Assessment of Factors Influencing Health Seeking Behaviors of Elderly in Bilida Kebele, Manna Woreda, Jimma Zone, South West Ethiopia

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Abstract

Background: Health seeking behavior is preceded by a decision making process that is further governed by individual and/or household behavior, community norms and expectations. Multiple factors influence elderly people's choice and use of health care services. Therefore, there is a need to assess health seeking behaviors of elderly, status and influencing factors.

Objective: Assess health seeking behaviors of elderly, status and influencing factor in Bilida kebele, Manna Woreda, Jimma Zone, South west Ethiopia.

Methods: A descriptive cross-sectional study design was conducted to assess health seeking behaviors of elderly and influencing factor in Bilida kebele. The questions were grouped and arranged according to particular objectives that they addressed and semi structured open ended interview guide was developed and used. Data were coded, numbered, entered and analyzed using SPSS version 20.0. Binary and multivariate Logistic regression was performed to determine each factor and how they are associated with health seeking behaviors. And also chi-square was also used to see if there is association between dependent and independent variables, and significant association considered when p-value is less than 0.05.

Result: The study result shows that, nearly 51.12% are not living with their spouses. This group includes divorcees, widows/widowers and separated older people. About 32.57% of older people reported their livelihoods depend on support from their relatives. Nearly 47% of the respondents reported that they were, affected by at least one type of disease. The study shows that, about 80.77% of respondent who didn't seek health care was due to lack of economic support.

Conclusion and Recommendation: The result showed that older people are subject to multiple problems which affect their health status and health seeking behavior. Some of the respondent have aging related problem during data collection like hypertension, eye and hearing impairment, cardiac ailments and arthritis due to economic problem. The Ethiopian government should establish or reinstate an authority or a unit that would be solely responsible for planning and executing activities concerning older people health and economic support, schemes of income-generating activities (IGA) should be encouraged.

Introduction

The 21st century is witnessing a rapid demographic change due to a worldwide increase in the number of people aged 60 and above. Globally, the percentage of older people is projected to double from 10 per cent in 2000 to 20% in 2050 [1]. Moreover, relevant studies indicate that by 2050, nearly 80 per cent of the world's older population will be living in less developed countries [2]. According to this estimation by 2050, there will be 9.2 Africans, 8.2 Latin Americans, and 55 Asians over the age of 60 for every 10 Europeans of the same age group [3]. This is due to the advancement in medical treatment and technology, prevention and eradication of many infectious diseases, and improved nutrition, hygiene and sanitation [4].

Health seeking behavior is preceded by a decision making process that is further governed by individual and/or household behavior, community norms and expectations. For this reason, the nature of care seeking is varied depending on cognitive and non-cognitive...
factors that call for a contextual analysis of care seeking action. This context may include factors such as cognition or awareness, as well as socio cultural and economic factors [5].

Multiple factors influence elderly people's choice and use of health care services. The perceived severity of old people's health problems is a key factor affecting health-seeking behavior. As in many countries, self-care including self-treatment (or treatment by family members) is common when severity of illness is perceived to be low [6].

Studies conducted in Kenya, South Africa and Pakistan identified that lack of finance, absence of family support, physical inaccessibility of health service providers and practicing quacks are the major factors deterring older people from seeking healthcare services [7]. In addition to this, under-financing of health systems, over-stretched health workforces (from doctors to community health workers), poor health management information systems, unreliable supply of medicines, physical barriers to access healthcare and distance-related barriers are other factors that contribute to older people's poor access to healthcare [8]. Financial constraint is, however, their main barrier. Since older people are not usually covered by health insurance schemes, that are commonly available to the better-off and to those who are in the formal-sector of employment, they are usually required to pay for almost all the medical treatments they receive [9-13].

Empirical evidence from Bangladesh indicates that socio-economic status is a strong determinant of health-seeking behavior, even among the elderly. The high cost of formally trained allopathic physicians is normally the reason to avoid them unless high severity demands it as also indicated by other studies from Bangladesh [14-16].

In Ethiopia, the 2007 Central Statistical Authority report shows that 3,565,161 (4.8%) of the total Ethiopian population are 60 years and above. Of these, about 532,093 (14.9%) live in urban areas, whereas the rest 3,033,068 (85.1%) live in rural areas of the country [17]. In spite of the fact that there is a general consensus that the living and health conditions of older people in Ethiopia is precarious, alike the situation in most developing countries, there is hardly any exhaustive data on their livelihood and health status, making tailored intervention difficult [18].

In Ethiopia, only very few studies are available on older people. Although these studies are not national, they provide valuable insights that could be taken as applicable at the broader level. Out of these study, the survey conducted on the living condition and vulnerability of poor urban older people in all sub cities of Addis Ababa, Sep 2010 disclosed that; among 1,070 older men and women respondents, 79% eat only once or twice a day, 78% have health problems, 51% receive no family support, and about 50% carry out household activities, such as housekeeping and caring for grandchildren [19,20]. This study intends to assess health seeking behavior of elders and associated factors in Bilida Kebele of Jimma zone.

Justification of the Study

Study Area

The study was conducted in Bilida kebele, which is located 370 km from Addis Ababa in Southwest direction in Oromia region and has climatic condition of Wayna Dega. According to 2011 census by central statistical Agency of Ethiopia (CSA), it has total population of 24, 778 of whom 12,945 are men and 11,833 women. The elderly people were 1487 in per cent 6%. The three largest ethnic groups reported in the kebele were the Oromo (56.71%), the Amhara (7.14%) and the Dawuro (10.05%). Afan Oromo was spoken as a first language followed by Amharic. The majority of inhabitants (86.84%) were Muslims, 10% were practiced Ethiopian Orthodox Christianity and 3.06% were protestant.

Study Design and Period

The study design is cross-sectional. Therefore, the of the study objective should be to “describe” health seeking behaviors of elderly and influencing factors in Bilida kebele, Jimma Zone, Southwest Ethiopia, July 2017.

Populations

Source population: All person aged 60 and above in Bilida kebele.

Study population: Those people aged 60 and above, present during data collection.

Study variable

Dependent variable:
- Health seeking behavior

Independent variable
- Age
- Sex
- Marital status
- Educational level
- Religion
- Location of health facility
- Cost of health service
- Economic status
- Support from local government

**Inclusion and Exclusion criteria**

**Inclusion criteria:** Included being at least 60 years, present during data collection and identified as Bilida kebele resident.

**Exclusion criteria:** Exclusion criteria were being 60 or above, do not present during data collection.

**Sample Size and Sampling Technique**

**Sample Size Determination:** Sample size was determined using single population proportion formula by considering, 95% confidence level and 0.05 margin of error. $P= 50\%$ proportion of elderly with health seeking behaviors of elderly (There was no such study done on health seeking behaviors of elderly).

$$n = \frac{(Z)^2 \times P \times (1-P)}{W^2} = \frac{(1.96)^2 \times 0.5 \times (1-0.5)}{0.0025} = 384$$

Where, $n = \text{minimum optimal sample size}$

$Z = \text{the standard normal deviation corresponding to specific confidence interval (95% confidence)} = 1.96$

$W = \text{margin of sample error tolerated} = 5\% = 0.05$

$P = \text{proportion of elderly people with health seeking behaviors} = 50\%$, because no research done at the area.

Since the total number of elderly population of Bilida kebele is not available, the same percentage of elderly population of Ethiopia which is 6% was used. So the 6% of Bilida kebele population is 1487 which is less than 10,000, so the correction formula was used.

$$n_f = \frac{n_i \times N}{n_f} + N$$

Where $n_i = \text{exact sample size}$

$N = \text{sample population}$

$n_f = 384 \times 1487/384 + 1487$

$n_f = 306$

**Sampling method:** The total numbers of elderly Bilida kebele population was 1487. Convenience, sampling technique was used due to resource and easily accessibility of the subject.

**Data collection instrument and procedure**

**Data collection instrument:** The data was collected by Interviewer administered questionnaire, which have three parts. Part one: Socio demographic information. Part two: Economic situations and means of livelihood. Part three: Health problem. Interviewer administered questionnaire that fulfill the objective of the study were prepared in English after reviewing different literature and previous similar studies. The questions and statements were grouped and arranged according to particular objectives that they could be addressed. The adopted questionnaire was conceptualized to the local situation and to the research objectives. The questionnaire was translated to their language while data collection by data collector, pre oral consent was taken, the purpose of study was discussed and then they was interviewed for health seeking behaviors and factors influencing it. The questionnaire was pretested before direct use

**Data collection procedure:** Data was collected by using interviewer administered face to face data collection technique by principal investigator and trained personnel, after they informed about the purpose of the study, importance of their participation and verbal consent was secured. The questionnaire was filled by the data collectors. Training was given for 8 data collectors by the principal investigator to make them familiar with the data collection tool. The data collectors selected among nurse who had data collection experiences.

**Data processing and analysis:** After data collection each questionnaire was checked for completeness and consistency. It was analyzed using SPSS version 20.0 software. The result is presented with narration, tables and graphs and discussed with present information.

**Data quality control**

Data collection instrument was pretested in nearby inhabitant (Somodo kebele) to check internal validity and reliability before data collection go ahead. Because people in Somodo kebele share the same culture and socio demographic characteristics. The test-retest reliability was established ($r=0.80$) and the Cronbach alpha was reported to be $0.70$. Based on the finding possible amendments were made. In addition, data collectors were trained for one day on the study instrument and data collection procedure before going data collection.
Ethical consideration

The proposal of the study was first submitted to Rift Valley University, Department of Nursing for ethical approval. After approval official letters was written to Bilida kebele administrative office to go ahead data collection. The respondents were informed about the objective and purpose of the study and verbal consent was secured from each respondent. In addition to this the societal cultural and norms was respected during data collection.

Operational definitions

Health seeking behavior: a state in which a person in stable health is actively seeking ways to alter his or her personal habits or environment in order to move toward a higher level of health.

Health status: the level of health of individual as subjectively assessed by the individual itself.

Elderly: person aged sixty and above

Begging: practice of imploring others to grant a favor, often money, with little or no expectations of reciprocation as means of livelihood.

Limitation of Study

➢ Limited similar studies done both at national level and in the study area to compare the result.
➢ Recall bias.

Result

A total of 306 individual were participated, out of which 227 of them were male and the rest were female and the response rate was 100%. Concerning the age distribution, there are respondents in all ranges of age categorized into seven as shown in the Figure 1. It was found that the proportion of respondents between the ages of 60 and 64 were slightly higher (about 34.09%) followed by those in the range of 65 to 69 (21.97%) and 70 to 74 (19.68%). The age range of the respondent was from 60 to 94 years.

When it comes to marital status, the study result shows that, nearly 51.12% are not living with their spouses; This group includes divorcees, widows/widowers and separated older people. About 46.12% was living with their spouses (Figure 2).
As can be depicted from the Figure 3, about 32.57% of older people reported their livelihood depend on support from their relatives, while about 12.12% of the respondents reported they depend on pension.

![Figure 3: Main source of livelihood of respondents in Bilida kebele, Jimma zone, and south west Ethiopia, 2017](image)

As shown in Table 1, all respondents were asked to tell their average monthly income. About 11.43% of them get less than Birr 3600 (not more than $200) a month, while about 28.10% gets something between 3601 and Birr 6000 (between $ 200 and 300). About 12.41% of them reported that they get more than Birr 24,000 (about $ 1300).

<table>
<thead>
<tr>
<th>Monthly income (Birr)</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 3600 Birr</td>
<td>35</td>
<td>11.43</td>
</tr>
<tr>
<td>3601-6000 Birr</td>
<td>86</td>
<td>28.10</td>
</tr>
<tr>
<td>6001-12000 Birr</td>
<td>95</td>
<td>31.04</td>
</tr>
<tr>
<td>12001-24000 Birr</td>
<td>37</td>
<td>12.09</td>
</tr>
<tr>
<td>&lt; 24000 Birr</td>
<td>38</td>
<td>12.41</td>
</tr>
<tr>
<td>Don't know</td>
<td>15</td>
<td>4.90</td>
</tr>
</tbody>
</table>

Table 1: Monthly income of respondent in Bilida kebele, Jimma zone, Southwest Ethiopia, July 2017

From the following Figure 4, 42.42% of respondents reported that they depended on other people's support for their survival. Of these, 28.81% depended on their sons/daughters, about 20.33% on their grandsons/granddaughters and 15.25% on their sons'/daughters'-in-law.

![Figure 4: Economic dependencies of respondents in Bilida kebele, Jimma zone and Southwest Ethiopia, July 2017](image)

**Health problem of older people**

During study period, nearly 47% of the respondents reported that they were, affected by at least one type of disease (Figure 5).

The most common diseases older people are receiving medical treatment for are hypertension (19.44%), followed by heart disease (16.67%) (Figure 6).

From the above table majority of the respondent 267 (87.25%) has access to health care facility in the distance of less than five kilometers away from their home (Table 2).
As shown in above Table 3, out of 75 individuals who doesn’t undergoing medical treatment for their current health problem, 80.77% complain the reason for not seek health care is due to lack of economic support followed by cost of health care (61.53%) (Table 3). The association was done for all of the variable using five by two contingency calculation and the result obtained is; $\chi^2 = 14.02$, $P = 0.0072$ and $d_f$ is 4 since the p-value is less than 0.05 there is significant association with these factor.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total interviewed</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
<th>$\chi^2$</th>
<th>p-value</th>
<th>$D_f$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of health care</td>
<td>75</td>
<td>46</td>
<td>61.53</td>
<td>29</td>
<td>39.47</td>
<td>14.02</td>
<td>0.0072</td>
<td>4</td>
</tr>
<tr>
<td>Lack of support(economic)</td>
<td>75</td>
<td>61</td>
<td>80.77</td>
<td>14</td>
<td>19.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preference for traditional</td>
<td>75</td>
<td>26</td>
<td>34.61</td>
<td>49</td>
<td>65.39</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of hope for future</td>
<td>75</td>
<td>35</td>
<td>46.15</td>
<td>40</td>
<td>53.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaving</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of transport</td>
<td>75</td>
<td>32</td>
<td>42.3</td>
<td>43</td>
<td>57.7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Reason of not to seek health care in elderly of Bilada kebele, Jimma zone, Southwest Ethiopia, July 2017

Regarding how they cover expenses for the medical treatments they receive, about half (30.56%) said that they use their own savings, whereas 25% said they get money for such expenses from their sons/daughters. About 19.44% borrow money from someone whenever they fall ill (Figure 7).

As shown in above Table 2, out of 306 interviewed people, 87.25% of the elderly are within 5Km distance to the nearest health facility to the elderly in Bilida kebele, Jimma zone, Southwest Ethiopia, July 2017.
According to the result stated in Table 4, from 144 respondents who are seeking health care currently, 47.91% of individuals, who undergoing medical treatment currently, are accompanied to health service by son/daughter followed by relatives (24.30%). The entire respondent didn't get any support, like free health care service for poor elderly, IGA, housing service etc from the government.

<table>
<thead>
<tr>
<th>Accompanied by</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone</td>
<td>25</td>
<td>17.36</td>
</tr>
<tr>
<td>Son/daughter</td>
<td>69</td>
<td>47.91</td>
</tr>
<tr>
<td>Relatives</td>
<td>35</td>
<td>24.30</td>
</tr>
<tr>
<td>Others</td>
<td>15</td>
<td>10.42</td>
</tr>
</tbody>
</table>

Table 4: Persons accompanying older people to health services in Bilida kebele, Jimma zone, Southwest Ethiopia, July 2017

Discussion

A total of 306 individuals were interviewed and the obtained result was presented in the result part. Concerning marital status, the study result shows that, nearly 51.12% are not living with their spouse. This group includes divorcees, widows/widowers and separated older people. Regarding education, the findings disclosed that the majority of respondents (about 31.82%) are non-literate and 15.15% reported to have above grade 12, according to the nationwide research done by HAI, 2013 in Ethiopia the illiteracy rate is about 68% in the urban areas, whereas it is 85% in the rural areas. Few (less than 1%) reported to have College diplomas or higher-level education. This variation is due to the condition of the study area (urban).

The study showed that support from relatives is the source livelihood of larger portion of older people. About 32.57% of older people reported their livelihood depends on support from their relatives, while about 12.12% of the respondents reported they depend on pension. Similarly, from the national figure, by HAI 2013, 38.2% depend on relatives and about 19% depend on pension.

Although people may be engaged in one or another kind of work, or get additional income from one or another source, in the last resort, what determines whether these people are leading a decent life or not is the amount of money they get every month. Accordingly, about 10.6% of them get less than Birr 3600 (not more than $200) a year. That means this proportion of older people get less than a dollar a day. It should be noted that despite the fact that the current government has tried to make more than two increments on the pension rate, the lowest payment still remains to be Birr 292 per month.

The study showed that a number of respondents need others support for survival. About 42.42% of respondents reported that they depended on other people's support for their survival. Of these, 28.81% depended on their sons/daughters, about 20.33% on their grandsons/granddaughters and 5.24% on their sons'/daughters'-in-law. When compared to the nationwide survey done in 2013, 82% depended on their sons/daughters, about 6% on their sons'/daughters'-in-law and 5.24% on their grandsons/granddaughters.

Regarding current health status, the findings disclosed that nearly 47% of the respondents reported that they were affected by at least one type of disease at the time the interview took place. Of these, 58.1% were undergoing medical treatment. This number (the proportion of older people affected by disease) is much lower than what was shown in the Help Age-sponsored survey of Addis Ababa, cited here in above under chapter two. This variation may be due to the fact that, urban people has more health information than rural once. The most common diseases older people are receiving medical treatment for are hypertension (19.44%), followed by heart disease (16.67%). But from a recent study in Ethiopia, most common are eye problems (29%), and followed by arthritis.
(20.17%). Asked how they cover expenses for the medical treatments they receive, about half (30.56%) said that they use their own savings, whereas 25% said they get money for such expenses from their sons/daughters. About 19.44% borrow money from someone whenever they fall ill. In contrary a study conducted in Nation, Nationalities and Peoples reveals that; low/limited family support that resulted from the gradual erosion of the culture of extended family and mutual support, are the major problems older people are facing.

This study reveals that, nearly 81% of older people having health problem (who didn't seek health) are due to lack of economic support, these problem have significant association (p=0.0072). Similarly Studies conducted in Kenya, South Africa and Pakistan identified that lack of finance, absence of family support, physical inaccessibility of health service providers and practicing quacks are the major factors deterring older people from seeking healthcare services [21-23]. The study showed that the entire respondent didn't get any support, (like housing service, IGA, free health care service and etc), from government. Similar to study done by HAI in 2013.

**Conclusion**

The result of the study disclosed that older people are subject to multiple problems which affect their health seeking behavior, as well as their health status. Many of the respondents reported that they depended on other people's support for their survival. Due to this they don't seek health care, even if they sick.

Some of the respondent have aging related problem during data collection like hypertension, eye and hearing impairment, cardiac ailments, arthritis. However, getting medical service has never been an easy thing, since the health-care policy focuses on prevention of communicable diseases and also due to the fact that cost for medication and other economic support.

The most common diseases older people are receiving medical treatment for are hypertension, followed by heart disease. Although the Ethiopian government has a system in which the poor get free medical services, it seldom serves as intended, most of people didn't seek health due to lack of economic support.

**Recommendations**

Based on the study findings presented above and the suggestions made by older people, and other stakeholders in response to the study tools, as well as the experiences of other countries reviewed the following recommendations are forwarded.

- The government should establish or reinstate an authority or a unit that would be solely responsible for planning and executing activities concerning older people health and economic support, schemes of income-generating activities (IGA) should be encouraged by the government.
- Treatment for NCD should be given proper attention, and the proper implementation of policies and strategies regarding NCD should be ensured.
- Bilida health center should provide communities with continued health education on ageing-related health problems.
- NGOs, especially those working on health, should incorporate or mainstream issues of older people into all their health programs.

**References**

4. WHO (2004) Health of the Elderly in South East Asia: A profile Regional Office for South East Asia, New Delhi, WHO.