

CHAPTER FOUR

A STUDY OF HOUSING CONDITIONS AND UTILIZATION OF HEALTH SERVICES (WITH PARTICULAR REFERENCE TO ACHIMOTA VILLAGE, ADABRAKA AND TESANO) IN ACCRA¹

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From the standpoint of sociology, statistics on utilization of health services can be used as indices of certain kinds of population behaviour. They reveal how much health services are expected to cost under varying circumstances. From the standpoint of medical care, they may show to what extent a population is receiving medical care. In other words, utilization of health services reveals varying patterns of significance to a wide range of interests. It is reasonable to assume that patterns of utilization are not quixotic. In socio-cultural contexts, patterns of utilization are related to such factors as definition of health, age and sex composition of the population, presence or absence of health facilities, family, income, residence, and the perceptions of providers and recipients of health services. All of these are important, but some have more bearing on utilization than others. The socio-economic position of the individual has implications for the utilization of health services. In Ghana the type of housing one occupies can be used as an index of his socio-economic status vis a vis health standard. Occupation is also an important variable in this regard. In this context we shall examine the relationship between socio-economic status and the utilization of health services. Put differently the principal incentive in undertaking this study stems from the promise it affords to raise and to re-examine a number of challenging problems about socio-economic position and the utilization of health services.¹

Illness we know is an inevitable factor in every social group, with its social, psychological as well as biological implications. It is disruptive of social relationships and this fact of life must be explained and dealt with in some manner by each family unit and/or society, both pragmatically and philosophically.²

It is necessary to indicate the nature of the interrelationship between one's socio-economic standard and utilization of health services. What we consider of fundamental importance is to examine the manner in which one's social position continues to determine his health status. In approaching this problem the manifest objective is to formulate, at least in an exploratory way, an adequate sociological explanation of the nature of the interrelationship.

Such an approach to the study may be best understood through voluntaristic theory of action; because it goes without saying that the human variable is the most variable of all variables. We can only take certain factors into consideration. Very briefly, this scheme involves a subjective process of orientation to an objective situation. The influence of various norms enter into the determination of ends and govern the choice of means thereto. To an actor the scheme imputes a limited freedom to choose between alternatives and to indicate action.

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Action is thus teleologically conceived as a process directed toward the realization of goals or toward the expression of values. The individual uses his very limited powers of prediction and control in an attempt to bring some portion of the future into harmony with his social position, his ends and values.

Action implies effort directed toward the overcoming of obstacles. Action carries with it the ever present possibility of frustration and failure. Outcomes are only meaningful in terms of how the individual uses his resources available to maintain his health. The actor is thus forever involved in problems of "economizing", that is to say in counting costs of any given projected line of action in terms of the sacrifices the course he takes entails for other values he holds important.³

Using the different types of housing, it is possible to classify the residence in three areas (Achimota Village, Adabraka and Tesano) into strata of high, middle and low income groups of respondents. In a preliminary way it is possible to show the relationship between the housing type and one's socio-economic standing. As a component variable, socio-economic status usually indicates the occupation, incomes, residence and education. In operationalizing the variable socio-economic index we shall refer to occupation, residence and education. In this direction the housing type is an important determinant. In this regard, it is necessary to present some aspects of health problems that can be studied in their true social context and with the supporting facts and figures.

Field Method

The traditional field techniques were used in the study. These were interviewing, questionnaire and observation. The field assistants were first year medical students of the University of Ghana Medical School who carried out the project during the months of May, June, July and August of 1972. The students underwent intensive training in field work to give them the necessary background. It was necessary to provide this background in order to bring some measure of reliability and validity into the field data collected.

Sampling

The sampling scheme adopted was stratified sampling. We began this scheme with systematic sampling procedure with a random start for each stratum. Put explicitly the sampling technique adopted was based on the sampling theory of equi-probability.⁴

The three reference areas were: Achimota Village, Adabraka and Tesano. These areas, we refer to as survey areas, and could be regarded as low, middle and high income communities, respectively. These differences whereas allowing us to obtain more information do not contribute to the sampling error of the population mean.⁵

The choice of sample size for each stratum is an important consideration in any stratified sampling. If a stratum shows more variability than the others a larger sample is taken whereas a stratum of less variability gets a smaller sample. This method enabled us to explain variability more meaningfully. Our sample sizes were: (Achimota Village: 94 houses, 430 household; Adabraka: 428 houses, 1849 households; Tesano: 90 houses, 370 households.

Social Characteristics

We looked at ethnicity, sex composition, educational background, religious affiliation and marital status. Table 1 reflects the ethnic composition of the study areas. As pointed out by Addo and Kpedekpo⁶ (Community Health Survey Reports, 1967) this ethnic composition also reflects the migratory status of the population.

TABLE 1: ETHNIC COMPOSITION

Ethnic Composition	Achimota Village		Adabraka		Tesano		Total	
	No.	%	No.	%	No.	%	No.	%
No Answer	4	0.93	20	1.08	21	5.67	45	1.69
Ashanti/B. Ahafo ...	43	10.00	115	6.21	75	20.27	233	8.79
Gas, Adangbes, Krobos	127	29.53	690	37.31	60	16.21	877	33.10
Ewe	136	31.62	239	12.92	91	24.59	466	17.59
Fanti	33	7.67	92	4.97	29	7.83	154	5.81
Akwapim	19	4.41	200	10.81	4	1.08	223	8.41
Northern Ghana ...	27	6.27	113	6.11	17	4.59	157	5.92
Other Akan	11	2.55	259	14.00	28	7.56	298	11.24
Other African	30	6.97	110	5.94	11	2.97	151	5.70
Non African	—	—	11	0.59	34	9.18	45	1.69
Total	430	100.00	1849	100.00	370	100.00	2649	100.00

The Akans predominate — 34.22 per cent (when all the subgroups are put into the classificatory category of Akan). It is followed by the Ewes 31.69 per cent, and the Gas, Adangbes and the Krobo group, with 29.53 per cent.

TABLE 2: Sex Composition of Head of Household

Sex	Achimota Village		Adabraka		Tesano		Total	
	No.	%	No.	%	No.	%	No.	%
No Answer	1	1.06	3	0.70	—	—	4	0.67
Male	63	67.02	288	67.28	73	81.11	424	69.28
Female	30	31.91	137	32.00	17	18.88	184	30.06
Total	90	100.00	428	100.00	90	100.00	612	100.00

There are more male heads of households than female heads of households; 69.28 per cent are male heads and 30.06 per cent are female heads. It is not surprising because in both matrilineal and patrilineal systems males tend to be heads of family units. In the locations where females were heads, matrifocality was the norm.

TABLE 2B Sex of People in Household

Sex	Achimota Village		Adabraka		Tesano		Total	
	No.	%	No.	%	No.	%	No.	%
No Answer	—	—	1	0.05	—	—	1	0.05
Male	184	42.79	903	48.83	196	52.97	1283	48.43
Female	246	57.20	945	51.10	174	47.03	1365	51.52
Total	430	100.00	1849	100.00	370	100.00	2649	1000.00

The females outnumbered the males in the total population. The figures are 51.52 per cent females and 48.43 per cent males. It is only in Tesano that there are more males (52.97 per cent) than females (47.02 per cent). These figures do not differ significantly from the population census of 1960 (see also W. Birmingham, Neustadt and Omaboe "A Study of Contemporary Ghana;" George Allen and Urwin Ltd., 1967).⁷

A substantial number of heads of households have attended school (see Table 4). Of the educational status of the members of the households, all of the members of the different households have some form of formal education, in Achimota Village. In Adabraka 24.01 per cent have no formal education. In Tesano, 21.89 per cent have no formal schooling. This significant percentage of people with no formal education (in Tesano) is due to the fact that being a residential area for people of the higher socio-economic standard, the families keep household boys, gardeners and maids, who are illiterates. The point still stands, on the basis of the data, that in terms of educational standing, Tesano ranks very high.

TABLE 3 Educational Status of Members

Type of Education	Achimota Village		Adabraka		Tesano		Total	
	No.	%	No.	%	No.	%	No.	%
No Answer	11	21.55	85	4.48	13	3.51	107	4.03
Primary	87	20.23	39	21.14	87	23.51	565	21.32
Middle	109	25.34	540	29.20	79	21.35	728	27.48
Arabic	3	0.69	34	1.83	1	0.27	38	1.43
Secondary	24	5.58	225	12.16	56	15.13	305	11.51
Technical	9	2.09	31	1.67	6	1.62	46	1.73
Teacher Trng.	4	0.93	20	1.08	4	1.08	28	1.05
Commercial	9	2.09	55	2.97	9	2.43	73	2.75
University	3	0.63	26	1.40	34	9.18	63	2.37
None	—	—	444	24.01	81	21.89	696	26.27
Total	430	100.00	1849	100.00	370	100.00	2649	100.00

TABLE 4 Education of Head of Household

Type of Education	Achimota Village		Adabraka		Tesano		Total	
	No.	%	No.	%	No.	%	No.	%
No Answer	3	3.19	4	0.93	1	1.11	8	1.30
Primary	5	5.31	27	6.30	4	4.44	36	5.88
Middle	36	38.29	193	45.09	20	22.22	249	40.68
Arabic	—	—	12	2.80	1	1.11	13	2.12
Secondary	3	3.19	57	13.31	16	17.77	76	12.41
Technical	6	6.38	13	3.03	5	5.55	24	3.92
Teacher Trng.	4	4.25	15	3.50	1	1.11	20	3.26
Commercial	7	7.44	17	3.97	2	2.22	26	4.24
University	2	2.12	8	1.86	24	26.66	34	5.55
None	28	29.78	82	19.15	16	17.77	126	20.58
Total	94	100.00	428	100.00	90	100.00	612	100.00

Of the types of occupation we divided the categories into unskilled, skilled, farmer, fisherman trader, sales worker, clerical staff, retired, professional and administrative classes. Among the professional and administrative categories, 44.44 per cent reside in Tesano (professionals 31.11 per cent; administrative-executive class 13.33 per cent. Of these classes, Achimota had 20.12 per cent and Adabraka 19.39 per cent. Of the unskilled category, 21.11 per cent were found in Tesano: is indicative of the fact that unskilled people are mostly employed as general factotums, cleaners, housemaids and the like. In comparative terms, the professionals and the administrators live in Tesano. Tesano, in relative terms, is of high socio-economic status.

In the three survey areas, it was noted that, of the total population, 13.5 per cent were unemployed. Of this figure, the majority reside in Achimota Village (of a total of 430 Achimota respondents, 71 were unemployed; in Adabraka of the total population of 1849, 256 were unemployed; in Tesano of the total of 370, 33 were unemployed). The corresponding percentages for each community are: Achimota Village, 16.51 per cent; Adabraka 13.84 per cent and Tesano 8.91 per cent. It is also interesting to note that 12.64 per cent were in the category of pre-school age; 30.46 per cent were pupils and/or students; The point we need to stress is that a sizeable percentage of the population (58.12 per cent) depend on relatives. The dependency ratio is high (not uncommon in developing economies). In this regard Tesano had 46.21 per cent of pre-schoolers and students. In Adabraka, the figure was 42.34 per cent; and in Achimota Village, 43.71 per cent. A fairly sizeable percentage of relatives were found living together in Achimota Village, 41.49 per cent; Adabraka, 62.14 per cent and Tesano, 63.55 per cent. Many families own their houses in Tesano: 46.67 per cent live in their own houses. In Achimota Village, 60.63 per cent rent houses; and in Adabraka, 63.55 per cent rent houses (they do not live in their own houses). This is not surprising because most of the lower income group live in the Achimota Village and Adabraka areas.

Most of the population were Christians (76.03 per cent). Of the Christian population, 27.59 per cent were Presbyterians, followed by Methodists, 23.25 per cent; Catholics, 13.62 per cent; Anglicans, 10.98 per cent and Zion Church members, 0.56 per cent (see Table 5).

In terms of marital status, the majority of the population were married, (in Achimota Village 70.21 per cent were married; in Adabraka, 63.55 per cent and Tesano 64.44 per cent). Of the single, Achimota had 15.95 per cent; Adabraka, 17.05 per cent and Tesano had 32.22 per cent. However, most of the heads of the families were married.

TABLE 5
Religion of Members of Households

Type of Religion	Achimota Village		Adabraka		Tesano		Total	
	No.	%	No.	%	No.	%	No.	%
No Answer	25	5.81	43	2.35	12	3.24	80	3.02
Moslem	55	12.79	208	112.4	25	6.75	288	10.87
Catholic	69	16.04	200	10.81	92	24.86	361	13.62
Methodist	41	9.53	509	27.52	66	17.83	616	23.25
Presbyterian	101	23.48	524	28.33	106	28.64	731	27.59
Zion	—	—	14	0.75	1	0.27	15	0.56
Spiritual Church	17	3.95	46	2.48	28	7.56	91	3.43
Traditional Pagan	9	2.09	29	1.56	5	1.35	43	1.62
Anglican	37	8.60	228	12.33	26	7.02	291	10.98
Others	76	17.67	48	2.59	9	2.43	133	5.02
Total	430	100.00	1849	100.00	370	100.00	2649	100.00

Summary Notes of the Social Composition of Survey Areas

1. The ethnic composition is quite heterogeneous, reflecting the fact that as an urban area, with the necessary acquisition of the required skills many Ghanaians from the hinterland prefer to stay and work in Accra.
2. The sex ratio: there are more females than males.
3. The dependency ratio is quite high in keeping with a common demographic characteristics of developing economies.
4. Of the three areas studied, Tesano is regarded as a high socio-economic area.

Housing Conditions

The physical conditions of the houses, spacing, house and household amenities, physical outlay, were considered to be important to reflect the household health status. In this regard, the criteria used to judge the type and quality of houses were the following: mosquito netting, drainage system, type to bathroom, type to water system, toilet facilities and type of kitchen facilities. Using these criteria we arrived at the following classification (see Table 5).

TABLE 6: Distribution of Houses by Standard (See Appendix)

Categories of Housing Standard	Achimota Village		Adabraka		Tesano		Total	
	No.	%	No.	%	No.	%	No.	%
Above Average	1	1.06	4	0.93	27	30.00	32	5.22
Average	32	34.04	230	53.73	54	60.00	316	51.63
Below Average	61	64.89	194	45.32	9	10.00	264	43.13
Total	94	100.00	428	100.00	90	100.00	612	100.00

Tesano has predominantly more houses in the above and average categories. Of the total 90 houses, 30% were in the above average type (meaning the household amenities, sanitation systems, etc. were adequate); and 60% of the houses were in the average category. Only nine houses (10%) were found to be below average category. On the basis of the data presented we can safely conclude that of the three areas, Tesano is judged to approximate a relatively healthy living area. In this regard, our main basic postulate is that a healthy living environment helps inmates to prevent many health hazards. To live in a healthy environment means that the individuals or their relatives possess the means to enable them to keep their environment healthy and to provide the required amenities. These indices reflect one's socio-economic status.

Utilisation of Health Services and Health Awareness

In the city of Accra, the health and welfare of the population are provided by a number of statutory and voluntary institutions, by a number of private physicians and other paramedical personnel (see Health Statistics 1970, Ministry of Health, Publication).⁸ The Central Government, however, is the largest single employer of doctors and other paramedical personnel. Most of the doctors and other medical personnel work in Korle Bu Teaching Hospital, the Polyclinics and other Clinics in the city.

Of the survey area, only Adabraka has a polyclinic (situated near the mental hospital). In the Achimota Village area, the inhabitants travel outside their area to seek medical aid. In Tesano, there is no government medical establishment but there are few private practitioners.

Most of the population prefer to go to Korle Bu Hospital. As the specialist facilities are available in Korle Bu, the majority of the patient population (whose illnesses demand specialist attention) will have to end up in Korle Bu. There are no government facilities in both Achimota Village and Tesano so, a significant percentage prefer to seek private medical attention (Achimota Village, 26.59 per cent; Tesano, 27.77 per cent seek private medical attention). These data do not indicate the type of private medical attention. However on the basis of data provided in preceding pages, I would suspect that since many private practitioners loom large in Tesano, Tesano sick population (who seek private attention) will be able to go to private medical personnel because they can afford to pay; whereas the Achimota sick population who seek private medical attention may not be able to afford the services of private practitioners.

TABLE 7

Do You Go Outside Area To Seek Aid?

Type of Clinic	Achimota Village		Adabraka		Tesano		Total	
	No.	%	No.	%	No.	%	No.	%
No Answer	2	2.12	46	10.74	1	1.11	49	8.00
Korle Bu	15	15.95	101	23.59	21	23.33	137	22.38
Ridge	—	—	7	1.63	1	1.11	8	1.30
Children P'nic.	1	1.06	1	0.23	—	—	2	0.32
Mental Hospital	—	—	3	0.78	2	2.22	5	0.81
Military	3	3.19	4	0.99	2	2.22	9	1.47
Tema	1	1.06	—	—	—	—	1	0.16
Private	25	26.59	31	7.24	25	27.77	81	13.23
Adabraka P.	16	17.02	4	0.93	4	4.44	24	2.92
Kaneshie P.	1	1.06	—	—	5	5.55	6	0.98
Korle Bu	4	4.25	10	2.23	—	—	14	2.28
Labadi	—	—	2	0.46	—	—	2	0.32
Kotobabi	2	2.12	8	1.86	2	2.22	12	1.96
Jamestown	—	—	1	0.23	—	—	1	0.16
Other	12	12.76	18	4.20	14	15.55	44	7.18
Not Applicable	12	12.76	190	44.30	13	14.44	215	35.13
Total	94	100.00	428	100.00	90	100.00	612	100.00

Within a given year, when respondents were asked whether they have sought medical attention, these were the figures (see Table 8).

TABLE 8

SOUGHT MEDICAL ATTENTION 1972

Sought Medical Attention	Achimota Village		Adabraka		Tesano		Total	
	No.	%	No.	%	No.	%	No.	%
No Answer	4	4.25	11	2.57	7	7.77	22	3.59
Yes	40	42.55	218	50.93	34	37.77	292	47.71
No	50	53.19	199	46.49	49	54.44	298	48.69
Total	94	100.00	428	100.00	90	100.00	612	100.00

Significant variables, such as type of illness, age, sex, etc. are not obtained. However these data suggest that only 37.77 per cent of the people in Tesano have sought medical aid, whereas in Adabraka 50.93 per cent and in the Village 42.55 per cent have sought medical aid.

TABLE 9

MEDICAL ATTENDANCE THIS YEAR BY EDUCATION

	Achimota Village Education				Adabraka Education				Tesano Education				Total Education			
	Yes		No		Yes		No		Yes		No		Yes		No	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No Answer...	2	5.8	3	5.0	4	2.4	8	3.1	6	10.0	2	6.7	12	4.5	13	3.7
Yes ...	12	35.2	47	78.4	66	38.8	160	62.0	14	23.3	18	59.9	92	34.9	225	64.6
No ...	20	58.8	10	26.7	100	58.8	90	34.9	40	66.8	10	33.3	160	60.6	110	31.6
Total ...	34	99.8	60	100.0	170	100.0	258	100.1	60	100.1	30	99.9	264	100.1	348	99.9

There is clear indication that the educated used the health facilities less than the uneducated.

The educated people had good knowledge about health conditions and illnesses. These data then could lead us to infer that the uneducated with lack of knowledge about how we contact diseases will be more prone to health hazards than the educated.

TABLE 10

KNOWLEDGE ABOUT HOW WE CONTACT DISEASES, SUCH AS FEVER, CONVULSION, DIARRHOEA, MEASLES, COUGH, KWASHIORKOR, T.B., V.D., MENTAL ILLNESS, MALARIA

Level of Knowledge	Achimota Village Education				Adabraka Education				Tesano Education				Total Education			
	Yes		No		Yes		No		Yes		No		Yes		No	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Good Knowledge	40	40.0	5	5.5	115	46.0	15	8.3	65	65.0	15	16.6	220	48.8	35	9.7
Fair Knowledge	36	36.0	5	5.5	95	38.0	45	25.0	15	15.0	35	39.0	146	32.4	85	23.5
Poor Knowledge	10	10.0	35	39.0	14	5.6	96	53.4	5	5.0	25	27.7	29	6.4	156	47.4
No Knowledge	14	14.0	45	50.0	26	10.4	24	13.3	15	15.0	15	16.6	55	12.2	84	23.3
Total ...	100	100.0	90	100.0	250	100.0	180	100.0	100	100.0	90	100.0	450	99.8	360	103.9

TABLE II

OPINION ABOUT HOSPITAL PERSONNEL: DOCTORS, MIDWIVES, NURSES

	Achimota Village Education				Adabraka Education				Tesano Education				Total Education			
	Yes		No		Yes		No		Yes		No		Yes		No	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Sympathetic	45	45.0	45	50.0	175	70.0	105	58.3	60	60.0	40	44.4	280	62.1	190	52.6
Rude to Patients ...	20	20.0	35	38.9	35	14.0	45	25.0	10	10.0	30	33.3	65	14.4	110	30.5
Don't Know	35	35.0	20	11.1	40	16.0	30	16.7	30	30.0	20	22.2	105	23.3	60	16.6
Total ...	100	100.0	90	100.0	250	100.0	180	100.0	100	100.0	90	99.9	450	99.8	360	99.7

Generally, the educated seem to understand and appreciate the doctors and the para-medical people (see Table II). Among the educated, 62 per cent said that the medical personnel were sympathetic, 14.4 per cent said that the medical men were rude. Among the uneducated, 52.6 per cent indicated that the doctors were sympathetic. In this area 30 per cent of the illiterates spoke against the medical men.

TABLE 12
EDUCATION AND INFANT MORTALITY

Education Level	No. of Deaths per each Household						Total
	0	1	2	3	4	5+	
No Formal Education	103	16	10	16	2	3	150
Primary	75	8	10	2	3	2	100
Secondary/Technical	90	8	0	1	1	0	100
Teacher Training/Commercial	48	1	1	0	0	0	50
University/Other Equivalent	49	1	0	0	0	0	50
Total	365	34	21	19	6	5	450

The educated had fewer deaths (see Table 12).

Discussion

Poor housing conditions, lack of respectable level of socio-economic standard and poor education are contributory factors in the causation of many preventable diseases (see Health Statistics, 1969).⁸ In Ghana, the argument put forward by the health authorities is that the two main causal agents of infectious diseases are malnutrition and insanitary conditions (see Medical Reports, 1969). These twin processes are more likely to be found in the areas of low income groups and people with little or no education. As the data clearly indicate among the people with decent level of living standards, there is relatively low infant death rate, because of an awareness of health problems and the capacity to live in decent houses. In his *Asian Drama*,⁹ one of Myrdal's central theses is that one cannot isolate health standard from the total developmental processes. The people in the higher socio-economic group are favoured in this respect. They can afford to "live clean." "They can clothe and feed themselves properly, etc." Health affects socio-economic factors and is itself affected by socio-economic factors, notably income and level of living. Recognizing this inter-relationship one must caution against over-simplifying the understanding of health by isolating it from the total developmental process. This implies the notion that rationally (to cut down on the cost factor,¹⁰ the health problem becomes integrated with the general problem of planning for development. It is also difficult to determine how much understanding exists between the illiterate population and the scientific medical community in terms of understanding disease causation and/or establishing cordial therapeutic relationships. Medical sociologists have found that different cultural systems tend to colour one's orientation vis a vis medical notions.¹¹ Data from Achimota Village, Adabraka and Tesano clearly point to this—that consciousness of the kind is developed in people who have had formal education, that the higher one's educational level the more likely he is aware of many health problems and will have the ability to understand the medical people. David Mechanic points out that, whether a person views the doctor as a relevant helper will depend on such varied factors as his social background and information, his personal characteristics, how he perceives and defines particular indications of illness, the social and physical accessibility of the doctor, the personal and monetary costs of seeking medical help compared with alternative approaches to problems and many other social-psychological factors. Precisely Mechanic's insights have relevance, to our situation. The ability of a person to cope with his medical problems depends on how he

defines the problem: the causes he identifies that have brought the problem about, the alternatives he sees for reversing the problem, and the resources he has for making use of various alternatives.

The life styles that characterize various social groups may expose them to different environmental risks which have an important bearing on health status, although such risks may occur with greater frequency and intensity in some social strata as compared with others.¹¹ They are not distributed throughout the socio-economic structure in any fully consistent way because other social-psychological factors need to be taken into account. In short, although it is reasonable to assume that lower social status and poverty may produce greater disease risks and vulnerabilities than does the style of life characteristic of the affluent classes, we must not fail to note the extent to which variability is apparent within particular socio-economic categories.¹² Moreover, as an increasing proportion of the population reaches a level of satisfactory subsistence, linked with a continuing decline in the importance of the infectious diseases affecting health and longevity, it will be increasingly difficult to characterize life styles and health risks through gross socio-economic indicators. At present, however, there is a link between one's social position and health status: that the lower one's social standing the more he is exposed to risk and uncertainty in the area of contacting diseases in our environment.

Recommendations

1. Although doctors must continue to treat human ills in a developing nation such as Ghana, the preventive emphasis is more crucial. These data clearly point out that there is a relationship between one's socio-economic standing and the utilization of health services.
2. Comparative studies of use of health services must allow for possible age, sex and social class differences in the population to be studied. At most, however, these variables may provide some idea of patterns and variations of utilization of services. Except for age and sex, socio-economic variables do not reveal why the variations exist. Future research may look into these. This context then becomes the frontier of social research on the use of health services. There are many social-psychological factors that can be studied, e.g. perceptions of health and health services in different situations, general life styles, the priorities families place on how they spend their monies, and knowledge of disease.

CONCLUSION

The concept of socio-economic status or life-style itself is global; and as it is usually used, it encompasses a large variety of interacting variables: nutrition and housing; infant rearing and care; habits, attitudes, and values; life aspirations and goals; willingness to take risks; self-care and concern with health; and so on. It should at least be clear that investigations relating social status to health status require careful consideration of specific components of the more complex variables of life-styles. What we have done is to use type of housing as an important indication in conceptualizing social status. It has helped us at least in a pragmatic way to categorize life styles and to point out that there is a relationship between one's social position (using housing type) and the utilization of health services.

As Frantz Fanon noted, "Many of the diseases are effects of lack of proper education and economic deprivation." Socio-economic factors are relevant in this regard.

APPENDIX

A STUDY OF HOUSING CONDITIONS AND UTILIZATION OF HEALTH SERVICES WITH PARTICULAR REFERENCE TO THE POPULATION OF ACHIMOTA VILLAGE, ADABRAKA AND TESANO AREAS IN ACCRA JUNE/JULY 1972

Grading of Houses	Code	Points
1. Material of Walls		
Concrete and landcrete	2	7
Swish and woodboard	4	3
Corrugated metal, packing, asbestos	5	1
Others	6	0
2. Material of Roof		
Concrete, metal, asbestos, tiles	2	7
Felt	3	5
Thatch	4	3
Swish, palm leaves, raffia, others	5	1
3. Mosquito Netting		
The whole house	1	10
Some rooms or none	6	0
4. Drainage System		
i. Dirty water from bath and washed clothes		
ii. Dirty water from kitchen		
i and ii	2	7
If only i or ii	3	5
Others	6	0
5. Type of Bathroom		
Bath or shower (for both)	2	7
Without shower or bath (only one)	4	3
Others	6	0
6. Type of Water		
Several points in the house	1	10
One point in the house	2	7
Others	6	0
7. Type of Latrine		
W.C. in house for household	1	10
Pan latrine for exclusive use of household	4	3
Others	6	0
8. Type of Light		
Electricity	2	7
Others	6	0
9. Type of Kitchen		
Gas/Electric	2	7
Coal Pot	4	3
Others	6	0

Points	Grade	Code
55-72	Above Average	1
35-54	Average	2
0-34	Below Average	3

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