DETERMINANTS OF HEALTH CARE SEEKING BEHAVIOUR AMONG FEMALE STUDENTS OF HEALTH INSTITUTIONS IN KANO METROPOLIS

BY

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APPROVAL PAGE

This research work has been read and approved as meeting the requirements for the award of masters of science degree in Physical and Health Education (Msc. HEALTH EDUCATION) in the Department of Physical and Health Education Bayero University Kano.

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CERTIFICATION

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DECLARATION

I hereby declare that this work is the product of my own research efforts, undertaken under the supervision of Dr. A M. Getso and has not been presented and will not be presented elsewhere for the award of a degree or certificate. All sources have been duly acknowledged.

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DEDICATION

This dissertation work is dedicated to my late mother Hajiya Aishatu Sani Abubakar, my beloved wife Hajiya Jamila Abdullahi Muhammad and all our children Aisha, Hafsat, Rabiatu, Mahfouz, Hafiz, Fatima and Hanifullah.

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ABSTRACT

This study investigated determinants of health care seeking behaviour among female students of health institutions in Kano Metropolis. To achieve this purpose, Five (5) research questions and five (5) hypotheses were formulated to guide the research. Ex-post facto design was adopted and the population of the study comprised of all the female students of the four health institutions in Kano Metropolis. The sample for the study was made up of 233 participants selected through proportionate sampling techniques of equal distribution. The instrument used in the study was a researcher's developed questionnaire which had been validated with a reliability coefficient of 0.78.The 233 questionnaires were distributed by the researcher with the help of 3 trained research assistants out of the number, 204 copies were duly completed and returned for analysis. A period of one week was used for the exercise. Descriptive statistics of frequency count and percentages were used to organize and describe the demographic data of the respondents while chi-square and ANOVA were used to analyze the formulated hypotheses at 0.05 level of significant. The findings of the study revealed that cultural beliefs $t = 145.020$ $df1$ $p< 0.05$, poverty $t = 101.647$ $df1$ $p< 0.05$ health policy $t = 101.647$ $df1$ $p< 0.05$ and health facility $t = 113.255$ $df1$ $p< 0.05$ are all significant determinants of health care seeking behaviour among female students of health institutions in Kano Metropolis. Also differences were found to exist among the three health institutions with respect to the determinants based on their school type. It was recommended based on the findings of the study that adequate and standard medical health facilities need to be provided to increase the level of patronage among female students of health institutions in Kano Metropolis.

CHAPTER ONE

INTRODUCTION

1.0 Background to the Study

Health care is essential for both social and economic development of every society. It is considered as a resource for everyday living and it is therefore often sought by all. The link between health and human behaviour is a major concern and hence an area of interest in public health and that also means that health care seeking behaviour is a particular aspect of health care seeking behaviour.

Health care seeking behaviour varies greatly among different population and even within the same population, and is influenced by numerous factors like age, gender, education, family, society, law, availability of drugs and facilities, exposure to advertisement and nature of illnesses (Montastrue; Bagheri; Geraud; Capayre; 1997, Martins; Miranda; Mendes; Soares; Ferrier, Nogueira, 2002). It is also obviously clear that people differ in their willingness to seek help from health care services providers. Some readily go for treatment when ill, others do so only when in great pain and in advanced stages of the ill-health.

Common concern among people related health care includes doctors, nurses, pharmacists and students (McAuliffe; Rohman; Santangelo; Feldman; Magnuson, Sobel; Weiss man (2001, Vavranate; Vladimir; Zdravko; 2005) Moreover, (WHO, 2005) reported that the high rate of female mortality could be attributed to poor medical facilities, low level of income, poor attitude of medical practitioners as well as lack of education which are all signal towards poor health care seeking tendencies.

Long before the advent of orthodox (modern medicine), and knowledge of the aetiology of ill health was due to all sorts of happenings like anger of the gods or the goddess or deity recognized by community sacrileges committed or the adversary of their enemies.

All there attributions greatly affect the health seeking behaviour of who holds that notion in mind which in turn encourages them to patronize traditional healers, and the use of charm for protection. Contrastingly, with the advent of modern medicine and care, increased knowledge about the causes of ill health has also had great influence on people's health care seeking behaviour. Health care utilization is the use of health care services by people. The health care utilization of a population is related to the availability, quality and cost of services, as well as to socio-economic structure, and personal characteristics of the user (Manzoor 2009; Onah 2009). The underutilization of the health services in public sector has been almost a universal phenomenon in developing countries (Zwi, 2001). It is therefore in recognition of this fact that various Nigerian governments have made numerous great efforts towards the provision of health care facilities to its population. Notable among these efforts were the expansion of medical education, improvement of public health care, provision of primary health care (PHC), in many rural areas.

However, overt concern has not been given to the need for equity in the planning and distribution of health care facilities over the years in the country (HERFON, 2008).Public and private health care facilities are sparsely provided in many regions within the country, such regions with difficult terrain and physical environment are often neglected (Onokerhoraye, 1999). This makes the distance between the rural dwellers and the health care center far apart, given the transportation problem experience in these areas and its attendant cost.

Thorough understanding of the determinants of health care seeking will go a long way to providing the required opportunity to early detection and prevention of poor health conditions in a given population such that rampant cases of unprecedented morbidity and mortality can greatly be reduced. Health care seeking behaviours are those activities undertaken by individuals in response to disease symptoms experienced (Reilly & brown, 1997). Furthermore, studies conducted by (Mackhian, 2003 and Sule, 2008), on health seeking behaviour have also indicated numerous influences on individual's health behaviour. These influences include past experience an individual has with health services, perception about quality and efficiency of the health services and influences at the community level. The decision to seek for help may be found to be influenced by individual's educational and economic status, the extent to which he/she is worried about the symptoms and the duration of experiencing the symptoms (Katung, 2001 & Amaghionyeodiwe, 2008).

It has been reported in several studies by (Hussain, 2010), that many developing and under developing economically deprived countries, that most episodes of illness are treated by self-medication and mostly a common practice due to quality concerns related to health care delivery system as well as the uncertainty of health consumers on the benefit of professional health care. The care of Nigerian health is no exception to this trend of practice as females tend to find it difficult to ask for help especially when it comes to health issues in which the major barriers for them to access health services remain the concern about confidentiality, embarrassment in the disclosure of health issues, absence of medical insurance or limited financial accessibility (Ford, Bear man & Moody, 1999) while others may be due to lack of knowledge of the existing health services as well as lack of trust in health professionals (Booth, 2004). In that case therefore, when females face health concern, they often seek health care informally. In other words, they do

not refer health problems to health professionals or to formal health services first (formal health care seeking behaviour), but rather, they are more likely to seek help from people closer to them such as parents, friends or others they trust (informal health care seeking behaviour) he further believed that the need for autonomy that defines female's health seeking behaviour generates self-help practice based on internet browsing or self-medication.

Health care seeking behaviour among females is also partially affected by their socio-economic status and the cost of health services. Urban and Rural origins as well as gender are more likely to seek help from health care providers than their young male counterparts (Zimmer-gem back, Alexander & Nystrom, 1997). The choice of health providers consulted for symptoms is also linked to the perceived cause of the symptoms (Ahmed, 2001).In a recent survey in rural community in south-western Nigeria, it was discovered that only about 44% of the respondents utilized health care facilities when ill, a habit that hinder the possibility of achieving the lofty "health for all" goal (Sule, 2008).

In Nigeria, health seekers like in any developing country in the world, tend to do so base on the resources available to them and at the disposal of the family (Nyonator and Kutzin 1999, Nigeria health review, 2006). Several other factors are also involved in health care seeking behaviour among female which include the severity of the disease symptoms, socio-cultural influences, distance to place of service provider, cost of treatment, income level, educational attainment and quality of health facilities, Health Reform Foundation of Nigeria (HERFON 2006 & Sullivan 2001).

In Kano state, the scenario is somewhat similar as the above mentioned factors seem to have play a role in influencing the health care seeking behaviour of those students of health

institutions even though considered as highly enlightened on the consequences whereas females trooped to the informal care providers, traditional healers and many were even reluctant to expose health issues particularly with respect to restriction made by Islam of female to mingle with their male counterparts a practice that is likely to deny them to seek for help them.

Although government is making all possible effort to provide adequate health services and facilities to meet the yearning and aspirations of people in term of their health needs, but, young females can still be seen recognizing the activities of quacks, fortune tellers, self-medication and many other forms of traditional healers under which the practice has the potential to cause increase in poor health services accessment, utilization and undesirable health care seeking behaviour among others. Therefore, this study investigated cultural beliefs, poverty, and health policy and health facility as determinants of health care seeking behaviour among female students of health institutions in Kano State.

1.2 Statement of the Problem

Kano State has been known and recognized long ago for its position in Nigeria as the centre of commercial activities and the famous route for trans-Sahara trade. This commercial nature of Kano opens chances for jobs and other employment opportunities which in turn encourage massive rural-urban migration especially among youth who are desperate for employment to survive. However, such commercial and employment attraction resulted in making Kano to be over-populated with young people as job seekers leading to different anti-social behaviours, disease outbreak from poor sanitary conditions, economic crisis, poor health care delivery system and lack of facilities. These problems promote the activities of various drugs peddlers, fortune tellers, Quacks, mission homes and self-medication who are patronized more by females.

In contrast to their males counter- parts, females have been recognized as the most populous beings on the global chart since male population is constantly decimated by the devastating effects of war and other unpredicted calamities, United Nations population Fund (UNFPA, 2000). Females seek for medical care when face with apparent health problems in the study area as they usually express serious concern about the welfare of themselves and their children. The National Demographic Health Survey (NDHS, 2008), however, shows that in spite of the positive health care seeking behaviour and readiness of females to achieve wellness, the rate of HIV/AIDS is still very high among them.

Many people see knowledge as a strong factor in determining positive health care seeking behaviour but it alone is not sufficient enough to influence one's health care seeking behaviour positively. (Mugisha, Bocar, Dong, Chepng, Sauerborn 2004) believed that going by this, one can see that health care seeking determinants are multi-factorial. Other factors capable of influencing health care seeking behaviour include motivational factors, stigma, treatment expectations, satisfactory healthcare services, decision making for health care services, financial constraints and accessibility of health services.

People may tend to perceive that with exposure of female students especially those of health institutions to the consequences of poor health care seeking by being acquainted with various literatures related to causes of ill health and because the general public consider them as the most enlightened citizens on health related matters, that will bear a more positive impact on them to remain more conscious about their health and therefore strive hard to avoid engaging themselves in lifestyle capable of either jeopardizing or constituting threat to their health like smoking, drug abuses, unprotected sexual relationship, premarital sex to habits that can promote healthy

lifestyle like adequate nutrition, exercise that will boost their immune system and confer on them protection through regular medical checkup (Manzoor, Hashim, Mukhtar 2009).

For example, one may expect to see the best practice in use of condom during sexual intercourse among these students especially for those who could not abstain or easily control their sexual urge; yet, these students join their less enlightened colleagues in engaging on poor health promoting habits. Also WHO (2005), observed that poor health seeking practice among people is responsible for the stagnation in the nation economy and a bedrock for social crisis.

In Kano State, females face difficulty in reporting health issues and accessing health services probably due to the cultural influence, high moral and religious influence and availability of traditional care and healers operating under highly receptive and friendly manner. In addition to this, economic hardship facing the country, non-availability of health facilities and qualified personnel probably contributed to making many females in Kano Metropolis to shift their health care preference to traditional healers and fortune tellers as alternative to orthodox treatment. It is against this background that the researcher investigated determinants of health care seeking behaviour among female students of health institutions in Kano State and answered the following research questions embedded in the research hypotheses.

1. Is cultural belief a determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis?

2. Is poverty a determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis?

3. Is literacy level a determinant of health care among female students of health institutions in Kano Metropolis?

4. Is availability of health facilities a determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis?

5. Do female students of health institutions in Kano Metropolis differ in their determinants of health care seeking behaviour?

1.3 Hypotheses

In order to guide the conduct of this study, one major hypothesis and five sub-hypotheses were formulated.

Major Hypothesis

There are no significant determinants of health care seeking behaviour among female students of health institutions in Kano Metropolis.

Sub-Hypotheses

1. Cultural belief is not a significant determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

2. Poverty is not a significant determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

3. Literacy level is not a significant determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

4. Health facility is not a significant determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

5. Determinants of health care seeking behaviour do not significantly differ among female students of different health institutions in Kano Metropolis.

1.4 Purpose of the study

This study investigated determinants of health care seeking behaviour among female students of

Health institutions in Kano Metropolis with a view of offering possible suggestions on how problems related to the determinants' influence on female students' health care seeking behaviour could be tackled.

1.5 Significance of the study

This study would be of benefit through the following ways:

- The finding of this study would help the participants to understand more the fundamental importance of reporting health issues pertaining to health care by reporting health problems to the appropriate experts as well as use the readily available health facilities and services at their disposal.
- The information gathered in the study would also help intending researchers in this area to advance their knowledge by consulting the already reviewed literature.
- Community, government and non-governmental organizations would find this research useful by making use of the reported information to streamline their objectives towards programmes capable of eradicating factors that are likely to encourage poor health seeking behaviour among female students of health institutions.

1.6 Delimitation of the study

The study was delimited to the determinants of health care seeking behaviour among female students of health institutions in Kano State and to the following variables: cultural beliefs, poverty, literacy level and availability of health facilities. It was delimited to only female students of health institutions in Kano State, namely School of Health Technology, School of Nursing/Midwifery and School of Hygiene.

1.7 Limitation of the study

The targeted populations of this study was two thousand, three hundred and thirty one (2331) female students of health institutions that are located within Kano metropolis even though new ones were recently established around the out sketch of the metropolis but are yet to start programmes and are therefore part of limitation to this study.

1.8 Operational definition of terms:

Determinants: Are those factors which ginger a person to seek or otherwise for medical attention and hence make prompt use or otherwise of the medical services and facilities available at his/her disposal.

Health care seeking: The actions of an individual towards patronizing and utilizing medical health care facilities and services available within his/her reach.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2 .0 Introduction

This study investigated the determinants of the health care seeking behaviours among female students of health institutions in Kano State. Literature related to this study were organized and reviewed under the following sub-headings.

- Concept of health care seeking behaviour
- Factors Influencing Health Care Seeking Behaviour
- Health Care System in Nigeria
- Health Information
- Health care seeking behaviour among females
- Problems and prospects of health care seeking behaviour
- Summary

2.1 Concepts of Health Care Seeking Behaviour

Free Medical Dictionary.Com defined health seeking behaviour as a state in which a person in stable health is actively seeking ways to alter his or her personal habits or environment in order to move toward a higher level of health. WHO (2005), described health as the stable health as the age-appropriate illness prevention measures with reporting of good or excellent health, and signs or symptoms of disease when present and being controlled.

Health care seeking behaviour as defined by Reilly and Brown, (1997), are those activities usually under taken by individuals in response to disease symptoms experienced. Also, Haddad,

Fournier, Mahout (1998), sees health care seeking behaviour as an "activity under-taken by individuals who perceived they have a health problem or to be ill for the purpose of finding an appropriate remedy."

Afolabi, Irinoye, Adegoke (2013), viewed health care seeking behaviour as the varied response of individuals to state of ill-health, depending on their knowledge and perception of health, socioeconomic constraints, adequacy of available health services and attitude of healthcare providers. WHO (2005) declares that health seeking behaviour is any activity or effort made by a person who believes himself to be healthy for the purpose of preventing disease or detecting in asymptomatic state.

Health care seeking behaviour is one's consciousness on how to remain healthy and how to consult when the person perceives any threat to his/her health. Health is a major form of human capital and there exists substantial agreement in the literature on the relationship between health and economic development through its relationship between capability and poverty (Strauss and Thomas 1998). It is assumed that improvement in health leads to improvement in life expectancy which is a robust indicator of human development.

A simple channel through which health affects human development is by improving living conditions. As living conditions improve, human longevity is expected to improve and vice versa (Strauss and Thomas 1998).Empirical evidence has shown that among poor countries, increase in life expectancy is strongly correlated with increase in productivity and income (Deaton 2003).

2.2 Factors Influencing Health Care Seeking Behaviour

Researchers such as (Ahmed 2001), Mackian (2003), Tipping & Segall (1995), have long been interested in what facilities, the utilization of health services and what influences people to

behave differently in relation to their health. Tipping & Segall (1995), proposed in their popular health seeking behaviour theory, that providing knowledge about causes of ill health and choice available will go a long way towards more beneficial health care seeking behaviour. Moreover, abundance of studies revealed by Segall et'al (1995) on health care seeking behaviour demonstrated the complexity of influence on an individual's behaviour at a given time and place. And that health promotion program worldwide has long been premised on the idea that knowledge and choices will play a significant role towards shaping individual's health care seeking behaviour.

However, there is a growing recognition in both developed and developing nations that providing education and knowledge alone at the individual level is not sufficient in itself to promote a change in behaviour.

In south Africa for example, health services are offered through multiple, sometimes overlapping channels echoing what is true in many parts of the developing world (Develay 1996, Ahmed et, al 2000 & Baum, 2000).Qualifying the extent to which ill people are presenting both at public and at private doctor's office and at the sometimes seeking cures from the traditional healers and non prescribed treatments from pharmacies is necessary if informed choices are to be made.

In Guatemala, Goldman and Heuvehine (2000) found that family size and parity, educational status and occupation of the head of the family are also associated with health seeking behaviour, beside age, gender and marital status. Mugisha (2004) identified household income, education, and expected competency of the provider as positive determinants of utilization of health services by women in rural Burkina Faso.

Buor (2005) identifies the determinants of utilization on health services by women in both rural and urban areas in Ghana using multiple regressions posited that income and family size affects the rural areas in Ghana during utilization while education and marital status affect those in urban areas. The influence of education in the use of health services has also been examined.

Generally, education, income and health seem to have positive relationship with utilization of modern health care facilities. In other words, people with higher educational attainment stand to benefit better income and invariably could afford payment for quality health care.

Babar (2004) in a study on health seeking behaviour and health service utilization in Pakistan asserted that the factors determining the health behaviour may be seen in various contexts: physical, socio-economic, cultural and political. Therefore, he concluded that the utilization of a health care system, public or private, formal or non-formal, may depend on socio-demographic

health care system, public or private, formal or non-formal, may depend on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political system, environmental conditions and the disease pattern and the health care system itself.

In Haiti, Alexandre (2005) in a study of antenatal care utilization in rural areas and urban areas, used logistic model to identify which factors explained the decision to seek prenatal care and negative binomial model to determine how many prenatal visits are conducted by the subgroup of women who did make prenatal visits. He found out that a substantial percentage of pregnant women have access to prenatal care service in Haiti, but mothers in rural areas who decided to seek care still fell slightly below the four visits recommended by the World Health Organization,

the education level of both the mothers and their partners are dominant predictors of prenatal care use.

In a study in South-eastern Nigeria, Uzochukwu and Onwujekwe (2004), found that the private health facilities were the initial choice of health care for the majority with a decline among those choosing them as second source of care and an increase in the utilization of public health facilities as a second choice of care. Self-diagnosis was practiced more by the poorer households while the least poor used the patent medicine dealers and community health workers less often for diagnosis of malaria. All these studies showed that utilization of health care facilities is influenced by physical, socio-economic, psychological as well as organizational factors.

For instance, in designing an anti-retroviral therapy (ART) delivery program, successful adherence to ART will be influenced by the way in which ill people interact with health care system. Although it was discovered that many people in South Africa patronized both western medicine and traditional healers when ill. The use of the latter was not found to be systematically qualified (Ashforth, 2004). It has also been noticed that traditional healers were consulted by almost half of all ill people and by nearly 60% of young adults. The cost of traditional care varies substantially and can be very expensive to those who visited both private doctors and traditional healers, with more money spent on the latter (Franzini 2004).

In Uganda, studies by (UNICEF 1998) have also revealed that more than 40% of the Ugandan population falls below the poverty line and that income has been the major factor that affects the health care demand. Thus, in a research conducted under the Ugandan National Housing Survey, and in which other endogeneity issues are controlled, it was discovered that income is strongly associated with increased health care usage across all age ranges but especially for women.

Furthermore, significant difference in health seeking behaviour was also found to be related to age and gender and that increased level of education leads to improvement in health care accessment and utilization (Ensor, 1998) In Nigeria, health seekers like in any developing country in the world, tend to do so based on the resources available and at the disposal of the family (Nyonator and Kutzin 1999, HERFON, Nigeria health review, 2006). Several other factors are also involved in health care seeking behaviour among many different households in Nigeria; these factors include, the severity of the symptoms, socio-cultural influences, distance to health facility, cost of treatment, income, level of education and quality of health facilities (HERFON, Nigeria health review, (2006) and Sullivan, (2001).

Studies by Bloom (2001), Dharmalingam & Navaneeham, (2002), showed that education of the mother is an important social variable that has a positive effect on the utilization of maternal and child health services. The other socioeconomic factors usually found to be important are place of residence, religion and standard of living of the household. The economic status of the household also determines the utilization of anti-natal care and delivery care services Pandey (2002). Some studies on health care seeking behaviour have focused on the importance of availability and accessibility of services as well as the distance of the health care center. Quite far away centre from the health provider discourages women from receiving anti-natal care (Baker 1993 & Develay, 1996).

Addressing health system factors and socioeconomic barriers is imperative for increasing women's overall utilization of health services. Reducing mortality through increased utilization requires more effective public health interventions built on clear understanding of women perceptions of maternal care services within their cultural context. For instance, women should be made to understand that delay attention to complications during labour leads not only to

death, but also to poor outcomes such as intrapartum stillbirth, neonatal illness and disability, obstetric fistula and other long term obstetric complications (Lawn 2006). Apart from the demographics influence, factors like religion, place of residence, educational level, exposure to mass media, household structure, wealth index, birth order and maternal age all have significant influence on utilization of maternal health care services.

2.2.1 Cultural beliefs.

Cultural beliefs have the tendencies to affect health behaviour in so many different dimensions. For instance, according to Dewitt, (1994), as cited by Kitts and Roberts, (1996), cultural beliefs influence the way an illness is produced, perceived and acted upon in Nigeria. And those cultural factors include gender, norms, birth practice, and nutritional taboo especially during pregnancy which all results in to mitigation of individual women and girl's health or their quality of life (Dewitt, 1994). These factors condition women's reproductive intention that is the number of children they want and how they want their birth spaced.

Women do not always get support they need to fulfill their reproductive intention hence cultural restrictions limit choice and that belief about appropriate behaviour can reduce access to health information and care and so impair its quality.Nyonator and Kutzin (1999) believed that early reporting of illnesses in health facilities is likely to reduce the degree of complication of such illnesses and also to some extent reduce cost of care and agreed further that delay in reporting the illnesses in hospital is known to be influenced by cultural beliefs and ability to pay for care.

Thus, delay in receiving care for health problems can be costly and dangerous and as such it is necessary to educate people generally on this problem. Moreover, it has been argued that perception of illness is affected or influenced by different beliefs system in societies (Jegede,

1998, Kitts and Roberts, 1996). Also Jegede, (1998) noted that magico-religious belief systems do influence how people perceived diseases. For this reason, quite significant number of patients utilized the services of assorted traditional healers before seeking care from western style or modern health workers and facilities (Erinosho, 2005).

Today, there is a new dimension due to the influences of religion, such as Christianity and Islam. Most pregnant women seek to patronize mission homes in order to be protected from evil during delivery. According to Isaac Owolabi (2012), the Oyo State commissioner of health, no fewer than 36000 expectant mothers die annually from avoidable complications before and after birth in the mission homes mostly as a result of lack of qualified health personnel. In Nigeria, the Islamic religious practice severely restricts women's interaction with men and strangers and as such couldn't find it easy to seek for help from them.

Cultural beliefs and practices often lead to self care, home remedies and consultations with traditional healers particularly in rural communities (Baker 1993 and Develay 1996). Advice of the elder woman in the house is also very instrumental and cannot be ignored (Covington, 2006). These factors result in delay in treatment seeking which is more common amongst women, not only for their own health but especially for children's illnesses. Family size and parity, educational status and occupation of the head of the family are also associated with health seeking behaviour beside age, gender and marital status (Covington et'al, 2006).

However, cultural practices and beliefs have been identified to be more prevalent regardless of age, socio-economic status of the family and level of education (Covington et'al, 2006). These factors also affect awareness and recognition of severity of illness, gender, and availability of services and acceptability of service (Bloom, 2001). Gender disparity may affect the health of a

woman by putting an unrewarded reproductive burden on her, resulting in early and excessive child bearing leading to a normal maternity being lumped with diseases and health problems. Throughout life cycle, gender discrimination in child rearing, nutrition, health care seeking, education, attitude of health workers, facilities as well as policy are all fundamental ingredients of health care seeking behaviour.

2.2.2 Poverty:

Many documented studies have proved that a woman's position in the household largely determines her range of acceptable reproductive roles and options (Orobuloye 1991, Gupta, 1997, Falkingham, 2003, Ogujuyigbe and Liasu, 2007). Women's status is a broad concept that encompasses multiple facets of women's lives. It has been defined as the degree of women's access to (and control over) material resources (including food, income, land and other forms of wealth) and also to social resources (including knowledge, power, and prestige) within the family, in the community and in the society at large are essential barriers that often prevent easy access to transport by local people (Dixon, 1995). In rural areas in Nigeria, vehicles are sometimes scarce and in poor conditions. The cost of arranging emergency transportation can therefore be daunting (Melntyre and Hotchkiss, 1999).

According to Jegede, (1998), treatment of any disease depends on ability to pay by mothers who were solely dependent on their husbands and were not able to respond immediately to any health problems concerning their children, and this also invariably concerns themselves. Lanre-Abass (2008), opined that user charges coming at a time of spreading deepening poverty have become a great barrier to access for many Nigerian women who are not educated and hence economically

disempowered. To Lanre-Abass, (2008), getting money for treatment was the problem most commonly reported by Nigerian women of all backgrounds.

There is a strong negative correlation between both level of education and wealth quintile. The process of economic reform affects access to health services particularly when services are not provided free of charge or have (increased) associated cost (transportation, drug fees and informal payments) (Ward, Martins, Thomas 1997).

In central Asian economies for example, average incomes have declined substantially whereas, average incomes have on the whole risen in East Asian economies (Glewwe, 1998). Also, in Vietnam, rapid economic growth (an average annual growth rate of 8% in the 10 years since the market reforms were adopted in 1986), has raised household's incomes across the country's seven regions and across both urban and rural area; this enables people to buy what is previously state subsidized health care services (Glewwe, 1998), however, not all households are enjoying this increase in incomes.

Also, it has been identified in Vietnam that poor households have difficulties accessing social and health services, the cost of which represents disproportionately high proportion of household's incomes. In particular, research by (GOS 1994), has found that the official and unofficial cost of higher level hospital services prevent the poor from accessing services. Preliminary analysis of the Second Vietnam Living Standards Survey (general statistical office, 1994), conducted in 1998, also suggested that access to hospital care is inequitable.

Thus the poor with their disproportionately low share of health insurance cover find accessing hospital services especially inpatient care, very difficult, whereas the rich, by having the lion's

share of health insurance coverage, make greater use of higher level hospital services and so benefit more from state subsidies for health care (Deolalikar, 1999).

Meanwhile of greater concern may be that even of commune level. Health care can prove prohibitive for poor households (Segall, 1995). In china, research has shown that increasing income differential negatively affects equity of access. Across sectional study of equity and use of medical care by Yu, Coa and Lucas (1997), found little difference in utilization of outpatient services by income group, but greater difference at higher level of care. The poorest group was more likely not to use any services and to avoid hospital inpatient care due to an inability to pay. This erosion of China's pre-reform equality of access to health with increase in income inequalities is also reported by Tang, Bloom, Feng, Lucas, Gong and Segall, (1994).

Analysis of Vietnam living standard data showed that the cost of services affects decision-making for health. Seventy percent of the poorest quintile were found to use the cheapest option of self-medication as opposed to fifty four percent of the wealthy (Guttler and Litvack, 1998).Similarly, research conducted in Vietnam 1992-93, by (Tipping, 1995), found an inverse relationship between the average cost of a range of health care have made traditional care to be the most cheapest option and hospital care the most expensive and largely avoided option especially by the poor.

Vinard, (1994), in Laos and by Holland, Phimphachanh, Conn and Segall, (1999), also reported greater reliance on the cheaper option of self-medication by the poor. Similar coping strategies by the poor have also been reported in Cambodia (Wilkinson, 2001). A variety of factors have been identified as the leading causes of poor utilization of primary health care services, including poor socioeconomic status, lack of physical accessibility, cultural beliefs and perceptions, low

literacy level of the mothers and large family size (Bloom, 2001). Review of global literature, by Bloom et'al (2001), suggests that these factors can be classified as cultural beliefs, socio-demographic status, women autonomy, economic conditions, physical and financial accessibility and disease pattern and issues related to health services.

2.2.3 Literacy Level

Health literacy is an emerging concept that involves the bringing together of people from both health and literacy fields. Health literacy builds on the idea that both health and literacy are critical resources for everyday living. Our level of literacy directly affects our ability to not only act on health information but also take more control of our health as individuals, families and communities (www.who.int/./en/.)

WHO (2005), believed that while many definitions for health literacy exist, definitions such as "The degree to which people are able to access, understand, appraise and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life course" has been adopted. Thus WHO (2005), identified the scope of health literacy below as having three distinct levels:

Functional literacy: Skills that allow an individual to read consent forms, medicine labels and health care information and to understand written and oral information given by physicians, nurses, pharmacists or other health care professionals and to act on directions by taking medication correctly, adhering to self-care at home and keeping appointment schedules.

Conceptual literacy: The wide range of skills and competencies that people develop over their lifetimes to seek out, comprehend, evaluate and use health information and concept to make informed choices, reduce health risks and increase quality of life.

Health literacy as empowerment: Strengthening active citizenship for health by bringing together a commitment to citizenship with health promotion and prevention efforts and involving individuals in understanding their rights as patients and their ability to navigate through the health care system acting as an informed consumers about the health risks of products and services and about options in health care providers and acting individually or collectively to improve health through the political system, through voting, advocacy or membership of social movements. Low level of literacy often means that a person is unable to manage their own health effectively, access health services effectively and understand the information available to them and thus make informed healthy decisions. Improving the health literacy of those with the worst health outcomes is an important tool in reducing health inequalities (www.who.int/./en/), WHO Track 2. While much is not expected from people with low level of literacy in terms of managing their own health effectively, those with high level of education are expected to act more quickly and wisely and will also tend to minimize delay period in reporting to health facilities when ill. Finding from numerous studies like Kitts and Roberts, (1996), Gupta, (1997), Falkingham, (2003), Ogujuyigbe and Liasu, (2007), on maternal health care and mortality conducted in developing countries over the last decade showed a positive association between maternal education and maternal health care. The influence of education on health is assumed to derive from various dimensions of educational experience.

Schooling imparts literacy skills, which enable pupils to possess a wide range of information and stimulate cognitive development. As Graczyk, (2007), situates it, lack of education can also affect health when it limits young women's knowledge about nutrition, birth spacing and contraception. Before a woman decides to seek for care, she must be able to recognize the signs and symptoms that indicate the need for care (Kitts and Roberts, 1996). However, a lack of

educational opportunities may lead to poor understanding of health related matters; therefore, many women may not be familiar with different diseases and their presentation.

2.2.4 Health facilities:

Good health is an individual's priceless asset and it is a function of the environment, whereby in this context, the focus is on the impacts of socio-cultural determinants on health care seeking behaviour (Okereke, 2005).Nigeria has a public health system that includes federal, state and community hospitals, clinics and health centers. Also a large component of health care is provided in private fee for service centers usually with some beds, which are often referred to as clinics or hospitals. As such, no clear distinction really exists in the private sector between physician practice, clinics and hospitals (Hens haw, 1998). This perhaps is one of the major reasons why there is a tremendous lapse in the progress towards improving maternal health delivery system generally in Nigeria. For instance, as at 1999, the national mortality rate was at 704 per 100,000 live births, though with considerable regional variation (FOS/UNICEF, 2000, Shiffman, 2006).

Also, the quality of maternal health facilities in Nigeria is poor. A study in 2003 of 12 states randomly selected, revealed that only 18.5% of facilities overall and only 4.2% of public facilities met internationally acceptable standard for essential obstetric care (Fatusi, 2003). As such, approximately two-thirds of all Nigerian women and three-quarters of the rural Nigerian women deliver outside of health facilities and without medically skilled attendants present (NPLC, 2004).

Moreover, while majority of the improved high grade and better equipped medical facilities are located in the urban areas, few and poorly maintained, shortage of equipment, drugs buildings

and personnel are located in the rural areas. Thus, majority of the medical centers were described as mere consulting clinics (Orubuloye, 1991).

To sum it up, Nigeria is facing a health crisis struggling through socio- cultural and all encompassing political factors that contribute to inequitable health outcomes, which are the bane of the Nigerian health care system (Orubuloye, et'al 2003). Some of the factors are the neglect and decay of government health facilities in the last two decades, the political instability that the country has witnessed since independence in 1960 coupled with various economic problems. The outcomes of the problems have adversely affected the health care seeking behaviours of the Nigerian consumers.

Also in Nigeria, as reported by Babatunde (1990), the increased use of private health facilities may be related to the frequent establishment of the private health sectors. Continued economic difficulties have undermined the public health system and there is the rise in the 'informal' private sectors like traditional healers, itinerant drug peddlers and hawkers, mixed trade dispensers, unlicensed patent medicine dealers and injection doctors. This sector, which is likely to offer very low quality treatment(treatments without laboratory diagnosis, making wrong diagnosis, sale of drugs with little regard to dosage or treatment regimen and use of fake and expired drugs), is also likely to be a more important source of disease treatment and prevention for the poor, and government encourages frequent media advertisement of traditional medicine healers who openly challenge the utility of western medicine, thus making them very popular especially among the poor (Sheikh, Hatcher, 2004, Gruskins and Torontola 2002).

.Accessibility which is also an important determinant of health care seeking is not always considered by its sake. It is generally examined in relation to the pattern of distribution of the

service supplying unit and the user population. The usual goal is to see whether the pattern of distribution is beneficial to the people or not. In other words, the distribution meets the criteria of either efficiency or quality (www.healpromotionresouce.ir/attachment/912.pdf)

Accessibility to health care facilities has been studied and discovered to be a very crucial determinant in the location and utilization of health facilities, given the nature of its consumption. In a study on distribution effects of location of government hospitals in Ibadan, Okafor (1991), using the index of access opportunity (AO) mode, revealed that the areas which are mostly accessible lie to the north and largely outside some high, middle and lower income class districts. Using multiple regression models, he found out that the pattern of distribution of government hospitals was in fact not regressive.

Ajala (2005) using the same index of accessibility model in a study titled accessibility to health care facilities; a panacea for sustainable rural development in Osun State, revealed that the available health facilities are grossly inadequate and their distribution depicts serious inequality and he therefore suggested that there is urgent need for serious intervention on the part of the government in the provision of health facilities in the state focus at equitable distribution and accessibility to enhance sustainable rural development. Moreover, in Nigeria, doctors in public services are allowed to operate private clinics. Some of these facilities are below standard (unregistered, poorly equipped, lacking diagnostic facilities, dirty premises, employing unskilled personnel (Ward, Martins, Thomas, 1997).

2.2.5 Health Personnel:

It has been affirmed during the Bamako Initiative on Malaria Prevalence in Africa that the reasons that deter the least poor households from using health facilities were lack of drugs and

poor staff attitudes. In logistical analysis to the determinants of use of health centre, the availability of good services, proximity of the centers' to the homes and polite health workers were among the reasons given to what made the people to patronize the services there (Pandey, 2002). Other factors may be attributed to the frequent migration of health care personnel to other countries which is a taxing and relevant issue in the health care system of the country.

From a supply push factor, a resulting rise in exodus of health care nurses may be due to dramatic factors that make the work unbearable and knowing and presenting change to arrest the factors may stem the tide (Darlene, Clark, Paul, Clark, James, Steward, (2006). However, because a large number of nurses and doctors migrating abroad benefited from government fund for education, it poses a challenge to the patriotic identity of citizens and also the right of return of federal funding of health care education. The state of health care in Nigeria has been worsened by physician shortage as a consequence of severe "brain drain".

Many Nigerian doctors have emigrated to North America and Europe. In 2005, 2,392 Nigerian doctors were practicing in the U S alone, in U K the number was 1,529. This poses a serious threat to the health development and improvement in Nigeria. Brieger (1991), and Udoh (1981),indicated disease causation, type of illness, location of medical help, flexibility of treatment, perceived competence of providers, the individual's perception and attitudes towards health services, the quality and location of the services are both significant determinants of health care seeking behaviour among people.

2.2.6 Location of residence

The geographical proximity of services to people's homes has been noted as one of the most important factors that affect utilization of health services, particularly in rural areas of the

developing countries(World Bank Report, 2004); as the distance increases, the level of utilization decreases and vice versa. People who live far away from services suffer greater disadvantage regarding the use of services this becomes worst if they are also poorer and transport is expensive. Lawn (2006), believed that long distances, financial constraints, poor communication and transport, weak referral links and at times, low quality care in health facilities, can limit access to care for those that need it most.

In Ghana a study by Van den Boom, (2004) has identified that cost of care, cost of transportation, time spent at the health provider and inability to work while at the provider were the major determinants of health care seeking practice. Van den Boom, (2004), estimates that consulting a doctor takes on average four hours and costs eight times more than self-medication in rural Ghana. He also estimated that one trip to the doctor may cost a family one-third of their income.

Health care system in Nigeria is influenced by different local and regional factors that impact the quality or quantity present in one location. Due to the aforementioned, the health care system in Nigeria has shown spatial variation in terms of availability and quality of facilities in relation to needs of the people. However, this is largely as a result of the level of state and local government involvement and investment in health care and education. Also, the Nigerian ministry of health usually spends about 70% of its budgets in urban areas where 30% of the population resides. It is assumed by some scholars that the health care service is inversely related to the need of the patients (Rais Akhtar, 1991).

Nigerian government has made efforts to ensure that the consciousness of her citizenry is awakened concerning their health and to influence their health seeking behaviour through the

establishment of primary health centers in all parts of the country. This is imperative because of the world's move towards healthy living; this was a result of primary health care declaration in Almata in 1978. This is in line with Okoronkwo (2004) who asserted that the component of primary care include education and information on health problem and their prevention and control, support for adequate food supply and nutrition, assurance of safe water and maternal child health care including family planning and immunization; the treatment of common ailments and injury, mental health and provision of safe essential drugs.

Babatunde, (1990), revealed that the proximity of health care services in terms of cost and nearness, attitudes of health personnel and alternative health care services are significant in promoting health care accessment and utilization.

2.3 Health Care System in Nigeria.

The choice of health facilities for health care by an individual is largely determined by his/her taste, satisfaction with service and the perceived quality of care provider (Razzak, Hyder, Akhtar, Khan, and Khan 2008). The choice is however limited by factors such as availability, accessibility, affordability of services of the health facilities, cultural beliefs, the situation per time (urgency of care need), and whether the kind of services provided meet the yearning need of the user (Bashoor, Abdussalam, 2007). The choice is also influenced by the user's understanding of the functions of the different levels of health facilities which ultimately result in the appropriate utilization of health services.

In Nigeria, health care system comprises both public and private health facilities (FMOH, 2004), in the public sector, the facilities are in three levels (primary, secondary and tertiary) which corresponds to the three tiers of government (FMOH, 2004). The primary health care (PHC)

facilities which are the prerogative of the local government are often poorly managed (HERFON, 2008) and founded as evidenced by lack of skilled and competent personnel, inadequate equipment, irregular drug supply and poor state of infrastructure in which many centers are dilapidated and waste (FMOH,2004, HERFON 2008)

For example, while less than half of PHC facilities in Nigeria provide antenatal care (ANC), a reproductive health resource inventory carried out by FMOH and WHO in (2001), found that almost 60% of the PHC offering antenatal care and delivery services had no midwives and another 17% had neither midwives nor senior community extension workers. This has rendered them underutilized and sometimes the tertiary facilities overburdened (Akande, 2004).

Ajala et'al (2005) summarises that there are three main health providers in Nigeria. These are government or public health service provider, private health care provider and non-governmental health care providers that are coordinated by ministry of health. That the underutilization of these health facilities in rural area which are occasioned by inaccessibility has led to death from illness which ordinarily could be treated and prolonged state of illness thus reducing productivity from the area. They also asserted that the resultant effect of inadequate access to health care delivery on sustainable development can be exemplified by the number of man hour loss annually to malaria alone which culminate in to lower productivity by workers.

The quality of Nigerian health care institutions is generally considered poor. There might also be shortages of medical supplies and the blood supply of the country is not considered safe. Hygiene conditions are problematic, especially outside the large cities and the Nigerian health care has suffered several down falls (Asangansi and Shaguy, 2009). Despite Nigerian's strategic position in Africa, the country is greatly undeserved in the health care sphere. Health facilities

(health care centers, personnel and medical equipment) are inadequate in this country, especially in rural areas (HERFON, 2006). Through various reforms have been put forward by the Nigerian government to address the wide ranging issues in the health care system, they are yet to be implemented at the state and local government area level (NNHC, 2009).

According to the 2009 communiqué of the Nigerian National Health Conference, health care system remains weak as evidenced by lack of coordination, fragmentation of services dearth of resources, including drugs and supplies, inadequate and decaying infrastructure, inequity in resource distribution, and access to care and very deplorable quality of care. The communiqué further outlined the lack of clarity of roles and responsibilities among the different levels of government to have compounded the situation.

Commenting on the condition of the primary health care system in Nigeria in an inclusive interview with Daily Times in his office, the Chairman Nigerian Medical Association Lagos State Branch Dr Francis Faduliye described the primary health care system in Nigeria as comatose. According to him, the tertiary institutions relegate the primary health care system which is supposed to cater for over 70% of people who have health needs on minor treatment of all health issues "and I must tell you that the primary health care system in Nigeria is comatose, it is still abysmally poor in indices that we have seen, the funding is terribly poor and nobody is looking at it.

"All these have brought so much pressure on the tertiary health institutions. There are things that are not to be seen at the tertiary institutions which are causing a lot of pressure on the medical professionals and because of this, the real work to be done at the tertiary health levels are not done appropriately". Decrying the poor medical equipments at the hospitals, he added "The

equipment are still far from what it should be, we have so many obsolete equipments and it is unfortunate that even the newer equipments that are being imported, many of them are not entirely new, some of them are refurbished but they are presented as new and based on this, "I think generally the health care system is still very low" lamented Dr. Francis.

(FMOH, 1998), observed that a major problem afflicting the health care system in Nigeria is the so-called "brain drain" of doctors and medical staff. It is estimated that there are four doctors for every 10,000 inhabitants. Highly-trained experts often leave the country in order to pursue their profession in countries with better infrastructure or higher wages.

2.4 Health Information

Unarguably, problems in health care system of any country abound to a certain extent (Dougherty, Conway, 2008). Although health has the potential to attract considerable political attention, the amount of attention it actually receives varies from place to place. In commentary of the 3T'S road map to transform US health care, Denise Dougherty and Patrick Conway, rightly stated a step by step transformation of the US health care system from 1T-2T-3T which is required to create and sustain information-rich and patient-focused health care system that reliably delivers high quality care (Dougherty, Conway, 2008).

Provision of timely information aimed at combating possible health menace among many other things is an important function of public health. Hence, inadequate tracking techniques in the public health sector can lead to huge health insecurity, and hence endanger national security (Davis, Schoenbaum, Audet, 2005). For decades ago, communicable diseases outbreak was a threat not only to lives of individuals but also to national security. Today it is possible to track outbreaks of diseases and step up medical treatment and preventive measures even before it

spreads over a large area. Medical and epidemiological surveillance, besides adequate health care delivery, are essential functions of public health agencies whose mandate is to protect the public from major health threats, including communicable diseases outbreaks, disaster outbreak, and bioterrorism (Sanders, Labonte, Baum and Chopra, 2004). To avoid the various threats and communication lapses to strengthen the health work force planning, management, and training which can have a positive effect on the health sector performance, one requires timely and accurate medical information from a wide range of sources.

The Nigerian health care had suffered several infectious disease outbreak and mass chemical poisoning for several years. Hence, there is immense need to tackle the problem (NPHCP, 2010). Multimedia presentations may improve knowledge of people with both low and high literacy skills but this does not appear to change health-related behaviours. Participatory education principles and theories of empowerment appear to help patients access, understand and use health information for the benefit of their own and their children's health.

2.6 Health Care Seeking Behaviour among Females.

People seek help on health issues based on several reasons and factors which influence the choice of treatment sources when symptoms occur include socio-cultural factors, social networks, gender and economic status. In fact, over 500,000 female are dying each year worldwide from avoidable complications associated with pregnancy, childbirth, abortion and reproductive tract infections (Desmeuete, Turner & Robert 2006). Access to health care facilities in terms of cost of treatment and healthcare provider attitude are also determinants of health seeking behaviour (Enykwola & Sunusi, 2010).

There are indicators that cost of prescribed medicines, poor access to facilities and patient delays affect the patronage and utilization of public health services which increase the use of other treatment sources such as community pharmacies, drug peddlers, herbal medicine, religious or spiritual care organizations and students in health related academic disciplines. Ill-health is a major life event which may cause people to question their existence as this condition disrupts basic activities which are essential to a healthy living, spiritually has been found to play a critical role in mitigating the pains and sufferings of ill-health because the relationship with transcendent being or concept can give meaning, purpose to people's life and sufferings.

Student's health care seeking behaviour may be influenced, essentially by nature of ailment/ waiting time in the health facility and attitudes of healthcare professional, implications for policy, practice, spiritual beliefs or delivery. Students of health institutions of Kano State are no exception to the influence of these factors as several studies and surveys have demonstrated the relevance of spirituality in the health of patients Afolabi, (2013).

Individuals differ in their choice of treatment sources depending on the type and perceived intensity of sickness, accessibility to public health facility and demographic characteristics (Afolabi et'al, 2013). What people do when they have symptoms of illness has major implications for morbidity and progression of the illness and consequences for creating a health community.

Delays or refusal in seeking and obtaining proper diagnosis and treatment can allow for greater probability of adverse squealed. Several studies have attempted to examine health seeking behaviour of university students in Nigeria, but there has been very little or none done among students of health institutions hence, understanding of health seeking behaviour of such students

could be of paramount benefit if a healthy community is to be maintained. For obvious reasons, barriers with respect to appropriate accessment of health services in our institutions do occur. There is also little empirical evidences on the level of patronage of alternative sources of healthcare among these students or the impact of services delivery on the utilization of health care facilities as such, knowledge of this is believed to have play a vital role in assisting the authorities of those health institutions in the management and development of accessible and effective health care policy and services.

Therefore, the objective of this research work is to investigate the determinants of health care seeking behaviour among female students of health institutions in Kano Metropolis by seeking their responses on the influence of the identified determinants on their effort to patronize promptly or otherwise seek medical attention. This study therefore viewed health care seeking behaviour as a tool for describing how individuals engaged themselves with health facilities available at their disposal.

2.7 Problems of Health Care Seeking Behaviour

Several factors converged to discourage/ encourage people from accessing health care services and facilities. The common predisposing, restricting / enabling factors that affects the individual's health care seeking behaviour differ by country and region (Mackian 2003). Various researches in different parts of the world, has revealed that cost, distance of health provider, perceived quality of health provider options, time spent e t c. were among the major barriers that affect the health care seeking behaviour among individuals.

(a) Cost: the cost of seeking health care includes more than the cost of consultation and medicine. It involves a hidden cost which in economic term is referred to as the opportunity

costs. Two such costs that significantly affect health care seeking behaviour are the direct cost of care and the cost of transport to the health provider. In any case, individuals close to the health providers frequent health clinics more than those that live far away from them. Conversely, individuals from rural communities spend more money to get to the health providers and also spend significantly more at the health providers.

(b) Wait Time: This is also another key opportunity cost varying among health providers with some of them having shorter wait time than others and this initiate different responses and patronage of health services among individuals.

Other significant opportunity costs in health seeking incurred in the decision to go to a health provider is the loss of income from a day's work missed, the tiresome experience of travelling to and from the clinics, waiting time and are trip to health provider all negate a whole day's worth of work. Thus many individuals work through illness and that the only time they cease working is when they go to the health provider.

(c) Distance of health provider: This is another factor worthy of consideration in terms of its effects on decision to seek for health care invested in the time it takes for a trip to reach a health provider. Therefore, the time it takes to get to the health provider varies significantly among communities this together with poor condition of the roads deter the individuals effort to seek health care.

Long times travel and greater distances to health centers is the most important factor that influences the utilization of health services in the Ahafo-Ano South district of Ghana. The effect of travel time on utilization reflects that of the distance and utilization. The inadequacies in access to health facilities have reduced the life expectancy of rural inhabitant and increase infant

mortality (Ajala et'al 2005). They further asserted that rural people often waste lot of time getting to the nearest available health care center of which they have trek long distance on many occasion because they are often faced with the problem of reliable means of transportation.

(d) Perceived quality of health provider options: As both cost and distance have been identified playing significant roles in the individual's choice and patronage of health care services and the decision to visit a health service provider, similarly, perceived quality is another major issue in health care seeking. It follows from reason that individuals will only patronize and report to health provider they perceived is high quality, the number and times to which people report to a health provider, proved as evidence that quality is an important factor in accessing health services.

2.8 Prospects of health care seeking behaviour

Whereas factors such as cost, distance, wait time and perceived quality of health provider posed threat to prompt health care seeking practice among individuals, however, factors such as proper medical diagnosis, cost subsidy, allotting and making health facilities easily accessible and readily available to people, improvement in quality of services, shorter wait time, better operating hours including promptness to work by health workers has the required potential to transform the behaviour of individuals to rightly seek for health care.

One study has demonstrated that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to services and perceived quality of the services (Tipping and Segall, 1995). In that regard, proper understanding of health care seeking behaviour could reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies in variety

of context. Health services that use their formal structures to support a more accessible way of engaging women in social networks, and are more responsive to their own institutions barriers to participate would enable a greater proportion to benefit from health services they are currently not utilizing.

Despite the ongoing evidences that people do choose traditional and folk medicine or providers in a variety of contexts, and which have potentially profound impact on health, few studies recommend ways to build bridges to in cooperate in to a more responsive health care system. For instance, Ahmed et al (2001) that incorporating these un-qualified providers in to a more formal training may be beneficial by providing an additionally accessible means of reaching the western medicines to a wider range of the population.

2.8 Summary

In this chapter, essential sub-headings related to health care seeking behaviour were reviewed. Health seeking behaviour has been defined as the activity under-taken by individuals who perceived they have a health problem or to be ill for the purpose of finding an appropriate remedy.

Abundance studies on health care seeking behaviour has demonstrated that complexity of factors on individual's behaviour at a given time and place and that health promotion programs worldwide has long been premised on the idea that knowledge and choices play a significant role towards shaping individual's health care seeking behaviour. Significant differences in health care seeking behaviour existing among people was found to be related to age and gender and that increased level of education leads to improvement in health care accessment and utilization.

In a research study conducted under the Ugandan national health survey, it was discovered that income is strongly associated with increased health care usage across all age ranges especially for women. In Nigeria, health seekers like in any of the developing nations in the world tend to seek help for care based on the resources available at the disposal of the family. Other factors involved in health care seeking behaviour among different household in Nigeria includes the severity of the symptom, socio-cultural influences, distance to place, cost of treatment, income, level of education and quality of health facilities.

Studies also revealed that student's health care seeking behaviour may be affected essentially by the nature of ailment, wait time in visited facility and attitudes of health care professional, implication for policy, practice, spiritual beliefs or delivery.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This study investigated the determinants of health care seeking behaviour among female students of health institutions in Kano State. Under this chapter, research design, population of the study, sample and sampling techniques, instrument for data collection, its validity and reliability, data collection procedure and data analysis are discussed.

3.1 Research Design:

The design for this study was Ex-Post-Facto research design which is a non experimental research and is usually under-taken when the situation already existed that need to be evaluated. The design is suitable for this study as recommended by Akuezuilo (2001), who described it as after the fact.

3.2 Population of the study

The population of this study comprised of all female students of the health institutions in Kano State totaling 2331 as at June 2014 based on the information gathered from student affairs and records department of the institutions (Students' affairs and records department as at June 2014).This cover student's enrolment in the current 2013/2014 academic session.

3.3 Sample and Sampling Techniques

Out of the total population of 2331 female students, 233 respondents were selected using the proportionate sampling technique of equal distribution as suggested by Singer (1986). And this is

considered suitable for this study. The table below summarises the sample selected from the study area.

Table 3.1 distribution of sample in selected female health institutions in Kano Metropolis.

	Institutions	population	Sample Selected
1	Sch. of health tech.	387	38
2	Sch. of nursing and midwifery	449	44
3	Sch. of hygiene	1495	149
	Total	2,331	233

3.4 Data Collection Instrument

The research instrument used in this study for the data collection was a researcher developed questionnaire based on five point Likert Scale. The questionnaire was tagged as determinants of health care seeking behaviour questionnaire (DIHCSBQ). The questionnaire consisted of five (5) sections, namely A, B, C, D & E. Section A was designed to seek demographic information of the respondents. Sections B, C, D & E, were used to collect information on the determinants of the health care seeking behaviour of the respondents. Each item of the questionnaire B, C, D &E, has six statements respectively to which the students responded given maximum score of 30 for each section by each respondent.

A five point Likert scale:

Strongly agree	5 points
Agree	4 points
Undecided	3 points
Disagree	2 points
Strongly disagree	1 point

The highest possible points a participant can score was 30 for each section of the instrument, while the least was 6 and the mid- point was 15 on each variable. For easy analysis, the options were collapsed as agree and disagree. Therefore, any respondent who score 16-30 was regarded as agreed and 1-15 as disagreed.

3.5 Validation of the Research Instrument

The instrument used in the study was a researcher developed questionnaire tag "determinants of health seeking behaviour questionnaire" (DIHCSBQ). The instrument was given to 5 experts in the Department of Physical and Health Education, Bayero University, Kano to determine both the face and content validity after which all their observations and corrections were incorporated in the final draft.

3.7 Reliability of the instrument

In determining the reliability of the instrument, a pilot study was conducted at Jigawa State College of Health Technology Jahun. Thirty (30) copies of the questionnaire were administered to the respondents. The split-half method was applied to determine the reliability index.

Spearman Brown Prophecy of reliability of 0.78r was obtained which was deemed enough to be used for data collection.

3.8 Data Collection procedure

An introductory letter was collected from the Head of Department of Physical and Health Education Bayero University Kano which was taken to the Principals of the selected health institutions to obtain their permission. With their permission granted, Two hundred and thirty three (233) copies of the designed instruments were thereafter administered to the respondents of this number, only Two hundred and four were returned with the help of three (3) research assistants who have already been trained on the procedures for distribution and retrieval of the questionnaire and the exercise lasted for two weeks.

3.9 Data Analysis

The following statistical techniques were used to analyze the data: Descriptive statistics of simple frequency count and percentage were used to organize and describe the demographic information of the respondents. Chi-Square was used to test the major and sub- hypotheses at alpha level of 0.05 significance while ANOVA was used to test the differences among the students based on their institutions at 0.05level of significance.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This study investigated determinants of health care seeking behaviour among female students of health institutions in Kano State. Two hundred and four (204) copies of the questionnaires representing 87.6% were duly completed, returned and used for data analysis. Therefore, this chapter presents results and discussion of the analyzed data. The results are presented in the tables below.

4.1 Results:

Table 4.1 Demographic information of respondents

Variables		
Age of respondents	Frequency	Percentage
15-20 years	76	37.3%
25 years and above	128	62.7%
Total	204	100
Marital status		
Single	152	74.5%
Married	48	23.5%
Divorced	04	1.9%
Widow	00	0%
Total	204	99.9%
Institutions		
Nursing and Midwifery	40	19.6%
Hygiene	136	66.7%
Health Technology	28	13.7%

Table 4.1 above shows that respondents aged 15-20 years were 76(37.3%) while respondents age 25 years and above were 128(62.7%). The results revealed that respondents age 25 years and

above were the highest among those who responded to the questionnaires. However, for the marital status, single were 152 (74.5%), married were 48 (23.5%), divorced were 4 (1.9%) and widowed were (0%). Also for school type, nursing/midwifery were 40 (19.6%), hygiene were 136 (66.7%), while health technology were 28 (13.7%). The result shows that female students who are not married (single) were the highest followed by married and divorced, while no widow was identified among the respondents.

Hypothesis I: Cultural belief is not a significant determinant of health care seeking behaviour among female students of health institutions in Kano State.

Table 4.2: Chi-square Summary table on students' opinion on cultural belief as a determinant of their health care seeking behaviour

Cultural belief	Agree	Disagree	Total	df	^{2} value	prob.
Fo	188	16	204	1	145.020	.001
Fe	102.0	102.0				

^{2}145.020 df1, $p < 0.05$

Information on the table above, reveals that 188(92.2%) of the respondents agreed while 16(7.8%) disagreed that cultural belief is a significant determinant of health care seeking behaviour among female students of health institutions in Kano State. Statistical computation of chi-square indicated ^{2} value of 145.020 df 1,($p < 0.05$) that there are significant difference. Therefore the null hypothesis is rejected on the account that cultural belief is therefore a significant determinant of health care seeking behaviour among female students of health institutions in Kano State.

Hypothesis II: Poverty is not a significant determinant of health care seeking behaviour among female students of health institutions in Kano State.

Table 4.3 : Chi-Square summary table on students' opinion on poverty as a determinant of their health care seeking behaviour.

Poverty	Agree	Disagree	Total	df	^{2} value	prob.
Fo	174	30	204	1	101.647	.001
Fe	102.0	102.0				

^{2} = 101.647 df1, $p < 0.05$

The information on the table above, reveals that 174(85.3%) of the respondents agreed while 30(14.7%) of the respondents disagreed that poverty is a significant determinant of health care seeking behaviour among female students of health institutions in Kano State. Statistical computation of chi-square indicated ^{2} value of 101.647 df 1, ($p < 0.05$), that there are significant difference. Therefore, the null hypothesis is rejected on the account that poverty is therefore a significant determinant of health care seeking behaviour among female students of health institutions in Kano State.

Hypothesis III: Heath policy is not a significant determinant of health care seeking behaviour among female students of health institutions in Kano State.

Table 4.4. Chi-square Summary table on students' opinion on health policy as a determinant on their health care seeking behaviour.

Health policy	Agree	Disagree	Total	df	^{2} value	prob.
Fo	174	30	204	1	101.647	.001
Fe	102.0	102.0				

^{2} = 101.647 df1, $p < 0.05$

Information displayed on table 4.4 above, reveals that 174(85.3%) of the respondents agreed while 30(14.7%) disagreed that health policy is a significant determinant of health care seeking behaviour among female students of health institutions in Kano State. Statistical computation indicated ^{2} value of 101.647 df 1, ($p < 0.05$), that there are significant difference. Therefore, the null hypothesis is rejected on the account that health policy is therefore a significant determinant of health care seeking behaviour among female students of health institutions in Kano State.

Hypothesis IV: Availability of health facility is not a significant determinant influencing health care seeking behaviour among female students of health institutions in Kano State.

Table 4.5: Chi-square summary table on students' opinion towards health facilities on health care seeking behaviour among female students of health institutions in Kano State

Avail. of health facility	Agree	Disagree	Total	df	^{2} value	prob.
Fo	178	26	204	1	113.255	.001
Fe	102.0	102.0				

^{2} = 113.255 df1, $p < 0.05$

The information from table 4.4 shows that 178(87.3%) of the respondents agreed while 26(12.7%) disagreed that health facility is a significant determinant of health care seeking behaviour among female students of health institutions in Kano State. Statistical computation indicated ^{2} value of 113.255 df 1, ($p < 0.05$), that there are significant difference. Therefore the null hypothesis is rejected on the account that availability of health facility is therefore a significant determinant of health care seeking behaviour among female students of health institutions in Kano State.

Table 4.6: ANOVA Summary on cultural belief, poverty, literacy level and facility as the determinants of health care seeking behaviour among female students of health institutions of Kano Metropolis based on their school type.

Variables		Sum of squares	df	Mean square	F	Sig.
Cultural belief	Between groups	5.145	2	2.573	53.863	.0001
Within groups				.048		
Total		9.600	201			
		14.745	203			
Poverty	Between groups	18.088	2	9.044	242.382	.0001
Within groups				.037		
Total		7.500	201			
		25.588	203			
Health policy	Between groups	18.088	2	9.044	242.382	.0001
Within groups				.037		
Total		7.500	201			
		25.588	203			
Health facility	Between groups	13.586	2	6.793	150.046	.0001
Within groups				.045		
Total		9.100	201			
		22.686	203			

$F(2, 201) = 53.863$ $P < 0.05$

$F(2, 201) = 242.382$ $P < 0.05$

$F(2, 201) = 242.382$ $P < 0.05$

$F(2, 201) = 150.046$ $P < 0.05$

Table 4.6, Item 1: ANOVA was conducted to determine the difference on cultural belief as a determinant of health care seeking behaviour among female students of health institutions in Kano State based on their school type. Statistical computation indicated calculated F value of 53.863 dF2, 201 ($p < 0.05$). This means that significant difference exists among the institutions

with respect to cultural beliefs. Therefore, null hypothesis is rejected on the account that significant difference exists among the three schools.

Table 4.6, Item 2: ANOVA was conducted to determine the difference on poverty as a determinant of health care seeking behaviour among female students of health institutions in Kano State based on their school type. Statistical computation indicated calculated F value of 242.382 dF2, 201 ($p < 0.05$). This means that significant difference existed among the institutions with respect to poverty. Therefore, null hypothesis is rejected on the account that significant difference exists among the three schools.

Table 4.6, Item 3: ANOVA was conducted to determine the difference on health policy as a determinant influencing health care seeking behaviour among female students of health institutions in Kano State based on their school type. Statistical computation indicated calculated F value of 242.382 dF2, 201 ($p < 0.05$). This means that significant difference exists among the institutions with the respect to health policy. Therefore, null hypothesis is rejected on the account that significant difference exists among the three schools.

Item 4.6, item 4: ANOVA was conducted to determine the difference on health facility as a determinant of health care seeking behaviour among female students of health institutions in Kano State based on their school type. Statistical computation indicated calculated F value of 150.046 dF2, 201 ($P < 0.05$). This means that significant difference exists among the institutions with respect to health facility. Therefore, null hypothesis is rejected on the account that significant difference exists among the three schools.

Table 8: Post Hoc Scheffes test.

Variables		(I) type of school	(J) type of school	mean diff.	std error	prob.
Cultural belief	scheffes	School of hygiene	sSchool of health ttectechnology	-25443	0,79998	
			School of health technology	-1.15846	0.72332	.001 .001
		School of health technology	school of hygiene	.25443	0.79998	.001
			School of nursing	-90403	0.95981	.001
		School of Nursing	School of hygiene	1.15846	0.72332	.001
			School of health technology	.90403	0.95981	.001
poverty	scheffes	School of hygiene	School of health technology	1.79845	0.77050	.001
			School of nursing	.91861	0.69666	.001
		School of health technology	school of hygiene	-1.79845	0.77050	.001
			school of nursing	-87980	0.092443	.001
		School of Nursing	school of hygiene	-91861	0.69666	.001
			school of health technology	.87984	0.92443	.001
Health Policy	scheffes	School of hygiene	School of health technology	.77856	0.89161	.001
			School of nursing	-43515	0.80617	.991
		School of health technology	school of hygiene	-77856	0.89161	.001
			School of nursing	-1.21371	1.06973	.001 .
		School of Nursing	School of hygiene	.43515	0.80617	.001
			School of health technology	1.21371	1.06973	.001 .
Health Facilities	scheffes	School of hygiene	School of health technology	2.79699*	0.81615	.001
			School of nursing	.92199	0.73794	.001 .
		School of health technology	school of hygiene	- 2.79699*	0.81615	.001
			School of nursing	-1.87500	0.97920	.001
		School of Nursing	School of hygiene	-92199	0.73794	.001
			school of health technology	1.87500	0.97920	.001

Scheffes was conducted to determine where the differences exist among the three schools i.e. school of Hygiene, Health Technology and Nursing.

Differences exists between School of Hygiene and School of Health Technology with a mean difference of -25443, Hygiene and Nursing with a mean difference of -1.15846, also between School of Health Technology and Hygiene with a mean difference of .25443, and Nursing with a mean difference of -90403 as well as among School of Nursing and Hygiene with a mean difference of 1.15846 and Health Technology mean difference of .90403, on cultural belief as a determinant of health care seeking behaviour among female student. School of hygiene differs with the rest of the institutions mean difference of 1.15846.

Differences exists between School of Hygiene and School of Health Technology with a mean difference of -1.79845, Hygiene and Nursing with a mean difference of -.87984 also between School of Health Technology and Hygiene with a mean difference of -.79845, Health Technology and Nursing with a mean difference of -.87984, as well as among School of Nursing Hygiene with a mean difference of -.91861,as well as between Nursing and Health Technology with a mean difference of .87984, on poverty as a determinant of health care seeking behaviour among female students. School of hygiene differs with rest of the institutions with mean difference of .87984.

Differences exists between School of Hygiene and School of Health Technology with a mean difference of .77856, Hygiene and Nursing with a mean difference of -43515, Health Technology and Hygiene with a mean difference of -.77856 Health Technology and Nursing -.121371 also between Nursing and Hygiene .43515, as well as between Nursing and School of Health Technology with a mean difference of 1.21371, on health policy as a determinant of health care

seeking behaviour of female students. School of hygiene differs with the rest of the institutions with mean difference of 1.21371.

Differences exists between School of Hygiene and School of Health Technology with a mean difference of 2.79699*, Hygiene and Nursing .92199, also between School of Health Technology and Hygiene with a mean difference of -279699*, Health Technology and Nursing with a mean difference of -1.87500, Nursing and Hygiene with a mean difference of -.92199 as well as among Nursing and School of Health Technology with a mean difference of 1.87500, on health facility as a determinant of health care seeking behaviour of female students. School of hygiene differs with the rest of the institutions with the mead difference of 2.79699. The discrepancy among hygiene and the rest of these institutions may be due to the variation in enrolment as it has the highest number of students coming from different local governments and socio-economic background.

4.2 Discussion

The finding of this study revealed that cultural belief is a significant determinant of health care seeking behaviour among female students of health institutions in Kano State. This could be due to the fact that majority of the female students of those institutions come from a society with a cultural background where such beliefs were fully recognized and encouraged. This seems to have influenced the students to resort to traditional health care rather than the orthodox one. This finding is in agreement with Jegede (1991), who asserted that magico-religious beliefs influenced how people perceived diseases. The study is also in agreement with (Baker 1993, and Develay 1996) that cultural beliefs and practices often lead to self care, home remedies and consultations with traditional healers in rural communities. It also contravenes the research conducted by (Bloom, 2001), who reported that cultural beliefs and practices negatively affect

awareness and recognition of severity of illness, gender, availability of services and acceptability of services.

Findings also revealed that poverty is a significant determinant of health care seeking behaviour among female students of health institutions in Kano State. This situation may not be unconnected with dwindling nature of the economy, low employment opportunities, non training of students on entrepreneur and vocational skills to make them self-reliance making it necessary for them to resort to traditionally available medicine as against orthodox one. This study is in line with earlier research reported by Lanre-Abass (2008), who opined that the introduction of user charges especially coming at the time of spreading poverty, become a great barrier to access for many Nigerian women.

The study is also in agreement with the report of (Tipping, 1994), who discovered that an inverse relationship occurred between average cost of health care which made traditional care to be cheaper option and health care the most expensive and largely avoided option among the poor. These situations may not be unconnected with dwindling nature of the economy, low employment opportunities non training of students on entrepreneur and vocational skills to make them self-reliance are responsible for their resort to traditionally available health care as against orthodox one.

Findings revealed that literacy level is a significant determinant of health care seeking behaviour among female students of health institutions in Kano State. Thus higher level education and training are expected to change positively student's behaviour to encourage higher level patronage of modern medicine other than traditional care. But probably the attitude observed with the students resorting to traditional medicine may be due to its simplicity and receptiveness

of its operators. The finding agrees with report by WHO (2005 who believed that health literacy remain the degree to which are able to access, understand and communicate information in accordance with demands of health context so as to promote and maintain good health across the life course.

This study is in harmony with the findings of UNICEF (1988), that health care seeking behaviour is a complex interplay of many factors operating at individual, family and community level. It is also in line with opinions of (Ogujuyigbe and Liasu, 2007) reporting that maternal care and mortality in developing countries over the last decade showed a positive association between maternal education and maternal health care. In the same vein, Kitts and Roberts (1996), agreed that lack of educational opportunities may lead to poor understanding of health related matters, therefore, many women may not be familiar with different diseases and their perception.

Finding revealed that health facility is a significant determinant of the health care seeking behaviour among female students of health institutions in Kano State. This finding agreed with the report by (Herfon 2006), that despite Nigeria's position in Africa, the country is greatly underserved in the health care sphere as health facilities, health centers, personnel and medical equipment are inadequate in the country especially in rural areas.

This finding corroborates the research study conducted by Shiffman (2006), FOS/UNICE (2008), that the quality of maternal health facilities in Nigeria is poor as national mortality rate was at 704 per 1000,000 live birth though with considerable variation across the regions. The findings of this research also lends support from the work of (Fatusi, 2003), who conducted a study on 12 states of Nigeria randomly selected and revealed that only 18.5% of public facilities overall and only 4.2% of public facilities met internationally acceptable standard for obstetric

care. The study also corroborated with the report of Hackett (1991), that in spite of the attempts to improve and re-organize medical and social conditions, hospital facilities in urban and rural areas remain overloaded and medical workers in short supply.

This finding is also in tandem with the report of Ogundari (1990) that hospital and health centers are scanty and probably are the reasons why most Nigerians seek alternative medicine and more available forms of help from priests, traditional healers and syncretism. In addition, nature and dilapidating condition of health facilities especially in the rural areas which were considered as mere consulting clinics with few ones concentrated in urban areas, shortage of drugs, unskilled health attendants and frequent migration of health workers to foreign countries may all be the possible reasons why the students resort to traditional medicine rather than orthodox medicine.

Finding revealed that significant differences exist among the institutions with respect to cultural belief as a determinant of health care seeking behaviour. The difference may be due to the diversity in the cultural background of the students encouraging different belief practice among them. The finding share the belief of Dewitt (1994), that cultural factors such as gender, norms, birth practice and nutritional taboo especially during pregnancy result in the mitigation of individual women and girl's health or their quality of life. It also agrees with the findings of Jegede (1991), Kitts and Roberts (1996), who argued that perception of illness is affected or influenced by different beliefs system in the society. Similarly this study corroborates the findings of Baker (1993), Develay (1996), who reported that cultural beliefs and practices often lead to self-care, home remedies and consultations with the traditional healers particularly in rural communities

Finding revealed that significant differences exist among the institutions with respect to poverty as a determinant of health care seeking behaviour. This may be tied around the fact that the students come from mixed socio-economic status. This finding agree with the work of Yu, Coa and Lucas (1997), who conducted a cross-sectional study on equity and use of medical care, and found little difference in utilization of outpatient services by income group but greater difference at higher level of care. Also that increasing income differential negatively affects equity of access. Similarly with the data from Vietnam analyses of living standard carried out" between" 1992-93, which reported that cost of services affect decision making for health.

Finding revealed that significant differences exist among the institutions with respect to literacy livel as a determinant of health care seeking behaviour. This may be attributed to lack of awareness on the side of the students due to policy makers' failure to organize sensitization programs such as seminars and symposium coupled with the students' attitudes of dogging the tasking bureaucratic procedures in accessing health services.

The study also agrees in principle with report by (Sheik and Hatcher 2004, Gruskins and Torontola 2002), who believed that in order to foster a rational and evidence based policy, advocacy campaigns, lobbying for a policy shift and convincing donors to invest in priority areas, to implementing programs dealing with health promotion and disease prevention, the behavioral, social and economic determinants of health ought to be taken into account. This study is also in agreement with the assertion made by (Sanders et'al 2004), that strategic policy formation in all health care system should be based on information relating to health promotion, seeking and utilization behaviour and the factors determining these behaviours.

Graczyk (2007), also situates it that lack of education can affect health when it limit young women's knowledge about nutrition, birth spacing and contraception.

The finding equally agree with report by Kitts and Roberts (1996), believing that a lack of educational opportunities may lead to poor understanding of health related matters, and therefore, many women may not be familiar with different diseases and their presentation.

Finding revealed that significant differences exist among the institutions with respect to health facility as a determinant of health care seeking behaviour. The reason may be related to the fact that majority of the students are from rural areas where the facilities are grossly inadequate. This study is in line with the investigation conducted by (NPLC, 2004),who made the report that approximately two-third of all Nigerian women and three quarter of the rural Nigerian women deliver outside of health facilities and without skilled attendants present. Similarly, the finding agrees with Orubuloye, (1991), who observed that majority of the improved high grade and better equipped medical facilities are located in urban areas, those in the rural areas are poorly maintained, lack equipment and drugs, and are thus mere consulting clinics.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

This study investigated the determinants of health care seeking behaviour among female students of health institutions in Kano State. To achieve this purpose, four research questions and five hypotheses were formulated and ex-post facto research design was also used for the study.

The population of the study was made up of all the female students of health institutions in Kano State as at June 2014. The sample selected for the study consisted of two hundred and thirty three (233) female students drawn from four female health institutions in the state using proportionate sampling techniques.

Data were collected using researcher developed questionnaire shown in appendix A. The instrument was validated by experts from the department of physical and health education Bayero University Kano, reliability of 0.78r was also obtained. For the purpose of analysis, only questionnaire data from two hundred and four (204), respondents were duly completed and returned for analysis. Demographic information of the respondents was organized and described using simple percentage and frequency count. Chi-square (^{2}) and ANOVA were used to verify the hypotheses at 0.05 level of significant.

The following findings were reported;

1. Cultural belief is a significant determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

2. Poverty is a significant determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

3. Literacy Level is a significant determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

4. Health facility is a significant determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

5. Significant difference exists among the institutions with respect to cultural belief as a determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

6. Significant difference exists among the institutions with the respect to poverty as a determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

7. Significant difference exists among the institutions with the respect to literacy level as a determinant of the health care seeking behaviour among female students of health institutions in Kano Metropolis.

8. Significant difference exists among the institutions with the respect to health facility as a determinant of health care seeking behaviour among female students of health institutions in Kano Metropolis.

5.2 Conclusion

Based on the findings of this study, the following conclusions were drawn.

That cultural belief, poverty, literacy level and health facility are all significant determinants of health care seeking behaviour among female students of health institutions in Kano Metropolis.

That significant difference exists among the three institutions with the respect to the determinants of health care seeking behaviour among female students of health institutions in Kano Metropolis based on their school type.

5.3 Recommendations

Based on the findings of this study, the following recommendations were drawn

1. Health educators should try to inculcate the spirit of positive change in the cultural belief among the students so as to minimize its interference with their health care seeking behaviour.

2. Authorities should try to engage the students on vocational and entrepreneurship training to ease the financial problems facing them to facilitate utilization of health care services.

3. Authorities of the Female health institutions in Kano Metropolis should engage their students frequently in sensitization programmes on the implication of neglecting the determinants impacts on their health care seeking behaviour as this help them to patronize health products.

4. Adequate and standard health facilities need to be provided in all the communities to encourage patronage among female students.

5. Health institutions should try to tackle the existing differences among the institutions by organizing sensitization programs such as seminars, workshop and other relevant training for

their students so as to break off the wrong impressions students hold on orthodox care due to the influences of such determinants on their health seeking behaviour.

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Appendix A

Department of Physical and Health Education, Faculty of Education, Bayero University, Kano

Dear Respondents,

I am an MSc student wishing to conduct a research on the topic "Determinants of health care seeking behaviour among female students of health institutions in Kano State". The study is strictly for academic purpose and therefore, all information provided will be treated only for the said purpose and with a high degree of confidentiality.

SECTION "A" Demographic information of the respondents

(Indicate appropriately by ticking the box provided below)

1. Age: 15-20 ☐ 21- 25 ☐

3. Marital status: Single ☐ Married ☐ Divorced ☐ Widow ☐

4. School type: Health Technology ☐ Nursing/Midwifery ☐ Hygiene ☐

Please tick☐ in the appropriate box against the statement that best correspond to your feeling whether you strongly agree (SA); agree (A); undecided (UD); disagree (D) or strongly disagree (SD).

SECTION: “B, C, D & E.” DETERMIINANTS INFLUENCING HEALTH CARE SEEKING BEHAVIOUR AMONG FEMALE STUDENTS OF HEALTH INSTITUTIONS IN KANO STATE

S/N	STATEMENT	SA	A	UD	D	SD
B	CULTURAL AND RELIGIOUS BELIEFS					
i	Culture encourages the use of traditional health care when sick					
ii	Choice of traditional health care is determined by the societal believes					
iii	The power of magico-religious believes is responsible for my resorting to traditional medicine					
iv	Societal norms clash with my perception of disease symptoms and choice for medical health care services					
v	Religion is not a factor responsible for one’s choice of medical health care services					
vi	Accessing all sorts of medical facilities is based on religious permission.					
C	POVERTY					
i	High cost of prescription is not preventing me from attending modern health centre					
ii	Cost of transport fair to health provider does not prevent me from up taking healthcare facilities					
iii	High quality of modern health care encourages me to seek for medical care					
iv	Poor financial position discourages me from accessing health care services					
v	Qualitative health services are expensive and not affordable to me					
vi	Traditional medicines are cheap and affordable, hence					

	I seek traditional care					
D	Literacy level					
i	I do not patronize traditional medical care because it lacks prescription standard					
ii	I choose to attend orthodox medical care because it is guided by a well defined policy.					
iii	Iam well enlightened that on health issues that are why I patronize orthodox health care.					
iv	I utilize traditional health care because I consider it safe					
v	I resort to traditional medicine because I don't understand their side effects.					
vi	The label I read on drugs packs enables me to know the value of orthodox medicine.					
E	AVAILABILITY OF HEALTH FACILITIES					
i	Modern health care facilities provided the required medical health care services and are therefore better patronized					
ii	Science and Technology in the area of health encourage one's decision to attend health care facilities					
iii	Adequately equipped health centers in my area encourage me to patronize modern medical services.					
iv	Lack of medically skilled health attendants is the reason for my shift to traditional care					
vi	Sub-standard drugs in our hospitals are responsible for my preference to traditional health care.					