UNIVERSITY FOR DEVELOPMENT STUDIES

FACTORS AFFECTING THE HEALTH SEEKING BEHAVIOUR OF FULANI HOUSEHOLD IN THE GUSHEGU MUNICIPALITY

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BY

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DECLARATION

STUDENT'S DECLARATION

I hereby declare that this thesis, with the exception of citations contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

NAME OF STUDENT: HABIBA BEN SALIFU

SIGNATURE……..

DATE…….....

SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines for the supervision of the thesis as laid down by the University for Development Studies.

NAME OF SUPERVISOR: DR. GLOVER EVAM KOFI

SIGNATURE……..

DATE…….....

ABSTRACT

This descriptive survey assessed the health seeking behaviours behaviour of a sample of 86 households of Fulanis in the Gushiegu Municipality of Northern Region of Ghana. Data were collected through a structured questionnaire. The Data were analysed using Microsoft Excel 2016. Health seeking behaviours examined were: respondents seeking healthcare at health facilities (5%), self-medications from chemical or drugs stores (43%) and Traditional Healers like Mallams (52%). Challenges faced by Fulanis in seeking healthcare examined were: difficulty in access NHIS, negative attitude of health workers, delay in getting treatment and non-availability of drugs. The cost of services did not influence respondents decision to visit health facility or otherwise.

To encourage Fulani in Gushiegu Municipality to seek healthcare at professional health facilities, there is the need for public education and sensitisation in the Fulani communities. Ghana Statistical Service should provide accurate data on the number of Fulanis in Ghana to facilitate policy formulation and its implementation.

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Finally, I appreciate all the people in Gushegu Municipality.

DEDICATION

I dedicate this work to Precious Adwoa Pomaa Ntim

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CHAPTER ONE

INTRODUCTION

1.1Background to the study

Across the world, minorities and indigenous people are disproportionately exposed to discrimination. From intimidation and verbal abuse to targeted violence and mass killing, this discrimination often reflects and reinforces existing patterns of exclusion. Mhalanga et al., (2014), observe that these impacts extend beyond the immediate effects on individual victims to affect entire communities– in the process further marginalizing them from basic services such as healthcare, participation and other rights.

Minority groups mostly evolve out of migration of people into new geographical areas. Worldwide, the number of migrants has risen from 154 million in the early 1990s to 232 million today - equivalent to 3.25 per cent of the global population, or 1 in 30 people across the world (Foa, 2015). However, as migrants move from their home to their host country, they face a wide range of social barriers and obstacles to integration. Invariably, legal barriers to integration, the result of restrictions on citizenship and work authorisation frequently lead to problems of labour market exploitation and human trafficking. In addition, the increase in international migration over the second half of the twentieth century has also been accompanied by increasing social tensions and societal resistance to inclusion of migrants, with anti-immigrant mobilisation and social unrest affecting not only developed countries in Western Europe and North America, but also many developing nations (Foa, 2015).

All countries contain ethnic minorities, defined by the Framework Convention for the Protection of National Minorities as a group of people within a national state who are: numerically smaller than the rest of the population, not in a dominant position, having a culture, language, religion, or race that is distinct from that of the majority, whose members have a will to preserve their specificity, are citizens of the state, and have a long-term presence there (Kugelmann, 2007; Slimane, 2003). Ethnic minorities can be separated into different categories, depending on how minority status was acquired – some minorities are the descendants of migrants, others the descendants of groups brought to a country by coercive means, and other minorities are indigenous peoples, who became minorities as a result of settlement and colonization of their native territories. Slimane, (2003) notes that all ethnic minorities share typically identifiable physiological features that make them potential victims of group-based discrimination, and a disadvantaged socioeconomic status that makes such discrimination not only possible but also likely in a range of social, economic, and institutional settings.

The association of illness and poverty in such vulnerable groups is mediated by overcrowding, poorly ventilated housing, malnutrition, smoking, stress, social deprivation and poor social capital. The perceptions of health and illness in many minority groups are thus altered resulting in a negative impact on health-seeking behaviours and access to healthcare services. Important factors include disrupted social networks; social exclusion, reduced accessibility to healthcare; lack of egalitarian participation in society and lack of trust, understanding or respect for the system have phenomenal impact on health seeking behaviour (Slimane, 2003). Women, unemployed and homeless people especially, experience longer delays in seeking care resulting in

increased suffering and expenses and higher risk of community transmission of communicable diseases and sexually transmitted infections.

Africa as a continent is endowed with people of diverse cultural and ethnic backgrounds. Strive for supremacy therefore exists, which in turn displaces minority and weaker ones leaving them vulnerable. Ethnic and religious conflicts, political unrests and economic instability, all of which lead people out of their homes to become foreigners in neighbouring countries are major causes of the numerous ethnic minorities within the continent. Descendants of these people are also often marginalised and discriminated against in all dimensions. For instance, Mhalanga et al (2014) indicate that Uganda's ethnic minority groups and indigenous peoples (including the Batwa, Karamajong, Nubians and Ugandan Asians), have reported for many years of prejudices and stereotyping on the basis of their culture and ethnicity.

In West Africa, the Fulani, numbering between 20 and 25 million people in total, is one of the largest vulnerable ethnic groups widely dispersed across the Sahelian region and West Africa (Bukari & Schareika 2015; Glew et al, 2003). According to Soeter and colleagues (2017), the Fulani who inhabited the Sudano-Sahelian region north of Ghana during the pre-colonial era, periodically migrate into the southern Guinea Savannah belt in search for pasture and water resources for their livestock. However, the Sahelian droughts of the late 1960s and 1970s induced them to settle on a more permanent basis in the greener southern parts of West Africa, including Northern and Central Ghana (Bassett & Turner, 2007). Subsequently, increment in population led to competition with local farmers for the usage of land and water sources (Bukari&Schareika, 2015) which are fundamental for the survival of their cattle herding

occupation. With the elapse of time, this fierce competition for natural resources expanded to engulf utilisation of what is made by man as well. Bukari & Schareika (2015) and Tonah (2002) indicate that the Ghanaian Fulani are usually marginalised in access to services including basic health care, though Anter (2011) argues that there is nothing like 'Ghanaian Fulani', hence they should not be alienated by virtue of their nationality status and deny access to fundamental resources of livelihood.

"Health is wealth" is a popular adage used by many people across the world and predominantly in Africa. This demonstrates the magnitude of importance people attach to matters relating to their wellbeing as they hold onto the notion that their health status has a bearing on their productivity and income. As defined by the world health organisation, health refers to a state in which an individual enjoys complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 1946; cited in Gandhi, Verma, & Dash, 2017).

Many indigenous ethnic groups in Ghana however define health as a state in which the mind, body and spirit, which constitute the 3 parts of the human body, are in equilibrium and all function adequately and harmoniously (Appiah Kubi, 1981; cited in Kuuire et al, 2015). Therefore, a deviation in any of these may contribute to ill-health. In relation to this, most cultures in Africa believe that diseases are generally a spiritual phenomenon determined by the interaction of vital forces including deities, ancestral spirits, living beings, animals and objects (Akogun et al, 2012; Anter, 2011; Hampshire, 2003). The Antoa shrine in the Ashanti region is a known deity in Ghana used by people to invoke some of these curses and is believed to be reversed only by going to the shrine for certain rituals to be performed. Gandhi, Verma, & Dash (2017) however reiterate that the germ

theory cannot be disputed as it possesses scientific proof and validity and is found to be remarkably reliable in most situations of ill-health.

The individuals comprehension of the definition of health thus plays a major role in how and when to seek healthcare assistance and when not to, which is termed health seeking behaviour. In a nutshell, health seeking behaviour is the act of making a decision regarding one's state of health, usually when the individual is not feeling well, and whether or not to seek healthcare assistance from qualified personnel (Ihaji, Gerald &Ogwuche 2014). In a broader view, health seeking behaviour encompasses all those attitude and actions associated with establishing and retaining a healthy state, plus aspects of dealing with the departure from that state (Kanbarkar & Chandrick, 2017). The steps taken by any particular individual towards attaining optimum health however are often many and varied as the decisions are likely to be influenced by their prevailing social, cultural, economic, mental, religious, physical and even political circumstances (Ihaji, Gerald & Ogwuche 2014).

1.2 Statement of the Problem

According to Anter (2011), most Fulani found in Ghana are known to face discrimination that translates into low educational level, low socio-economic status and lack of appropriate access to health care. Low education level of the Fulani women and their semi-nomadism makes it more difficult to access information about reproductive health among others. Although their communities are known for using natural treatments (Akogun et al, 2012), they are however receptive to allopathic treatments; despite low rate of allopathic care utilisation, especially for chronic and non-urgent medical situations. Many women are familiar with the concept of health insurance, but the rates of

enrolment and utilisation are very low because of long waiting time, bureaucracy, lack of information and lack of understanding about how to utilise it (Kuuire et al, 2015). Some Fulani prefer using the private hospitals over the public or government hospitals despite its large out-of-pocket costs, due to low quality care delivery and discrimination they face in the public sector. The Fulani community as a whole faces stigma and discrimination while accessing health care but many are reliant on government services given their low socio-economic status.

Since "good health and well-being" and "reduced inequalities" are two main objectives of the United Nations Sustainable Development Goals, providing appropriate and equitable health care access for vulnerable populations is a global priority. The public health is focused on preventive health and particularly vaccination as well as on a portion of inpatient care (Kuuire et al, 2015).

However, there is pronounced difference in healthcare utilisation between the majority and minority or more vulnerable ethnic groups in Ghana. Majority of Ghanaians depend on the public health system as compared to the private providers who tend to charge exorbitant bills and are rarely located in remote areas. According to Kuuire et al (2015), the introduction of the National Health Insurance Scheme has made access to health care more affordable and easier as compared to the former cash and carry system. Other governmental interventions such as free maternal care as well as vaccination against childhood killer diseases among others have gone a long way to promote the accessibility of primary healthcare to the ordinary Ghanaian, and aid in the achievement of the Sustainable Development Goals (SDGs). The point of concern however lies in whether the entire population has equal access to these facilities which is obviously not the case.

Although the Fulani in Ghana should be entitled to the same health-care services as the general population, in practice there is a wide variability. Consequently, many of them are denied access or experience barriers such as lack of cultural sensitivity, language skills, awareness of rights and services provided. Stigmatization of diseases such as TB, HIV/AIDS, and mental distress further impede access to healthcare. These factors all contribute immensely to poor health seeking behaviour in particularly vulnerable minorities groups including the Fulani inhabiting Gushiegu Municipality.

The exact number of Fulanis living in Ghana is not known. Moreover the lack of research study and data on their health seeking behaviour impedes their inclusion in policy making and implementation.

1.3 Conceptual framework

According to Miles and Huberman (1994), a conceptual framework explains, either graphically or in a narrative form, the main things to be studied, namely: the key factors, constructs or variables and the relationship among them. The conceptual framework for health seeking behaviour looks at the key issues and factors that influence healthcare seeking behaviour relationship. The conceptual framework for this study is drawn from Andersen's behavioural model of healthcare services utilization (Kuuire et al 2015) as presented in Figure 1.

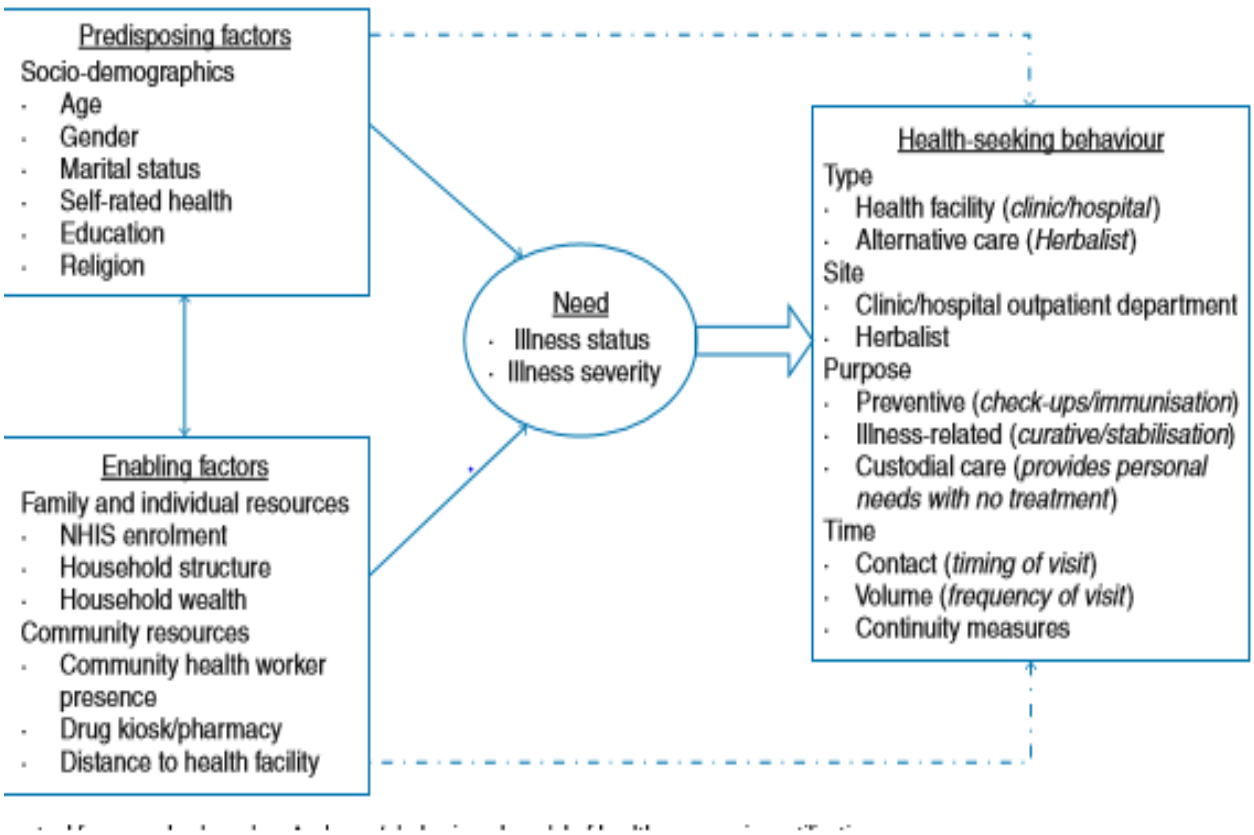


FIGURE 1.1: CONCEPTUAL FRAMEWORK-BASED ON ANDERSEN'S BEHAVIOURAL MODEL OF HEALTHCARE SERVICES UTILISATION. ADAPTED FROM KUUIRE ET AL (2015).

From figure 1, it can be deduced that health seeking behaviour is a product of socio-demographic factors and resource availability, and further catalysed by the need for optimum health. Adapted from Andersen (2008), the framework indicates that health seeking behaviour is a function of three groups of factors: predisposing, enabling and need. Predisposing factors describe the tendency to use services and include socio-demographics and health and illness values, while enabling factors describe the means available to use health services including personal and family resources. Although

predisposing and enabling factors are necessary for health service utilization, they are not sufficient for actual use. Actual use is initiated by need, which might arise as a result of illness level (Anderson, 2008; cited in Kuuire et al 2015).

1.4 Justification

The struggle for supremacy between different ethnic people is a constant phenomenon in Africa. Consequently, minority groups are marginalised making them vulnerable in their ability to access and utilise fundamental resources including access to healthcare. Though the Fulani have migrated into Ghana prior to the declaration of independence, they are generally considered as foreigners and alienated and stereotyped against in all facets of societal life (Anter, 2011).Yet no governmental or civil society organisations has made attempts to collate the numbers of these supposed 'foreigners' to help in policy making, let alone probing into their health seeking behaviour towards utilising some of these services.

Health is wealth in that a healthy body is able to work, increase productivity and improve economic status of households and society in general. For this reason, governments spend whopping amounts of money to improve the health of the populace. To ensure the success of such interventions, plethora of studies has been conducted to gain insight into the behaviour of Ghanaians (in terms of their knowledge, attitudes, and practices to health care usage). However, the Fulani are usually excluded in such exercise (Akogun et al 2012; Anter, 2011).

The study was thus conducted in the Gushiegu Municipality to probe into the health knowledge, health attitudes and health practices of Fulani households. The Gushiegu

Municipality has a prolong records of Fulani activities. Though there is no official record of their total number in this area, anecdotal evidence supports this assertion. There has also been constant conflict between Fulani and the indigenes (Anter, 2011) which buttress the assertion.

The purpose of this study is therefore to determine the health seeking behaviour of Fulani households in the Gushiegu Municipality of the Northern Region. To date, only very few studies have been conducted on the health of Fulani. These few studies are also predominantly focused on the prevalence of morbidity, illness profile and healthcare provision coverage (Seck et al, 2017; Kanbarkar and Chandrika, 2017; Bukari&Schareika 2015; Akogun et al, 2012; Otusanya et al, 2007). No vigorous research has so far been done on knowledge, opinions, attitudes and practices of the Fulani towards healthcare. In parallel terms, though many have noted the various challenges facing the Fulani in Ghana, there is hardly any systematic research on the health seeking behaviour of specifically Fulanis inhabiting the Gushiegu Municipality. This study seeks to provide data on health seeking behaviour of Fulanis so as to facilitate their inclusion in National policies and programmes.

1.5 Research Questions

1. What is the attitude of the Fulani towards seeking healthcare?
2. Where do the Fulani seek healthcare?
3. What challenges do Fulanis face in accessing healthcare?

1.6 General Objective

To determine the health seeking behaviours of Fulani households in the Gushiegu Municipality of the Northern Region.

1.7 Objectives

1. To explore the personal level factors influencing health seeking behaviour of Fulanis
2. To explore the enabling factors influencing the health seeking behaviour of Fulanis
3. To identify common places / facilities where the Fulanis seek healthcare
4. To investigate the challenges Fulanis face

1.8 Significance of the study

This study will contribute significantly to inform public policies concerning minority groups like the Fulani. Findings from this study may provide a strong evidence base for Government and key stakeholders to implement targeted community based interventions aimed at addressing disparities that fuel health, food and nutrition insecurity especially in rural areas. In this sense, the findings could help stakeholders in coming up with programs and interventions that may effectively reduce human suffering. The results might also help to come up with interventions that will help the Fulani access health services generally. The data will also serve as a source of reference for further studies in some other relevant aspects of the same research within similar settings in the country.

1.9 Organization of the Study

The study is structured into five chapters. Chapter one contains the introduction and background of the study, the problem statement, research objectives and significance of the study. Chapter two reviews related literature on the Fulani and health seeking behaviour of minority ethnic groups. Chapter three presents the research methodology used to conduct the study, sub-sections include profile of the study area, research population, sampling techniques, data collection methods, data analysis procedures, ethical considerations and limitations of the study; Chapter four deals with data presentation and analysis. Chapter five focuses on discussions of the study findings, summary, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction.

The activities of this chapter include defining the key terms of the research topic (Fulani, health seeking attitude/behaviour, and household), reviewing relevant and contemporary literature on Fulani, their perceptions on health, attitudes and their overall health seeking behaviour. The chapter further dwells on the type of health facilities they tend to patronise and the challenges they confront in accessing such facilities.

2.2 Overview of the Minority Fulani Race

The world over, numerous minority groups exit and in Africa, the Fulani (Fulbe), though a major ethnicity, forms minor tribal groupings in many West African countries, including Ghana. Hampshire, (2003) alleged that estimates of Fulani population size are problematic due to their fluid nature and government inability to involve them in census activities. However, Bukari & Schareika, (2015) as well as Glew et al (2003), argue that there is roughly 15–20 million nomadic Fulani living on the African continent. The Fulani are the major cattle-herding group in West Africa and most of their tradition is tied up with nomadic pastoralism. They are scattered throughout the savannah belt south of the Sahara from Senegal in the west as far as the border of Ethiopia in the east (Hampshire, 2003). There are Fulani in every West African state, but in each country they constitute a minority of the population (Dupire, 1970 & Riesman, 1992; cited in Hampshire, 2003). In rural northern Nigeria where the largest numbers of Fulani live, the majority of them follow a pastoral, semi-nomadic lifestyle in which the economy is

centred on cattle (Anter, 2011; Glew et al, 2003). While they tend to maintain permanent hamlets for their families, Fulani herdsmen commonly spend several months of the year in temporary settlements or camps located in the bush or savannah where they graze their herds (Glew et al, 2003; Tonah, 2002), exposing them to hazardous conditions which ultimately results in sickness and thus warrens health care.

The activities of Fulani in Ghana do not differ from elsewhere in Africa. Bukari & Schareika, (2015) maintain that though the exact numbers of Fulani in Ghana is not known, they are estimated to be more than 14,000. According to Soeter, (2017), the Fulani inhabit the Sudano-Sahelian region north of Ghana and from the pre-colonial period till now, the Fulani traditionally base their livelihoods on seasonal transhumance. As a result, during the dry-season, Fulani herdsmen migrate into the southern Guinea Savannah belt in search for pasture and water resources for their livestock. However, since the Sahelian droughts of the late 1960s and 1970s, groups of nomadic, transhumant Fulani pastoralists have started settling on a more permanent basis in the greener southern parts of West Africa, including Northern and Central Ghana (Bassett & Turner, 2007). As such, there are two broad categories of Fulani pastoralists in Northern Ghana today; nomadic pastoralists who migrate from the Sahelian belt during the dry-season, and return upon the onset of the rains, and sedentary or, semi-nomadic Fulani pastoralist, who have settled in northern Ghana and elsewhere on a more permanent basis. According to Hampshire (2003), this serious drought of the 1970s has compelled many Fulani to combine pastoralism with other economic activities, and some have forsaken pastoralism altogether and live in cities. Despite the fact that this group is settled or semi-settled, Soeters, Weesie & Zoomers (2017) note that they generally make low capital

investments, due to continued risk of being forced to move as result of conflicts with local farmers, which often happen as cited by Bukari & Schareika (2015) .

According to Hampshire (2003), the Fulani operate an essentially patrilineal descent system, with patrilocal residence. Once married, a woman moves to her husband's family, and their children become part of his lineage. However, this is interpreted flexibly, and women typically retain important rights in their natal homes, and in their own patrilineages. The typical Fulani household has a headman, his wives, children and dependents (Akogun et al, 2012). Duties and interactions are segregated by age and sex (elderly, married male, unmarried male, married female and unmarried female) and in-laws are not permitted to socially mingle. Responsibilities and duties are well defined. Women take care of food, children, and the tents while the young herd the animals. The elders serve as liaison to other clans and to the local community population. They gather news about pasture, potential conflict and patterns of local politics that may affect the Fulani community (Akogun, et al, 2012).

Tonah (2002) indicates that the Fulani and their families in Ghana usually reside on the outskirts of stable communities, but take their cattle to pasture and water sources daily. Consequently, they are regarded as aliens and are excluded in the decision making process of the community (Bukari & Schareika 2015). This reserved nature of the Fulani minorities affects their integration, acceptance and entitlements to basic amenities and needs within the community they reside, including access to health care (Rohrick, 2016). The challenge is therefore to explore the health seeking behaviour of the Fulani especially because of the peculiarities associated with their nomadic/semi nomadic nature in Ghana.

2.3 Predisposing Factors Influencing Health Seeking Behaviour

The Study of human behaviour is said to be an art and taking measures to solve its problems is science. The intention with which people behave in any particular way is governed by numerous factors. That is, people take decision on vital issues of life depending on their respective socio-cultural, economic and demographic circumstances. Mackian (2003) indicates that the decision to engage with any particular health institution is influenced by a variety of socio-economic variables, sex, age, social status, the type of illness, access to services and perceived quality of the service. This propensity of attempting to resolve an ill health describes health seeking behaviour.

Kanbarkar and Chandrika (2017) point out the health believe model, theory of planned behaviour, and the pathway model as some important theoretical models applied in studying health seeking behaviour of people. The health belief model (HBM) proposes that performance of any particular health behaviour by people is influenced by two major factors: The degree to which the disease (negative outcome) is perceived by the person as threatening and the degree to which the health behaviour is believed to be effective in reducing the risk of a negative health outcome. The first factor, - perceived threat - is determined by whether someone believes he or she is susceptible to (that is, likely to get) the disease, and how severe that person believes it would be if it develops. The second factor, perceived effectiveness of the preventive behaviour, takes into account not only whether the person thinks the behaviour is useful, but how costly (in terms of money, time and effort) it is to carry out the preventive behaviour **(**Oberoi, Chaudhary, Patnaig & Singh, 2016). Thus when health messages demonstrate to people

that there is a real threat to their health and also convinces them that a particular behaviour can reduce their risk, the likelihood of positive health seeking behaviour is greatly increased.

According to Kanbarkar and Chandrika (2017) understanding the health seeking behaviours of different communities and population groups is important to combat unaffordable costs of health care in places where health care systems are considered expensive with a wide range of public and private health care services providers. Therefore, the utilization of a health care system, public or private, formal or non-formal, depends on socio – demographic factors, social structures, literacy, cultural beliefs and practices, gender, status, economic and political systems, environmental conditions, disease pattern and access to services and perceived quality of the services (Kanbarkar and Chandrika , 2017; Siddiqui, Siddiqui, & Sohag , 2011). Thus Siddiqui, Siddiqui, & Sohag, (2011) confirm that the approaches to health-seeking behaviour are determined by the knowledge, attitude and practice (KAP) of the health seekers.

Just as in any settlement, the desire to seek health care and/or the kind of treatment sought in the typical Fulani community is much influenced by the perceived cause of the illness. For the Fulani, most illnesses are perceived to have their origins in malevolent external powers: spirits or djinns, witches, or non-human animals (Akogun et al, 2012; Hampshire, 2003). Such illnesses can only be treated by confronting and defeating those forces, and are thus amenable only to intervention by those with powers in the supernatural realm (Hampshire, 2003). Therefore, in the perspective of the Health Belief model (HBM), one can conclude that the nomadic Fulani household is inclined to seeking health care services in respect to individual lay definition of the given health problem.

2.4 Household

A household is made up of people staying in the same dwelling and also performing common routines and tasks. According to O'Sullivan, Arthur and Sheffrin (2003) the household is the basic unit of society and comprises one person or a group of people who have the same accommodation as their only or main residence and for a group, share at least one meal a day. Households form an integral part of many demographic, social and economic processes, as decisions on procreation, living arrangements, education and health care, labour force participation, migration and savings often are made at the household level.

The membership of a household could range from an individual to a group of people. A report from United Nations Database on Household Size and Composition (2017) indicates that larger household sizes of more than five persons per household live within the Africa continent, compared to smaller average household sizes, of fewer than three persons in most European and Northern American countries. Though fertility greatly influences household size, other factors including trends in health, longevity and migration; cultural patterns surrounding intergenerational co-residence, home leaving, co-habitation, marriage and divorce; and socioeconomic factors that shape trends in education, employment and housing significantly impact on household size(United Nations Database on Household Size and Composition, 2017).

The Fulani, though mostly non-sedentary, also belongs to households and what happens within the household have a direct impact on their entire community and ethnicity as a whole. Social relationship within the Fulani community, which embodies trust, norms, and social networks emanate from within the household level. As indicated by Hampshire

(2003), estimates of Fulani population size are problematic. However, Akogun et al (2012) indicate that the Fulani household comprises the father, mother, children; who could number up to seven (as cited by Hampshire, 2003), and several other relatives who comes and leave at any particular time. Anter (2011) added that the Fulani Households are patrilocal and range in size from one nuclear family to more than a hundred people.

Child bearing is an essential part of the Fulani culture. Hampshire (2003) reveals that marriage within the Fulani household is not formally recognized until a child is born. Thus for many Fulani, family size does not enter into the realm of conscious choice. According to Hampshire (2003) birth control methods in terms of contraceptive usage and induced abortion have no place within the Fulani household. Therefore, the membership of the Fulani household, especially the nomadic pastoralist may not be fixed.

Glew et al (2003) indicate that much of the economic activities of the Fulani household are tied with nomadic pastoralism, and duties are split according to sex, age and health status. Whilst the able males herd the cattle, the women milk the cows, sell dairy products and take care of the children and sick members of the family. The elderly members of the household rather engage in decision making, gather news about pasture, potential conflict and patterns of local politics that can affect the Fulani community as well as negotiating with the indigenes on any pertinent issue (Akogun et al, 2012).

However, suggestions are that since the cattle herding occupation of the nomadic Fulani household has been severely hampered by the drought of the 1970s (Soeter, 2017; Bassett & Turner, 2007; Tonah, 2002), many have abandoned cattle rearing and begin taking up permanent settlements among town folks (Bukari & Schareika 2015; Glew et al, 2003).

Town Fulani live in much the same manner as the urban people among whom they live, but maintaining their Fulani identity because of the prestige and other advantages to which it entitles its members. They however pursue the various occupations available to them: ruler, adviser to the ruler, religious specialist, landlord, business, and so forth (Bukari & Schareika 2015; Anter, 2011) which could as well alter their habit to seeking health care delivery. In this case, the entire livelihood of the pastoral Fulani nomadic may change, including a potential for new ways of seeking health care delivery.

2.5 Attitude towards health seeking among Fulanis.

Hampshire (2003) observes that health is wealth, and whoever holds wealth wields power. However, people can undertake meaningful economic activities only when they are healthy. The Fulani, who relies mainly on animal rearing, desires optimum good health to scamper in the thickets for pasture and water. Hampshire (2003) reveals that the Fulani populations suffer as a whole from relatively poor health status and poor access to health care services. For instance, Fulani who reports to the various health institutions are brought in a state of despair, usually at the point of dying. But the rationale to this situation is not far-fetched. Seck et al (2017) report that the nomadic Fulani are not included in health campaign-based preventive programs because of their fluid nature. They also frequently travel in remote areas, and may have infrequent contact with the health system, reporting only when an illness has progressed to an advanced stage (Seck et al, 2017). Thus Fulani in rural areas may be particularly disadvantaged because of their nomadic or semi-nomadic status.

In Africa, One of the major issues is how beliefs influence people's attitude in seeking health care as the concept of illness is informed by cultural identity (Gordon, 2000). For

example the Fulani express the sense of difference between them and other ethnicities through the manner in which they acknowledge illness. Being Fulani means perseverance, strength of character, discipline and providing leadership over others (Akogun et al, 2012). This conception henceforth greatly influences the attitude of the Fulani nomadic on health issues. There is often the tendency to perceive not being vulnerable to disease or equating seeking treatment to weakness, thereby aggravating simple health problems.

Besides, the Fulani Nomadics operate an authoritarian and hierarchical system of leadership style and decision making a sole responsibility of the household heads. A study conducted by Akogun and colleagues (2012), indicate that the decision to treat and the type of treatment administered to a sick Fulani rests largely on the household head. Upon receiving information about a member of the household being ill, will assesses the severity. However, the opinions of other men and in some cases suggestions of the old women are taken into account. Often the household head will not make known his decision but would leave the camp only to return later in the day with medicines for the treatment of the ill person. Hampshire (2003) also reports that every Fulani is a 'medical practitioner', tending to their own ailment and that of their household. Nevertheless, a medicine man (boka; described in Akogun et al, 2012) may be called in to manage the ailment. This decision is usually precipitated by the women who have to convince the household head. In order to influence the household head's decision, they often give examples of those with similar illness in some other places and how or where it was managed. Although the decision-maker often ignores the women, his eventual action

usually seems to have their influence. The older women serve as nurses administering medicines to children and other women when they are sick (Akogun, et al, 20012).

However, in exceptional cases the individual may be taken to a modern health facility when all hope is lost. Akogun et al (2012) reveal that out of 97.4% of Fulani who knew the location of the nearest health facilities, only a few (5.8%) visited or knew someone who had visited one. In such cases, the mother often informs the father whose responsibility it is to decide the course of action. When an adult is severely ill and unable to communicate, the most elderly male would decide the course of action to be taken. When illness is severe enough as to be life threatening only 10% of Fulani women would take a child to the health facility without the consent of the father (Akogun et al, 2012). Male children inform their fathers when they fall ill, while female children notify their mothers. If the head of a family is not available, the brother or other person to whom the household is entrusted would take decisions in his absence. However, no action would be taken until the 7th day when a definitive diagnosis is made. Once a decision is made the father would allocate resources for the mother to implement it. But in rare cases a father would take the child to the health facility (Akogun et al, 2012).

There is also marked variation existing even within the same household in terms of the health seeking behaviour of the Fulani. Akogun et al (2012) further indicate that whilst the females and children are usually treated at home, the herders are often left to resolve any health issues they may encounter while herding. They freely purchase whatever medicines they want and used them at will even without any ailment. On many occasions, the herders would purchase vials of injectable chloroquine or antibiotics, break it with the teeth and swallow the content (Akogun et al, 2012). They perceive it to be more effective

than pills in the absence of an injection. There is very little regard to expiration or distinguishing between different drugs and would sometimes take multiple medicines at the same time. The herders would also chew herbs and roots of various plants as well as modern medicines for different reasons: to keep warm, prevent or halt an emergent fever or cold (Akogun et al 2012).

The Fulani household as well prescribes different treatment models for different conditions depending on the cause. For many common ailments and for prevention of illness however, everyone becomes a 'medical practitioner' in the Fulani community. For instance, Hampshire, (2003) reports that Fulani mothers in northern Burkina Faso prepare 'Basi', an infusion of herbs and tree barks, which they give young babies to protect them from various ailments. Women learn the secrets of 'Basi' preparation from their mothers and grandmothers. In Chad, many common ailments are self-treated by Fulani using remedies made from ingredients found around the home, such as milk, butter, spices, and animal urine (Hampshire, 2003).

Akogun et al (2012) also added that fever is treated at dawn after the first recurrence by taking a handful of butter from cow milk, venturing far into the bush, the stuff is placed inside the leaf of a particular shrub, folded and then let go of it immediately. One should neither look back nor ever return to the particular spot. The next person that passes would take the illness from the victim and thus hinder subsequent episodes from emerging. Another approach is to cut an un-ripe pawpaw fruit into four equal parts, soak them in milk and allow it to ferment. The pawpaw would then be removed and the portion served to the patient to drink. Cotton leaves may also be boiled and drunk in order to reduce the severity of fever. Yet, another antidote is to take a handful of guinea corn with the left

hand and bury it under a 'Dingaali' (a woody plant with broad bitter leaves) on the second day of fever. This action will bury the fever within, and prevent it from "waking up" on the third day. On preventing fevers, the Fulani household take measures to protect themselves from mosquito bite by using insecticide treated nets, clothing (particularly during sleep), and burning of herbs to create smoke. Herders hang certain plants around their body while in the field and place some at different parts of their tent to repel mosquitoes. Children sleep among large animals such as cows to prevent mosquito bite (Akogun et al, 2012).

In conclusion, the attitude of the Fulani household with regards to seeking healthcare is not different from any other non-Fulani household in Africa continent. Culture and belief system greatly influence the health seeking habits of people. The impulse to seek treatment, the time spent in taking that decision and even the type of health facility patronise, all depend on prevailing circumstances surrounding the individual or groups which revolve around their socio-cultural, economic and spiritual dynamics. For the Fulani, sickness has variety of causes, but predominantly they perceive it to emanate from the spiritual realm. Treatment therefore commence by tackling the root causes of the ailment. The Fulani household would first of all attempt resolving the health issue with home remedies before consulting a spiritualist (traditional healer). Seeking modern health care usually remains the last resort for the Fulani household; when all other avenues have been explored without the sickness abating.

2.6 Common Places / Facilities Fulani Seek Healthcare

Everyone can fall sick at any point in life which usually interrupts normal daily routines. For the nomadic pastoral Fulani, this interruption means he cannot take his cattle out into

the pastures for grazing which forms a pivotal part of the his life. Therefore, measures would have to be taken to prevent and resolve any ailment within the household. Akogun et al, (2012) report that the Fulani will seek treatment for his ailment when it interrupts his normal daily routine, thus animal herding for the males and house chores as well as selling milk in the market for the females. The Fulani uses various remedies to prevent and treat diseases. The question then arises as to where the Fulani seeks treatment when taken ill.

Several factors can influence the choice of health care providers that patients patronise. These include factors associated with the potential providers (such as quality of service and area of expertise) and those that relate to the patients themselves (such as age, education levels, gender, and economic status). According to Musoke et al (2014), such factors can affect access to health care even when services do exist in a community.

Western health care remains distant both physically and socio-cultural to the nomadic Fulani pastoralist (Kanbarkar and Chandrika, 2017; Bukari&Schareika, 2015; Otusanya et al, 2007; Abubakar et al, 2007; Hamsphire, 2003). Hence every Fulani household finds suitable ways of curing common ailments (Hampshire, 2003). The first place in which attempts are made to result any health issue is the household. Plethora of remedies exist within the home environments which are used for the treatment of common ailments, such as fever, cold, cough and the like. Akogun et al (2012), cited milk, butter, yoghurt, cereals, animal dropping, leaves of plants and so on as some of the curative remedies used in the home setting of the Fulani.

However, some home remedies remain intriguing. For instance, Hampshire (2003) reveals that as anti-witchcraft measure, new born babies among the Burkinabe Fulani are

smeared with cow dung to make them unattractive to witches. Fulani children in Nigeria are also made to sleep among large animals to prevent mosquito bite (Akogun et al, 2012). Despite these unusual medical practices, the household remains a large receptory for the prevention and treatment of many ailments among the nomadic Fulani.

The Fulani do not only stuck to home stuff, but explore other avenues when the home remedies are exhausted. Disease causation is one of the factors that determine the choice of health care provider for the Fulani household. Diseases that defy treatment at the home setting are perceived to have been caused by evil forces. For such ailment, the Fulani would have to seek the services of those well versed in the spiritual realm (Akogun et al, 2012; Hampshire, 2003). Traditional healing thus remains an ideal alternative to home care for the Fulani household. Traditional Healers provide client-centered and personalized health care that is culturally appropriate, holistic and tailored to meet the needs and expectations of the Fulani (Abubakar, et al 2007). There is also a general belief that the remedies used in traditional medicine are safe and more readily acceptable by the body (Akogun et al, 2012; Abubakar, et al 2007; Hampshire, 2003). Although it is common for people to ignore traditional ideas, traditional treatments of diseases persist as these treatments are devoid of social and cultural barriers and thus enhance patient's compliance. Abubakar et al (2007) observe that there exists a strong doctor patient relationship and the communication skills utilised are understood and accepted by both parties. The patient and the practitioners share a common understanding of the medical beliefs, treatments, curative and preventive measures unlike in modern medical practice where only the doctor has a superior understanding of the pathophysiology and treatment of disease conditions (Abubakar et al, 2007; Hampshire, 2003).

The Fulani household is not however a profound user of the western healthcare delivery system. A study conducted by Akogun et al (2012) reveal that out of 97.4% of Fulani who knew the location of the nearest health facilities, only a few (5.8%) patronize it when sick. Even so, user preference for the Fulani is inclined towards private health facilities. For example, a survey conducted by Otusanya and colleagues (2007) on the health facility preference attitude of Fulani household reveal greater use of private clinics to government hospitals though the former costs more. This may reflect previous neglect by the government health sector as well as perceptions of distrust and discrimination by minority populations when health services are run by the majority. Payment conditions, distance from camp and politeness of the health care provider are also cited by Akogun et al (2012) as the most important considerations for the Fulani household when making a decision to patronize a particular health facility.

In addition, use of unprescribed over-the-counter medications is not uncommon for the Fulani household. According to Akogun et al (2012), mothers usually buy anti-malarials from local chemist stores for the treatment of fever in children, whilst herders purchase different medications and use it at will and for any purpose. Hampshire (2003) added that in the absence of healthcare centres, drug peddlers fill the vacuum by selling medications to Burkinabe Fulani nomads in the hinterlands. Over-the-counter chemical shops and drug peddlers thus provide ready access to medications by the Fulani in the face of so many disparities in healthcare delivery system within the rural areas.

The Fulani, just as any other ethnicity is also prone to sickness. However, preference for any treatment outlet by the Fulani household is governed by many factors that revolve around their culture, economy and most importantly perception of disease causation.

Though most disorders are conveniently managed within the home setting, some surpass the ability of the ordinary Fulani to cure. In such cases, the Fulani is obliged to consult a traditional healer or modern health facility as a last resort.

2.7 Barriers to health care for the Fulani Nomadic.

Policy and decision making for any population thrives on availability of data. However, quality demographic and epidemiological data for the Fulani are scarce, owing to the inadequacy of many national censuses and surveys (Bukari and Schareika, 2015; Hampshire, 2003).

The nomadic Fulani live in many of the world's poorest states, where health status is generally poor and health services under-developed (Hampshire, 2003). Thus the Fulani, who are mainly concentrated in rural areas, are the most affected by health care system challenges (Abubakar et al, 2007). Health facility coverage is greater in urban areas and there is less choice of health service provision in villages. Yet these vulnerable groups from the rural communities (including the Fulani households) are known to be the most in need of health care services. The non-use of health facilities thus leads to undesirable health seeking behaviour such as patients using bizarre traditional remedies (Akogun et al, 2012; Hampshire, 2003) or seeking no treatment at all, which has led to increase in mortality even for easily manageable conditions (Musoke et al, 2014).

When compared to the urban populations, rural communities are poorly served by the health care system (Musoke et al 2014), but in comparison with nomads, the gap between nomads and rural settled communities is even wider (Akogun et al, 2012). Pastoralists tend to live in sparsely populated and geographically marginal areas while health services are typically concentrated in more densely populated areas of permanent settlement.

Mobility in itself may restrict access, particularly where extended courses of treatment are recommended. Mobile populations, such as nomadic Fulani, may constitute a barrier to disease elimination efforts in some regions by reintroducing these conditions in areas where they have already been eliminated as confirmed in the works of Seck et al (2017) and Gidado et al (2014).

Other barriers include political marginalisation, cultural, ethnic, and linguistic differences with service providers, and very low levels of literacy (Bukari & Schareika 2015; Hampshire, 2003). Besides, Akogun et al (2012) reported that the formal health system appears ill-adapted for extending services to constantly mobile communities of nomads and local authorities often disregard their existence with respect to health service delivery; citing that guinea worm case detection scouts in Southwestern Nigeria "forgot" to include visits to nomad camps and ivermectin distribution in the control of onchocerciasis, often marginalized nomadic Fulani settlements. Another allegation is that being located at the outskirt of settled communities (Bukari & Schareika 2015), nomadic camps are often ignored to an extent that less than 3% of children below 2 years benefit from full immunization service (Akogun et al, 2012). The situation is not different in Ghana as Bukari and Schareika (2015) allege that the Fulani pastoralists are excluded from socio-political participation and access to resources both at the national and community levels.

The Fulani also suffer from logistic challenges. According to Akogun and colleagues (2012), simple diagnostic tools, behaviour change communication, appropriate chemotherapy, intermittent preventive treatment and community management of febrile illnesses and access to these services remain a challenge to the Fulani nomads of Nigeria.

In furtherance, the nomads are not often included at the planning stage of policy making. Bukari & Schareika (2015); Anter (2011) and Hampshire (2003) purport that the Fulani households are usually left out in Census activities. However allocation of resources and services according to Akogun et al (2012) is carefully computed and shared between spheres of governance at the federal, state, local government area and community in cognisance to set criteria which takes into consideration the population of the community. As a result, Fulani are excluded in resource allocation and it is unlikely that communities could be convinced to accept the sharing of limited consumable health resources with these temporary guests (the nomadic Fulani) whose population and health needs may often overwhelm that of the local population.

Distance is another barrier. Access to health care facilities remains a challenge to the nomadic Fulani due to their location from these facilities. Rohrick (2016) indicates that basic necessities, such as modern health care and clean drinking water are not readily available to the Fulani household because of their distance from towns. Tonah (2003) also added that the nomadic Fulani household usually resides at the outskirts of settled communities with limited access to basic necessities. Thus the Fulani households continually suffer from poor access to health care delivery as they live far from healthcare centres. Besides, access could be hampered as a consequence of poor road networks and irregular transport system connecting Fulani communities to the nearest health facilities. In such instance, the Fulani household would have to attempt resolving health issues themselves as the only alternative.

The challenges a Fulani household would have to embrace in accessing health care delivery are overwhelming in the face of a prevailing ill health. The mere fact that they

are of different ethnicity, have language barrier, are little understood and alienated remain a huge hurdle to health care access for them. In addition to long distances from health care centres, government too fails to consider them in policy making since they are usually left out in census activities; leading to a situation in which they have to compete with indigenes for scarce health care facilities and consumables.

To sum it up, the psychology of wellness or ill health has a broad spectrum, spanning from what people perceive to be a deviation from normal health, opinions of causative factors from such deviations, actions taken to resolve such abnormalities and even the modus operandi of such actions. These perceptions and the associated actions encapsulate health seeking behaviour. Health seeking behaviour in furtherance is governed by factors that revolve around the lives of individuals and groups (households as well as communities) in the context of culture, religion, economic and the like. Taking this analogy into play, the Fulani household is also prone to ailment, and actions have to be taking to resolve such ill health in the face of the above prevailing socio-cultural, environmental and economic dynamics. However, many obstacles in the form of socio-political, geographical and logistical factors impede the ability of the nomadic Fulani household to seek proper health care. It is therefore not surprising that though many Fulani households are knowledgeable of exiting modern health care facilities, they maintain their inward attitude of seeking healthcare, either within the comfort of their home environment or alternately from traditional healers. However, in rare cases, health care is sought from the modern health care facilities; but usually after the home remedies are exhausted without the particular health issue abating.

CHAPTER THREE

METHODOLOGY

3.1.0 Study Area

3.1.1 Profile of Study Area

Gushiegu Municipality is one of the twenty six Administrative districts of the Northern Region of Ghana. The district was created by an Act of Parliament (Act 18, 1959) and by the Legislative Instrument (LI) 1783. It was inaugurated on 20th March 1993 and attained a municipality status in March, 2018.Its capital is Gushiegu. The population of Gushiegu Municipality stands at 111,259 in 2010 with 395 communities (Ghana Statistical Service, 2014).

The Municipality is located on the eastern corridor of the region and shares boundaries to the east with Saboba and Chereponi Districts, Karaga District to the west, East Mamprusi District to the north and Yendi Municipality and Mion District to the south. The total land area of the Municipality is approximately 2,674.1 square kilometres. It is about 114 km from the Northern Regional capital, Tamale. The map of Gushiegu Municipality is shown in appendix 2.

3.1.1 Physical Features

The physical features of the Gushiegu Municipality is made up of natural environment namely climate, vegetation, relief and drainage, location and size, the social and cultural environment in which the people live. The physical features are therefore essential elements or factors affecting the socio-economic development of the Municipality.

3.1.2 Climate

Gushiegu Municipality is covered by a tropical climate, which is marked by the alternation of dry and rainy seasons. The dry season lasts between November and March and it is characterized by the predominance of north-east winds in the form of harmattan which is cold and dry. The Municipality has a tropical climate, which is typical of the Northern Region. The unique rainy season, influenced by south-east winds lasts from May to October. The rainfall varies between 900 and 1,000mm but the heavy rains are normally recorded in July and August. Temperatures are high throughout the year with a maximum of 36ºC recorded mainly in March and April. Low temperatures are recorded between November and February (the harmattan period).

3.1.3 Relief and Drainage

The topography of the land is generally undulating with elevations ranging from 140m at valley bottoms to 180m at highest plateaus. Being mostly a watershed of main rivers, the Municipality is endowed with many small valleys. These valleys can be found at Gaa, Katani, Sampemo and Sampegbiga areas. There are no major rivers in the Municipality, but tributaries and sub-tributaries of Nasia, Daka, Naboguand Oti rivers run through it. The Municipality lies entirely within the Voltaian sandstone basin dominated by sandstones, shales, siltstones and minor limestone. The soils are mainly savannah ochrosols, groundwater laterite formed over granite and Voltaianshales.

3.1.4 Political and Administrative Structure

The Municipal Assembly as a Legislative, Political and Administrative Authority has 25 electoral areas under one constituency. The Municipality consists of 36 Assembly members, 25 elected and 11 appointed. The Municipal Chief Executive is the Political

Head of the Municipality and also chairs the Executive Committee. Eight Town/Area Councils exist under the Assembly. They include Gushiegu Town Council, Galwei Area Council, Nabuli Area Council, Bogu Area Council, Kpugi Area Council, Nawuhugu Area Council, Kpatinga Area Council and Zanteli Area Council.

3.1.5 Ethnicity

The Municipality is predominantly inhabited by Dagombas (57.43%),Konkombas (33.05%) and the other ethnic groups make up ten percent. The settlers, who are mostly farmers, are found in the north-eastern portion of the Municipality.

3.1.6 Festivals and Religion

The Gushiegu Municipality, like many of the Municipality in the Northern Region can boast of a variety of festivals. The prominent festivals are the Damba and “Bugum” (Fire festivals) among others. The dominant religion in the Municipality is Islam, followed by Traditional worship and Christianity.

3.1.7 Economy

The major economic activities in the Municipality include farming, agro-processing and trading in foodstuffs. Farming is the main economic activity and source of income for the people. The dominant crops produced are maize, rice, yam, beans, and groundnuts. Some farmers rear animals like sheep, goats, cattle, pigs and fowls. The women sometimes engage themselves in shea-butter production. There is a vibrant weekly market in the capital and traders from neighbouring Karaga, Kpatinga, Yendi, Bolga, Bawku and Tamale patronise it. Infrastructure: The main Trunk roads in the Municipality are Yendi-Gushiegu, Tamale-Karaga-Gushiegu, and the Nakpanduri-Gbintiri-Gushiegu roads. The

total length of feeder roads in the Municipality is 311.1km out of which 147.8km is engineered, 108.2km partially engineered and 55.1km is not engineered.

3.1.8 Agriculture

About nine in ten of the population is engaged in agriculture. The Municipality is a major producer of groundnut and beans. Agro-based industrial activities centre on shea-butter extraction and rice processing. The type of farming system prevailing is mixed farming. Besides crop production, the average farm family raises a wide variety of livestock and poultry. With regards to crop production, semi-permanent to shifting cultivation is practiced in the remote areas of the Municipality where land is available and population density is low. Mixed cropping dominates the cropping pattern. Mono cropping activities in the Municipality are relatively large commercial rice and maize farms. Most farming practices involve the traditional labour-intensive type characterised by the use of the hoe and cutlass. The rest of the farming population use animal traction.

3.1.9 Health Facilities

The Gushiegu Municipal Hospital is the highest level of health facility in the Municipality. This is supported by Health Centres at Kpatinga and Nabuli. The Tamale Teaching Hospital serves as a referral centre for medical conditions that these facilities are unable to manage. Other people also assist to provide health services to the population are Trained Traditional Birth Attendants (TBAs), Village Health workers and guinea-worm volunteers. There is a Post Midwifery Training School in the Municipality that was established in September 2012 to augment the human resource needs of the sector.

3.1.10 Education

The Municipality has 111 schools: Twenty-four are Kindergarten and nursery schools, 74 Primary schools, 12 Junior High schools and only one Senior High school (Ghana Statistic Service, 2014).

3.2 Research Design

The study design adopted for this study is the descriptive study design. According to Kothari (2004), when adopting this type of study design, it is required that a clear definition of what the study seeks to measure be spelt out and adequate methods for measuring it along with a clear cut definition of the 'population' to be studied.

The design in descriptive studies as proposed by Kothari (2004) must be rigid and not flexible and must focus attention on the following:

(a) Formulating the objective of the study (what the study is about and why is it being done?).

(b) Designing the methods of data collection (what techniques of gathering data will be adopted?).

(c) Selecting the sample (how much material will be needed?).

(d) Collecting the data (where can the required data be found and with what time period should the data be related?).

(e) Processing and analysing the data.

f) Reporting the findings.

3.3.0 Study Population

The exact number of Fulani in the Gushiegu Municipality has not been quantified. There were also no documentation on the dominant communities Fulanis in the Gushiegu Municipality reside.

3.3.1 Inclusion and Exclusion Criteria

For purposes of this research, the target population covered Fulani households within Gushiegu Municipality. Those who refuse to consent to the study were excluded.

3.4.0 Study Variables

Dependent and Independent variables were considered in this study.

3.4.1 Dependent Variables

Two dependent variable were measured: health seeking behaviour, and the challenges faced in seeking healthcare.

Health seeking behaviour was assessed in three different forms; seeking healthcare at modern health facilities, seeking healthcare from Traditional healers and resorting to self-medication or licensed chemical or drug stores.

Challenges faced in seeking healthcare was also assessed according to the following possible challenges; availability and closeness of health facilities to place of residence, right to decision to seek health care, access to health insurance, cost of services and attitude of health workers towards them.

3.4.2 Independent Variables

The independent variables considered in this study were; Household sizes, Religion, Employment state. Household size was defined as the total number of persons per

household, Religion was set to look at the influence of religious beliefs on health seeking behaviours, Employment state was categorised as Unemployed (not involved in any income generation activities), Petty traders (engaged in selling of goods like household or industrial commodities), Farmers (engaged in crop or animal rearing), Civil / Public servant (employed in the formal sector) and Others (any other activities other than those stated).

3.5 Sampling

3.5.1 Sample Size Determination

According to Kothari (2010), if the sample size ('n') is too small, it may not serve to achieve the objectives and if it is too large, we may incur huge cost and waste resources. Therefore, the sample size should be large enough to give a confidence interval of desired width. However, one of the challenges encountered in this study is determination of the sample size. The total number of Fulani in the Gushiegu Municipality has not been quantified, nor did the dominant communities they reside documented. As such, no statistical calculation could be employed to determine an appropriate sample size which is representative enough of the entire Fulani population within the Municipality. In furtherance, limitation in resources too could not permit for a survey of the entire Municipality. Hence five communities which are inhabited by large numbers of Fulani (determined from key informant interviews) were chosen using purposive sampling technique. Thus given this peculiar nature of the study population and area, the researcher used a snowballing approach to identify subjects for the survey. As noted above, it is uncertain how many Fulani live within the Gushiegu Municipality since their numbers

have not been captured in any census report. Hence subjects in the study serve as a lead, recruiting the next batch of respondents.

The approach to setting limits to the size selected was to identify between 50-100 households. A total sample size of 86 households was therefore realised at the end of the field survey. The number of households surveyed from each community is shown in table 3.1 below.

TABLE 3.1 NUMBER OF HOUSEHOLDS SURVEYED IN EACH OF THE FIVE COMMUNITIES

Community	Number of households surveyed	Percentage
Zinindo	18	20.8%
Limo	17	19.8%
Dagbila	17	19.8%
Kpalpala	17	19.8%
Bilsinga	17	19.8%
Total	86	100%

Source: Field Survey May, 2018

3.5.2 Sampling Technique and Procedure

A Purposive sampling technique was employed to select the communities for the research. As a result, there was the need to select the right communities and the right respondents. Through key informant interviews, it was revealed that most communities in the Gushiegu Municipality have Fulani residents, but with greater numbers in five communities namely; Zinindo, Limo, Dagbila, Kpalpala and Bilsinga. Since resource constraint could not allow for a survey of the entire Municipality, respondents were

recruited from these communities. For each of the five communities, Snowball sampling technique was adopted to locate the Fulani households. Snowball sampling (or chain sampling, chain-referral sampling, or referral sampling) is a non probability sampling technique where existing study subjects recruit future subjects from among their acquaintances. Thus, the sample group is said to grow like a rolling snowball. As the sample builds up, enough data are gathered to be useful for the research. This sampling technique is often used in hidden populations, such as drug users or sex workers, which are difficult for researchers to access. Though this technique is subject to numerous biases as sample members are not selected from a sampling frame, it is the most appropriate approach to identifying subjects in this study since respondents are bonded by a unique social capital and thus easily identify each other.

3.6.0 Data Collection Tool

A structured questionnaire was used as the data collection tool. Most of the questions were close-ended with few being open-ended. The questionnaires were then administered to respondents after explaining the purpose of the study to them and assuring them of confidentiality. From the households selected, only one member per household, preferably the household head, was allowed to participate in the study. The questionnaire was interpreted into Hausa and Dagbani to enhance the understanding of the subjects. After answering the questionnaire, the respondents were then asked the location of the nearest Fulani household. The field survey continued this way until a total of 86 households where covered at the end of three weeks.

3.6.1 Pretesting of Data Collection Tool

A pre-test survey was conducted on five household each from the five selected communities. This lasted for one week. The objective of this exercise was to determine adequacy of the questionnaire, non-response rate to be expected, how the respondents understood the questions as well as testing the systematic flow of the questions. Again, the suitability of the data collection methods and efficacy of the questions were pretested from the perspective of the Fulani households.

3.7 Data Processing and Analysis

Data analysis was done after the data had been collected and checked for completeness and accuracy. The answers for a particular question were arranged according to the questionnaire number. The answers were categorized and coded. The questionnaires were double entered in Microsoft excel 2016. The categorised variables were tabulated as frequencies and percentages. Further, these tables were edited and re-framed in Microsoft Word and Microsoft Excel 2016. Findings were presented as text and tables and sometimes charts.

3.8 Ethical Consideration

An introductory letter was obtained from the University for Development Studies.

Before issuing the questionnaire, the consent of each respondent was sought after the purpose of the research was explained to them.

Respondents were guaranteed confidentiality of all information that would be collected.

They were also informed that all data will be used solely for the purpose for which it was collected and that they were not under any obligation to participate in the study.

CHAPTER FOUR

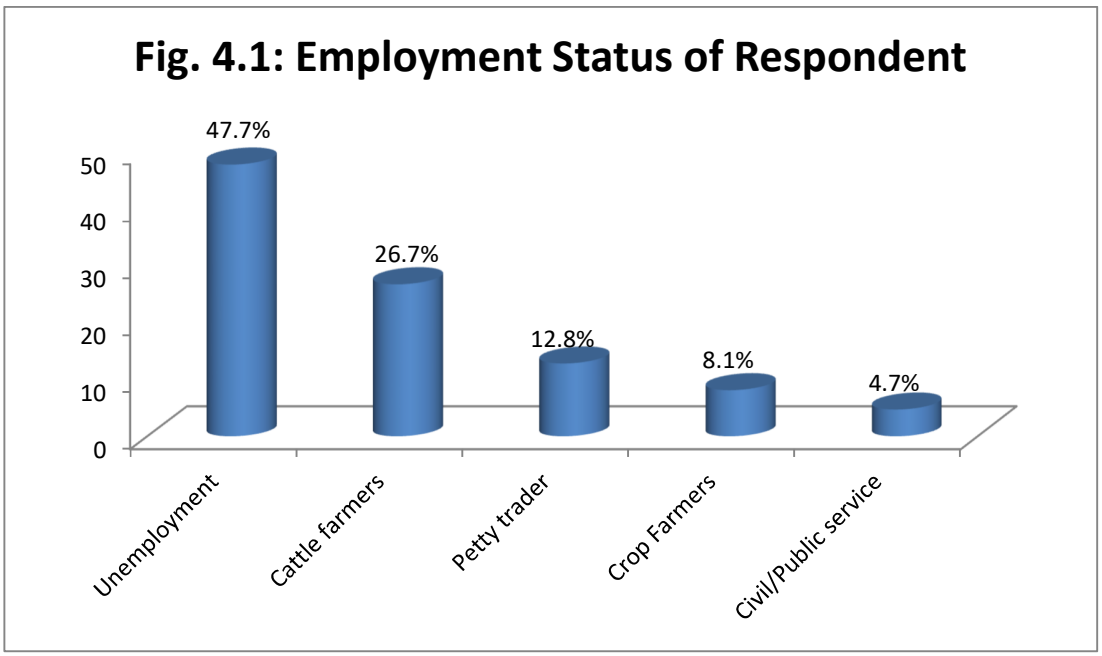
RESULTS

4.1 Social Demographic Characteristics of Respondents.

Socio-demographic groups are used for analyses in the social sciences as well as for marketing and medical studies.

4.1.1 Household Employment Status

The occupational status of the respondents was assessed and it revealed startling statistics. 47.7% of the respondents are unemployment (not engaged in any form of income earning venture). 12.8% of the respondents are petty trader, 26.7% are into Cattle farming and 4.7% are civil / public servants. The details are presented in Fig 4.1 below.



4.1.2 Religion

The result shoes that all 86 respondents were Muslims. This finding alludes to the fact that the Fulani ethnicity across the length and breadth of many African countries is strict adherents to the Islamic faith.

4.1.3 Household Size of Respondents

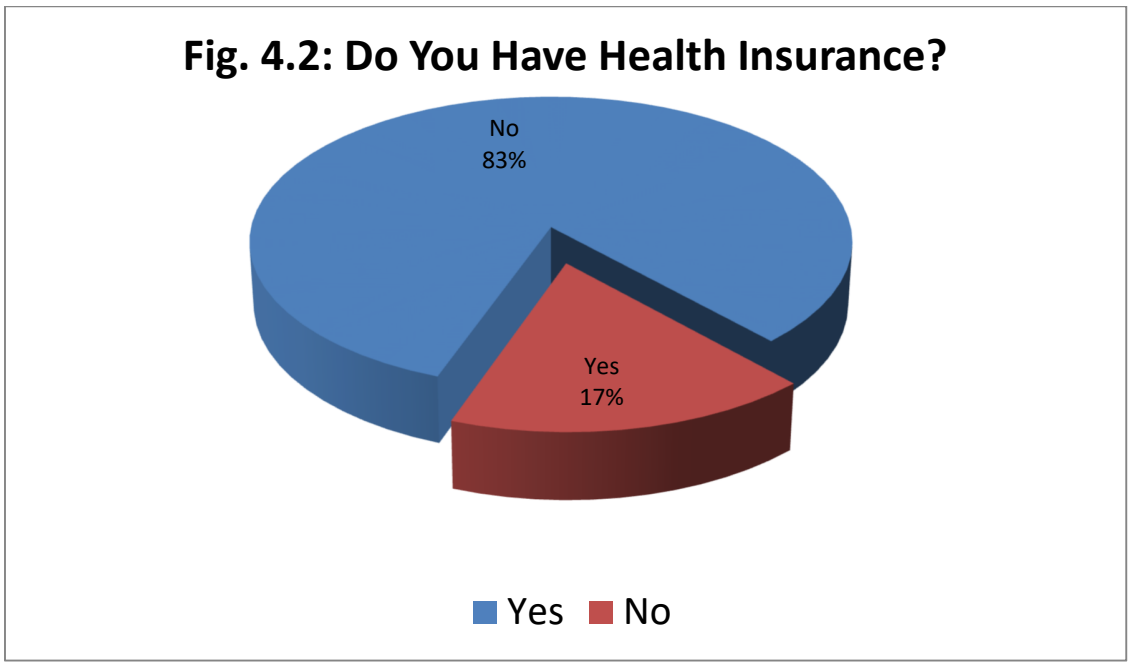
The research also sought to determine the average number of inhabitants of the Fulani households. The findings indicate that the Fulani tends to keep large households sizes. From the results, 53.5% of the respondents have a large household size of 7-10 persons. Small households (1-3 persons) were limited only to newly established homes. This finding has a huge economic implication for the Fulani, considering particularly that most households do not have meaningful sources of income (from the employment data of the respondents). Details are shown in table 4.1 below.

TABLE 4.1AVERAGE HOUSEHOLD SIZE OF RESPONDENTS

No_ of persons per households	Frequency	Percentage (%)
1-3	5	5.8
4-6	27	31.4
7-10	46	53.5
10 plus	8	9.3
Total	86	100

4.2 Health seeking attitude of the Fulani households in the Gushiegu Municipality

Perception about health and illness usually inform people's decision to seeking health care. Questions on what constitute positive health seeking attitudes and behaviour therefore had to be probed subtly by the data collection tool (questionnaire). In this regard, certain domains of positive health habits were tested; the response to which by the households could therefore be inferred as ascertaining or otherwise 'positive' health seeking habits. So the idea was to determine attitudes of the Fulani households towards western health care delivery system. Thus respondents were quizzed on their attitude to health and measures taken to counteract ill health. The results are shown in Fig 4.2 below.



The figure shows that most Fulani have not registered under NHIS. 83% of the respondents do not have NHIS.

Establishing that respondents are conscious of their invincibility to ill health, the study sought to ascertain attitudes of the Fulani households with regards to utilising modern health care facilities. Respondents were asked if they would visit a health facility as the initial step to resolving health issues (Fig 4.3).

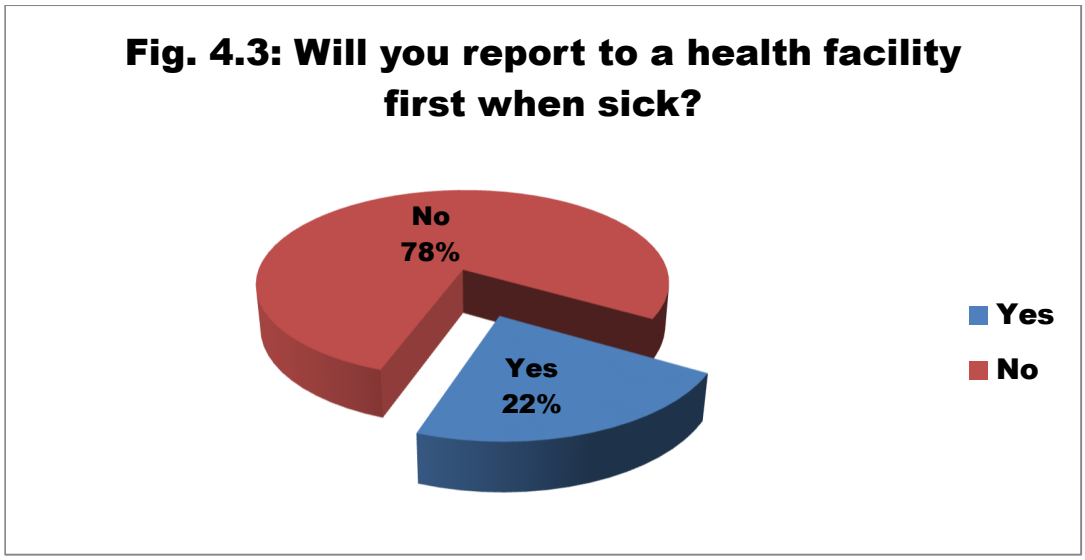


Fig. 4.3 shows that 78% of the respondents (n=67) would not visit a health facility as the initial step to resolving health issues. Traditional healers are preferred by respondents than seeking health care from modern health facilities, a 43 year old respondent explains the situation as follows:

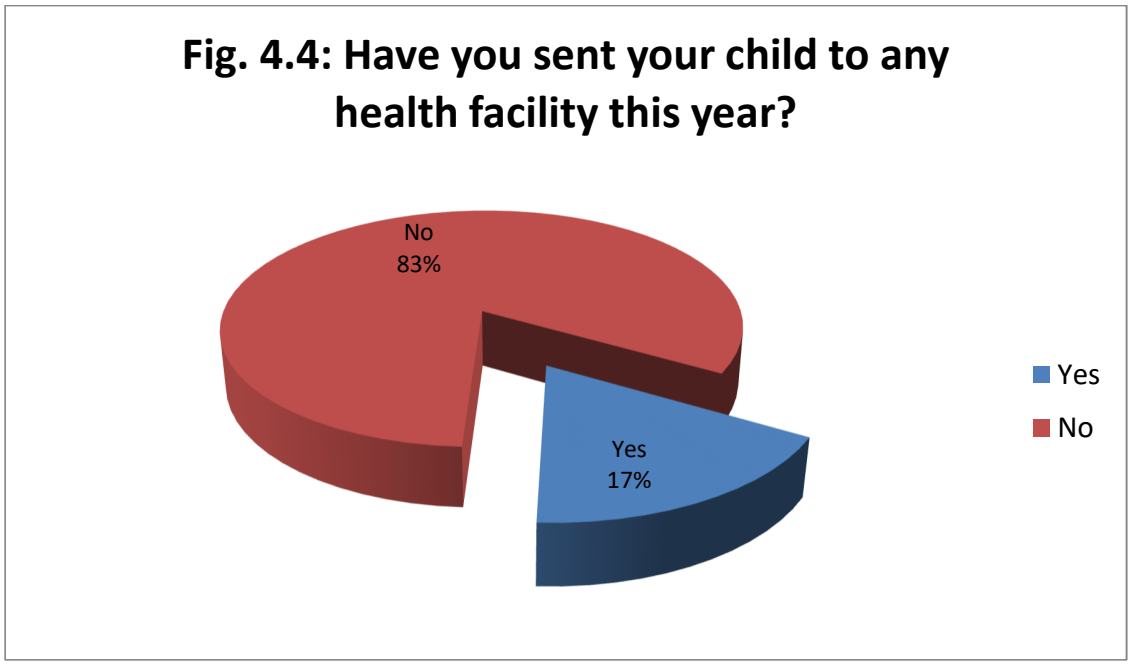
> *When I went to register under the NHIS, they asked me if I was a Ghanaian. I said my parents were born in Ghana and I was born in Ghana. I was asked to show my birth certificate. But not even my parents have; far in the bush, nobody got registered at birth and therefore I have no birth certificate. That was all. I was not registered.*[1] (Fulani #30)

This challenge stems from the fact that some Fulani households are not able to obtain birth certification for their children at birth. That alone excludes such individuals from

[1] Interviews were done in the local language and translated by Research Assistant into English.

accessing basic national identity. Such lack of basic national identity manifests itself in being excluded and sidelined in any subsequent national exercises including health care, banking, education and formal employment.

When the respondents were further asked if they had sent their sick children or whether any sick family member attended any health facility within the year of this study, majority (78%) of them responded negatively. Fig 4.4 gives a summary of the findings.



83% of respondents said they have not sent their sick child to any health facility within the year. Only 17% of respondents have visited a modern health facility within the year. Further probe reveals a number of reasons avail for why only a few respondents would utilize modern health facilities.

Another respondent (Fulani #43), noted that because of the lack of NHIS cards for family members, it is difficult to afford the services of modern health facilities. People who do

not have the card are treated under the cash-and-carry system regarded to be comparatively expensive. But Adams explain that it is not just the fact that it is comparatively expensive, but rather, once the patient has no NHIS card, corrupt health personnel jump to the occasion and exploit.

> *You have no card, disaster. You're the goldmine for health staff. To be desperate is what they need ... then services provided become personalized. Official fees aside, you are made to pay every staff in the chain including interpreters and even cleaners. Everyone will seek to take his share of the booty.*[2] *(Fulani #43)*

(Fulani #43) view gives a lucid description of the predicament that faces the Fulani whose inability to obtain an NHIS registration seem to put health treatment as a special category and endorses 'personalized service' provision to him or the family. Almost all respondents pointed to the exploitative attitude of health personnel generally. The challenge is about the level of extortion by some health personnel and their cronies. *(Fulani #70)*, another respondent notes:

> *At every stage of the modern health care system, emergency demands huge money from the family: the hired car from the village; the registration point at the hospital; the lab; the practitioner who may be called at an odd hour to duty; the drugs provided outside NHIS membership; the ability to access a hospital bed, as well as the need to sustain the interest of personnel during admission.*[3]

Fulani #30 however explained that the more severe the problem, the more exploitative it is for the Fulani family even for families with NHIS cards:

> *The Fulani is always different. A special patient must pay for favours ... The more severe the problem the more you are pushed to commit yourself into debt. I don't visit public health facilities when sick. Traditional treatment or the drug store is convenient. But in case a family member is threatened after all traditional*

[2] *Interviews were done in the local language and translated by Research Assistant into English*
[3] *Translated by Research Assistant into English*

treatments fail, then we may rush to the clinic. But then the family must first weigh whether the sick person would survive or not and whether resources could be brought together for the excessive demand that is expected from health personnel at emergencies.

The lack of identity as a citizen compounds the problem further. The impression for almost all respondents is that the Fulani family is often singled out and discriminated against. Public Health facilities are generally seen as problematic and inaccessible. All respondents preferred private health facilities to public ones because the Fulani arrives here knowing it is going to be comparatively expensive but health personnel here being profit oriented, are seen as relatively fair and non-judgemental.

The research further sought to understand the decision making protocol of Fulani households in relation to seeking health care. The respondents were made to choose who takes the decision when a child for example is sick as to which health facility to go for treatment. Table 4.2 below summarises the responses.

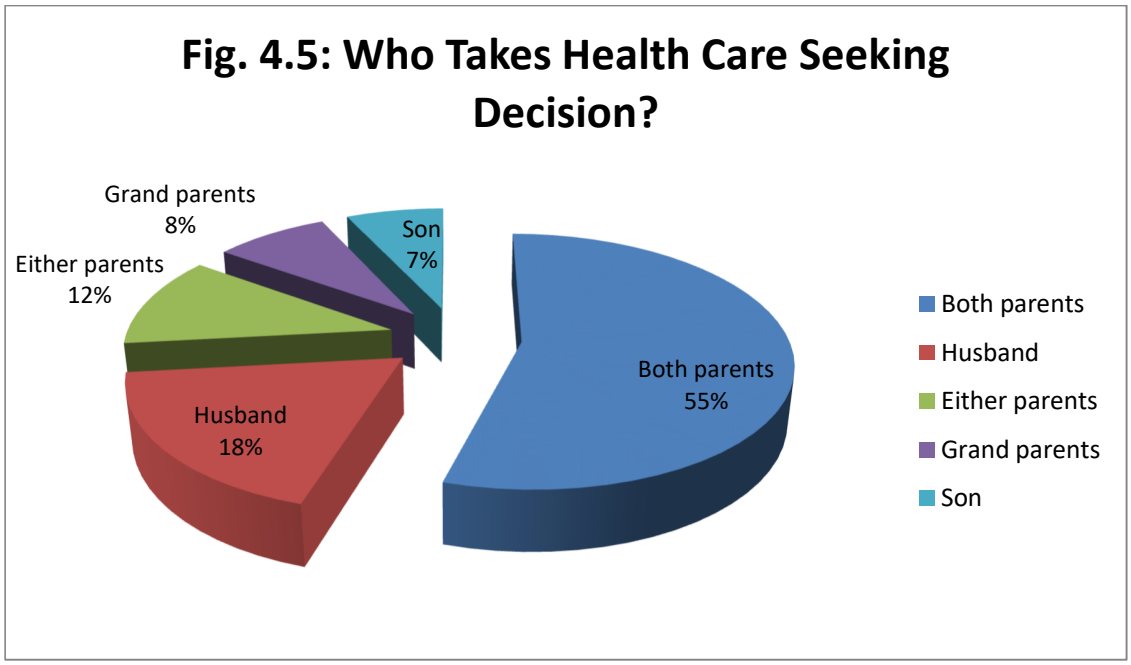


Figure 4.5 shows that decisions about health issues concerning children is the responsibility of elders (93%). The figure further demonstrates that even though respondents show strong patriarchal tendencies, the respect for the elderly irrespective of gender has equally emerged as a critical decision making influence.

The literature generally suggests that health seeking behaviour is also a function of lay diagnosis of a given health challenge. The lay definition of a given health problem definitely dictates how the family therapy management group may react. Respondents were therefore asked if there were any illness which in their perception is not meant for modern health treatment. The findings suggest that almost all respondents (94.2%) thought all illnesses could be treated at the modern health facility. Ideally therefore, respondents voted massively for the near supremacy of modern health care generally. Interestingly however, if read with Figure 4.4, it seems obvious that even though almost all respondents have faith in the efficacy of modern health care, only 17% ever sent a sick child to these facilities within the year of this study. We may conclude that poor patronage of the modern health system by respondents (who have massively demonstrated good faith in the comparative efficacy of modern health care) may therefore not be attributable to poor knowledge about its efficacy but largely about other factors including poor accessibility.

However, an equally important finding is that very few respondents (5.8%) do not regard some health problems as treatable by the modern health system. Mention was made of health problems including: Menstrual pain, mental illness/depression, mumps, boils and spiritual illness. The impression is that these types of illness are best treated using local remedies and consulting Mallams for rituals.

4.3 The Decision Making Process and health seeking Behaviour

The Conceptual framework-based on Andersen's behavioural model of healthcare services utilization adapted from Kuuire et al (2015) gives a lucid portrayal of the relationship between predisposing factors, the perceived severity of the health problem and the ultimate choice of therapy – modern or traditional. In this light, respondents were asked to describe the decision making trajectory within the household and the community when a member is taken ill. The process described concerns the decision making progression that the family therapy management group that emerges around the sick person goes through. Based on analysis of the qualitative enquiry, it is apparent that the Fulani family passes through four stages in arriving at the decision as to where to send a sick person for health care. These stages include:

1) **The lay definition of the health problem:** At this primary level, the individual sick person may realize that he/she has a health problem. He may ignore the symptoms depending on the perceived severity and previous experience of the given health problem. However, when seen as severe, depending on how old the sick person is, he may try to do something about the health problem by himself. He may use some local herbs/buy drugs including basic drugs over the counter of the local chemist shop. At this personal level, the treatment sought is related to the personal experience and the perceived cause of the disorder.
2) **The second level emerges when this personal effort fails to solve the problem**. The sick person may tell his elders about the disorder. The family elders then decide to consult the Mallam. Here the concern is to explore the cause of the disorder in relation to three levels: whether spiritual or physical; spiritual and

physical; spiritual only; or physical only. Each of these dimensions has its own management regimen and the Mallam would make that clear. Where evil spirits or the evil eye is culpable, it is a spiritual battle.

3) **The diagnosis of the Mallam** then becomes crucial for the next step of what type of remedy to use and the perceived efficacy. Here a decision is made whether the nature of the condition requires home remedies. Among other considerations, this is based on the previous knowledge of the symptoms of the condition and the Mallams judgement and experience in treating that problem before. Depending on the definition of the situation, the Mallam may consider whether to seek treatment from an outside source including the modern health facility.
4) **The family then may consider suggestions from elders from other families** as to where to go. Each of these elders may share their past experiences of similar conditions for various health facilities including traditional healers and the modern health system. The issue of physical and financial accessibility becomes major considerations at this level. Given the pressure, the family therapy management group takes the decision of where to go based on the perception of the aetiology of the disorder, affordability, and the perceived efficacy of treatment.

4.4 Health facilities patronized by the Fulani.

Respondent were asked to indicate the distance of the nearest health facility to their homes. This question sought to measure physical accessibility to health facilities by respondents (Figure 4.3).

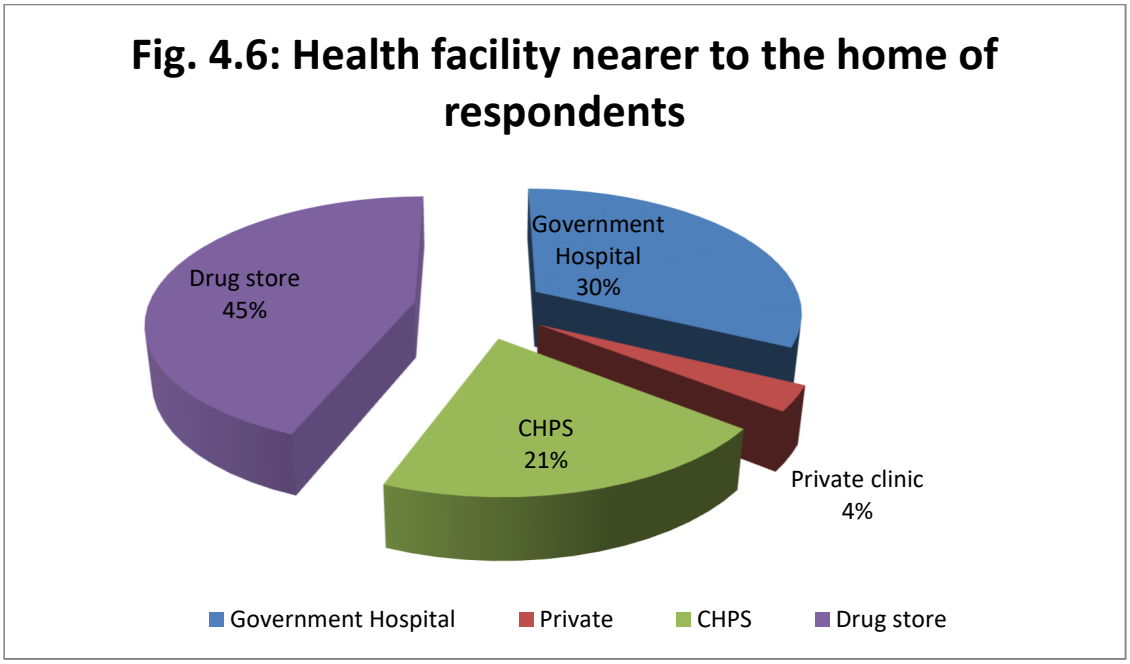


Figure 4.6 shows that the most common health facility in the immediate environment of the Fulani is the licensed/non licensed itinerary chemical seller (45%). These facilities are generally scattered in remote rural areas compared with other health facilities. Slightly more than half of all respondents (51%) mentioned public health facilities (Government Hospitals, 30% and CHPS 21%).

Availability of health services may not necessarily translate into accessibility. In this wise, efforts were made in this study to find out what health facility is the first string when a person is ill. The result is shown in Fig 4.5.

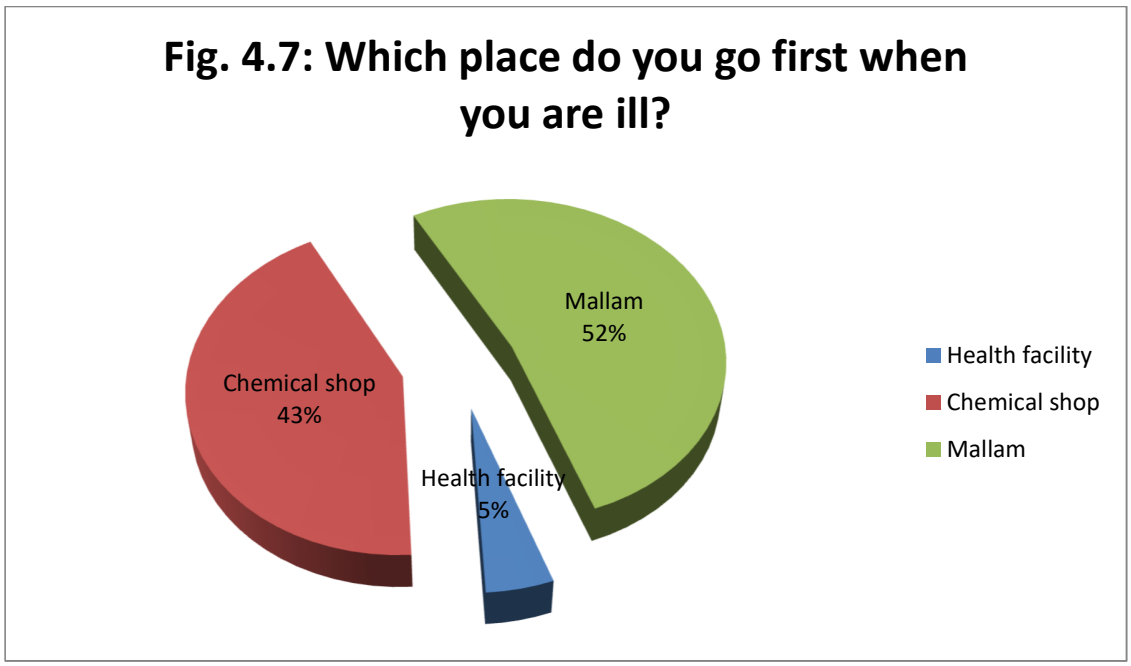
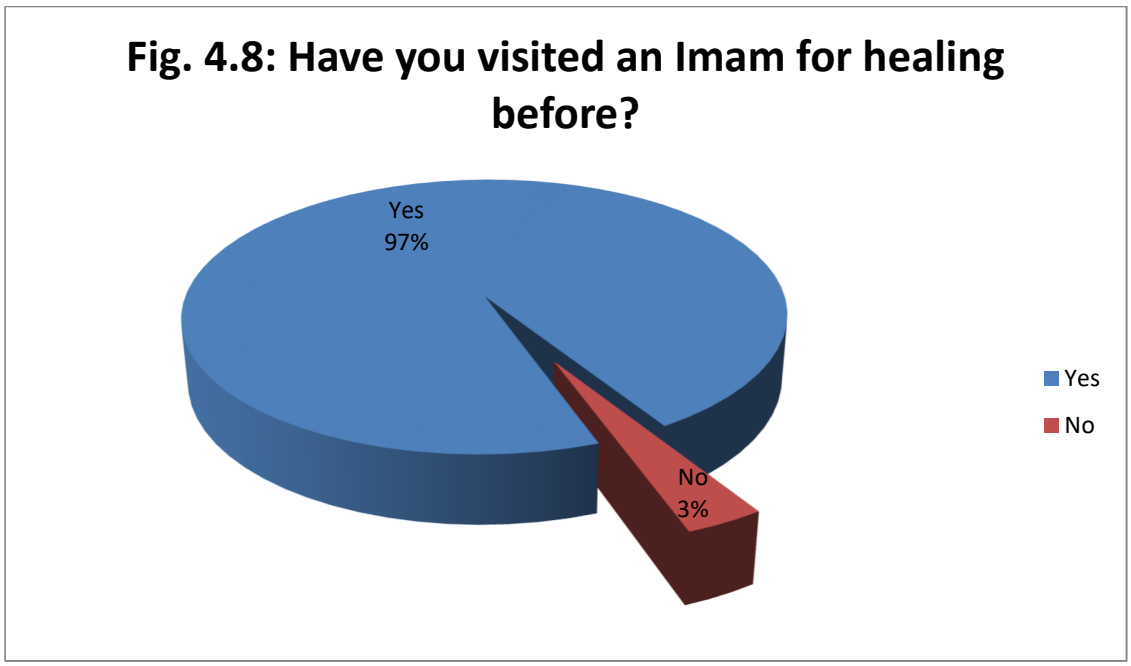


Figure 4.7 suggests that slightly more than half (52%) of respondents would first resort to the Mallam for performance of rites as the first line of treatment in any health situation. However it was noted that the choice of which health facility to go depends largely on the lay diagnosis of a given health problem and also the comparative advantage each of these systems is perceived to offer. Findings show that the majority of respondents (96%) would resort to the Mallam for the following treatments; Fractures, diarrhea, headache, snake bites, general body pains, and bizarre illnesses especially spiritual illness (Fig 4.6).



Visiting the Imam is seen as the most important first step when someone is sick. The Imam/Mallam as religious leaders is seen to be the most important decision makers outside the immediate family authority. The decision of the cleric may override any family decisions generally.

> *Fulani is a Muslim so the Mallam is central in most decision making even at the household level. The Mallam is visited first and he may suggest what to do. We only go to the hospital when the Mallam agrees.*

4.5 Challenges to health care access

The effort to access healthcare may come with some challenges. Respondents were asked to identify some of the possible obstacles that impede access to healthcare. Table 4.4 below gives a summary of the findings.

TABLE 4.2: HIGH COST OF SERVICE IS THE REASON WHY WE DON'T GO TO THE HOSPITAL FIRST?

Variables	Frequency	Percent
Agree	16	18.6
Strongly agree	27	31.4
Disagree	22	25.6
Strongly disagree	21	24.4
Total	86	100.0

31.4% of the respondents strongly agree to the fact that high cost of service is a reason why they don't go to the hospital first.

TABLE 4.3 WHAT ARE SOME OF THE REASONS WHY YOU DON'T LIKE GOING TO THE HOSPITAL?

Variables	Frequency	Percent
Poor attitude of staff	25	29.1
Delay in getting treatment	18	20.9
Non-availability of drugs	19	22.1
unfriendly hospital Environment	4	4.7
Others	20	23.3
Total	86	100.0

The Table shows that the main challenge facing the Fulani in relation patronage of modern health facilities could be summed under poor human relations by personnel at these service delivery points (54.7%). The issue of non-availability of drugs and others

are mainly related largely to the challenge of the Fulani not being registered under the NHIS scheme.

On the issues of distance and accessibility, 54.7% of respondents disagree with the statement that long distance from home affects their decision to go to the hospital when they are ill. The challenge of relative poor patronage of these facilities seems to be related to perceived poor human relations and negative attitude of personnel at these facilities towards the Fulani.

For those who had ever patronized the services of modern health facilities, a question sought to find out what they perceived as the rating of services (Table 4.3).

TABLE 4.4: HOW WOULD YOU RATE THE SERVICES PROVIDED BY THE HEALTH FACILITIES?

Variables	Frequency	Percent
Poor	27	31.4
very poor	6	7.0
Average	29	33.7
Good	19	22.1
very good	5	5.8
Total	86	100.0

Majority of respondents (72.1%) rated modern health services provided at health facilities as poor (38.4%), average (33.7%) and 27.9% admitted that it was good.

CHAPTER FIVE

DISCUSSION OF RESULTS

5.1 Introduction

In order to successfully tackle the health challenges facing society generally and especially vulnerable populations like the Fulani households in the Gushiegu Municipality of the Northern Region in particular, there is a need to investigate the health seeking behaviour of the people. Accordingly, this study has tried to look into the health seeking behaviour of the Fulani in the Gushiegu Municipality of the Northern Region. This chapter entails discussion of the results and findings presented in chapter four. It discusses the results with respect to the objectives of the study.

5.2 Objective 1: To explore the personal level factors influencing health seeking behaviour of Fulanis

The question here is; how does the Fulani household respond to the illness of a member? The findings show that out of the 86 respondents, the overwhelming majority (83%) do not have NHIS card. Because of the challenge of not having NHIS card and also because of fear of exploitation, the Fulani depended largely on the traditional healing system when sick. Without the NHIS cards therefore, the Fulani faces high cost charges. High cost of services may not be a major concern as to why respondents do not go to hospitals to seek treatment.

Fifty seven of the respondents (66.3%) however disagrees to the statements that long distance from home affected their decision to go to the hospital when they were ill. This finding is thus in contrast with the views of Rohrick (2016) and Tonah (2002) who allege

that basic necessities, such as modern health care and clean drinking water are not readily available to the Fulani household because of their distance from towns and that explains their poor patronage of health facilities.

The current study also found that the Fulani has equally high confidence in the modern health care generally but would seek traditional health care as the first string. In this wise, the decision as to where to seek health care is based on the lay diagnosis of the health problem first. This finding confirms precepts of the Health Believe Model (HBM) explained by Kanbarkar & Chandrika (2017) which postulates that performance of any particular health behaviour by people is influenced by the degree to which the disease (negative outcome) is perceived by the person as threatening and the degree to which the choice of the type of health care is believed to be effective.

The findings of this study also show that when a member of the family is ill, the decision as to what to do and the processes for seeking health care is dependent on the family therapy management group and not the sick person. The decision making role as far as health issues are concerned among respondents is delegated to older members of the family. This finding is consistent with results from the work of Akogun et al (2012) which revealed that decision making within the Fulani household flows in a hierarchical order, resting largely on the head of the household and the elderly.

On the issue of the lay classification of health problems, findings show a series of illnesses that are perceived as “non-hospital problems”. Eighty one of the respondent (94.2%) cited the following as conditions that should not be sent to the hospital; menstrual pain, mental illness, mumps and spiritual illness.

According to Gordon, (2000), one of the major issues is how beliefs influences people's attitude in seeking healthcare as the concept of illness is informed by cultural identity.

Another finding of this study that a pattern of decision making about sick family members exists as guide for the family therapy management group in making decisions is important. Based on analysis of results it is apparent that the Fulani family passes through four stages in arriving at the decision as to where to send a sick person for health care. This finding has been confirmed in the literature. Mackian (2003) indicates that the decision to engage with any particular health institution is influenced by a variety of socio-economic variables, sex, age, social status, the type of illness, access to services and perceived quality of the service. Ihaji, Gerald & Ogwuche (2014) observe that steps towards optimum health are often as many and varied as the social, cultural, economic, mental, religious, physical, and even political circumstances of the family.

5.3 Objective 2: To identify common places / facilities where the Fulanis seek healthcare

Accessibility to modern health services which includes physical distance and affordability has been found by this study to be a crucial determinant in the choice of health facilities when sick. Indeed the local drug store and the CHPS compound have been found to be a more convenient facility not only because of proximity but also because it is local. However, availability and accessibility per se do not necessarily translate into patronage of modern health facilities. When asked if respondents would report to a health facility first when sick, majority of the respondents (78%) indicated they would not and also 83% try home remedies first when a child is sick. This finding is consistent with the study done by Akogun et al (2012) in which they report that out of

97.4% of Fulani who knew the location of the nearest health facilities, only 2.6% patronise it when sick. Just as found in this study also, Akogun et al (ibid) found that the negative attitude of health personnel in modern health facilities may serve as a deterrent for patronage.

The study also established that self-medication using pharmaceuticals is a very common phenomenon among respondents. The possibility is that most illness are treated and/or attempted resolving within the home setting first using any possible means hence they are not reported immediately to modern health facilities. This correlates with findings by Akogun et al (2012) where most Fulani household are found to attempt resolving health issues within the family level before seeking help elsewhere. This revelation is not however peculiar to only the Fulani household but can be attributed to Ghanaian households in general. The preference is to attempt tackling health problems at home before seeking advance medical consultation at the hospital. It is therefore common to find repository of medications (usually purchased from over the counter chemical stores or from peddlers) in most Ghanaian homes. This finding also correlates with findings by Hampshire (2003) which reveals that most Fulani in Burkina Faso purchase and use pharmaceutical drugs from drug peddlers especially those in the remote rural communities with low access to health facilities.

Related to this is also the fact that the dominant stereotype that the Fulani hardly believes in the efficacy of modern medicine is suspect. This study found that respondents do not ascribe disease causation to supernatural forces alone. This finding is thus inconsistent with the works of Akogun et al (2012); Anter (2011) and Hampshire (2003) who purport that Fulani attribute most sickness to spiritual causes hence they seek treatment from the

traditional healing system. This finding also buttresses the earlier assertion that the Fulani in the Savalugu-Nanton Municipality of the Northern region of Ghana might have settled among the indigenous dwellers and thus imbibed their lifestyles, including that of their health seeking attitudes. This correlates with the findings by Bassett & Turner (2007) which reveal that the nomadic Fulani is abandoning the cattle rearing business and taking up jobs offered by settled communities, hence taking after their lifestyles including that of their attitudes and practices towards seeking health care.

5.4 Objective 3: To investigate the challenges Fulanis face in seeking healthcare

The results of the study also indicate that the Fulani encounter some challenges in seeking health care. For instance, the respondents indicated that they were not satisfied with the treatment they received at the health facilities, slightly more than a third (31%) rating the services provided by the health facilities as poor, 33.7% rated them as average but only 22.1% of the respondents maintained the services as good. These findings correspond with statement made by Otusanya et al (2007) that there is insecurity and distrust among minority populations when health services are run by the majority.

The respondents further added the following as some of the challenges they encounter when they seek treatment at the hospital: 29.1% was poor attitude of staff, delay in getting treatment was 20.9%, Non-availability of drugs was 22.1%, and unfriendly environment was only 4.7%. These findings were also indicated by Akogun et al (2012) as some challenges encountered by Fulani in Nigeria in their attempt to resolve health their problems.

CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.0 Conclusion:

This study has found that Fulani households within the Gushiegu Municipality of the Northern Region do not have access to good health system coverage. This is especially worrying because of the expressed challenges in acquiring NIHS cards as Ghanaian citizens.

However, the presence of health facilities alone does not necessarily translate to patronage. The findings have shown that inconveniences encountered at previous visits to a modern health facility can deter people from making subsequent attempts of seeking care at modern health facilities. Because of these challenges, the Fulani comparatively find drug stores/peddlers as well as home remedies readily convenient when in need.

Consequently diseases may be reported to the hospitals at an advanced stage. This issue is not peculiar to the Fulani household only, but to the entire Ghanaian society as a whole. The implication for health seeking behaviour is that people will engage in undesirable health seeking behaviour such as depending on drug peddlers or placing their hopes in faith healing.

6.1 Recommendations

1. The Gushiegu Municipal Health Directorate should enhance its public education efforts, specifically to the Fulani communities on the dangers of self-medication and emphasise the need to seek health care at recognised health centres.

2. Health workers (doctors, nurses, pharmacists, auxiliary workers and so on) in the Gushiegu Municipality should be sensitised and educated on the particular needs of the Fulanis so as to improve healthcare delivery to them.
3. The Regional office of the Pharmacy Council should coordinate and regulate the activities of chemist sellers and drug peddlers to help minimise the risk of drug abuse and its accompanied dangers among the Fulani and Ghanaians in general.
4. The Ghana Statistical Service should get Fulani across the country registered to aid in policy making regarding health care delivery

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APPENDIX

QUESTIONNAIRE ON THE TOPIC: HEALTH SEEKING BEHAVIOUR OF FULANI HOUSEHOLDS IN THE GUSHIEGUMUNICIPALITY

This research work is being undertaken by a student of the above named department. I assure you that any information given would solely be used for academic purposes and would be treated with confidentiality. You are kindly requested to read through the items and respond to them.

Thank you.

SECTION A: BIOGRAPHIC DATA

Write or thick [√] the appropriate box that respond to your choice concerning each statement below.

1. Occupation of households

   1. Unemployed [ ] 2. Petty trader [ ] 3. Farmer [ ] 4.Civic/public servant [ ] 5. Others (specify)……

2. Religion

   1. Muslim [ ] 2. Christian [ ] 3. Traditional [ ] 4. Others specify……

SECTION B: HEALTH SEEKING ATTITUDES

3. What type of health facility is nearer to your house?

   1. Government hospital [ ] 2. Private hospital. [ ] 3. CHAG hospital [ ]

   4. health worker [ ] 5. CHPS [ ]

4. Do you have health insurance? 1. Yes [ ] 2. No [ ]
5. If no, why have you not registered?

   ……

6. Have you reported sick at a health facility this year? 1. Yes [ ] 2. No [ ]
7. Have you sent your child to any health facility this year? 1. Yes [ ] 2. No [ ]
8. If yes, what was the reason for your visit?.....

   .....

9. Who takes the decision to seek health care when a family member is sick?

   1. Father [ ] 2. Mother [ ] 3. Grandparents [ ] 4.others specify…….

10. Long distance from home affects my decision to go to the hospital when am ill.

    1. Agree [ ] 2. Disagree [ ] 3. Don't know [ ]

11. Do you know any illness which should not be sent to the hospital?

    1. Yes [ ] 2. No [ ]

12. If yes, mention them…….

13. Which place do you go first when you are ill?

    1. Health facility [ ] 2. Chemical shop [ ] 3. Church [ ] 4. Mallam [ ]

    5. Traditional healer [ ]

14. Where do you take your child to when he/she is ill?

    1. Health facility [ ] 2. Chemical shop [ ] 3. Church[ ] 4. Mallam[ ]

    5. Traditional healer[ ]

15. Are you satisfied with the services provided in the health facility in your area?

    1. Yes [ ] 2. No [ ]

16. High cost of services is the reason why we don't go to the hospital first.

    1. Agree [ ] 2. Strongly agree [ ] 3. Disagree [ ] 4. Strongly disagree [ ]

Section c: impact on health seeking decisions

17. Under what circumstances do you decide to go to the traditional healer for treatment?.....

    .....

18. Under what circumstances do you decide to go to the medical doctors for treatment?.....

    .....

    .

19. Have you visited a traditional healer for treatment before? 1. Yes [ ] 2. No [ ]
20. If yes, what did the traditional healer treat you for?

    .....

21. Have you visited an Imam for healing before? 1. Yes [ ] 2. No [ ]
22. If yes, what did the Imam heal you of? .....
23. When the hospital is unable to treat your illness, what is the next action taken?.....

    .....

24. What are some of the reasons why you don't like going to the hospital?

    1. Poor attitude of staff [ ] 2. Delay in getting treatment [ ]

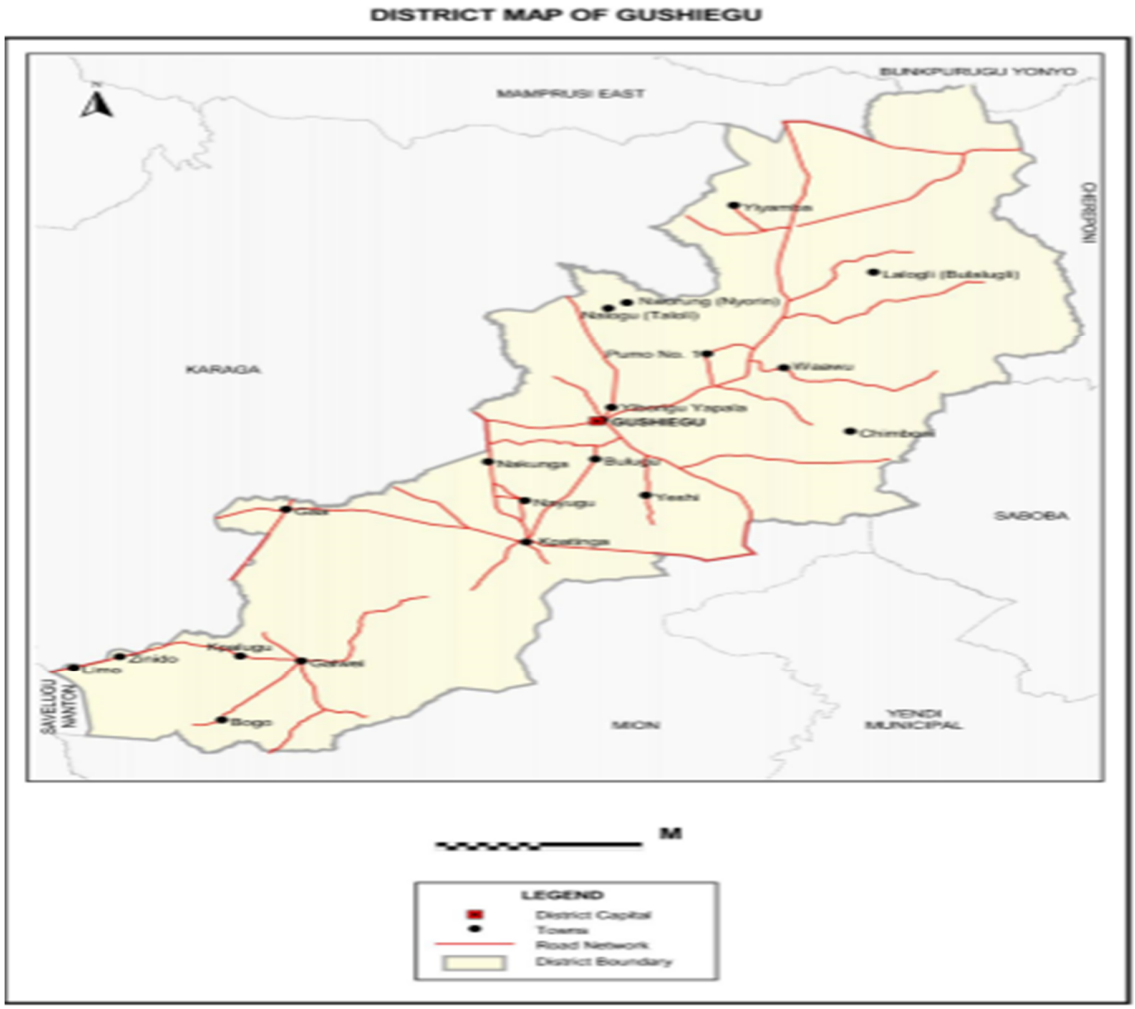
    3. Non- availability of drugs [ ] 4. Unfriendly hospital environment [ ]

5. Others (specify)…….

25. How will you rate the services provided by the health facilities?

1. Poor [ ] 2. Very poor [ ] 3.Average [ ] 4. Good 5. Very good [ ]

Appendix 2. Map of Gushiegu Municipality



Map of Gushiegu Municipality .Source: Ghana Statistical Service (2014)