



Assessment of Health Care Seeking Behavior among House Hold Heads in Dale Woreda, Sidama Zone, Southern Ethiopia, Ethiopia

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GJMR-F Classification: *NLMC Code: W 84*



ASSESSMENT OF HEALTH CARE SEEKING BEHAVIOR AMONG HOUSEHOLD HEADS IN DALE WOREDA SIDAMA ZONE SOUTHERN ETHIOPIA ETHIOPIA

Strictly as per the compliance and regulations of:



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Abstract- Introduction: Health seeking behavior refers to activities undertaken by persons related to diseases experience. The initiation and treatment need for sick women, children, adolescents, and the old household members are usually determined by household heads. While household heads who are sick will independently decide to seek health care. There is limited information on the level of health care seeking behavior and associated factors among household heads. Therefore, assessing factors associated with health care seeking behavior among household heads have significant role in filling the information gap to control inappropriate health care seeking practice and its outcomes.

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Result: A total of 804 household heads (625 rural and 179 urban) giving a response rate of 95.3%. Among the study participants male comprises 693(86.2%) and female comprises 111(13.8%).Majority of the sick individual lies in age group of 18-30 years which accounts for 372(46.3%). The overall appropriate health care seeking behavior of household heads was 585 (72.8%) at the study area. Residence [AOR=3.32, 95% CI: 1.94, 5.68], Educational level [AOR=4.26, 95%CI: 2.16, 8.43], Monthly income [AOR=2.98, 95%CI: 1.37, 5.68] and Family size [AOR=2.29, 95%CI: 1.64, 3.19] were the independent predictor of health seeking behavior.

Conclusion: The magnitude of appropriate health-seeking behavior was satisfactory. Residence, educational level, monthly income, and family size affects the household's heads health care seeking behaviors.

Keywords: appropriate health seeking behavior, inappropriate health-seeking behavior, keble, urban, rural.

1. INTRODUCTION

Health seeking behavior refers to activities undertaken by persons related to diseases experience. (1). It is affected by different factors such as individuals' Characteristics, disease status and

access to health services (2). Also, it is affected by the Individuals knowledge and awareness. Among different populations, this behavior has difficult outcome of many factors operating at different hierarchical levels especially in rurals including their biologic, social profile, previous experiences with the health care services, community level influences, availability of health care providers alternatives (1).

Many of health-seeking behavior studies indicate that health service and resources remain inadequately used. To adopt and increase the health practices understanding human behavior is a factor. Regarding the provision of health care services and health policy different experts were aware. (3).

The general prevalence in south-west Ethiopia was 58.4% (4) 38.7% in rural populations in Ethiopia (5). The factors which alter the health-seeking behavior are Cultural customs, residence, distance to functioning health centers and finance in health facilities (6). Worldwide Health promotion supports providing knowledge about the causes of illness and possible alternatives will go a long way to promote a change in health-seeking behavior. However, in the world, the recognition is growing up, and health education and the level of knowledge is not adequate to promote a change in behavior. Different Studies conducted on health-seeking behavior, confirm that various factors, demonstrates the individual behaviors complexity and its influence in a specified period and area (7).

Generally, it is recognized that identifying and controlling the determinants associated with health care seeking behavior have positive impacts on modern health services utilization.

Recognition of manifestation of diseases is essential for early initiation of health care seeking. Household-level illness diagnosis is related with the choice made between health treatment alternatives. The resulting patterns of health-seeking behavior determine the net disease magnitude in a given society.

At the household level, the process of seeking modern health care was found to vary considerably between the adult men on one hand, and other household members on the other. While adult men who fall sick can independently decide to seek health care, women, children, adolescents and the old consistently indicated that it is another household member who

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usually determines the timing and the type of treatment when they are attributable to illness episodes.

In different regions of Latin America, Asia and Africa traditional medicine (TM) is performed. 80% of the population's in Africa and also 80% in Ethiopia traditional medicine is used for health care because the populations culture accepts the traditional healers due to the inaccessibility of the modernized health institutions and in need of cost minimization (3, 8).

Early detection of diseases or its indicator is needed to initiate health seeking and treatment. Household-level illness diagnosis is related with the choice made between health treatment alternatives. The resulting patterns of health-seeking behavior determine the net burden of disease in a given society.

At the household level, the process of seeking modern health care was found to vary considerably between the adult men on one hand, and other household members on the other. While adult men who fall sick can independently decide to seek health care, women, children, adolescents, and the old consistently indicated that it is another household member who usually determines the timing and the type of treatment when they are subject to illness episodes. The main underlying reason for the above decision-making process is that adult men are responsible for the health care costs for women and children. The study found that even in situations where the wife pays for her health care, the husband must reimburse the money spent on her afterward. Depending on whether or not he is willing and able to pay for medical attention, the husband/father of a sick woman/child may decide to delay modernized treatment and rely on cheaper traditional medicines for a while. Depending on their assessment, adult males may also judge the illness of a woman/child as not enough to merit medical attention.

When community members get sick, they do not usually seek health care from modern health facilities immediately. Instead, they opt for other alternatives, including not seeking medical care at all, self-medication with drugs obtained from drug vendors, back street marketers, over the counter in shops and pharmacies, and traditional medicine (9).

The study conducted in Addis Ababa indicated that One-third of all illnesses were treated by modern services 19.9% by self-care. The utilization rates of modernized medicine is varied due to the type of disease and its duration, socioeconomic characteristics and level, sex, age and the area of residence (10).

Health care policies and programs' planning requires knowledge about health-seeking behavior for early diagnosis, effective treatment, and appropriate intervention implementation (11).

Also, health service delivery was inefficient and unfair, and quality of healthcare was usually poor between urban and rural (12). The former residents are expected to be open to different new ideas and

exposures, and they are committed to practicing different things on a trial and correct errors (13). But also they are exposed to a certain tradition, not changing and does not accept change and refuse the cultural values and expectations (14, 15).

Most studies on health-seeking behavior in Ethiopia have been disease specific particularly on malaria, TB, & Maternal health etc (16). Since no similar study in the study area on health care seeking behavior among household heads, this study helped to assess the health-seeking behavior among household heads and identified factor affecting health care seeking behavior.

This study determined the magnitude of health care seeking behavior and identified the common determinants that affect health care seeking behavior. The results of this study are expected to provide evidence-based information to the community, local government and health care providers and policy makers'. Based on the available information possible intervention will be made.

The objective of this study was to assess health care seeking behavior & its associated factors among household heads in Dale woreda, Sidama Zone, Ethiopia, 2017.

II. METHODS AND MATERIALS

a) Study Area

Dale woreda is one of nineteen woredas in Sidama Zone having total population 242,658 of which 122,918 are males and 119,740 are females. Yirgalem town is one of the town administration in Sidama Zone found in Dale woreda which is 45 km far from Hawassa. Dale woreda has a total of 31 rural kebele and seven urban kebeles and 49, 244 households. The health service coverage of the woreda in 2010 is 86%. (Census 2007, CSA).

b) Study Period

The actual data collection was carried in February- March 2017.

c) Study Design

A community-based cross-sectional study was conducted among household heads residents of Dale Woreda to assess health-seeking behavior and its associated factors. This design was selected considering the time allocated for data collection and availability of study subject.

III. POPULATION

a) Source Population

All households in Dale woreda with household heads were sick in the last four week before the survey date.

b) Study Population

Randomly selected household heads from the source population.

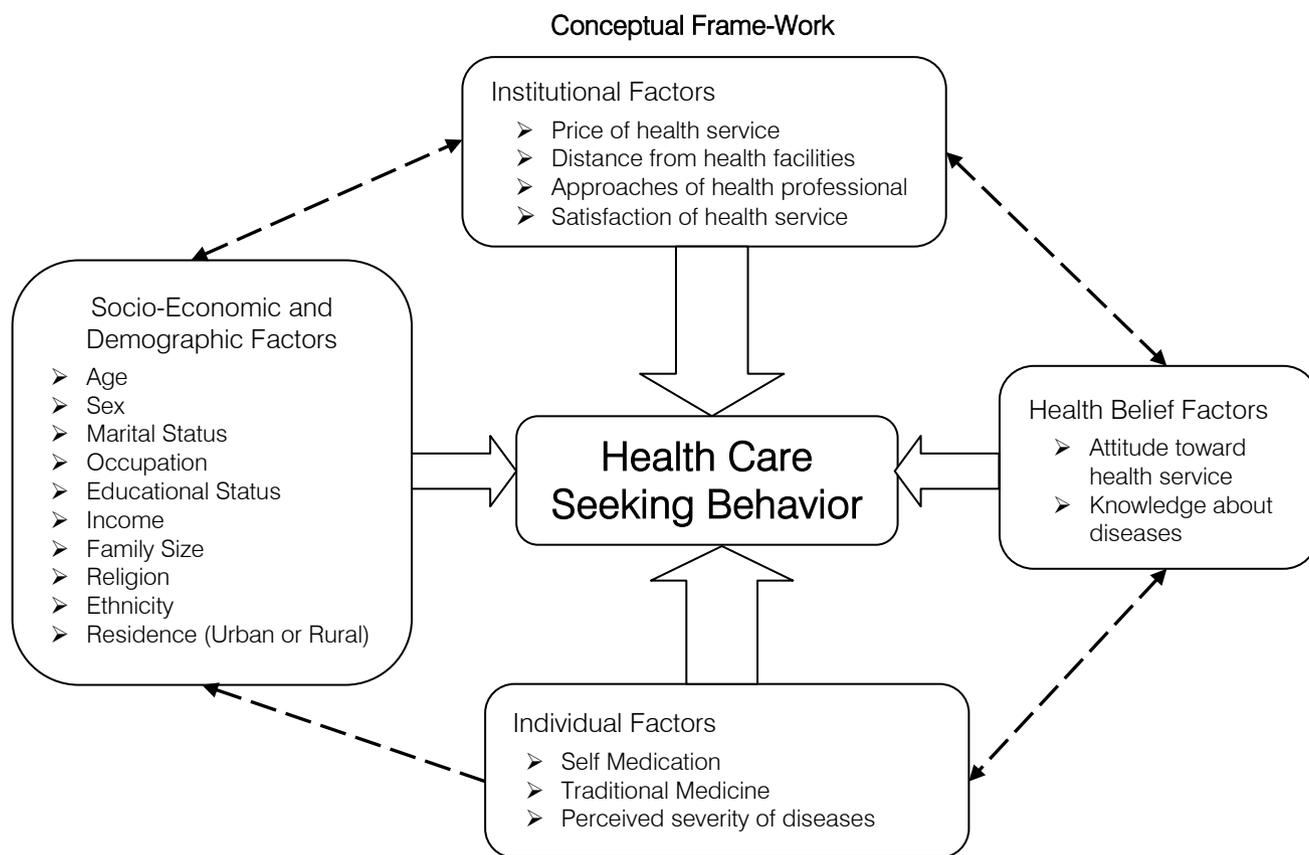


Figure 1: Conceptual frame-work of health-seeking behavior

c) *The Sampling Unit*

Household heads who were sick in the last four weeks from the survey date.

d) *Inclusion and Exclusion criteria Inclusion Criteria*

Household head's who were sick in the last four weeks from the survey date.

i. *Inclusion Criteria*

Household head's who were sick in the last four weeks from the survey date.

ii. *Exclusion Criteria*

- ❖ Household heads who were critically sick and non-communicative for the last four Weeks.
- ❖ Household heads who were sick for the last four week with self-limiting diseases like common cold.

IV. SAMPLE SIZE DETERMINATION AND SAMPLING PROCEDURE

a) *Sample Size Determination*

The final sample size was determined using a single population proportion formula through considering the following assumptions; P=proportion of health care seeking behavior. Since the proportion for this particular study was unknown, p = 50%, to get the maximum sample size.

Z= the standard normal deviation of 95% i.e. 1.96

d= the margin of sampling error i.e.5 %

$$n = \frac{(Z_{\alpha/2})^2 P (1 - P)}{d^2}$$

Where,

n= Initial Sample Size

$$n = \frac{(1.96)^2 0.5 (1 - 0.5)}{(0.05)^2}$$

$$n = 384$$

By considering the design effect of the sampling technique (2) and 10% non response rate the final sample size was= 844.

b) *Sampling Techniques*

A multi-stage sampling design was used to select primary sampling units (kebeles) and secondary sampling units (households) from the woreda. The kebeles were selected using simple random sampling method. A complete census was carried out in all the selected kebeles before the actual data collection time. By using the information from census, representative sample of individuals/household head from each Kebeles included in the study by using PPS. Systematic sampling method was employed to select the household heads from each kebele, where the sampling interval was the total numbers of sick household heads in each kebele divided by the corresponding number of sick household heads were interviewed in each kebele. Data was collected from the first household head by

using the kebele house number given during census for urban and rural household head register using simple random sampling method.

The next household heads were interviewed systematically. The corresponding number of sick household heads were interviewed in each kebele /total number of sick household heads in each kebele, =1/5.3, a k=5 interval for urban household heads and systematically at (corresponding number of sick household heads were interviewed in each kebele /total number of sick household heads in each kebele 1/3.8, k =4) interval for rural household heads.

V. MEASUREMENTS

a) Questionnaires

The data was collected by using structured a local language (sidamigna) version questionnaires consisting of Socio-demographic characteristics of sick household heads different questions regarding health-seeking behavior including the utilization of health services and types of health care needed and factor affecting health-seeking behavior.

b) Data Collection Techniques

The data collection was carried out using structured questionnaires filled by data collectors. The data collection format was prepared in English and was translated from English to local language (sidamigna) and was re-translated back to English to check the reliability of the instrument. Datas were collected by interviewing the Household heads .The house to house visit continued until the sample size required was secured. During data collection, the data collectors found locked houses and re-visited.

c) Quality Assurance

Before undertaking the data collection, instrument was tested taking 44 household heads in Abesto kebele for the feasibility of the questionnaires. Based on the findings Modifications were done. The pre-tested data was not included in the data. Validity and reliability of the questionnaire was checked.

The Grades 10th completed ten interviewers were selected as data collectors who could speak the local language (Sidamign) fluently. Two nurses were recruited as supervisor considering their knowledge of biomedical practice (this was taken as a resource of information for data collectors). Both interviewers and supervisors were trained, demonstrated, and practiced on the data collection technique.

The data collectors were given data collecting instrument on the morning of each day. At the end of each day, the supervisors checked the completeness of the questionnaires. The data collectors came cross with the locked house during data collection and re-visited.

VI. DATA ANALYSIS

To ensure that all needed information was collected and recorded appropriately, the supervisors and principal investigator checked data in the field. Data analysis was started by sorting and performing quality control checked up at the field.

The data entered into Epi Info version 3.5.1 and analyzed using SPSS version 20 software. It was justified that all totals correspond to the total number of study units. There were columns for no response or missing data to arrive at accurate total figures. Data clean up was performed by check for frequencies, accuracy, outliers, and consistencies and missed values and variables. Frequencies, proportions, and summary statistics were used to describe the study population about relevant variables using tables, charts and graphs. Odds ratio and the chi-square test were computed to assess the strength of the associations. The bivariate analysis was carried out to calculate the crude odds ratio (OR) and a 95% confidence interval (CI). For all statically significance tests, the cut of value set was $P < .05$ as this considered statically significant. Since crude odds ratio (OR) did not take into account the effect of the confounding variable(s), multivariate analysis were applied by fitting the logistic regression.

VII. ETHICAL CONSIDERATIONS

Before data collection, ethical clearance was taken from the ethical clearance committee of the Jimma University, Institute of health science. A formal letter of permission was obtained from administrative bodies of the zone to the woreda and then to the respective kebeles. Moreover, confidentiality assured for the information provided since the name of study participant was not stated on the questionnaire rather coding system was applied. The purpose of the study was described to the study participants. Before starting the interview, the respondents were requested for their verbal consent to participate in the study and obtained. During survey, the interviewer did not find the debilitated, neglected and sick individuals in critical condition

VIII. RESULT

a) Socio-Economic and Demographic Factors

A total of 804 households heads were involved in giving a response rate of 95.3 %. Among the study participants male comprises 693 (86.2%) and 111 (13.8%) were females. Majority of the sick individual lies at the age group of 18-25 years which accounts for 372 (46.3%). Seven hundred thirty-one (90.9%) of study participant had monthly income <1170 birr.

Table 1: Socio-economic and demographic characteristics of household head respondents (n=804) in Dale woreda, Sidama Zone, SNNPR, May 2017

Characteristics	No	%
Residence		
Urban	179	22.3
Rural	625	77.7
Sex		
Male	693	86.2
Female	111	13.2
Age in year		
18-25	372	46.3
26-35	324	40.3
36-45	66	8.2
46+	42	5.2
Religion		
Orthodox	125	15.5
Protestant	558	69.4
Muslim	63	7.8
Others	58	7.2
Ethnicity		
Sidama	503	62.6
Amhara	74	9.2
Gurage	67	8.3
Woilata	92	11.4
Others	68	8.5
Occupation		
Farmer	561	69.8
Employee	169	21
Others	74	9.2
Marital status		
Married	528	65.8
Single	197	24.5
Others	78	9.7
Educational status		
Illiterate	336	41.8
Primary education (1-8)	333	41.4
High school and above	135	16.8
Monthly income (in birr)		
<1170	731	90.9
≥1170	73	9.1
Family size		
<5	480	59.7
≥5	324	40.3

b) Health care seeking behavior

i. Appropriate health care seeking behavior

Overall appropriate health care seeking behavior of household heads was 585 (72.8%) at the study area. Public health center was the most common place where two hundred twenty-two (37.9%) participants sought health care, and only 10 (1.7%) participants sought health service from a private hospital.

Inappropriate health seeking care behavior reported among household heads was self-treatment 81(37.0%), traditional healer 38(17.4%) and did not know where to go/ nothing 100(45.6%). In addition to that 34 (15.5%), respondents did not know where best treatment is available. But 145 (66.2%) and 40 (18.3%) respondents believed that best treatment is available in a modern health institution and traditional healer respectively.

Table 2: Health-seeking behavior among household heads in Dale woreda, Sidama Zone, SNNPR, May 2017

Characteristics	No	%
Appropriate health care seeking (n=585)		
Public Health Center	222	37.9
Private Clinic	95	16.2
Health Post	96	16.4
Public Hospital	162	27.7
Private Hospital	10	1.7
Inappropriate health care seeking (n=219)		
Self-Treatment	81	37
Traditional Healer	38	17.4
Did not know where to go/ nothing	100	45.6

ii. Reason for not seeking modern health care

Two hindered Nineteen (27.2%) of household heads did not seek health care from modern health facility. The main reason reported for not seeking health care were lack of money 94 (42.9%), not effective treatment available 54 (24.7), symptom is not serious 17 (7.8%) and long distance 13 (5.9%).

Among the participants who did not seek health care from the modern health facility 81 (37%) practiced self-treatment. The main reason reported for practicing self-treatment were I know the treatment by myself 26 (32.1%), it is cost effective 22 (22.7%), diseases is not critical 17 (21%).

Table 3: Reason for not seeking modern health care among household heads in Dale woreda, Sidama Zone, SNNPR, May 2017

Variable	No	%
Reason for not visiting modern health facilities (n=219)		
Lack of money	93	43
Not effective treatment available	55	25
The symptom is not critical	17	7.8
Long distance	14	6.4
Others	40	18
Reason for preferring self-treatment(n=81)		
I know the treatment my self	26	32
It is cost effective	22	27
Diseases is not serious	17	21
Long waiting time	6	7.4
Others	10	12
Time of health care seeking in response to symptom experienced (n=585)		
Immediately as illness start	118	54
≤1 days	110	19
2-5 days	98	17
≥6 and above days	299	51

iii. Approaches of health professional and Satisfaction of health service seeker

The title of health professionals reported among modern health facility visitors were Doctors 162 (27.7%), Nurses 145 (24.8%), health officer 16 (2.7%), health extension workers 94 (16.7%) and 168 (28.7) did not know the title of health care providers. Participants reported Health professional approach during health care provision as respectful 301 (73.6%), polite 299

(72.6%), knowledgeable 276 (67.3%) and friendly 358 (87.3%) and 417 (71.3%) of participants reported they would return to seek medical care, but 168 (28.7%) of households reported that they would not return to seek medical care from those health care giver.

Table 4: Approaches to the health professional and households Satisfaction with health service sought in Dale woreda, Sidama Zone, May 2017

Variable	No	%
Who did you talk to / see at modern health service care unit? (n=585)	162	27.7
Doctors	16	2.7
Nurse	94	16.1
Health extension workers.	168	28.7
I do not know		
Health professional approach during treatment provision (n=585).	301	73.6
Respectful	299	72.9
Polite	276	67.3
Knowledgeable	358	87.5
Friendly		
Would you return to seek advice or treatment (n=585)	417	71.3
Yes	168	28.7
No		

iv. *Factors associated with the outcome variable*

Urban residents were 3.32 times more likely to seek appropriate health care as compared to rural residents [AOR=3.32, 95% CI: 1.94, 5.68]. Having family size <5 were 2.29 times more likely to seek appropriate health care as compared to whose family size were ≥5 [AOR=2.29, 95% CI: 1.64, 3.19]. Educational level of High school and above households were 4.26 times more likely to seek appropriate health care as compared

to those households who did not have formal education [AOR=4.26,95% CI: 2.16, 8.43]. The odds of having appropriate health - seeking behavior for symptom experienced among household heads earning a monthly real per capita income of ≥1170 ETB was 2.98 times higher than those household heads earning a monthly real per capita income of <1170ETB [AOR=2.98,95% CI:1.37, 6.44].

Table 5: Bivariate analysis of factor associated with outcome variables, May 2017

Variables	Health Care Seeking Behavior		COR (95% CI)
	Yes No (%)	No No (%)	
Ethnicity			1
Sidama	359(71.4)	144(28.6)	
Amhara	50 (67.6)	24(32.4)	0.84(0.49,1.41)
Gurage	55(82.1)	12(17.9)	1.84(0.96,3.53)
Woilata	68 (73.9)	24(26.1)	1.14(0.69,1.89)
Others	53(77.9)	15 (22.1).	1.42(0.77,2.59)
Residence			4.23(2.53,7.09)**
Urban	161(89.9)	18(10.1)	
Rural	424(67.8)	201(32.2)	1
Family size			2.21(1.61,3.02)**
<5	380(79.2)	100(20.8)	
≥5	205(63.3)	119(36.7)	1
Educational status			5.56(2.88,10.72)**
Had no formal education	225(67.0)	111(33.0)	1
Primary education (1-8)	236(70.9)	97(29.1)	1.20(0.86,1.67)
High school & above	124(91.9)	11(8.1)	
Monthly income (in birr)			3.29(1.56,6.99)*
<1170	520(71.1)	211(28.9)	1
≥1170	65(89.0)	8(11)	
Occupational status			1.71(0.99,3.10)
Farmer	391(69.7)	170(30.3)	1
Employee	135(79.9)	34(20.1)	1.73(1.14,2.62)*
Others	59(79.7)	15(20.3)	

Table 6: Multivariable logistic analysis of independent predictors of health seeking behavior in Dale Woreda, May 2017

Variables	Health Care Seeking Behavior			AOR (95%CI)
	Yes No (%)	No No (%)	COR (95% CI)	
Ethnicity				
Sidama	359(71.4)	144(28.6)	1	
Amhara	50 (67.6)	24(32.4)	0.84(0.49,1.41)	
Gurage	55(82.1)	12(17.9)	1.84(0.96,3.53)	
Wolaita	68 (73.9)	24(26.1)	1.14(0.69,1.89)	
Others	53(77.9)	15 (22.1)	1.42(0.77,2.59)	
Residence				
Urban	161(89.9)	18(10.1)	4.23(2.53,7.09)**	3.32(1.94,5.68)**
Rural	424(67.8)	201(32.2)	1	1
Family size				
<5	380(79.2)	100(20.8)	2.21(1.61,3.02)**	2.29(1.64, 3.19)**
≥5	205(63.3)	119(36.7)	1	1
Educational status				
Had no formal education	225(67.0)	111(33.0)	1	1
Primary education (1-8)	236(70.9)	97(29.1)	1.20(0.86,1.67)	1.32(0.94,1.86)
High school & above	124(91.9)	11(8.1)	5.56(2.88,10.72)**	4.26(2.16,8.43)**
Monthly income (in birr)				
<1170	520(71.1)	211(28.9)	1	1
≥1170	65(89.0)	8(11)	3.29(1.56,6.99)*	2.98(1.37,5.68)*
Occupational status				
Farmer	391(69.7)	170(30.3)	1	
Employee	135(79.9)	34(20.1)	1.73(1.14,2.62)*	
Others	59(79.7)	15(20.3)	1.71(0.99,3.10)	

Note: *-significant result, 1-reference category, ** p-value <0.001, * p-value <=0.05

IX. DISCUSSION

In this study, the magnitude of appropriate health care seeking behavior among household heads for symptom experienced was 72.8 % in the surveyed communities with urban household heads sought 89.9 % and 67.8 % rural household heads. There is an increment of utilization of modern health service in both residences in current study compared to a study done in Amhara region, Ethiopia revealed that 52.3% in urban and 29.6% in rural and similar Study conducted in Zambia and Nigeria indicated 43.5% and 48.9% respectively (35,24). The study conducted in Senegal showed almost similar findings (75%) with current study (28).

The improvement might be due to continuous efforts to strengthen the health system, infrastructure, increase public awareness, and involvement of community health extension workers and building staff capacity.

Similarly, study conducted in Tanzania indicated 87.7% of rural respondents sought health service from the modern facility (37). This finding is high compared to current study findings which shows 67.8% of rural households sought health service from a modern facility. The big difference observed here might be due to the differences in methodologies (difference in geographical differences, sampling techniques and the difference in definition of health care seeking behavior).

In this study, the magnitude of inappropriate health care seeking behavior among household head for symptom experienced was 27.2 % in the surveyed communities. The research conducted in Amhara region, Ethiopia, Kenya and Zambia indicated that preference for non formal facilities was 47.3%, 37.5% and 56.5 % respectively (35, 36). The difference might be due to improvement in accessibility of institutions and health information delivery by health extension program (HEP). Forty-three percent of household heads reported lack of money was the most common reason for not seeking health service from a modern health facility. Study conducted in Pakistan and Nigeria 62% & 50.3% respectively supported the current study findings (34, 25).

The study conducted in Tanzania showed that only 12.3% did not seek health service from a modern health facility which is three times less than the current findings (37). The possible explanation might be due to the differences in methodologies (the different approach in data the collection, study population, the location of studies, and difference in definition of health seeking behavior).

Average monthly income was significantly affects health care seeking behaviors of household heads in the study area. The odds of having appropriate health-seeking behavior for symptom experienced among household heads earning a monthly real per

capita income of ≥ 1170 ETB was 2.98 times higher than those household heads earning a monthly real per capita income of < 1170 ETB [AOR=2.98, 95% CI: 1.37, 6.44]. Study conducted in Pakistan, Kenya, Nigeria and Ethiopia supported the findings (34, 36, 24, 19). The possible explanation might be those household heads who earn high monthly income may have more access to information. The affordability of health care service may not bother them.

In this study, family size showed highly significant ($p=0.00$) association with health care seeking behavior. Household heads whose family size < 5 were 2.29 times more likely to have appropriate health-seeking behavior than those household heads whose family size ≥ 5 . Population-based cross sectional Study conducted in North West Ethiopia revealed similar findings (19). This might be because that those who have the larger family members should carry more responsibilities and experienced severe socio-economic hardship which prevented them from seeking appropriate health care from modern health facilities for symptom experienced.

Educational status was highly significant ($p=0.00$) with the utilization of modern health service. Those household heads whose Educational level high school and above were (AOR =4.26, 95%CI 2.16, 8.43) 4.26 times more likely to have appropriate health-seeking behavior than those household heads who had non-formal education. The study conducted in four regions of Ethiopia revealed that household heads with informal education are 1.6 times (95% CI 1.07 to 2.46, $p=0.02$) more likely to take their children to health centers for ARI/pneumonia (baseline is health posts) which potentially offer a higher quality of care as compared with household heads with no education. Household heads with primary or secondary education are systematically more likely to seek care immediately as opposed to their less educated counterparts. Study conducted in Pakistan showed that educational status of head of household (OR =3.4 95%CI 2.1, 5) were significantly related to utilization of modern health institutions.

A similar study conducted in Benue state also revealed that educational level is statistically significant on health-seeking behavior (34, 47, 18).

This might be due to that better-educated people are aware of health problem, know more about the availability of health-care services, and use this information more effectively to maintain or achieve good health status.

Residence of household's heads was highly significant with appropriate health-seeking behavior. Urban households were 3.32 times more likely to seek health care than rural households (AOR=3.32, 95% CI: 1.94, 5.68) at p -value < 0.001 . This study is similar to the findings in Jamaica that indicated healthcare seeking behavior could be explained by area of residence in

which urban households were more likely to have health-seeking behavior than rural households. Consistent study conducted in Pakistan showed that urban residence (AOR= 2.8, 95%CI 1.8, 4.5) were significantly related to utilization of modern health institutions (44, 34). This might be due to urban households had better accessibility to service.

The limitation of the study is it may have social desirability bias and recall bias.

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