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HEALTH SEEKING BEHAVIOUR AND QUALITY OF LIFE AMONG OLDER ADULTS IN THE LA-NKWANTANANG MADINA MUNICIPALITY

BY

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JUNE, 2022

DECLARATION

I, Sarah Awuttey Apau, do hereby declare that except for references to the literature and works of other researchers which have been duly cited, this dissertation is the result of my work done under supervision and has not been submitted in whole or in part elsewhere for another degree.

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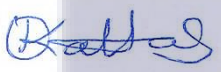
SIGNATURE: 

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LIST OF ABBREVIATIONS

CI	Confidence Interval
GHS	Ghana Health Service
HRQOL	Health Related Quality of Life
LEAP	Livelihood Empowerment Against Poverty
LI	Legislative Instrument
MOH	Ministry of Health
MPH	Master of Public Health
NCD	Non-Communicable Diseases
NHIS	National Health Insurance Scheme
OPD	Out Patient Department
QoL	Quality of Life
SDG	Sustainable Development Goals
SPH	School of Public Health
SPSS	Statistical Package for Social Sciences
TV	Television
UN	United Nations
WHO	World Health Organization

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ABSTRACT

Background: It is projected that 21.1% of the world's population will be aged 60 years or older by 2050 with 80% of them living in low-and-middle income countries. Aging is a desired process accompanied with health-related challenges and disabilities, which affect the quality of life of the older adults. The health challenges associated with aging require regular health care service utilization. Health seeking behaviour is the act of deciding to seek or not to seek care from qualified medical personnel when not feeling well. This study examined factors associated with health seeking behaviour and quality of life of older adults in the La-Nkwantanang Madina Municipal Area.

Objective: The main objective of this study is to examine factors associated with health seeking behaviour and quality of life of older adults in the La-Nkwantanang Madina Municipal Area.

Methods: A descriptive cross-sectional study design was employed to examine health seeking behavior and quality of life among older adults aged 60 years and above in the La-Nkwantanang Madina Municipal Area. A multi-stage sampling technique was employed to select participants for the study. Data on quality of life was collected using EQ-5D questionnaire, a standardized measure of health status developed by the EuroQol Group. Face-to-face interviews were carried out among the participants. Data was analyzed using Statistical Package for the Social Sciences (SPSS) version 20. Univariate analysis was performed; chi-square test of association done at the bivariate level and logistic regression analysis was done to determine predictors of good health seeking behaviour.

Results: A total of 465 older adults were interviewed. The average age of respondents in this study was 76.97±11.38 years old. The majority 371 (80%) were staying with relatives; either their

children 205 (55.3%) or partners/spouses 128 (34.5%). Most of them 341 (73.5%) have subscribed to the National Health Insurance Scheme (NHIS) sought care from public health facilities. More than half, 243(52.4%) of the adults sought regular medical check-up. Only 69 (14.9%) resort to self-medication.

Respondents between **80-89** years old have 1.6 times the odds of having regular medical check-up compared to those aged 60-69 years old. Education (X^2=29.967, p<0.001), staying with a relative (X^2=27.793, p<0.001), profession (X^2=27.184, p<0.001), receiving income (X^2=5. 810, p=0.016), subscribing to some health insurance (X^2=32.974, p<0.001) were significantly associated with positive health seeking behaviour. Adults with health insurance were 8.4 times more likely to go for regular medical check-up than those who were not insured (AOR=8.4, CI: 2.398-29.502). Participants without health insurance were 73% less likely to go for regular medical check-ups than those who have. Older adults who do not receive support from their family members were 59% times less likely to go for regular medical check-ups compared to those who receive support. Older adults who received support from their family members were (AOR=4.3, CI: 1.489-12.441) times more likely to go for regular medical check-up than those without family support.

Conclusion: Older adults in the municipality are conscious of their health care needs. More than half of them sought regular medical check-up from public health facilities. Very few resort to self-medication. Families should support the elderly while government enrol them into the NHIS to enable them seeking health care regularly.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

The United Nations defines older adults as persons over sixty years of age. The past decades have demonstrated distinctive demographic processes due to rapid aging population caused by reductions in fertility and mortality rates. Annually, the number of people aged 60 years and above increases by 3.2%, with further increase projected (UN, 2017). Most studies among elderly people thus far have classified elderly adults into one group. Although there are different ways to classify this population, some studies have classified elderly adults into three categories: 65-74 years are known as youngest-old, 75-84 years middle-old, 85 years and above as oldest-old .

Aging is a subtle, quiet process which is a success story but poses a public health challenge. Older adults are faced with an increased risk of disease and disability (Chatterji et al., 2015). The phase of old age is often linked to degenerative conditions that hinder their capacity to function efficiently, hence requires not only specialized care but also support to prevent neglect and rejection (Kpessa-Whyte & Tsekpo, 2020).

Health seeking behavior is the act of deciding to seek or not to seek care from qualified medical personnel when not feeling well.

Ghana has a 7.2% elderly population which is currently the highest in the sub-Saharan Africa regions (Ghana Statistical Service, 2013). Following this trend, it is projected that Ghana's elderly population will reach 2.5 million by 2025 and 6.3 million by 2050 (Ghana Statistical Service, 2013). In sub-Saharan Africa, Ghana is among the few countries has a fastest-growing older population

with an estimated 12% general population increase by 2050 (Agyemang-Duah et al., 2020). With such remarkable population growth, addressing health care needs of older adults and preventing diseases are critical and vital for improving their quality of life (QoL). Also, there is increasing concern about disease complexity particularly multimorbidity among older adults. The construct for improving the QoL among this population is widely affected by their health seeking behaviour. Concurrently, the fundamental concept and grandness of good health seeking behaviour is considered critical for the success of health-related interventions to reduce incidents and the burden of disease as well as death among older adults.

Ageing associated conditions such as frailty, disability, chronic diseases, and physiological changes are among many reasons to promote health seeking behaviour among older adults. Unfortunately, basic structures such as hospitals are not evenly distributed across demographics. Similarly, older people are trammeled in vicious cycles of poverty (Agyemang-Duah et al., 2019). This circumstance was found to likely have a negative effect on healthcare use pattern, quality of life and increase the incidence of diseases (Kpessa-Whyte & Tsekpo, 2020).

Ageing and disease are major predictors for poor health-related quality of life for the elderly (Devraj & D'mello, 2019). Weak and compromised immune system, cognitive decline, and functional limitations increase morbidities among older adults. A study conducted among the elderly in Ghana found oral health problems (45%), hypertension (33%), arthritis (14%), cardiovascular condition (6%) and 4.9% of them receiving treatment for stroke (Devraj & D'mello, 2019). They also reported that various life circumstances such as retirement and irregular incomes could result in poor seeking behaviour leading to unmet care needs among older adults and poor QoL.

The WHO defines QoL as an individual's perception of their position in life in relation to their goals, expectations, standards and concerns in a cultural context and value systems in which they live (World Health Organization., 1998). Quality of life is also described as the concept of physical, mental, social relationships and well-being (Atakro et al., 2021). For older adults, QoL is a combination of life-course and some immediate influences. Understanding factors influencing quality of life for the elderly population is important for a country's policy making, planning, and implementation of healthcare and other supporting programs. Further, it will also inform support for older adults which is vital for healthy aging and wellbeing.

Healthcare utilization is directly related to number of factors such as availability and affordability of services, health literacy, social resources, adequacy of the service and the healthcare system factors of individual countries. Healthcare utilization patterns of a country reflected the healthcare-seeking behaviors of people. Generally, studies have shown that healthcare utilization of the older adult population is good and encouraging as compared to younger adults. A study conducted in Indonesia found that young people aged ten to twenty-four are less likely to visit clinics regularly as compared to older adults. Another study also indicated that only 66.7% of adults aged between 18 and years seek formal care at health facilities when ill.

Notwithstanding the upsurge of ageing in Ghana, the country is yet to develop interventions and policies targeted at addressing age related vulnerabilities. Although some aspects of public policies such as pensions schemes, the NHIS and the Livelihood Empowerment Against Poverty (LEAP) were instituted to address challenges of income, and other poverty adjusted constraints, the concern these policies are not able to address the inequality and inadequate to address the health care needs of the aged. It is thus important to explore health seeking behaviour among older adults to guide

policy and inform service utilization interventions. This study seeks to determine factors associated with the health seeking behaviour and quality of life of older adults in the La-Nkwantanang Municipal Area of Ghana.

1.2 Problem statement

Global increase in the older population is an emerging challenge, particularly for developing countries. Despite the current 7.2% of older adults in Ghana, a corresponding increase in social and health care support has not been met (Agyemang-Duah et al, 2019). Older adults face the burden of disabilities and chronic diseases and have limited access to health care and social protection schemes (Adam & Koranteng, 2020)

Conditions associated with ageing such as frailty, disability, chronic diseases, functional limitations, psychological distress, and cognitive decline cause older people to seek treatment and health information to address their ailments and maintain good health and wellbeing. These malfunctions contribute to poor QoL among older adults. For older adults, it is a combination of life-courses and some immediate influences. Understanding the factors influencing health seeking behavior of the elderly population is important information for countries' policymakers, planning, and implementation of healthcare and other supporting programs for the elderly.

Since health challenges affects the QoL of older adults, their access to periodic health care and support should be a top priority. Unfortunately, the health system in Ghana is denied a multifaceted functioning (Kpessa-Whyte & Tsekpo, 2020); its services only focused on management of individual diseases leading to inefficient, insufficient and infective health care for the aged. This burden is further compounded by downward trends of support through traditional welfare systems due to modernization and globalization (Atakro et al., 2021). Also, older adults are generally perceived to

be more reluctant to seek health care and very often fail to seek health care, believing that the ailments are a part of the ageing process (Hakmaosa et al., 2015). The older adults tend not to access the healthcare recommended to them. This phenomenon creates a major challenge in providing an environment a secured and dignified environment in order to improve the elderly's QoL (Patle & Khakse, 2015).

Inequalities in older adult's care is particularly true for Ghana. Two-thirds of the older adult population live in rural settings and are vulnerable to socio-economic and health marginalization (Agyemang-Duah et al., 2019). Whereas robust health services for the younger population exist in the urban parts of the country, similar services for the elderly are non-existent particularly in the rural areas due to a lack of pragmatic research to inform programme interventions. Again, in Ghana, the few available services for older adults are rarely patronized due to socio-demographic and economic challenges (Atakro et al., 2021). Nonetheless, promoting the heath seeking behaviour and support systems for older adults is critical in improving the day-to-day functioning, personal development and wellbeing of older adults.

As part of promoting universal health, the sustainable development goals 3 and 10 aim at improving wellbeing, seeks to promote good health-wellbeing, and reducing inequalities. Unfortunately, the older population is vulnerable to inequalities and poor health seeking behaviors in developing countries (Atakro et al., 2021). This leads to the worsening of the existing problems and the development of complications from acute health conditions. In Ghana, adult healthcare seeking is ruined by inadequate information from health workers regarding care of the older person, queuing frustrations, financial burden and focused elderly care demand (Atakro et al., 2021). There are inadequate strategies to address the health challenges and also improve the QoL of the older adults.

The La-Nkwantanang Madina municipality consist of both urban and rural communities with five health care facilities. The estimated population of older adults was 7,055 of which only 22% of the older adults seek health care (DHIMS 2, 2020). This study therefore seeks to determine factors that are associated with health seeking behaviour of older adults in the La-Nkwantanang Municipality.

1.3 Justification

The proportion of older adults in Ghana is projected to increase from 5.3% to the 2014 total population to 8.9% by the year 2050 (Kpessa-Whyte & Tsekpo, 2020). This increase could be tied to the better health outcomes and improved technologies in health. With such expected exponential growth of the elderly population, it is important to develop appropriate policies and interventions to address their needs and guarantee their good QoL. Similarly, assessing the QoL of older adults is becoming an urgent public health concern and priority. However, in order to effectively and efficiently address these needs, accessing fundamental health care services remains a key issue for the older population in Ghana. It is critical to first understand the health seeking behaviour and how this affects the QoL of the elderly. The World Health Organization's study on global ageing adults in Ghana, reported that an increased proportion of the elderly require health care coupled with the worsened quality of life among older adult and urban households needing more health care than rural residents (Awoke et al., 2017). Hence this study, therefore, seeks to explore factor that influence the health seeking behaviour of older adults of older adults in the La-Nkwantanang Madina Municipality. Findings from this study will provide guidelines for formulating policies and interventions for older adults to improve their health seeking behavior.

1.4 Objectives

1.4.1 General objective

To examine factors associated with health seeking behaviour and quality of life of older adults in the La-Nkwantanang Madina Municipality.

1.4.2 Specific objectives

1. To examine factors associated with health seeking behaviour and quality of life of older adults in the La-Nkwantanang Madina Municipality
2. To assess the utilization of health services of older adults in the La-Nkwantanang Madina Municipality
3. To assess the health-related quality of life among older adults in the La-Nkwantanang Madina Municipality
4. To assess the relationship between health seeking behaviour and health-related quality of life among older adults in the La-Nkwantanang Madina Municipality

1.5 Theoretical framework

The use of health services is primarily based on the point where the needs and demands of patients meet the professional system. It is well known that apart from need-related factors, health care utilization is also supply-induced and thus strongly dependent on the structures of the health care system (Babitsch et al., 2012). This study will be based on Anderson's Behavioural Model of healthcare utilization the model suggests that health seeking behaviour of older adults is a function of three groups of factors: predisposing, enabling and need.

Predisposing factors: According to Anderson, individual factors which could influence the utilization of healthcare consist of demographic characteristics such as age and sex, "biological

imperatives", social factors such as education, occupation, ethnicity as well as social relationships (marital status, family size, etc) and health beliefs such as attitudes, values, and knowledge related to health and health services. Contextual factors include the demographic and social composition of communities, collective and organizational values, cultural norms and political perspectives.

With regards to enabling factors, financing and organizational factors influence health care utilization. Financing factors relate to the income and wealth at the individual's disposal to pay for health services. In some countries, this is covered by health insurance and cost-sharing requirements. Organizational related factors include, whether an individual has a regular source of care and the nature of that care. It also refers to the amount, varieties, locations, structures and distribution of healthcare facilities and personnel. It also involves physician and hospital density, office hours, provider mix, quality management oversight, and outreach and education programs (Babitsch et al., 2012).

Anderson further differentiates between the perceived need for health services (i.e., how people view and experience their own general health, functional state and illness symptoms) and evaluated need (i.e., professional assessments and objective measurements of patients' health status and need for medical care). Contextually, they made a distinction between environmental need characteristics and population indices. These environmental needs involve the health-related determinants of the environment whereas population indices are the overall measures of community health, thus epidemiological indicators of mortality, morbidity, and disability. Anderson further indicates that, although predisposing and enabling factors are vital for health service utilization, they alone are not sufficient for actual use, rather, actual use is initiated by need, which sometimes results from the illness level

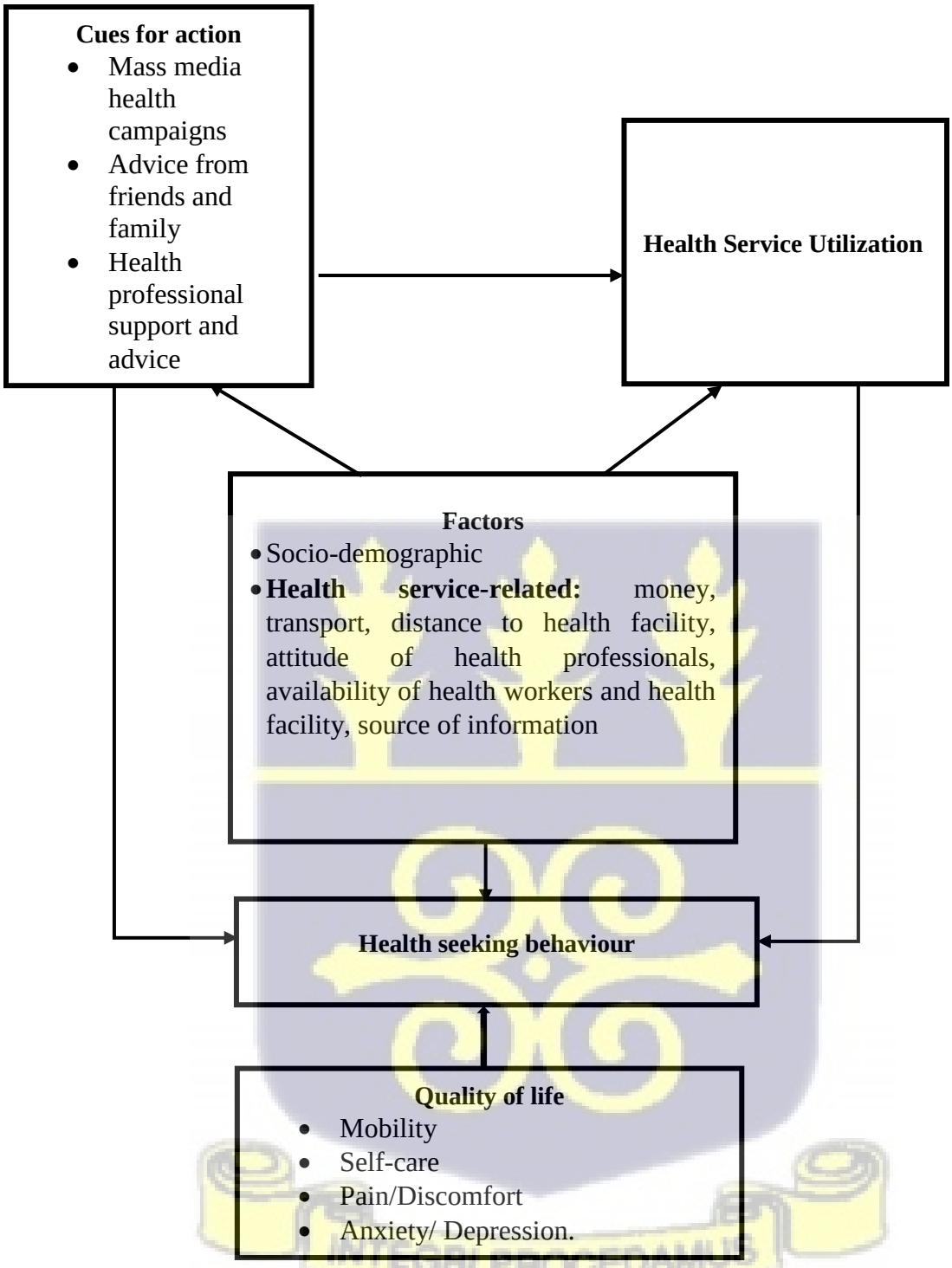

Figure 1: Conceptual framework

Source: Adapted from Andersen and Newman (1968) and Current Nursing (2012)

CHAPTER TWO

2.0 LITERATRE REVIEW

This chapter is a review of several studies on health seeking behaviour and quality of life among older adults. The review focused on studies carried out and relevant documents to understand health seeking behaviour and quality of older adults.

2.1 Health seeking behaviour of older adults

According to the United Nations (UN), an elderly person is an individual aged 60 years or above. It has been estimated that the world's population of the aged will double from 12% to 22% between 2015 and 2050 with the majority residing in low and middle-income countries. This sub population suffers from a myriad of degenerative health problems such as chronic conditions, injuries, depression, hearing loss and malnutrition. As such, periodic contact with health care is vital for this population. Unfortunately, they do not receive the care they need. Although variation exists in the assessment of health seeking behaviour, some studies have indicated poor utilization of healthcare services among older adults particularly in developing countries.

A study of the morbidity pattern and health-seeking behaviour of the elderly in urban slums of the Assam Region of India report that nearly 84% of the elderly who were sick sought treatment for their illnesses (Barua, Borah, Deka, & Kakati, 2017). About 52% of the elderly preferred to use allopathic medicine for their illness with only 5% getting treatment from traditional healers. Furthermore, they reported that about 49% and 22% of the sick elderly had treatment from government and private health facilities respectively whilst about 30% practiced self-medication. While only 52% of the elderly in Assam of India preferred allopathic treatment for their ailments, about 98% of the elderly sought allopathic medicine for their chronic illnesses with government

hospitals (52%), private hospitals (37%) and private practitioners (10.4%) being the type of health facilities visited for health care (Gnanasabai, Kumar, Boovaragasamy, Rahman, & Ramamurthy, 2020).

Lack of money and no need to see a doctor were reasons why about 81% and 63% respectively of the elderly in Assam did not seek any health care for their illness (Barua et al., 2017). A study conducted in India however indicated good health seeking behavior where about 83.7% were seeking health services for health problems (Falaha et al., 2016). Poverty is thus a barrier to the use of health care services by the elderly has in Ghana (Nwakasi, Brown, & Anyanwu, 2019) and rural areas of Puducherry in Sri Lanka (Gnanasabai et al., 2020).

Among 72 persons aged 65 years or more in a study on health-seeking behaviors and its determinants in the Turkish Republic of Northern Cyprus, it was found that about 56% and 44% of them preferred to frequently visit a government health centre and private health respectively but only 4% of them refused to visit a Health Center although they felt ill during the five years preceding the study (Abuduxike, Aşut, Vaizoğlu, & Cali, 2020). These findings are dissimilar to findings made in an Indonesian study where 89%, 94% and 99% of older persons did not regularly visit a public health centre, private clinic and hospital respectively with regular and irregular visits defined as more than six visits and less than six visits to a health facility in the past year whilst only 9% of them never visited any health care facilities in the preceding year of the study (Irwan et al., 2016).

A similar influence of wealth on health seeking behaviour has been reported in Western Ethiopia where being poor is likely to increase the chance of poor health seeking behaviour among the elderly by two times as compared to the richest (Feyisa, Deyaso, & Tefera, 2020).

To address the challenge of financial access to health services, health insurance schemes have been in some countries to prevent out-of-pocket payments at the point of receiving health care. However, in Western Ethiopia, it was found that about 855% of 779 elderly persons did not have a health scheme. Of the 113 (14.5%) of them having a health insurance scheme, about 12% of them utilized it (Feyisa et al., 2020).

The number of health conditions or diseases being experienced by a person including the elderly may influence the person's decision to seek health care for the treatment of his or her ailment. An elderly person with a single disease whether serious or not might delay in getting health care compared to another with multiple conditions. (Feyisa et al., 2020) found in Western Ethiopia that 584 (75%) of elderly persons reported morbidity in the year preceding the study with 45.2% of them having co-morbidities. Musculoskeletal problem, neurologic problem, visual problem, gastric problem, hypertension, genito-urinary problem were the health conditions most prevalent among the geriatric population in the Western Ethiopian study. Abdulraheem (2007) in his study among 1,125 elderly in Ilorin Metropolis of Kwara State, Nigeria reports that nearly 69% of them never visited health facilities for medical check-up in a year. The study also reports that 45% of the elderly resorted to family care/consultation for the treatment of their illness with about 23% and 18% also consulting health workers and drug sellers respectively for their health care services. It is further reported that the utilization of health services by the elderly in the metropolis did not differ by age and sex. Self-medication was reported among nearly a quarter of elderly persons in Western Ethiopia with about 63% of them self-rating their health status as being good (Feyisa et al., 2020) which is lower than the 81% of 403 elderly persons with chronic illnesses seeking self-treatment in rural Puducherry of Sri Lanka (Gnanasabai et al., 2020). Further, cross-sectional study conducted in Wolaita showed that, all older adults were actually seeking help for a health problem. Out of this

proportion, about 90.6% do seek help from modern medication and 9.4% do seek help from alternative medication. This is fairly consistent with another study conducted in Kamrup (Rural) district, Assam which found that, about 72% elderly sought treatment for chronic illness and of this, most sought care from a government hospital as compared to 98.5% allopathic treatment. A much lower prevalence of health seeking behaviour was reported older adults in Myanmar where 60.2% seek health care from a doctor, health assistant (21.9%) at a nearby clinic or rural health center; 1.6% reported seeing non credentialed medical persons (Aye et al., 2019). Attributed reason to the difference in behaviour could be due to the varied tools used in the assessment of the health seeking behavior. Further, the unique health system available in each country could influence this observation due to the different health care packages (intervention available to older adults). Another study conducted in rural communities in South Africa indicated that, out of a total of 5,795 older adults, the majority (96%) used health care often at a public health facility (Ameh et al., 2014). A cross-sectional conducted in Zimbabwe found that about 72.5% of adults have good health seeking behaviour (Ndarukwa et al., 2020). Contrary, a cross-sectional study conducted in rural Ethiopia found the health seeking behaviour of older adults to be 57.9%.

2.2 Factors associated with the health seeking behaviour

Several studies have found numerous factors associated with the health seeking behaviour of adults. Whiles these factors vary from country to country, their existence cannot be ignored or emphasized enough. Several factors are said to influence the use of health care services by the elderly. Demographic factors such as age, sex, education, marital status, ethnicity and religion have been found to influence health seeking behaviour among older persons in one or the other (Abdulraheem, 2007; Abuduxike et al., 2020; Akuffo-Henaku, 2019; Baral & Sapkota, 2018; Barua et al., 2017;

Irwan et al., 2016; Latunji & Akinyemi, 2018; Nwakasi et al., 2019; Osei Asibey & Agyemang, 2017; Patle & Khakse, 2015).

A study conducted among older adults in Nigeria found that, being unemployed increases the likelihood of adults seeking health whereas lack of education and low household income was associated with lower health care consultation (Atchessi et al., 2018). In another study conducted in rural South Africa, older adults with six or more years of education had increased odds of seeking health as compared to those without any form of formal education (Aye et al., 2019). Another cross-sectional survey conducted in Nigeria shows that, Socio-economic indicators and nature of illness were the most pervasive determinants of health care seeking behaviour among the elderly, overriding age and sex (Abdulraheem, 2007). One major unexpected consequence of ageing is increasing prevalence of non-communicable diseases (NCD) (Aye et al., 2019). In 2008 for example, NCDs were seemingly responsible for two-thirds of all mortality globally, with about 80% of these deaths occurring in Low-middle-income countries alone (WHO, 2010). Unlike children and women whose health-related problems have been included in the Sustainable Development Goals (SDGs), older adults were not clearly visible in most global policy dialogue until recently (UN, 2011). Consequently, commodity among adults was found to be strongly associated with health seeking behaviour. In a study conducted among adults in South Africa, adults with both chronic communicable and non-communicable diseases had higher odds of seeking health care as compared to those with acute conditions (Aye et al., 2019). Similarly, in another study conducted in India, majority of the people who had chronic disease were found to be more likely to visit health facilities regularly (Bhat & Kumar, 2016).

In the Ilorin Metropolis of Kwara State in Nigeria, it is found that more than 50% of the elderly persons had their health seeking behaviour influenced by poverty whilst the nature of illness

influenced the health seeking behaviour in 25% of the elderly with quality of service provided (10.8%), the attitude of health caregivers (3.6%), waiting time (3%), availability of service (2.8%), accessibility in terms of distance (2.3%) and level of education (2%) being the other factors. (Abdulraheem, 2007). It was observed that poverty reduced the odds of seeking health care from qualified medical practitioners but increased the odds of using home remedies from the family. Also consulting patent drug sellers with education increases the odds of seeking healthcare from qualified medical practitioner (Abdulraheem, 2007). While distance to health facility, availability of health services and nature of a health problem significantly predicted health seeking behaviour among the elderly, the contrary was found in Nepalese district of (Baral & Sapkota, 2018).

(Latunji & Akinyemi, 2018) in Ibadan of Nigeria found that 66% of 187 civil servants aged 50 years and above sought care from formal source when they were sick within a month.

Although it is expected that old age could result in the utilization of health care services, it was observed to the contrary that an increase in age reduces outpatient care utilization rate in Ghana (Nwakasi et al., 2019). Another study in Ghana also found age to be associated with utilization of formal health care where 93% and 96% of the elderly aged 60-69 years and 70+ years respectively it to informal health care services (Akuffo-Henaku, 2019). This is could be due to a possible vote of confidence and trust in the formal health care system. The study further observed that marital status, religion, ethnicity, education, gender/sex did not influence the health seeking behaviour of the elderly. This agrees with findings in Indonesia and rural India where the variables of sex, age, marital status, educational level, occupation, and health status were not associated with health seeking behaviour among older persons except age and having a health complaint (Bhat & Kumar, 2017; Irwan et al., 2016). While the Ghanaian study has it that gender and having a health insurance were found to have significant statistical associations with the rate of OPD utilization, it was in contrast

with study findings in the India town of Assam where gender, educational status, socioeconomic status and financial dependence, were found to be statistically not significant health-seeking behavior (Barua et al., 2017). Similarly, (Bhat & Kumar, 2017) reported that age, gender, education, socio- economic status and religion were not associated with the source of health facility chosen for acute illness in rural Karnataka of India (Bhat & Kumar, 2017). Another Ghanaian study by (Amegbor et al., 2019) found that religion and marital status influenced health seeking behaviour in different directions; whereas religion has a positive influence on the type of health facility frequently visited by Muslims had 36% increased odds of frequently seeking traditional medicine healers compared to Christians, marital status had a negative influence in which widows had 29% decreased odds of frequently seeking traditional medicine relative to those who were married (Amegbor et al., 2019). A study conducted in Ghana, found wealth index to be associated with the health seeking behaviour of adults. In that study, adults in the poor and poorest wealth quintiles were less likely to seek treatment as compared to those in the richest wealth index quintile (Kuuire et al., 2016).

Area of residence is found to influence use of health care services among older adults. The elderly in rural areas are not as likely to seek health care when sick as compared to those living in major towns because of possible disparities in economic power and availability of other social amenities. A study among the geriatric population in Western Ethiopia found that elderly persons living in the village are two times more likely to have poor health seeking behaviour than their urban colleagues (Feyisa et al., 2020). In 2019, a similar observation has been made in Ghana where old persons in rural areas have a 92% higher rate of not utilizing outpatient care than their urban counters as reported in a Ghanaian study (Nwakasi et al., 2019). The study found that highly educated older adults have a 17% rate of utilizing health services at the Outpatient Departments than those with low education. The study also reported good health status of older adults and need for care among the

older adults influence the utilization of OPD services on a lower rate at 15% and 11% respectively (Nwakasi et al., 2019). The findings on higher education, higher economic power and perceived better health in this Ghanaian study agrees with the observations in a study on health-seeking behaviors and its determinants in the Turkish Republic of Northern Cyprus (Abuduxike et al., 2020). While the need for care among older adults in the Turkish Republic of Northern Cyprus was associated with health care utilization, the contrary was found in Ghana. In Ghana, need for care, family, community and government support did not significantly predict the use of formal healthcare (Abuduxike et al., 2020; Akuffo-Henaku, 2019) and in Bharatpur Municipality of Chitwan District in Nepal (Baral & Sapkota, 2018).

Lifestyle behavioural attitudes especially healthy eating has been found to influence health seeking behaviour among older persons in Ghana. Healthy eating promotes good health outcomes and likely will reduce the number of illnesses to necessitate persons especially the elderly. Nwakasi and Co (2019) report that eating fruits and vegetables have less than 1% and 8% reduction in OPD care utilization in Ghana respectively. Furthermore, they observed that moderately exercising reduces OPD visitation by nearly 30% whilst lack of exercise increases utilization of OPD services by about 2%.

2.3 Utilization of health services of older adults

Advancing in age comes with challenges in health outcomes of an individual. Older persons than their younger counterparts are likely to have more health problems. It should be encouraging to have older persons take interest in their health status so as to be able to detect any ailment should it arise. In Indonesia, public health centres and free monthly health check-ups as part of the primary health care for older persons to screen them and refer those with serious health problems to more comprehensive health facilities for better care was found not to be highly patronized as about 89%

of them did not regularly visit the public health centres as well as more than two-thirds (69%) of them not doing the monthly health check-ups with lack of a specific medical complaint being the reason for not visiting MHCs (Irwan et al., 2016).

In the health seeking behaviour among elderly people of Bharatpur Municipality of Chitwan District in Nepal, it was found that 87% of the elderly reported some form of a health problem with 38% of having hypertension and, 37% having gastritis, joint pain, piles and hearing problem followed by asthma and diabetes at 13% and 11% respectively (Baral & Sapkota, 2018). The study found that about 84% of the elderly in the municipality sought modern medication as against 16% for alternative medication for their ailments. Though this proportion of the elderly utilizing modern medication is good, it is lower than the 97% of elderly persons who frequently used modern health facilities for health care services as against 3% for traditional healers in Ghana (Amegbor, Kuuire, Bisung, & Braimah, 2019).

In the Turkish Republic of Northern Cyprus, (Abuduxike et al., 2020) reported in their study on health seeking behaviour and its determinants that only 14% of persons aged 65 years and more visited health centres for care and that older persons (64%) did routine checkups more frequently compared to the younger adults (45%) while 72% of the older adults visited a health centre in the event of a health problem. In rural Karnataka of India, 72% of the elderly had visited health facility for a routine health check-up in the last year with 65.3% of them having a chronic illness.

Older persons would prefer and opt for different types of health care in the event of illness. Formal health care was the most preferred by about 95% of the elderly in Ghana in a study on financial sources and health seeking behaviour among the elderly in Ghana. The kind of health care services to be opted for by people including older persons depends on the available information and the

attitude of health workers. It has been found that inadequate knowledge about the benefits of seeking health information, perceived poor attitude of health workers, and language problem are main factors that limit low income earning older adults from acquiring health information from healthcare providers in Ghana (Agyemang-Duah, Arthur-Holmes, Peprah, Adei, & Peprah, 2020)

2.4 Quality of life among adults

With the continuing increase in the elderly population, the debate about maintaining their physical and mental health, independence, and QoL and its determinants is also intensifying (Soósová, 2016). In the Tehran City of Iran, it was found that age, sex, education and economic status were significant determinants of high health-related QoL (Tajvar, Arab, & Montazeri, 2008). The authors observed that the elderly who live with others had a higher average in all health-related QoL scale compared to people living alone. Similarly, Acharya et. (2021) assessed the QoL and associated factors amongst older adults in a remote community in Nepal. They found that 82.4% of older adults have a fair quality of life while only 9.8% and 7.8% of them had high and low scores respectively. The factors associated with high QoL among the older adults were: those aged <70 years had higher QoL than those >70 years old (OR= 5.843, 95% CI=2.743-12.449, p<0.001), being male compared to female (OR= 3.376, 95% CI=1.919-5.939, p<0.001), being literate compared to illiterate (OR= 3.309, 95% CI=1.973-5.550, p< 0.001) and married adults compared to the unmarried (OR=1.683, 95% CI=0.946-2.993, p< 0.007). A study on multimorbidity and health seeking behaviour among older people in Myanmar found that 92.8% of older adults in urban areas and 91.3% in rural areas were able to do daily activities by themselves with 36.1% of them involved in community activities. In terms of their overall general health, it was reported that only 27.9% rated their general health status as poor with 26.1% in urban areas and 29.8% in rural areas. This contrasts with Samadarshi

et al.'s (2020) study in Nepal which found that 82.4% of older adults reported fair QoL with only 9.8% and 7.8% of them indicating high and low QoL respectively.

Similar findings were made by Eisele et al. (2015) in their study in six German cities. While these studies found good QoL among the elderly, Wen & Dong (2019) in their study found poor health related QoL among those in Guangzhou province of China. The main factors associated with the physical and mental health-related QoL of elderly persons were the number of chronic diseases, loneliness, age and educational level.

A cross-sectional study conducted in the province of Gipuzkoa in Spain found 46% of older persons rating their health-related quality of life as poor. Scores <70 indicated poor health with pain/discomfort (28%), followed by mobility (13%) and anxiety/depression (10%) being the dimensions more frequently reported to cause moderate problems (Machón, Larrañaga, Dorronsoro, Vrotsou, & Vergara, 2017).

In a five-country study assessing gender differences in quality of life among community-dwelling older adults in low- and middle-income countries, males were found to consistently report higher QoL scores than females across all five countries and the QoL scores of both males and females from China were the highest with Ghana being the least (Lee, Xu, & Wu, 2020). A similar observation was made in Tanzania women are more have high probability to report poor health as well as being scored for lower quality of life than men. Lower quality of life was also significantly associated with the two lower socio- economic quartiles (Mwanyangala et al., 2010). The authors further observed that good quality of life and good health status was associated with being married, a high level of education and higher socio-economic status of the household.

A study assessing the QoL and its determinants among older adults attending a general practice clinic in Southwest Nigeria found that 75% of the adults had poor quality of life. It further revealed that older adults who resided in urban areas, those from the high socioeconomic class, those with sources of income other than family contribution, and those who lived above the poverty line and strong family support had a good quality of life (Fakoya et al., 2018). Having multiple morbidities was associated with poorer QoL.

In Ghana, 20.1% of the elderly rate their health status as poor and 79.9% as good. Only 23.4% of them engaged in moderate exercises. About 79% of elderly persons who do no physical activity reported poor health (Fonta, Nonvignon, Aikins, Nwosu, & Aryeetey, 2017). Older adults who receive support, provide support and/or perceive the availability of support are less likely to report better health and wellbeing outcomes (United Nations Department of Economic and Social Affairs Population Division, 2015a, 2015b).

CHAPTER THREE

3.0 METHODS

Chapter three describes the methods used for the study. The chapter includes study design, study area, study population, inclusion and exclusion criteria, sample size determination, data collection instruments, data collection procedure, variables, data processing and analysis, ethical considerations and informed consent.

3.1 Study design

The study was a descriptive cross-sectional community survey. This approach allows the collection of both exposure and outcome data at the same time. It makes it relatively quick and easy to conduct the study since it does not require long periods of follow-up. This study is also good for descriptive analyses and generating hypotheses.

3.2 Study area

The study was conducted in the La Nkwantanang-Madina Municipality. La Nkwantanang Madina Municipal was established by Legislative Instrument (L.I.) 2131 and inaugurated in June 2012. It was carved out of the Ga East Municipality. The La Nkwantanang -Madina Municipality is located in the northern part of the Greater Accra Region. It covers a total land surface area of 70.887 square kilometers. It is bordered on the West by the Ga East Municipal, on the East by the Adentan Municipal, the South by La-Dade-Kotopon Municipal Area and the North by the Akwapim South District **(**Ghana Statistical Service, 2014). The population of the municipality is 145,498 as projected from the 2010 Population and Housing Census. The municipality has five sub-districts namely Danfa, Nkwantanang, Pantang, Social Welfare and Tatanaa (GHS dhims2, 2021).

3.3 Variables of the study

The variables of the study were categorized into dependent and independent variables. The dependent variable is health seeking behaviour (defined as the utilization of health care services or ever sought health care) while the independent variables were some demographic characteristics (age, sex, level of education, marital status, religion, income level, number of children, family size), NHIS status, health system service factors such as staff attitude, distance to health facilities, cost of health care, availability of drugs, availability of health workers, perceived quality of care, source of health information, quality of life (mobility, self-care, usual activities, pain or discomfort and anxiety or depression)

Table 1: Definition of study variables

Variable	Operational definition	Scale measurement
Age	Age at as last birthday	Continuous (years)
Sex	Male and female	Nominal
Educational level	No formal education, primary, JHS, SHS, vocation, tertiary	Ordinal
Marital status	Single, married, divorced, widow	Nominal
Religion	Christian, Muslim, traditional	Nominal
Ethnic group/tribe	Ga, Akan, Ewe, Northern-tribe	Nominal
Occupation	Formal or informal work	Nominal
NHIS	Have or do not have	Nominal
Health status	Good, somehow good, poor, bad	Ordinal
Place of seeking healthcare	Health facility, self-medication, herbal, spiritual treatment	Nominal
Chronic diseases	Have chronic disease or do not have chronic disease	Nominal
Regular medical check-up	Seek regular medical care or do not seek regular medical care	Nominal

Healthcare accessibility challenges	Challenges encounter whiles seeking health care	Nominal
Quality of life	Mobility, self-care, daily activities, pain, mode disorders	Nominal
Your health today	Zero to hundred	Ordinal

3.4 Study population

The study involved resident older adults who were 60 years old and above (60+ years old) in La Nkwantanang Madina Municipal.

3.4.1 Inclusion and exclusion Criteria

3.4.2 Inclusion criteria

To meet the inclusion criteria for the study, an adult should be aged 60 years and above and must be resident in the La Nkwantanang Madina Municipal or an adult visitor aged 60+ years who had stayed in the area for more than one year.

3.4.3 Exclusion Criteria

Adults younger than 60 years, adults who are seriously ill or a visitor aged 60+ years and lived in the municipality less than one year.

3.5 Sample size determination

To estimate the sample size for the study, Cochran's formula was used. The population of the district was over 100,000 inhabitants.

$$n = \frac{z^2 p(1-p)}{e^2} \times DEFF$$

where n= sample size; z= score of 1.96; p=proportion of the variable of interest (the outcome variable in this study was the proportion of usage of health services by older adults in La Nkwantanang Madina Municipal), e=acceptable margin of error and DEFF=design effect as a correction factor to adjust for the sample size because of the random sampling in the multi-stage sampling of the communities. It has been set at 1.5 as the minimum.

From the Ministry of Health, Ghana Health Service and District Health Information Management Software 2 (dhims2), about 22% of adults aged 60 years and attended health facilities for out-patient and in-patient care in 2020 in the La Nkwantanang Madina Municipal. Therefore, 22% (0.22) was used as the proportion (p) of the utilization of health services among older adults with z=1.96, e =0.05 and substituting these values into the above equation, DEFF=1.5, the sample size is calculated as follows: $n = \frac{1.96^2 0.22(1-0.22)}{0.05^2} \times 1.5$

$n = \frac{3.8416x0.22(0.78)}{0.0025} \times 1.5$=263.687424*1.5=395.531136.

To cater for non-responses, incomplete and inconsistent responses during the administration and processing of the questionnaire, the sample size was adjusted by 10%. The final sample size was 395.531136*1.10=435.084≈=435. Therefore, the sample size for the study came up to **435** older adults aged 60 years and above.

3.6 Sample selection

Multi-stage sampling techniques were employed to select participants for the study. The Municipality consists of five sub-districts with three urban (Tatanaa, Nkwantanang and Social Welfare) and two rural (Danfa and Pantang). A simple random process was used to select one sub-district from the urban and rural sub-districts. Danfa and Social Welfare sub-districts were selected

for the study in order to have a fair representation of the rural and urban geographical composition of district. The largest community from each of the two selected sub-district (New Adoteiman; rural and Arapaji; urban) were selected they being the largest and capital centres of the sub-districts, were likely to have residents from both rural and urban, and to some extent, resource constraints.

A random walk was done by starting at a central point in the selected communities. By spinning a bottle to get the first house to start with, the interviewer moved to the house in the direction of the tip of the bottle points. Sample intervals of four and two houses were used to select the house to enter. On entering the house, and introducing the purposes of the research, the researcher asked if there were any eligible participants for the study. The interviewer goes back to the starting point and moved to a different direction to spin the bottle again till the required sample size was obtained for each of the selected sub-districts. After selecting a direction, an interviewer entered every house and interviewed eligible older adults for the study. Where there was no eligible older adult, the interviewer moved to the next house. The process was repeated till the number of respondents for the study was obtained.

Table 2: The estimated population of older adults in the selected sub-districts in 2021

Sub-district	**Estimated population of 60 years old and above in 2021***	**Number of participants to be interviewed**
Danfa	706	(706/2,329)*435=**132**
Social Welfare	1,623	(1,623/2,329)*435=**303**
Total	**2,329**	**435**

Source: Municipal Health Directorate, 2021 Population La Nkwantanang Madina Municipal Area.

3.7 Data collection instrument

Data was collected using an interviewer-administered questionnaire which consists of both close and open-ended questions. The approved questionnaire was uploaded onto mobile application software and administered to older adults in their residence by trained research assistants and the researcher using English, Ga-Adangbe and Ewe (the dominant local languages spoken in the study area).

3.8 Data collection procedure

Data on QoL was collected using the EQ-5D questionnaire; a standardized measure of health status developed by the EuroQol Group to provide a simple, generic measure of health for clinical and economic appraisal. The EQ-5D-3L is one of the most widely used instruments worldwide for measuring health status. The questionnaire provides a simple descriptive profile of a respondent's health state. The EQ VAS provides an alternative way to elicit an individual's rating of their own overall current health (EuroQol Research Foundation, 2019).

The questionnaires were piloted among 20 respondents in a similar district (Adenta Municipal Area) after which it was fine-tuned and the challenges with its administration addressed. Data collection took three weeks to complete. Interviews started at 9:00 am and ended at 4:00 pm each day.

3.9 Data processing and analysis

The data collected was checked, coded and analyzed using Statistical Package for the Social Sciences (SPSS) version 20. Descriptive statistics (standard deviations, frequencies and proportions) was used to summarize the data. Chi-square test of associations was used to determine relationship between dependent and independent variables at a p-value of 0.05 as the significance level. Logistic regression analysis was done to determine the predictors of the outcomes with an estimation of the odds ratio at Confidence Interval (CI) of 95%. Independent variables which were found to have

significant associations in the Chi-square analyses were entered into the logistic regression model to identify the determinants of health seeking behaviour.

3.10 Ethical consideration

Ethical clearance was obtained from Ghana Health Service Ethics Review Committee through the School of Public Health of the University of Ghana. In addition, an introductory letter was given by the School of Public Health was sent to the Assembly members of the Electoral Areas within the La Nkwantanang Madina Municipal to inform them about the study for permission and support for a successful study. Identity cards were developed for the Research Assistants. The respondents were given assurance of respecting their privacy and maintaining confidentiality rules throughout the study.

3.10.1 Study area approval

Permission was granted by La-Kwantung Madina Municipal Health Directorate through the Greater Accra Regional Health Directorate before the commencement of the study.

3.10.2 Informed consent

Informed consent was obtained from all respondents who were required to sign or thumbprint the consent form. The purpose of the study was explained to them before their written consent and verbal informed consent were obtained.

3.10.3 Potential Risks

There were no risks to the study participants. Possible long duration of the interview or perceived to be time wasting may be discomforting to respondents.

3.10.4 Benefits

There were no direct benefits for consent to take part in the study.

3.10.5 Costs to participants

No cost was directly incurred by the participants.

3.10.6 Compensation

There was no payment of compensation to participants or their family members. However, messages of appreciation were extended to them and their families.

3.10.7 Confidentiality

The data collected from the respondents was handled with the utmost confidentiality. Names of respondents were not recorded on the questionnaire. The data being for academic purposes will not be shared with any third party.

3.10.8 Sharing of participants Information/Data

For security and trust between the respondents and the research assistants, the data collected was not shared with any unauthorized third party other than the School of Public Health and Ghana Health Service. They were saved in an email and would be destroyed after five years if there is no further need for it. Findings from the study were presented to the GHS and the participants.

3.10.9 Provision of Information and Consent for participants

Information was provided by qualified participants who consented to be part of the study.

3.10.10 Declaration of conflict of interest

The researcher does not have any conflict of interest to declare in this study.

CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

The results of the study conducted with 464 older adults from the Social Welfare and Danfa sub-municipalities are presented in this chapter. The results are categorized into the seven sections.

4.1 Socio-demographic characteristics of older adults in La Nkwantanang Madina Municipal Area

The average age of respondents in this study was 76.97±11.38 years old at the time of this survey. Nearly 50% (49.4%) of the participants were widows whiles 147 (31.7%) were still married. They are mainly from two ethnic groups the Ga-Adangbe 176, (37.9%) and the Ewe 147, (31.7%). Also 371 (80.0%) respondents lived with relatives, with respondents' child(ren) being 205 (55.3%) and partners/spouses being 128 (34.5%). Prior to this survey, 248, (53.4%) participants were businessmen and women and 107, (23.1%) were farmers. Concerning income, almost half 214, (46.1%) indicated earning some income and the main source being either from self-employment 118, (55.1%) or remittance from their child(ren) 79, (36.9%). Only 60 (28.0%) indicated earning from their pension funds. The average monthly income for most participants was GH¢690.95±698.84. (Table 3)

Table 3: Socio-demographic characteristics of older adults in La Nkwantanang Madina Municipal

Variables	Frequency (465)	Percent
Age in group (years); MD±SD (76.97±11.38)	**n=465**	
60-69	157	33.80
70-79	119	25.6
80-89	114	24.6
90+	74	15.9
Sex of respondent	**n= (464)**	
Male	186	40.1
Female	278	59.9
Educational level	**n= (464)**	
None	209	45
Primary	98	21.1
Middle School	123	26.5
Secondary	10	2.2
Tertiary	24	5.2
Marital status	**n= (464)**	
Single	57	12.3
Married	147	31.7
Divorced	31	6.7
Widowed	229	49.4
Religion	**n= (464)**	
Christianity	352	75.9
Islam	62	13.4
Traditional	50	10.8
Ethnicity	**n= (464)**	
Akan	80	17.2
Ewe	147	31.7
Ga-Adangbe	176	37.9
Northern tribe	61	13.1
Currently staying with a relative	**n= (464)**	
No	93	20.0
Yes	371	80.0
Who respondents are currently staying with	**n=371**	
Partner/spouse	128	34.5
Child(ren)	205	55.3
Sibling(s)	16	4.3
Extended family member	22	5.9
Formal occupation	**n=465**	
Farming	107	23.1
Teaching	21	4.5
Health worker	13	2.8
Banking/finance	5	1.1
Businessman/ woman	248	53.4
Other (specify)	70	15.1

Currently earning income	**n= (464)**	
No	250	53.9
Yes	214	46.1
Source of Income	**n= (267)**	
Pension	60	28.0
Self-employment	118	55.1
Remittance from children	79	36.9
Support from other family members?	13	6.1
Average monthly income MD±SD	691.0 ±698. 0	

4.2 Health seeking behaviour of older adults in La Nkwantanang Madina Municipal

Table 4 gives information on health seeking behaviour of respondents in the study. It shows that 348 (75.0%) respondents indicated heaving some form of health insurance scheme. Almost three-quarters of these are insured with the national health insurance (NHIS) 341, (73.5%). When asked how they perceived their health status at the time of the survey, 275 (59.3%) described their health status as "somehow good", and 131 (28.2%) indicated feeling "good" whiles 57 (12.3%) described their health status as "poor". Most 341, (73.5%) participants reported to "health facilities" when seeking health care services, and the other minority 69, (14.9%) resorted to self-medication. For those who assessed formal care public/government health facilities were the most preferred choices 295, (63.6%). Regarding support, 377 (84.5%) indicated they receive support from their family. For most of them 358, (95.0%), these supports were in the form of money. Other participants 297, (78.8%) were receiving only aid related to feeding.

Many 175, (40.8%) participants indicated suffering some chronic disease that lasted six months in the year proceeding the survey. The most frequently reported illnesses were Hypertension 71, (40.6%) and Arthritis 69, (39.4%). The decision to visit health facilities when sick was made by 258, (55.6%) of the respondents while Child(ren) 155, (33.4%) decided for the participants. Spouse/partner really decided for less than a tenth of the respondents 36, (7.8%).

Regarding seeking regular medical check-ups which is the dependent variable of the study, more than half, 243 (52.4%) of the participants indicated reporting to health facility (Table 4.2).

Of the 221 (47.6%) respondents who gave reasons for not going for medical check-up, 121 (59.6%) mentioned financial difficulties as prime reason. Only 12 (2.6%) of them prefer self-medication to regular medical check-ups. When asked about their source of information on health conditions, the radio 353, (76.1%) happened to be the most common source of information followed by healthcare workers 278 (59.9%), family members 184 (39.7%) and the TV, 183 (39.4%).

Table 4: Health seeking behaviour of older adults in La Nkwantanang Madina Municipal

Variables	Frequency (464)	Percent
Health insurance		
No	116	25.0
Yes	348	75.0
Type of health insurance	**n=348**	
National Health Insurance Scheme	341	73.5
Private health insurance scheme	3	0.6
Workplace insurance scheme	4	0.9
Current health status	**n= (464)**	
Good	131	28.2
Somehow good	275	59.3
Poor	57	12.3
Bad	1	0.2
Where health care is sought if or when sick	**n= (464)**	
Health facilities	341	73.5
Self-medication	69	14.9
Herbal/traditional treatment	48	10.3
Spiritual healing	6	1.3
Type of health facility used when sick	**n= (464)**	
Public/government	295	63.6
Private	59	12.7
Self-medication	110	23.7
Support from family member when sick	**n=446**	
No	69	15.5
Yes	377	84.5
Type of support	**n= (464)**	95.0
Financial/ money	358	78.8
Feeding	297	47.2
Psychological	178	
Suffering from chronic disease (	**n=429**	
No	254	59.2
Yes	175	40.8
Type of chronic disease	**n= (201)**	
Arthristis	69	39.4
Hypertension	71	40.6
Asthma	3	1.7
Diabetes	25	14.3
Stroke	3	1.7
Ulcer	3	1.7
Others	27	15.4
Who decides when to seek health care when you are sick?	**n= (464)**	
Self	258	55.6
Spouse/partner	36	7.8

Child(ren)	155	33.4
Sibling(s)	4	0.9
Extended family relations	11	2.4
Seek regular medical check-ups as an elderly person	**n= (464)**	
No	221	47.6
Yes	243	52.4
Reasons for not seeking regular medical check-ups (n=203)	**n= (203)**	
Financial difficulties	121	59.6
Feel Fine	61	30.0
Self-medication	12	6.0
Others	9	4.4
Sources of health information*	**n= (464)**	
Healthcare workers	278	59.9
Books	35	7.5
Family members	184	39.7
TV	183	39.4
Radio	353	76.1
Internet	8	1.7
Social media (WhatsApp)	19	4.1
Friends	171	36.9

**Multiple response*

4.3 Factors influencing health seeking behaviour of older adults in La Nkwantanang Madina Municipal

As shown in Table 5, only a few 125, (26.9%,) of the participants indicated facing some challenges in accessing health care services. For those who reported facing some challenges, the Cost of drugs 120, (96.8, %), waiting time at health facilities 104, (83.9%,), attitude of health workers 81, (65.3%) and the lack/cost of transportation 72, (58.1%,) were the most recurrent.

Table 5: Factors influencing health-seeking behaviour of older adults in La Nkwantanang Madina Municipal.

Variables	Frequency(464)	Percent
Challenges accessing health care	**n= (464)**	
No	339	73.1
Yes	125	26.9
Type of challenges	**n= (464)**	
Difficulty in getting or renewing NHIS card	79	63.7
Distance to health facilities	50	40.3
Attitude of health workers	81	65.3
Waiting time at health facilities	104	83.9
Cost of drugs	120	96.8
Lack/cost of transportation	72	58.1
Quality of care	46	37.1

4.4 Health-related quality of life among older adults residing in La Nkwantanang Madina Municipal

Table 6 shows that most participants had no problems walking about 243(52.4%), 238(51.3%) are able to care for themselves by washing or dressing themselves. and, 212 (45.7%) could sustain their usual activities. Ten participants (2.2%) indicated having severe problems doing their usual activities. Also, 245(52.8%) participants indicated they experience slight pain or discomfort. Regarding anxiety 179(38.6%) of the participants indicated being slightly anxious whiles 53(11.4%) of them were moderately anxious. Averagely, participants perceived their health to be 71.03±14.65 percent good. Perceived health status of respondents was grouped into three categories thus 0-50 as poor, 51-80 as good and 80-100 as very good QoL.

Table 6: Quality of life residing of older adults residing in La Nkwantanang Madina Municipal

Variables	Frequency (464)	Percent
Mobility	**n= (464)**	
I have no problems in walking about	243	52.4
I have slight problems in walking about	165	35.6
I have moderate problems in walking about	45	9.7
I have severe problems in walking about	8	1.7
I am unable to walk about	3	0.6
Self-care	**n= (464)**	
I have no problems washing or dressing myself	238	51.3
I have slight problems washing or dressing myself	181	39
I have moderate problems washing or dressing myself	35	7.5
I have severe problems washing or dressing myself	10	2.2
Usual activities	**n= (464)**	
I have no problems doing my usual activities	212	45.7
I have slight problems doing my usual activities	200	43.1
I have moderate problems doing my usual activities	40	8.6
I have severe problems doing my usual activities	10	2.2
I am unable to do my usual activities	2	0.4
Pain/discomfort	**n= (464)**	
I have no pain or discomfort	134	28.9
I have slight pain or discomfort	245	52.8
I have moderate pain or discomfort	71	15.3
I have severe pain or discomfort	12	2.6
I have extreme pain or discomfort	2	0.4
Anxiety	**n= (464)**	
I am not anxious	223	48.1
I am slightly anxious	179	38.6
I am moderately anxious	53	11.4
I am severely anxious	8	1.7
I am extremely anxious	1	0.2
Health status estimation in percentage (%):		
MD±SD	71.03±14.65	

4.5 Association between background characteristics and health seeking behaviour of older adults in La Nkwantanang Madina Municipal.

In Table 7 Education was found to be significantly associated (29.967, $p<0.001$) with positive health seeking behaviour. Respondents with higher level of education (Elementary and Tertiary) had more

regular medical check-ups than those without any form of education. Also, staying with a relative was significantly associated (27.793, p<0.001) with having regular medical check-ups. Those who indicated staying with either their partner/spouse or siblings have having medical check-ups more frequently compared to those staying alone. Participants' profession prior to the survey was significantly associated (27.184, p<0.001) with positive health seeking behaviour. Those who had formal occupation such as business, banking/finance, and health workers, had more regular medical check-ups than those who were farmers and teachers. Receiving incomes showed to be significantly associated (5.810, p=0.016) with positive health seeking behaviour. Subsequently, we observed that those who often go for medical check-ups had more net income (GH¢871.87±764.873) than those less frequently visited health facilities (GH¢436.85±495.933). (p <0.001).

Table 7: Association between background characteristics and health seeking behaviour older adults in La Nkwantanang Madina Municipal

	Seek regular check-up of elderly persons		
Variables	**No**	**Yes**	**χ^2 (P-value)**
	n (%)	**n(%)**	
Age group(years)	**n= (221)**	**n=243**	**4.779(0.189)**
60-69	74(47.1)	83(52.9)	
70-79	50(42.0)	69(58.0)	
80-89	54(47.4)	60(52.6)	
90+	43 (58.1)	31 (41.9)	
Sex of respondent	**n= (221)**		0.09(0.76)
Male	87(46.8)	99(53.2)	
Female	134(48.2)	144(51.8)	
Educational level	**n= (216)**		27.63(**<0.001)***
None	124(59.3)	85(40.7)	
Primary/Elementary	32(32.7)	66(67.3)	
Middle School	55(44.7)	68(55.3)	
Secondary	5(50)	5(50)	
Tertiary	5(20.8)	19(79.2)	
Marital status	**n= (221)**		33.18(**<0.001)***
Single	46(80.7)	11(19.3)	
Married	63(42.9)	84(57.1)	
Divorced	19(61.3)	12(38.7)	
Widowed	93(40.6)	136(59.4)	

Religion	**n= (221)**		29.97(**<0.001)***
Christianity	154(43.8)	198(56.3)	
Islam	25(40.3)	37(59.7)	
Traditional	42(84)	8(16)	
Ethnicity	**n= (221)**		14.38**(0.002)***
Akan	25(31.3)	55(68.8)	
Ewe	78(53.1)	69(46.9)	
Ga-Adangbe	94(53.4)	82(46.6)	
Northern tribe	24(39.3)	37(60.7)	
Staying with a relative	**n= (221)**		27.79(**<0.001)***
No	67(72)	26(28)	
Yes	154(41.5)	217(58.5)	
Who respondents currently staying with	**n=371** 53(41.4)		10.05(**0.018)***
Partner/spouse	80(39)	75(58.6)	
Child(ren)	5(31.3)	125(61)	
Sibling(s)	16(72.7)	11(68.8)	
Extended family member		6(27.3)	
Respondents Occupation	**n= (221)**		27.18(**<0.001)***
Farming	69(64.5)	38(35.5)	
Teaching	8(38.1)	13(61.9)	
Health worker	1(7.7)	12(92.3)	
Banking/finance	0(0)	5(100)	
Business man/woman	109(44)	139(56)	
Other (specify)	34(48.6)	36(51.4)	
Currently earning income	**n= (221)**		5. 81**(0.016)***
No	132(52.8)	118(47.2)	
Yes	89(41.6)	125(58.4)	
Source of income	**n= (102)**		21.46**(<0.001)***
Pension	14(23.3)	46(76.7)	
Self-employment	57(48.3)	61(51.7)	
Remittance from children	29(36.7)	50(63.3)	
Support from other family members?	2(15.4)	11(84.6)	
Average monthly income MD±SD	436.85±495.93	871.87±764.87	**<0.001****

*p***: t-test significant when <0.05; *p* *: chi-square significant *when <0.05*

4.6 Factors associated with health seeking behaviour of older adults in La Nkwantanang Madina Municipal.

Table 8 shows that subscribing to a health insurance scheme was significantly associated (32.974, $p<0.001$) with positive health seeking behaviour. Those with health insurance visit a health care facility for medical check-up most frequent. Also, most of those who go for regular check-ups

indicated perceiving their health status as “Good” or “Somehow good” compared to those with less frequent medical check-ups who described their health status as “poor” or” bad”. (10.372, p=0.016). Most people who went for frequent medical check-ups were doing so at public/government health facilities and the association between participants sought health care services and the positive health seeking behaviour was significant (150.818, p<0.001). Receiving support from family members was significantly associated with positive health seeking behaviour (4.351, p=0.037). The type of support received was also significantly associated with positive health seeking behaviours (22.009, p<0.001). Those who frequently visited health facilities were those receiving financial support from their family. Those who went for regular medical check-ups did so for diseases such as hypertension, diabetes and stroke, and the association was significant (85.969, p<0.001). In most cases, the decision to seek health care services came from spouse/partner and child(ren) more often than from older adults themselves, and the association was also significant (9.643, p=0.047). Most of those who had frequently visited health facility were those who received information from healthcare workers, TV, and Radio and the association was significant (190.568, p<0.001).

Table 8: Factors associated with Health seeking behaviour of older adults in La Nkwantanang Madina Municipal

	Regular medical check-ups by elderly persons		
Variables	**No**	**Yes**	**χ^2 (P-value)**
	n (%)	**n (%)**	
Health insurance	**n= (221)**		32.974(<**0.001**)*
No	82(70.7)	34(29.3)	
Yes	139(39.9)	209(60.1)	
Type of health insurance	**n=348**		4.751(**0.930**)
National Health Insurance Scheme	139(40.8)	202(59.2)	
Private health insurance scheme	0(0)	3(100)	
Workplace insurance scheme	0(0)	4(100)	
Current health status	**n= (221)**		10.372**(0.016)***
Good	50(38.2)	81(61.8)	
Somehow good	135(49.1)	140(50.9)	
Poor	35(61.4)	22(38.6)	
Bad	1(100)	0(0)	
Where respondents seek health care when sick	**n= (221)**		141.496**(<0.001)***
Health facilities	106(31.1)	235(68.9)	
Self-medication	63(91.3)	6(8.7)	
Herbal/traditional treatment	46(95.8)	2(4.2)	
Spiritual healing	6(100)	0(0)	
Type of health facility used	**n= (221)**		150.818**(<0.001)***
Public/government	88(29.8)	207(70.2)	
Private	25(42.4)	34(57.6)	
Self-medication	108(98.2)	2(1.8)	
Support from family member when sick (	**n=446**		4.351**(0.037)***
No	42(60.9)	27(39.1)	
Yes	178(47.2)	199(52.8)	
Type of support	**n= (334)**		22.009**(<0.001)***
Financial/ money	145(40.5)	213(59.5)	
Feeding	129(43.4)	168(56.6)	
Psychological	60(33.7)	118(66.3)	
Suffer from any chronic disease (lasting more than six months) in the past one year	**n=429**		3.607(0.058)
No	120(47.2)	134(52.8)	
Yes	99(56.6)	76(43.4)	

Type of chronic disease suffered in the last one year	**n= (95)**		85.969**(<0.001)***
Arthritis	55(79.7)	14(20.3)	
Hypertension	24(33.8)	47(66.2)	
Asthma	1(33.3)	2(66.7)	
Diabetes	0(0)	25(100)	
Stroke	0(0)	3(100)	
Ulcer	2(66.7)	1(33.3)	
Others	13(48.1)	14(51.9)	
Who decides when to seek health care when sick?	**n= (221)**		9.643**(0.047)***
Self	131(50.8)	127(49.2)	
Spouse/partner	16(44.4)	20(55.6)	
Child(ren)	64(41.3)	91(58.7)	
Sibling(s)	1(25)	3(75)	
Extended family relations	9(81.8)	2(18.2)	
Health information source	**n= (464)**		190.568**(<0.001)***
Healthcare workers	80(28.8)	198(71.2)	
Books	6(17.1)	29(82.9)	
Family members	70(38)	114(62)	
TV	61(33.3)	122(66.7)	
Radio	148(41.9)	205(58.1)	
Internet	1(12.5)	7(87.5)	
Social media (WhatsApp)	4(21.1)	15(78.9)	
Friends	100(58.5)	71(41.5)	

p *: chi-square significant *when <0.05*

4.7 Utilization of health services of older adults residing in La Nkwantanang Madina Municipal

Most participants 448, (96.6%) knew some health facilities in or near their residence. Most of the respondent 253, (56.5 %,), indicated knowing the hospitals close to them, Health Centres 153, (34.2%) and Clinics 87, (19.4 %,). The ownership of these health facilities their residences were mostly public health facilities followed by faith-based. Regarding distance, most participants takes an average of 10.146±20.60 minutes to reach their health facility, and the nearest health facility was located within 1.817±3.90 km from their residence. The average number of visits to a health care

facility was 3.85±1.88 in a year, and participants reported spending an average of GH¢128.95±192.51 a month to receive health care services.

Table 9: Utilization of health services of older adults in La Nkwantanang Madina Municipal

Variables	Frequency (464)	Percent
Awareness of health facility in the community	**n= (464)**	
No	16	3.4
Yes	448	96.6
Type of health facility	**n= (464)**	
CHPS Compound	17	3.8
Clinic	87	19.4
Health Centre	153	34.2
Hospital	253	56.5
Herbal Centre	13	2.9
Other(specify)	2	0.4
Ownership of the health facility	**n=448**	
Government/public	300	67
Private	21	4.7
Faith-based/mission/religious	127	28.3
Seek health care from any health facility in the past year	**n= (465)**	
No	198	42.7
Yes	266	57.3
Duration to health facility in minutes: MD±SD	10.146±20.60	
Distance to health facility in kilometres: MD±SD	1.817±3.90	
Have health condition which you sought health care in the past one year	**n= (465)**	
No	199	42.9
Yes	265	57.1
Health conditions for which are is sought (	**n=265***	55.5
Hypertension	147	23.0
Diabetes mellitus	61	53.6
Joint pains/arthritis	142	7.5
Ulcer	20	7.9
Skin infection	21	13.6
Chest pains	36	3.8
Hearing impairment	10	22.6
Eye problems	60	9.1
Dental problems	24	1.9
Uterine problem	5	3.0
Asthma	8	12.1
Other(specify)	32	

Sought health care with the above health condition	**n= (464)**	
No	208	44.8
Yes	256	55.2
Where health care was sought with the above health condition	**n= (207)**	
Chemical store	25	5.4
Danfa Clinic	48	10.3
Dodowa government hospital	3	0.6
Lakma hospital	1	0.2
Legon hospital	1	0.2
None	49	10.6
Pentecost Hospital	30	6.5
Prayer camp	1	0.2
Rawlings circle Madina polyclinic	3	0.6
Self-medication	31	6.7
Stanford clinic	1	0.2
Traditional treatment	14	3.0
How many times respondents report at the hospital	**n= (207)**	
MD±SD	3.85±1.88	
How many health conditions reported (	**n=256**	
One illness	54	21.1
Two illnesses	121	47.3
Three and more illnesses	81	31.6
Amount of money spent on health care per visit: MD±SD	128.95±192.51	

4.8 Association between Utilization of health services and Health seeking behaviour of older adults in La Nkwantanang Madina Municipal.

Participants who had regular medical check-ups more were living near either a hospital, a health centre or a clinic, than those living far away (28.748, $p<0.001$). Participants with frequent medical check-ups spent less time reaching out their health facility than those with less frequent medical check-ups ($p=0.019$). Participants with positive health seeking behaviour had reported to health facilities for diseases such as hypertension, diabetes mellitus, and joint pains/arthritis, and the association was also significant (141.385, $p<0.001$). There was significant association between the amount of money spent in a health facility and the frequency of medical check-ups ($p<0.001$).

Participants who had more frequent medical check-ups were spending more money in health facilities than those with less frequent medical check-ups.

Table 10: Association between Utilization of health services and Health seeking behaviour of older adults in La-Nkwantanang Madina Municipal

	Seek regular medical check-ups as an elderly person		
Variables	**No n(%)**	**Yes n(%)**	**χ^2 (P-value)**
Awareness of health facility in the community	**n= (221)**		3.402(0.065)
No	4(25)	12(75)	
Yes	217(48.4)	231(51.6)	
Type of health facility is in your community	**n= (221)**		28.748(**<0.001)***
CHPS Compound	10(58.8)	7(41.2)	
Clinic	25(28.7)	62(71.3)	
Health Centre	76(49.7)	77(50.3)	
Hospital	112(44.3)	141(55.7)	
Herbal Centre	11(84.6)	2(15.4)	
Other(specify)	1(50)	1(50)	
Ownership of the health facility (	**n=448**		
Government/public	137(45.7)	163(54.3)	2.885(0.236)
Private	12(57.1)	9(42.9)	
Faith-based/mission/religious	68(53.5)	59(46.5)	
Visited any health facility in the past year with any health condition	**n= (221)**		83.745**(<0.001)***
No	143(72.2)	55(27.8)	
Yes	78(29.3)	188(70.7)	
Duration to health facility of choice for treatment:	**n= (221)**	8.2436±19.83	**0.019****
MD±SD	14.7314±21.78		
Distance to the nearest health facility	**n= (221)**	1.9704±454.03	0.318
MD±SD	1.4471±126.949		
Ever had a health condition (illness) and sought care in the past one year?	**n= (221)**		36.614**(<0.001)***
No	127(63.8)	72(36.2)	
Yes	94(35.5)	171(64.5)	

Health condition suffered and sought care	**n= (221)**		141.385	**(<0.001)***
Hypertension	39(26.5)	108(73.5)		
Diabetes mellitus	7(11.5)	54(88.5)		
Joint pains/arthritis	66(46.5)	76(53.5)		
Ulcer	14(70)	6(30)		
Skin infection	16(76.2)	5(23.8)		
Chest pains	32(88.9)	4(11.1)		
Hearing impairment	1(10)	9(90)		
Eye problems	17(28.3)	43(71.7)		
Dental problems	13(54.2)	11(45.8)		
Uterine problem	2(40)	3(60)		
Asthma	1(12.5)	7(87.5)		
Other(specify)	16(50)	16(50)		
Visited a health facility with any of the above health conditions	**n= (221)**		125.475	**(<0.001)***
No	159(76.4)	49(23.6)		
Yes	62(24.2)	194(75.8)		
Where care as sought to with any of the above health conditions	**n= (221)**		38.138	**(<0.001)***
	24(96)			
Chemical store	30(62.5)	1(4)		
Danfa Clinic	3(100)	18(37.5)		
Dodowa	1(100)	0(0)		
Lakma	0(0)	0(0)		
Legon hospital	35(71.4)	1(100)		
None	18(60)	14(28.6)		
Pentecost Hospital	0(0)	12(40)		
Prayer camp	2(66.7)	1(100)		
Rawlings circle	31(100)	1(33.3)		
Self-medication	1(100)	0(0)		
Stanford clinic	14(100)	0(0)		
Traditional treatment		0(0)		
Number of times respondents visit health facility in the past one year: MD±SD	2.81±1.513	4.19±1.868		**<0.001 ***
Number of health conditions reported with the health facility	**n=256**		0.822	0.663(**<0.001 ****
One illness	11(20.4)	43(79.6)		
Two illnesses	29(24)	92(76)		
Three and more illnesses	22(27.2)	59(72.8)		
Amount of money spent per visit MD±SD	73.94±151.08	178.98±211.84		

*p***: t-test significant when <0.05; *p* *: chi-square significant *when <0.05*

4.9 Factors associated with health seeking behaviour of older adults in La Nkwantanang Madina Municipal

From Table 11, participants who went for regular medical check-ups reported facing no challenges at the health facility. Participants with irregular medical check-ups experience the following challenges and the association was significant (14.965, $p<0.001$). These challenges included cost of drugs, waiting time at health facilities, attitude of health workers, and lack/cost of transportation. These differences were significant (37.891, $p<0.001$).

Table 11: Factors associated with health seeking behaviour of older adults in La Nkwantanang Madina Municipal

	Regular medical check-ups by elderly persons		
Variables	**No n(%)**	**Yes n(%)**	**χ^2(P-value)**
Do you face any challenges in accessing health care?	**n= (221)**		14.965(**<0.001)***
No	143(42.2)	196(57.8)	
Yes	78(62.4)	47(37.6)	
Challenges to accessing health care	**n= (221)**		37.891**(<0.001)***
Difficulty in getting or renewing NHIS card?	60(75.9)	19(24.1)	
Distance to health facilities	25(50)	25(50)	
Attitude of health workers	51(63)	30(37)	
Waiting time at health facilities	63(60.6)	41(39.4)	
Cost of drugs	75(62.5)	45(37.5)	
Lack/cost of transportation	51(70.8)	21(29.2)	
Quality of care	21(45.7)	25(54.3)	

p *: chi-square test significant *when <0.05*

4.10 Association between health seeking behaviour and health-related quality of life of older adults residing in La Nkwantanang Madina Municipal.

As shown in Table 12, there was a significant association between patients with regular medical check-ups not feeling anxious or depressed, compared to those with less frequent medical check-ups

(15.935, p<0.003). Also, more participants with frequent medical check-ups perceived their health to be better compared to those with less frequent medical check-ups. This association was also significant (p<0.001).

Table 12: Association between health seeking behaviour and health-related quality of life of older adults residing in La Nkwantanang Madina Municipal

	Regular medical check-ups by elderly persons		
Variables	**No n(%)**	**Yes n(%)**	**χ^2(P-value)**
Mobility	**n= (221)**	**n= (244)**	
I have no problems in walking about	111(45.7)	132(54.3)	4.829(0.305)
I have slight problems in walking about	78(47.3)	87(52.7)	
I have moderate problems in walking about	25(55.6)	20(44.4)	
I have severe problems in walking about	4(50)	4(50)	
I am unable to walk about	3(100)	0(0)	
Self-care	**n= (221)**		0.333(0.95)
I have no problems washing or dressing myself	111(46.6)	127(53.4)	
I have slight problems washing or dressing myself	87(48.1)	94(51.9)	
I have moderate problems washing or dressing myself	18(51.4)	17(48.6)	
I have severe problems washing or dressing myself	5(50)	5(50)	
Usual activities			0.056(1.000)
I have no problems doing my usual activities	100(47.2)	112(52.8)	
I have slight problems doing my usual activities	96(48)	104(52)	
I have moderate problems doing my usual activities	19(47.5)	21(52.5)	
I have severe problems doing my usual activities	5(50)	5(50)	
I am unable to do my usual activities	1(50)	1(50)	
Pain / Discomfort	**n= (221)**	**n= (244)**	1.16(0.885)
I have no pain or discomfort	61(45.5)	73(54.5)	
I have slight pain or discomfort	120(49)	125(51)	
I have moderate pain or discomfort	32(45.1)	39(54.9)	
I have severe pain or discomfort	7(58.3)	5(41.7)	
I have extreme pain or discomfort	1(50)	1(50)	
Anxiety/depression	**n= (221)**		
I am not anxious or depressed	89(39.9)	134(60.1)	15.935**(0.003)***
I am slightly anxious or depressed	91(50.8)	88(49.2)	
I am moderately anxious or depressed	36(67.9)	17(32.1)	
I am severely anxious or depressed	4(50)	4(50)	
I am extremely anxious or depressed	1(100)	0(0)	
Estimated health status in percentage: MD±SD	68.42±15.686	73.4±13.23	**<0.001****

*p***: t-test significant when <0.05; *p* *: chi-square test significant *when <0.05*

4.11 Relationship between health seeking behaviour and health-related quality of life among older adults in the La-Nkwantanang Madina Municipality

Table 4.11 shows the relationship between health seeking behaviour and health-related quality of life, binary logistic regression analysis was carried out. In the binary logistic regression analysis, the factors that were significantly associated with health seeking behaviour such as, age group, staying with a relative, receiving family support, and facing challenges in accessing healthcare (p<0.05). Respondents between 70-79 age group has 1.6 times the odds of 60-69 age group having regular medical check-ups. While the 80-89 years have 1.9 times the odds of going for regular medical check-ups compared to the 60-69 age group. Participants without health insurance were 73% less likely to go for regular medical check-ups than those who have. Older adults who do not receive support from their family members were 59% times less likely to go for regular medical check-ups compared to those who do. Respondents who do not stay with relatives have 0.36 times the odds of those who stay with relatives in seeking regular medical check-ups. Participants who are not earning monthly income are 30% less likely to seek regular medical check-ups compared to those who do. Respondents who do not face challenges in accessing healthcare have 2 times the odds of those who face challenges in seeking regular medical check-ups.

Table 13: Relationship between health-seeking behaviour and health-related quality of life among older adults in the La-Nkwantanang Madina Municipality

	Binary logistic regression		
Factors	**OR**	**95%CI**	**P-value**
Age group (years)			
60-69	1.000		
70-79	1.556	0.890-2.718	0.121
80-89	1.914	1.063-3.446	0.030*
90+	1.541	0.854-2.781	0.151
Staying with a relative	1.000	Ref	
Yes	0.361	0.21-0.63	**0.000***
No			
Currently earning monthly income?		Ref	
Yes	1.000	0.46-1.08	0.104
No	0.703		
Subscribed to health insurance?		Ref	
Yes	1.000	0.16-0.45	**0.000***
No	0.270		
Receive family support	1.000	Ref	
Yes	0.412	0.23-0.73	**0.002***
No			
Face any challenges in accessing health care?	1.000	Ref	
Yes	2.028	1.28-3.22	**0.003***
No			
Quality of life (VAS score)	1.000	Ref	
Very Good	0.672	0.31-1.46	0.314
Poor	1.158	0.66-2.03	0.606
Good			

*p**: significant *p*-values<0.05; Cl: confidence level; OR: odd ration

4.12 Quality of life among older adults in the La-Nkwantanang Madina municipality

In order to determine quality of life among older adults, the VAS score was categorized into three, 0-50 as poor, 60-80 as good and 90-100 as very good. Few of the respondents 68 (14.7%) perceived their health as poor, while more than half 313 (67.5%) perceived their health as good with less than a quarter 83 (17.9%) perceiving their health as very good.

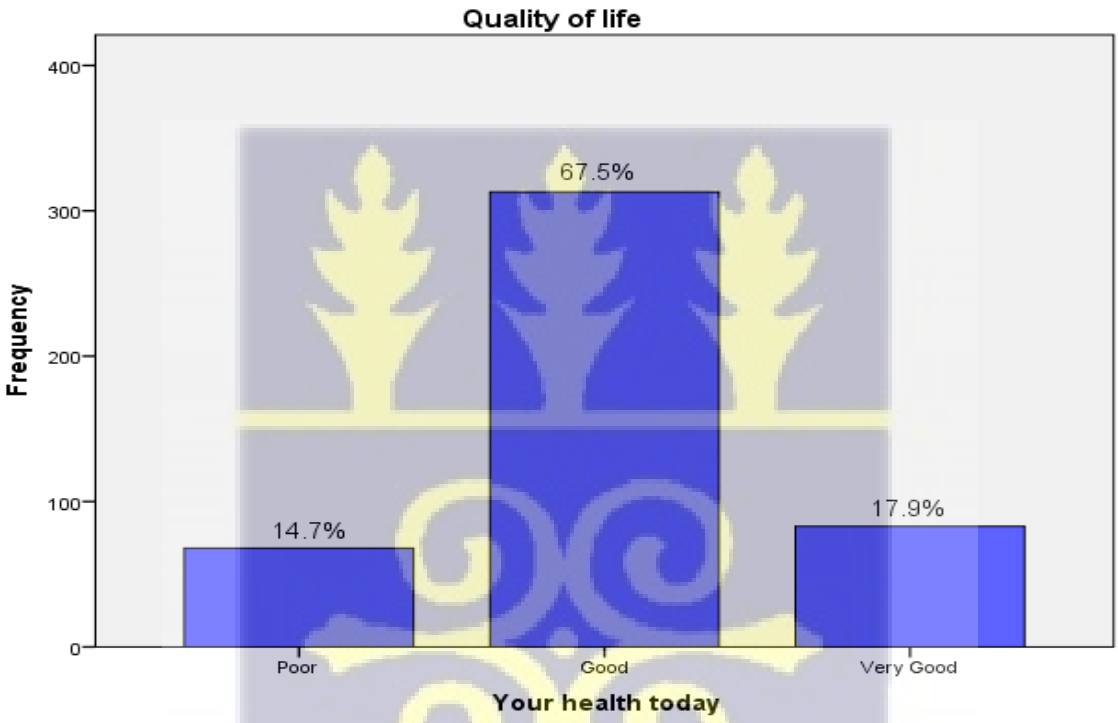

Figure 2: Quality of life (VAS categorization) among older adults in La-Nkwantanang Madina municipality

CHAPTER FIVE

5.0 DISCUSSION

5.0 Introduction

This chapter discusses the results of the study. The discussion covers factors associated with health seeking behaviour, utilization of health services and the relationship between health seeking behaviour and health-related quality of life among older adults in the La-Nkwantanang Madina Municipal Area

5.1 Health seeking behaviour of older adults in La Nkwantanang Madina Municipal

The study found that three-quarters of the older adults in the municipality have some form of health insurance with almost them subscribing to the NHIS. The high proportion of NHIS coverage among the elderly in this study is in contrast with studies in Ghana and Ethiopia which found only 43.3% and 14.5% of them having a health insurance scheme (Feyisa, Deyaso, & Tefera, 2020; Fonta, Nonvignon, Aikins, Nwosu, & Aryeetey, 2017).

The study found that being enrolled in a health insurance scheme was significantly associated with positive health seeking behaviour. Insured participants visit a health facility most frequently for medical check-ups. These findings agree with results of previous studies (Agyemang-Duah, Arthur-Holmes, Peprah, Adei, & Peprah, 2020; Baral & Sapkota, 2018; Chatterji, Byles, Cutler, Seeman, & Verdes, 2015; Devraj & D'mello, 2019; Fakoya et al., 2018; Feyisa et al., 2020; Hoi, Chuc, & Lindholm, 2010; Samadarshi, Taechaboonsermsak, Tipayamongkholgul, & Yodmai, 2020; Wen & Dong, 2019).

Another finding of this study was that less than 15% of the elderly resorted to self-medication compared to the nearly 75% of them seeking care at health facilities. This results compares with the

results of a study conducted in Assam District of India that about 30% of sick elderly persons practiced self-medication (Barua, Borah, Deka, & Kakati, 2017). Also, 75% of the adults who report to health facilities to seek health care is similar to the results of a Zimbabwe study (Ndarukwa, Chimbari, Sibanda, & Madanhire, 2020) but lower than the 85% and 96% in an Indian district (Tesfaye Falaha, 2016) and rural South Africa (Ameh et al., 2014) respectively.

This study found the most frequently reported illnesses to be hypertension, diabetes and Arthritis. This result agrees with that of several studies across the globe (Eisele et al., 2015; Feyisa et al., 2020). Demographic characteristics of older adults that were associated with positive health seeking behavior were education, marital status, religion, ethnicity, occupation, income and staying with a relative, NHIS and family support whilst age and sex did not have an association with health seeking behaviour. This is at variance with some studies which found the contrary (Daanko 2020. Naah, 2019)

5.2 Utilization of health services of older adults residing in La Nkwantanang Madina Municipal.

In this study, it has been found that knowledge of a health facilities close to the elderly, type of health facility, type of health condition being suffered and challenges to accessing health care were associated with use of health care services by the older adults.

The results of this study show that almost 97% of the older adults in the study know of a health facility closer to their community of residence; located within 1.8 to 3.9 km from their residence. This explained why it takes about 10 to 20 minutes for most older adults to reach health facility. Surprisingly, 43% of the older adults who had health conditions never sought health care from a

health facility with most of the conditions being chronic such as hypertension, diabetes mellitus and joint pains/arthritis. This proportion who do not seek health care from health facilities in spite of their close proximity is lower than the 69% of elderly persons who never visited health facility in the Illorin metropolis of Kwara State in Nigeria (Abdulraheem, 2007). Nonetheless this is not good for the elderly persons who by natural order of things are more vulnerable to negative health conditions which needs frequent visits to health facilities for medical attention and advice. The challenges that undermine the use of health care services among adults found in this study were cost of drugs, waiting time at health facilities, attitude of health workers and the lack or cost of transportation. This resonates with results of some studies elsewhere (Barua et al., 2017; Feyisa et al., 2020; Gnanasabai et al., 2020; Nwakasi, Brown, & Anyanwu, 2019). This study reveals that the average number of visits to a health care facility was 3.85±1.88 in a year suggesting high OPD per capita in the municipality which could be an expression of satisfaction with the health care received by the adults. An OPD per capita of at least one is the standard in the country.

5.3 Health-related quality of life residing of older adults in La Nkwantanang Madina Municipal

The study found that more than half of the older adults had no issue of mobility as they were able to walk around without problems. Also, nearly 90% of the adults in the study area have slight or no problem doing their usual activities. This is in sharp contrast with the finding of 92% of the elderly being unable to do their usual activities in the province of Gipuzkoa in Spain (Machón, Larrañaga, Dorronsoro, Vrotsou, & Vergara, 2017). Being able to walk about and do some activities should keep them healthy as they are likely to be engaged in slight physical activities. It is the expectation that everybody including the elderly should perform some physical activities in order to remain active as a way of promoting health.

While this study found physical activity to indicate better QoL among the adults, the contrary was found where physical health was a poor quality of life outcome among elderly persons (Soósová, 2016; Tajvar, Arab, & Montazeri, 2008). It is opined that ageing has a primary influence on the deterioration of health-related quality of life (HRQoL) at older ages, mainly due to reduction in physical rather than mental functions (Hoi et al., 2010; Tajvar et al., 2008).

In this study, older adults with regular medical check-ups reported not feeling anxious or depressed, more often than those with less frequent medical check-ups. Anxiety and depression which can be associated with old age possibly due to a lot of thought processes and moody situations in the minds of the elderly, this study found no expression of extreme anxiety/depression among the adults. This is in contrast with (Soósová, 2016) who reported 18.6% of moderate and 14.7% of severe anxiety in elderly persons.

Adults with frequent medical check-ups perceived their health to be better compared to those with less frequent medical check-ups. Whilst this study found that the quality of life of older adults to be rated between 71.03±14.65% among the older adults, the contrary was found in studies in Western Ethiopia where 63% of adults rated their health to be good and Puducherry district of Sri Lanka which had 81% of elderly persons seeking self-treatment rating their health to be good (Gnanasabai et al., 2020).

This study found that older adults who stay with a relative have a good health-related QoL resonates well with Tajvar et al. (2008) reported that a better health-related quality of life (HRQoL) was overserved among elderly people living with others compared to those living alone. Also, having a health insurance scheme was a significant determinant for positive health seeking behaviour. Participants with health insurance were more likely to go for regular medical check-ups. This results

agrees with (Lee, Xu, & Wu, 2020). Furthermore, receiving family support was a significant determinant for positive health seeking behaviour with regular medical check-ups leading to better HRQoL compared to those without support. This agrees with (Machón et al., 2017) that older persons with low level of social support were more likely to evaluate their HRQoL as poor, compared to those with high levels of social support. Anxiety/depression is found to have an association with the quality of life among the older adults in this study as was the case by some studies (Feyisa et al., 2020; Soósová, 2016)

5.4 Limitations of the study

A major limitation of the study are:

1. The self-assessment of health status by the elderly may be over or under exaggerated in order to meet social desirability responses as such caution should be exercised in the generalization of the findings.
2. The cross-sectional study design used only helped establish associations but not causal relationship between the variables, health related quality of life and health seeking behaviour.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents a summary of the key findings of the study. The study examines factors associated with health seeking behaviour among older adults in the La-Nkwantanang Madina Municipality. This chapter also provides recommendations that will improve health seeking behavior and QoL of the elderly in the La-Nkwantanang Madina municipality.

6.1 Conclusion

The study shows that older adults in the municipality are conscious of their health care needs as more than half of them sought regular medical check-ups at health facilities most of which were public health facilities. Resort to self-medication was very minimal among the elderly. The study shows a high coverage of NHIS subscriptions among the elderly comparable to the national coverage. Despite the good attitude towards seeking health care services regularly among the adults, there abound challenges when accessing care at health facilities such as the high cost of drugs, long waiting time and attitude of health workers. The difficulty in getting or renewing NHIS cards by the older adults could negatively affect their health seeking behaviour. The need for enhanced support systems from the family, community and the state are shown in this study promote and enhance the good health-seeking behaviour of the elderly people.

6.2 Recommendations

1. The government through its appropriate agencies should ensure that all older adults in the municipality enrolled in the NHIS as this have positive influence in the health seeking behaviour of older adults
2. Families should be encouraged to support the elderly as this contributes to good health seeking behaviour and promotes their psychological well-being.
3. The local assembly and interested stakeholders should consider the development of health-related programmes that promote active and healthy living especially physical activity as it is known to result in good health and long life.
4. The NHIS should consider adding most of the chronic conditions experienced by the elderly to the benefits package of the scheme.
5. The Ghana Health Service should consider establishing a health facility- a Geriatric Hospital- to be solely responsible for the health needs of the elderly in the municipality and beyond to reduce waiting time at health facilities.
6. The government should design social and economic policies and expand the LEAP programme: could be extended to cover all vulnerable old people to improve their health seeking behaviour

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APPENDICES

Appendix 1: Participant's information sheet

Title of the Study: Health Seeking Behaviour among Older Adults in the La-Nkwantanang Madina Municipality.

Introduction: I am Sarah Awuttey Apau (principal Investigator), a MPH student at the School of Public Health, University of Ghana. I am undertaking this research in partial fulfillment for the award of a Master of Public Health. My contact details are, Tel: 0547444104 and Email: apau.sarah @yahoo.com

This is a quantitative cross-sectional study to examine the health seeking behaviour among older adults in the La-Nkwantanang Madina Municipality. Four hundred and thirty-five eligible older adults aged sixty years and above will be interview. This study aimed to examine the health seeking behaviour among older adults in the La-Nkwantanang Madina Municipality. Two sub-districts (Danfa and Social welfare) will be selected from the Municipality.

Participants will answer questions on socio-demography (age, sex, level of education, marital status, religion, income level, number of children, family size, NHIS status, etc); **health system service factors** such as staff attitude, distance to health facilities, cost of health care, availability of drugs, availability of health workers, perceived quality of care, source of health information, etc; **quality of life** (mobility, self-care, usual activities, pain or discomfort and anxiety or depression). The principal investigator and research assistants will administer the questionnaire which is anticipated to be with 10-15minutes.

Participating in this study is completely voluntary. There will be no risks to the study participants. Aside having to spend about 10 minutes of your time answering a few questions, or feeling a bit

uncomfortable answering some of the questions due to their personal nature, no direct risk is expected to you for participating in this study. You are however under no obligation to answer all questions, and you may skip answering questions you are uncomfortable with or withdraw from at any point during the interview.

For further clarification regarding this study, contact Sarah Awuttey Apau (principal investigator) 0547444104. Dr. Agnes Millicent Kotoh, University of Ghana. (Supervisor). You can also reach out to the Administrator of the Ghana Health Service Ethics Review Committee by contacting on tel: 0503539896 and Email: ethics.research@ghsmail.org on issues concerning ethics.

Appendix 2: Consent form

Title of study: Health Seeking Behaviour among Older Adults in the La-Nkwantanang Madina Municipality

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and all questions satisfactorily explained to me in a language I understand (English, Twi, Ga Ewe and Hausa). I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.
Initials of
Participants……
Participants' signature……
Or Thumb Print……..
Date …….

INTERPRETERS' STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to therefore named participant to the best of my ability in the (English, Twi, Ga, Hausa, Ewe) language to his proper understanding. All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter……
Signature of Interpreter……..
OR Thumb Print ……..... ….
Date:……
Contact Details……

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood (English, Twi, Ga, Hausa, Ewe). I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:……

Signature…….....

OR Thumb Print …….....

Date:……

Appendix III: Questionnaire

Introduction: My name is Sarah Awuttey Apau, a Master of Public Health (MPH) student of the University of Ghana, Legon. I am doing a study on the topic: ***Health Seeking Behaviour among Older Adults in the La Nkwantanang Madina Municipality***. My academic supervisor is Dr. Agnes Kotoh. The main purpose of my study is to know the factors influencing health seeking behaviour among the elderly in this municipality. The outcome of the study will help to design and implement policies that address the needs and concerns of adults in this municipality and Ghana as a whole. So feel free to provide honest answers as possible to the questions being put to you.

Name of Sub-municipality: ……Community/section…….

Interview date:..…/……/2021 **Time of interview: Start……. End…….**

Section A: Demographic descriptions of respondents

1. Age of respondent? ……years (complete)
2. **Sex of respondent?**
   a. Male [ ]
   b. Female [ ]
3. **What is your educational level?**
   a. None [ ]
   b. Primary/elementary [ ]
   c. Middle School [ ]
   d. Secondary [ ]
   e. Tertiary [ ]
4. **Marital status of respondent?**
   a. Single [ ]
   b. Married [ ]
   c. Divorced [ ]
   d. Widowed [ ]
5. **Religion of respondent?**
   a. Christianity [ ]
   b. Islam [ ]
   c. Traditional [ ]
   d. Other (specify)……..
6. **Which ethnic group/tribe do you belong to?**
   a. Akan [ ]
   b. Ewe [ ]

c. Ga-Adangbe [ ]
d. Northern tribe [ ]
e. Other (specify)……

7. **Currently staying with a relative?**
   a. Yes [ ]
   b. No [ ]
8. **Who are you currently staying with?**
   a. Partner/spouse [ ]
   b. Child(ren) [ ]
   c. Sibling(s) [ ]
   d. Parent [ ]
   e. Extended family member [ ]
   f. Other (specify) [ ]
9. **What is/was your profession?**
   a. Farming [ ]
   b. Teaching [ ]
   c. Health worker [ ]
   d. Banking/finance [ ]
   e. Business man/woman [ ]
   f. Other (specify)……
10. **Currently earning some income?**
    a. Yes [ ]
    b. No [ ] If no, skip Q11-12
11. **Source of income? (Tick as apply to you)**
    a. Pension [ ]
    b. Self-employment [ ]
    c. Remittance from children [ ]
    d. Support from other family members [ ]
12. **What is your average monthly income? GH¢……**

Section B: Health seeking behaviour of older adults

13. **Do you have or subscribe to any health insurance scheme?**
    a. Yes [ ]
    b. No [ ] If no, skip Q14
14. **Which health insurance scheme do you subscribe to?**
    a. National Health Insurance Scheme [ ]
    b. Private health insurance scheme [ ]
    c. Workplace insurance scheme [ ]
15. **How will you describe your health status now?**
    a. Good [ ]
    b. Somehow good [ ]
    c. Poor [ ]
    d. Bad [ ]
16. **Where do you seek health care if or when sick?**

a. Health facilities [ ]
b. Self-medication [ ]
c. Herbal/traditional treatment [ ]
d. Spiritual healing [ ]
e. Others (specify)……

17. **What type of health facility do you use when sick?**
    a. Public/government [ ]
    b. Private [ ]
    c. Self-medication [ ]
18. As an elderly person, do you receive support from any family member when sick?
    a. Yes [ ] If yes, go to Q19
    b. No [ ]
19. **What form of support do you receive during illness from family members? (Tick all as apply to you)**
    a. Financial/money [ ]
    b. Feeding [ ]
    c. Psychological [ ]
    d. Other (specify)…….
20. **Have you suffered from any chronic disease (lasting more than six months) in the past one year?**
    a. Yes [ ]
    b. No [ ]
21. **Which chronic disease (s) did you suffer from in the last one year? ……. ……., ……., …….**
22. **Who decides when to seek health care when sick?**
    a. Self [ ]
    b. Spouse/partner [ ]
    c. Child(ren) [ ]
    d. Sibling(s) [ ]
    e. Extended family relations [ ]
23. **Do you go for regular medical check-ups as an elderly person?**
    a. Yes [ ]
    b. No [ ] if no, go to Q24
24. **Why don't you go for regular medical check-ups?**
    ……
    ……
    ……
25. **Which Sources do you get information on health conditions? (Tick all that apply)**
    a. Healthcare workers [ ]
    b. Books [ ]
    c. Family members [ ]
    d. TV [ ]
    e. Radio [ ]
    f. Internet [ ]
    g. Social media (WhatsApp) [ ]

h. Friends [ ]

Section C: Utilization of health services of older adults

26. **Do you know of any health facility in or near your community of residence?**
    a. Yes [ ]
    b. No [ ] If no, skip Q27-28
27. **Which type of health facility is in or near your community of residence? (Tick all that apply)**
    a. CHPS Compound [ ]
    b. Clinic [ ]
    c. Health Centre [ ]
    d. Hospital [ ]
    e. Herbal Centre [ ]
    f. Other (specify)……..
28. **What is the ownership of the health facility in the question above?**
    a. Government/public [ ]
    b. Private [ ]
    c. Faith-based/mission/religious [ ]
29. **Have you visited any health facility in the past year with any health condition?**
    a. Yes [ ]
    b. No [ ]
30. **How long does it take you to reach your health facility of choice for treatment? (provide** answer in minutes or hours): ……...minutes …….hrs
31. **What is the estimated distance from your residence to your nearest health facility? ……..metres ……km**
32. **Have you ever had a health condition (illness) for which you sought care in the past one year?**
    a. Yes [ ] if yes, go to Q33
    b. No [ ]
33. **With what health condition did you seek care? (Tick all that apply)**
    a. Hypertension [ ]
    b. Diabetes mellitus [ ]
    c. Joint pains/arthritis [ ]
    d. Ulcer [ ]
    e. Skin infection [ ]
    f. Chest pains [ ]
    g. Hearing impairment [ ]
    h. Eye problems [ ]
    i. Dental problem [ ]
    j. Uterine problem [ ]
    k. Asthma [ ]
    l. Others (specify)……
34. **Did you visit a health facility with any of the above health conditions?**
    a. Yes [ ]
    b. No [ ] If no, go to Q35

35. **Where did you visit or report or seek care to with any of the above health conditions?**
……, ……., ……
36. How many times did you visit a health facility in the past one year? ……..
37. How many health conditions did you report with at the health facility?
    a. One illness [ ]
    b. Two illnesses [ ]
    c. Three and more illnesses [ ]
38. How much did you spend on health care in a month, on average? ……

Section D: Factors associated with health seeking behaviour of older adults

39. **Do you face any challenges in accessing health care?**
    a. Yes [ ]
    b. No [ ]
40. **What are the challenges to accessing health care?**

	Issue	**Yes**	**No**
a	Difficulty in getting or renewing NHIS card	[ ]	[ ]
b	Distance to health facilities	[ ]	[ ]
c	Attitude of health workers	[ ]	[ ]
d	Waiting time at health facilities	[ ]	[ ]
e	Cost of drugs	[ ]	[ ]
f	Lack/cost of transportation	[ ]	[ ]
f	Quality of care	[ ]	[ ]
g	Other (specify):		

Section E: Quality of life

The questionnaire is adopted from the EQ-5D developed by the EuroQol Group to provide a simple, generic measure of health for clinical and economic appraisal

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

41. I have no problems in walking about □
42. I have slight problems in walking about □
43. I have moderate problems in walking about □

44. I have severe problems in walking about □

45. I am unable to walk about □

SELF-CARE

46. I have no problems washing or dressing myself □

47. I have slight problems washing or dressing myself □

48. I have moderate problems washing or dressing myself □

49. I have severe problems washing or dressing myself □

50. I am unable to wash or dress myself □

USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

51. I have no problems doing my usual activities □

52. I have slight problems doing my usual activities □

53. I have moderate problems doing my usual activities □

54. I have severe problems doing my usual activities □

55. I am unable to do my usual activities □

PAIN / DISCOMFORT

56. I have no pain or discomfort □

57. I have slight pain or discomfort □

58. I have moderate pain or discomfort □

59. I have severe pain or discomfort □

60. I have extreme pain or discomfort □

ANXIETY / DEPRESSION

61. I am not anxious or depressed □

62. I am slightly anxious or depressed □

63. I am moderately anxious or depressed □

64. I am severely anxious or depressed □

65. I am extremely anxious or depressed □

We would like to know how good or bad your health is TODAY.

This scale is numbered from 0 to 100.

 100 means the best health you can imagine.

0 means the worst health you can imagine.

 Mark an X on the scale to indicate how your health is TODAY.

 Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = 100 95 90 85 80 75 70 65 60 55 50 45 40 35 30 25 20 15 10 5 0 The best health you can imagine is 100 and The worst health you can imagine is 0.

Thank you for your time. You may contact me with issues of concern regarding this study on telephone number 0547444104 and email at apau.sarah@yahoo.com or my supervisor, Dr. Agnes Kotoh on telephone number 0246397590.

Appendix iv: Ethical Approval Letter

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Digital Address: GA-050-3303
Mob: +233-50-3539896
Tel: +233-302-681109
Email: ethics.research@ghsmail.org

*My Ref. GHS/RDD/ERC/Admin/App*122/016
Your Ref. No.

17th January, 2022

Sarah Awuttey Apau
P.O. Box 288, Taifa North Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 048/11/21**
Project Title	Health Seeking Behaviour and Quality of Life Among Older Adults in the La-Nkwantanang Madina Municipality
Approval Date	17th January, 2022
Expiry Date	16th January, 2023
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
Dr. James Akazili
(Head, Ethics & Research Management Department)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra