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Factors Influencing Readiness to Seek Medical Care in the Event of Illness Among Hohoe Residents in Ghana: A Community-Based Cross-Sectional Study

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Abstract

Background: Optimal health plays a significant role in enhancing one's quality of life, empowering individuals to actively engage in productive endeavors for wealth generation. Recently, the unhealthy lifestyles of individuals resulting from their healthcare-seeking behavior have gained significant attention in research circles, both at the national and international levels, as this issue has become a central concern for healthcare stakeholders worldwide. This study evaluated the factors influencing readiness to seek medical care in the event of illness among residents in Ghana.

Methodology: A community-based cross-sectional study was employed in this study. A multi-stage sampling procedure was used to sample 400 study participants. Data were collected with a paper-based questionnaire, coded and entered into Epi-Data version 4.6.0.2. Data analysis was carried out in STATA V.16.0.

Results: From our study, 193 (48.2%) participants expressed readiness to seek medical care in the event of illness. Our findings further revealed that participants who were educated to the tertiary level, participants who have private health insurance cards and the usage of traditional treatment were key influencers of readiness to seek medical care [aOR = 4.2 (95% CI: 1.73–10.25), p=0.002], [aOR = 8.8 (95% CI: 2.62–29.41), p=0.000], and [aOR = 1.73 (95% CI: 1.10–2.70), p=0.016] respectively.

Conclusion: Conclusively, our findings emphasize the complex interplay of individual, cultural, and structural factors in shaping healthcare-seeking behavior. Addressing these factors through targeted interventions and policies can enhance healthcare utilization, reduce health disparities, and ultimately contribute to the overall well-being and socio-economic development of the community and the country at large.

Keywords: Factors; Readiness; Medical care; Health; Behaviour; Health-seeking behaviour

Introduction

Optimal health plays a significant role in enhancing one's quality of life, empowering individuals to actively engage in productive endeavours for wealth generation (Osei Asibey & Agyemang, 2017). In as much as it serves as a fundamental factor influencing human development (Osei Asibey & Agyemang, 2017), it is largely influenced by the health-seeking behavior (HSB) of the individual (Khadka et al., 2022). Recently, the unhealthy lifestyles of individuals resulting from their HSB have gained significant attention in research circles,

both at the national and international levels, as this issue has become a central concern for healthcare stakeholders worldwide (Ikhioya, G.O; Akerele, 2021).
Healthcare-seeking behavior (HSB) has been defined as,any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy (Olenja, 2003). HSB is a component of the broader concept of health behavior, which encompasses various actions aimed at preserving overall well-being, preventing illness, and addressing any deviation from a state of good health (Latunji & Akinyemi, 2018a). Achieving a commitment to HSB plays a crucial role in lowering the economic burden, diminishing disability, and preventing deaths caused by diseases (Haileamlak, 2018). Nonetheless, the process of HSB involves a decision-making journey influenced by individual and household choices, community norms and expectations, as well as provider-related attributes and conduct (Oberoi et al., 2016). The intricate interplay of these factors significantly shapes an individual's decision-making (Olenja, 2003). The decision to seek alternative medicine or engage in self-medication is another aspect of an individual's HSB. This choice distinguishes itself from self-care because it often involves medications that carry the potential for both positive and negative effects (Khadka et al., 2022).

Research conducted by (Arnold et al., 2021) emphasized that behavior can be influenced by beliefs regarding the perception and causes of diseases, including traditional, intuitive, supernatural, and magical explanations for certain ailments. However, (El-Ghitany et al., 2018) established that individuals do not rely on a single source of healthcare, and their HSB vary depending on who is affected and the specific diseases they are experiencing.

Moreover, the Health Belief Model (HBM) posits that an individual's decision to engage in a specific health behavior is influenced by two primary factors: the perception of the disease (negative outcome) as a personal threat and the belief in the effectiveness of the health behavior in reducing the risk of this negative health outcome. The first factor, perceived threat, is contingent on whether a person believes they are susceptible to contracting the disease and how severe they perceive the consequences of developing it to be. The second factor, the perceived effectiveness of the preventive behavior, considers not only whether the individual deems the behavior useful but also factors in its cost in terms of money, time, and effort (Oberoi et al., 2016). This model facilitates the recognition and comprehension of individuals' HSB, extending beyond their knowledge, attitudes, and practice (Carico et al., 2021; Didarloo et al., 2017).

Theb HSB serves as a reliable predictor of healthcare service utilization within the community (Ng'ambi et al., 2020). According to (Carico et al., 2021), the state of HSB of members of a given society can be an important indicator of society's well-being and is linked to its overall socio-economic development. Inappropriate HSB has been associated with unfavourable health consequences, heightened morbidity and mortality rates, and less favourable health statistics (Latunji & Akinyemi, 2018b). While existing literature underscores the critical role of HSB in enhancing the quality of life, reducing health burdens, and contributing to overall socio-economic development, there remains a notable research gap in understanding the specific factors influencing HSB. Previous researches emphasized the complexity of HSB, which is influenced by individual choices, community norms, beliefs, and healthcare provider-related characteristics. However, the current state of knowledge does not address the unique dynamics and determinants of HSB. In our study, we evaluated the factors that influence HBS among residents in the Hohoe Municipality.

Methods

Study setting, and design

The study employed a cross-sectional study design among residents of the Hohoe Municipality. The Hohoe Municipality is one of the eighteen (18) districts in the Volta Region. The city of Hohoe, of which the district was named, serves as the capital and the administrative or local government centre. It shares borders with the Republic of Togo on the east; on the southeast by the Afadzato district and southwest by Kpando Municipality; on the north with the Jasikan district; and on the northwest with the Biakoye districts. Its capital, Hohoe, is about 78 kilometres from Ho, the regional capital and 220km from Accra, the national capital. The Municipality consists of one hundred and two (102) communities with a population of 167,016 projected from the 2010 National Population Census.

Study population and participants

The exact population figure for those aged 18 – 60 years in the Hohoe Municipality wass not availabe and unknown but the study included all individuals in all four townships in the Municipality within the age bracket. However, the participants consist of 400 residents of the Hohoe Municipality who are aged between 18 and 60 years.

Inclusion and exclusion criteria

Study participants were selected based on the following criteria (I) they must be residents of the Hohoe Municipality (II) they must consent to participate in the study voluntarily (III) they must be between the ages of 18-60 years. The study, however, excluded non-residents and non-consenting individuals as well as individuals who met the inclusion criteria but were critically ill at the time of study. Individuals who were below the age of 18 years and above 60 years were also excluded from the study.

Sample size and sampling procedure

The sample size of 381 was calculated using Cochrane's single proportion formula as follows: $n = \frac{z^2\, p(1-p)}{d^2}$, considering a 5% margin of error, 95% confidence interval =1.96 and a national prevalence of readiness to seek medical care of 45.6% from a study conducted by (Nuhu, 2018). Where;

n = Estimated sample size
p = 0.174
q= (1-p)
d = margin of error (0.05)
Z = Test Statistic (1.96)

Accounting for a 5% non-response rate, the total sample size increased to 400.

In our study, we employed a multistage sampling procedure to ensure the representation of the Hohoe Municipality's diverse population. In the initial stage, we organized the Hohoe Municipality into pre-existing clusters based on its division into four townships. These existing clusters were retained for the study. Within each township cluster, we used purposive sampling to select two communities, resulting in a total of eight communities under consideration. Within each of the eight selected communities, a simple random sampling technique was employed to select 50 participants from each community to arrive at 400. This approach ensured that each individual within these communities had an equal opportunity to be included in the final sample.

Data Collection

The study adhered to all methods in accordance with the Declaration of Helsinki. The University of Health and Allied Sciences Research Ethics Committee (UHAS-REC) reviewed the study and approved it with a reference [ID: **UHAS-REC A.11 [56] 20-21**]. Permission was also obtained from the Hohoe Municipal Assembly before the commencement of the study. A written informed consent was obtained from all of the participants.

The research was extensively explained to the participants and they were briefed on their responsibilities in the study. A paper-based questionnaire was used to collect the data. The items were constructed in the English Language based on the research objectives with both closed and open-ended questions. The questionnaire was translated into the local language, 'Ewe', for those participants who were unable to read and understand English without changing the context of the study. The questionnaire was categorized into 3 sections. The Section 'A' was based on the background characteristics of the participants. Section 'B' includes questions on medical care-seeking behaviors, the Section 'C', focuses on the factors that influence readiness to seek medical care. The questionnaire was pretested on twenty (20) individuals from the community who were not part of the study sample but had similar characteristics as the study population to check for consistency of variables and identification and correction of errors. The reliability of the instrument was extablished using Cronbach apha, the reliability index of .78 was obtained and the questionnaire was therefore adjuged reliable for the study. 400 copies of the questionnaire were administered to the participants on face-to-face bases and were collected on the spot. This helped to achieve a 100% return rate.

Variables of the study

Dependent variable

The dependent variable under investigation in our study was the readiness to seek medical care in the event of illness, which was assessed using a set of eight (8) items from the questionnaire. These items are as follows: (I) I seek medical care at the health facility for treatment when ill (II) Seeking medical care at the health facility is my first point of call following ill health (III) During my past illnesses, I sought treatment from a medical care practitioner at the health facility (IV) During my future illnesses, I will seek treatment from medical care practitioner at the health facility (V) If I had equal access to all options of care, I would routinely seek medical care (VI) I seek medical care from the health facilities for illnesses I consider mild (VII) I seek medical care from the health facilities for illnesses I consider severe (VIII) I seek medical care from the health facilities for illnesses I consider life-threatening.

Each participant was asked to respond to these items by choosing from four options: *"Never," "Rarely," "Sometimes," "Most times," and "Every time."* To create a composite variable for readiness, we assigned a score of "1" to all positive responses and "0" to all negative responses for each of the items (I-VIII). The mean score was computed by summing up all these responses. Participants who scored below the mean were categorized as "*Not ready*" to seek medical care, while those who scored above the mean were categorized as "*Ready"* to seek medical care.

Independent variables

In the study, we included seventeen (17) independent variables in our estimations. These variables comprised: Residence, Sex, Marital status, Religion, Educational level, Occupation, Monthly income, Health insurance Status, Negative attitude of care providers, Cost of care, Long queues, Religious beliefs, Cultural beliefs, Cost not covered by NHIS, Care quality,

Traditional treatment usage, and Prayer therapy usage. All these variables were included in our inferential analysis.

Statistical analysis

The collected data were coded and entered into Epi-Data version 4.6.0.2. Data extraction and cleaning were carried out in Excel Sheet and then later exported into STATA V.16.0 (StataCorp. 2019. Stata Statistical Software: Release 16. College Station, TX: StataCorp LLC.) for analysis. To ensure the quality of the data extracted, double entry was done in Epi-Data to address discrepancies which may have occurred during extraction. Descriptive analysis such as simple frequencies and percentages were used to summarize the data. Logistic regression such as bivariate and multivariate analysis were performed. The odds ratio and 95% confidence interval were calculated, and a p-value of less than *0.05* was considered statistically significant.

Results

Table 1**: Sociodemographic characteristics of participants**

Variables	Frequency (n=400)	Percentage (%)
Age group (*in years*)	SD (48.2, ±1.66)	
18-25	126	31.5
26-35	118	29.5
36-45	78	19.5
46-55	48	12
56-60	30	7.5
Sex		
Male	189	47.2
Female	211	52.8
Marital status		
Married	168	42
Single	184	46
Cohabitating	30	7.5
Divorced/separated	15	3.8
Widowed	3	0.7
Religion		
No religion	7	1.7
Christian	328	82
Islam	50	12.5
Other religion	15	3.8
Ethnicity		
Ewe	231	57.8
Akan	90	22.5
Dagbani	11	2.8
Guan	25	6.1
Others	43	10.8
Place of residence		
Hohoe	102	25.5
Fodome	104	26
Alavanyo	101	25.5

Wli	93	23
Educational level		
No formal education	40	10
Primary/JHS education	81	20.2
Secondary education	167	41.8
Tertiary education	112	28
Occupation		
Unemployed	20	5
Student	117	29.2
Government worker	56	14
Trader	11	27.8
Farmer	38	9.5
Others	58	14.5
Monthly income		
<=500	82	20.5
501-1000	118	29.5
1001+	63	15.7
Not applicable	137	34.3
Health insurance type		
No health insurance	99	24.8
Private health insurance	23	5.7
Government health insurance (NHIS)	278	69.5

We interviewed a total of 400 participants in this study. Out of the 400, the majority of them 211 (52.8%) were males, and 184 (46%) were single. A significant majority 328 (82%) of the participants were Christians. Prominent among them 167 (41.8%) had a secondary level of education. Furthermore, more than two-thirds (69.5%) of the participants reported they have government health insurance cards (Table 1).

Table 2**: Participants readiness to seek medical care in the event of illness**

Variables	**Responses n (%)**				
	Every Time	**Most Times**	**Some Times**	**Rarely**	**Never**
I seek medical care at the health facility for treatment when ill	50 (12.5%)	92 (23%)	157 (39.2%)	61 (15.3%)	40 (10%)
Seeking medical care at the health facility is my first point of call following ill-health	56 (14%)	90 (22.5%)	126 (31.5%)	68 (17%)	60 (15%)
During my past illnesses, I sought treatment from a medical care practitioner at the health facility	70 (17.5%)	87 (21.7%)	126 (31.5%)	54 (13.5%)	63 (15.8%)
During my future illnesses, I will seek	134 (33.5%)	80 (20%)	126 (31.5%)	41 (10.3%)	19 (4.7%)

treatment from medical care practitioner at the health facility					
If I had equal access to all options of care, I would routinely seek medical care	93 (23.3%)	76 (19%)	117 (29.3%)	73 (18.2%)	41 (10.2%)
I seek medical care from the health facilities for illnesses I consider mild	30 (7.5%)	31 (7.7%)	90 (22.5%)	119 (29.8%)	130 (32.5%)
I seek medical care from the health facilities for illnesses I consider severe	156 (39%)	129 (32.3%)	86 (21.5%)	15 (3.7%)	14 (3.5%)
I seek medical care from the health facilities for illnesses I consider life-threatening	194 (48.5%)	110 (27.5%)	69 (17.3%)	14 (3.5%)	13 (3.2%)

Table 2 abve presents the readiness of participants to seek medical care. A significant proportion of them 157 (39.2%) reported seeking medical care at a health facility sometimes when they fall ill. Participants' past and future care-seeking behavior showed interesting patterns. In the past, 70 (17.5%) sought treatment from a medical care practitioner at a health facility every time they were ill. Looking ahead, 134 (33.5%) expressed a strong intention to seek treatment from a medical care practitioner at a health facility every time they face illness. When presented with the hypothetical scenario of equal access to all options of care, 93 (23.3%) of participants stated that they would routinely seek medical care.

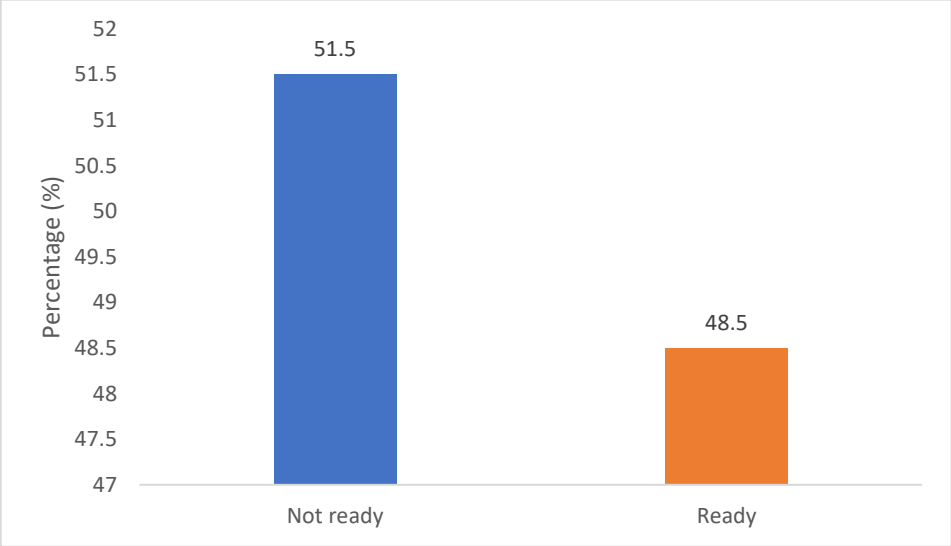

Figure 1**: Participants' readiness to seek medical care in the event of illness.**

The figure above presents respondents' readiness to seek medical care. This was assessed by creating a composite variable for readiness. We assigned a score of "1" to all positive responses and "0" to all negative responses for each of the questions assessing readiness to seek medical care. The mean score was computed by summing up all these responses. Participants who scored below the mean were categorized as "*Not ready*" to seek medical care, while those who scored above the mean were categorized as "*Ready"* to seek medical care. According to our findings, out of the 400 participants, a substantial 193 individuals (48.5%) expressed readiness to seek medical care in the event of illness (Figure 1).

Table 3**: Enablers and Inhibitors of readiness to seek medical care in the event of illness**

Variables	**Responses n (%)**				
	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
Negative attitude of medical care providers	94 (23.5%)	130 (32.5%)	51 (12.7%)	98 (24.5%)	27 (6.8%)
Distance to medical care facility	82 (20.5%)	155 (38.8%)	85 (21.2%)	63 (15.8%)	15 (3.7%)
Cost of medical care	82 (20.5%)	155 (38.7%)	85 (21.2%)	63 (15.8%)	15 (3.8%)
Long queue	110 (27.5%)	158 (39.5%)	35 (8.8%)	69 (17.3%)	154 (38.5%)
Religious beliefs constrain	21 (5.2%)	20 (5.0%)	40 (10.0%)	165 (41.3%)	154 (38.5%)
Cultural beliefs constrain	19 (4.7%)	17 (4.3%)	36 (9.0%)	179 (44.7%)	149 (37.3%)
Cost of care is not covered by NHIS	51 (12.7%)	104 (26.0%)	162 (40.5%)	63 (15.8%)	20 (5.0%)
Quality of medical care is poor	35 (8.7%)	83 (20.7%)	116 (29.0%)	107 (26.8%)	59 (14.8%)
Use of traditional treatment	60 (15.0%)	83 (20.7%)	44 (11.0%)	138 (34.5%)	75 (18.8%)

Believe in prayer therapy	67 (16.7%)	72 (18.0%)	98 (24.5%)	88 (22.0%)	75 (18.8%)

According to our findings, majority 130 (32.5%) of the participants agreed that negative attitudes of medical care providers hindered them from seeking medical care. Another substantial concern was the proximity of medical care facilities. A substantial majority 155 (38.8%) agreed that distance posed a significant barrier. Long queues at healthcare facilities were a concern for 158 (39.5%). Furthermore, traditional treatment methods and belief in prayer therapy were significant factors for a significant number 138(34.5%) of respondents. Interestingly, 41.3% and 44.7% of respondents disagreed that religious beliefs and cultural beliefs respectively constrained their decision to seek medical care in the event of illness (Table 3).

Table 4**: Factors influencing readiness to seek medical care among participants**

Variables	Readiness to seek medical care					
	Ready n (51.5%)	Not Ready n (48.5%)	$\chi 2$ (p-value)	cOR (95%CI)	aOR (95%CI)	P-value
Residence			0.71 (0.871)			
Hohoe	51(24.8%)	51(26.3%)		-	-	-
Fodome	47(27.7%)	57(24.2%)		-	-	-
Alavanyo	51(26.3%)	50(24.3%)		-	-	-
Wli	45(23.3%)	48(23.3%)		-	-	-
Sex			0.54 (0.463)			
Male	88(45.7%)	101(49.0%)		-	-	-
Female	106(54.6%)	105(51.0%)		-	-	-
Marital status			2.90 (0.574)			
Married	89(45.9%)	79(38.4%)		-	-	-
Single	85(43.8%)	99(48.1%)		-	-	-
Cohabitating	12(6.2%)	18(8.7%)		-	-	-
Divorced/Separated	7(3.6%)	8(3.9%)		-	-	-
Widowed	1(0.5%)	2(1%)		-	-	-
Religion			7.31 (0.063)			
No religion	1(0.5%)	6(2.9%)		-	-	-
Christian	167(86.1%)	161(78.2%)		-	-	-
Islam	22(11.3%)	28(13.6%)		-	-	-
Other religion	4(2.1%)	11(5.3%)		-	-	-
Educational level			27.14 (**0.000*****)			
No formal education	10(5.2%)	30(14.6%)		**Ref**	**Ref**	
Primary/JHS level	32(16.5%)	49(23.8%)		1.96 (0.84-4.55)	2.10 (0.88-5.05)	0.096
Secondary level	77(39.7%)	90(43.7%)		2.57 (1.18-5.59)	2.21 (0.97-5.05)	0.060
Tertiary level	75(38.7%)	37(18%)		6.08 (2.69-13.76)	4.22 (1.73-10.25)	**0.002***
Occupation			21.54 (**0.001*****)			
Unemployed	9(4.6%)	11(5.3%)		-	-	-
Student	67(34.5%)	50(24.3%)		-	-	-

Government worker	37(19.1%)	19(9.2%)		-	-	-
Trader	49(25.3%)	62(30.1%)		-	-	-
Farmer	10(5.2%)	28(13.6%)		-	-	-
Others	22(11.3%)	36(17.5%)		-	-	-
Monthly income			15.89 (**0.001*****)			
<=500	30(15.5%)	52(25.2%)		**Ref**	**Ref**	
501-1000	48(24.7%)	70(34%)		1.19 (0.67-2.12)	1.08 (0.58-2.00)	0.815
1001+	40(20.6%)	23(11.2%)		3.01 (1.52-5.96)	1.54 (0.72-3.29)	0.266
Not applicable	76(39.2%)	61(29.6%)		2.16 (1.23-3.79)	1.13 (0.600-2.14)	0.701
Health insurance Status			35.45 **(0.000***)**			
No health insurance	25(12.9%)	74(35.9%)		**Ref**	**Ref**	
Private health insurance	19(9.8%)	4(1.9%)		14.06 (4.37-5.29)	8.78 (2.62-29.41)	**0.000*** **
Government health insurance	150(77.3%)	128(62.1%)		3.47 (2.08-5.78)	3.00 (1.75.29.42)	**0.000*** **
Negative attitude of care providers			2.38 (0.305)			
Agree	109(56.2%)	115(55.8%)		-	-	-
Neutral	20(10.3%)	31(15.1%)		-	-	-
Disagree	65(33.5%)	60(29.2%)		-	-	-
Distance			1.09 (0.580)			
Agree	103(53.1%)	105(51%)		-	-	-
Neutral	30(15.5%)	40(19.4%)		-	-	-
Disagree	61(31.4%)	61(29.6%)		-	-	-
Cost of care			4.29 (0.117)			
Agree	105(54.1%)	132(64.1%)		-	-	-
Neutral	45(23.2%)	40(19.4%)		-	-	-
Disagree	44(22.7%)	34(16.5%)		-	-	-
Long queues			3.01 (0.222)			
Agree	122(62.9%)	146(70.9%)		-	-	-
Neutral	20(10.3%)	15(7.3%)				

Disagree	52(26.8%)	45(21.8%)				
Religious beliefs			5.35 (0.069)			
Agree	15(7.7%)	26(12.6%)		-	-	-
Neutral	15(7.7%)	25(12.1%)				
Disagree	164(84.5%)	155(75.2%)				
Cultural beliefs			13.20 (**0.001*****)			
Agree	11(5.7%)	25(12.1%)		**Ref**	**Ref**	
Neutral	10(5.2%)	26(12.6%)		0.87 (0.32-2.42)	0.80 (0.29-2.25)	0.675
Disagree	173(89.2%)	155(75.2%)		2.54 (1.21-5.32)	2.10 (0.98-4.50)	0.055
Cost not covered by NHIS			0.43 (0.805)			
Agree	72(37.1%)	83(40.3%)		-	-	-
Neutral	81(41.8%)	81(39.3%)				
Disagree	41(21.1%)	42(20.4%)				
Care quality			0.78 (0.676)			
Agree	57(29.4%)	61(29.6%)		-	-	-
Neutral	60(30.9%)	56(27.2%)				
Disagree	77(39.7%)	89(43.2%)				
Traditional treatment Usage			10.12 (**0.006***)			
Agree	56(28.9%)	87(42.2%)		**Ref**	**Ref**	
Neutral	19(9.8%)	25(12.1%)		1.18 (0.60-2.34)	1.25 (0.62-2.54)	0.524
Disagree	119(61.3%)	94(45.6%)		1.20 (1.28-3.03)	1.73 (1.10-2.70)	**0.016***
Prayer therapy usage			4.81 (0.090)			
Agree	57(29.4%)	82(39.8%)		-	-	-
Neutral	52(26.8%)	46(22.3%)				
Disagree	85(43.8%)	78(37.9%)				

***χ2*:** chi-square, ***aOR*:** adjusted odds ratio, ***CI*:** confidence interval, ***cOR*:** crude odds ratio, ***Ref*:** Reference point; ***p < 0.05; ***p ≤ 0.001**

In the bivariate analysis, we performed, educational level, health insurance status, cultural beliefs, and traditional treatment usage ($\chi2$= 27.14, p=0.000), ($\chi2$= 35.45, p=0.000), ($\chi2$=13.20, p=0.001), ($\chi2$=10.12, p=0.006) respectively, were factors statistically associated with readiness to seek medical care in event of illness. After controlling for all covariates in a multivariate analysis, we found that educational level, health insurance status, and traditional treatment usage were the factors significantly associated with readiness to seek medical care. Our findings further revealed that participants who were educated to the tertiary level were 4.2 times more likely to seek medical care than those with secondary and primary/JHS levels of education [AOR = 4.2 (95% CI: 1.73–10.25), p=0.002]. Additionally, participants who have private health insurance cards were 8.8 times more likely to seek medical care than those who were on the government health insurance scheme (NHIS) [AOR = 8.8 (95% CI: 2.62–29.41), p=0.000]. Furthermore, participants who disagreed that traditional treatment can hinder readiness to seek medical care were 1.7 times more likely to seek medical care [AOR = 1.73 (95% CI: 1.10–2.70), p=0.016] (Table 4)

Discussion

In our study, we evaluated participants' readiness to seek medical care in the event of illness. Our findings indicate that 193 (48.2%) participants demonstrated readiness to seek medical care in the event of illness. However, it's worth noting that this proportion is lower in comparison to a study conducted in Nigeria, where 61.3% of participants reported a similar inclination (Latunji & Akinyemi, 2018a). The discrepancy in the readiness to seek medical care between our study and the study conducted in Nigeria can be attributed to several factors such as (I) Cultural beliefs and practices which often influence healthcare-seeking behavior. Different regions and cultures may have varying perceptions of illness severity and the role of healthcare providers (Sarfo, 2015; Uddin et al., 2012), It is possible that cultural factors in Ghana, where our study was conducted, may have influenced participants to be less inclined to seek medical care compared to those in Nigeria, (II) Disparities in healthcare access and infrastructure between the two countries can also play a significant role (Anselmi et al., 2015). If healthcare facilities are more accessible and affordable in Nigeria, it may encourage a higher proportion of individuals to seek medical care compared to those in Ghana who may face barriers to access, (III) Differences in healthcare education and awareness campaigns can impact individuals' understanding of the importance of seeking medical care (Li et al., 2020). If Nigeria had more extensive health education programs promoting early HSB, it could lead to a higher percentage of individuals willing to seek medical care. The differences in HSB between these regions underscore the need for context-specific policies and practices. A delicate and culturally sensitive approach to healthcare delivery and promotion is essential to ensure that individuals in these different regions are encouraged to seek medical care promptly, ultimately leading to better health outcomes for all.

Additionally, our study found that the educational level of participants was significantly associated with participants' readiness to seek medical care in the event of illness. This is in line with a prior study conducted across 31 countries in sub-Saharan Africa (Li et al., 2020) which revealed similar findings. This finding also shares with the findings of a study conducted by (Benuto et al., 2020). The similarity in findings is likely due to a combination of factors, including the regional context, research methods, demographics, and the influence of existing literature, all of which may have contributed to a convergence of results in these related studies. However, this underscores the importance of educational initiatives and health literacy programs to achieving a more equitable and effective healthcare system.

Another notable finding in this study was the substantial correlation between participants' readiness to seek medical care and possession of private health insurance. This finding aligns with the results of a previous study conducted in both Kenya and Ghana (Suchman et al., 2020), which reported analogous outcomes. The consistent association between private health insurance and readiness to seek medical care underscores the need for an interdisciplinary approach that involves healthcare providers, insurance companies, and policymakers. This collaborative effort can improve access to healthcare, enhance the quality of care, and promote better health outcomes for individuals with insurance coverage.

In our study, we also identified an association between the utilization of traditional treatments and the readiness to seek medical care in the event of illness. Interestingly, our findings suggest that participants who disagreed with the use of traditional treatment were more likely to seek medical care when facing illness. This contradicts the results of a prior study, which indicated that participants who opted for traditional treatments were more inclined to seek medical care (Musinguzi et al., 2018). This highlights the need for a balanced and culturally sensitive approach. Thus, healthcare practices should be patient-centred and informed by individual preferences, while policies should promote the safe and effective integration of traditional treatments into the broader healthcare system, all with the goal of improving overall health outcomes and patient satisfaction.

Overall, it is pertinent to acknowledge the limited body of existing literature in our research area. Notably, the majority of prior studies have taken a qualitative approach and have not specifically addressed the study population under examination in our research. This scarcity of quantitative research in our context posed challenges during the study design phase, particularly in terms of finding relevant comparators. Our study, however, not only addresses this gap in the literature but also provides valuable quantitative insights into the factors influencing participants' readiness to seek medical care in the events of illness. The absence of prior quantitative research on findings emphasizes the novelty and significance of our findings. Moving forward, these insights not only contribute to the existing body of knowledge but also open doors for future quantitative investigations in our study area.

Strengths and limitation

The strength of the study is accorded to its unique contribution to the existing body of knowledge, especially in a context with limited quantitative research. It addresses a research gap by providing valuable quantitative insights into HSB. The study however identified a few limitations which must be acknowledged. The cross-sectional design used in this study provides a snapshot of HSB at a single point in time. Thus, it cannot establish causal relationships between variables or capture changes over time. Data collection relied on self-reporting through questionnaires, which may introduce socially desirable response bias leading to overestimation or underestimation of certain behaviors or beliefs. Additionally, there may be other variables not considered in the study that could influence HSB. While this highlights the novelty of the study, it also underscores the need for further research to validate and expand upon these findings.

Conclusion

Our study sheds light on the critical issue of HSB. We found that a substantial proportion of participants were unwilling to seek medical care in the event of illness. Notably, our research identified educational level, private health insurance and usage of traditional treatment as significant influencers. This highlights the importance of educational initiatives and health literacy programs in promoting timely HSB. Furthermore, our finding emphasizes the need

for culturally sensitive healthcare approaches that respect and integrate traditional beliefs and practices where appropriate. Addressing these factors through targeted interventions and policies can enhance healthcare utilization, reduce health disparities, and ultimately contribute to the overall well-being and socio-economic development of the community and the country at large.

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