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**MOTHERS' SATISFACTION WITH HEALTH CARE SERVICES AND HEALTH  
CARE SEEKING FOR CHILDREN UNDER-FIVE:  
THE CASE OF OKWAMPA COMMUNITY IN GHANA**

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Author: **Abigail Nketiah**

Supervisor: **Kristina Jönsson**

## **ABSTRACT**

The purpose of this study was to understand the influence of mothers' satisfaction with health care on health seeking behaviour for children under-five. With a qualitative approach, this study used focus group discussions and one-on-one interviews to collect data from thirty seven (37) respondents but the focus was on twenty (27) mothers with children under-five in Okwampa, a small rural community in Ghana.

The health care utilisation and the Donabedian models were adopted as analytical frameworks to structure the analysis. The study found out that mothers perceive health care service for children under-five in Okwampa to be socially and culturally accepted. However, it was revealed that their decision to seek health care was influenced by the severity of sickness. Another finding was that recovery of the sick child is the main factor that affects of mothers' satisfaction with health care services for children. Regarding the purpose of the study, it was evident that mothers' satisfaction with characteristics of both health care providers and the facility influenced their decision to seek health care for the sick under-five.

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## LIST OF ABBREVIATION

ARI	Acute Respiratory Infection
CHC	Community Health Committee
CHO	Community Health Officer
CHPS	Community-based Health Planning and Services
CSDH	Commission on Social Determinants of Health
CHV	Community Health Volunteer
FGD	Focus Group Discussion
HCUM	Health Care Utilisation Model
HIRD	High Impact Rapid Delivery
ITN	Insecticide-Treated Nets
MDG	Millennium Development Goal
MOH	Ministry of Health
ORT	Oral Rehydration Therapy
TBA	Traditional Birth Attendant
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

## **1.0 INTRODUCTION**

The health of children who are below age five, normally referred to as children under-five, is an essential component of a country's development. This issue has gained international recognition and has been listed as the fourth goal among the eight Millennium Development Goals that the United Nation member countries hope to achieve by the year 2015. This goal aims at decreasing the mortality rate of children under-five by two-thirds by the end of 2015. To achieve this, global efforts have gone into programmes such as exclusive breastfeeding campaigns, immunisation and others that are being implemented by governments of low income countries with support from their development partners (Ellis and Allen, 2006; UN, 2009).

Amid all the global efforts to reduce under-five mortality, UNICEF (2011:84) still records approximately 8.1 million children under-five deaths every year. Chances of a child falling victim to this are ten times higher in low income countries than high income countries (WHO, 2009). For example, in 2009, the average mortality rate in low income countries was 121 deaths per 1,000 live births compared to 6 per 1,000 in high income countries (UNICEF, 2011:83). About 50 percent of under-five deaths in the world are accounted for by the situation in countries in Africa (UNICEF, 2011:84). This means that one out of every six children dies before the age of five in Africa (ibid: 28). According to the state of the world's children report for 2011, almost all the first 35 countries with high under-five mortality rate are in Africa with Chad ranked as the first (209 deaths per 1000 live births). The Ghanaian situation (69 deaths per live births) in comparison with these other African countries is better (UNICEF, 2011:87). However, under-five mortality accounts for more than 50 percent of the total deaths in Ghana (Odoi-Agyarko, 2003: 17). Therefore, the urgency of the under-five situation in Ghana and in other low income countries remains a major public health issue which needs more attention (Ellis and Allen, 2006; UNICEF, 2000; 2009).

### **1.1 Criticality of under-five health as a major public health concern**

Child health, most especially the health of the child under-five, is crucial to human development (Case *et al.*, 2005). This is because the period before age five is a high vulnerability stage particularly to diseases and it also constitutes the foundation phase in a child's psychosocial development (WHO, 2011). As a result, conditions that an under-five child is exposed to can

affect the child's freedom to enjoy a healthy life and to contribute to societal development (Sen, 1999).

According to Lindstrand et al. (2006), under-five mortality is dependent on the socio economic status of a country and as such, is used as an indicator of the country's overall socio-economic development. It reflects a population's access to health care among other basic needs such as nutritional diet, female education, quality water and sanitation. In the same way, WHO (2009) asserts that under-five mortality is worrisome because a greater proportion (70 percent) of these deaths is attributable to pneumonia, diarrhoea, malaria among others which can be prevented and cured with simple interventions.

The situation of under-five mortality in low income countries, particularly in Sub-Saharan Africa, tells a lot about the inadequate attention given to the health of children under-five (UNICEF, 2009). This is because while the global under-five mortality has improved from 12.4 million in 1990 to 8.1 million in 2009, figures in Africa remains almost the same (4.2 million in 1990 and 4.1 million in 2009) whereas figures in Sub-Saharan Africa has increased from 3.9 to 4 million over the same period (UNICEF, 2011). Poverty is the major threat to health and also it underlines other challenges such as inaccessibility to health care facilities and other essential needs for the health of children under-five. One of the major determinants of child health is primary health care services (Commission on Social Determinants of Health (CSDH), 2008). Even though accessibility to health care facility may not bring an end to under-five mortality, upgraded health care facilities which provide effective primary health care have the capacity to greatly improve the situation of the under-five (WHO, 2009). Apart from the physical access which is mostly emphasised, socioeconomic and cultural barriers such as beliefs, cost of treatment, perceptions about medical care as well as attributes of health care facilities have been also indicated as barriers to health care accessibility (Chibwana et al., 2009).

It must however be noted that, health care seeking for the sick under-five child depends on their care-givers (who are mostly their mothers). From the view that seeking inappropriate health care and delayed health care seeking are some of the causes death or disability in sick children, the care-givers perceptions' about these factors need to be of great concern. Again, this is important



because these factors could be preventing care-givers from seeking appropriate or early health care for the sick under-five child.

## **1.2 The under-five and health care services in Ghana**

In Ghana, UNICEF (2011: 87) estimates that under-five mortality is estimated to be 69 per 1,000 live births. It has also been recorded by the WHO (2010: 24) that, a child out of every thirteen children dies in this sub-Saharan African country before the age five. Majority (about 60 percent) of these deaths occur between birth and the first month after birth (GSS et al., 2009: 29).

Policies such as health care user fee exemption (Oxfam, 2011), National Breastfeeding Policy, School Health Education Policy, Vitamin A Supplementation Guidelines have been developed to improve child health in Ghana (Odoi-Agyarko, 2003: 17). Yet, Ghana is still off track in the attainment of MDG 4 (MDG Monitor, 2010). The situation in rural areas (90 deaths per 1,000 live births) is higher than in urban areas (75 deaths per 1,000 live births). Generally, it is argued that children who have no access to health care services stand a higher risk of falling victims to such mortality (GSS *et al.*, 2009; Philips *et al.*, 2005).

According to Philips *et al.*, (2005), about 70 percent of Ghanaians did not have access to improved health care in the 1990s. This alarming report intensified Governments' effort in pursuit of the goal - *provision of basic health care services for all* - and set it as a major priority in the area of health. Strategies such as outreach services were initiated to ensure that people who lived beyond eight kilometres from health care facilities (remote areas) could be served with improved health care. These efforts could not make significant impact because the services were provided at inappropriate points which were inconvenient for some people and the health care providers could not follow up on the sick that came for treatment. It was also reported that the services had little or no community participation and in some cases, there was no privacy for patients who visited the health facilities (ibid).

Currently in Ghana, the provision of health care for all the populace remains one of the main agenda being pursued in the health sector. Before 1999, the government of Ghana had succeeded in providing hospitals, clinics, health centres, etc as part of its strategy to provide basic health care for inhabitants in all regions of the country (van den Boom, undated cited by Salisu et al.,

2009). However, the services provided by these facilities were basically enjoyed by urban residents. These urban residents also had access to private health care facilities and so they had the luxury of choosing from the several options, while the population living in rural areas on the other hand had limited access to these health facilities. The situation is worse in the case of those who live in very remote areas (MOH, 1998 cited in Philips et al., 2005).

In 1999, the Ministry of health adopted the Community-based Health Planning and Services (CHPS) initiative as a plan of action to achieve its primary health care goals and to bridge the health equity gap between rural and urban residents (MOH, 1999). The CHPS initiative is a collaborative effort with the High Impact Rapid Delivery (HIRD) approach which was introduced by the Ministry of Health, Ghana Health Service and its allies in 2005 to fill in the gaps in service delivery (USAID, 2008).

### **1.3 Purpose of the research and research questions**

The purpose of this study is to understand the influence that mothers' satisfaction with health care has on their health seeking behaviour for children under-five. This will be done by exploring the factors that affect health care seeking for children under-five and factors that constitute mother's satisfaction in Okwampa community, a small rural community in Ghana with a health care facility situated within the community. This purpose will be achieved by answering the following research questions.

- How do mothers perceive health care services for children under-five in Okwampa community?
- What factors affect mothers' attitudes toward health care seeking for children under-five?
- What factors influence mothers' satisfaction with health care?

### **1.4 Research rationale**

The issue of patients' satisfaction with health care services has gained attention as an indicator of quality health care. Research in this area has noted that satisfaction with health care providers influence patients' health care seeking behaviour (Hadorn, 1991; Margolis et al., 2003; Rakin et al. 2002). These studies emphasise adult and youth satisfaction with health care. It is however

unfortunate that there is very little literature on care givers' satisfaction with health care services for under-five. Although in the view of Nketiah-Amponsah (2009), children as health care users may not voice their opinions about health care services; hence, their care givers can stand in for them.

It could be argued that improving health care based responses from adults and youth surveys may result in an improved health care for the under-five since they are all users of health care facilities and are likely to have the same concerns. Yet, it cannot be taken for granted since results from such studies may not have any positive effect on health care for children. Children under-five, like every other person, have a right to improved health care. Thus, they should be treated equally.

### **1.5 Disposition**

This dissertation has six chapters. The first chapter introduces the study by discussing critical issues regarding the health of children under-five and the research problem then narrows the focus to the situation in Ghana. It also gave the purpose of the research, the research questions and the rationale of the study. Chapter two discusses how the study was done and the quality and ethical concerns in it. The third chapter briefly examines literature on interventions to improve access to health care; health care seeking; and satisfaction with health care services for children under-five. Based on this, chapter four describes how this study organised the empirical data from the field using the HCUM and Donabedian models. Chapter five then discusses and analyses the results in relation to literature whereas the last chapter summarises the findings as they have answered the research question and proposes areas for further studies which can complement this study.

## **2.0 METHODOLOGY**

This chapter discusses how the research was carried out in detail describing the research design, scope of the study, sampling and the methods used for the data collection and analysis.

## **2.1 Research design**

The study used a qualitative approach to enhance the exploration and interpretation of the study elements (mothers' satisfaction with health care services and health care seeking for children under-five) (Brockington and Sullivan, 2003: 57). An interpretivist perspective was employed to ensure that the detailed views of mothers were not lost in the study and to give mothers' perception of the study elements (Schwandt, 1994: 118). The basic assumption here is that reality is socially constructed and the researcher becomes the means by which reality is revealed (Cavana et al., 2001). Through this approach, the social world is constructed by the interaction between the researcher and the respondents (mothers). Hence my interpretation of this study is fundamental to bring out the subjective issues supported with quality point of views (Garcia and Quek, 1997: 459).

A single case (one community) was then selected to unearth the factors that influenced the study variables (Yin, 2003:13).

### ***2.1.1 Study area***

The selection of Okwampa community as a single case study was motivated by its uniqueness (Bryman 2004: 387; Yin 2003:53). Since the CHPS initiative started in one of the poorest regions in the northern parts of the country, the study was preferred in the southern part of the country to find out what the situation of health care seeking for children under five has been after the introduction of the initiative. The central region was chosen for this study because it is the poorest in the southern part of the country in terms of health indicators and development indicators (Heyen-Perschon, 2005: 18). This motivated a personal interest in understanding how the CHPS initiative serves the health care needs of children in the rural community.

Owing to this, Okwampa community which is located in the Awutu-Senya District, Central Region was specifically selected (See Appendix I). This is a small community, about 75 km from Ghana's capital city, Accra. According to the Okwampa CHPS profile, the community has a population of about six hundred and eighteen (618) people. Out of this total, women in their reproductive age constitute 24% (148) and 17% (108) are children under-five year. The major economic activities are farming and gari processing.

I selected Okwampa based on the unique characteristics of the CHPS facility whose establishment was motivated partly by high under-five mortality in the community (Yin, 2003:41). The facility was established through a collaborative effort of an NGO (PLAN Ghana) and the Government. PLAN Ghana, a child centred international NGO, facilitated the construction and the furnishing CHPS facility whereas the Government provided the health workers. These health workers, Community Health Officers (CHOs), are part of the Ghana Health Service and are also on government payroll. Another unique feature is that the facility serves as a learning facility for students from within Ghana, particularly medical students from the University of Cape Coast who come there yearly and visitors from Abroad who come to learn about CHPS concept as rural health care delivery. As part of the CHPS compound, PLAN Ghana provided an accommodation facility for the CHOs plus a flat for the medical students. According to the CHOs, all these exclusive features have won the facility a title - '*an international CHPS*'.

As narrated by the CHO and the PLAN Bawjiase Programme Area Health Facilitator (HF), the CHPS was launched in Okwampa in December, 2004 but it started full operation in January, 2005. The facility has two (2) staff - a midwife/CHO and a CHO supported by a night watchman. According to their work schedule, the CHOs are the frontline health care providers, facilitators and liaison between the community and the sub-District Health Management Team (DHMT) (See Appendix II). The facility serves additional seven (7) communities in the sub-District. Consequently, the CHOs have the responsibility of providing both preventive and curative health care services including counselling on maternal and child health, family planning, malaria prevention and treatment and HIV/AIDS prevention to all the eight communities.

Some community members are involved in the direct management of the facility as Community Health Volunteer (CHV) and Community Health Committee (CHC) members. There is a CHV in each of the community who assists the CHOs directly in health care delivery but only one CHC for all the eight communities. In an interview with the Okwampa CHV, he said that in the absence of the CHOs, he can prescribe treatment for minor sicknesses. He added that he goes on home visiting either alone or he joins the CHOs. During post natal care which was referred to as Child Welfare Clinic (CWC) days, he helps with records keeping and administers the vitamin A supplement among others. As gathered from an interview with 2 members of the CHC, they said

that the CHC is made up 7 members, 3 from Okwampa and 5 from the other communities. They assist the CHOs with publicity, mobilisation of the community to keep the CHPS facility tidy and also ensure the welfare of the CHOs and visitors.

## **2.2 Sampling**

Purposive sampling was used for the selection of twenty seven (27) mothers of children under-five as the main respondents (Mark *et al.*, 2005: 5). In this target population, two sub-groups were formed; the first group was mothers who had children below five years and the second group was mothers who had children below five years as well as children between 5 and 10 years. This was done to ensure that the study would be well informed about both the situation before and after the CHPS initiative was introduced. With the assistance of the CHV, such mothers who were available were informed about the research. Interested mothers were given times to participate in the focus group discussions. Those who were interested but could not be a part were engaged in one-on-one interviews.

After engaging with the twenty seven mothers in either FGD or one-on-one interviews, I noted that subsequent interactions were not bringing new understanding into the study elements (theoretical saturation) (Mark *et al.*, 2005: 5). Therefore the number of respondents involved in the study was determined by the trend of the responses. The views of four (4) fathers were sought for crosschecking mothers' responses on health care seeking in the community. These were fathers who were available and willing to participate in the study. Six (6) key informants who had information about the CHPS and were also involved in health care delivery in the community were included to provide information about the CHPS and to comment on mothers' attitude toward health care seeking for children under-five. In all thirty seven (37) respondents were involved in the study (See Appendix III).

## **2.3 Data collection**

Initial contacts were made with the CHOs who later introduced the CHV as the gatekeeper who links the research team to the target population. The CHV then facilitated contact with the target population. This visit was made in January, 2011, two weeks before the actual data collection (Murray and Overton, 2003: 31). There were traditional leaders but due to the chieftaincy dispute

in the community, the CHV remained the gatekeeper. During the visit, it was observed that women sat in groups to work alongside chatting. A little interaction with some women showed that they were more open and shared their thoughts and experiences freely in small groups. This informed my decision to use FGDs. The possibility of this assumption not being true informed my decision to complement the FGD with some one-on-one interviews. With the knowledge gained from the initial visit, the interview guides were re-structured and the times for the interviews were scheduled to meet mothers' usual availability for data collection.

Three people who have first degree and have had data collection experience before offered to assist in the data collection; one as co-moderator and the remaining two as note-takers. The co-moderator had better understanding of the purpose of the study because he joined me for the initial visit and afterwards assisted me to re-structure the interview guides (See Appendix IV). There were several meetings to discuss the interview questions to ensure shared understanding and their interpretation into the local language (Hennink, 2007:7). During the data collection period, there were regular debriefing meetings to discuss the data and observations.

The actual data collection was carried out in January with a follow-up in February, 2011 to clarify inconsistencies after transcribing the data. Semi-structured interview guides were used for gathering data in the focus group discussion and one-on-one interviews. The semi-structured interview guides were used to ensure flexibility in the discussions while keeping the discussion within the research scope (Bryman, 2008:438-9).

### ***2.3.1 Focus group discussions***

As stated earlier, FGD was found as an appropriate technique for collecting data from the mothers about their views on health care services for under-five, health care seeking for the under-five as well as their satisfaction with health care (Mack et al. 2007:51-2). Again, the homogeneity of the target population also informed the decision to use FGDs (Silverman 2010:132). The mothers were comfortable in the groups, talking freely and challenging responses that were not a reflection of the truth. The different temperaments of the mothers spiced up by dynamism, bringing up issues from different angles and giving different interpretation. The blend motivated each person to contribute to the discussion (Mack et al. 2005; Hennink, 2007:6).

In all, two (2) focus group discussions were held with seventeen (17) mothers; one group was made of eight (8) mothers who had only children under-five and had experienced health care for under-five from only the CHPS. The other group comprised of nine (9) mothers who had children under-five plus children between the ages of five (5) and ten (10) and had experience of health care for their children under-five before and after the establishment of the CHPS. This categorisation was done to bring out the differences in the health care service in the CHPS and the other health facilities that mothers used before the CHPS. The duration of the FGDs was between 75 to 90 minutes.

### ***2.3.2 One-on-one interviews***

In view of the purpose of the study, the two CHOs, the CHV, two CHC members and the health facilitator of PLAN Ghana for that area were involved in the study as key informants (Flick, 2009). They were also interviewed one-on-one with semi-structured interview guides to find out about health care seeking for under-five and the measures they have in place to ensure that children receive health care delivery for under-five.

Ten (10) mothers and four (4) fathers of children under-five were engaged in one-on-one using a semi-structured interview guide. This action was done to probe into the motivation for the frequent visits and the contribution of their satisfaction with health care delivery to this. Again, this was done to complement the FGD; to find out personal issues that may have not been discussed in the group discussion (Mack et al. 2007:51-2). These mothers were selected based on the consultation register which showed that their children under-five had visited the CHPS facility the most. Each interview was done within 30 to 45 minutes.

## **2.4 Transcription and Data analysis**

The process of the analysis started immediately after the first set of data was collected to ensure that identified gaps and unclear issues were taken up for further discussion to avoid information gap in the research.

All interviews were tape recorded. After all the data collection exercise, the first phase of the analysis was the transcription of the tape recordings and field notes to bring out the full picture



of the data set in a form of transcript. The transcription was done by the researcher but with some assistance from other data collectors.

The analysis then proceeded reiteratively in three stages: identification of themes, descriptive accounts and interpretative analyses. Based on the research questions, themes were identified from the data. With the analytical framework in mind, the themes were derived inductively so as to ensure that they remained grounded in the data (Pope *et al.*, 2000; Fereday and Muir-Cochrane, 2006). A descriptive account and interpretative analyses were done to give meaning to the themes identified.

Thematic analysis approach for qualitative data analysis is used to identify the significant commonalities in qualitative data to form patterns which are referred to as themes which represent the shared views in the collected data (Braun and Clarke, 2006; Hayes, 2000; Ryan and Bernard, 2000). Though thematic analysis does not make full assertion of the verb communication, it was the preferred over other techniques such as grounded theory and content analysis. Unlike other approaches such as grounded theory (Aronson (1994; Boyatzis, 1998), thematic analysis facilitated a better understanding of the concrete views from the transcript for adequate reporting (Leech and Onwuegbuzie, 2005, 2007; Green and Thorogood, 2004). Secondly, it helps in communicating results from the study through categorisation which presents the authentic data without distortion (Miles and Huberman, 1994; Attride-Stirling, 2001; Auerbach and Silverstein, 2003; Bradley *et al.* 2006; Simons *et al.*, 2008).

Themes derived from data on mothers' satisfaction were then structured and analysed using the Donabedian model of quality care and the health care utilisation model respectively. The results are presented in summaries and in some cases quotes under sub-headings within the health care utilisation model and the Donabedian model which were the analytical framework for the study. They were then discussed in relation to previous research works.

## **2.5 Research quality considerations**

In qualitative research, analysis is mostly dependant on subjective judgment of the researcher; therefore, this study considered some issues and observed some research ethics which make this study valid and offers reliable reflection of the real situation in the community under study.

For the purpose of validity in this single case study, an initial visit was made to find basic information about the community which may be needed for the data collection such as mothers' availability and the language they speak. During the visit, we had interactions with the Community Health Officers (CHOs) who were also not indigenes but have been successful in their work and have also witnessed other research works in the community. This was important because they shared information about the community and on how we could maintain good impression to have maximum co-operation and to avoid problems during the data collection (Scheyvens and Nowak, 2003: 100-104). The findings served as the basis for the selection of focus group discussion as the main data collection method and also informed the approach vis-à-vis dressing code, mode of communication, their availability, and other issues that could have been hindrance.

Again, both FGDs and one-on-one interviews were used for the data collection to ensure that the gathered data reflect the true situation in the community. A convenient venue was selected for the FGDs to ensure that mothers were relaxed to express themselves. However, the one-on-one interviews were conducted in the homes of participants. Different ways; the use of several sources and methods for data collection served the purpose of triangulation in the study (Bryman, 2008:379). Though observation was not a major method for collecting data, off-the-record information helped in the interpretation of the data (Rabiee, 2004). Inconsistencies were then clarified with follow-up visits after the data collection.

Although satisfaction with health care seemed new to mothers, they were asked to reflect and narrate a typical visit to the CHPS describing everything that happened. This technique was helpful; it helped mothers to assess their satisfaction with health care services.

To strengthen the reliability, two people were involved in both the FGD and the one-on-one interviews. Again, the data collection was conducted in a local dialect, Twi but transcribed into English. The possible cross-language issues were checked by the involvement of all data collectors in the transcription before the analysis to ensure that the final transcript reflected the full information collected regarding the purpose of the research.

The possible effects of my personality and background on data were curtailed by the involvement of people to assist with the data collection and transcription. However, the interpretation of the data is a reflection of my understanding of the issues in the study.

## **2.6 Ethical consideration**

Permission was sought from the CHOs who have a mandate from Ghana Health Service to oversee the health issues of the community. All participants, particularly mothers, who were the target group, were informed that participation in this study was not compulsory and that their decision to withdraw at any point in time would be respected. All respondents were informed about the purpose of the study, stressing that it was for academic work and it served no government or any other organisation's agenda. However, they were told that the study may be shared with interested individuals or organisations.

The gatekeeper was the CHV who was part of the health team in the country and the venue for the FGDs was a shed near the CHPS facility. To clear any association of the study to the government or any other organisation, each section started with a brief introduction to remind participants that the study was for academic purposes. This ensured sincerity in communication (Scheyvens and Nowak, 2003:146). Again, before the start of any discussion, both parties (the data collectors and the respondents), especially in the focus groups, assured each other of confidentiality. Both parties agreed that the issues discussed would not be made public with reference to any specific person or name. This was also done to promote trust (Hennink, 2007:33).

## **2.7 Reflexivity**

Knowledge gained from the development management and field research method courses as well as previous experiences in community work were very helpful. The initial visit was a great asset during the fieldwork. These minimised the possible influences for instance, researchers beliefs, values, etc, which could affect the study process (Patton, 2002; Denscombe, 2007).

Exploring mothers' satisfaction with health care services for children under-five in Okwampa community was not easy but it turned out to be an interesting experience. Mothers initially

thought of satisfaction as luxury enjoyed in big towns and cities where people had lots of options to choose from. The expectation approach to studying satisfaction (Crow et al., 2002) became very useful in helping mothers understand this.

### **3.0 LITERATURE REVIEW**

This chapter discusses previous studies that have been done on children under-five's access to health care in low income countries, health care seeking and satisfaction with health care for such children.

#### **3.1 Interventions to improve under-fives' access to health care in low income countries**

Through researches ranging from epidemiological studies to evaluation of interventions, a number of public health interventions have been introduced to improve access to health care, and to reduce the spread of preventable diseases, among others (Dabis et al., 2002). These were adopted in the 1990 World Summit for Children. Some of the interventions included Vitamin A supplementation for resistance against mortality caused by measles, childhood blindness, and diarrhoea; the Oral Rehydration Therapy (ORT) for treating diarrhoeal diseases; and the WHO strategy for the management of Acute Respiratory Infections (ARI) (Dabis et al., 2002; UNICEF, 1994; WHO 1990).

As noted by Ellis and Allen (2006), several studies show that these inexpensive interventions focusing on health care for newborns, nutrition, vaccination, preventive measures and case managements can prevent about 60-70 percent deaths in children under-five.

Different studies have identified a number of factors that have kept under-five mortality rate high. Rutstein's (2000) review of health demographic surveys, the Mosley–Chen framework and the Commission on Social Determinants of Health (CSDH) on factors underlying the health of children under-five shows five (5) categories. They are nutrition (nutritional status, breastfeeding, infant feeding), usage of health services by mothers and for children, environmental health conditions, fertility behaviour, and socioeconomic factors. She also stresses other factors such as incidence of parental HIV/AIDS, decline in medical care seeking for children with fever, and increasing malaria resistance to drug treatment (Rutstein, 2000).

### **3.2 Health care seeking for children under-five**

Seeking obtaining and using drugs from the right sources are necessary actions for effective management of diseases in children (WHO, 2004). Even though seeking health care is very important for the survival of a sick child; this is sometimes prevented particularly when health facilities are non-existent (van den Boom et al., 2004).

According to UNICEF (2009), poverty is a major factor that undermines health seeking behaviour and also underlines almost all other factors like accessibility (geographical and economic) and socioeconomic factors. Beliefs also have effect on health seeking for children under-five (UNICEF, 2009: 15-19). A study in the northern parts of Tanzania showed that poor quality of health care can be a hindrance to accessibility (ibid: 54).

Shaikh and Hatcher (2007), in their study in Pakistan, argued that a health system can influence health seeking behaviour positively when viewed as a holistic organization. Here, health system transcends the physical structure to include the people, their culture, environment and others. They also mentioned that perception about severity of ailment and the type of health care provided are factors that influence health care seeking behaviour (Shaikh and Hatcher, 2005).

Other studies have shown that people living in areas without access to health care facilities resort to traditional methods and self medication with all the dangers involved (van den Boom et al., 2004). Shaikh and Hatcher (2005) have said that these practices are also influenced by cultural and socio-demographic factors. However, cultural factors override socio-demographic factors in most cases. Some researches in Ghana (van den Boom et al., 2004), Sudan (Abdel-Hameed, 2000; Malik et al., 2006) and Tanzania (Comoro et al., 2003) have shown traditional and self medications as normal practices particularly in rural areas. Therefore, Rahman (2000) advocates that improving health seeking behaviour will require recognition of traditional health care providers especially in areas where traditional health care is preferred. Green (1994) and Outwater et al. (2001) have added that the unofficial providers should be included in trainings and in service delivery to ensure proper practice.

In a review of studies on health seeking behaviour, MacKian (2003) reported that factors that influence this behaviour are multifaceted. At times, findings from similar studies in different

areas may be comparable but this may not always be the case. Although there may be similarities, literature is quite silent on the situation for children under-five in rural areas where access to public health care facility is not an issue. Therefore, this study tries to find out factors that influence health seeking behaviour in the context of a rural community with access to one public health care facility.

### **3.3 Satisfaction with health care services for children under-five**

Satisfaction with health care is gaining prominence as a way to improve health care services (Smith *et al.*, 2006). However, it is broad but in literature four main approaches - patients' expectation and what they have received; patients' assessment of the features of a health facility; economic approach; and the holistic approach - have been used (Crow *et al.*, 2002:2).

Previous studies have shown that characteristics of health workers, especially patient-health worker communication and patients/care-givers', have effect on patients' satisfaction with health care service. More also, efficiency of the health care services, early detection of the cause of ill health and less waiting time are some of the constituents of patients' satisfaction (Handler *et al.*, 1998; Krahn *et al.*, 1990; Marcinowicz *et al.*, 2009; McKay and Hensey, 1990). Other researchers have found social acceptability, promptness, accessibility, continuity and effectiveness of health care as factors that affect satisfaction (Nketiah-Amponsah and Hiemenz, 2009; Smith *et al.*, 2006).

Generally, it was observed that existing literature greatly focused on general patients' satisfaction, adults or the youth and these studies are mostly conducted in areas where people have several options, particularly in urban areas. In some case, the focus was on specific treatments which included young people or children and in rural areas. However, literature on satisfaction with health care for children under-five is inadequate (Nketiah-Amponsah and Hiemenz, 2009). Currently, the literature appears to be silent on the influence of care-givers' satisfaction with health care on health care seeking for the under-five in rural communities. Therefore, this study would add to existing literature as it explores the situation of children under-five in a rural context.

## **4.0 ANALYTICAL FRAMEWORK**

This chapter discusses the health care utilisation model and the Donabedian Model which are used as the analytical framework for the analysis. It also specifies the aspects of the models that will be used in the analysis.

### **4.1 Health care utilisation model**

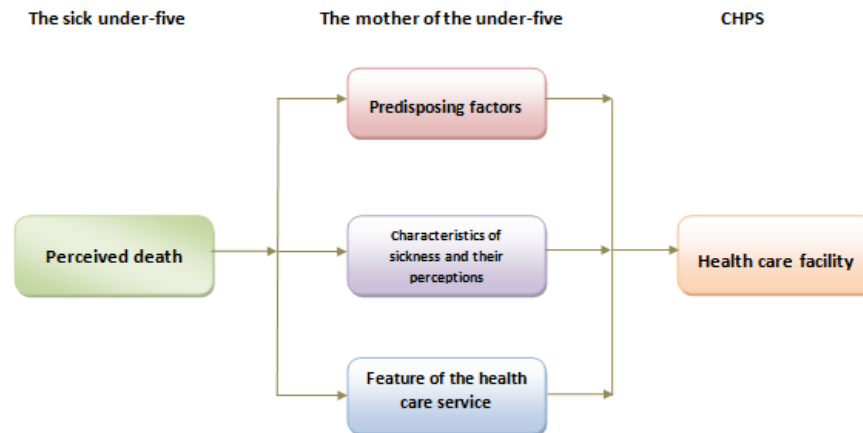
For better conceptualisation of the findings on health care seeking for children under-five, a social and medical anthropology model which is known as the health care utilisation model was found useful for this study. In this model, the factors that can influence health behaviour are classified into three – predisposing, enabling and need factors. The health care utilisation model was initially purposed for the assessment of biomedical health services. Later works by Weller *et al.* (cited in Hausmann-Muela et al., 2003) broadened it to include health care facilities. The international collaborative for health also substituted health service system factor for the need factor in the model. Again, Kroeger (cited in Hausmann-Muela et al., 2003) altered the original work by Andersen on the basis of extensive and a thorough study of works in this field. Here, health care utilisation is motivated by probability of death.

Thus Kroeger's viewpoint is appropriate for the purpose of this study since Okwampa community was noted for high under-five mortality. This model was selected because it connects the various factors and summarises them into three (3) factors (see Fig. 1). They include predisposing factors or individual traits, characteristics of disorder (sickness) and their perception, and features of the services which include the organisation of health care services and enabling factors (Hausmann-Muela *et al.*, 2003).

Predisposing factors describe the patients and their unique characteristics such as age, gender, marital status, formal education, employment, status in the household, size of household, extent of cultural adaption, social network interactions, tribe and property holdings. The second factor of the health care utilisation model, the characteristics of disorders and their perception illustrates the nature of the sickness (physical or emotional), causes, persistence and severity of the sickness and the likely benefits or treatment (current or traditional). The last factor, features of the services (health care service organisation and enabling factors), describes aspects such as

acceptability, accessibility, quality, communication, cost and appeal are considered (Hausmann-Muela *et al.*, 2003:13).

**Fig. 4.1 Health care utilisation model**



Adopted from Kroeger's view point

In the analysis of health care seeking for children under-five, the health care utilisation model was used based on the findings from the data.

## 4.2 Donabedian Model

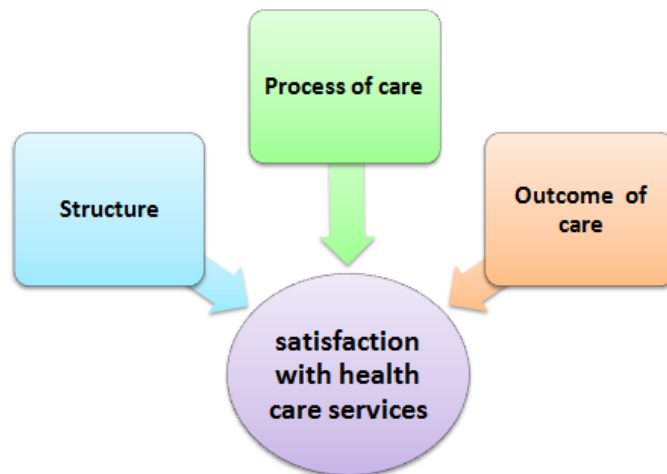
For easy structuring of data on mothers' satisfaction with health care for children under-five, the Donabedian model is used. The model envisages satisfaction with health care as a resultant of a person's entire experience with health care considering the reaction to three (3) main aspects – structure, process of care and outcome. This interrelated linear model was introduced by Avedis Donabedian in 1966 in the field of public health to serve as a guide for assessing and ensuring health care quality (Naranjo, 2011). The model is one of the widely recognised models for assessing quality of care which originated from robust theory which underlines programme evaluation. It has since been adapted in several forms (Rossi and Freeman, 1993 cited in Sibthorpe, 2004).

The first component; structure, describes the set up of the facility providing the health care services. Although this is complex, the basic aspects include the human and material resources



with all the other factors that may influence service delivery in the health facility. The process of care also focuses on the actual service and how it is delivered in the facility. The last component which is outcome deals with the result of the service received (Naranjo, 2011).

**Fig. 2 Donabedian Model**



Adopted from the Donabedian model

This model was adopted because it relates the findings from both literature and this study in an organised form. Given the context in which this study was conducted (a rural community with a simple health care services and semi-literate mothers as the target); the model was adopted to suit the situation based on the findings.

## **5.0 RESULTS AND ANALYSIS**

This chapter gives brief demographic information about the mothers and continues to analyse and discusses the results. The results have been organised under components of the analytical framework with the themes from the data as sub-themes.

### **5.1 Demographic information**

This study involved twenty seven (27) mothers aged between 18 and 35 years. Seven of the mothers had no formal education and the remaining 20 had basic level education. These

respondents were engaged in farming, gari processing, petty trading and tailoring as their economic activities with an average annual income less than GH¢ 300 (approximately 140 Euros). It was noted from the CHOs that the average household size in the community is 7.

It was observed that some of the women had difficulty in remembering their ages which can be linked to the problem of high rate of home delivery (57 percent in rural areas and 46 percent in the central region in Ghana), poor birth registration (45 percent of the population in rural areas and in the central region have birth certificates) and low education of mothers (GSS *et al.*, 2009:155 and 29).

## **5.2 Predisposing factor**

Social support was the main theme identified in the data as a predisposing factor which influenced health care seeking for children under-five.

It was noted that the whole community was concerned about child health. There were whistle-blowers who inform the CHOs when a child under-five was sick. Mothers said that since the CHPS came, health care seeking for the under-five had become the concern of the whole community; anybody can prompt mothers to send the sick child for treatment or reported to the CHOs. Such mothers receive surprise visits from the CHOs.

This is an indication that the decision to seek health care for a sick child is a communal affair than the responsibility of the mother as it was before the CHPS which was similar to the situation in places like Sudan (Malik *et al.*, 2006). Regardless of this change, it became apparent that fathers who partook in caring for their sick children were laughed at and in some instance, their wives were said to have bewitched them. This means that the inherent belief that caring for children is a basic responsibility of mothers still exists.

It was also observed that mothers interacted a lot with themselves more than with the CHOs concerning the health of their children. Hence if mothers are well-informed, they could support each other in maintaining good health among children. This social support in the community can be used as way to influence of child health through knowledge-sharing and peer encouragement (Rutherford *et al.*, 2009).

### **5.3 Characteristics of sickness and their perception factor**

Perceptions about common sicknesses in children under-five, the severity, causes and treatments were the themes that emerged from the data which correlated with characteristics of sickness and their perception factor.

#### ***5.3.1 Perception about common sicknesses in children under-five***

From the data, it was obvious that mothers perceived some sicknesses as normal and others as spiritual. Malaria, a normal sickness, was said to be the most common sickness among children under-five. They listed malaria, tetanus and measles with sores in the mouth as some of the commonest sicknesses the children under-five suffered from prior to the establishment of the CHPS. Malaria, which was also called fever, was again mentioned as the commonest in present times. They mentioned mosquito bites and too much exposure to the sun as the main causes. Rise in temperature was the main symptom indicated. For measles, they mentioned itchy rashes which made the children very restless in the dry seasons.

Such knowledge about sicknesses affected health care seeking. For instance, mothers with the perceptions that tetanus had spiritual implications and those who perceive measles as a seasonal condition may not see the essence of immunisation for children but may prefer to consult a spiritualist for protection against such sickness. Inadequate knowledge about sicknesses could also be a reason to the persistence of malaria among children under-five. Therefore, an improvement in mothers' knowledge of sicknesses can be a step toward disease prevention and improvement in health care seeking behaviour (WHO, n.d.).

#### ***5.3.2 Severity of the sickness***

It was found from the study that severity of sickness played a key role in health care seeking for the sick child. Mothers often delayed in seeking health care for their children when they perceived that the illness was not severe. This finding is similar to what Shaikh and Hatcher (2007) found out in their study in Pakistan which also found severity of sickness as a motivation for health care seeking. Mothers unanimously said that under normal circumstances, they do not take their sick children under-five to the CHPS as soon as they realise a change in their health

condition. From the discussion, it also became clear that mothers took the early symptoms of sicknesses lightly especially the rise in the body temperature of the child. This suggests that health care seeking for a sick child is a response to the severity of sickness. However, the study realised from the FDGs that there has been a change in this response. Before the CHPS, severity was defined by the inability of the child to do any of the usual activities. Therefore, health care was sought in a rush when mothers realised that the child was very sick. When delays occurred in the health facility, it resulted in mortality. Now, severity refers to failure of home treatment to heal the sick child within three (3) days. This practice is deep-seated in mothers as they expressed that health care should be sought when the sickness is severe after home treatments have failed.

### ***5.3.3 Treatment for the sicknesses***

Following the knowledge mothers have about sicknesses, it was further noted that they believed that treatments from both traditional and formal health workers were needed. According to the mothers, sick children under-five were sent to either traditional or health centre before the CHPS started operating. Sicknesses which were deemed to have spiritual implications were treated accordingly. For instance, tetanus was said to be a spiritual disease which was disgraceful. A mother narrated that *‘a child who suffered from tetanus went through a ritual which demanded that such a child should be left naked on the refuse dump for some time as part of the ritual’* (FGD A: 4). This process depicts socio-cultural influence on health care seeking by delaying it or leading to death. Socio-cultural factors were also noted in a study on febrile children under-five in Mwanza-Neno district, Malawi (Chibwana et al., 2009).

Mothers said that the CHPS facility is now their source of health care for the sick child. Exceptional conditions which demand traditional treatment are sought with the permission of the CHOs. A kind of swellings under the skin which may look like boils but are not was cited as an example of such health condition which medical treatment could not treat. For this kind of condition, the CHOs recommend traditional treatment.

Again, with the CHPS in operation, only health conditions which needed intensive care were now referred to Bawjiase health centre (the government health facility that served the District in which Okwampa is located). A mother gladly said in a focus group discussion that:

*‘All minor diseases are diagnosed and treated in the community, immunisation of children under-five is done on time without mothers going through an ordeal and information about children’s health is always available in the community’ (FDG A: 4).*

Mothers’ previous experiences with under-five mortality and health care before the CHPS were the main yardsticks against which mothers measured the present health care services. The unpleasant experiences from the previous facility made them appreciative of the current health care service.

#### **5.4 Features of the Health care service**

Eight themes emerged from the study that reflected the features of the health care services as factors that influence health care seeking for the sick child. These include alternative health care services; self-medication; involvement of local people in the health care delivery; accessibility; benefits of the services; characteristics of the service providers; external support and internal support.

##### ***5.4.1 Alternative health care services***

It was established from this study that the alternative health care services that were available to mothers have been better placed in the present health care system. Mothers who had experience with health care services for children under-five before and after the establishment of the CHPS indicated that before CHPS, they could send their sick children under-five to Bawjiase health centres, Kodua clinic, herbalist (traditional health care provider) or prayer camps to seek health care. Herbalists and prayer camps were mentioned because they believe that not all sicknesses can be treated in the formal health care facilities. In those days, traditional treatment could be sought either before or after visiting the formal health care and treatment had failed. Furthermore, health conditions which were spiritual were handled accordingly.

Presently, all health conditions are brought to the CHPS for examination and treatment but in some cases, the CHO recommend mothers seek herbal treatment for faster healing as mentioned earlier. For instance, snake bites and twisted or broken bones are some of the health issues which are treated by the herbalists with the consent of the CHOs.

The mothers said that they preferred to be treated in Okwampa than in Bawjiase health centre. It was obvious that the preference of treatment in Okwampa ties in with the social and cultural acceptance of the CHPS. For the mothers with experience from before the CHPS, this was because they believe in severity motivating health care seeking but this behaviour resulted in bitter experiences (death of their children) with health care from the Bawjiase health centre. This has created fear in them and thus they do not want their sick child to be referred to the health centre for treatment. However, they have not had such experiences with the CHPS facility. For the mothers with only experience from the CHPS on the other hand, the preference of the CHPS was based on proximity and affordability. This clearly shows that if mothers had access to the Bawjiase health centre alone, health care seeking would have been delayed more than if they had access to only the CHPS due to the fear from previous experience.

#### ***5.4.2 Self-medication***

Self-medication was noted as a trait common to majority of the mothers. It was perceived as the first step in treating a sick child. Mothers were aware of the importance of health care for a sick child. They said that if a child was denied health care, it increases the risk of the child dying. They showed awareness of the importance of seeking health care for the sick child as they continued that seeking health care late is dangerous. However in their view, this action should be taken on the third day or after self-medication has failed. It came up in all the focus group discussions that CHOs do not agree with this behaviour. One of them said that *'as for the CHOs, they wish that sick children are brought to the facility immediately if we notice a change in the behaviour or body temperature of the child preferably before the third day'* (FDG B: 3).

Conversely, a mother said that *'I have observed the CHOs and am very familiar with the different medications that they give to my child under-five when the child exhibits certain symptoms. I administer the drugs accordingly when my child is sick'* (FDG A: 7). This statement

was supported by other mothers who said that they administered the drugs that the CHOs normally gave for such conditions but if this effort failed, they then brought the sick child to the CHPS for further treatment.

Others also admitted that they did not have the capacity to give the right medical care to their sick children hence they took their sick children to the CHPS without any self-medication. This group were mainly those who have had experience with under-five mortality. One of such mothers said that *'there is no motivation to practice self-medication or delayed health seeking after one has had such an experience especially when there is a health facility right here at my doorstep'* (Int. 8).

Although health care for children under-five is free as mentioned earlier, this practice was partly blamed on financial challenges. Mothers are aware of this policy but their challenge was with the cost of the prescribed drugs. This makes self-medication a preferred option especially when they do not have money to pay readily. A mother narrated the process of the self-medication as she said;

*'When the temperature of a child rises, depending on the severity, the child is sponged then paracetamol syrup is administered and the child observed for three days. The child is taken for medical treatment on the third depending on how the child responded to the home treatment'* (FGD A: 5).

In the interviews with the CHOs, they concurred that this was a good practice particularly in places where access to health care facility is an issue. However, they do not promote this practice because there is a likelihood of it being abused or causing delayed in health seeking.

From the analysis, the concerns of the CHOs were found to be the situation as some mothers disclosed that they sought health care within 4 to 7 days after they realised that their child is sick. This delay was attributed to situations where the initial self administered medication cures the sick child before the three day but the sickness comes back afterwards. Despite their knowledge of the CHOs disapproval and discouragement of self-medication, mothers' belief about self-medication as the first step in health care, spurred them on in this practice. This finding shows

that belief has influence on health care seeking for the under-five as noted in literature (UNICEF, 2009: 15-19).

Self-medication is a normal practice among a greater portion of the respondents. This supports the finding from the study by van den Boom et al. (2004) that self-medication is a normal practice in Ghana. The same has been found in some other African countries such as Sudan (Abdel-Hameed, 2000; Malik et al., 2006) and Tanzania (Comoro et al., 2003). Inferring from the field experience, if this practice could be managed properly with professional advice, this could be a good strategy to ensure that the sick under-five child has access to timely health care before seeking professional care especially in remote areas.

This practice could have negative effect on health care seeking if not managed properly (UNICEF, 2009). There are dangers like mortality and morbidity associated with this practice as van den Boom et al. (2004) have reported. Considering that some mothers are illiterate, this norm could be dangerous particularly in the context of this community. For example, mothers were likely to use the unfinished medication from the previous consultation which may have expired at the time of the subsequent use.

#### ***5.4.3 Involvement of local people in health care delivery***

From the study, it was observed that mothers appreciated the involvement of the local people in the health care delivery. Mothers said that the idea of the CHOs working with the traditional health providers, precisely the herbalist and the Traditional Birth Attendants (TBAs) was very good. This is because not all sicknesses can be cured with the formal health care; every drug has a limit and thus needs complement with traditional treatment. They added that the traditional health providers are part of the community hence they could not be ignored; this practice gives them the opportunity to do what they were best at. Again, this prevents the mothers from visiting the traditional health providers in secrecy. A mother said that when a person went to the traditional health workers, they were asked if you had permission from the CHOs. This shows that the CHPS initiative has social and cultural acceptance of the local people. It is also an indication of a network in support of a healthy community. Although the roles of the traditional health providers have not been compiled in a written document, mothers said that the CHO gave



the traditional health worker the opportunity to handle the treatment of fractured bone and snake bites among others in the Okwampa community. This practice is in line with the view of Green (1994) and Outwater et al (2001), who have proposed that there is the need for traditional health providers to be included in health care system and the health service trainings. Even though this is being practiced, the inclusion of the traditional health providers in health service trainings has not been extensive in Okwampa. The contribution of the traditional health providers is also an example of the importance of acknowledging local knowledge (Price, 2001; Runganga, Sundby and Aggleton, 2001).

The involvement of the community members as CHV and CHC has also contributed to the acceptance of the CHPS. It was mentioned that the CHV acted as the health care provider in the absence of the CHOs. Again, these people mobilise mothers during CWC days and also for health education. Although mothers were aware that the CHC members and the CHV were trained by PLAN Ghana and they have been assigned specific roles, they could not give the specific roles of the CHC. They said that the CHV helps the CHOs during Child Welfare Clinic (CWC) days and sometimes joins the CHOs on home visiting. Evidently, the current health care system surpasses just the treatment of the sick to a level of involving the community in the provision of health care. It confirms the role of health system in health care seeking when viewed holistically (Shaikh and Hatcher, 2007).

From observation, the collaborative work being done by the health care professionals, the CHOs, with the traditional health providers and the community members have contributed to the current health care in the Okwampa community, particularly for children under-five. This could be a form of sustainability assurance for the initiative because the community is actively involved in the health care delivery. Nonetheless, the future of the portfolio of the involved community members does not look bright because there are no plans in place to ensure continuity. The CHC and the CHV have not thought of training young people to take up their positions in the future.

#### ***5.4.4 Accessibility***

Another aspect of the health care services factor that influence health care seeking for the sick child was accessibility. Before the CHPS, the closest formal health facility that mothers accessed

was about 20 km away from the community. Mothers recounted that the distance a person had to travel to access health care combined with transportation costs, poor conditions of the road system and the cost of treatment were hindrances to seeking health care for children from the Bawjiase health centre before the CHPS facility started operating. Mothers related accessibility to health care to mortality of children under-five. A mother shared that *'If we had easy access to a near-by facility in those times, my child would be alive today (Int. 3)*.

Beside the effect it had on health care seeking, the frequency of health outreach to the community was also affected. This affected health care delivery such as immunisation of children under-five in Okwampa. Cost of treatment also inhibited accessibility of health care seeking for children under-five. Mothers alleged that the thought of their inability to afford the treatment caused them to resort to other inexpensive sources such as traditional treatment and always hoped that such treatments improved the condition of the sick child. However, this did not always happen and resulted in delayed health case seeking.

In the mothers' opinion, the current accessibility to health care facility has prevented a lot of under-five deaths. With this background, the mothers said that the introduction of CHPS has made health care services within the Community easily accessible at all times. These findings support financial and geographical access as common factors which influence health care seeking in other low income countries. Similar findings were noted in a study in Tanzania that accessibility hinders health care seeking (UNCEF, 2009:54).

#### ***5.4.5 Benefits of the services***

Another aspect of the feature of the health care services which was found as a factor that influenced health care seeking for children were the benefits enjoyed from these services. Mothers pointed out that presently, health care was delivered in the comfort of their homes through health education and treatment of minor sicknesses. Unlike the situation before the CHPS, children were immunised on time and there was monthly CWC. Mothers who were not able to attend the CWC were served in their homes with all the needed health care services at no cost. It also became obvious that the CHPS was basically about home visiting. Relating these findings to mothers' belief about health care seeking, the constant home visits by the CHOs have

brought great improvement in the health of children under-five. Evidently, home visit could be an effective strategy to the survival of all children under-five and not only the newborn as it has been declared in the WHO/UNICEF joint statement (WHO, 2009).

The mode of payment was another benefit that has influenced health care seeking. Mothers recounted that in the previous health care facility, they did not have patient-centred facilities in terms of payment. For instance, a mother who visited the Bawjiase health centre without health insurance paid more money for drugs than if the person visited the CHPS facility. Moreover, with the previous facility, they paid for the drugs before they received it but in the case of the present facility, they receive the drugs for deferred payment.

In spite of the claim about the current payment system, some mothers mentioned financial constraint as one of factors that hindered them from visiting the CHPS. Such mothers said they did not know about the flexibility of payment. They explained that they did not have reliable source of income therefore when a child was sick during times when they did not foresee having any time soon, it was difficult for them to mobilising adequate resources to pay for the drugs. This led to delayed health care seeking. It was also found that some mothers had sheer reluctance in utilising this payment facility. Although some mothers took drugs with deferred payment, they never paid back the money.

The mothers were aware that health care for children under-five is free in Ghana but their concern was the payment for medication. The National Health Insurance Scheme (NHIS) was introduced as one of the remedies to curtail the cases of financial matters hindering utilisation of health care facilities. It was also noted that mothers who had health insurance visited the CHPS without paying for the drugs. The mothers also said that the CHOs encouraged them to register their children for the health insurance so that they can benefit from this. Notwithstanding, they were not willing to patronise this facility because they could not afford the initial registration fee and the cost of annual renewal. Considering mothers' average incomes and their family sizes, these could be a confirmation of their inability to pay. Some also said that they do not understand the health insurance concept. Those who had registered for the health insurance for their children alleged that when the sick child is referred to other health facilities, the health insurance was not attractive. They explained that patients who came to the facility with money in-hand to pay for

the drugs are given better treatment than people who come to the facility with health insurance. Although the mothers complain of cost of the insurance, the shared reasons show that they perceive the health insurance as a waste of money. They said that when the health insurance holder does not fall sick within the validity period of the insurance, the person still has to renew it for the next year.

These findings point out that the National Health Insurance Scheme has not accomplished the purpose for its institution. For those who had had unpleasant experiences with it, they had resolved not to patronise the health insurance. Although they also complained about the cost involved in the insurance, their bad experiences with people was a major reason why most of the mothers were either reluctant to get their children under-five insured or renew it after its expiry. These reasons maintain financial matters as a challenge to health care seeking for the sick child under-five.

Looking at the findings, it is evident that mothers appreciate home visits better than the other benefits from the health care services. This also shows a sense of acceptability of the CHPS initiative for both the curative and preventive health care it provides. They prefer being served at home than in the CHPS facility.

#### ***5.4.6 External support***

External support to the health care facility was identified as an aspect of the feature of health care services which influenced health care seeking. It was obvious from the data that the CHOs are proactive and this nature has contributed to the current health care. Through their efforts, the community is now connected to the national electricity grid. According to the mothers, before the community was connected to electricity, accessing health care in the night was difficult. Some mothers said that it was inconvenient going to the CHPS after sunset. This is no more the situation. Now, they can go to the facility at any time of the day.

The collaborative work of the CHOs and the community has also improved health care. This explains why the facility receives numerous visitors very year. These visitors also support the facility in diverse ways. For instance, one of the current CHOs decided to work in the community after taking an internship with this facility. Again, some of the students donate food

items such as supplements which are given to malnourished children. During the times that the medical students are around, there is always somebody in the CHPS to meet the needs of the community.

More also, data collected revealed that the Okwampa CHPS enjoys a lot of external support from PLAN Ghana. Aside facilitating the establishment of the facility, the organisation supplies the facility with materials such as medicine which makes the facility appealing to visit.

#### ***5.4.7 Internal support***

Apart from the external supports, the data showed that the mothers and the community as a whole have contributed to the present state of the health care services. This also confirms community acceptance of the CHPS initiative. Fathers spoke of mothers' adherence to the lessons from the health education as one of the factors that have contributed to the current health care. In confirmation of this, the CHOs and the CHV stated that almost every child under-five sleep under insecticide-treated nets (ITNs). However, there still needs to be more education since malaria prevalence is still a challenge. They made it clear that mothers who stay outside with their children in the evenings exposed their children to mosquito bites while executing chores or conversing with friends. This was witnessed during the data collection period. A baby less than 6 months was found almost naked lying on a mattress in front of a house around 6 pm while the mother did something else. The fathers added that mothers sought health care within three days of a sickness in the under-five. They confirmed that children under-five do not get sick as the situation was before the introduction of the CHPS. This has reduced the frequency of referrals.

The CHO and CHV in separate interviews mentioned that 80 percent of the mothers are practising early health seeking at the moment. The remaining 20 percent is made up of those who are yet to change. The CHOs excused the latter by saying that some people have hard times adapting to change. Accordingly, change does not happen to everyone at the same time. The improvement has resulted in limited referral because the illness is treated early enough to avoid critical situations which demand referral.

In the view of the CHOs, the change in health care seeking for the under-five has progressed since the CHPS initiative was introduced. There has not been any record of under-five mortality

in the community for the past three (3) years or so. There has also been a reduction in the incidence of major child killer diseases such Tetanus. This was also attributed to mothers' responsiveness to health education and the tireless dedication of the health team (CHOs, CHV and CHC).

As a partial remedy for the transportation menace, it was observed that the community members who owned taxi had agreed to help in transporting patients on referral to the Bawjiase health centre. Nonetheless, the condition of the road remained a hurdle.

The dedication of the CHV and the CHC members was also noted as internal support that has contributed to improved health care. Even though the CHV said that his work as a CHV was not lucrative, the impact of the CHPS on the health of children under-five was a motivation for him. He also talked about the knowledge he has gained through the training workshops from PLAN Ghana and the experience from working with the CHO as benefits that motivated him. Now, he is able to offer first aid in the absence of the CHOs.

CHOs and CHV made known that awareness creation about the importance of seeking early health care from the CHPS for children under-five has not yielded 100 percent success but about 80 percent of the mothers bring their sick children under-five to the CHPS within three days of signs and symptoms of sickness in a child. The CHC and CHV said that health education has increased mothers' action against the incidence of child mortality.

Evaluating the external and internal supports to CHPS initiative, there is a sense of community ownership of the health care service and this can enhance the sustainability of the initiative (Lopes and Theisohn, 2003: 21).

## **5.5 Process of care**

Two themes that represent mothers' satisfaction with health care were in consonance with the process of care of the Donabedian model. They include patient-centeredness and diagnosis and treatment.

### ***5.5.1 Patient centeredness***

A comparison of mothers' experiences with health care services before and after the CHPS showed that mothers were satisfied with the current health care (CHPS) services because the health of the patient (child) is central to service delivery. They cited the home visits by the CHOs and the cordial communication that they have with the CHOs as ways that point to the fact that the health care services are patient centred. Again, the CHOs give them information about the causes and preventive measures of sicknesses, unlike their experience with the previous health providers. They added that the relaxed atmosphere also encouraged them to ask any question and they receive answers to them. Notwithstanding their assertion that the atmosphere in the present health care facility is conducive for adequate communication, it was revealed that the mothers do not disclose the actual time they notice the sickness in the child to the CHOs. This is linked to their practice of self-medication before health care seeking and their awareness of the CHOs displeasure of such delays. In spite of this, the mothers were confident in telling the CHOs about the trivial changes in the sick child for treatment.

### ***5.5.2 Diagnosis and treatment***

It was discovered that mothers were satisfied with the diagnosis and treatment that they received from the CHPS. They narrated that when they take a sick child to the CHPS, the CHO takes the temperature and also examine the child before administering any medicine. They added that in cases when the sick child had high temperature, the CHO sponged the child before administering the medication. From observation, it was noted that the CHPS does not have any laboratory or the sort to do any rigorous diagnosis. This was confirmed by mothers. However, the mothers said the diagnosis and treatment their children receive from the health facility were effective. This supports effective health care as a constituent of satisfaction (Nketiah-Amponsah and Hiemenz, 2009).

A mother, whose child died before the age five, said that '*I am very satisfied with the CHPS because the CHOs are able to detect the causes of the sickness in my child and treat it accordingly* (Int. 4). The information about diagnosis and treatment in this study shows that detection of the causes of ill health and efficiency of the health care services in treating them are

the constituents of mothers' satisfaction (Handler et al., 1998; Krahn et al., 1990; Marcinowicz et al., 2009; McKay and Hensey, 1990).

## **5.6 Outcome of health care**

Recovery of the child after the treatment was the only theme found as an aspect of the outcome of health care that influence mothers' satisfaction with health care.

From the data, it was found out that mothers believe recovery of the sick child should be the topmost constituent of satisfaction with care. They said that every mother should be more concerned with their sick children gaining back their health than any other thing. A mother accentuated that *'when she takes a sick child to the health facility, her main expectation is to bring the child home healthier than before'* (FDG A: 4). In support of this, another mother said that

*'As for me, I do not care about whatever the CHOs may do or say, all that I need is to get help from the CHOs so that the child is able to recover from the sickness'* (FDG B: 3).

In the same spirit, a mother alleged that *'life is more important than anything'* (Int. 1). All these suggest that recovery of the sick child was the main factor which makes mothers satisfied with health care for the under-five. In their opinion, all the factors can be improved when there is a problem with the exception of a lost life. When the child does not recover from a sickness and dies, nothing can be done to bring the child back to life.

Although mothers were more satisfied with the recovery of the sick child, the data also showed that they do not complete administering medication to their sick child. They said that they forgot to administer the full medication to the sick children. They claimed it was not an intentional practice. This normally occurred when mothers realise that the child has recovered and is active again, going about the normal activities. Undoubtedly, this is dangerous because the child's immunity can build resistance to medications when this is done repeatedly. This practice could be a cause of malaria resistance to drug treatment which may also lead to under-five mortality (Rustein, 2000).



This aspect of outcome; recovery of the sick child is dependent both on the mother and the health care providers but mothers expect more from the health care providers than from themselves. They consider the role of the health care providers as more crucial than theirs.

## **5.7 The relationship between satisfaction with health care and health care seeking**

From the data, it became evident that most aspects of the characteristics of CHOs and features of the CHPS constituted mothers' satisfaction with health care. Furthermore, these aspects played a major role in their decision to seek health care for the sick child. They also relate to aspects of both the health care utilisation and Donabedian models.

### ***5.7.1 Characteristics of health providers***

Under the characteristics of the health care providers, attitude of the health care provider was an apparent aspect in this study. Generally, mothers said that the health workers in the health centre were not as friendly as the CHOs. Based on experiences, some added that the CHOs were selfless and very understanding. Mothers revealed that because of the manner in which the CHOs related to them, their approach was extremely easy. Nonetheless, some complained about their displeasure with instances when the CHOs scolded them because they had delayed in bringing the sick child for treatment. Some mothers believed that the CHOs do that out of concern for their children and took it in good faith whereas others used that as an excuse and continued in delaying health care seeking for the sick child. Sociability of the CHOs and their interestedness in children as well as their sensitiveness to their needs were emphasised. They said these are basic characteristics of health care providers they look out for. For instance, a mother in a group discussion said that

*'I am satisfied when I encounter health care providers who treat children gently and are willing to assist me to sponge my sick child whose temperature is high (FGD A: 6).*

The study found out that mothers received such assistance from the CHOs. They went on to explain that they battled a lot within themselves when they had to take their children to the health centre because of the behaviours of the health workers in the facility.

Weighing this assertion against mothers' narration of the condition in which they sent the sick child to the health centre and what they said about the CHOs when they delayed health care seeking for the sick child, the behaviours of the health workers could have also been their expression of displeasure with mothers because they delayed health care seeking. Taking into account the frequent communication that took place among mothers, it could also be that mothers' perceptions were a generalisation of bad experiences some mothers' have had with a particular health care worker or a number of them which have become everybody's story.

Another finding was that the CHOs were genuinely concerned for children under-five. Mothers added when a sick child was brought to the facility, the child received immediate care regardless of the severity of the condition and mothers' ability to pay for the medication. Mothers said that CHOs have become a part of the community and they are a mother to every child in the community. This translates further into the CHOs' passion for their profession; they are always talking about the welfare of children under-five. They give out their personal resources such as money for the purchase of prescribed medication and food to ensure that the sick child recovers. A mother said that

*The CHO are ever ready to do their best to save the sick child. This gives me a feeling of hope even when the condition of the child is critical (FGD: 7).*

Although such monies are supposed to be paid back, mothers confessed that some of these debts were never settled yet the CHOs still assisted them for the sake of the health of the child. They narrated that the CHOs mostly met them with a smile and gently took the history of the sick child upon their visit. Although they got upset when they notice mothers are giving them wrong information, it did not affect the treatment of the sick child. The health team had the trust of the mothers. If a child was sick and there was no money to pay for medication, they could boldly discuss it with the CHOs. Some of the mothers also mentioned that the CHOs willingly support patients on referral so that they would receive the needed care from referral point. Others expressed satisfaction with their tolerance for mothers who do not bring their sick children to the CHPS for treatment. They visited such children and treat them in the home once they are notified. Again, they follow up on sick children who had received treatment to ensure that they are doing well. Additionally, they take time to explain the causes and effect of our children's

sickness. All these may have led to the good relationship that exists between the CHOs and the mothers. As discovered by Marcinowicz et al (2009), the cordial relationship between health care workers and mothers have influence the health of the people they serve. These findings may have led to the social acceptability of the CHOs which has influenced mothers' satisfaction (Nketiah-Amponsah and Hiemenz, 2009).

Competency of the CHOs was another finding that mothers were satisfied with and that also motivated health care seeking for the sick child. Mothers said they could count on the confidentiality of the health team and diligence in the execution of their tasks regarding the health of their children. Although mothers did not have much knowledge about what goes into diagnosis and treatment, they had their own way of assessing this. Mothers said the CHOs were very good at detecting causes of sicknesses and no sickness could elude them. A mother added that, *'the CHOs are very good at detecting the number of days sicknesses have been with a child'* (FDG A: 5). They disclosed that they lie about the start day of the sickness out of fear of being scolded by the CHOs; but the CHOs diagnose the sickness and in cases when health care was delayed, they told them with precision the number of days the child had been sick. They added that the CHOs have a heart for their profession. Throughout the interactions with mothers, it became apparent that the CHOs and the CHV took advantage of every opportunity to educate mothers. For instance, a mother stated that:

*'The health providers do not limit health education to times when mothers take their children to the CHPS for treatment, CWC and during visits to our homes. They can meet you in the street and advise you or draw your attention to healthy practices when necessary'* (FGD B: 6).

In their estimation, mothers said that this practice had improved their knowledge about good practice, signs and symptoms of the major under-five killer diseases.

Following this, it was observed that mothers were satisfied the availability of health providers in the community and it also inspired them to visit health care for the sick child. According to the mothers, they expected to meet the CHOs in the CHPS every time they visited with a sick child. Nevertheless, concerns were raised about the absence of the CHOs from the facility to either go

about their regular routine visits in other communities which were served by the Okwampa CHPS or on weekend trips to visit their families. They stated this as a hindrance to health care seeking from the CHPS. Mothers said that when they go to the health facility and the CHOs are absent, they were reluctant to return. Mothers acknowledged the need for the CHOs to visit their families and also the importance of their visits to other communities but they shared that the CHOs could alternate the times so that there is always at least one of them around to attend to the sick.

From all these findings, it is clear that the characteristics of health providers have had influence on the health care seeking for children under-five. These findings corroborate with findings from Shaikh and Hatcher (2007) study which also found characteristics of health providers as one of the factors that influence health care seeking behaviour. Furthermore, this is an indication that the attitude of a patient or the person taking care of the sick plays an important role in the effective treatment and management diseases (WHO, 2004:3).

Undoubtedly, decision to seek health care for the sick child under-five is informed by mothers' satisfaction with the attitude of the health providers.

### ***5.7.2 Features of health care services***

The study also found out that the CHPS satisfies mothers' expectations of a health care facility for children under-five. The mothers alleged that they expected that a health facility serving the needs of children should have affordable services and flexible payment scheme for patients who did not have health insurance. More also, the facility should be furnished with all the needed drugs. In addition to the features of the health care services that contribute to mothers' satisfaction, they further talked about the nearness of facility which cuts out travel cost and time. As a result, mothers are satisfied with the current health care facility, following the expectation approach (Crow et al., 2003).

Mothers also said that even if they had more money to be able to afford other health facilities, they would choose health care services in Okwampa community over all others. With the presence of the CHPS in the community, mothers mentioned that they could not visit any other public health facility without a referral note. However, this was not an issue of concern because

the treatments they received were effective, the services were affordable and there was flexibility in payment. Moreover, the facility is within walking distance and less time was spent in the facility. Beyond doubt, this statement is an expression of mothers' satisfaction with health care facility regarding the health of children under-five.

Health care seeking for children under-five in Okwampa community appears to be motivated mostly by severity of sickness. Mothers' satisfaction on the other hand indicates recovery of the sick child as the main thing that brings them satisfaction. This shows that the survival of the sick child is important to the mothers but it may be that the criticality of sickness in children under-five has not been understood.

Aside these, the characteristics of the CHO and the CHPS were emphasised both as factors that influence health care seeking behaviour and elements that contribute to mothers' satisfaction with health care services. This commonality shows a relationship between the factors that influence mothers to seek health care and those that influence their satisfaction with health care. Based on these findings, it can be said that mothers' satisfaction with health care services has influence on health care seeking for the sick child. Yet, since severity of sickness is a main factor that influences health care seeking, recovery of the sick child overshadows this phenomenon in Okwampa community. Another factor that could mask the affect of mothers' satisfaction with health care services on health care seeking for the under-five is the frequent home visits by the CHOs. This is because the CHOs may notice the initial signs and symptoms of sicknesses in the children and treat them during home visits.

## **6.0 CONCLUSION**

The study sought to understand the influence of mothers' satisfaction with health care on health care seeking behaviour for children under-five using Okwampa community as a case. Using the health care utilisation and Donabedian models, the situation of health care seeking and mothers' satisfaction with health care services for children under-five have been explored. These were done by answering three research questions listed below.

- How do mothers perceive health care services for children under-five in Okwampa community?

- What are mothers' attitudes toward health care seeking for children under-five in Okwampa community?
- What factors influence mothers' satisfaction with health care services in Okwampa community?

The study found out that mothers perceived the health care services for their under-five as one that reflects their needs and desires. This means that health care services are socially acceptable. This assertion has been greatly influenced by previous experience with health care before the CHPS initiative was introduced in the community. The acceptability of health care services is largely dependent on the structure of the health facility which includes the attitude of the health workers, their competencies and home visits. Another aspect is the involvement of the traditional health workers and the community in health care provision. Again, it was found out that the main factor that influences decision to seek health care for the sick child was severity of sickness. Nonetheless, the frequent home visits and the existing social network which support early health care delivery hide the influence of this practice on health care seeking. Mothers in Okwampa community also have a culture of trying to treat sicknesses in the children before seeking health care. Delays in health care seeking from formal health facility which were caused by consultation with traditional health workers has been curbed by the involvement of the traditional health workers in the health care system in the community.

Again, the study showed that recovery of the sick child is the main factor that influences mothers' satisfaction with health care for children under-five. Patient centeredness, effective diagnosis and treatment were other factors that influence mothers' satisfaction in Okwampa community.

Having answered all the research questions, it is realised that the attitudes of health care providers and the features of the health care facility are the two factors that influence both attitude toward health care seeking and mothers' satisfaction with health care services for the children under-five. This study shows that mothers are satisfied with the attitudes of health care providers and the features of the health care facility and this influences their attitude toward health care seeking for children under-five.

Consequently, these findings imply that public health interventions to improve health care seeking for children under-five need to give particular attention to factors that influence mothers' satisfaction with health care services. Again, mothers' beliefs about health care seeking have to be addressed to improve health care seeking for the sick under five.

Although the study has accomplished its purpose, further studies could give more insight into this area of public health. An example is a quantitative study on the extent to which satisfaction with health care influences health care seeking for children under-five. Another area of study that could be looked at is a comparative study of a government sponsored and an NGO sponsored CHPS facilities and their impacts on health care seeking for children under-five. A further study on gender issues regarding satisfaction with health care and health seeking for children under-five is also suggested.

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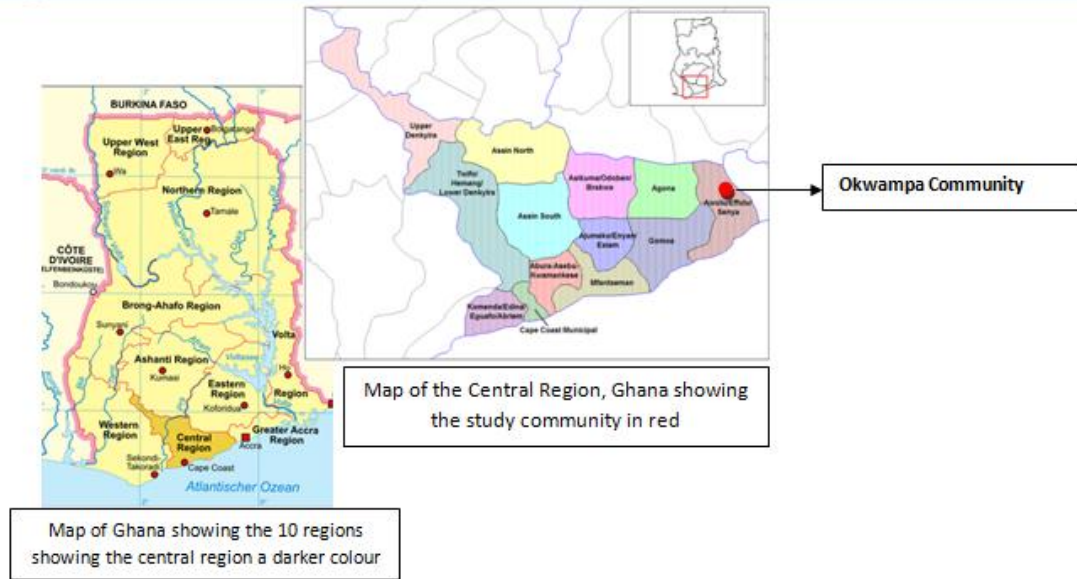
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## Appendix I: Location of Okwampa Community



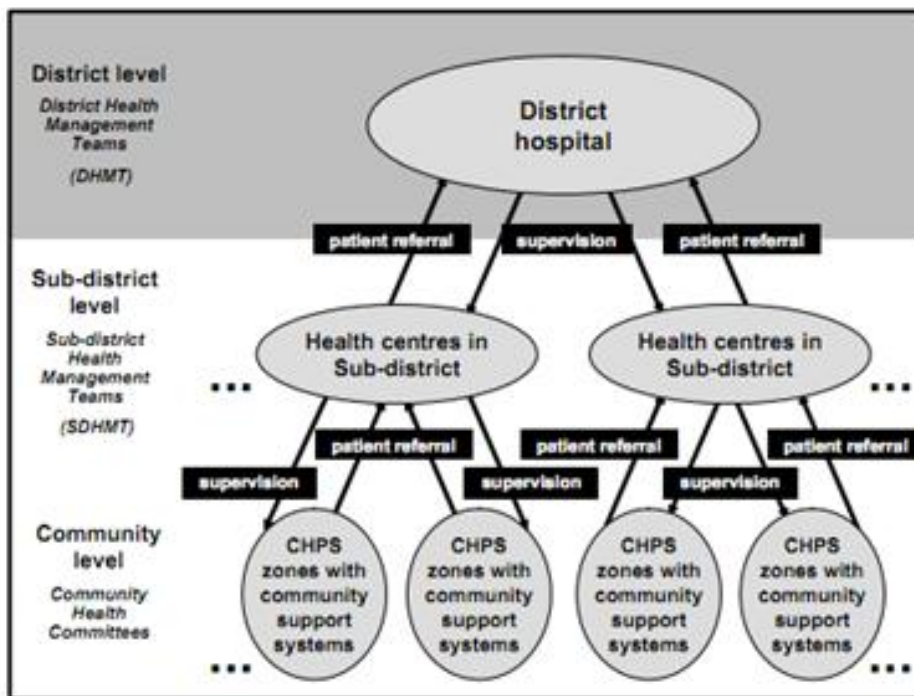
### Source of maps

Map of Ghana - <http://de.academic.ru/dic.nsf/dewiki/243623>

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## Appendix II: Health care structure at the District level



The structure of health care system at the district level (Heyen-Perschon, 2005:12)

**Appendix III:** List of respondents

<b>FGD A: mothers who children under-five and children aged between 5 and 10 years</b>	<b>FGD B: mothers who have only children under-five</b>
FGD A: 1	FGD B: 1
FGD A: 2	FGD B: 2
FGD A: 3	FGD B: 3
FGD A: 4	FGD B: 4
FGD A: 5	FGD B: 5
FGD A: 6	FGD B: 6
FGD A: 7	FGD B: 7
FGD A: 8	FGD B: 8
FGD A: 9	
<b>One-on-one Interviews with mothers</b>	
Int. 1	Int. 6
Int. 2	Int. 7
Int. 3	Int. 8
Int. 4	Int. 9
Int. 5	Int. 10
<b>Key informant interviews</b>	
CHO 1	CHC 1
CHO 2	CHC 2
CHV	PLAN HF
<b>One-on-one Interview with fathers</b>	
Int. 11	Int. 13
Int. 12	Int. 14

**Appendix IV: Data collection guides**

<b>Basic information about children under-five</b>		
	Mother	Father
Name		
Age		
Marital status		
Educational background		
Occupation		
Income range		
Do you have Health Insurance		
How many children do you have?		
	Male	Female
Number of children under-five		
Sequence of birth (1 <sup>st</sup> , 2 <sup>nd</sup> , ... born)		
Encounter with child mortality		
Age of the child		
Does your child have NHI?		

***Information from mothers***

1. How is the sick child under five care for?
  - a. Who takes care for the child at home
  - b. How do you ensure that a change in the child's health comes back to normal?
  - c. When you notice that your child is not feeling well, how many days does it take you before you take the child to a health care
  - d. Who decides when to take the child to a health care facility?
  - e. Who takes the child to a health care facility
2. What alternatives do you have in terms of health care facilities?
3. Where do you seek health care and information concerning your under-five child's health?
4. What do you expect when you take a sick child to a health care facility?
5. Have you taken your child to the CHPS before? (How many times have taken your child to the CHPS over the past one year)? Why?

6. What role does the CHPS play regarding child health issues in this community?
7. Why would you take your child to the CHPS and why would you not?
  - a. What motivates a visit to the CHPS?
  - b. What prevents you from taking your sick child to the CHPS facility?
8. Reflect and narrate the procedure you went through from you visit the CHPS with a sick child.
  - a. What were some of the things that pleased you?
  - b. What were of the things that displeased you?
  - c. What was your general impression about the service?
  - d. What was your impression about the workers there?
9. If you had the capacity to improve the service in the CHPS facility, what would you promote, change, improve or remove?

### ***Information from fathers***

1. How are the sick children under-five cared for?
  - a. Who takes care for the child at home
  - b. How do you ensure that a change in the child's health comes back to normal?
  - c. When you notice that your child is not feeling well, how many days does it take before the child taken to a health care facility?
  - d. Who decides when to take the child to a health care facility?
  - e. Who takes the child to a health care facility
2. What other alternatives are there aside the CHPS?
3. Where is the child normally taken to?

### ***Key informants***

1. What are your responsibilities towards the children under-five?
2. Who established the CHPS?
3. Which year was the facility established?
4. Why was the facility established?
5. What are the responsibilities of the Community Health Officer/Volunteers/Committee (CHO/CHV/CHC) regarding the under-five child health?
6. How would you describe health care seeking for the children under-five?