

**FACTORS AFFECTING HEALTH SEEKING BEHAVIOR AMONG  
COMMUNITY MEMBERS IN WARD III, ISHAKA  
BUSHENYI MUNICIPALITY SOUTH  
WESTERN UGANDA**

**A RESEARCH REPORT SUBMITTED TO UGANDA NURSES AND MIDWIVES  
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**BY**

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## **ABSTRACT**

In Uganda, health seeking behavior among community members is still at a small extend especially in rural areas. This is attributed to a number of unknown influencing factors. In ward III, Ishaka-Bushenyi municipality, most of the children are dying of malaria, malnutrition, measles, and opportunistic infections like diarrhea due to a high preference of home treatment and a tendency of using traditional medicine instead of seeking for health services.

In order to determine factors affecting health seeking behavior, this study was carried out with the objective to determine the factors affecting the community members' decision in seeking for health services mainly focusing on socio-demographic factors and health system related factors affecting health seeking behavior.

Through a cross sectional descriptive study design employing qualitative approach and using a randomized simple sampling technique, a total of 192 participants were recruited.

The study found out that individuals' age, education level, sex and occupation had a great impact on one's health seeking behavior. Also a long distance from the facility, expensive medical services, inadequate staffing and rudeness of health workers were contributing factors affecting health seeking behavior among individuals.

It is recommended that health units should be extended nearer to the community members, government should increase the staffing and motivation of staffs, public sensitization through radios, television and other communication medias on early seeking behaviors as well as women empowerment on health policies.

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**AUTHORISATION PAGE.**

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**DECLARATION.**

I ATHOLERE EDWIN , to the best of my knowledge hereby declare that this is my own work and has not been submitted and will not be presented to any other nursing school for a similar or any other award

Signature.....

Date.....

ATHOLERE EDWIN

AUTHOR/ RESEARCHER

**APPROVAL.**

I hereby affirm that this research report entitled “factors affecting health seeking behavior among community members of ward III, Ishaka-Bushenyi municipality, Bushenyi district” has been produced under my supervision and submitted with my approval for partial fulfillment of requirement of diploma in nursing sciences of Kampala International University

Signature.....

Date.....

MR NAMARA GORDON

[Supervisor]

Sign.....

Date.....

Name.....

Dean school of nursing, Kampala International University

**DEDICATION.**

I dedicate this work to my parents MR and MRS ASIIMWE JOHNSON, all my relatives, friends and to all my class mates in their struggle to see me through this course.

## **ACKNOWLEDGEMENT.**

My gratitude goes to the Almighty God who granted me with knowledge, wisdom and understanding throughout my course of study and for his steady love and blessings through the challenges I encountered during the study period.

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## **ACRONYMS**

AIDS: Acquired Immune Deficiency Syndrome

HIV: Human Immune deficiency virus.

AVERT: AIDS Education and Research Trust

CDC: Centre for Disease Control

DDP: District Development Plan

KIU: Kampala International University

KIU-SON: Kampala International University School of Nursing

KNBS: Kenya National Bureau of Statistics

TB: Tuberculosis

TBAs: Traditional Birth Attendants

W H O: World Health Organization

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## **OPERATIONAL DEFINITIONS**

**Health;** is the state of complete, physical, mental and social wellbeing of an individual and not merely absence of disease or infirmity

**Seeking;** Means endeavoring to obtain or reach for services at a health facility

**Behavior;** is a response of an individual or group to an action, environment, persons or stimulus

**Community;** A group of people living in the same locality and under same governance

**Members;** People who are part of a particular society or community

**Services;** is the act of helpful activity

## **CHAPTER ONE: INTRODUCTION**

### **1.0 Introduction**

This chapter introduces the background, problem, statement, objectives of the study, research questions and justification of the study.

### **1.1 Background**

Globally it is estimated that 287000 maternal deaths occurred in 2010, of which 85% occurred in sub-Saharan Africa (Asibong; et al., 2014) the Uganda maternal mortality rate (MMR) stands at 210/100000 live births (Ogwang; et al., 2009) it clearly shows a big gap between these two mortalities an indicator that there is a gap in care mothers receive in Uganda.

Developing countries have had challenges in accessing universal primary health care and the provision of essential medicine (Chudi I P, 2010) These countries have major resource challenges with large patient to health service provider ratio despite accounting for a significant global burden of disease (WHO, 2012) As at the end of 2009 there was an estimated 22.5 million people living with HIV in sub-Saharan Africa including 2.3million children (AVERT, 2012). During the same year an estimated 1.3million Africans died of AIDS-related illnesses with almost 90% of the 16.6million children orphaned by AIDS living in sub-saharan Africa. At the end of 2009, there was an estimated 1.5million and 1.2million people living with HIV in Kenya and Uganda respectively.



All there has been a major effort to scale up access to HIV treatment, a significant number of people living with HIV who are eligible for HIV treatment still lack a positive health seeking behavior or attitude (A R et al., 2010)

Recent estimates of the total population of Kenya put it at a total population of 39.4million (KNBS 2009) and infectious diseases that can be easily managed and controlled continue to be a problem in the country responsible for a significant level of morbidity and mortality.

National statistics showed that 106,438 people suffered from new and relapse cases of tuberculosis with 24435 recorded deaths in 2007 and this is attributed to reluctance of patients towards collecting their drugs from the nearby health units (WHO, 2009).

Uganda which shares its eastern border with Kenya has a population of 43.2million people (WHO, 2012). Of which there were 28686 recorded deaths as a result of tuberculosis while in 2009 about 40909 of new and relapse cases were reported.

The number one cause of death in developing countries was lower respiratory infections that would be managed through early health care seeking (WHO, 2012).

In Bushenyi district south western Uganda, the involvement of men in health issues is low as evidenced by the proportion of males involved in health interventions that require community participation. This may partly be attributed to an attitudinal problem in part of men.

Since men are the major source of money required while seeking for health, their not being positive towards health matters undermines the women and children's health (DDP, 2008).

## **1.2 Problem statement**

In Uganda the health seeking behavior among community members is still at a small extent especially in rural areas compared to urban areas. This is to some extent attributed to use of traditional medicines by community members thus do not go to hospitals to seek health care and eventually report with complications. This is basically due to poor perception of community members towards professional health care services thus a low extend of seeking health care (2008).

In ward III (Ishaka-Bushenyi municipality) most of the children are dying of malaria, malnutrition, measles, and other opportunistic infections like diarrhea following a high preference of home treatment and a tendency of using traditional medicine instead of seeking for health services. There is attendance of visiting health centers, private clinics, and hospitals only after home treatment has failed thus this puts lives of many people at risk (MOH, 2008).

This therefore prompted the researcher to carry out the study to establish the factors contributing to continued poor health seeking behavior so that the findings and results can be used by the leadership of ishaka-bushenyi municipality, Bushenyi District and other development partners to come up with appropriate intervention to reduce or minimize the risks that come with it.

### **1.3 Purpose of the study**

To determine the factors affecting the community members' decision to seek for health services in Ward III, Ishaka-Bushenyi Municipality, Bushenyi District.

### **1.4 Specific objectives**

1. To identify the socio-demographic factors influencing the health seeking behavior among community members in ward III in Ishaka-Bushenyi Municipality.
2. To establish health system related factors that affect health seeking behavior among community members in ward III in Ishaka-Bushenyi municipality.

### **1.5 Research questions.**

1. What are the socio-demographic factors that influence the health seeking behavior among community members in ward III in Ishaka-Bushenyi Municipality?
2. What are the health system related factors that affect health seeking behavior among community members in ward III in Ishaka-Bushenyi Municipality?

### **1.6 Justification.**

#### **1.6.1 Nursing practice**

The findings of this study are expected to help nurses learn and identify better approaches to encourage community members to seek proper health care and be able to appreciate the weaknesses and strengths in delivery of health care services and consequently strengthen the weak areas and deliver quality health care services.

### **1.6.2 Nursing education**

The finding of the study may help tutors and curriculum designers in nursing to come up with new approaches that can strengthen early health care seeking behaviours and for study purposes as in providing knowledge and skills to related studies.

### **1.6.3 Nursing Research**

This research is expected to provide information that may create new knowledge for studies in related phenomena as part of literature review aimed at improving health seeking behavior of community and health care services provided to them. Similarly the recommendations may serve as a basis for future research.

### **1.6.4 Nursing Management.**

The research finding can be used by school administrators and relevant authorities to devise solutions towards provision of necessary equipment and staffs to carry health care services that may otherwise improve on community members' health seeking behavior.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.0 Introduction.**

This chapter introduces an overview of various studies done on factors that affect health seeking behavior of community members. This review has been guided by the following heading;

#### **1. Socio-demographic factors,**

#### **2. Health facility related factors.**

### **2.1 SOCIO-DEMOGRAPHIC FACTORS AFFECTING HEALTH SEEKING BEHAVIOR.**

#### **2.1.1 Gender.**

Gender has been used interchangeably with 'sex'. 'Gender' is a social construct that refers not only to the biological 'sex' differences between men and women, but to the different roles and expectations, behaviors and constraints that are placed upon an individual by culture and society, by virtue of their sex. (Vlassof, 2012) Until the last two to three decades, little attention had been paid to women's health as it was assumed that the male biological model could simply be adapted (Vlassoff, 2012).

The main criticism inherent in these 'solutions' however is the overriding assumption that women are somehow passive recipients of whatever it is felt should be good for them. Certainly, 'gender' has become a fashionable word for government and nongovernment, international and national organizations. The fact remains that in

developing countries there is still inadequate understanding of how gender influences health seeking behavior itself (Abouzahr, V, et, al 2014).

This is important because if we believe that health is genetically, biologically, ecologically, culturally and socially determined, then gender must be recognized as being one of these determinants as it is interconnected with biology and the socio-cultural factors that affect health (Vlassoff,G, et al, 2012).

Once it is established that gender does play a role in health, the focus can be taken away from ‘gender’ per se and turned toward the social divisions of the sexes, so called ‘gender relations’ (WHO, 2008).

Furthermore, a wealth of literature has been produced from studies in various regions of India and Bangladesh which has its unique cultural, caste, and religious norms. In researching the literature it is often difficult to separate gender from other interrelated factors such as literacy, education and socioeconomic status (Tomson, P, at el, 2010). These studies generally show an association with gender and health seeking (Ahmed et al., 2010), including differences in seeking treatment for other family members, such as female and male children (Bhan, B, T et, al, 2011).

On the other hand, studies again show that for certain conditions, gender, income and literacy determinants do not affect any delay in health care seeking behaviour (Dhingra, R, T et al, 2012).

However in terms of access, it has been noted that lack of available time may also impede women from seeking health care services. Responsibilities for childcare and household tasks often make it difficult for them to leave home, particularly if they also have wage-earning activities. Moreover, cultural practices that do not allow women to be seen in public during the day, like in many Muslim communities, limit access (Hartigan, 2011)

In addition to that, a study in Nepal for general health issues, gender has been shown not only to affect illness reporting, but also the decision to choose a health care provider and how much to spend on a sick child (Pokhrel et al., 2010). In terms of specific conditions such as tuberculosis, women were more likely to delay in seeking treatment than men (Yamasaki-Nakagawa et al., 2011), while perceptions of illness were found to be different between men and women (Pokhrel & Sauerborn, 2014).

More so in according to a study in Syria, they found that gender did not affect the knowledge and attitudes of Tuberculosis patients, although women did report more barriers to seeking care. Interestingly, women proved to be more compliant with treatment and being male was a significant predictor of a negative treatment outcome, after controlling for other significant socio-demographic and health care related variables (Bashour & S Mamaree, 2013).

More studies in Africa show mixed patterns of health seeking. In Ghana, women are more likely to seek health care than men (Danso, A, D, et al; 2014) while in another study in Zambia, women were more likely to delay in seeking treatment, particularly if

their education level was low (Faussett, N, F, et al; 2011). There are other issues as to how the introduction of user fees affects the use of health services by women (Soucat et al., 2007, Nanda, 2012), where one of the main issues for women is consideration of household income (Foreit & Forfeits, 2013).

Furthermore, a study in Zaria, Northern Nigeria found out that in most instances, husband's permission is required for a woman to seek health services and if he is away, those present are unwilling to make a decision (WHO 2009).

### **2.1.2 Literacy.**

Inequities in a country can often be gauged by the health of populations, particularly the most vulnerable groups. As a determinant of health care seeking behaviour, literacy is intimately tied to gender, education level, and regular income and is considered an indicator of socio-economic status (Bharmal, 2010; Sudha et al., 2013).

Similarly, male literacy levels are consistently higher than for females, particularly in developing countries (Institute for Statistics Literacy and Non Formal Education Sector, 2012). It is currently estimated that female literacy has increased from 54% to 74% (WHO; 2008). Literacy is used as an indicator for dimensions of poverty (Mattes et al., 2012) and female literacy and education levels are often used by the World Bank and United Nations organizations (United Nations Population Fund, ) among others to assess the mortality rates of children under five years of age (Moore et al., 2013; Shimouchi, O, H, et al; 2014).



Surprisingly to note, some of the direct effects of low literacy levels are for instance, the inability to access health information presented in print form, to read labels and instructions for medications, or even safety advice. Low levels of literacy are not just a phenomenon of developing countries but also in developed countries. A Canadian study found low literacy skills correlated with low quality housing, living in unsafe areas with higher rates of pollution and environmental hazards, and that those with low levels of literacy were less likely to seek care early for their illness (Perrin, 2008).

In addition to that, literacy levels remain low for women in India (Ahmed et al., 2011), especially in rural areas, where literacy has been found to be the most significant factor correlating to survival (Berhane et al., 2012). Low levels of literacy have been shown to be an indicator of higher hospitalization rates (Arozullah et al., 2008), greater rates of malnutrition (Bharmal, 2010), and skin diseases (Gibbs, 2010), for instance. In Senegal, Ndaye et al 2009) concluded that illiteracy had a significant link to poorer outcomes in maternal and child health, unexpected pregnancies and refusal to be examined by a male health worker.

And in recognition of the effect of low literacy levels on health, the term health literacy has become a way of describing the particular influence literacy has on the health status of individuals and families. Newer fields of study about health literacy seek to define the causal pathways and social constructs which affect the utilization of health services and overall health status (Lee et al., 2014). While even at the macro level,

improvements in the level of literacy are seen to increase media participation and improve economic and political developments (Sonaike, 2008).

### **2.1.3 Education.**

A key socio-cultural determinant of health is education (Kick Busch, 2010). Again it is difficult to separate education from literacy and other indicators that are regularly used as convenient markers of socio-economic status. Available data in all countries points to the relationship between the risk of disease and lower levels of education (Marmot, 2009; Mackenbach et al; 2013). Occurrence of illness is significantly in groups with higher education because they know when to seek for health services, especially among men, but there was no difference between occupational and economic groups in Vietnam (Giang & Allebeck, 2009).

Women in developing countries are frequently confronted with a myriad of socio-cultural factors which negatively impinge upon physical well-being and accessibility to appropriate health care services. Institutional, economic, and educational barriers affect and lower their standard of living when compared to their male counterparts (Nash Ojanuga & Gilbert, 2012).

More so, education is tied to gender, culture, social status, occupation and economic wellbeing. It is difficult to make any definitive statements about education without including socio-economic status. The World Bank views the two as interlinked and regard the “economic and social benefits of education for girls and women as a form of human capital investment” (cited in Moss, 2007,) as well as poverty reduction,

specifically in Africa (Nduru, 2009). Secondary or higher education consistently correlates with modern family planning practices and contraceptive use (Magadi & Curtis, 2013; Nash Ojanuga & Gilbert, 2012).

Education may be the single most important factor to influence women's health seeking behaviour (Heiberg, 2008). According to the National Council for Population and Development in Kenya "one of the most important determinants of a woman's social and economic status is her education level". It is evident that education level and socioeconomic status are related, as is gender, when examining health inequalities in minority groups that live in developed countries with access to a national health service (Cooper, 2014). Therefore it is not surprising to find that education and socio-economic status directly affect women's access to healthcare, specifically in developing countries (Nash Ojanuga & Gilbert, Soucat et al., 2007) and that education and economic status of the household are positively related with choosing to act and seek health care when ill in Zambia (Hjortsberg, 2013), even a women's perception of her social status and increased self-esteem is positively related to her education level (Fallon, 2009). Level of education is viewed as important in the creation and maintenance of health inequalities through socio-economic differences in the labour market (Cooper, 2012).

As for Buor (2013) speculates that a patient with a high income who does not see the need for health care would not access it even if they had to travel 1 kilometer; whilst the one who appreciates the need for it due to a good level of education would risk

raising a loan if the distance and service cost are such that he has to pay so much for them.

#### **2.1.4 Regular Income.**

Income is used in this study as a determinant for health care seeking behavior, and has been used in previous studies to determine not just health seeking behavior, but risk factors associated with health outcomes (Colin, A, et al; 2014; Mackenbach, H, et al; 2013), barriers to seeking health care , types of treatment (Nyamongo, 2012) and delays in service.

Many studies identify economic status as the most significant predictor of service use (Pillai et al., 2013) and how income affects the level to which health care facilities are sought and used (Buor, 2013). While often the decision to seek health care is based upon the cost as compared to the perceived benefit (Hjortsberg, 2013).

According to Buor (2013) the ability to pay determines the use of health services. A lack of finances seriously affects health care seeking (Taffa & Chepngeno, 2010), so although the willingness to pay for services may be there (Foreit & Foreit, 2013), the means to do so, may not. Not surprisingly low income has been found to be a barrier to health seeking and can create an overwhelming financial burden for some (Gotsadze, B, et, al; 2010).

However, in Bulgaria, Pavlov, G, et al; (2011) found that although clinical quality was the most important consideration for use of health care facilities, the importance of size of payment was inversely related to those with progressively lower education and lower

income. This finding is not unexpected and similar pragmatism is found in multiple studies, particularly in Africa of shopping around for health care services (Graft Aikins, 2010) and balancing cost with quality and severity of illness (Taffa & Chepngeno, 2010).

In general, those of a lower income bracket were more likely to experience ill-health and to battle health inequalities. Correlations exist in the data between low levels of education and income and levels of health, where individuals are more exposed over a lifetime to factors that may promote ill-health (Mackenbach & Howden-Chapman, 2013), for example geographic challenges or losing more person-ill days (Onwujekwe & Uzochukwu, 2010).

In this study, we follow the example of Hjortsberg 2013) in Zambia and use income as a determinant of health care seeking behavior. For Hjortsberg, financial resources in terms of income were found to be better correlated with health, particularly in rural populations. One consideration for those that are self-employed in farming or small business from the tourist trade for example, is that income can be unpredictable in terms of amount and regularity and this can be problematic in using health care.

Onwujekwe and Uzochukwu (2010) in a study in Southeast Nigeria, found that rural populations were less likely to pay the cost of health care treatment upfront and more likely to pay in installments. The assumption in the current study therefore is that regularity of income may be a more appropriate predictor, for these particular survey populations, of not just willingness to pay for health care services, but ability to do so.

### **2.1.5 Age.**

Age is a factor associated with health (for example Kaplan, N, et al, 2011; Mishra, B, et al 2012). It can be a determinant on its own or in conjunction with other factors. Age can be considered a factor of greater vulnerability, as with children under five years or the elderly, or greater robustness, or because the age group 18 to 25 years is more likely to be engaging in higher risk behaviors such as sexual activity, and alcohol, tobacco and other drug use. It is a useful demographic indicator. Worldwide, there is an increase in the aged. For many developing countries, rapid population aging and the phenomenon of a "double burden" of both infectious disease and emerging chronic diseases represent a major challenge. Many of those who will contribute to these extraordinary transitions will live in rural areas. Many countries, especially the poorest, still have a huge burden of infectious diseases, including increasing rates of HIV/AIDS along with a growing problem of chronic diseases (Andrews, 2011).

While women are likely to live longer than men older women are substantially more likely to experience functional impairment in mobility and personal self-care than men of the same age. These findings persist after controlling for the differential social position of men and women according to their marital status, social class, income and housing tenure. (Arber & Cooper, 2009).

Children in lowest quintiles demanded care the least because user fees was particularly important in determining access to health services thus heavily affected the poor Deinniger M, et al (2008).

Examination of incomes, health status, social support of the elderly shows... there have been persistent inequalities related to age, gender and social class in terms of resources, access to informal and formal care and value accorded to later life. These inequalities are due to differences in status and resources raises the questions of health status of the oldest generations, income distribution among generations and genders, of access to informal and formal care and adequacy of the latter for the frail elderly. (Henrard, 2007)

The elderly may be more likely to use informal health care, home and folk remedies, traditional healers and medicine (Eisenberg et al., 2008), and even faith healers not just because of economic reasons although often traditional medicine can be more expensive (Good & Kimani, 2008)), but as likely out of habit (Balkrishnan, K, Vet al; 2014), tradition (Good & Kimani, 2008; Sandhu & Heinrich, 2012), or personal beliefs and attitudes (Astin, 2008). Those in lower social positions are more likely to make health-related decisions out of habit, association between habits and preferences, more likely to rely on their habits and less likely to change behaviour (Lindbladh et al., 2008).

#### **2.1.6 Knowledge and attitudes towards health services.**

Limited knowledge and attitudes as well as ignorance about health services are the two most common significant factors affecting peasants from seeking health care services (Amarin, Z, O et al, 2008).

Taib et al, (2007) adds that there are a number of possible motivations for seeking therapies outside the western medical system including fear of surgery, a friends influence, an earlier bad hospital experience thought that an alternative therapy

works, fear that they will be unable to work again after surgery and shyness about seeing the doctor.

Howerton A et al (2007), adds that fear of being diagnosed of a condition, distrust towards the system and lack of confidence in health professions have been documented to make people hesitate to professional help.

#### **2.1.7 Cultural beliefs.**

Culture beliefs feature as a constrain to effective health care service delivery since some patients are said to harbour divergent opinions emerging from their cultures, thus leading to a clash of values since health workers sometimes fail to impress the diversity, therefore compromising patients care. Cultural influences interpersonal style and thus affects the way patients engage in health promoting activities with health workers. (M, Locher, 2008).

In a related study, traditional beliefs such as “EVIL EYE” Satanism and witchcraft were commonest perceived cause of Tuberculosis. In Tanzania, a significant number of people mentioned that witch craft was the cause of T B. (Mangesho P, et al 2007).

Furthermore, a study in Ethiopia showed that 46% of patients seeking care at health facilities did so after informal treatment failed. Moreover, patient's poor perception of cause of T B such as “EVIL EYE” were related to a prolonged delay to seek medical care. (Mesfin M, M; et al, 2009).



### **2.1.8 Lack of time.**

The multi-level analysis indicated that the long waiting hours were associated with lower probability for health seeking behavior. This can also be seen in self-reported reasons for not seeking any medical care while they were ill nearly a third reported having no free time. The findings strongly suggested that attention should be paid to over working in migrant population to maintain migrants' well-being, the labour and social security sectors should design and implement appropriate regulations. The investigations showed that working overtime is common for migrant workers and nearly a third of the migrants work more than 12hours per day and most of them do not rest on statutory holidays. More over 31.7% work in manufacturing and construction sectors which belong to labour intensive sectors and high risk jobs in which overtime will severely harm their physical and mental health (Jian, X, H, et al; 2007). In another study by Muzanah, M, et al (2012), it was revealed that those who go to the hospital end up changing their mind to go to traditional healers because of waiting for long before they get their test results, see the doctor or even get their treatment done, they make use of the waiting period to make appointment or schedule procedure to consult a traditional healer.

## **2.2 HEALTH SYSTEM - RELATED FACTORS AFFECTING HEALTH SEEKING BEHAVIOUR.**

### **2.2. 1 Closest Facility Type.**

This determinant is concerned with which type of health facility that is more available to prospective users. This would include the level of expertise and treatment that could be assumed from the type of facility, that is a hospital versus a dispensary, or if public facilities are limited and not accessible, so private facilities have filled the gap, according to the case in Vietnam (Ha et al., 2012; Tuan, Dibley, 2010), or Uganda (Birungi, M, et al; 2011;Witter & Osiga, 2014) , or India (Rajeswari et al., 2012; Sudha et al., 2013).

Accessibility issues for those living in rural areas are well documented, whether in developed countries (Andrews, 2011), or developing countries (Mehrotra & Jarrett, 2012). This is not the only issue facing those in rural areas, where there may be questions about the quality of the service, capacity or the facilities of the nearest service. Perhaps there are few options for residents of that area, and with limited choices they are bound to use any health facility, over taking no action at all. Or perhaps instead they turn to alternative therapies (Eisenberg et al., 2008), traditional methods (Good & Kimani, 2010) and/or self-medications (Mc Combie; 2012).

A number of factors influence the choice of a health service physical access to health care, including distance from the health facility, availability of transportation, and the condition of the roads. The distance separating potential patients from the nearest health facility is an important barrier to its use, particularly in rural areas (Noorali et al., 2009).

Again this means difficulties with separating out variables directly responsible for health seeking and service choice. There are also other factors which may be the primary determinants for the use of some health facilities over others, particularly for treating an ill child for example (Noorali et al., 2009). Physical accessibility, along with cost and perception of the health service provider are reasons for use (Ager & Pepper, 2010).

### **2.2.2 Cost of health services:**

According to self-reported reasons in china, the high cost of health services was a significant barrier to health care access .The multi-level model analysis also indicates that house hold income is a key factor in the utilization of health services that is being unable to pay, some may choose not to seek health services when they fall sick. Studies showed that the high cost of health services and lack of any insurance have resulted in underutilization of health care services among migrants in Beijing and led to a series of ineffective health seeking behavior s such as un supervised self-treatment, going to un regulated clinics or just hold on without seeking any medical care. Self-medication was at 33.3% and no measures at 30.3%(Hong Y et al., 2008).

Thompson R (2009), reported that although the cost of traditional healers is almost the same as for private health facilities payments to former is more flexible for instance , in rural areas traditional healers may accept payment in cash or in kind ( usually livestock ) while traditional healers may follow a no cure

no pay practice. A once off payment may be accepted for multiple services that extended over a period of time.

### **2.2.3 Inadequate medicines and supplies:**

Availability of resources necessary to carry out health care services also affect the quality of care given to patients. In a study carried out in Iganga and Bushenyi districts it was revealed that lack of equipments at a health facility affects the capacity to diagnose, test and provide the necessary health care (Kiguli J, 2009). It is further classified that, Uganda is facing a shortage of essential drugs in most government health facility by 32-50% to treat the common diseases like malaria pneumonia diarrhea HIV/ AIDS TB Diabetes and hypertension. This has a serious effect on patients perception of quality health care (Baguma A, 2009).

Kasese district annual report 2009/2010 showed that drugs at health facilities were out of stock because health workers used them in their practices. This therefore seems to have contributed to reduced quality of patients care.

### **2.2.4 Inadequate staff.**

Global health workers are on adverse impact on health systems And because of increased need for health care services an alley of health care professionals allied health workers and others have been known to acquire, dispense and in some cases administer medicines (R King and H foundation, 2010). This shift in health care personnel availability and accessibility is therefore concluded that the major challenge to provision of health care services is due to inadequate number

of health care providers who receive overwhelming number of patients and thus this affects the quality of care provided (Muhwezi, 2008).

#### **2.2.5 Attitudes of health staffs.**

Ojwang B O (2010), Indicated that patients expressed their feelings towards health workers as being poor communicators who use medical terminologies and get less concerned when patients approach them for help.

In another study it was reported that health workers especially nurses have a serious problem with their image that is to say they don't handle patients appropriately.

They mistreat clients and as a result clients do not come to health facilities because they fear unkind treatment and abuse from them. Less than half of sick people who come to health visits have fear of being mistreated by health workers so they end up in the hands of untrained traditional healers while many others do not have access to good quality influenced by quality of services expected especially the quality of nursing care (WHO, 2007).

#### **2.2.6 Motivation of health staff.**

Studies have revealed that, many health workers are de-motivated and frustrated because they are unable to satisfy their professional conscience and impeded in performing their vacation due to lack of means and supplies and due to inadequate or inappropriately supplied human resource management tools(Ingo Imhoff and Mthauer, 2008).

It is further supported that many nurses are being demoralized and thus work without commitment because their efforts are not appreciated and therefore have to struggle to make ends meet both at work and at home (Martin M H, 2009).

#### **2.2.7 Supervision of health staff.**

Over sight in monitoring and supervision of staffs leads to inadequate health service delivery as raises into common abuses like informal charging of patients, theft of drugs and medical supplies which would be used by patients, absenteeism on duty, thus leaving patients not attended to (chauhury Nicholas, 2013).

#### **2.2.8 Distance.**

A study conducted in Uganda by the Center for Disease Control in 2008 showed that many patients had difficulties in accessing health services in Uganda because some health facilities are situated far away such that poor ones cannot afford transport to go there . As with type of transport and closest health facility, time taken to travel to a health facility is often discussed in terms of geographic or physical access. This makes comparison with other study results difficult “as most of the available literature has focused on the influence of physical accessibility on the use of health services in general” (Noorali et al., 2009).

The determinant distance seeks to include a number of issues addressing access to health and medical services. Actual distance in kilometers or miles is an easier measure, but does not seem an accurate representation of what logistical barriers may be involved. As the distance increases, a number of health seekers especially in developing

countries become reluctant to seek medical care. Not to mention what that journey might do for the ill person. (Bennet, S., Ranson, K., & Gzirishvili, 2010).

## **CHAPTER THREE: METHODOLOGY**

### **3.1 Introduction.**

This chapter described the methods that were to be used in the study. This consisted of a study area, study design, study population, sample size determination, sampling procedure, definition of variables, data collection procedure, quality control, data management, data analysis, ethical considerations, limitations of the study, and dissemination of results.

### **3.2 Study area and rationale.**

The study was carried out in ward III which is located in Ishaka-Bushenyi municipality in Bushenyi district. Bushenyi district is found in south western region of Uganda about 300km from Kampala the capital city by road. ward III consists of three local council I villages namely Bugomora, Kanyamabwenda and Katungu having a total population

of 1234 community members. During the 2014 Uganda population census, the population of Bushenyi was estimated to be 251400 people (UBOS, 2014) and that of Ishaka division where ward III is found to be 16227 people (UBOS, 2014). The infrastructures in ward III include commercial, residential houses and both marum and tarmac roads. The major economic activities in ward III is trade and small scale farming. Bushenyi district has a number of health facilities where majority are privately owned and the rest belong to the government of Uganda. There is marked higher levels of poor health seeking behaviour.

### **3.3 Study Design and rationale.**

A descriptive cross-sectional study design was used to determine the factors affecting health seeking behavior among community members in ward III, Ishaka-bushenyi municipality. The study design was selected because it enables easy access to the required subjective data and it also enables the research to be done in a specific time.

### **3.4 Study Population.**

The study included male and female community members of 18years and above , living in ward III ,Ishaka-bushenyi municipality.

#### **3.4.1 Sample size Determination.**

The sample size was determined using Fishers et al., 2003 formula .The formula was used to estimate the smallest possible categorical sample size for the population



community members seeking health services in ward III. It is given in an expression as;

$$n = \frac{z^2 p (1-p)}{d^2}$$

$$d^2$$

Where; **d**= margin of error

**n**= minimum sample size

**z**=standard normal deviation set at 95% confidential level corresponding to 1.96

**p**= expected prevalence (proportion)

Therefore taking

$$p = 50\% = 0.5$$

$$z = 1.96$$

$$1-p = 0.5$$

$$d = 5\% = 0.05$$

$$\text{Thus } n = \frac{(1.96)^2 \times 0.5 \times (1-0.5)}{(0.05)^2}$$

$$(0.05)^2$$

$$n=384$$

Because of limited time and resources, half the value of n (192) respondents was used as the desired sample size in the study.

#### **3.4.2 Sampling procedure and rationale.**

A randomized simple sampling technique was used where 192 respondents were chosen randomly in villages that make up ward III that is Katungu, Kanyamabwenda and Bugomora. This sampling technique was used because it would save the researcher's time since households were numbered and every first 64 respondents from households that had even numbers in every village were selected for the study that is in the three villages that make up ward III respectively.

#### **3.4.3 Inclusion criteria.**

The study included community members of ward III, that is Katungu, Kanyamabwenda, and Bugomera respectively that were available during time of the study, and had consented to be part of the study after being chosen to be part of the study.

#### **3.4.4 Exclusion criteria.**

The study excluded individuals who were not members of ward III like by-passers and visitors, and community members who refused to consent.

#### **3.5 Definition of variables**

This includes both dependent and independent variables.

### **3.5.1 The dependent variable.**

The dependent variable in this study is health seeking behaviour.

Health seeking behavior refers to any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding remedy.

### **3.5.2 The independent variable**

The independent variable in this study were the socio-demographic and health system related factors affecting health seeking behaviors.

### **3.6 Research instruments.**

A semi-structured questionnaire with both closed and open ended questions was used. The questionnaire had three sections namely; section A ; socio-demographic characteristics, section B; socio-demographic factors affecting health seeking behavior, and section C; Health system related factors affecting health seeking behaviors.

### **3.7 Data collection procedure.**

Data collection followed consent from the responsible community leaders. This was collected using a semi-structured questionnaire. The interview was conducted among community members of ward III who accepted to participate in the study and who met the inclusion criteria, Responses of the respondents filled into the questionnaire by the researcher and research assistants, This method was used

because it would allow accurate recording of responses from both illiterate and literate respondents.

### **3.7.1 Data management and quality control.**

Questions in the tool (questionnaire) were pre-coded to help the researcher to get uniform qualified data, coding frames were met, facilitated by the codes given to responses given in the tool (questionnaire) This would make the process of presentation and analysis easy.

The research instruments were checked for errors and omissions in order to ensure consistency, completeness and accuracy in filling the questionnaire. This was done in the field before going to the next respondent.

**Quality control;** Burns and grove (2007) maintain that reliability deal with consistence of the measurement of the technique. The instrument used should indicate similar results each time it is used; the following measures were employed.

**Pre-testing;** The questionnaire was pre-tested in a tenth of a sample size in kijumo village found in ward I, ishaka-bushenyi municipality but with similar characteristics, before data collection to ensure accuracy, relevancy, validity, and reliability of tools.

**Training of research assistants;** Four research assistants who were village health team members, able to speak the local language Runyankole were selected, introduced to the study and trained how to use the questionnaire.

### **3.7.2 Data analysis and presentation.**

Data was analyzed manually coding frame was made for each question, Respondents responses were tallied, counted frequencies and computed into percentages using a manual calculator, also electronically by feeding into MS-Excel software and exported to SPSS for analysis to generate descriptive statistical information which were then presented in form of tables, figures, pie-charts and bar graphs.

### **3.8 Ethical considerations.**

This research report was approved by my supervisor. The researcher sought permission from the research committee after approval. The dean school of nursing then issued out an introductory letter to the researcher after a researcher proposal that was earlier presented to the university research committee.

The introductory letter was then presented to the local council two chairperson, who then introduced the researcher to the local council one chairpersons , And the local council one chairpersons introduced the researcher to the respondents.

The researcher then explained the importance of the research and its objectives to the respondents. The researcher then sought consent from the respondents and request them to participate in the interview in order to collect data from them.

I told the respondents that there would be no harm regarding participating in the research and that they should be free to withdraw if they feel uncomfortable to continue at any point of the interview.

### **3.9 Study limitations.**

The study was not free from the following obstacles like;

The study relied on participants answers and some respondents would wish not fully reveal some information, However this was overcome by thorough explanation of the objectives of the study to the participants as well as ensuring confidentiality of the data to be collected.

Inadequate funds to facilitate the study's activities and this was addressed by soliciting funds from relatives, friends, and well-wishers and the researcher reduced on unnecessary expenditures.

The study interfered the researchers revision for final examinations and this was overcome by extending on the revision timetable and to minimize the researchers leisure time.

### **3.10 Dissemination of results.**

On completion of the report , a copy was disseminated to the Uganda Nurses and Midwives Examination Board, Kampala international university school of nursing, and a copy remained with the researcher for reference and finally to ward III community leaders.

## **CHAPTER FOUR: RESULTS.**

### **4.0 Introduction.**

The results were from a cross sectional study carried out in Ward III, Ishaka-Bushenyi Municipality, Bushenyi district. The data was obtained from 192 community members who voluntary consented to be interviewed, satisfied the Inclusion criteria and successfully completed filling the questionnaire.

### **4.1 DEMOGRAPHIC CHARACTERISTICS.**

**Table I: Shows respondents social demographic characteristics**

<b>VARIABLE</b>	<b>CATEGORY</b>	<b>FREQUENCY n=192</b>	<b>PERCENTAGE %</b>
SEX	Male	80	41.7
	Female	112	58.3
AGE	18 -29	71	37
	30-39	42	21.9
	40- 49	57	29.7

	Above 50	22	11.4
Level Of Education	Primary	44	22.9
	Secondary	78	40.6
	Tertiary	62	32.3
	None	8	4.2
Marital Status	Single	60	31.3
	Married	92	47.9
	Widowed	29	15.1
	Separated	11	5.7
Occupation	Farming	75	39
	Business	57	29.7
	Civil servants	17	8.9
	Other	43	22.4
Religion	Catholics	71	36.98
	Protestant	48	25
	Moslems	28	14.58
	Born again	33	17.18
	S D A	12	6.25

**Source Primary**



From table I above, the majority of respondents 112 (58.3%) were female while 80 (41.7%) were males. Regarding age of respondents, Majority 71(37%) were in age group of (18-29) years, 42 (21.9%) were between 30-39 years, 57 (29.7%) were 40-49 years and 22(11.4%) were above 50 years.

Regarding level of education, most of the respondents 78(40.6%) had attained secondary level, 62 (32.5%) had attained tertiary level, 44 (22.9%) had studied up to primary level and only 8(4.2%) had never gone to school.

Regarding marital status of the respondents, majority 92 (47.9%) were married, 60(31.3%) were single, 29(15.1%) were widowed, 11(5.7%) were separated.

In regards to occupation of respondents, majority 75 (39%) were farmers, 57 (29.7%) were business men and women, 17(8.7%) were Civil servants and 43 (22.4%) were having other occupations.

Furthermore, concerning the respondents religion majority 71(36.98%) were Catholic, 48(25%) were Anglicans, 33 (17.18) were Born Again Christians, 28(14.58%) were Moslem, and 12(6.25%) were Seventh day Adventists.

#### **4.2 SOCIO-DEMOGRAPHIC FACTORS AFFECTING HEALTH SEEKING BEHAVIOR AMONG COMMUNITY MEMBERS.**

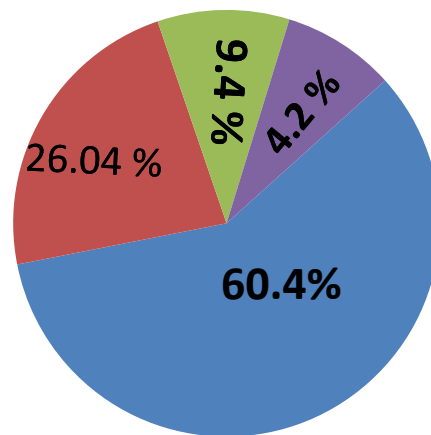
**Table II shows respondents who thought medical treatment recently.**

<b>VARIABLE</b>	<b>FREQUENCY</b>	<b>PERCENTAGE (%)</b>
-----------------	------------------	-----------------------

YES	192	100%
NO	0	0
<b>TOTAL</b>	<b>192</b>	<b>100%</b>

From the table II above, results of the study revealed that all respondents 192 (100%) had thought medical treatment recently.

**Figure I a pie-chart showing the first treatment option of respondents on falling sick.**



**Key:**

■ Self- treated

■ Private health facility

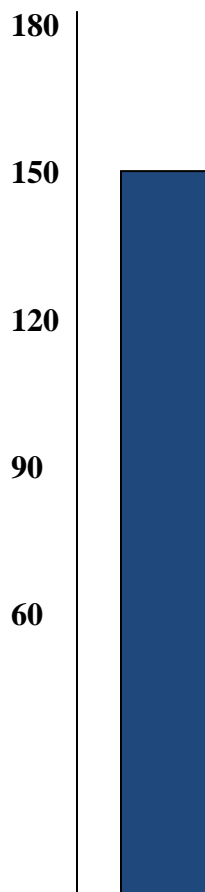
■ Traditional healer

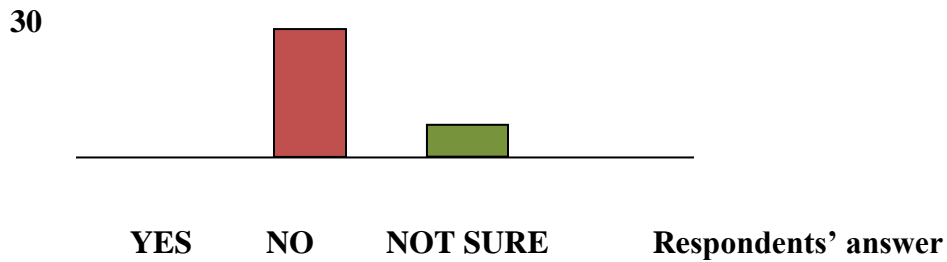
■ Gov't health facility

**Source: primary.**

From the figure I above, Majority 116(60.4%) of the respondents opted for self-treatment as their first treatment option, followed by 50(26.04%) of the respondents opted for government health facility as their first choice, 18(9.4%) of the respondents opted for private health facility as their first treatment choice, lastly 8(4.2%) of the respondents opted for traditional healers as their first treatment choice.

**Figure II A bar graph showing respondents thinking about the effect of their nature of Job on seeking health services**

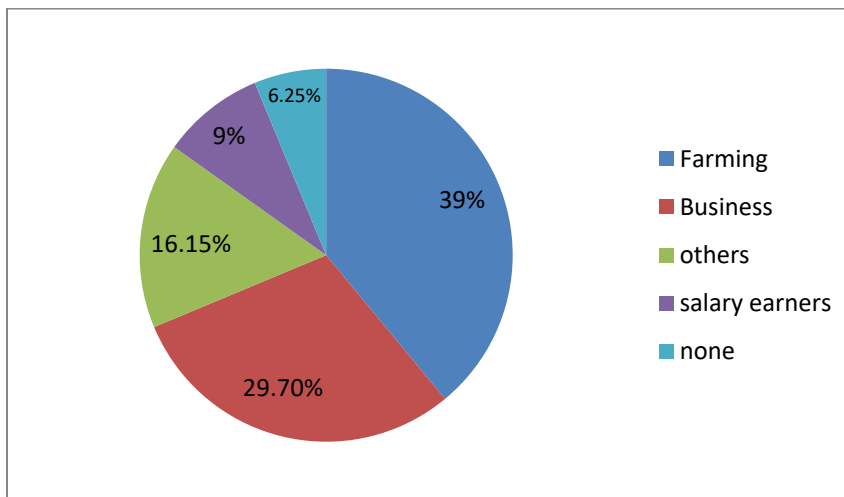




**Source: primary.**

From the figure above, majority 150 (78.125%) of the respondents revealed that the nature of their Job limits them from seeking health services, 30(15.6%) of the respondents revealed that the nature of their job does not limit them from seeking health care services, while 10(5.2%) were not sure of whether nature of their job can limit them from seeking health care services.

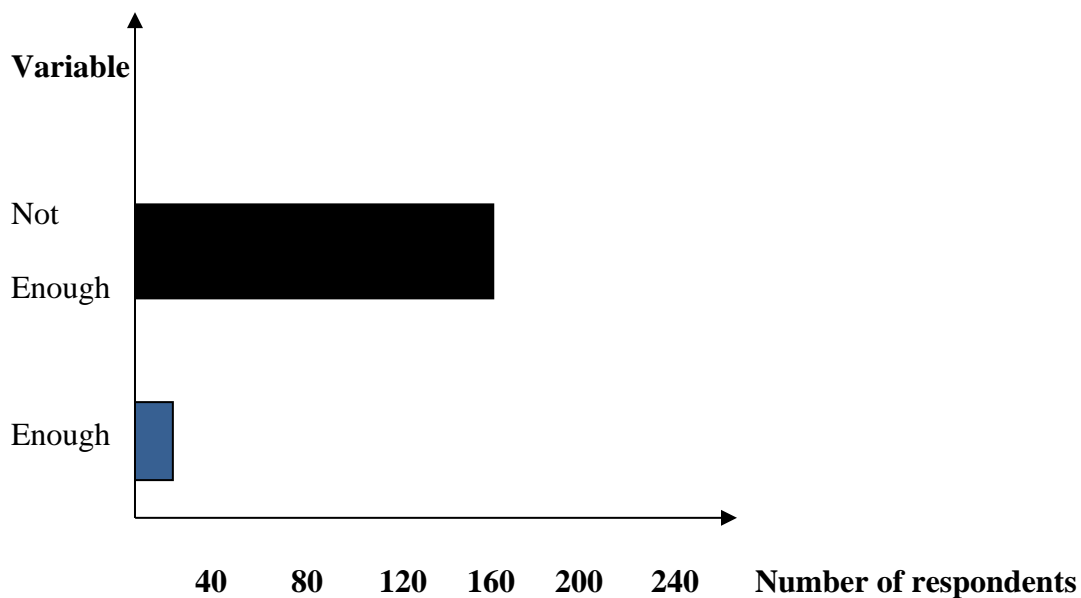
**Figure III; A pie-chart showing the source of income of respondents.**



**Source: primary.**

From figure III above, majority 75(39%) of the respondent revealed farming as their source of income, 57(29.7%) of the respondents revealed business as their source of income, 31(16.15%) of the respondents revealed other sources of income, 17(8.9%) of the respondent revealed salary as their source of income and 12(6.20%) revealed that they had no source of income.

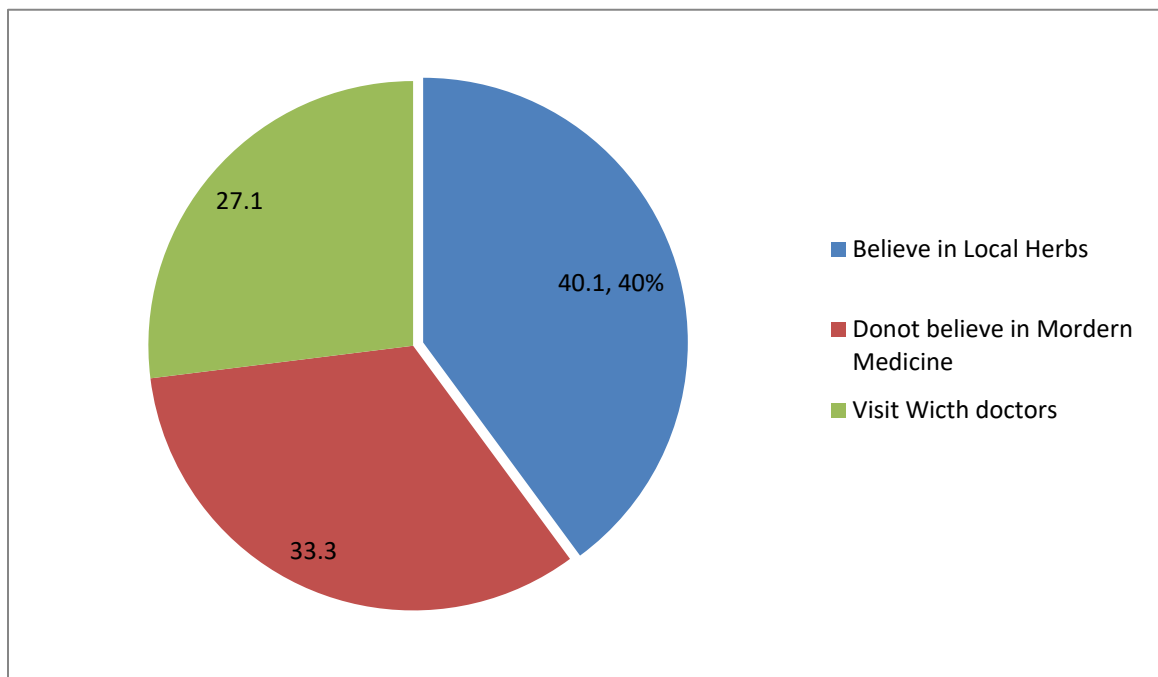
**Figure IV; a bar graph showing respondent rating of their monthly income**



**Source: primary.**

From figure IV above, majority 162 (84.375%) of the respondents reported that their monthly income was not enough and the minority 30(15.625%) reported that their monthly income was enough.

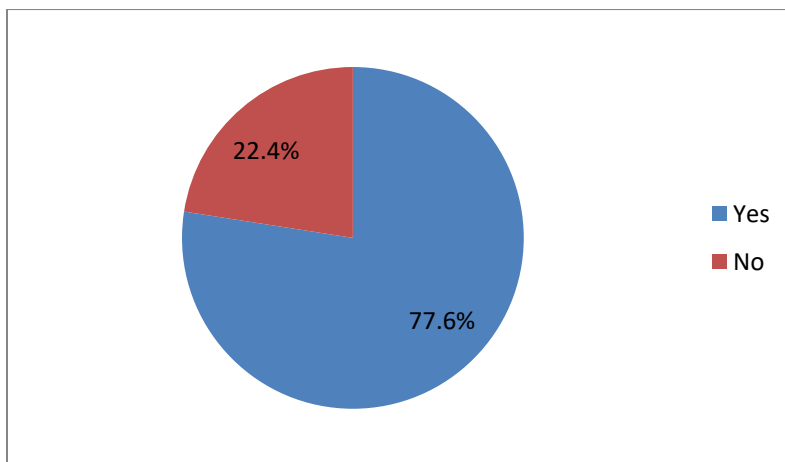
**Figure V; A pie-chart showing cultural limitations that would hinder the respondents from discussing their health issues with a health worker.**



**Source: primary.**

From the figure VI above, majority 77(40.1%) of the respondents reported that believing in herbs is a cultural limitation to seeking health care services from the health worker, 64(33.3%) of the respondents revealed that Not believing in modern medicine is another cultural limitation to seeking health care services from health worker, and lastly 52(27.1%) of the respondents reported that visiting witch doctors is another limitation towards seeking health services from health worker.

**Figure VI; A pie-chart shows respondents' thought of their income influencing their access to health care services.**



**Source: primary.**

From the figure VI above, majority 149 (77.6%) the respondents revealed that income influences their access to health care services and minority 43(22.4%) of the respondents revealed that income does not influence their access to health care services.

**Table III shows other additional Socio-demographic factors affecting health seeking behaviour.**

Variable	Frequency ( n=192)	Percentage (%)
Culture	153	79.7
Poverty	143	74.5
Distance	146	76.04
Lack of time	122	64
Stigma	70	36.4
Fear of medicine	65	33.8
Ignorance	63	32.8
Religious beliefs	58	30
Mistrust in health workers	44	22.9

**Source; primary.**

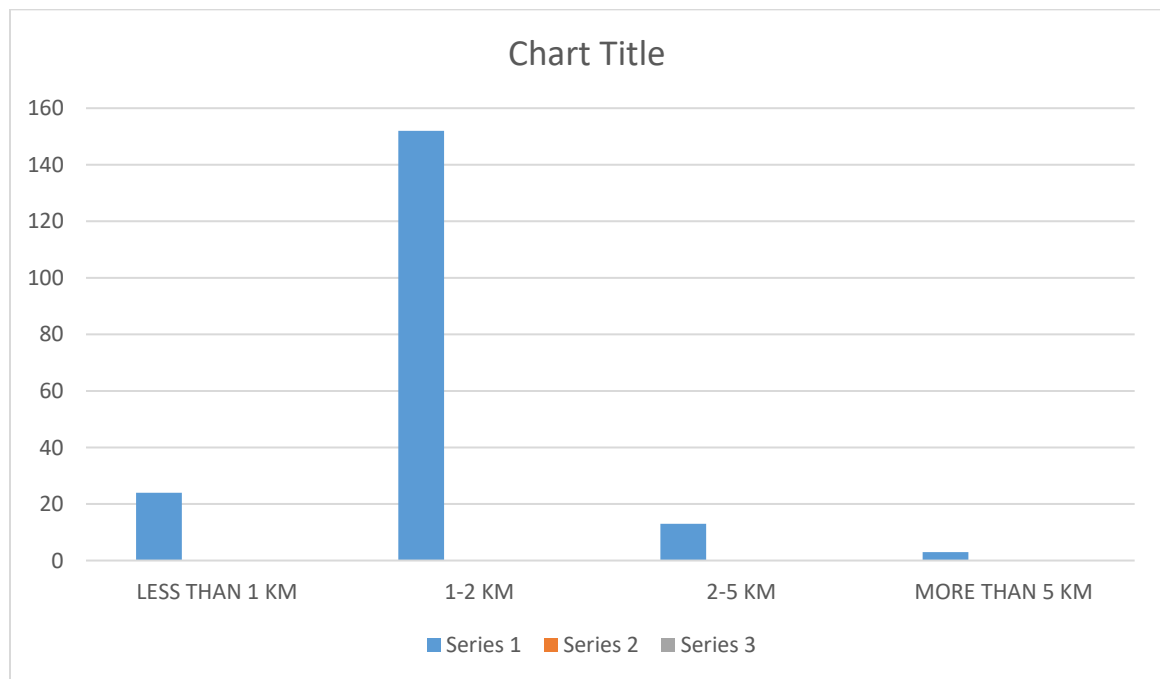
From table III above, majority 153 (79.7%) of the respondents reported culture, more than a half 143(74.5%) of the respondents revealed poverty, 146(76.0%) reported distance, more than a half 122(64%) of the respondents reported lack of time,



70(36.4%) of the respondents reported stigma, 65(33.8%) reported fear of medicine, 63(32.8%) of the respondents reported ignorance, 58(30%) of the respondents reported religious beliefs and almost a quarter 44(22.9%) of the respondents reported mistrust in health workers as factors that limit community members from seeking health care services from health facilities.

#### 4.3 HEALTH SYSTEM RELATED FACTORS AFFECTING HEALTH SEEKING BEHAVIOUR.

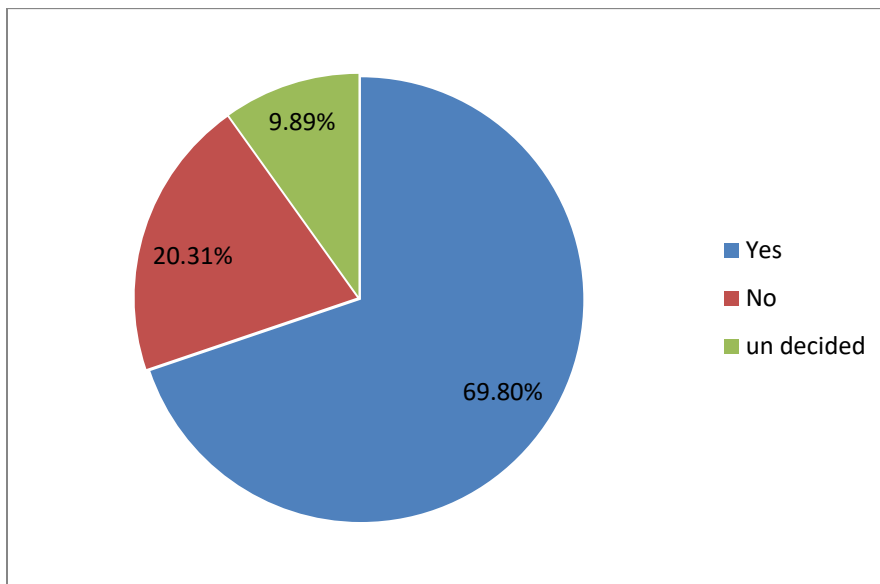
**Figure VII; A bar graph showing Distance to the nearest health facility of respondents.**



From figure IV above, majority 152(79.16%) respondents were moving a distance of between 1 and 2 kilometers from home to the health facilities, 24(12.5%) of the

respondents reported that they move a distance less than 1 kilometer to access health facilities, 13(6.77%) of the respondents reported that they move a distance between 2 and 5 kilometers, and 3(1.56%) of the respondents reported that they move 5 kilometers to access the health facilities.

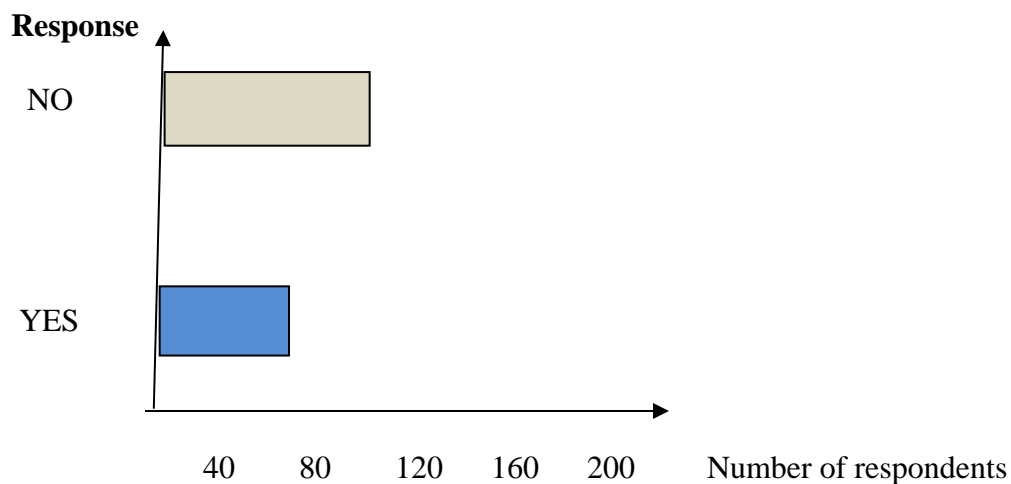
**Figure VIII A pie chart showing respondents thinking about long distance being a hindrance to accessing health care services.**



**Source; primary.**

From figure VIII above, majority 134(69.89%) of the respondent revealed that long distance can hinder them from seeking health care services, 39(20.31%) of the respondents revealed that long distance cannot hinder them from seeking health care services and 19(9.89%) of the respondents were undecided.

**Figure IX, A bar graph showing respondents option about the health services rendered at their nearby health facility.**



**Source: primary.**

From figure VIII above, majority 117 (60.9%) of the respondents revealed that the health facility near them does not provide all the health services and minority 75(39.1%) of the respondents revealed that the health facility near them provides all health services.

**Table IV showing the waiting time for the respondents when they go to the health facility**

<b>Variable</b>	<b>Frequency n=192</b>	<b>Percentage (%)</b>
Less than 10 minutes	57	29.69
10-20 minutes	24	12.5
30-60 minutes	41	21.35
Above one hour	70	36.46

**Source: primary.**

From table IV above, majority 70(36.46%) of the respondents reported that they wait for more than one hour while at the health facility, 57(29.69%) of the respondents reported that they wait for less than 10 minutes, 24(12.5%) of the respondents reported that they wait for between 10-20 minutes and lastly 41(21.35%) of the respondents reported that they wait for 30-60 minutes to be worked on while at the healthy facility.

**Table V Showing other additional Health System Related Factors Affecting Health Seeking Behavior.**

<b>Variables</b>	<b>Frequency n=192</b>	<b>Percentage (%)</b>
Costly health services	157	81.8
Inaccessibility of health facilities	136	70.8
Long distance	134	69.8
Under staffing	116	60.4
Absenteeism of health worker	79	41.1
Rude health workers	104	54.2
Inadequate medical services	117	60.9
Long waiting hours	115	59.8

**Source: primary**

Majority 157 (81.8%) of the respondents revealed costly health services, almost three quarters 136(70.8%) of the respondents reported in accessibility of health services, 134(69.8%) of the respondent reported long distance to access health facilities, 116(60.4%) of the respondents reported under staffing at the health facilities,

104(54.2%) of the respondents revealed rude health workers, 79(41.1%) of the respondents reported absenteeism of health workers, 117(60.9%) of the respondents reported inadequate medical services at the health facilities and 115(59.8%) of the respondents reported long waiting hours while at the health facility as the health system related factor affecting health seeking behavior.

## **CHAPTER FIVE: DISCUSSION, CONCLUSION, AND RECOMMENDATION.**

### **5.0 INTRODUCTION.**

This chapter presents the discussion of the study findings in relation to the literature review ,also presents the conclusion and recommendation about the study.

The study mainly focused on factors that affect health seeking behavior among community members in ward III, Ishaka-Bushenyi municipality, Bushenyi District.

A total of 192 respondents were recruited for the study.

### **5.1 DISCUSSION.**

#### **5.1.1 Socio-demographics.**

According to the study , findings revealed more than a half 112(58%) of the respondents were females. This means that females have a bigger belief in modern health services than males. This is supported by the fact that male biological model could simply be adopted as explained by Vlassoff,( 2012).

The model age of the respondents was between 18-29 years that was 71(37%). This showed that these were mature and able to decide on which treatment option to use. They should have had an experience in the case of modern health services and traditional health services. This is in line with a similar study by Elsevier (2008) who revealed that pregnant adolescent mothers seek health care in both modern and traditional sectors in order to get safety and empathy however findings indicated

that they mostly utilize the traditional sectors because it's most accessible in terms of distance, cost and cultural context. And also in another study, it was revealed that age is a factor associated with health ( for example Kaplan,Newsom,at el 2011; mishara at el 2012) stated in a similar study conducted that age can be considered a factor of greater vulnerability as with children under five years and elderly or greater robustness, or because age group 18-25years is more likely to be engaging in higher risk behaviors such as sexual activity, alcohol, tobacco and other drug use.

Majority 92(47.9%) of the respondents were married. Marital status may influence health seeking behavior As this may be attributed to the responsibilities married people have especially ladies for example taking care of the children, husband, and the entire home in their view they said that they tend not to have enough time to go and seek medical advice unless it is a very serious health issue. In the same study, majority (84%) of the respondents reported that they are men who pay medical bills and make decisions for the treatment option and yet men's involvement in health issues is low. Since men are the major source of money required while seeking health services, their not being positive towards health matters undermines the women's health. In a related study in Zaria, Northern Nigeria found out that in most instances husband's permission is required for women to seek health services and if he is away those present are un willing to make a decision(WHO 2009).



According to the current study, level of education was another factor affecting health seeking behavior. Majority 78(40.6%) had attained secondary level, poor health seeking behavior was most seen among those who had never gone to school. Similarly according to (marot,2009; mackenbach: at el 2013;) available data in all countries points to relationship between the risk of disease and lower levels of education. Also occurrence of illness is significantly lower in groups with higher education, and this is because they do not know when to seek for health services especially among men, but there was a difference between occupational and economic groups in Vietnam (Giang &Allebeck 2009).

Concerning occupation and economic activities of respondents, majority 75(39%) were farmers, 57(22.4%) were business men and business women, 17(8.9%) were civil servants and 43(22.4%) were having other occupations and this determined their regular income and some respondents' occupations could not yield enough money hence could not enable them to pay medical bills which they reported as a factor that makes them not to seek health services. In a similar study those of lower income bracket were more likely to experience ill health and battle health inequalities (Onwujekwe &Uzochukwu, 2010). They also stated that correlations exist in the data between low levels of education levels of health where individuals are more exposed over a life time to factors that may promote ill-health.

### **5.1.2 SOCIO-DEMOGRAPHIC FACTORS AFFECTING HEALTH SEEKING BEHAVIOUR.**

Majority 153(79.7%) of the respondents revealed that culture does limit them from discussing their health problems with health workers so as they are affected by cultural practices where majority 77(40.1%) of the respondents believe in local herbs, 64(33.3%) of the respondents do not believe in modern medicine, and 52(27.1%) of the respondents visit witch doctors and this is attributed to the frequent advertisements on media trying to show people that modern medicine does not completely heal and that herbal medicine has no side effects. And this is in line with a similar study in Ethiopia which showed that 46% of the patients seeking care at health facilities did so after informal treatment had failed. More over patients' perception of the cause of diseases were related to a prolonged delay to seek medical care (Mestiri, M, et,al; 2009).

Majority 143(74.5%) of the respondents revealed that poverty is a key factor contributing to poor health seeking behavior, and also majority 143(74.5%) their income is not enough and thus unable to pay for health services such as consultation fee, laboratory tests, and medication. Low income residents face significant obstacles in accessing health care services. And this is in line with a similar study carried out by Deiniger, M et al (2008) which revealed that children in the lowest quintiles demanded care the least because user fees was particularly important in determining access to health care services thus heavily affected the poor.

More than a half 122(64%) of the respondents revealed that the time they give to their jobs limit them from seeking health care services where most of them reported working for long hours as a minimum of ten hours per day and therefore do not get resting phases in between sessions thus fail to seek for health services unless it is a very serious health problem. This is supported by a study that was carried out in china showed that working overtime was common for migrant workers, nearly three quarters of the subject worked more than 12 hours a day and most of them could not rest on statutory holidays. More over 31.2% worked in manufacturing and construction sectors which belong to labour intensive sectors and high risk jobs, work where over time was severely harmful to their physical and mental health.(Jian X,H et al;2007). Furthermore ,respondents Majority 70(36.46%) of the respondents reported long waiting hours before they attended to by the health worker that is above 60minutes and also reported delay in service delivery and this is in line with a related study by Muzanah M et al (2012), which revealed that even those who go to hospitals end up changing their mind to go to traditional healers because after waiting for a long period of time before they get their test results , see the doctor or get their treatment done they make use of the waiting time for an appointment or scheduled procedure to consult a traditional healer.

More than a quarter 73( 38.02%) of respondents reported that ignorance of community members heavily affected them from seeking health services. This could be due to inadequate knowledge about health care services, prevention and

treatment of diseases. In a related study by( Amarin, Z, O at el 2008), showed limited knowledge, attitude as well as ignorance about health services were most significant factors affecting community members from seeking health care services.

### **5.1.3 HEALTH SYSTEM RELATED FACTORS AFFECTING HEALTH SEEKING BEHAVIOUR AMONG COMMUNITY MEMBERS.**

According to the current study, majority 157(81.8%) of the respondents reported that the cost of health services is very high thus limits them from seeking health care services. And this is supported in a similar study that was done in china where the cost of health services was a significant barrier to health access. In addition to that a multi-level analysis also indicated that household income is a key factor to the utilization of health services, that is being unable to pay, some may choose not to seek health services when they fall sick (Hong Y Et al 2008).

More than a half 104(54.2%) of the respondents revealed that health care providers are rude and not welcoming. Therefore treat them in a weird way causing psychological set back towards modern health services since the providers are unfriendly. WHO( 2007), Revealed that health workers especially nurses have a serious problem with their image. They mistreat clients and as a result clients do not seek health care services from hospitals because of the fear to be mistreated and end up seeking health care from un trained traditional healers.

From the study, long distance from the health facilities was a hindrance to health seeking behavior. According to a similar study conducted in Uganda by Centre for disease control in 2008 showed that many patients had difficulties in accessing health services in Uganda because some health facilities are situated far away in that poor community members cannot afford transport costs to go there. And this is in line with the study where type of transport and closet health facility, time taken to travel to the health facility is often discussed in terms of geographical or physical access. The determinant distance seeks to include a number of issues addressing access to health and medical services. Actual distance in kilometers or miles is an easier measure, but does not seem an accurate representation of what logistical barriers may be involved. As the distance increases, a number of health seekers especially in developing countries become reluctant to seek medical care. Not to mention what journey might do for ill person when he or she is being taken to the health facility as supported in a study by Benet S, R et al,( 2010)

Majority 116(60.4%) of the respondents revealed inadequate staffing as a factor influencing utilization of health services. This could be due to centers having a few qualified health workers. And despite of them being few, they don't always turn up for duty as per respondents' report that they go to some centers and do not find them there. This is in line with the same study carried out by muhwezi (2008) who revealed that health care personnel availability influences health care seeking behavior as inadequate number of health care providers who receive over whelming

number of patients is a major challenge in provision of health care services and thus this affects quality of care.

Almost a half 86(44.8%) of the respondents revealed that health services provided at the nearby health centers are poor, citing to lack of medical equipment and drugs as a great constrain in provision of health care more over after wasting a lot of time waiting, only to hear nurses tell you that they don't have some drugs and that you will buy them in any nearby clinic but this could be due to many cases reporting to the health centres and high drug consumption to mention but a few. This is in agreement with Baguma A (2009) who revealed that Uganda is facing a shortage of essential drugs in most government health facilities by 32-50% to treat common diseases like HIV/AIDS , diarrhea , diabetes and hypertension thus this has a serious effect on patients' perception of quality of health.

## **5.2 Conclusion**

Therefore, the socio-demographic factors influencing health seeking behaviors were majorly sex, age, and level of education, marital status and occupation which requires specific interventions upon them to improve the health seeking behaviors of community members.

Health facility based factors influencing health seeking behavior were long distance from home to the health facility, inadequate staff at the health facility, expensive medical services, absent health workers and rude health workers.

### **5.3 Recommendation.**

The government should increase the staffing of health units such that people can be encouraged to seek health services.

Health workers should do more health education to community members about a need for earlier health seeking services in order to promote health of people.

Pregnant mothers should be encouraged to attend antenatal care services where they can be encouraged to bring their husbands as well to seek health facilities.

The government should use mass media like radios, televisions to encourage masses to seek health services on large scale.

Women should be empowered by the government on health policies because they are the focal points in seeking health services. with patients so that patients can encourage others to seek health services.

The government should motivate staff so that they are encouraged to spend more hours working as well as stress management.

### **5.4 NURSING IMPLICATIONS.**

#### **5.4.1 Knowledge.**

The findings from this study will add on existing knowledge related to factors affecting health seeking behaviors of which nursing curriculum designers may utilize the study findings in policy formulations and curriculum development.

#### **5.4.2 Practice.**

The findings from the this study may be utilized to influence health workers attitudes so as to develop a positive attitude towards health care seekers hence their practice appreciated.

#### **5.4.3 Research.**

The findings from this study may be utilized by other nursing researchers as part of their literature review and recommendations being a basis for further research.

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## **APPENDIX 1: CONSENT FORM**

I am **Atholere Edwin** a student of Kampala International University pursuing a diploma in nursing sciences; I am conducting a study on factors affecting health seeking behavior among community members in ward III, Ishaka Bushenyi municipality.

And I am kindly requesting you to participate in this study, because your contribution to this topic will be of great importance, as the purpose of the study is to determine the factors affecting the community members' decision to seek for health services

Your contributions will be highly treated confidential. Do not write your name and phone numbers on this questionnaire. You are free to withdraw from the study at any point and the decision will not affect you in any way.

But full information to be generated will give a considerable meaning to the purpose of the study. If there is any un clear information you may ask for further clarification.

**Declaration of the participant.**

I have understood the purpose of the study and consent voluntarily to participate in this study, I also understand that the information to be provided will be confidential.

Participant initials or thumb print	Date
.....	.....
Researchers signature	Date
.....	.....

**APPENDIX 2: QUESTIONNAIRE.**

I am **ATHOLERE EDWIN** a student nurse of Kampala international university school of nursing (KIU-SON) Carrying out a study on factors affecting health seeking behavior among community members in ward III , Ishaka –Bushenyi municipality, Bushenyi district so as to devise means of minimizing them

All information obtained will be confidential feel free to give your answers that suit your interest and fill the blank spaces

**Code**

**No.....**

**SECTION A: Socio-demographic characteristics**

1. Sex

(a) Male ☐ (b) Female ☐

2. Age

(a) 20-29 ☐ (b) 30-39 ☐

(c) 40-49 ☐ (d) 50-59 ☐

3 Level of education

(a) Primary ☐ (b) secondary ☐

(c) Tertiary ☐ (d) none ☐

4. Marital status

(a) Single ☐ (b) married ☐

(C) Widowed ☐ (d) separated ☐

5. Religion

(a) Catholic ☐ (b) protestant ☐

(C) Moslem ☐ (d) others please specify.....

**SECTION B: SOCIO-DEMOGRAPHIC FACTORS AFFECTING HEALTH  
SEEKING BEHAVIORS**

1. Have you thought of medical treatment in the recent days?

(a) Yes ☐ (b) No ☐

2. Where do you go normally for treatment?

(a) Government Health facility ☐ (c) Private health facility ☐

(b) Traditional healer ☐ (d) Self- treated ☐

3. Give reasons for your choice

.....

4. Do you think the nature of your job can limit you from seeking health care services?

a) Yes ☐ b) No ☐

5. Give reasons to support your answer

.....

6. What is your source of income?

a) farming ☐ b) salary earner ☐ c) Business ☐ d) None ☐

e) Others specify.....

7. How do you rate your monthly income?

a) enough ☐ b) not enough ☐

8. Do you feel your income influences your access to health care services?



a) yes ☐      b) no ☐      c) not sure ☐

9. Give reasons to support your answer.....

10. Who usually makes decisions for the treatment option?

.....

11. mention reasons why people don't seek treatment from health facilities

.....

12. How do you feel being treated by a health worker of the opposite sex?

a) normal ☐      b) embarrassing ☐

13 What cultural limitations would hinder you from discussing your health issues with a health worker?.....

### **SECTION C: HEALTH SYSTEM RELATED FACTORS AFFECTING HEALTH SEEKING BEHAVIOUR**

1. How far is the nearest health facility from your place of residence?

(a) Less than 1KM ☐

(b) 1-2 KM ☐

(c) 2-3 KM ☐

(d) 3-5KM ☐

(e) More than 5km ☐

2. Do you think long distance may hinder one from accessing health care services?

a) Yes ☐      b) no ☐      c) un decided ☐

3. Give reasons to support your answer

.....

4. Do you find enough and conducive environment at the health centre?

a) Yes ☐      b) No ☐

5. For how long do you wait for the health worker to attend to you?

(a) Less than 10 minutes ☐

(b) 10-20 minutes ☐

(c) 30-60 minutes ☐

(d) Above one hour ☐

6. How do you comment about health services provided at your nearby health centre?.....

7. Does the health facility near you provide all the required services during your visit?      (a) Yes ☐      (b) No ☐

8. In your own opinion, what do you think could be the reason for your less services?.....

9. What has not been done by the nearby health facility that could be contributing to low health service utilization by community members?.....

10. How can the issues mentioned above be overcome?

.....  
.....

**THANK YOU FOR ACCEPTING TO BE PART OF THIS STUDY.**

**APPENDIX 3: LETTER OF APPROVAL.**

Office of the Dean - School of Nursing Sciences

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE: **ATHOLERE EDWIN** - **DNS/E/2649/153/DU**

The above mentioned is a student of Kampala International University – School of Nursing Sciences undertaking Diploma in Nursing Science and he is in his final academic year.

He is recommended to carry out his data collection as a partial fulfillment for the award of the Diploma in Nursing Science.

His topic is factors AFFECTING HEALTH SEEKING BEHAVIOUR AMONG COMMUNITY MEMBERS OF WARD 3 ISHAKA - BUSHENYI MUNICIPALITY BUSHENYI DISTRICT SOUTH WESTERN UGANDA

Any assistance rendered to him will be highly appreciated.

Thank you in advance for the positive response.



### *"Exploring the Heights"*



**A MAP OF UGANDA SHOWING THE LOCATION OF STUDY AREA,  
(WARD III, ISHAKA BUSHENYI MUNICIPALITY).**



LOCATION OF STUDY AREA ON UGANDAN MAP.

[illegible]

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