availability of health resources to fisher folks in Prampram. Since majority of the respondents highly agree that they are aware of the availability of health resource which are available to them, it could be concluded that health resources are available to fisher folks in Prampram. The availability might be the fact that the ever growing population all over the world has compelled government to provide adequate health resources.
2. The study indicated that accessibility of health resources may depend on some factors like language, financial cost, personnel opening days and times and distance. The study further revealed that majority of the respondents has access to health resources in terms of the factors mentioned above. Based on this, it could be concluded that health resource are accessible to fisher folks in Prampram. This might account for why Phillips (1980) concluded that physical accesses to health resources are better for most urban areas than for rural areas.
3. Affordability is factor which greatly influences health seeking behavior. According to the study majority of the respondents can afford health resources in terms of financial costs, transport and time spent at the resource. Based on this it could be concluded that fisher folks in Prampram can afford health resources. This justifies the opinion of Phillips (1990) that health cost is normally financed by the sufferer, and

that those we think are poor and cannot afford health care may be having the money but health care might not be their priority.

4. More than 50% of the respondents stated their preference for some health resources. From the results of the study, since majority the respondents have preference for some health resources in terms of financial cost, transport and time spent at the resource, it could be concluded that fisher folks in Prampram have preference for some health resources like Nurses (87%) Clinics, (82%) and Maternity and Child Health Centre (93%).
5. Factors which fisher folks in Prampram consider when seeking health, according to the study are: attitude of health personnel, (87%), Gender of the health personnel (76%), Financial cost (73%), Opening times (67%), Status of the health centre (71%) Time spent at the resource (64%), Opening Days (64%), Religion of the Centre (55%), Nature of buildings (50%).
6. The findings indicate that more that 50% of the respondents agree that they are satisfied with the health facilities available to them. For instance satisfaction with location of the facilities (89%), satisfaction with opening days (85%) and satisfaction with the number of facilities 71% are those which rank very high. Based on these it could be concluded that fisher folks and Prampram and satisfied with the health facilities available to them.

7. Since above 80% of the respondents agree that they are satisfied with their health seeking endeavours, it could be concluded that fisher folks in Prampram are generally satisfied with their health seeking endeavours.

Recommendations

With regards to the findings, discussions and conclusions, the following recommendations are made:

1. Since it is generally agreed that health resources are centralized in the cities particularly in developing countries, governments, Non Governmental Organizations and other health providing agencies should consider providing more health resources to deprived communities.
2. Since accessibility of health care can be influenced by some factors, health care providers should consider such factors like distance, language and costs in terms of finance and time, when it comes to the provision of health resources, particularly to deprived communities.
3. Since it has been established that affordability of health resources in terms of financial cost is one of the major factors which often hinder health seeking, particularly among the poor, people living in the deprived communities should be encouraged to register with Health Insurance Scheme.
4. Health personnel should be called upon to be very professional when it comes to health care delivery, so that, some of them do not scare away prospective health seekers.

5. There should be a gender balance of health deliveries so that people who see the gender of health personnel as barrier to their seeking would have a large pool of health personnel to choose from.
6. There is the need for diversifying health delivery, and the encouragement of some local health providers like Herbalist, Traditional Birth Attendant and Spiritualist to augment existing official health providing centres.
    a. Religious groups like Muslims and Christians should consider providing health facilities for their members so that the religion attached to a health centre should not be a barrier to health seeking at such health seeking centres.

Suggested Areas for Further Study

1. Since time, financial and other resources did not permit the researcher to conduct this study over a wider geographical area, it is recommended that further studies should be carried out in other towns or in one short national study on health seeking behavior among fisher folks.
2. A comparative study be carried out to find out health seeking behavior in other groups like farmers, teachers and traders.
3. A similarly study should be carried out focusing on health care delivery particularly in poverty stricken communities in Ghana.

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APPENDICES

APPENDIX A

UNIVERSITY OF CAPE COAST

INTERVIEW GUIDE FOR FISHER FOLKS ON FACTORS WHICH INFLUENCE HEALTH SEEKJNG BEHAVIOURS AMONG FISER FOLKS IN PRAMPRAM

Section A

Sex [ ]

Age [ ]

Level of Education [ ]

A. Awareness of health resource available to fisher folks in Prampram

Please answer Yes or No which of these health resources you are aware are available in Prampram.

No.	Human/ Health Resources	Tick ( )
1	Medical doctors	
2	Nurses	

3	Hospitals	
4	Spiritualists	
5	Counselors	
6	Pharmacists	
7	Physical Fitness Centres	
8	Nutritionists	
9	Traditional Birth Attendants	
10	Maternity and Child Care Centre	
11	Hospitals	
12	Clinics	
13	Community Health	
14	Herbalists	
15	Community Health Centres	
16	**Dr**ug stores	

B. Health Resources are Accessible to Fisher Folks in Prampram

Please tick (√) which of the following resources are accessible to you

No.	Human/ Health Resources	Yes	No
1	Doctors		
2	Nurses		
3	Herbalists		
4	Spiritualists		
5	Counselors		
6	Pharmacies		
7	Physical Fitness Centres		
8	Nutritionists		
9	Clinics		
10	Maternity and Clinic Health Care Centres		
11	Community Health		
12	Traditional Birth Attendants		
13	Drug Stores		

C. Health Resources are Affordable to Fisher Folks in Prampram

Please tick (√) which of the following resources are accessible to you

No.	Human/ Health Resources	Yes	No
1	Doctors		
2	Nurses		
3	Herbalists		
4	Spiritualists		
5	Counselors		
6	Pharmacies		
7	Physical Fitness Centres		
8	Nutritionists		
9	Clinics		
10	Maternity and Clinic Health Care Centres		
11	Community Health		
12	Traditional Birth Attendants		
13	Drug Stores		

C. Health Resources are Affordable to Fisher Folks in Prampram

Please tick (√) which of the following resources are accessible to you

No.	Human/ Health Resources	Yes	No
1	Doctors		
2	Nurses		
3	Herbalists		
4	Spiritualists		
5	Counselors		
6	Pharmacists		
7	Physical Fitness Centres		
8	Nutritionists		
9	Clinics		
10	Maternity and Health Care		
11	Community Health		
12	Traditional Birth Attendants		
13	Drug Stores		

D. Health Resources are Affordable to Fisher Folks in Prampram

a. (In terms of Transports)

Please tick (√) which of the following resources are accessible to you

No.	Human/ Health Resources	Yes	No
1	Doctors		
2	Nurses		
3	Herbalists		
4	Spiritualists		
5	Counselors		
6	Pharmacists		
7	Physical Fitness Centres		
8	Nutritionists		
9	Clinics		
10	Maternity and Clinic Care Centres		
11	Community Health Centres		
12	Traditional Birth Attendants		
13	Drug Stores		

D. Health Resources are Affordable to Fisher Folks in Prampram

b (In terms of Financial Cost)

Please tick (√) which of the following resources are accessible to you

No.	Human / Health Resources	Yes	No
1	Doctors		
2	Nurses		
3	Herbalists		
4	Spiritualists		
5	Counselors		
6	Pharmacies		
7	Physical Fitness Centres		
8	Nutritionists		
9	Clinics		
10	Maternity and Clinic Health Care Centres		
11	Community Health		
12	Traditional Birth Attendants		
13	Drug Stores		

D. Health Resources are Affordable to Fisher Folks in Prampram

c. (In terms of Time Spent)

Please tick (√) which of the following resources are accessible to you

No.	Human/ Health Resources	Yes	No
1	Doctors		
2	Nurses		
3	Herbalists		
4	Spiritualists		
5	Counselors		
6	Pharmacies		
7	Physical Fitness Centres		
8	Nutritionists		
9	Clinics		
10	Maternity and Clinic Health Care Centres		
11	Community Health		
12	Traditional Birth Attendants		
13	Drug Stores		

E. **Health Resources Preferences of Fisher Folks in Prampram**

Please tick (√) which of the following resources are accessible to you

No.	Human/ Health Resources	Yes	No
1	Doctors		
2	Nurses		
3	Herbalists		
4	Spiritualists		
5	Counselors		
6	Pharmacies		
7	Physical Fitness Centres		
8	Nutritionist		
9	Clinics		
10	Maternity and Clinic Health Care Centres		
11	Community Health		
12	Traditional Birth Attendants		
13	Drug Stores		

Please tick (√) for the respondent response the factors which fisher folks in Prampram consider when seeking health.

1. Religion attached to the health centre [ ]
2. Gender of the health personnel [ ]
3. Attitude of the health personnel towards patients [ ]
4. General status of the health centre [ ]
5. Structures at the health facility [ ]
6. Total costs involved in terms of money, transport and time spent at the facility [ ]

F. Fisher Folks in Prampram are Satisfied with Health Facilities available to them

Please tick (√) whether or not fisher folks in Prampram are satisfied with the health facilities available to them in terms of following;

1. The number of health facilities available [ ]
2. Where the health facilities are located [ ]
3. Availability of health personnel [ ]
4. Quality of health personnel [ ]
5. Availability of drugs and prescriptions [ ]
6. Quality of equipment at the health centres [ ]
7. Opening days [ ]
8. Opening times [ ]
9. Total costs involved in seeking health [ ]

G. **Satisfaction of Fisher Folks in Prampram with their Health Seeking Endeavours**

Please tick (√) Yes or No on the satisfaction of fisher folk's health seeking endeavours in Prampram

	Satisfaction :	Yes	No
1	Revisit the same health centre next time you seek health		
2	Recommended the health centre where you seek health to other people		
3	Recover early when you seek health		
4	Feel you have wasted time and money after seeking health		