

Health Seeking Behaviours and Challenges to Utilizing Health Facilities in the North West Region of Cameroon

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Abstract: In a given community, health seeking behaviours determine how health care services are used. This in turn determine the health outcomes on members of this community. Utilization of health care facilities can be determined by cost, cultural beliefs, level of education, family income and distance to health facility. The purpose of this study was to determine the influence of socio-demographic factors on healthcare seeking behaviors and challenges in utilizing health facilities in the North West Region of Cameroon. The study was a cross sectional survey that used a structured questionnaire to collect quantitative data from 430 participants. The findings showed that despite low incomes and education levels, the study communities have moderate levels of access to services for curative and preventive care. About half of the participants preferred Government health facilities (50.5%) while a small number of participants preferred seeking care from traditional medicine (0.9%). In rural areas, Government health facilities are more preferred than in urban areas; 69.6% of participants in rural zones preferred government facilities whereas they were 43.7% in urban areas ($p < 0.001$, $V = 0.228$). In conclusion, the study sought to evaluate health seeking behaviors of rural and urban dwellers. The goal is to trigger discussions and re-evaluation of health promotion and education policies and programmes to bring about improvement in health seeking behaviours and address issues around health disparities and inequalities.

Keywords: Health Seeking Behaviours, Health Facilities, Cameroon

1. Introduction

In a given community, health seeking behaviours determine how health care services are used. This in turn determine the health outcomes on members of this community [1, 19]. Formulating strategic policy for health care systems should strive at promoting health seeking behaviours and contribute to increase health service utilization behaviours. It has been demonstrated that health seeking behaviours develop within institutional structures such as family, community or the health care services. There are various factors that determine health seeking behaviours ranging from physical, cultural, socio economic and political. The utilization of health care facilities may also depend on

educational levels, environmental conditions, the health care system, gender issues and sociodemographic factors [2, 14]. The organization of health care systems is a determining factor for health seeking behaviours. In the health systems of developing countries, illiteracy, poverty, under funding of the health care sector, inadequate water and poor sanitation in health facilities has a big impact on health care seeking behaviours and the utilization of health care facilities [3]. Even though a large number of diseases in low-income countries like Cameroon are preventable and treatable, they still form a big threat to people's health and well-being. There is a critical connection between diseases and poverty [4]. The attitudes and practices towards health seeking behaviours and utilization of health care services depend on the motivation to seek appropriate health care. These

attitudes include: the ability to recognize signs and symptoms of diseases, availability of treatment resources, social characteristics and financial resources [5].

In a poor resource setting, a number of factors can determine the choice of health care providers that patients seek. These factors can include: the quality of health care and expertise of the service provider. Other factors are related to the patient themselves such as age and education [6]. It is possible that these factors affect health care service utilization even if these services are available. It is important therefore to not only evaluate availability of health care services but also to evaluate accessibility to these available services. Despite the availability of health care services in Cameroon, there are disparities that make these services inaccessible to a greater proportion of the population. Poor populations normally have limited accessibility to health facilities and thus do not utilize services provided to them even though these services may be free or subsidized by the state or its partners. To be able to get to health facilities and utilize available services the patient will have to provide for transportation, in some cases the patient will need child care services before he or she can access health facilities. There are significant inequalities between the rich and the poor in accessing health care providers [7, 15, 16].

Social inequalities play an important role in determining the health seeking behaviours of patients. During the last decades, African countries including Cameroon have seen a substantial improvement in the living standard of their populations. Life expectancy, literacy and per capita income improved in all countries and consequently, human development index has been steadily increasing. Beyond the global trend, however, improvement was not equally enjoyed. Indeed, urban-rural disparities, discrepancies between regions and inequalities among socioeconomic groups have persisted or even increased in Cameroon during the same period. This disparity is equally observed across the health sector where the rich live a healthy life and have better health seeking behaviours and utilize health facilities while the poor who need more health services do not have access to these services. Since the 1980s, there has been a growing call for nations to address health inequities, which are systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as socioeconomic status, demographics, or geography [8].

In recent years, the Ministry of Public Health in Cameroon has increased the number of health facilities throughout the North West Region and has also authorized private institutions to open up new health facilities. However with this move there are still disparities in rural and urban communities where the rich most of who live in urban areas have better health seeking behaviour and have more access to utilizing health facilities compared to the poor most of who live in rural communities. The absence of health facilities in some communities which are often poor communities, is often likely to affect the health seeking behaviours and health facility utilization of patients. The inequity of health facility distribution between rich and poor neighborhoods affect

health seeking behaviours of several populations thus affecting health facility utilization.

In the North West Region of Cameroon there is growing insecurity due to the armed conflict between the Government forces and separatist fighters. This has a great impact on health seeking behaviours where the patient compares the risk of being killed while seeking health care and the risk of staying at home with the illness. This thus, affects health seeking behaviours.

A number of studies on health seeking behaviours in Cameroon have focused on particular diseases including Malaria, Cholera and Childhood diseases [9]. Thus knowledge is limited on general health seeking behaviours and health facility utilization of patients. The purpose of this study was to determine the influence of socio-demographic factors on healthcare seeking behaviors and challenges in utilizing health facilities in the North West Region of Cameroon.

2. Methods

2.1. Study Setting

The study was undertaken in four health facilities in the North West Region of Cameroon. Participants were from rural settings (Azire Integrated Health Center, Nkwen Rural Health Center) and urban settings (Nkwen Baptist Health Center and Bamenda District Hospital). The North West Region of Cameroon is well known for its scenic hilly locations, cold climate and rugged relief, which render communication difficult. Facilities included public district hospitals and primary health centres; private health care facility (mission health centre). Inhabitants in the targeted communities were mostly English and Pidgin English speakers with the major source of income being subsistence farming.

2.2. Data Collection Methods

This is a quantitative study based on exit pool interviews. Interviews were conducted in the English and Pidgin English languages depending on which language the participant was more comfortable. The interviews were carried out by trained data collectors. The data collection took place from August 2019 until October 2019. Prior to data collection, a pilot study was done in a different health facility reaching 40 participants. This pilot study permitted the research team to correct the data collection tools and also correct the phrasing in the questionnaires to be better understood.

2.3. Study Participants

Study participants were recruited from patients and caregivers seeking health care services in the targeted health facilities. The minimum sample size for the number of patients who were interviewed was calculated using the Leslie and Kish formula for descriptive studies [10].

$$N = P(1-P) Z^2/D2$$

Where N is the minimum sample size needed

D is the level of error that can be tolerated (0.05 chance of error) and CI 95%

P is the estimated prevalence rate (50%).

Z is the standard variation corresponding to confidence level. At confidence level of 95%, $Z=2$

$N=0.5 (1-0.5) 22/0.052$

$N=400$

To allow for a non-response rate of 10% (40 respondents), the sample size was increased by 40 to make 440 respondents. The sample size was consistent and realizable when compared with the target population.

2.4. Ethical Considerations

Ethical approval for the study was obtained from the Cameroon Baptist Convention Health Board Institutional

Review Board while administrative clearance was obtained from the North West Regional Delegation for Public Health. All participants gave their informed consent before participating in the study, and their anonymity, privacy and confidentiality was respected. A written consent was obtained from each participant of the study.

2.5. Data Management and Analysis

Data from exit pool was coded and fed into Statistical Package for Social Sciences (SPSS) soft-ware, for analysis. Descriptive statistical analysis was used to summarize information and explore the data for the distribution of responses. Microsoft excel spread sheet was used to provide means, frequency and drawing various charts. Inferential statistics of Chi square and Wilcoxon were used to test association between variables as appropriate.

3. Results

3.1. Socio Demographic Data

Table 1. Participant's socio demographic variables.

Variable		Urban (n=318)		Rural (n=112)		Together (n=430)	
		n	%	n	%	n	%
Sex							
	Male	105	33,0%	16	14,3%	121	28,1%
	Female	213	67,0%	96	85,7%	309	71,9%
Age group							
	20 – 30	30	9,4%	12	10,7%	42	9,8%
	31 – 40	133	41,8%	66	58,9%	199	46,3%
	41 – 50	110	34,6%	21	18,8%	131	30,5%
	More than 50	45	14,2%	13	11,6%	58	13,5%
Marital status							
	Married	156	49,1%	61	54,5%	217	50,5%
	Divorced	2	0,6%	0	0,0%	2	0,5%
	Widowed	13	4,1%	2	1,8%	15	3,5%
	Single	143	45,0%	47	42,0%	190	44,2%
	Free union	4	1,3%	2	1,8%	6	1,4%
Level of education							
	No School	9	2,8%	2	1,8%	11	2,6%
	Primary School	62	19,5%	15	13,4%	77	17,9%
	Secondary School	60	18,9%	24	21,4%	84	19,5%
	High School	56	17,6%	22	19,6%	78	18,1%
	Studied a trade	15	4,7%	3	2,7%	18	4,2%
	University	116	36,5%	46	41,1%	162	37,7%
Work Situation							
	Unemployed not seeking for work	66	20,8%	24	21,4%	90	20,9%
	Unemployed and seeking for work	54	17,0%	43	38,4%	97	22,6%
	Part time work	83	26,1%	23	20,5%	106	24,7%
	Full time work	115	36,2%	22	19,6%	137	31,9%
Monthly income							
	No regular income	122	38,4%	74	66,1%	196	45,6%
	Less than 50,000 Frs	83	26,1%	17	15,2%	100	23,3%
	50,000 - 100,000 Frs	54	17,0%	7	6,3%	61	14,2%
	100,000 - 150,000 Frs	21	6,6%	6	5,4%	27	6,3%
	150,000 - 200,000 Frs	22	6,9%	5	4,5%	27	6,3%
	200,000 - 300,000 Frs	13	4,1%	2	1,8%	15	3,5%
	Above 300,000 Frs	3	0,9%	1	0,9%	4	0,9%

3.2. Health Seeking Behaviors

Health seeking behaviors were measured on two aspects: the type of health facility preferred by the participant to seek care from; and the reasons of selecting a health facility for care.

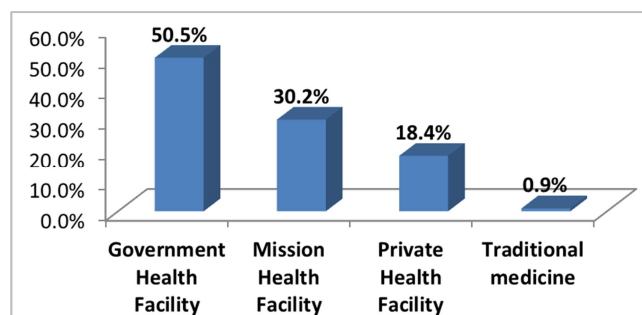


Figure 1. Type of health facility preferred (n=430).

In general, about half of the participants preferred Government health facilities (50.5%). A small proportion of participants preferred seeking care in traditional medicine (0.9%). For the remaining participants, private health facilities were preferred.

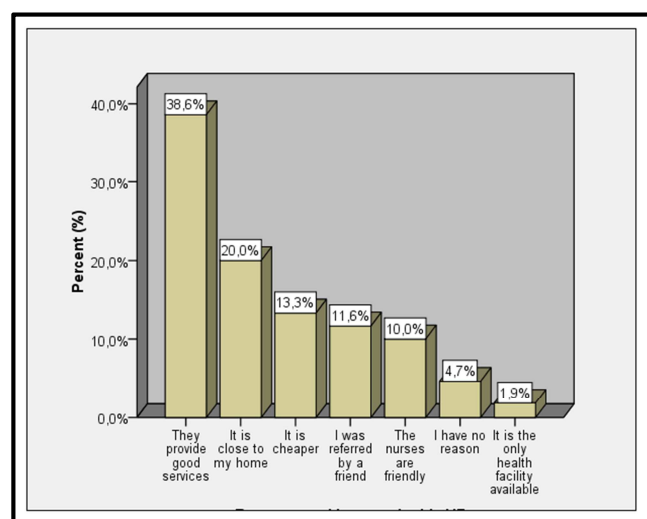


Figure 2. Reasons of selecting health facilities for care.

Government health facilities were chosen because of cheap cost of care (43.3%) and professionalism of staff (31.3%). Criteria of cheap cost is more present in government facilities than private where 2.3% in mission health facilities and 1.5% in lay private health facilities

pointed out cheap prices as their reason of choice. The mission health facilities were preferred because of good care (51.5%) and caring attitude (31.5%). For lay private health facilities, they were chosen for caring attitudes (53.2%) and good care (43.0%).

Comparing type of health facility and preference for health facility, as regards to the Government health facilities, 43.3% preferred them because they were cheap, 31.3% preferred them because they are professional, 14.3% preferred them because they provide good care and 11.1% preferred them because they are caring. While in Mission health facilities, 2.3% preferred them because they were cheap, 14.6% preferred them because they are professional, 51.5% preferred them because they provide good care and 131.5% preferred them because they are caring.

3.3. Challenges to Health Service Utilization

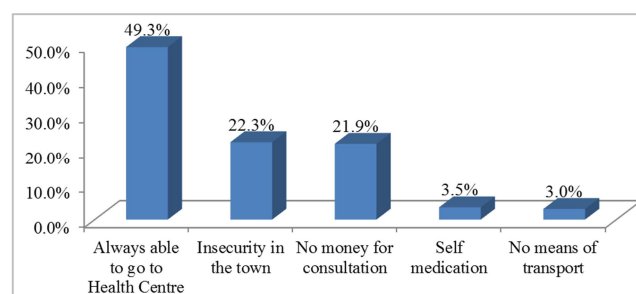


Figure 3. Reasons of inability to go to the health center (n=430).

Participants were asked whether they have been sick and unable to go to the health center. Amongst them, 49.3% (n=212) had always been able to go to a health facility when sick. 22.3% (n=96) of the participants could not go to the health center due to insecurity; it represents 44% of all the inability to go to health the health facility; 21.9% (n=94) of the participants were not able to go to the health facilities because of lack of money to afford for consultation fees. Other reasons were found including self-medication (3.5%, n=15) and lack of money for transportation (3.0%, n=13). The association between health seeking behaviors and socio demographic characteristics was assessed using a chi-square test and a rank-Wilcoxon test. Categories of health facilities were grouped into Government and non-government health facilities. Socio demographic characteristics assessed were place of residence, gender, the working situation and the monthly income.

Table 2. Chi-square test of health seeking behaviors and sociodemographic characteristics.

Variables		Preferred type of HF				Chi-square	Cramer's V
		Government		Non-government			
		n	%	n	%		
Place of residence	Urban	139	43,7%	179	56,3%	P< 0,001*	0,228
	Rural	78	69,6%	34	30,4%		
Gender	Male	51	42,1%	70	57,9%	0,031*	0,104
	Female	166	53,7%	143	46,3%		

Variables		Preferred type of HF				Chi-square	Cramer's V
		Government		Non-government			
		n	%	n	%		
Work situation	Employed	109	44,9%	134	55,1%	0,009*	0,128
	Unemployed	108	57.8%	79	42.2%		

Table 3. Result of Wilcoxon test for health seeking behaviors according to income.

	type of facility preferred	N	Mean Rank	P-value
Monthly income	Government	217	203.03	0,027*
	Non-Government	213	228.21	
	Total	430		

The type of preferred health facility to seek care from, showed a significant relationship with the place of residence, the gender, the work situation and the income. In rural areas, Government health facilities are more preferred than in urban areas; 69.6% of participants in rural zone preferred government facilities whereas they were 43.7% in urban areas ($p < 0.001$, $V = 0.228$). Government facilities were also preferred by female participants (53.7%) more than males ($p = 0.031$). concerning the work situation, unemployed participants preferred Government facilities compared to employed participants ($p = 0.009$). identical tendencies were observed for monthly income; the participants who preferred Government health facilities were associated with lower incomes than those who preferred private health facilities ($p = 0.027$).

4. Discussions

In this study, 443 participants were interviewed in the four health facilities. Questionnaires where participants refused to continue were deleted; they represented 13 (2.9%) of the participants. The final number of participants (97%) with complete information on key variables was 430. Participants between the age bracket of 31-40 years represent the highest number of participants (46.3%), while only 42 (9.8%) were between 20-30 years of age. About half of the participants are married (50.5%) while 44.2% are single with 1.2% living in a free union. As for educational level, 17.9% of participants have had just primary education while 19.5% have had secondary education. The findings showed that 20.9% of participants were unemployed but not seeking for work while 22.6% were unemployed and seeking for work giving an unemployment rate of 43.5%. This results show that the population is living in poverty with high unemployment rates.

Based on average monthly income levels, low educational level and high unemployment, the participants of the study were mostly low income earners. This relates to the general level of poverty in the North West Region of Cameroon. Such poverty levels can determine health seeking behaviours of patients. Health seeking is an important behavioral issue that in recent time keen attention has been paid by individuals, communities and Governments.

A regular job guarantees good and regular flow of income to the family and thus guarantees good health seeking behaviours. This has been demonstrated by the findings of

other studies in which they reported that high-income earners and those with higher formal education have better health seeking behaviours compared to patients with low incomes and low educational levels [12, 19]. These findings have also been corroborated by a study done in Trinidad where findings showed that almost half of patients seeking care in traditional medicine were unable to pay for conventional health care [13].

The type of preferred health facility to seek care from, showed a significant relationship with the place of residence, age, the gender, the work situation and the income. Similar findings have also been reported in Uganda where David reports that low income levels can affect uptake and utilization of health services [3]. This finding is also consistent with a findings in a study in Nigeria [2] where maternal age, maternal education, and family socioeconomic status are predictors of appropriate healthcare-seeking behaviors for childhood illnesses. In rural areas, Government health facilities are more preferred than in urban areas; 69.6% of participants in rural zone preferred Government facilities whereas they were 43.7% in urban areas ($p < 0.001$, $V = 0.228$). Government facilities were also preferred by female participants (53.7%) more than males ($p = 0.031$). However these findings are contrary to findings in Tanzania where 35% preferred Government health services while 41% preferred private facilities and self-treatment was 27% [18]. Wyss states that there was an apparent tendency for people with a high level of education or belonging to a rich socio-economic class to use private facilities more often. As regards to the work situation, unemployed participants preferred Government facilities compared to employed participants ($p = 0.009$). identical tendencies were observed as far as monthly income is concerned; the participants who preferred Government health facilities were associated with lower incomes than those who preferred private health facilities ($p = 0.027$).

In rural communities, several treatment options are being utilized in a bid to finding solutions to their health challenges. The educational level of participants has direct impacts on participants' awareness of good health behavior. It implies the more people are educated, the more they seek to dwell in urban centers and the more they become aware of their health status and thus seek for health services whenever they fall sick. These findings have also been reported in Nigeria where highly educated mothers are known to be better users of

health information and services [2] and are thus expected to have better care-seeking behaviors for their ill children. Similarly, they are better equipped for initiating and controlling decision making with regard to health [2].

This study has demonstrated that the insecurity in the North West Region is affecting the utilization of health care services. This is due to the fact that patients feel insecure to go out to the health facilities to seek for treatment. There is therefore the need to not only provide populations with better education and living standards but also to provide community security to ensure people feel safe to go to health facilities to seek health services when they get ill.

5. Conclusion

The study has revealed the health seeking behaviors of urban and rural dwellers of the North West Region of Cameroon. Behaviour change in the seeking of healthcare among rural and urban dwellers requires a full understanding of the challenges and motivations associated with a particular society. The success in implementing any plan or solution towards a change in health seeking behaviour requires the full engagement and participation of the beneficiaries of such behaviour change interventions from the onset through to the implementation and monitoring of the program. Security is an important factor to consider when analyzing health seeking behaviours.

6. Recommendations

Based on the findings from this study, we recommend that:

- i. The study be extended to other parts of the country to understand health seeking behaviours in these parts of the country to permit comparisons of variables within the Country.
- ii. More advance study using qualitative means to understand reasons for particular health seeking behaviours.
- iii. Policy makers in Cameroon assess closely these behavioural patterns and health services utilization in a bit to design policies that can remedy and promote increased access and patronage of healthcare facilities.

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