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# **Assessment of Socio-Economic Differences and Health-seeking Behaviour among Locals in Coastal Communities of Tanzania: A Case of Dunda Ward in Bagamoyo District**

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## **Abstract**

This study intends to assess the socioeconomic differences concerning health-seeking behaviour among locals in coastal communities of Tanzania. Specifically, the study intends to assess the variations in terms of socioeconomic differences among locals in coastal communities and their relationship with health-seeking behaviour and established factors influencing health-seeking behaviour among locals in coastal communities. The study used both quantitative and qualitative research methods. Questionnaires were used for data collection; in-depth interviews were conducted with key informants, and four focus group discussions were conducted within the study area. In all, 200 respondents comprising 64 males and 134 females were interviewed, while in-depth interviews included five sub-village chairpersons and four health staff from the primary health centres within the study area. Data were examined and subjected to statistical tests, mainly chi-square ( $P \geq 0.05$ ). The findings of the study revealed that most of the respondents within the study area were highly influenced by financial capability, belief in a particular disease (nature of the disease), education level, and availability of health facilities. These were the influencing factors concerning the decision taken at the household level when a person falls ill. Variations among locals in coastal communities based on the mentioned forces. This study, among others, recommends that locals within the study area should use the available health services once they become ill. The decision about health care should be made by understanding illness, seriousness, and financial capacity for the health and productive community.

**Keywords:** Socio-Economic Differences, Health Seeking Behaviour, Coastal Communities

## **1. Introduction**

### **1.1 Background information**

Falling sick can happen anytime and hence affect the household. Once a household is confronted with sickness, the decision to seek medical care varies from one household to another (Haque *et al.*, 2019). The decision to seek medical services from either informal or formal health institutions varies among households. Examples of formal health institutions include dispensaries, health centres, and hospitals, while informal health institutions include traditional healers, herbalists and spiritual healers and others may decide not to seek any medical care at all (Corno, 2014). It is from this point of view, this study focuses on assessing the socioeconomic factors that influence health-seeking behaviour among locals in coastal communities.

There have been a plethora of studies addressing aspects of this debate, conducted in different countries. Such as the study carried out by (Hossain *et al.*, 2020) in Bolivian revealed the following factors which produce a pattern of health-seeking availability of good health services, the proximity of the health centres to the household, polite health workers, cultural beliefs and socio-demographic factors. Khamis & Njau (2014) were of the view that determinants of health-seeking behaviour can be described as cultural, age, sex, household resources (socioeconomic) cost of care, distance and physical access to the health institutions, and perceived quality of health services provided. It has further been noted by Mremi *et al.* (2018) that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables such as sex, age, type of illness, access to medical services, and perceived quality of the service prevailed in a respective area. There is a growing recognition, in both developed and developing countries, that education and knowledge at the individual level can promote a behaviour change. Various studies highlight similar or unique factors that demonstrate the complexity of influences on an individual's behaviour at a given time and place.

Health-seeking behaviour has been differently defined by various scholars, such as any action undertaken by individuals who perceive themselves to have a health problem or to be ill to find an appropriate remedy (Bhat and Kumar, 2017). The definition of a particular illness consists of signs and symptoms by which the illness is recognized the presumed cause of the illness, and the prognosis established (Banerjee and Dixit, 2017). These symptoms are eventually interpreted by individuals as well as other close relatives, hence

labelling the problem; and proceeding to address it appropriately based on their contextual environment (Mncono, 2018). An example of the definition of health-seeking behaviour was observed in the study carried out in Ghana by Fenny *et al.*, (2015), whereby health-seeking behaviour for the diagnosis and treatment of malaria in households and individuals relied on the knowledge and duration of sickness, the anticipated cost of treatment, the patient's judgment of the intensity of sickness accessibility to health facilities, level of endemicity in the population and demographic characteristics.

Asfaw *et al.* (2018) further argued that health-seeking behaviour is preceded by a decision-making process that is further governed by individual and/or household behaviour community norms and expectations, and provider-related characteristics and behaviour. In addition, Arnold *et al.* (2019) were of the view that behaviour is affected by both the belief in the disease perception and attribute causation based on tradition, intuition, supernatural, and magic behind the respective disease such as evil eye, infection, or accident. Treatment is based on the beliefs of either medical doctors or traditional healers. In most cases, people do not seek one source of health care, and their variation in terms of behaviour is related to who is affected and the kind of disease that affects them (El-Ghitany *et al.*, 2018). On the contrary, other people believe that any kind of illness is associated with God's hand alone (Andarin *et al.*, 2019). In this regard, the nature of health-seeking behaviour is not homogenous; instead, it depends on either cognitive or non-cognitive factors, which call for a contextual analysis of health-seeking behaviour. Context may be a factor of cognition or awareness as well as a social-cultural and economic factor (Deng and Liu, 2017).

Similarly, Basch *et al.* (2018) and Cross *et al.* (2019) were of the view that health-seeking behaviour involves recognition of symptoms and the perceived nature of illness, followed by initially appropriate home care and monitoring. This may require seeking care at the health facility, medication, and compliance. Amir *et al.* (2019) pointed out that, treatment failure may require a return to the health facility or alternative healthcare provider. Thus, client-based factors, provider-based factors, caretaker perceptions, social and demographic factors, decision-making power, and social networks where close relatives provide counselling advice, family support, and sympathy towards family members in illness and biological signs and symptoms work synergistically to produce a pattern of health-seeking behaviour. A sequential behaviour pattern is often drawn from a redefinition of illness and a multiplicity of treatment sources (Dheresa *et al.*, 2020).

Several genres of models exist, and variations have been developed around them. This study was built on the health belief model (HBM). The model was developed by social psychologists Hochbaum and Rosenstock (1951). The model illustrated the socioeconomic differences and their influence on health-seeking behaviour among locals in coastal communities. Furthermore, the model managed to comprehend people's health-seeking behaviour beyond their knowledge, attitudes, and practices (Didarloo *et al.*, 2017). The major assumption of the model is based on the notion that behaviour is a function of the subjective value of an outcome and of the subjective probability or expectation that a particular action will achieve that outcome (Patterson *et al.*, 2018). In this regard, the health-seeking behavioural pattern is based on the decision taken by the person, household, and family in a respective setting, on the belief that the action taken would have provided a better solution versus the predominant ill health (Haque *et al.*, 2019).

The health belief model is based on the idea that people are more likely to change their behaviour and adhere to treatments if they perceive that they are at risk of contracting the disease (perceived susceptibility), (ii) They perceive that the disease might have an unfavourable outcome (perceived severity), and iii. They perceive the proposed health behaviour to be both effective and practical (perceived benefits), (iv) they perceive the barriers to adopting the behaviour to be minimal (perceived barriers), (v) they perceive themselves to have the ability to apply and practice the specific behaviour proposed (perceived self-efficacy), and (iv) they have cues for motivating their actions, such as internal cues such as pain, symptoms, and past experiences, or external cues (advice from friends, relatives and mass media campaign) (Patterson *et al.*, 2018). The Health Belief Model is suitable for illumination of the individual decision-making process concerning health-seeking behaviour, which is described as the status of women (culture), age and sex (social), income/household resources (socioeconomic), cost of care (economic), distance and physical access (geographical, quality organization) (Bhat and Kumar, 2017; Deng and Liu, 2017). Generally, the Health Belief Model emphasizes preventive health behaviours, sick role behaviours, and clinic use. In this model, individual beliefs provide the link between socialisation and behaviour.

On the contrary, Kleinman's Explanatory Model of Illness and associates (1978) in their seminal paper further discuss the importance of the explanatory model. For them, "eliciting the patient's (explanatory) model gives the physician knowledge of the beliefs the patient holds about his illness, the personal and social meaning he attaches to his disorder, his expectations about what will

happen to him and what the doctor will do, and his own therapeutic goals. In that, a comparison of the patient model with the doctor's model enables the clinician to identify major discrepancies that may cause problems in clinical management. Such comparisons also help the clinician know which aspects of his explanatory model need clearer exposition to patients (and families), and what sort of patient education is most appropriate. And they clarify conflicts not related to different levels of knowledge but different values and interests. Part of the clinical process involves negotiations between these explanatory models, once they have been made explicit."

Eliciting the Patient's Explanatory Model of illness through a set of targeted questions is an important tool for facilitating cross-cultural communication, ensuring patient understanding, and identifying areas of conflict that will need to be negotiated. Generally, the model expresses that the person is knowledgeable of what he/she is suffering, the process of expression is the complex, culturally determined process of making sense of one's illness, ascribing meanings to symptoms, evolving causal attributions, and expressing suitable expectations of treatment and related outcomes. The explanatory model is capable of explaining health-seeking behaviour since every person; household and family have variations in terms of understanding the respective illness versus the choice of treatment to be provided.

Khamis and Njau (2014) and Mremi *et al.* (2018) in their studies conducted in various parts of Tanzania concerning health-seeking behaviour in that there is a huge explanation of the factors influencing or hindering health-seeking behaviour from one region to the other or from one disease to the next. From the reviewed literature, many studies have only studied the specific types of disease health-seeking behaviour such as TB, malaria, children's illness, and mental health among others. These studies have been conducted in cities such as Dar es Salaam, Kilimanjaro, and Mwanza. Senkoro *et al.* (2015) were of the view that other factors that influence health-seeking behaviour include actual money income, social status, social life, networks, autonomy, and liability. Other factors mentioned by Khamis and Njau (2014) included the status of women's disease patterns, access to public health services in terms of physical proximity and perceived quality of service in terms of technical efficiency. Additionally, Mremi *et al.* (2018) mentioned that poverty, economic factors and knowledge concerning the type of illness were the main factors in deciding the type of treatment to be taken when a person falls sick. Therefore, this study aims to assess the socioeconomic differences and health-seeking behaviour among locals in coastal communities.

Despite the various explanations of health-seeking behaviour this study there is limited documentation on how people seek healthcare services in association with social and economic differences among locals in coastal communities. Understanding gaps, barriers, and other factors will further influence healthcare choices among locals in coastal communities. This study intended to understand the socioeconomic differences among locals and their health-seeking behaviour.

The general objective of this study was to assess socio-economic differences and their relationship with health-seeking behaviour among locals in coastal communities. Specifically, this study sought: (i) To establish factors influencing health-seeking behaviour among locals in coastal communities, and (ii) To determine the variations between socioeconomic differences and health-seeking behaviours among locals in coastal communities. These objectives were achieved by answering two research questions, namely, (i) Factors that influence health-seeking behaviour among locals in coastal communities, and (ii) How socio-economic differences influenced health-seeking behaviour among locals in coastal communities.

## **2. Materials and Methods**

### **2.1 Study Area and Justification**

The study was conducted in the Kaole Suburban area, within Dunda ward in Bagamoyo District Council. Bagamoyo is one of the six districts of the Coastal (Pwani) Region of Tanzania. Bagamoyo District is situated 75 km north of Dar-es-Salaam (Bagamoyo District Profile, 2009). It is bordered to the north by the Tanga Region, to the west by the Morogoro Region, to the east by the Indian Ocean, and to the south by the Kinondoni and Kibaha Districts (Bagamoyo District Profile, 2009). Bagamoyo District lies between 370 and 390 Longitude and between 60 and 70 Latitude (DP 2006; 2009). The district covers an area of 9,842 km<sup>2</sup>, where 855 km<sup>2</sup> is covered by water (Ocean and river), while the remaining part, which is 8,987 km<sup>2</sup>, is occupied by dry land (Bagamoyo District Profile, 2009). Dunda ward has been chosen because it is among the wards located along the coast in the Bagamoyo district council. Locals in the area engage in fishing, seaweed farming, tourism activities, farming, and other petty business. Furthermore, the locals within the study area have their ways of seeking healthcare services, while others tend to attach meaning to certain diseases as well as treatments based on their beliefs and context (Bagamoyo District Profile, 2009). In terms of access to health facilities, literacy level, and availability of health care, the selected ward has two health facilities. Meaning,

a public health centre and a private hospital with few medical stores (Bagamoyo District Profile, 2009).

## **2.2 Study Design and Setting**

This was a cross-sectional study, designed as a mixed-method approach; both qualitative and quantitative data were collected from the study area. Triangulation of data collection methods enhances the validity and reliability of the collected data (Rwegoshora, 2016). The design provides more insight into the topic under study. In the qualitative, the design enables the researcher to capture respondents' attitudes, feelings, and opinions on health-seeking behaviour (Cheung *et al.*, 2016). Interviews and questionnaires were the main data collection instruments. The design allows the researcher to comprehend factors that influence health-seeking behaviours among locals in the coastal communities through interviews and focus group discussions and to obtain qualitative data related to the study objectives. Moreover, structured questionnaires take less time with a higher response rate, provide clear instructions and enable the respondent to understand easily. In the FGD discussion respondents freely expressed their views, and opinions without any interference, one after another and built on their points about the topic under study (Rwegoshora, 2016). In the quantitative approach, simple random sampling was used to select the study participants to capture their experience with health-seeking behaviour, a total of 196 respondents were interviewed and a structured questionnaire was used to collect data.

## **2.3 Sample techniques and sample size**

The sampling process involved three main procedures. First, the sample is purposefully sampled by selecting the ward located along the ocean. Dunda Ward was purposefully selected; it has 16 suburban areas. Second, was the selection of suburban areas, whereby five suburban areas were selected within Dunda ward as they are located along the ocean. After the selection of the study ward and suburban area, the next step was to identify specific households that were surveyed and interviewed as respondents and key informants. The total number of households from the five selected suburban areas was 1216, including Mwambao (147), Dunda (219), Majanimapana (700), Kaole Bondeni (77), and Kaole secondary (73) (Bagamoyo District Profile, 2009). The statistical analysis requirements approach was used, whereby the formula for calculating the sample size developed by Cohen (2014) was used to calculate the sample size as follows:

$$S = \chi^2$$



$$\frac{NP(1-P)}{d^2(N-1)+X^2P(1-P)} \dots\dots\dots \text{Equation 1}$$

Where X = Z –score (1.96 for confidence level)  
 P = population portion (50% for maximum sample)  
 d = degree of accuracy (0.05 for 95% confidence level)  
 N = population size (1216)

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

$$\frac{1 + (1.96)^2 \cdot 0.5(1-0.5)}{(0.5^2)(1216)}$$

$$\frac{3.8416 \times 0.25}{0.0025}$$

$$1 + \frac{3.816 \times 0.25}{304}$$

$$\frac{0.9604}{0.0025}$$

$$1 + 0.954$$

$$\frac{384.16}{1.954}$$

$$n = 196.6$$

The total number of households to be surveyed as per the formula developed by Cohan (2014) was 196; however, the researcher managed to collect information from 200 respondents. The specific households to be surveyed as per selected suburban within Dunda ward were as follows:

$$\text{Mwambao (147)} = 147 \times \frac{196}{1216} = 24 \text{ Households}$$

$$\text{Dunda (219)} = 219 \times \frac{196}{1216} = 35 \text{ Households}$$

$$\text{Majanimapama (700)} = 700 \times \frac{196}{1216} = 112.8 = 113 \text{ Households}$$

$$\text{Kaole Bondeni (77)} = 77 \times \frac{196}{1216} = 12 \text{ Households}$$

$$\text{Kaole Sekondari (73)} = 73 \times \frac{196}{1216} = 12 \text{ Households}$$

## **2.4 Data Analysis**

Data obtained through the questionnaire were coded, summarised and fed into the computer using the SPSS software. The chi-square test was carried out to establish the level of significance in differences ascribed to the resulting responses, whereas data from in-depth interviews and FGD were coded into themes following the specific objectives of the study (Rwegoshora, 2016). Eventually, the findings were presented using simple frequency tables, pie charts, and histograms coupled with narrative presentations.

## **3. Results and Discussion**

### **3.1 Socioeconomic characteristics of respondents**

The sociodemographic characteristics of respondents included descriptions of their gender, age, education, occupation, marital status, and religion. Table 1 shows that the total number of cases was 200, of which 66 (33%) were male and 134 (67%) were female respondents. There were more female respondents than men, meaning that more female respondents were found in various households during the survey. Findings from the study revealed that more respondents were in the 32 - 39 age group than in the remaining three age groups. The age groups in this study represented different categories of respondents within the study with variations in health-seeking behaviour. In terms of occupation (55%) and (72%) of male and female respondents, respectively, were doing petty business, meaning that few of the respondents were employed 10% and 7%, respectively. The findings of the study further revealed that (29%) and (75%) of male and female respondents had secondary education. Similarly, Siddiqui (2014) argued that education is directly related to the health-seeking behaviour of people in respective areas. In terms of marital status, (68%) and (96%) of male and female respondents were married. While (71%) and (83%) of male and female respondents were Muslims. There was no significant difference between gender, age group, education, occupation, marital status, and religion concerning health-seeking behaviour among locals in the study area, as described in Table 1. Meaning, that the pattern of health-seeking behaviour among locals within the study area was not influenced by gender, age group, education, occupation, marital status, and religion. Additionally, health-seeking behaviour is an important factor to study in coastal communities, as noted in Martiyana and Handayani (2016), who noted that coastal communities in Indonesia are usually poor and have low education. These two factors alone may affect their healthcare-seeking behaviour, which will eventually affect their health. Their study further reported that only (88.5%) of farmers and fishers accessed the antenatal care service (ANC) and (71.2%) went at least 4 times. It

was also reported that (25%) of this group of the population gave birth without assistance from health professionals. Winkelman (2008) was of the view that how people understand and react to illness is culturally and biologically determined.

**Table 1: Socio-demographic characteristics of respondents**

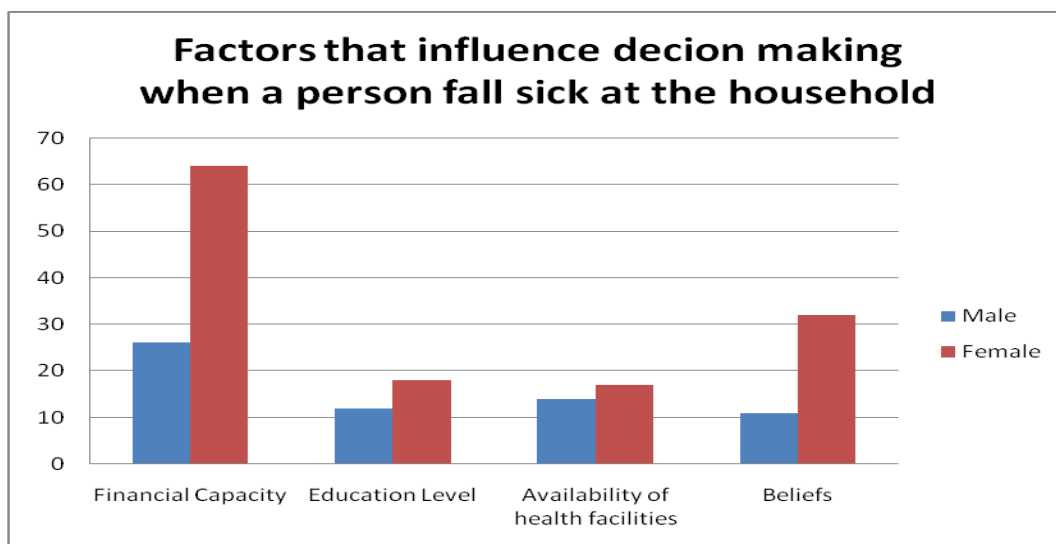
Characteristics:	Gender		P-Value
	Male (n)	Female (n)	
<b>Age:</b>			
18 -25years	4 (6%)	18 (13%)	.026
25–32 years	12 (18%)	39 (29%)	
32–39 years	26 (40%)	40 (30%)	
Above 40 years	24 (36%)	3 (28%)	
<b>Total</b>	<b>66 (100%)</b>	<b>134 (100%)</b>	
<b>:Occupation:</b>			
Employed	8 (12%)	10(7%)	.074
Self Employed	22 (33%)	52(39%)	
Petty Business	36 (55%)	72(54%)	
<b>Total</b>	<b>66(100%)</b>	<b>134 (100%)</b>	
<b>Education Level:</b>			
Primary	21(32%)	44(33%)	.003
Secondary	29 (44%)	67(50%)	
Tertiary	6 (9%)	21(16%)	
University	10 (15%)	2(1%)	
<b>Total</b>	<b>66 (100%)</b>	<b>134 (100%)</b>	
<b>Marital Status:</b>			
Married	45 (68%)	96(72%)	.540
Single	17 (26%)	28(21%)	
Divorced	4 (6%)	10(7%)	
<b>Total</b>	<b>66 (100%)</b>	<b>134(100%)</b>	
<b>Religion:</b>			
Muslim	47(71%)	111(83%)	.147
Christianity	19 (29%)	23(17%)	
<b>Total</b>	<b>66 (100%)</b>	<b>134 (100%)</b>	

**Source:** Surveyed Data, June 2023

### **3.2 Forces that influence the choice of treatment to be taken at the household level**

Findings from the study revealed that among the factors that influence the decision to be taken at the household level when a person falls sick, vary include financial capacity, education level, availability of health facilities, and belief

towards a particular disease. It was revealed that (25%) and (65%) of male and female respondents, respectively, agreed that financial capacity was the most determinant factor. This was followed by beliefs towards a particular disease by (11%) and (32%) of male and female respondents, respectively. It was also noted by Zhou *et al.* (2020) also noted that health-seeking behaviour is preceded by a decision-making process that is further governed by individual and/or household behaviour community norms and expectations, and provider-related characteristics and behaviour. Deolia *et al.* (2020) pointed out that behaviour is also influenced by beliefs on disease perception or attribute causation based on tradition, intuition, supernatural, and magic behind certain diseases, such as evil eye, infection, or accident, and treatment is based on beliefs like by the medical doctors or traditional healers. It has been further noted by El-Ghitany *et al.* (2018), that people do not seek one source of health care and differ in their behaviours according to who is affected and what diseases are experienced. The nature of health-seeking behaviour is not homogenous as it varies based on both cognitive and non-cognitive factors, which calls for a contextual analysis of care-seeking behaviour. Context may be a factor of cognition or awareness as well as sociocultural and economic factors (Deng and Liu, (2017). Figure 1 shows factors that influence decision-making when a person falls sick at the household level.



**Figure 1:** Factors influencing decisions at the household level

It was further added by the participant in a female FGD that:

*The nature of the disease was among the factors that influenced the decision to be taken at the household level. This is because other diseases are highly attached by certain circumstances such as falling abruptly and making noise, which is closely related to the so-called 'kapatwa upepo mbaya', and the only*

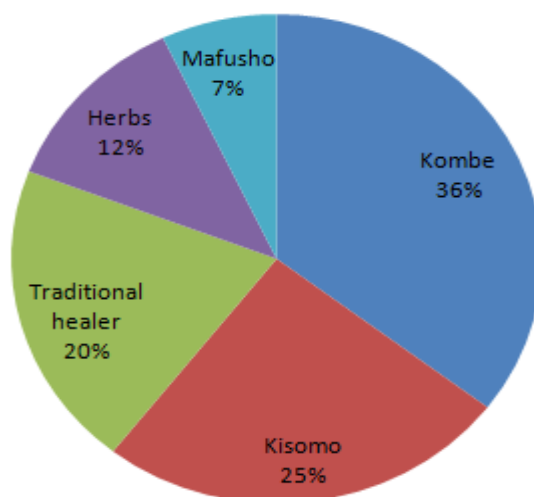
*treatment is spiritual healing from the sheikh. It was further supported by another participant in the FGD that time is another factor; thus, if someone falls sick during the late at night, you can assist the patient by providing an inhaler or 'mafusho'. In other words, to inhale a kind of air mixed up with local herbs, the patient is supposed to be covered by either a bed sheet or kanga. This is an initial kind of treatment for the patient before taking the respective patient to the nearby health facility (Female participants in an FGD, Kaole Bondeni Suburban, Dunda Ward, June 2023).*

Another male participant in the focus group discussion (FGD) had the following views:

*The majority of health facilities involve the use of money for treatment. In this regard, it is easier to go to the traditional healer available in the area rather than a nearby health facility because little money is used to the traditional healer and you get cured (Male participants in FGD, Mwambao Suburban, Dunda Ward, June 2023).*

### **3.3 Local medicine commonly used in the study area**

Findings from the study further revealed that there were five local medicines mainly used by locals in the area as their pattern of seeking treatment once they fell sick. This included *kombe* (a drink mainly used by locals by (32%), followed by Kisomo (22%) (a kind of spiritual healing used by locals), herbs by (18%), mafusho or local inhaler by (15%), and traditional healers by (13%). Figure 2 shows the commonly used local medicine in the area.



**Figure 2:** Local medicine mainly used in the study area

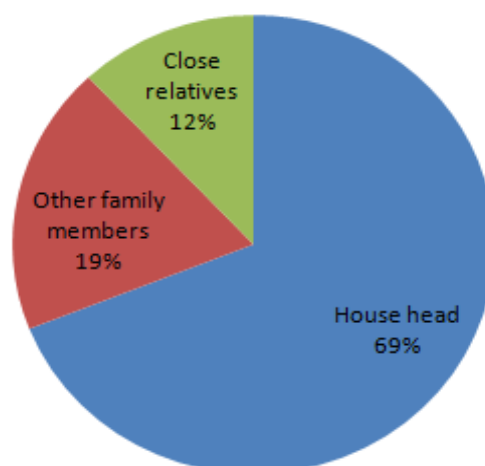
It has been noted by Sullivan *et al.* (2018) that there are several patterns of resort in seeking treatment that are applied by both local people and the elite in communities. For them, in health-seeking behaviour, people are essentially pragmatic as they will do what they think is necessary for survival, using the resources available to them. They may use different avenues of treatment that have very little to do with one another. Vasquez (2020) reported that the health-seeking behaviours of a rural village take into consideration the social, cultural, economic, political, and historical factors that influence those behaviours.

It has been further explained by one of the participants in the male focus group discussion that:

*More traditional methods of healing are perceived by locals to have power and efficacy rather than using modern medicine. However, in some circumstances, the two can be combined, meaning modern and traditional methods of healing* (Male participants in FGD, Majani mapana Suburban, Dunda Ward, June 2023).

### **3.4 Decision at the household level in health-seeking behaviour**

Findings from the study revealed decision-making was mainly made by the household head (69%) followed by other family members (19%) and close relatives (12%). This means household heads were responsible for making decisions when a person fell sick at the household level. Figure 3 provides more information on health decisions made at the household level in the study area.



**Figure 3:** Health decisions at the household level when a family member falls sick

In contrast, Winkelman (2008) noted that health decision-making within families had changed over time, with responsibility and authority no longer held solely by the head of the household as it had been in the past. However, for the majority of participants, health decisions were made collectively and informed by the opinions of family members, partners, and, in some cases, employers. This was often linked to the financial implications of care choice.

### **3.5 Most common diseases in the study area**

The study findings revealed that the most common diseases in the area include malaria (25%), urinary tract infection (22%), upper respiratory tract infection (20%), migraine headache (15%), and other diseases (18%). It has been reported that malaria is a tropical endemic disease that comprises the number one public health problem in Bagamoyo. It has been noted that malaria is the major cause of mortality and morbidity and has an economic burden on communities (Bagamoyo District Profile, 2009).

### **3.6 Available health facilities in the study area**

It has been revealed that there are eight health facilities in the study area and seven medical stores. Additionally, the study findings revealed that health facilities are owned by the government to a large percentage, followed by private ownership. In the mentioned health facilities, findings revealed that several services are provided, such as laboratory services, treatment, consultation, and other medical services. It has been further noted that the distance to the health facility is not very far by (76%) and (70%) of male and female respondents, respectively, while few reported that it involves the use of a car or motorcycle (9%) and (8%) respectively. The study findings further revealed that both female and male respondents had similar views on whether the prevalent health facilities involved the use of money or not. This is because both female and male respondents reported that the majority of health facilities involve money in the provisioning of health services (67%) and (33%) respectively. The above was further supported by one of the participants in the male focus group discussion, as he was of the view that:

*“Locals in the area saw medical stores as a suitable option for common diseases such as colds, coughs, and headaches. Once a condition is thought to be more serious, other options for the treatment will be chosen, mostly will be more formal services with the use of money”*

(Male participants in FGD, Kaole secondary Suburban, Dunda Ward, June 2023).

### 3.7 Relationship between forces behind decisions to be made and health-seeking behaviour

Findings from the study revealed that 57.5 and 23.5 per cent of female and male respondents, respectively, agreed that there was a relationship between the decision to be taken when a person falls sick at the household level and cultural practices in the study area. While (9.5%) and (9%) of female and male respondents, respectively, reported that there was no relationship. Similarly, a female respondent in a focus group discussion (FGD) was of the view that:

*It is very easy to understand what is common. It is very difficult to understand a serious disease. Therefore, if it is very serious or not stable, then I talk to older people in the family. They eventually assist by advising the use of local medicine. If the disease persists, the patient will go for a different care-seeking avenue for further treatment* (Female participant in FGD, Kaole Bondeni Suburban, Dunda Ward, June 2023).

It has been further pointed out that in case of uncertainty and confusion created by fragmented provision of services, contradictory recommendations are received. The situation impacted the decision-making power, as it is associated with economic autonomy, hence affecting the competing household financial priorities more. Therefore, the use of local herbs is inevitable as they are affordable and easily accessible (Mannan, 2018). It has been further revealed that there was no statistically significant difference between the decision to be taken when the family member falls sick versus the predominant culture practices within the study area, as shown in Table 2.

**Table 2: Chi-square tests between the decisions made at the household level and the existing cultural practices in the study area**

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.847 <sup>a</sup>	1	.174		
Continuity Correction <sup>b</sup>	1.334	1	.248		
Likelihood Ratio	1.783	1	.182		
Fisher's exact test				.221	.125
Linear-by-Linear Association	1.838	1	.175		
N of Valid Cases	198				



- 
- a. 0 cells (0.0%) have an expected count of less than 5. The minimum expected count is 10.67.
- b. Computed only for a 2x2 table

#### **4. Conclusions and Recommendations**

Health-seeking behaviour is a complex phenomenon. Findings from the study revealed that the most determinant factor in health-seeking behaviour is financial capacity, followed by beliefs, education level, and availability of health facilities. It has been noted that there are several health facilities in the study area, although all facilities involve the use of money. More importantly, cultural practices nature of the disease, and beliefs towards a particular disease influence the decision to be taken when a person falls sick at the household level. However, the household head is responsible for the decision-making process. The whole process of health-seeking behaviour in the study area takes into consideration internal and external factors that influence health understanding, ill experiences, and health-seeking behaviour. Therefore, this study recommends that the following locals within the study area should use the available health services once they fall sick: The decision about health care should be made by understanding illness, seriousness, and financial capacity for the health and productive community.

#### **2. Acknowledgement**

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