

SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
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HEALTH CARE SEEKING BEHAVIOUR FOR CHRONIC
MORBIDITY AMONG THE AGED IN NEW JUABEN
MUNICIPALITY

BY

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JULY, 2014

DECLARATION

I hereby declare that except for other people's investigations which have been duly acknowledged, this work is the result of my own original research, and that this dissertation, either in whole or in part, has not been presented elsewhere for any other degree.

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DATE

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DATE



DEDICATION

I dedicate this study to Daisy, my wife, with lots of love; Kekeli, Dela and Akusoe, my children; with the best wishes of *Dadiida*.



ACKNOWLEDGMENT

This work cannot be submitted without acknowledging some individuals who have contributed to it in diverse ways.

My first gratitude goes to Dr. Irene A. Agyepong, my academic advisor and lecturer, for her direction and leadership she has displayed during the conduct of this work. I am most grateful for them and hope that I will live to utilise the store of knowledge and expertise you have showed to me.

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To Miss Patricia Zanu and Mrs. Gladys Akussah with her entire staff at Talent Creche and Early Childhood Development Centre, Koforidua, I say thank you very much for protecting my 2 year old boy, especially when both parents had to inevitably leave for further studies. God richly bless you in many folds.

I am finally, but certainly never the least but perhaps the most revered amongst all, extending my sincere gratitude to Most Rev. Joseph Afrifah-Agyekum, Catholic Bishop of Koforidua, with his Vicar General, Rev. Msgr. Francis Twum-Barimah, for understanding, encouraging and coping with my day to day absence from office for a year. I am most grateful to you.

In all, I can only say thank you all for nurturing me into the future.

ABSTRACT

While most societies undergoing epidemiological and demographic transitions experience increase in number and proportion of the aged, we have unfortunately observed the reverse in the New Juaben Municipality between 2000 (13.2 per cent) and 2010 (7.3 per cent) (GSS, 2012). This coupled with high prevalence of some chronic diseases among the aged with poor access to professional or formal health care services in the study area (Britwum et al, 2013). This study was therefore designed to describe health care seeking behaviour for chronic morbidity among the aged and factors associated with it in the study area.

The study recruited individuals aged 60 years and above with at least 3 months of signs or symptoms of chronic conditions or diagnosed medically of at least a chronic condition as respondents. We captured the various health care seeking behaviours for chronic conditions at first, second and third lines as against their self-rated health status and type of financing for them. We also appraised their last health care seeking behaviour prior to the interview for health systems responsiveness using WHO dimensions of dignity, autonomy, confidentiality, prompt attention, choice, communication and basic amenities using a closed ended questionnaire.

The results showed that there was no association between self-rated health status of the aged in the study and their health care seeking behaviour for chronic morbidity ($P > 0.05$). It was, however, observed that there strong association between health care seeking behaviour for chronic morbidity among the aged and their type of financing the behaviour ($P < 0.01$). Indeed, this was observed at all the three lines of seeking care for a chronic condition. Health systems

responsiveness conducted on the various health care seeking behaviours ranked them as follows: Professional/Formal medical systems, 54.7 per cent, Professional Herbalists, 60.9 per cent, Non-professional herbalists, 55.1 per cent, Faith healers, 52.74 per cent, Use of self-prescribed modern medicines, 62.37 per cent, Visit to pharmacies/chemical sellers for advice and treatment, 56.1 per cent, Use of self-prescribed herbal/traditional preparations, 48.5 per cent and Use of local herbs/materials on advice of family members and friends, 34.0 per cent.

Type of financing health care was significantly associated ($P < 0.01$) with seeking the type of health care seeking behaviour to be sought by the aged for chronic morbidity in the New Juaben Municipality. Meanwhile, the Professional or formal health care seeking behaviour could be made more attractive for responsiveness if efforts are geared towards responding to the dimensions of health systems except for dignity and basic amenities in relation to its competing and complementing health systems.

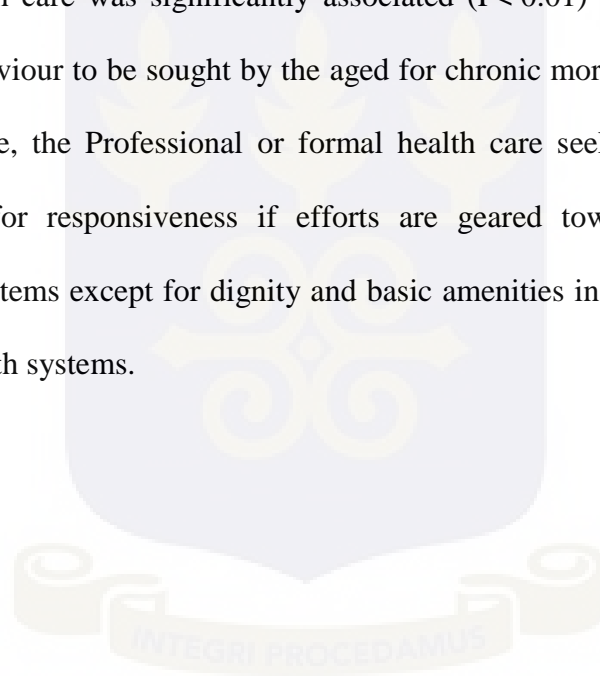


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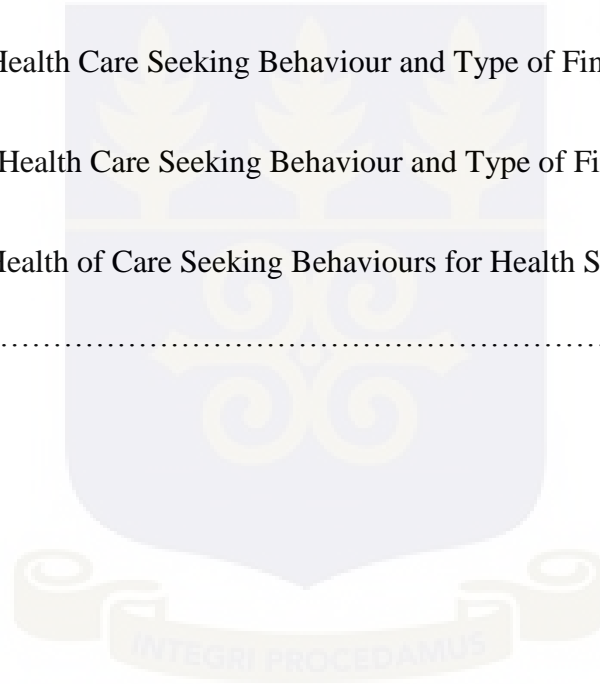
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LIST OF ABBREVIATIONS

GSS	Ghana Statistical Service
HCI	Household Crowding Index
MESW	Ministry of Employment and Social Welfare, Ghana
MOH	Ministry of Health, Ghana
NCHS	National Centre for Health Statistics, US
UN	United Nations
WHO	World Health Organization



CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The concept of aged or elderly people refers to adults who have attained advanced age of 60 or 65 years or more depending on the degree of development of the country (WHO, 2013). The WHO (2013) explains that most developed countries have accepted the chronological age of 65 years as the beginning of ageing. This is because at the moment, there is no United Nations (UN) standard numerical criterion for the aged. Nonetheless, it agreed on 60 years as the cut off to refer to the older population (WHO, 2013). To come to some sort of consensus, the concept is essentially applied to the age at which an adult can cease active work and start receiving his pension benefits (WHO, 2013).

The population of the aged has been increasing worldwide. In 1985, there were 427 million persons aged 60 years and above constituting 8.8 per cent of the world population (Troisi, 2010). It is projected that by 2025, 14.3 per cent of the world's population will be 60 years and above. This is expected to increase to 2 billion by the year 2050 (Troisi, 2010). The trend has not been different in Ghana. The proportion of the elderly increased from 4.9 per cent in 1960 to 7.2 per cent in 2000, while the number rose from 0.3 million to 1.4 million over the same period (an increase of 367 per cent). The population of the elderly in 2010 was estimated to be 1.64 million. Projected results indicate that by 2050, the aged population will account for 14.1 per cent of the total population (GSS, 2012).

Life expectancy is the average number of years a person can expect to live, if in the future they experience the current age-specific mortality rates in the population (UN, 1996). Globally, the indicator has been increasing. The average was 48 years in 1955, increased to 65 years in 1995. In 2011, life expectancy at birth at the global level was 70 years. It has been projected to reach 73 years in 2025 (WHO, 1998). Life expectancy at birth has increased over the years in Ghana. It was 57 in 1998, 58 in 2003, 60 in 2009, 61 in 2010 (GSS, 2012) and 64 in 2011 (WHO, 2013).

Life expectancy at age 60 is defined as the average number of years that a person of 60 years old could expect to live, if he or she were to pass through life exposed to the sex-and age-specific death rates prevailing at the time of his or her 60 years, for a specific year, in a given country, territory, or geographic area. It reflects the overall mortality level of a population over 60 years. It summarizes the mortality pattern that prevails across all age groups above 60 years (WHO, 2011). It was 16 years in 1990 as compared to 18 years in 2011 (WHO, 2013). Life expectancy at age 60 in Ghana for 2011 was only 6 years (World Bank, 2013).

Indeed, as people age they become more prone to ill-health, disease and dependency (WHO, 2003). This ultimately leads to higher demand for health care services especially for chronic diseases to meet their health care needs for longevity (Smith and Mensah, 2003). Chronic morbidity especially in the elderly presents itself in the form of co-morbidity.

Ward et al. (1997) defines health care seeking behaviour as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. A study on health care seeking behaviour aims at understanding the

underlying issues and factors affecting access to and utilisation of health care services and to provide an evidence base for future health policy, planning and management of health systems.

1.2 Statement of the Problem

The world is projected to have about its population composed of 10 per cent of the elderly by 2025 (WHO, 2013). Ghana's population of the aged stood at 1.64 million as at 2010 indicating about 6.8 per cent of the population as compared to 7.2 per cent in 2000 (GSS, 2012). Ghana's life expectancy at age 60 in 2011 was only 6 years as compared to the global average of 20 years.

Meanwhile, in Ghana, policies of the Ministries of Health and Employment and Social Welfare have placed emphasis on longevity through access to health care and decrease in excessive morbidity, mortality and disability, especially in marginalised segments of society, including the aged (MOH/PPME, 2007; MESW, 2010). Over the past few years, the health sector has seen development health services, policies, human resources and infrastructure to enhance the attainment of this goal. In the face of these efforts, however, there was significant drop in the proportion of the aged in the New Juaben Municipality between 2000 (13.2%) and 2010 (7.3%) reflecting a drop in numbers of about 4600 between 2010 and 2000. This observation is contrary to increasing trends in the Eastern Region (1960 (5.4%), 1970 (6.2%), 1984 (6.6%) 2000 (8.0%)(GSS, 2012) and characteristic features of populations undergoing epidemiological transitions. Meanwhile, information about significant number of deaths among the aged in the Municipality attributable to accidents, natural disasters and significant out and in migration among the people could not be sighted.

In a recent independent research on the aged covering the study area, Britwum et al. (2013) reported varying prevalence of a number of chronic diseases. They were arthritis, 13.8 per cent; stroke, 2.8 per cent; angina 3.6 per cent; diabetes, 3.8 per cent; chronic lung disease, 0.6 per cent; asthma, 3.3 per cent; depression, 1.9 per cent and hypertension, 14.2 per cent. In addition, the study reported issues pointing to poor access and utilisation of formal or professional health care amongst others. A key factor in ensuring access and utilisation of formal health care for longevity and quality of life of the aged is primarily seeking available health care without any barriers.

Reconciling the significant drop in the proportion of the aged in the New Juaben Municipality, reports of poor access and utilisation of professional health care and lack of research about the aged, a study into health care seeking behaviour of the age group is necessary. This is to identify, describe and analyse factors on the part of the aged influencing their health care seeking behaviour. The results may provide information for strategizing programmes and formulating and implementing policies to address general access to health care among them. These interventions may potentially be associated with reduction in early deaths among the aged so as to increase their average number of years lived.

1.3 Conceptual Framework

In describing factors that influence individual's choice of a particular health care seeking behaviour, a number of authorities have developed several concepts (Anderson, 1968; Rosenstock, 1967; Kroeger, 1983; Young, 1981). However, the study area of health care utilisation and health care seeking behaviour has used Anderson's Behavioural Model to a large

extent. Anderson has later modified the model with his colleagues (Aday and Anderson, 1974; Aday, Anderson and Fleming, 1980; Anderson and Newman, 1973) in response to findings gathered by them in similar studies.

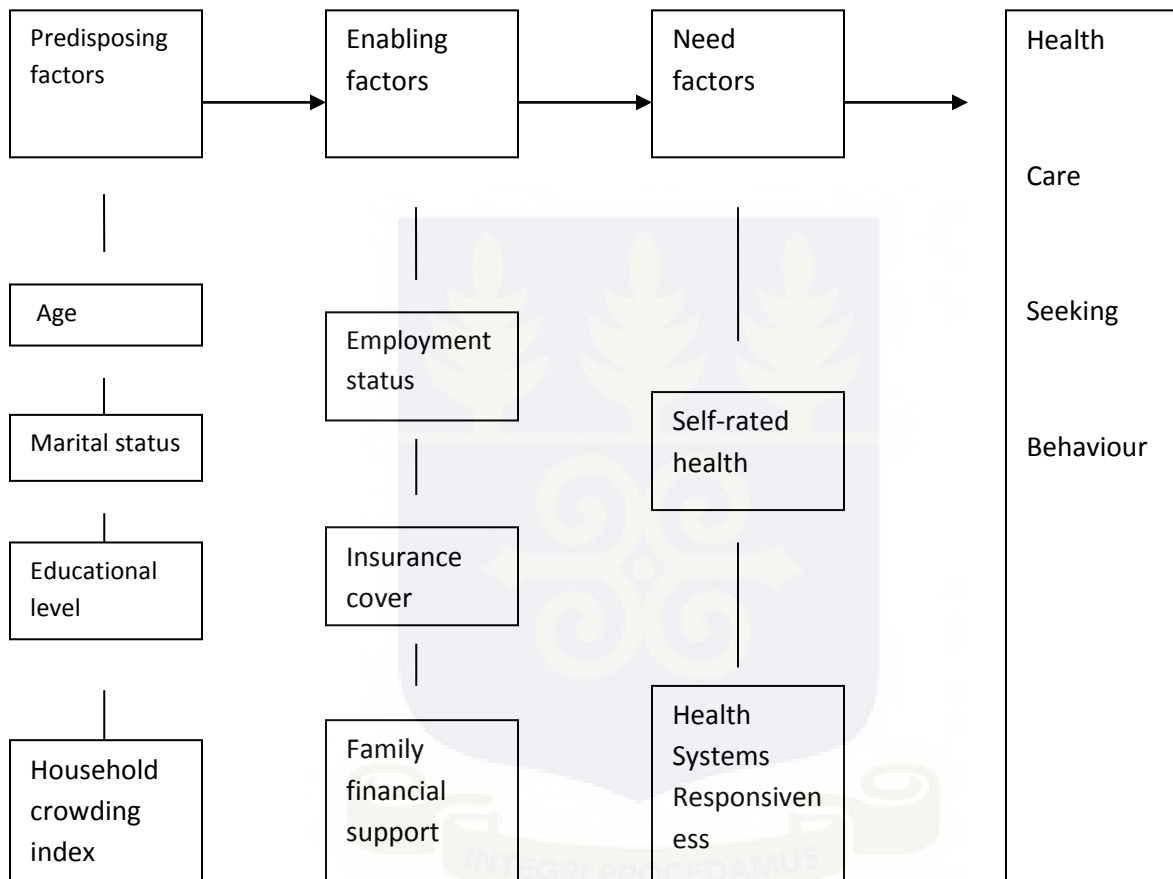


Figure 1.1: Anderson’s Health Behavioural Model (1968)

The Behavioural Model describes three factors influencing seeking a specific health care. These are the predisposing, enabling and need factors.

The predisposing factors refer to demographic and some socio-cultural characteristics of the individual. They include age, gender, marital status, level of education and the household crowding index of the individual. In this modified Anderson's Health Behavioural Model, they are independent variables that can influence the health care seeking behaviour of the aged.

The enabling factors in this model describe the person's personal, household or community resources. Indeed, they are the means of seeking health care. In the context of this study, the occupational status of the aged person, health insurance status and availability of family or community financial support systems are independent variables that could affect health care seeking behaviour.

The need or illness level factors are the third and last set of factors. They describe individual's perception of his or her health status, gravity of perceived illness and perception of benefits to be derived from seeking or not seeking a particular health care behaviour. Anderson (1968) describes these set of factors as the immediate and preceding factors to health care seeking. This study will measure the need factors as self-rated health (SRH) and perception of an aged about the quality of care provided by the various health care systems.

Health care seeking behaviour in the model is the dependent variable of interest. It is directly related to access to and utilization of a specific health service. A combination of levels or types of predisposing, enabling or need factors will therefore influence the type of health care seeking behaviour.

Anderson Behavioural Model was first applied to hospital, physician and dental services (Andersen, Lion and Anderson, 1984; Wolinsky and Coe, 1984). The model however gained widespread adoption for research into other health related areas. These include health care seeking behaviour and utilisation of maternal care services (Fosu, 1994), by mothers for childhood diseases (Mao, 2013), by the youth for a range of health problems (Kahi, 2011) among the rural elderly in Ghana (Exavery et. al. 2010)

1.4 Rationale of the Study

Health care seeking behaviour is a crucial factor affecting quality and longevity of life especially among vulnerable segments of society such as the aged, children, pregnant women and the poor. The health sector in Ghana has done several studies about health care seeking behaviour among these groups except for the aged. There has not been any study on health care seeking behaviour among the aged in the New Juaben Municipality.

The study is therefore designed to determine factors that influence health care seeking behaviour among the aged in the New Juaben Municipality. The results may inform strategies of the health system to improve upon health care seeking behaviour among the aged as part of the ageing process for prolonged life.

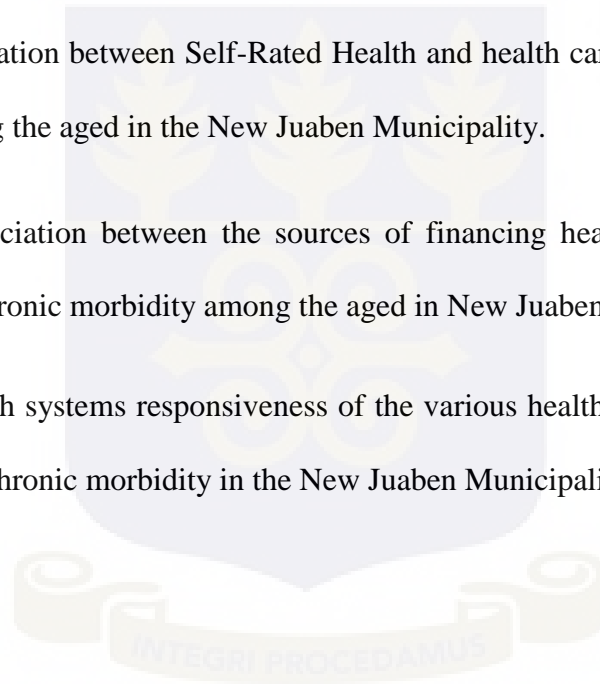
1.5 Objectives of the Study

1.5.1 General Objective

The main objective of this study was to describe the health care seeking behaviours for chronic morbidity among the aged and factors influencing the behaviours among them in the New Juaben Municipality.

1.5.2 Specific Objectives

- i) To describe the association between Self-Rated Health and health care seeking behaviours for chronic morbidity among the aged in the New Juaben Municipality.
- ii) To describe the association between the sources of financing health care and health care seeking behaviour for chronic morbidity among the aged in New Juaben Municipality
- iii) To describe the health systems responsiveness of the various health care seeking behaviours utilised by the aged for chronic morbidity in the New Juaben Municipality.



CHAPTER TWO

LITERATURE REVIEW

2.1 Health Care Seeking Behaviour

Health care seeking behaviour is a type of help seeking behaviour (Grundy and Annear, 2010). Psychology Wiki (2013) describes help seeking behaviour as social behaviour emitted to seek assistance from others. The authority further explains that with regard to health challenges, the appropriate terminology is health care seeking behaviour.

Ward et. al.(1987) defines health care seeking behaviour as the action undertaken by individuals who perceive themselves to have a health problem or to be ill for a purpose of finding an appropriate remedy. Indeed, Olenja (2003) stated that the decision not to take action to remedy a perceived poor health state is a health care seeking behaviour.

Ahmed et. al. (2011) explains that health care seeking behaviour includes professional health care (public or private health facilities), alternative medicine and traditional spiritual care. In addition to these care seeking behaviours, Kahi (2010) stated that a good number of care seekers resort to self medication and support from colleagues they believe could help them get treatment or healing.

Indeed, globally it is known that scientific orthodox medical practice has evolved, developed and continue to develop in response to the myriad of diseases that have plagued mankind over the years. This health care seeking behaviour is more prevalent in developed countries as compared to the least developed and developing countries. In contrast to the scientific orthodox medical practice of treating diseases and other health conditions is a number of health care seeking

behaviours based on faith and supernatural forces perceived by the practitioners or the patients in need of treatment or healing (Twumasi, 2005). The author has indicated that before the practice of modern scientific medicine, the traditional medical practitioner was the sole personality treating all forms of illnesses and other health problems in Ghana. He classified the traditional medical practitioner into four (4) categories. These are traditional birth attendants, faith healers, spiritualists (or diviners) and herbalists. Indeed, he stated that traditional medical practice had a major advantage of social control of individuals resulting in a more morally conscious society as against the orthodox medical practice designed toward treatment, cure and discharge of patients.

While traditional and orthodox medical systems have dominated the practice over the years, there is currently the emergence of alternative and comprehensive medical practice in Ghana (Tsey, 1997) especially in the face of heightened cross cultural interactions at the global level (Chan et al, 2010). Examples of these practices are naturopathy and acupuncture.

Chuma et al.(2007) have noted that in Kenya treatment seeking behaviours for both acute and chronic diseases have been the use of self-prescribed modern medicines from chemical sellers and pharmacies especially as the first line of action while ‘waiting to see if symptoms would go’ before accessing treatment with an orthodox medical health facility. For specific health care seeking behaviours for specific chronic diseases, Mshana et al. (2008) reported that interestingly most patients with stroke in urban Tanzania would often prefer treatment from spiritual traditional healers most of the time to seeking treatment from scientific medical practitioners. On the contrary, the study revealed that stroke patients located in rural Tanzania were instead often seeking care with scientific orthodox medical systems; an observation that challenged trends in most parts of world including South-Sahara Africa.

Health behaviour is sometimes confused with health seeking behaviour. Conner and Norman (2002) describe it as any activity undertaken for the purpose of preventing or detecting disease or for improving health and wellness. Such activities could include exercise, non-smoking, moderate use of alcohol, exercise, screening and sexual behaviour.

To draw the difference, health care seeking behaviour is undertaken in response to an already expressed and perceived disease state while health behaviour is for asymptomatic state of a potential disease.

Health care seeking behaviour studies produce results that reflect the prevalent health conditions among the study population (Olenja, 2003). The study also unearths where individuals and communities go to seek help from for the treatment of both biomedical and psychosocial challenges (Kahi, 2011). For the use of these results, MacKian (2003) states that it informs the specific health system to respond by influencing factors that are amenable. She added that this will ensure that people are educated, supported and empowered to seek health care at facilities where risks are low and benefits maximal. Hausmann-Muelaet. al. (2003) also stated that the end-point of health care seeking behaviour study among a group of people is toward behavioural change for saving of lives and improved quality of life.

2.2 Chronic Diseases

Goodman et al. (2013) described the definition of and classification of chronic conditions or people with chronic conditions as problematic and inconsistent. They described the situation to be unfortunate especially in the face of the need for accurate case definition for public health surveillance and monitoring of health status of populations.

Nonetheless the inconsistency, a few authorities have defined the concept using duration of symptoms, results of functional ability or not and the need for on-going medical attention or not.

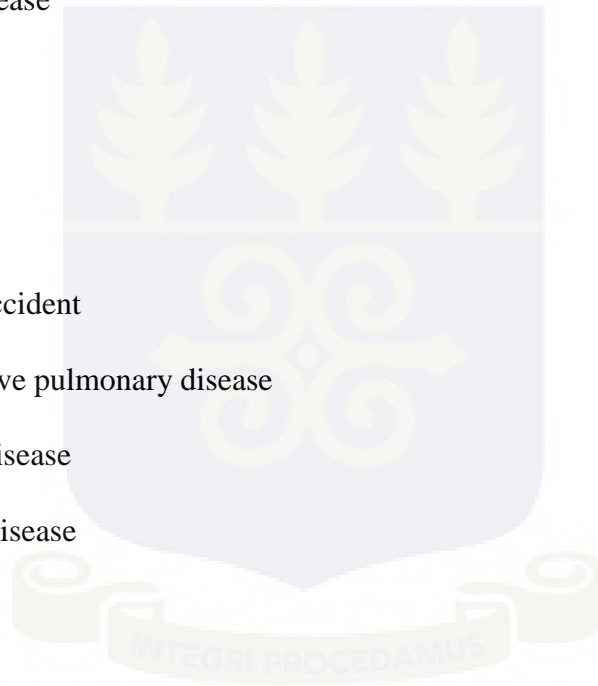
Hwang et al. (2001) defined a person as having a chronic condition if that person's condition had lasted or was expected to last 12 or more months and resulted in functional limitations and/or the need for on-going medical care. Bernstein et al. (2003) defined a chronic disease or condition as one with at least one of the following characteristics: is permanent; leaves residual disability; is caused by non-reversible pathological alteration; requires special training of the patient for rehabilitation; or may be expected to require a long period of supervision, observation, or care. In a different, but similar, way Friedman et al. (2008) defined a chronic condition as a condition that lasts 12 months or longer and meets 1 or both of the following tests: 1) it places limitations on self-care, independent living, and social interactions; and 2) it results in the need for on-going intervention with medical products, services, and special equipment.

While the above cited definitions generally classified chronic conditions to be at least 1 year and requiring on-going medical attention, the National Centre for Health Statistics (2011) describes the concept as conditions that are not cured once acquired and must have been present for 3 months or longer. The Centre however includes any congenital condition in children aged less than 1 year as always chronic. Further, it excludes pregnancy as a chronic condition.

Chronic diseases could be sometimes confused with non-communicable diseases. Indeed, while all non-communicable diseases are chronic cases, the reverse is not always valid. Chronic cases can be communicable e.g. HIV/AIDS or non-communicable e.g. diabetes and asthma (Wikipedia, 2014).

A standard comprehensive list of all chronic diseases is rare or at least could be sighted. However, a number of cases have been known to be classified as chronic diseases. These include:

- Angina pectoris
- Arthritis
- Asthma
- Bipolar mood disease
- Brochiectasis
- Cardiac failure
- Cardiomyopathy
- Cardiovascular accident
- Chronic obstructive pulmonary disease
- Chronic kidney disease
- Coronary artery disease
- Crohn's disease
- Depression
- Diabetes insipidus
- Diabetes mellitus (type 1 and type 2)
- Dysrhythmia (irregular heartbeat)
- Epilepsy
- Glaucoma
- Haemophilia



- HIV
- Hyperlipidaemia (high cholesterol)
- Hypertension (high blood pressure)
- Hypothyroidism (inactive thyroid gland)
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis
- Oral chronic disease (eg. caries, periodontal disease)

(Health24.com, 2011)

Chronic diseases are prevalent among children, adults and older adults or the aged. However, the distribution among the different strata of age groupings is highest in the aged (WHO, 2012; CDC, 2013). CDC (2014) reported that chronic diseases cause 7 in 10 deaths each year in the United States while about 133 million Americans—about 50 per cent adults—live with at least one chronic illness. It added that more than 75 per cent of all health care financial costs are due to chronic conditions.

In Ghana the upsurge of chronic conditions has been experienced in recent times with slight decrease in acute communicable diseases in general but with increased road traffic accidents

depicting some features of the epidemiological transition (Agyei-Mensah and Aikins, 2010; Mock et al., 1997).

Britwum et al. (2013) surveyed and reported the prevalence of common chronic diseases among the older adults (at least 50 years of age) in Ghana using two approaches- symptom reporting/algorithm and self report. Using the averages of the two approaches the findings could be summarised as follows: Arthritis, 13.8 per cent; Stroke, 2.8 per cent; Angina 3.6 per cent; Diabetes, 3.8 per cent; Chronic lung disease, 0.6 per cent; Asthma, 3.3 per cent; Depression, 1.9 per cent and hypertension, 14.2 per cent.

2.3 Self-Rated Health

Ginneken and Groenewold (2012) described Self-Rated Health (SRH) as a common measure of self-perceived health status or morbidity. The indicator also refers to the following: self-rated health status, self-rated general health and self-reported health. The use of the indicator is premised on the fact that there exists an association between an individual's SRH and the average time he or she would live till death, general health, functional decline and disease risk (Lee, 2000; Idler and Kasl, 1990). Specifically, SRH in the elderly predicted hospital admission rates and visits to outpatient departments (Boult et. al., 1993; Stull et. al., 1996). Indeed, an individual's decision to access and utilise health services is a complex phenomena involving SRH with other factors of the particular health system (Fernandez-Olano et. al, 2006).

Fries (1980) stated that SRH in cross-sectional studies is a reflection of the degree of inequality in access to health promotion programmes. In comparing the indicator to other measures of

health status, Mossey and Shapiro (1982), one of the earliest researchers into SRH rating, reported that it outweighed health care utilisation and medical history data in predicting survival of the elderly over a seven year period.

The measurement of SRH can be very simple. A simple general question could be used: ‘Would you say your health is excellent, very good, good, fair or poor (Kaplan and Camacho, 1983).

A major limitation of the indicator as predictor of mortality is that respondents could report poor health status in order to solicit free healthcare packages from the state and healthcare companies (Idler et al. 2000).

2.4 Socio-Economic Determinants of Health Care Seeking Behaviour

Studies have identified a number of factors to influence the health care seeking behaviours. Some are generally applicable to the phenomenon while others are only relevant to some settings. These factors include ethnicity, gender, age, economic status, socio-cultural beliefs, status of women in society, availability of health facilities, provision of specific services, distance to health facilities, perception of quality of care, knowledge about available facilities for treatment, cost of care, educational level, marital status and general political situation of the setting (Adamson et.al., 2003; Tipping et al., 1995; Anderson, 1968; Fosu, 1994; Exavery et. al., 2010). Wells et. al. (1987) added that an individual’s immigration status can seriously affect his or her care seeking behaviour. Even in some circumstances, an individual’s status as a regular patient in a specific facility enhances his or her chances of consulting a physician early for quality treatment (Escarce and Kapur, 2006).

Brown (1999) described the quality of care for the elderly in Ghana to be very supportive. The researcher, however, noted with grave concern that they could be the collapse of the extended family support system into the future with the increase of urbanization and increased unemployment especially among the youth.

The Institute of Medicine (2013) defines quality of health care as the extent to which health services provided to individuals and populations improve desired health outcomes. Davies and Crombie (1997) describe good health outcomes to professionals as end-point of a complex web of care, to patients as their highest hopes for cure and to politicians as 'health gain'. Aday and Anderson (1974) asserted that access and utilisation of health care in middle to high income economies are much affected by the quality of the service than by the quantity. They stated that doctor to patient ratio, for example, is irritating to the patient even more than the practitioner. In a study to evaluate factors influencing patients to seek formal health care for the treatment of malaria in Africa, Kizito et al. (2012) reported a strong correlation between seeking care and the belief by patients that the provider or his treatments would cure the illness. Among the elderly, Okumagba (2011) reported that perceived quality of health care, amongst other factors, is a strong determinant of health care seeking behaviour amongst the elderly for eye conditions.

The World Health Organization (2013) describes financing health systems as set of activities targeting the following objects: raising financial resources for health, reducing financial barriers to seeking health care, prepayment and subsequent of funds to discourage out-of pockets payments and allocating or using funds to ensure equity and efficiency. To the individual patient, she is concerned primarily with raising funds to meet health care needs (Dong H, 2003). Financing of health care is a determinant of health care seeking behaviour by all age groups and for almost all disease states especially in low income countries (Jacobs et. al. 2011). In India,

Krishna (2006) found that 85 per cent of all forms of extreme poverty were attributable to cost of treatment for illnesses. In Ghana Asenso-Okyere et. al. (1998) found out that the implementation of the cost-sharing system between 1985 and 1992 motivated people to resort to self-medication instead of seeking care from the formal system. With the introduction of national health insurance in Ghana since 2005, hospital attendance per capita increased sharply (Blanchet et. al. (2012) by about 0.52 in 2004 to about 0.81 as recorded by the Ghana Health Service in 2010 (Seddoh et. el., 2011).

2.5 Intrinsic Goals and Health Systems Responsiveness

Murray and Frenk (1999) defined 3 goals to be known as intrinsic goals. These are

1. Health – To improve and maintain the health of the population.
2. Fair financing and financial risk protection – To assure that households do not become impoverished or pay an excessive share of their income in obtaining needed health care.
3. Responsiveness – To enhance the responsiveness of the health system to the legitimate expectations of the population for non-health enhancing dimensions of their interactions with the health system.

The concept forms a very important aspect of health systems performance. De Silva (2000) explained that measuring health systems allows the understanding of why countries of similar income and other socio-economic indicators do not attain similar levels of health, responsiveness and fair health care financing. In addition, the writer intimated that it provides a set of indicators for measuring health systems overtime. He concluded that that both reasons for measuring health systems facilitate the accumulation of a pool of evidence that can provide the basis for

confirming or rejecting if specific health systems policies (including financing and provision mechanisms) are particularly appropriate under given socio-economic conditions.

Murphy-Cullen and Larsen (1984) indicated that patient satisfaction with non-medical aspects of care is often associated with better compliance with treatment instructions, prompt health care seeking behaviour and a better understanding and retention of medical information. This therefore relates best with measuring the responsiveness of health systems as a means of ensuring that patients seek early and appropriate care while being satisfied with it.

De Silva (2000) defined responsiveness of health system as 'the outcome that can be achieved when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals. Responsiveness can be viewed from two angles. Firstly, the user of the health care system is often portrayed as a consumer, with greater responsiveness being perceived as a means of attracting consumers. Secondly, responsiveness relates to the safeguarding of rights of patients to adequate and timely care. To operationalise these two dimensions of measuring responsiveness, the writer defined the following for the concept:

- i. Dignity - the right of a care seeker to be treated as a person
in their own right rather than merely as a patient who due to asymmetric information and physical incapacity has rescinded his/her right to be treated with dignity.
- ii. Autonomy - self-directing freedom expressed as four rights. These are
the right of an individual to information on his/her disease and alternative

treatment options (this facilitates informed choice), the right to be consulted about treatment, informed consent in the context of testing and treatment and the right of patients of sound mind to refuse treatment.

- iii. Confidentiality - information relating to the patient and his illness should not be divulged during the course of care, except in specific contexts, without the prior permission of the patient.
- iv. Prompt Attention - consists of three characteristics viz: patients should be entitled to rapid care in emergencies and patients should be entitled to care within reasonable time periods even in the case of non-emergency health care problems or surgery so waiting lists should not cover long periods; and patients seeking care at healthcare units should not face long waiting times for consultations and treatment.
- v. Quality of Basic Amenities - the provision of physical infrastructure and a conducive care environment including clean surroundings, regular procedures for cleaning and maintenance of hospital buildings and premises, adequate furniture, sufficient ventilation, clean water, clean toilets, clean linen and healthy and edible food.
- vi. Access to social support networks during care - procedures in the provision of inpatient health care should allow for regular visits by relatives and friends, provision of food and other consumables by relatives and friends, if not provided by the hospital and religious practices that do not prove a hindrance to hospital activities or hurt the sensibilities of other individuals.

- vii. Choice of Care Provider - choice with regard to institution and individual providing care.

In the appraisal of health systems responsiveness, Valentine et al.(2003) stated that while it is important to measure the achievement (average over the whole population), it is more beneficial to measure the distribution (equitable spread of this achievement to all segments of the population), where possible and appropriate.



CHAPTER THREE

METHODS

3.1 Study Design

We conducted a population based descriptive cross-sectional study using quantitative methods. It described the various health care seeking behaviours adopted among the aged for the first 3 consecutive times in response to when each had experienced symptoms characteristic of chronic diseases for at least the immediate past 3 months or medically diagnosed of a chronic condition. In addition, the study described the different types of financing health care seeking behaviours per each. We also measured the respondents' perception of health system responsiveness as experienced during the last time each respondent had sought a health care seeking behaviour prior to the data collection date.

3.2 Study Area

We carried out the study in the New Juaben Municipality of the Eastern Region of Ghana. The Municipality is made up of the Eastern regional capital, Koforidua, and about 23 small towns and villages.

In 2010, the Ghana Statistical Service estimated the population of the New Juaben Municipality to be 183, 727 (GSS, 2012). The Municipality hosted a number of health care institutions. These included the Eastern regional hospital, a secondary referral hospital; two mission hospitals with one specialised in orthopaedics and traumatology; a polyclinic; about 3 health centres; over 6 Community Health Planning and Services (CHPS) Centres and over 10 privately owned clinics providing formal or professional orthodox health care services. The Municipality hosted a few number of pharmacies and a large number of licensed chemical sellers that dealt in mostly

modern medicines. A myriad of traditional medical practitioners complemented the treatment or healing of patients in the Municipality. Indeed, within the districts that share boundaries with the Municipality were located similar health or treatment giving facilities except for Akwapim North District. It hosted the Mampong Centre for Research into Plant Medicine. This centre provided professional herbal medical services to patients all over Ghana including the New Juaben Municipal Area. Thus, geographical accessibility to these different service providers within the Municipality was without barriers.

3.3 Study Population

Adults aged 60 years and above resident in the New Juaben Municipality who have experienced symptoms and signs associated with chronic diseases (e.g. persistent pain, cough, dizziness, discomfort, physical weakness or tiredness, trouble sleeping, deep cut, sore, falls, lump, poor eye sight) that have lasted for more than 3 months or medically diagnosed of at least a chronic condition e.g. hypertension, diabetes, cancers etc. constituted the study participants.

The total number of the aged in the Municipality was estimated to be 13, 506 (GSS, unpublished) based on the 2010 national census. We did not know the number of the aged in the Municipality or of those living with chronic conditions.

3.4 Sample Size

We recruited 210 participants in this study. This was based on modified World Health Organisation (WHO) Expanded Programme of Immunisation Cluster Sampling Technique of 30 clusters by 7 study participants (WHO, 2008).

3.5 Sampling Techniques

We used a two stage probabilistic cluster sampling method similar to the World Health Organization sampling method for Expanded Programme of Immunisation (EPI) to select the respondents for the study. The lack of a sampling frame of the aged resident in the Municipality or of the aged living with chronic morbidity in the study area informed the choice of this method. On another, but lesser, criterion, we chose the method to minimise administrative cost required to cover the large land size of the Municipality.

In selecting the clusters, we obtained the 2012 list of the 179 polling stations of the Electoral Commission of Ghana located in the New Juaben Municipality. Each polling station of the Commission had approximately 630 voter population aged 18 years and above including the aged 60 years and above. Using a locally manufactured gambling spiral of 180 points (approximately 179 polling stations), we dialed it 30 times. At each dial, we picked the randomly selected number to correspond to the serial number of the polling station on the list from the Electoral Commission. We repeated the procedure 30 times to enable us select the 30 clusters of polling stations located in electoral areas required for the survey.

The second stage of the sampling technique involved two steps. First, at each selected polling station, we located the entrance of the facility, which could be a school or church or community centre, and spun an empty Coca-Cola bottle on the ground. We then picked the direction towards which the neck of the bottle would point. The second stage involved selecting households along the selected direction for identification of respondents. Where there was no aged person with the case or where present but refused to participate in the study, the following house along the direction was selected until we located and interviewed the seventh participant in the cluster.

3.6 Data Collection Tool

We used a survey questionnaire constituting of mostly closed ended questions for the data collection in line with the modified Anderson's Health Care Behavioural Model (1968).

With reference to the attached Variables Definition table (Table 3.1), the questionnaire sought responses from the participants to describe the key components of the conceptual framework. Specifically, the questionnaire inquired about the respondent's age in completed years, marital status, years of completed education and household crowding index to describe the predisposing factors. For the enabling factors, the questionnaire inquired about the respondent's health insurance cover status, employment status and type of financing mechanism used after seeking treatment or healing for their chronic conditions. In addition, we assessed need factors influencing health care seeking behaviour using Self-Rated Health of the respondents and their perception of responsiveness of their last specific health system they had accessed for a treatment or healing of a chronic condition.

3.7 Definition of Variables

We described health care seeking behaviour for chronic morbidity as our dependent variable. It was defined as Professional/formal when the respondent sought treatment from medical doctors, dentists, physician assistants, nurses, physiotherapists, dieticians /nutritionists, clinical or clinical psychologists; Professional herbalist when the respondent sought treatment from practitioners certified by MOH and had received formal training e.g. KNUST trained herbal medical practitioners; and Non-professional herbalist when the individual sought treatment from practitioners of herbal medicine who had not received formal training and certification by the MOH. Further, we defined Alternative medical practice as a health care seeking behaviour when

the respondent sought care from a chiropractor, acupuncturist or naturopathic and Faith healing being treatment or healing using faith and or supernatural forces such as use of prayer camps, pastors, spiritualists etc. Self-treatment described a number of health care seeking behaviours viz: Use of self-prescribed modern medicines purchased from chemical sellers or pharmacies, Visit to pharmacies or chemical sellers for advice and treatment, Use of self-prescribed herbal/traditional medicines purchased from dealers (pharmacies, chemical sellers, individual traders etc) and Use of local herbs/ materials on advice of family members and friends.

The type of health care seeking behaviour recorded on each responded was the one the respondent had adopted in response to the signs and symptoms of chronic diseases such as persistent pain, cough, dizziness, discomfort, physical weakness or tiredness, trouble sleeping, deep cut, sore, falls, lump, poor eye sight, depression that have lasted for more than 3 months or medically diagnosed condition e.g. hypertension, diabetes etc.

Table 3.1: Variables Definition Table

Name of Variable	Definition of Variable (Reference)	Measurement of Variable
1.Health Care Seeking Behaviour	Any action undertaken by an individual who perceives his or herself to have a health problem or to be ill for a purpose of finding an appropriate remedy (Ward et al, 1987)	1) Professional/Formal <i>(medical doctor, physician assistants, dentist nurse, physiotherapist, dietician/nutritionist, clinical psychologist)</i> 2) Professional Herbalist <i>(practitioners certified by MOH and had received formal training eg.</i>

		<p><i>KNUST trained herbal medical practitioners)</i></p> <p>3) Non-Professional Herbalist <i>(practitioners who have not received formal training and certification by the MOH)</i></p> <p>4) Alternative Medical Practitioners <i>(chiropractor, acupuncturist, naturopathic)</i></p> <p>5) Faith healers <i>(use of prayer camps, pastors and any other act based on faith and supernatural forces)</i></p> <p>6) Self-treatment</p> <p>6.1 Use of self-prescribed modern medicines purchased from chemical sellers or pharmacies</p> <p>6.2 Visit to Pharmacies or chemical sellers for advice and treatment</p> <p>6.3 Use of self-prescribed herbal/traditional medicines purchased from dealers (pharmacies, chemical sellers, individual traders etc)</p>
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		6.6 Use of local herbs/ materials on advice of family members and friends. 7) Any other
2. Age	Completed number of years from birth to time of data collection	Continuous indicator in years
3. Marital Status	Society's knowledge of an individual's identity with respect to marriage or not at the time of data collection	1.Married 2. Divorced 3.Separated 4.Widowed 5. Living together 6. Single
4. Years of Completed Education	Average total number of years an individual had spent pursuing formal education in life.	Number of completed years of education. Continuous variable.
5. Household crowding index (HCI)	Total number of co-residents per number of rooms in a house excluding toilets and kitchen (Melki et al., 2004) at the time of data collection	Continuous variable
6. Employment status	The state of whether or not an individual is engaged in an economic activity for an expected income within the past 7 days (GSS, 2008)	1. Full time formally employed (at least 35hrs per week (by someone else or entity) 2. Full time formally employed (at least 35hrs per week (by self)

		<p>3. Part time (less than 35hrs per week) employed (by someone else or entity) as sole primary job</p> <p>4. Part time (less than 35hrs per week) employed (by someone else or entity) but engaged in other jobs.</p> <p>5. Part time (less than 35hrs per week) employed (by self) as sole primary job</p> <p>6. Part time (less than 35hrs per week) employed (by self) but engaged in other jobs.</p> <p>7. Retired and on pension benefits only</p> <p>8. Unemployed <i>(i.e. not on pension benefits, fit physically for work but not engaged in any)</i></p> <p>9. Homemaker</p> <p>10. Unable to work <i>(i.e. not physically fit for work nor on pension benefits)</i></p>
<p>7. Health insurance cover</p>	<p>The presence of a valid and unexpired health insurance document at the time of data collection</p>	<p>1. Insured</p> <p>2. Non-insured</p>
<p>8. Chronic Condition or Disease</p>	<p>Signs and symptoms such as persistent pain, cough, dizziness, discomfort,</p>	<p>1. Diseased</p> <p>2. Not diseased</p>

	<p>physical weakness or tiredness, trouble sleeping, deep cut, sore, falls, lump, poor eye sight, depression that have lasted for more than 3 months (NCHS, 2011) or medically diagnosed condition e.g. hypertension, diabetes etc.</p>	
9. Self-Rated Health	<p>A self-ranked perception of a respondent's health status</p>	<p>1.Good 2.Moderate 3.Poor</p>
10. Health Systems Responsiveness	<p>How the system performs relative to non-health aspects, meeting or not meeting a population's expectations of how it should be treated by providers of prevention, health care or non-personal services (WHO, 2011)</p>	<p>1. Dignity <i>(assessment by patients with respect to not humiliating or demeaning them including privacy)</i></p> <p>2. Autonomy <i>(assessment by patients with respect to right to participate in choices about one's own health or treatment options)</i></p> <p>3. Confidentiality <i>(assessment by patients regarding their right to determine who has access to one's health information)</i></p>

		<p>4. Prompt attention <i>(assessment by patients with respect to time taken by health care professionals to respond immediately in emergencies and reasonable waiting times for non-emergencies)</i></p> <p>5. Choice <i>(this measures freedom patients have to choose who attends to them within a facility).</i></p> <p>6. Communication <i>(this measures whether providers listened carefully to patients for adequate information and involve them in decision making about their health care needs).</i></p> <p>7. Basic amenities <i>(adequacy and/or quality of cleanliness of environment, space and hospital food)</i></p>
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The predisposing, enabling and need factors were the stated background characteristics (age, marital status, completed years of education and employment status), Self-Rated Health, type of

health financing mechanism and health system responsiveness as experience during the last time the respondent sought health care.

We measured Self-Rated Health using the question ‘How would you rate your health? The options ranged from Good, Moderate and Poor using a 3 point Likert scale. Again, we defined health insurance cover as the validity and availability of a health insurance document; and family financial support for health care being whether or not the respondent had received financial support, cash or in kind, for treatment or healing. Lastly, we assessed health systems responsiveness at the last time each respondent sought health care or healing using the dimensions of dignity, autonomy, confidentiality, prompt attention, choice, communication and basic amenities on the scale of Good, Moderate and Poor as described in Table 3.1 above.

3.8 Quality Control

To ensure that questions solicited the appropriate answers from the respondents, we did pretest the questionnaire among 15 respondents with chronic morbidity but in a different community. We encouraged the respondents to give feedback with regard to clarity, choice of words, framing of questions and length of time for the completion of the questionnaire. The results of the feedback guided the design of the final questionnaire.

Another key issue was to achieve standardized interpretation of questions and appropriate completion of the questionnaire. We accomplished this by undertaking a joint training of the data collection officers using the final questionnaire prior to field data collection. On the quality of data collection officers, we deployed final year nursing training college students on vacation for the data collection. This ensured that the data collection officers collected appropriate responses

especially with regard to the appreciation and identification of symptoms and signs associated with chronic conditions.

Again, to ensure that we had appropriate and consistent responses from the respondents, we built in a number of control questions backed by a list of all professional health care providers rendering services in and around the study area. This helped us to validate responses that respondents had given with regard to the various health care seeking behaviours.

3.9 Statistical Analysis

We were most interested in capturing the various health care seeking behaviours of the aged for chronic morbidity at different stages as our outcome of interest. We captured these as first, second and third actions of health care seeking behaviours by the respondents for chronic morbidity. For clarity of observed association between factors and health care seeking behaviours, we regrouped the initially 9 practices as defined in the Variables Definition Table as follows:

- i.) Formal/Professional (included both practitioners of orthodox medicine (medical doctors, nurses etc) and Professional herbal medicine). This was principally based on the fact that both groups are common by being regulated by councils established by the Ministry of Health and the very small number of respondents (4) that accessed care from Professional herbalists.
- ii.) Faith Healers/ Non-professional herbalists
- iii.) Use of self-prescribed medications (including modern medicines, local herbal preparations in the market and herbs/materials)
- iv.) Visit to pharmacy/chemical seller for advice and treatment.

All the aged who satisfied the selection criteria for the study and had agreed to complete the questionnaire or the interview were included in the analysis.

Using SPSS (Version 19.0), we first tested the association between the reported health care seeking behaviours at the 3 stages on one hand and self-rated health on the other hand using the Pearson Chi-square test. Secondly, we ran similar test between the various health care seeking behaviours and types of financing used by the respondents. The last analysis we conducted was to measure on percentage basis ratings of the health systems responsiveness by the respondents as experienced the last time each had sought care for a chronic condition. We used cross tabulations and bar charts to display findings.

Age, a continuous predisposing variable, was categorized as 0(60-64 years), 1(65-69years), 2(70 +years). Likewise, Household crowding index (HCI), another continuous predisposing variable, was categorised as 1(≤ 1 , not crowded), 2(1.1-1.49, crowded) and 3(≥ 1.50 , severely crowded).

3.10 Ethical Considerations

We undertook a number of measures in compliance with ethical expectations of a health related research. Data collectors on the field explained to each participants the purpose of the study to inform their willingness to participate in it or otherwise. We also handled information gathered from the participants with utmost privacy and confidentiality.

We did not provide any material motivation for the study participants prior to, during and after the study.

The investigator and the data collectors had no personal interest or intend to use the findings of this study for any predetermined material interest. It is purely to inform health sector policy.

3.11 Limitations of the Study

We identified recall bias especially on the part of the very old (71 years and above) respondents a limitation to accuracy of their responses in this study. This is because ageing increases with decline in memory. Therefore, the chances of these respondents not being able to accurately describe their health care seeking behaviours and the factors associated with them for their first, second and third actions could be high.



CHAPTER FOUR

RESULTS

4.1 Background Characteristics of Study Participants

210 respondents drawn randomly from 30 electoral areas located in the New Juaben Municipality participated in the survey held consecutively between July 2, 2014 and July 6, 2014. There was 100.00 per cent response rate.

With reference to Table 4.1, of the total number of participants, 43.8 per cent of them were aged 71 years and above, 64.8 per cent were not married nor living together. On employment, only 19.0 per cent of the participants had full time employment in the formal or informal sectors while 34.3 per cent were either unemployed or homemakers. With regard to completed number of years of formal education, as high as 30.0 per cent had no formal education while 45.2 per cent had 1-10 years.

Household Crowding Index measured among the study participants recorded 46.7 per cent of them located in households that were not crowded. Further, while 11.9 per cent were located in crowded homes, as high as 41.4 per cent of them were located in severely crowded homes. On health insurance cover, as high as 24.8 per cent of the participants were not insured while 75.2 per cent were insured. Self-rated health ranked among the participants showed that only 11.4 per cent ranked themselves to be good as 52.4 per cent ranked it moderate. 35.7 per cent rated themselves as poor.

Table 4.1: Background Characteristics of Study Participants

Characteristic		Frequency (n=210)	%
Age	60 – 65	74	35.2%
	66 – 71	44	21.0%
	Above 71	92	43.8%
Current Marital Status	Married	74	35.2%
	Not Married	136	64.8%
Employment	Full time employed	40	19.0%
	Part time employed	53	25.2%
	Retired or Pension	45	21.4%
	Unemployed / Homemaker	72	34.3%
Number of Years spent in Formal education	None	63	30.0%
	1 – 10	95	45.2%
	Above 10	52	24.8%
Household Crowding Index	Not Crowded	98	46.7%
	Crowded	25	11.9%
	Severely Crowded	87	41.4%
Health Insurance Cover	No	52	24.8%
	Yes	158	75.2%
Self-Rated Health	Good	24	11.4%
	Moderate	110	52.4%
	Poor	75	35.7%
	Don't know	1	0.5%
Last Time of Seeking Care	Less than 1 month	48	22.9%
	1 - 4 months ago	151	71.9%
	More than 4 months ago	11	5.2%
First Time of Experiencing Symptoms	Less than 3 months now	1	0.5%
	At least 3 months now	209	99.5%

4.2 Association between Self-Rated Health and Health Care Seeking Behaviour

The first specific objective of this study was to describe the association between Self-Rated Health of participants and their health care seeking behaviour. With reference to Table 4.2, this study could not establish significant association between Self-Rated Health of the participants

and any of the health care seeking behaviours ($P > 0.05$). Specifically, study participants' Self-Rated Health of Good, Moderate and Poor had no association with particular health care seeking behaviours for the last time each had sought care for their chronic morbidity.

Table 4.2: Self-rated Health and Health Care Seeking Behaviour

	Self-Rated Health								Row Tot.	Chi-sq value/ df (P-value)
	Good		Moderate		Poor		Don't know			
Last Sought Health Care Seeking Behaviour	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %		
Professional/Formal and Professional Herbalist	18	11.4%	88	55.7%	51	32.3%	1	0.6%		11.575 / 9 (0.238)
Faith healers/Non Professional Herbalist	4	19.0%	9	42.9%	8	38.1%	0	0.0%		
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	0	0.0%	11	57.9%	8	42.1%	0	0.0%		
Visit to Pharmacy / chemical seller for advice and treatment	2	16.7%	2	16.7%	8	66.7%	0	0.0%		
Column-Totals	24	11.4%	110	52.4%	75	35.7%	1	0.5%	100.0 %	

Figure 4.1 displays the distribution of Self-Rated Health among the aged in the study area. About more than half of the respondents rated themselves to be of Moderate Self-Rated Health. In contrast, about 11 per cent rated themselves Good as against about 36 per cent to be Poor.

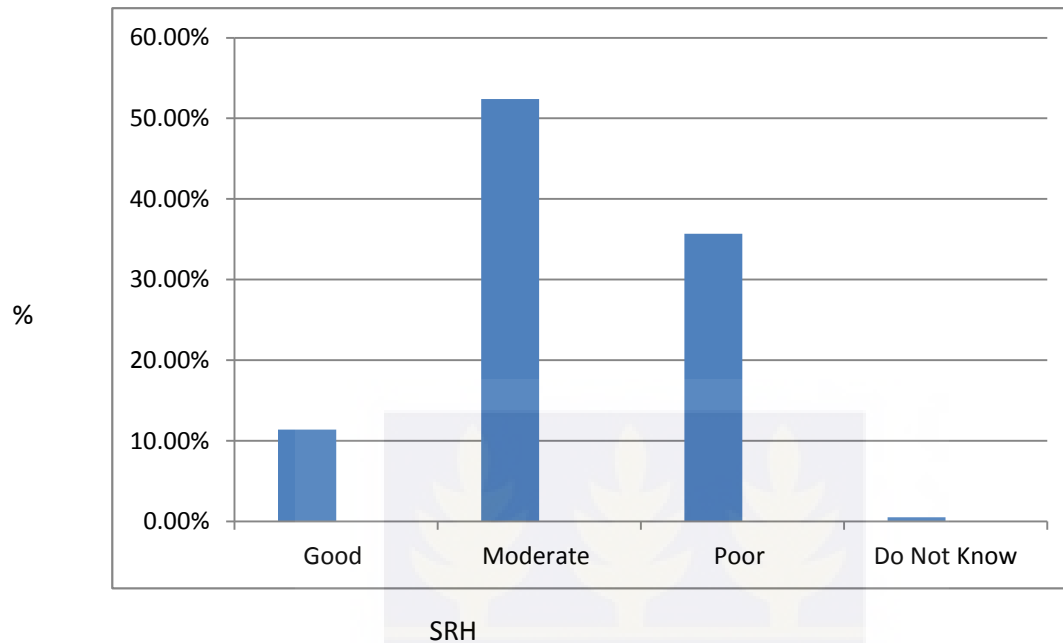


Figure 4.1: Distribution of Self-Rated Health among the Aged

4.3 Association between Health Care Seeking Behaviour and Type of Financing

The second specific objective of the research was set out to test the association between health care seeking behaviour and type of financing used for it. Health care seeking behaviour tends to be sequential. Depending on outcome of earlier actions in response to a diseased condition, people therefore explored the first, second and third care seeking behaviours for a given episode of ill health.

4.3.1 Association between First Action of Health Care Seeking Behaviour and Type of Financing

At the first action of health care seeking behaviour (Table 4.3), 77.1 per cent of respondents with health insurance cover sought treatment with the professional/formal health provider while only 2.1 per cent sought treatment with faith healers/non-professional herbalists.

Table 4.3: First Action of Health Care Seeking Behaviour

Type of Financing Health Care	Health Care Seeking Behaviour 1								Total
	Professional/Formal and Professional Herbalist		Faith healers/Non Professional Herbalist		Use of self-prescribed modern medicines/ local herbs/Herbal preparation		Visit to Pharmacy / chemical seller for advice and treatment		
	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %	Chi-square/ df (P-value)
Health Insurance	27	77.10%	1	2.10%	0	0.00%	0	0.00%	170.457/9 (0.001)
Out-of-Pocket	3	8.60%	20	41.70%	44	64.70%	42	71.20%	
Family financial support	4	11.40%	12	25.00%	10	14.70%	15	25.40%	
Free/In-kind	1	2.90%	15	31.20%	14	20.60%	2	3.40%	
Total	35	100.00%	48	100.00%	68	100.00%	59	100.00%	

Only 8.6 per cent of those who paid out of pocket for the health care seeking behaviour attended a professional/formal health facility. Indeed, as high as 64.7 per cent of those who sought care by using self-prescribed modern/traditional medicines paid out of pocket. Again, of those who visited the pharmacy or chemical seller for advice and treatment, as high as 71.2 per cent paid for the service out of pocket. Of the individuals who paid for their treatments at first line of health

care seeking behaviour with the support of family, only 11.4 per cent sought treatment with the professional/formal health sector. About 25.0 per cent each were those that sought treatment with use of self-prescribed modern/traditional drugs and visit to pharmacies or chemical sellers for advice and treatment. Overall, there was a strong association between financing type and health care seeking behaviour as first line ($P < 0.001$).

Table 4.4 displays further analysis of association between first action of health care seeking behaviour for chronic morbidity among respondents and health insurance status. Again, there is very significant association between the health insurance status of the respondents and their health care seeking behaviour. Respondents with health insurance cover sought care with Professional/formal/Professional herbalists almost most of the time for chronic morbidity.

Table 4.4: Health Insurance Cover Status and First Action of Health Care Seeking Behaviour

	Health Insurance Status					Chi-sq/df (P-value).
	Health Insurance Covered		Non Health Insurance Covered		Total	
Health Care Seeking Behaviour	Freq.	Row n%	Freq.	Row n %	Column Total	
Professional/Formal and Professional Herbalist	27	77.10%	8	22.90%		148.13 / 3 (0.001)
Faith healers/Non Professional Herbalist	1	2.10%	47	97.90%		
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	0	0.00%	68	100.00%		
Visit to Pharmacy / chemical seller for advice and treatment	0	0.00%	59	100.00%		
Total	28	13.30%	182	86.70%	100.0%	

77.10 per cent of respondents with health insurance cover had first action of health care seeking behaviour for chronic morbidity with the Professional/Formal/Professional Herbalists. In contrast, only 2.10 per cent of the health insured respondents sought care with Faith

Healers/Non-Professional Herbalists. Indeed, none of the health insured respondents sought care with Use of self-prescribed medications or herbs. Further, it could be observed that 100.00 per cent of respondents who sought health care with Use of self-prescribed modern medicines or herbs; and Visit to pharmacy/chemical seller for advice and treatment had no health insurance cover.

4.3.2 Association between Second Action of Health Care Seeking Behaviour and Type of Financing

Table 4.5 describes the association between type of financing and second line of health care seeking behaviour for chronic morbidity among the study participants.

82.4 per cent of those who sought treatment with the professional/formal sector were covered by health insurance. All other forms of financing health care with the professional/formal system at this stage constituted only 17.6 per cent. Visit to pharmacies or chemical sellers for advice and treatment and use of self-prescribed modern/traditional medicines saw about 62.0 per cent each for those who financed the service out of pocket payment. Again, there was an association established between the various health care seeking behaviours and their type of financing ($P < 0.001$).

Table 4.5: Second Action of Health Care Seeking Behaviour

Type of Financing Health Care	Health Care Seeking Behaviour 2								
	Professional/Formal and Professional Herbalist		Faith healers/Non Professional Herbalist		Use of self-prescribed modern medicines/ local herbs/Herbal preparation		Visit to Pharmacy / chemical seller for advice and treatment		
	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %	Chi-square/df (P-value)
Health Insurance	75	82.40%	0	0.00%	0	0.00%	0	0.00%	169.413/9 (0.001)
Out-of-Pocket	10	11.00%	22	44.00%	33	62.30%	10	62.50%	
Family fin. Support	6	6.60%	13	26.00%	10	18.90%	6	37.50%	
Free/In-kind	0	0.00%	15	30.00%	10	18.90%	0	0.00%	
Total	91	100.00%	50	100.00%	53	100.00%	16	100.00%	

Table 4.6 shows analysis of association between second action health care seeking behaviour for chronic morbidity among respondents and health insurance status. Again, there is very significant association between the health insurance status of the respondents and their second action of health care seeking behaviour. Respondents with health insurance cover sought care with Professional/formal/Professional herbalists almost most of the time for chronic morbidity

Table 4.6: Health Insurance Cover Status and Second Action of Health Care Seeking Behaviour

	Health Insurance Status					
	Health Insurance Covered		Non Health Insurance Covered		Total	
Health Care Seeking Behaviour	Freq.	Row n%	Freq.	Row n%	Column Total	Chi-sq/ df (P-value)
Professional/Formal and Professional Herbalist	75	82.40%	16	17.60%	100.0%	152.56 / 3 (0.001)
Faith healers/Non Professional Herbalist	0	0.00%	50	100.00%		
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	0	0.00%	53	100.00%		
Visit to Pharmacy / chemical seller for advice and treatment	0	0.00%	16	100.00%		
Total	75	35.70%	135	64.30%	100.0%	

While 82.40 per cent of the respondents who sought care with Professional/Formal/Professional Herbalists for chronic morbidity had health insurance cover, only 17.60 per cent sought same health care seeking behaviour as second action without health insurance cover. Indeed, all respondents who sought care with Use of self-prescribed modern/local herbs; Visit to pharmacy/chemical seller for advice and treatment; and Faith healers/Non-professional herbalists as second action of health care seeking behaviour were non-insured.

4.3.3 Association between Third Action of Health Care Seeking Behaviour and Type of Financing

Table 4.7 describes the association between type of financing and third line of health care seeking behaviour for chronic morbidity among the study participants.

78.6 per cent of respondents who sought care for chronic diseases at professional/formal facilities had health insurance cover while only 21.4 per cent did so using financing types like

family support, out of pocket payment and free/in-kind. On the other hand, 100.0 per cent of the respondents who used self-prescribed modern/traditional medicines paid using non-insurance means of financing. Again, 100.0 per cent of respondents who visited a pharmacy or chemical seller paid using non-health insurance means of financing. Association between type of financing and specific health care seeking behaviour was very strong ($P < 0.001$).

Table 4.7: Third Action of Health Care Seeking Behaviour

Type of Financing Health Care	Health Care Seeking Behaviour 3								
	Professional/Formal and Professional Herbalist		Faith healers/Non Professional Herbalist		Use of self- prescribed modern medicines/ local herbs/herbal preparations		Visit to Pharmacy / chemical seller for advice and treatment		Chi-square/df (P-value)
	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %	
Health Insurance	110	78.60%	1	4.50%	0	0.00%	0	0.00%	
Out-of-Pocket	20	14.30%	14	63.60%	21	65.60%	10	62.50%	
Family financial support	10	7.10%	2	9.10%	5	15.60%	6	37.50%	
Free/In-kind	0	0.00%	5	22.70%	6	18.80%	0	0.00%	
Total	140	100.0%	22	100.0%	32	100.0%	16	100.0%	

Table 4.8 shows analysis of association between third action of health care seeking behaviour for chronic morbidity among respondents and health insurance status. Again, there is very significant association between the health insurance status of the respondents and their health care seeking behaviour. Respondents with health insurance cover sought care with Professional/formal/Professional herbalists almost most of the time for chronic morbidity

Table 4.8: Health Insurance Cover Status and Third Action of Health Care Seeking Behaviour

	Health Insurance Status					
	Health Insurance Covered		Non Health Insurance Covered		Total	
Health Care Seeking Behaviour 3	Count	Row n %	Freq.	Row n %	Column Total	Chi-sq/df (P-value).
Professional/Formal and Professional Herbalist	110	78.60%	30	21.40%	100.00%	111.57/ 3 (0.001)
Faith healers/Non Professional Herbalist	1	4.50%	21	95.50%		
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	0	0.00%	32	100.00%		
Visit to Pharmacy / chemical seller for advice and treatment	0	0.00%	16	100.00%		
Total	111	52.90%	99	47.10%		

At the third action of health care seeking behaviour for chronic morbidity among the aged, 78.60 per cent of the respondents who sought care with the Professional/Formal/Professional Herbalist had health insurance coverage. Those without health insurance coverage sought care for chronic morbidity mostly with non-professional providers of health care.

4.4 Appraisal for Health Systems Responsiveness

The third specific objective set out for this study was to appraise the various health care seeking behaviours for health systems responsiveness.

Figure 4.2 describes the general average percentage scores for the 7 dimensions of WHO health systems responsiveness (i.e. dignity, autonomy, confidentiality, prompt attention, choice, communication and basic amenities)

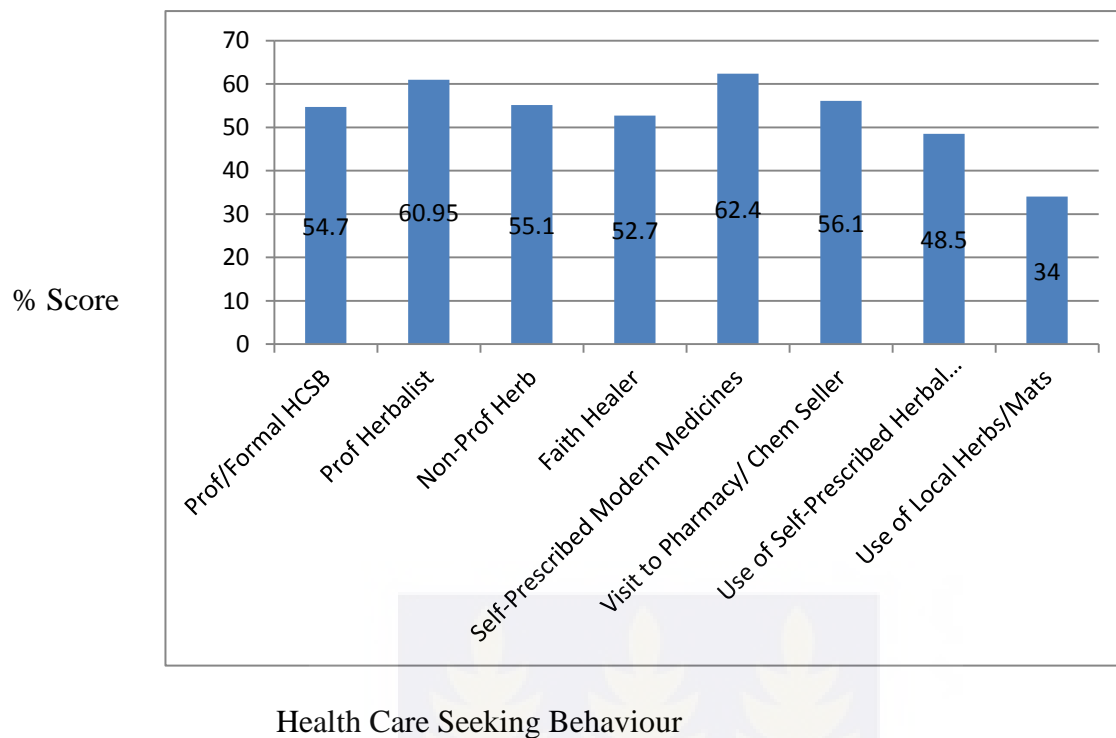


Figure 4.2: Health Systems Responsiveness per Health Care Seeking Behaviour

The study rated Professional/Formal medical systems, 54.7 per cent and Professional Herbalists, 60.9 per cent. The others were Non-professional herbalists, 55.1 per cent; Faith healers, 52.74 per cent; Use of self-prescribed modern medicines, 62.37 per cent; Visit to pharmacies/chemical sellers for advice and treatment, 56.1 per cent; Use of self-prescribed herbal/traditional preparations, 48.5 per cent and Use of local herbs/materials on advice of family members and friends, 34.0 per cent.

With regard to the details of the average percentage scores (Table 4.6), Professional/formal system recorded for Dignity Good (84.6 per cent), Moderate (71.4 per cent and Poor (50.0 per cent) among the other health care seeking behaviours. The respondents also appraised the sector for Confidentiality Good (77.7 per cent), Moderate (77.9 per cent) and Poor (73.3 per cent). However, professional/formal health care seeking behaviour rated for Autonomy Good (53.8 per

cent), Moderate (77.9 per cent) and Poor (84.0 per cent). Again, for Prompt Attention, Professional/formal health care seeking rated Good (36.6 per cent), Moderate (83.5 per cent) and Poor (92.3 per cent). In addition, Choice rated Good (57.9 per cent), Moderate (81.0 per cent) and Poor (83.3 per cent).

On the other hand, Visit to pharmacy/chemical seller rated for Prompt Attention Good (22.0 per cent), Moderate (1.2 per cent) and Poor (1.3 per cent). Faith healers/non-professional herbalists rated for Prompt Attention Good (12.2 per cent), Moderate (11.8 per cent) and Poor (6.4 per cent).

Table 4.9: Health Systems Responsiveness Ranking with Last Health Care Seeking Behaviour

Dimension of Health Sys. Responsiveness Health Care Seeking Behaviour	Ranking							
	Good		Moderate		Poor		Don't know	
	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %	Freq.	Column n %
Dignity								
Professional/Formal and Professional Herbalist	77	84.60%	80	71.40%	1	50.00%	0	0.00%
Faith healers/Non Professional Herbalist	5	5.50%	15	13.40%	0	0.00%	1	20.00%
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	6	6.60%	10	8.90%	0	0.00%	3	60.00%
Visit to Pharmacy / chemical seller for advice and treatment	3	3.30%	7	6.20%	1	50.00%	1	20.00%
Total	91	100.00%	112	100.00%	2	100.00%	5	100.00%
Autonomy								
Professional/Formal and Professional Herbalist	14	53.80%	81	77.90%	63	84.00%	0	0.00%
Faith healers/Non Professional Herbalist	3	11.50%	10	9.60%	7	9.30%	1	20.00%
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	6	23.10%	8	7.70%	2	2.70%	3	60.00%
Visit to Pharmacy / chemical seller for advice and treatment	3	11.50%	5	4.80%	3	4.00%	1	20.00%
Total	26	100.00%	104	100.00%	75	100.00%	5	100.00%

Confidentiality								
Professional/Formal and Professional Herbalist	87	77.70%	60	77.90%	11	73.30%	0	0.00%
Faith healers/Non Professional Herbalist	10	8.90%	7	9.10%	3	20.00%	1	16.70%
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	10	8.90%	4	5.20%	1	6.70%	4	66.70%
Visit to Pharmacy / chemical seller for advice and treatment	5	4.50%	6	7.80%	0	0.00%	1	16.70%
Total	112	100.00%	77	100.00%	15	100.00%	6	100.00%
Prompt Attention								
Professional/Formal and Professional Herbalist	15	36.60%	71	83.50%	72	92.30%	0	0.00%
Faith healers/Non Professional Herbalist	5	12.20%	10	11.80%	5	6.40%	1	16.70%
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	12	29.30%	3	3.50%	0	0.00%	4	66.70%
Visit to Pharmacy / chemical seller for advice and treatment	9	22.00%	1	1.20%	1	1.30%	1	16.70%
Total	41	100.00%	85	100.00%	78	100.00%	6	100.00%
Choice								
Professional/Formal and Professional Herbalist	22	57.90%	94	81.00%	40	83.30%	2	25.00%
Faith healers/Non Professional Herbalist	5	13.20%	10	8.60%	5	10.40%	1	12.50%
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	9	23.70%	6	5.20%	1	2.10%	3	37.50%
Visit to Pharmacy / chemical seller for advice and treatment	2	5.30%	6	5.20%	2	4.20%	2	25.00%
Total	38	100.00%	116	100.00%	48	100.00%	8	100.00%
Communication								
Professional/Formal and Professional Herbalist	65	78.30%	77	75.50%	15	88.20%	1	12.50%
Faith healers/Non Professional Herbalist	9	10.80%	10	9.80%	1	5.90%	1	12.50%
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	5	6.00%	9	8.80%	0	0.00%	5	62.50%
Visit to Pharmacy / chemical seller for advice and treatment	4	4.80%	6	5.90%	1	5.90%	1	12.50%
Total	83	100.00%	102	100.00%	17	100.00%	8	100.00%
Basic Amenities								
Professional/Formal and Professional Herbalist	30	76.90%	112	84.20%	15	60.00%	1	7.70%

Faith healers/Non Professional Herbalist	2	5.10%	9	6.80%	9	36.00%	1	7.70%
Use of self-prescribed modern medicines/ local herbs/Herbal preparation	3	7.70%	8	6.00%	0	0.00%	8	61.50%
Visit to Pharmacy / chemical seller for advice and treatment	4	10.30%	4	3.00%	1	4.00%	3	23.10%
Total	39	100.00%	133	100.00%	25	100.00%	13	100.00%



CHAPTER FIVE

DISCUSSION

5.1 Introduction

The purpose of this study was to describe the various health care seeking behaviours for chronic morbidity prevalent among the aged and the various factors that influenced them. While some of the factors were captured as general socio-demographic characteristics like employment status, marital status, educational attainment and household crowding index, we studied the association between the various health care seeking behaviours at 3 stages of health care seeking behaviour on one hand and Self-Rated Health on the other hand. In addition, we studied the association between the health care seeking behaviours for chronic morbidity and the type of financing for the behaviours. Lastly, we conducted an appraisal of the health systems responsiveness for the last sought health care seeking behaviour of the study participants.

5.2 Background Characteristics of Study Participants

With reference to Table 4.1, the investigator observed a decreasing proportion of the aged with increasing age group. This trend agrees with literature and common knowledge that as people age they become prone to life threatening diseases, especially chronic ones, and eventually die (Smith and Mensah, 2003). The above observed trend could explain the high rate of the aged widowed or unmarried. Again, a significant proportion of the aged covered in the study were either unemployed or doing home making. These characteristics may associate with poor income generating status or financial liquidity of the participants especially in a country like Ghana currently experiencing lower family financial support coupled with the gradual breakdown of the strong extended family support system (Brown, 1999). With regard to health care seeking behaviour for these groups of the aged, the situation could serve as an enabling factor for seeking

health care with systems that may not require direct payment of money or travelling to seek care. An example is as observed in some participants using faith healers as first, second and third actions of health care seeking behaviour for a chronic disease instead of professional or formal health care seeking behaviour (Tables 4.3, 4.4, 4.5, 4.6, 4.7 and 4.8).

With reference to educational attainment of the participants, as high as 30.0 per cent of them had no form of formal education while 45.2 per cent could have only 1-10 years of education. This predisposing factor among the aged strongly points to the low level of knowledge about health and health care seeking behaviours required for treating and managing chronic diseases. It therefore puts these mass of the aged believing and hoping that chronic diseases had cure and the eventual possible practice of ceasing treatment with the formal or professional practitioners for non-professional herbalists and faith healers.

Household Crowding Index measures population density in a household. Specifically, it is expressed as the number of inhabitants living in a household per number of living rooms. The indicator is known to be associated with socio-economic status of respondents and could predict possible health care seeking behaviour of household members in a setting. Among the study participants, it showed that over 50 per cent were located in either severely crowded or crowded homes; a scenario pointing to low socio-economic status of majority of the aged in the study area. This phenomenon therefore points to the possibility of the majority of respondents to be of low socio-economic status (Melki et al. 2004). Low socioeconomic status of the aged in the absence of protection from high health costs could predispose respondents to seeking care outside the formal or professional health care system.

5.3 Association between Self-Rated Health and Health Care Seeking Behaviour

With reference to Table 4.2 we failed to establish any statistically significant association between Self-Rated Health of the participants and their pattern of health care seeking behaviour. This observation disputes works by Boulton et al. (1993), Stull et al. (1996) and recently by Fernandez-Olano et al. (2006). Indeed, while these researchers observed that the Self-Rated Health of people associated with their health care seeking behaviour, especially with hospital admissions and out-patients visits as health care seeking behaviours, the same could not be said about the phenomenon among the aged in the study area. A possible explanation to this observed lack of association between the factors could be the very complex and pluralistic health system in the study area in particular and Ghana as a whole as against the settings of the earlier researchers in Europe and Americas where the systems are not as pluralistic as the former (Twumasi, 2005). The policy implication of this observation is that the health sector should not link Self-Rated Health of the aged in the study area to their possibility of seeking care with the professional or formal sector or any other health system. It thus does not associate with seeking care among them. Other factors should instead be explored to attract the aged to seeking care with the formal system. The observation also implies that if the formal health sector cannot attract the aged to seek care for chronic morbidity, it should be able to strengthen capacity at such other systems outside it for at least prompt referral of cases to appropriate facilities for early and effective treatment.

5.4 Health Care Seeking Behaviour and Type of Financing

We refer to Tables 4.3, 4.4, 4.5, 4.6, 4.7 and 4.8 of this study report. It can be seen from first, second and third actions of health care seeking behaviour that there existed a strong association

($P \leq 0.001$) between a specific health care seeking behaviour and the type of financing the respondents used for them. Specifically, it could be observed that at first action of seeking health care or healing, participants with health insurance cover sought health care with the Professional or formal system (77.1 per cent) while only 2.1 per cent of same category sought care with faith healers or non-professional herbalists. Indeed none of the members of the cohort sought care with the Use of self-prescribed medicines/local herbs or Visit to pharmacies/chemical sellers for advice and treatment.

At the second action of health care seeking behaviour, it was also observed that type of health care financing was strongly associated ($P \leq 0.001$) with health care seeking behaviour. Again, 82.4 per cent of health insured patients attended a professional or formal health care facility while 0.00 per cent of those who paid in-kind or had it for free never sought it.

Indeed, similar trend characterized the third action of health care seeking behaviour for chronic morbidity among the study participants.

These observations confirmed studies by Jacobs et. al (2011) and locally by Asenso-Okyere et al. (1998) that lack of financial security for patients could make them resort to self-medication and other unprofessional health care seeking behaviours.

This statistically significant association between type of financing and health care seeking behaviour has a key policy implication for the health sector of the country. There is therefore the need to provide fee free and compulsory health insurance for the elderly aged at least 60 years as part of the National Health Insurance Scheme. This will facilitate improved access to seeking health care with the professional or formal sector. This is more important because of the myriad of non-professional herbalists and faith healers using advertisement to attract patients to seek

care with them for so-called cure for almost every chronic disease; a practiced that is not permitted by law in the professional or formal practice of medicine, nursing and other orthodox biomedical practitioners of health care.

5.5 Appraisal of Health Care Seeking Behaviours for Health Systems Responsiveness

With reference to Figure 4.1, we have observed that health care seeking behaviour with Visit to pharmacies or chemical sellers rated best for the 7 dimensions of WHO health systems responsiveness with a score of 62.37 per cent. Professional herbalists rated second with 60.95 per cent. Interestingly, Professional or formal health care seeking behaviour rated 5th for the average of all the dimensions of dignity, autonomy, confidentiality, prompt attention, choice, communication and basic amenities.

Notwithstanding the rating of the professional or formal health sector, there is the need to examine the rating of the individual dimensions. It rated for dignity Good (84.6 per cent), autonomy Poor (84.0 per cent), confidentiality Poor (73.3 per cent), prompt attention Poor (92.3 per cent), choice Poor (83.3 per cent) communication Poor (88.2 per cent) and basic amenities Good (76.9 per cent) and Moderate (84.2 per cent).

The above ratings have obvious implications for policy on attracting the aged to the professional or formal health system. There is the need for concerted efforts to improve upon all the dimensions of health systems responsiveness except for, may be, dignity and basic amenities.

Again, with health care seeking behaviour with professional herbalists rating very well (60.9 per cent) as compared to the orthodox health system, there is also the need for the sector strengthen the development and regulation of the practice while establishing smooth and well coordinated

referral systems between the orthodox and the herbal practices. This could foster a more reliable health system at least for the formal sector.

Finally, with reference to the highest average responsiveness score for Visit to pharmacies or chemical sellers, the health ministry could strengthen the capacity of practitioners in this industry by strengthening their regulation and linkages with the formal health sector for prompt and effective referral of suspected cases of chronic disease requiring professional attention.



CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The purpose of this study was to describe the various health care seeking behaviours for chronic morbidity prevalent among the aged and factors that influenced them within the New Juaben Municipality. It was also set out to appraise the various health care seeking behaviours for health systems responsiveness.

The following findings were therefore the conclusions of the study:

1. There were 4 major health care seeking behaviours for chronic morbidity prevalent among the aged in the study area. These were Professional/formal (both orthodox biomedical and herbal medical practices), Faith healers/non-professional herbalists, Use of self-prescribed modern and traditional herbal preparations/ herbs and Visit to pharmacy/chemical sellers for advice and treatment.
2. Self-Rated Health was not associated with any particular health care seeking behaviour for chronic morbidity among the aged in the study area.
3. The study has established a strong association between a specific health care seeking behaviour for chronic morbidity and the type of financing for it among the study participants.
4. After rating the various health care systems prevalent in the study area with the WHO 7 dimensions of dignity, autonomy, confidentiality, prompt attention, choice, communication and basic amenities, it was found that the Professional/formal health care system (orthodox biomedical only) to be less responsive as compared to Professional Herbalists and Visit to pharmacies and chemical sellers for advice and treatment.

In a summary, the type financing available to an aged individual with chronic condition was strongly associated with the type of health care seeking behaviour.

6.2 Recommendations

1. It is recommended that the health sector undertakes the necessary policy changes to ensure that all people aged 60 years and above who are not employed and had not contributed to Social Security and National Insurance Trust be covered with free health insurance. This is believed to insulate them from seeking health care outside the professional or formal health care system for the treatment and management of chronic diseases.

2. It also recommended that the professional or formal orthodox biomedical facilities in the study area to largely improve upon 5 dimensions of health systems responsiveness (i.e. autonomy, confidentiality, prompt attention, choice, communication) while making concerted efforts to maintain their responsiveness to dignity and basic amenities.

6.3 Recommendations for Future Research

1. It is recommended that similar study be conducted in other study areas of the country. This is to enable us conduct a comparative analysis of the prevailing health care seeking behaviours for chronic morbidity among the aged in Ghana and the factors that associate with them.

2. In addition, it is recommended that future research looks at comparative rating of health systems responsiveness among state owned, mission owned or managed and private owned and managed health facilities treating and managing chronic conditions in Ghana.



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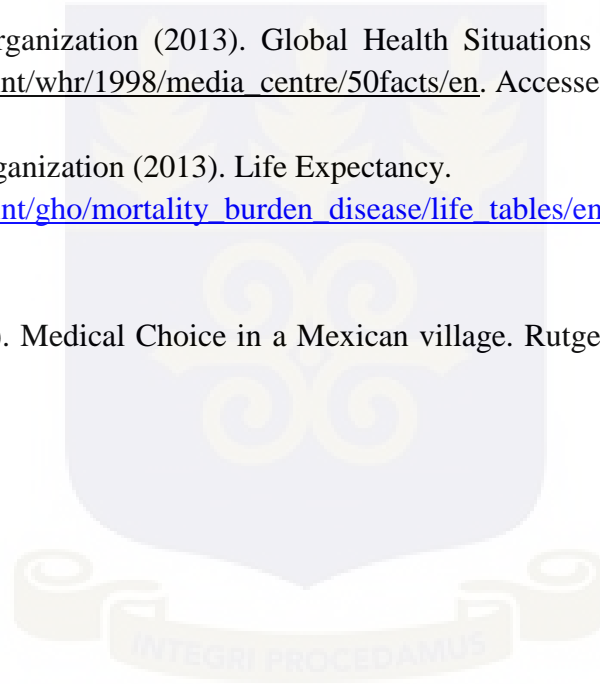
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APPENDIX 1: INFORMED CONSENT FORM WITH QUESTIONNAIRE

QUESTIONNAIRE ON HEALTH CARE SEEKING BEHAVIOUR AMONG THE AGED IN NEW JUABEN MUNICIPALITY

Serial No. of Questionnaire:

Informed Consent

My name is _____. I am working on behalf of Victus Kwaku Kpese, a Master of Public Health student of the School of Public Health, University of Ghana. He is studying the various health care seeking behaviours utilised by the aged for chronic diseases. The study is to help inform the formal health care system as to how to attract the aged to seek care for the increasing prevalence of chronic diseases among the aged in Ghana. Do I please have your permission to ask you the questions that follow? Yes _____ No _____ (if answer is No, please stop the interview and do not complete the questionnaire) and move to the next aged person with a chronic condition).

If Yes to the above question, do you have any symptoms or signs of ill-health e.g. *persistent pain, cough, dizziness, discomfort, physical weakness or tiredness, trouble sleeping, deep cut, sore, falls, lump, poor eye sight*) that have lasted more than 3 months or medically diagnosed condition e.g. hypertension, diabetes etc that has existed for more than 3 months?

Yes _____ No _____ (if answer is No, please stop the interview and move to the next aged person with a chronic condition).

Should you have any questions about this interview, you can please call Madam Hannah Frimpong of the Ghana Health Service Ethical Review Committee (ERC) on Telephone Number 0243235225.

Name of Polling/Electoral Area (EA) _____

Now I would like to ask you some questions about where and how you seek care for your chronic condition(s).

1.0 Background Information

1.1. What is your age in completed years (*Please quote*)

1.2 What was your marital status at the time you first experienced the symptoms/signs of your chronic condition (e.g. *persistent pain, cough, dizziness, discomfort, physical weakness or tiredness, trouble sleeping, deep cut, sore, falls, lump, poor eye sight*) or medically diagnosed of e.g. hypertension, diabetes etc

0. Single
1. Married
2. Divorced
3. Separated
4. Widowed

5. Living together

1.3 Which of the employment descriptions below is applicable to you?

0. Full time formally employed (at least 35hrs per week (by someone else or entity)
1. Full time informally employed (at least 35hrs per week (by self)
2. Part time (less than 35hrs per week) employed (by someone else or entity) as sole primary job
3. Part time (less than 35hrs per week) employed (by someone else or entity) but engaged in other jobs.
4. Part time (less than 35hrs per week) employed (by self) as sole primary job
5. Part time (less than 35hrs per week) employed (by self) but engaged in other jobs
6. Retired and on pension benefits only
7. Unemployed (*i.e. not on pension benefits, fit physically for work but not engaged in any*)
8. Homemaker
9. Unable to work (*i.e. not physically fit for work nor on pension benefits*)

1.4 What is your total number of years spent in formal education? (less the years of re-sitting or re-writing for a qualification)

Answer: completed years

1.5 How many of you are in this household?

1.6 State the number of rooms available for use by your household (less toilets and bathroom(s))
.....

1.7 Do you have a valid Health Insurance Card?

0. No
1. Yes (*as evidenced by inspection of valid and unexpired health insurance card*)

1.8 How will you rank your health today?

0. Good
1. Moderate
2. Poor
3. Don't know

2.0 Health Care Seeking Behaviours

2.1 When was the last time you took an action or sought treatment or any help for the signs or symptoms of *e.g. persistent pain, cough, dizziness, discomfort, physical weakness or tiredness, trouble sleeping, deep cut, sore, falls, lump, poor eye sight*) or medically diagnosed of *e.g. hypertension, diabetes*?

0. Less than 1 month
1. 1 month ago

2. 2 months ago
3. 3 months ago
4. 4 months ago
5. 5 months ago
6. 6 months ago
7. More than 6 months ago

2.2 When did you first suspect these signs or symptoms of the illness or first medically diagnosed of the condition?

0. Less than 3 months now
1. At least 3 months now

2.3. Which action did you take for the first (1st) time in response to the last time you experienced the symptoms/signs in 2 above?

0. Professional/Formal (*medical doctor, physician assistants, dentist nurse, physiotherapist, dietician/nutritionist, clinical psychologist*)
 - a. (Name and location of facility:.....)
1. Professional Herbalist (*practitioners certified by MOH and had received formal training e.g. KNUST trained herbal medical practitioners*)
 - a. (Name and location of facility:.....)
2. Non-Professional Herbalist (*practitioners who have not received formal training and certification by the MOH*)
 - a. (Name and location of facility:.....)
3. Alternative Medical Practitioners (*chiropractor, acupuncturist, naturopathic*)
 - a. (Name and location of facility:.....)
4. Faith healers (*use of prayer camps, pastors and any other act based on faith and supernatural forces*)
5. Use of self-prescribed modern medicines purchased from chemical sellers or pharmacies
6. Visit to Pharmacist or Chemical seller for advice and treatment
7. Use of self-prescribed herbal/traditional medicines purchased from dealers (pharmacies, chemical sellers, individual traders etc)
8. Use of local herbs/ materials on advice of family members and friends.

9. Any other

2.4. What was your reason for this choice of health care seeking behaviour?

.....
.....

2.5. How did you pay for the services provided by the health provider or healer for the first time of treating your illness as described above? (*If more than one source, please tick the main source of financing*)

- 0. Health insurance cover
- 1. Out-of pocket payment
- 2. By current or former employer
- 3. Family financial support
- 4. Free/In-kind (state).....
- 5. Don't know/ I have forgotten

2.6 Now, which action did you take for the second (2nd) time in response to the last time you experienced the symptoms/signs in 2.1 above?

- 0. Professional/Formal (*medical doctor, physician assistants, dentist nurse, physiotherapist, dietician/nutritionist, clinical psychologist*)
 - a. (Name and location of facility:.....)
- 1. Professional Herbalist (*practitioners certified by MOH and had received formal training e.g. KNUST trained herbal medical practitioners*)
 - a. (Name and location of facility:.....)
- 2. Non-Professional Herbalist (*practitioners who have not received formal training and certification by the MOH*)
 - a. (Name and location of facility:.....)
- 3. Alternative Medical Practitioners (*chiropractor, acupuncturist, naturopathic*)
 - a. (Name and location of facility:.....)
- 4. Faith healers (*use of prayer camps, pastors and any other act based on faith and supernatural forces*)
- 5. Use of self-prescribed modern medicines purchased from chemical sellers or pharmacies
- 6. Visit to Pharmacist or Chemical seller for advice and treatment

7. Use of self-prescribed herbal/traditional medicines purchased from dealers (pharmacies, chemical sellers, individual traders etc)
8. Use of local herbs/ materials on advice of family members and friends.
9. Any other

2.7 What was your reason for this 2nd choice of health care seeking behaviour?

.....
.....

2.8. How did you pay for the services provided by the health provider or healer for the second (2nd) time of treating the condition as described above?

0. Health insurance cover
1. Out-of pocket payment
2. By current or former employer
3. Family financial support
4. Free/ in-kind (state).....
5. Don't know/ I have forgotten

2.9 Again, please which action did you take for the third (3rd) time in response to the last time you experienced the symptoms/signs in 2 above?

0. Professional/Formal (*medical doctor, physician assistants, dentist nurse, physiotherapist, dietician/nutritionist, clinical psychologist*)
 - a. (Name and location of facility:.....)
1. Professional Herbalist (*practitioners certified by MOH and had received formal training e.g. KNUST trained herbal medical practitioners*)
 - a. (Name and location of facility:.....)
2. Non-Professional Herbalist (*practitioners who have not received formal training and certification by the MOH*)
 - a. (Name and location of facility:.....)
3. Alternative Medical Practitioners (*chiropractor, acupuncturist, naturopathic*)
 - a. (Name and location of facility:.....)
4. Faith healers (*use of prayer camps, pastors and any other act based on faith and supernatural forces*)
5. Use of self-prescribed modern medicines purchased from chemical sellers or pharmacies

6. Visit to Pharmacist or Chemical seller for advice and treatment
7. Use of self-prescribed herbal/traditional medicines purchased from dealers (pharmacies, chemical sellers, individual traders etc)
8. Use of local herbs/ materials on advice of family members and friends.
9. Any other

2.91 What was your reason for this 3rd choice of health care seeking behaviour?

- 2.92. How did you pay for the services provided by the health provider or healer for the third (3rd) time as described above?
0. Health insurance cover
 1. Out-of pocket payment
 2. By current or former employer
 3. Family financial support
 4. Free/In-kind (*state*).....
 5. Don't know/ I have forgotten

3.0 Health System Responsiveness

3.1. Based on your last visit to seek health care or healing for your chronic condition, how will you rate your perception of responsiveness of the facility for the following attributes?

(Type of Health Care Provider/Healer:

No.	HEALTH SYSTEM RESPONSIVENESS ATTRIBUTES	RANKING			
		1. Good	2. Moderate	3. Poor	4. Don't Know
3.11	Dignity <i>(assessment by patients with respect to not humiliating or demeaning them including privacy)</i>				
3.12	Autonomy <i>(assessment by patients with respect to right to participate in choices about one's own health or</i>				

	<i>treatment options)</i>				
3.13	Confidentiality (assessment by patients regarding their right to determine who has access to one's health information)				
3.14	Prompt attention (assessment by patients with respect to time taken by health care professionals to respond immediately in emergencies and reasonable waiting times for non-emergencies)				
3.15	Choice (this measures the freedom patients have to choose who attends to them within a facility)				
3.16	Communication (this measures whether providers listened carefully to patients for adequate information and involve them in decision making about their health care needs)				
3.17.	Basic amenities (adequacy and/or quality of cleanliness of environment, space and hospital food)				

Thank you for the time spent completing this interview.

Appendix 2: Schedule of Activities

Activity	Period / Deadline
1. Proposal Development and Presentation	February 15, 2014
2. Approval for Ethical Clearance	February 28, 2014
3. Development Of Data Collection Tool	April 25 , 2014
4. Data Collection	May 10 – 15, 2014
5. Data Collation and Cleaning	May 15- 20, 2014
6. Data Analysis and Reporting	May 21- 30 2014
7. Discussion of Results	June 4, 2014
8. Final Write-Up	July 10, 2014
9. Submission of Report	July 15, 2014

