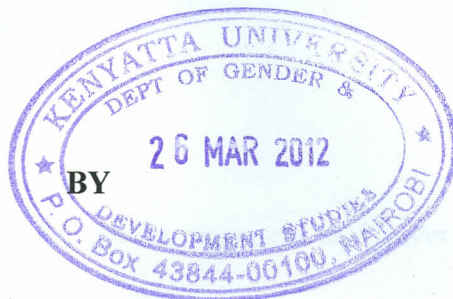


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**HEALTH-SEEKING BEHAVIOUR OF WOMEN AND  
MEN IN GITHIGA LOCATION, GITHUNGURI  
DISTRICT, KENYA**



**JANET NDUTA MUNGAI  
C50/10802/2008**

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## DECLARATION

This project is my original work and has not been presented for a degree in any other university.

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## DEDICATION

To my family for their support and patience during my studies and to the memory of my late parents, whose passion for education and hard work inspires me to keep going each day.

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## Abstract

This study set out to investigate the health status, health-seeking behaviour as well as the factors that influence the behaviour among elderly women and men in Githiga Location, Githunguri District. A total of 53 elderly women and men were interviewed using a semi-structured questionnaire. Of those, 49.1% were female and 50.9% were male. Besides the elderly women and men, health workers in Githiga and Githiga health centres as well as in private clinics and pharmacies were interviewed.

The data analysis was done using simple descriptive analysis technique and SPSS software. The study found that education, income, marital status and distance to health facilities affect health-seeking behaviour. The higher the level of education and income, the more the respondents sought health services; whereas the greater the distance, the less the health services were sought. A high percentage of women delayed visit to health facilities citing the many gender roles that required their attention.

The study concludes that health-seeking behaviour among women and men is influenced by gender roles and that the determinants of this behaviour, affect women and men differently. It is recommended that the elderly be given priority at health centres to avoid waiting in long queues or be treated in a room reserved only for them. This will not only save them valuable time wasted queueing but also encourage them to visit health facilities as need arises. Health workers should be sensitized on the need to handle the elderly with care as they appeared very sensitive and cited young health workers as disrespectful. Need for organization of free medical camps to bring the services nearer to the elderly as well as sensitizing them on the need to seek regular treatment was apparent. Availability of social amenities like social clubs and recreation for use by the elderly are also recommended. Based on the results, similar studies need to be conducted elsewhere in the country using a larger sample or targeting a different group of society like the youth for comparative purposes.

## ABBREVIATIONS AND ACRONYMS

AIDS	:	Acquired Immunodeficiency Syndrome
CBS	:	Central Bureau of Statistics
CSDH	:	Commission on Social Determinants of Health
CDF	:	Community Development Fund
GoK	:	Government of Kenya
ILO	:	International Labour Organization
JMAJ	:	Japan Medical Association Journal
KDHS	:	Kenya Demographic and Health Survey
KNASP	:	Kenya National HIV/AIDS Strategic Plan
MoH	:	Ministry of Health
NACC	:	National AIDS Control Council
NCAPD	:	National Coordinating Agency for Population and Development
NESC	:	National Economic and Social Council of Kenya
NGO	:	Non-governmental Organizations
NESC	:	National Economic and Social Council
NHSSP	:	The National Health Sector Strategic Plan
NMS	:	Kenya National Malaria Strategy
OAU	:	Organization of African Unity
SCT	:	Social Cognitive Theory
SPSS	:	Statistical Package for Social Sciences
UNESCO	:	United Nations Educational, Scientific and Cultural Organization
WHO	:	World Health Organization

## OPERATIONAL DEFINITION OF TERMS

**Health:** " Health " is a multi-dimensional concept that is usually measured in terms of: 1) absence of physical pain, physical disability, or a condition that is likely to cause death, 2) emotional well-being, and 3) satisfactory social functioning.

**Health literacy:** is defined as the extent to which people have the capacity to obtain basic health information, which they are able to process and understand so that they can make informed decisions about their health.

**Health Status:** is the rating of an individual along any of several dimensions, including presence or absence of life-threatening illness, risk factors for premature death, severity of disease, and overall health. Individual health status may also be assessed by asking the person to report his/her health perceptions in the domains of interest, such as physical functioning, emotional well-being, pain or discomfort, and overall perception of health.

**Health Behavior** is any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behavior is objectively effective towards that end.

**Elderly People:** males and females 60 years and above.

**Gender:** Refers to the socially constructed differences and relations between women and men which are learned, vary widely among societies and cultures and change over time.

**Gender Roles:** These are duties/roles classified by sex, in which the classification is social and not genetic.

**Social Norms:** refers to prescriptions by society on how women and men should behave. "Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles.

**Social Protection:** refers to policies and actions targeting the poor and vulnerable members of society. These initiatives are aimed at enhancing their capacity to reduce extreme poverty as well as economic and social vulnerability. Cash Transfer Programme to Older Persons is one instrument of social protection.

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background to the Study

According to Article 25 of the Universal Declaration of Human Rights (UDHR), everyone has the right to a standard of living adequate for the health and wellbeing of self and family, including food, clothing, housing, necessary social services and security (UN, 1948). UDHR does not just advise all signatory nations to recognize and respect these as civil rights but rather these rights are already recognized by the world body and the signatory nations.

Furthermore, the International Covenant on Economic, Social and Cultural Rights document recognizes ‘the right of everyone to the enjoyment of the highest available standard of physical and mental health (UN, 1969). Article 6.1 of the International Covenant on Civil and Political Rights also puts the right to life as a basic human right and stipulates that no one should be arbitrarily deprived of life. Guaranteeing right to life entails ensuring enabling conditions in both private and public institutions.

The World Health Organization (WHO) has been at the forefront of health issues and Dr. J. W. Lee, the former Director-General, set up a commission in March 2005 to bring together evidence on what could be done to achieve better and more fairly distributed health worldwide, and to promote a global movement to achieve

this. The Commission on Social Determinants of Health (CSDH), as it was named, is a global network of policy-makers, researchers and civil society organizations brought together by WHO to give support in tackling the social causes of poor health and avoidable health inequalities and health inequities. The CSDH was expected to gather and review evidence on what needs to be done to reduce health inequalities within and between countries and to report its recommendations for action to the Director-General of WHO. Building partnerships with countries committed to comprehensive, cross-government action to tackle health inequalities was integral to this. Experts were brought together to gather evidence, and civil society organizations also participated in the process. As a contribution to world health concerns, African heads of state and government met in 2001 in Abuja and committed themselves to set a target of allocating at least 15 per cent of their annual budgets to the improvement of the health sector (OAU, 2001).

In Kenya, health services are offered through multiple, sometimes overlapping channels, echoing what is true in many parts of the developing world. As a signatory to WHO and Abuja protocols, Kenya provides health services through the Ministry of Health. The organization of Kenya's healthcare delivery system revolves around three levels: the Ministry of Health (MoH) headquarters, the provinces and districts. The MoH coordinates, monitors, formulates and implements policy. It also oversees activities of non-governmental organizations

(NGOs) and other stakeholders in health matters. Provinces act as intermediaries between MoH and districts by overseeing implementation of health policy at district level, maintaining quality standards and managing District Health Management Boards. Districts concentrate on delivery of healthcare (NCAPD et al, 2005).

The health system in Kenya is organized and implemented through a network of facilities organized in a pyramidal pattern. The network starts at the dispensaries and health clinics with the bottom-up to the health centres, sub-district hospitals, district hospitals, provincial general and the apex is Kenyatta National Hospital which is the referral facility. Facilities become more sophisticated in diagnostic, therapeutic and rehabilitative services at the top level. Out of over 4,500 health facilities, MoH runs and controls 52% while the rest are run by local government and private sector as well as faith-based organizations. NGOs dominate clinics, maternity and nursing homes (ditto).

There are, however, marked inequalities in the health sector. Only 30% of rural population has access to health facilities within 4 km while access is available to 70% of urban dwellers. The quality of health services is low due to inadequate supplies and equipment as well as lack of personnel and regulatory systems. So, the government is making deliberate effort to decentralize health care provision. MoH has embarked on developing legal and regulatory framework and capacity

building to devolve entire authority for planning and financial management to districts (MoH, 2006).

Society prescribes to women and men different roles in different social contexts. Similarly, there are differences in the opportunities and resources available to women and men, and in their ability to make decisions and exercise their human rights, including those related to promoting health. Gender roles and unequal relations interact with other social and economic variables, resulting in inequitable patterns and exposure to health risk, and in differential access to and utilization of health information, care and services. It is, therefore, expected that in health-seeking behaviour, elderly female and males may demonstrate different approaches and responses. In a study carried out to assess 'health and well-being among older people in rural South Africa (Gomez-Olive et al., 2010), found that more women than men were associated with low health status, higher level of disability and therefore lower quality of life.

Health-seeking behaviour in Kenya is influenced by a combination of factors among which are income, level of education, social environment, physical environment such as distance to health facility, personnel at the health facility, among others (NESC, 2007). It is against this background that the study sought to investigate differences in health-seeking behaviour among women and men in Githiga Location. The issue of gender inequality appeared more pronounced

especially considering that women's gender roles have a lot of influence on their health-seeking behaviours.

## **1.2 Statement of the Problem**

Githiga Location has only two government health centres and the nearest district hospital is located at Kiambu town, 20 kilometres away. Alternative health-care can be obtained from private clinics, herbalists or off-the-counter drugs. Although health is a universal problem, some groups are more vulnerable to poor health than others. Aging is not synonymous with illness, but, the elderly are vulnerable to disease because of decreased physiological reserve, less flexible homostatic processes, and less defence mechanisms of the body (Brunner and Suddarth 1986). Vulnerability is also in nutrition and general hygiene which further complicates health issues. Reduced income due to retirement and a breakdown of traditional safety net mechanisms further add to vulnerability. Those entering old age in poverty are likely to remain poor as chances of improvement diminish with age. There is therefore need to cater for the health of the elderly especially as age which carries with it special problems like arthritis, susceptibility to accidents, high blood pressure, diabetes, prostate cancer among others. However, there are expected differences between elderly women and men due to different socially ascribed roles, responsibilities as well as opportunities, which also influence health-seeking behaviour. In light of this, it

was of interest to examine the ways in which the elderly women and men behave when they fall ill and the determining factors.

### **1.3 Purpose of the Study**

The study sought to explore the health-seeking behaviour as well as the factors influencing this behavior among women and men aged 60 years and above.

### **1.4 Objectives**

The specific objectives of this study were:

1. To establish the health status of the elderly women and men in the study area.
2. To identify the health-seeking behaviour of elderly women and men.
3. To examine the factors that influence health-seeking behaviour by women and men.

### **1.5 Research Questions**

The following research questions were formulated for the study:

- i. What is the health status of elderly men and women in Githiga Location?
- ii. What is the health-seeking behaviour of women and men aged 60 years and above in the study area?
- iii. Which factors influence health-seeking behaviour among women and men aged 60 years and above in the study area?

## **1.6 Justification and Significance of the Study**

The elderly are more vulnerable to health issues due to age and socio-economic deprivation. Information that can lead to improvement on their health is definitely important. The findings of this study may also help policy-makers in the health sector to initiate policies that respond to community needs. The health workers may be challenged to improve delivery of service to the elderly. Similarly, the general public can benefit and improve on their health-seeking behaviour while the academic fraternity could benefit from the findings which could add to the existing knowledge in the area of health-seeking behaviour. Finally, researchers may identify gaps on which to build future research.

## **1.7 Scope and Limitations**

This study was confined to health-seeking behaviour of women and men aged 60 years and above. It therefore, did not concern itself with specific illnesses or even the impact of the health interventive strategies in the area. The study locale was Githiga Location and thus the findings may not be generalized to the whole of Githunguri District. The study looked at the current health-seeking behaviour and not the past.

## CHAPTER TWO

### REVIEW OF RELATED LITERATURE

#### 2.0 Introduction

In this chapter, literature reviewed was presented under three sub-headings: health status of elderly people, health-seeking behavior as well as factors which influence health-seeking behaviour among women and men aged 60 years and above.

#### 2.1 Kenya Health Policy Framework

Healthcare delivery systems since independence has expanded vis avis the population and demand for healthcare. In 1994, the Ministry of Health produced Kenya's Health Policy Framework (KHPF) which is the government blue print for future development in the Health Sector today. This policy document is based on a comprehensive situational analysis of the various factors affecting the health sector and broadly addresses the agenda for reform for policy implementation (GoK, 1994).

The aim of the policy framework is to ensure that the health status of the Kenyan population is improved. It sets out the policy agenda for the health sector up to the year 2010. This includes strengthening of the central public policy of the Ministry of Health, adoption of an explicit strategy to reduce the burden of disease and definition of an essential cost-effective care package (ditto).

To make health policy framework operational, the National Health Sector Strategic Plan (NHSSP, 1991-2004) was developed. The strategic plan emphasizes the decentralization of the healthcare delivery through redistribution of health services to rural areas. The revised National Health Sector Strategic Plan II (NHSSP II-2005-2010) has been developed to reflect poverty reduction strategy paper (2001-2004) agenda. The new plan focuses on the essential key priority packages based on the burden of disease and the services required to deliver these services to the Kenyans. Major players in the health sector include government represented by the MoH and the local government, private sector and NGOs (Crouch, 2005).

With the formation of a coalition government in 2008 after the political crisis following the 2007 general elections, MoH was split into two: the Ministry of Public Health and the Ministry of Medical Services. This has not eased the burden of cost of healthcare as the budget is still one and therefore, there is competition over priorities (Wamai, 2009). Currently, there is a deliberate effort by the government to shift towards decentralization of healthcare provision. The MoH has embarked on developing the legal and regulatory framework and capacity building to devolve the entire authority for planning and financial management to districts (MoH, 2006).

## **2.2 Sources of Health Care in Kenya**

The Government as the key health provider and is faced by many challenges including the ever increasing demand of health services which is way over supply (GoK, 2003). There are, however, other health care providers who substitute government efforts. These include: private medical practitioners and clinics, traditional healers, medicinal herbs, fortune tellers, Non-African specialists like Chinese herbalists, spiritual healers, self-treatment using home remedies, voluntary organizations like AMREF and KEMRI, chemists and pharmacies, backstreet doctors (quacks).

## **2.3 Health Status of Elderly People**

At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behavior. These factors, which do not exist in isolation from each other, are referred to as determinants of health (Wilkinson & Marmot, 2003).

Health status is influenced by a combination of determinants. These include income and social status; social support networks; education; employment and working conditions; physical environments, biology and genetic endowment, personal health practices and coping skills, health services and gender (WHO, 2002).

### **2.3.1 Health Status Indicators**

Traditional health status indicators were death, disease and disability. However, a population health approach establishes indicators related to mental and social well-being, quality of life, life satisfaction, income, employment and working conditions, education and other factors known to influence health.

Sook (2006), identified the perceived health status of elderly women and men, and defined the difference between the two groups in Seoul, Korea. He studied 209 elderly people over 60 years living in urban areas through personal interviews using questionnaires. He observed that elderly women complained of types of pain (leg pain, arthritis, lumbago, headache) more than elderly men. Elderly men complained about decreased levels of activities such as walking and general weakness. Elderly men and women had discomforts in daily living such as walking and doing household chores. Further observation was that elderly men and women wanted good health and improvement of health status and that women wanted happiness for their offspring, while men wanted to improve the government and the laws. The researcher came to the conclusion that elderly women favoured relief from pain, but elderly men desired an increased level of activity. Sook's study was similar to the researcher's study in exploring health status of elderly women in urban areas. However, this study examined health status in elderly men and women in peri-urban Githiga Location.

In a related study, Go' mez-Olive' et al, (2010) identified factors associated with self-reported health, disability and quality of life of older people in the rural northeast of South Africa. Using a cross-sectional survey of 6,206 individuals aged 50 and over, they examined relationships between demographic variables and measures of self-reported health (health status), functional ability and quality of life. They found out that older age, lower education, single status and not working at present, were associated with a low health status and lower quality of life. Women were also more likely to report a higher level of disability as were older people, those with no education, with single status and not working at present. The researchers concluded that the health and social services would need to be restructured to provide effective care for older people living in rural South Africa with impaired functionality and other health problems. This study was relevant as it sought to find out the health status of elderly people, which is also a concern of this researcher.

#### **2.4 Health-Seeking Behaviour**

Many researchers have addressed health-seeking behaviour with special emphasis on specific diseases and ages. Malik et al, (2006) have demonstrated that effective management pattern of malaria in children under the age of five requires mothers to seek, obtain, and use medication appropriately. This is linked to timely decision, accessibility, correct use of the drugs and follow-up. Mothers usually

start childcare at home and, within an average of three days, shift to health workers if there was no response. The majority of mothers with feverish children reported giving drugs before visiting a health facility. The choice between the available options was determined by the availability of health facilities, user fees, satisfaction with services, difficulty to reach the facilities and belief in traditional medicine. The main health-seeking behaviour is to consult the nearest health facility or health personnel together as well as using traditional medicine or herbs. This study sought to establish how the elderly people in the study area react to their illness.

A related study done in Vietnam (Johansson et al, (2000) looked at health-seeking behaviour both in the south and north of the country and in urban and rural areas. Qualitative analysis of data was performed following general principles of modified grounded theory technique. Participants in the focus groups described three main factors as contributing to delay in health-seeking. These were fear of social isolation, economic constraints and inadequate staff attitudes and poor quality of health services. The main factor contributing to delay among women was described as fear of social isolation from the family or the community. Stigma was described as closely related to contextual factors such as gender-roles, socio-economic status and level of education and seemed to be mediated through denial and concealment of tuberculosis diagnosis and disease, thus causing delay.

The main factor contributing to delay among men was described as fear of individual costs of diagnosis and treatment. Staff attitudes and quality of health service facilities were described as not always corresponding to people's expectations of appropriate health services. A typical feature of the described health-seeking behaviour of men was that they neglected symptoms until the disease reached a serious stage, by which time they tended to go directly to public health services without first visiting private health practitioners. Women, on the other hand, were described as having a tendency to seek private services and practise self-medication before seeking care at public services. The conclusion was that there is a need for better understanding of behavioural factors and for developing strategies that take these into account. In this study, an attempt was made to explore the health-seeking behaviour in the study area in light of reviewed literature and what determines the behaviour.

Anastasia and Vogt (2007) sought to establish whether perceived age discrimination had any bearing on health. In their survey, they used telephone interviews as well as self-administered mail questionnaires. The study's hypothesis that persons who perceived they had experienced age discrimination have higher levels of psychological stress and lower levels of positive wellbeing compared to persons who reported no discrimination. The study illustrated how perceived age discrimination negatively influences wellbeing. Persons who reported that they had experienced age discrimination have more mental health problems than persons who reported no discrimination. This study consequently

tried to find out the challenges faced by the elderly which had a bearing on their health-seeking behaviour.

Some authors have contended that lack of time is among the variables associated with pattern of seeking care. In a study conducted by Margalith et al, (2004), women with urinary stress incontinence were found to delay seeking for health care for as long as three years. With the help of questionnaires, the researchers found that lack of time contributed significantly to delay seeking care. Shame was also found to be a variable in causing the delay and the results confirmed that consulting with a female health professional could eliminate part of the shame. This resulted in the inclusion of the question in the current study as to whether the elderly people felt more comfortable with a health professional of the same gender.

Taking a contrary view, Kunitz et al. (2004) assert that social support could affect health through physiological and/or behavioural pathways. The structure of a person's social relationships will determine the sources of support – spouse, children, other relative, and so on. The support in question here could range from affective and emotional to tangible aid that could include activities such as providing assistance with household tasks, transportation or financial assistance (Willis, 1985). This led to the question whether the elderly respondents lived alone or with significant others.

A related study was carried out in Dagoretti, Nairobi, Waweru et al. (2003) whose objective was to determine the health status and health-seeking behaviour of people aged 65 years and above. A descriptive cross sectional study of individuals interviewed through questionnaires and focus group discussions was done where four hundred people were interviewed. Economic constraints, negative attitude of health workers, inadequate access to healthcare, and inefficient health facilities were found to be among the factors contributing to delay in seeking healthcare among the elderly people in Dagoretti. The study pointed out the need to formulate policies that will target on the health needs of the elderly. This researcher carried out a similar study but the respondents are elderly men and women in a rural setting with different lifestyles from those in Dagoretti, a peri-urban area.

## **2.5 Factors Determining Health-Seeking Behaviour**

A variety of global factors have been identified as the leading causes of poor utilization of primary healthcare services: including poor socio-economic status, lack of physical accessibility, cultural beliefs and perceptions, low literacy level of the mothers and large family size. These factors can be classified as cultural beliefs, socio-demographic status, women's autonomy, economic conditions, physical and financial accessibility, and disease pattern and health service issues (Babar et al., 2004), as discussed below:

Cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities (Nyamongo, 2002). These factors can result in delay in treatment seeking. Family size, educational status and occupation of the head of the family are also associated with health seeking behaviour besides age, gender and marital status (Nyamongo, 2002). However, cultural practices and beliefs are prevalent regardless of age, socio-economic status of the family and level of education and they can affect awareness and recognition of severity of illness as well as acceptability of service.

Men play a paramount role in determining the health needs of a woman since they are in most cases the decision makers and in control of the resources. They can therefore decide when and where woman should seek health care. In some communities, the low status of women prevents them from recognizing and voicing their concerns about health needs. In such communities, women are usually not allowed to visit a health facility or health care provider alone or to make the decision to spend money on health care. Thus women might generally be unable to access health care in emergency situations (Kroeger, 1983). This certainly has severe repercussions on health in particular and self-respect in general of the women and their children.

Poverty not only excludes people from the benefits of health care system but also restricts them from participating in decisions that affect their health, resulting in

health inequalities. Possession for household items, cattle, agricultural land and type of residence signify not only the socio-economic status but also give a picture of livelihood of a family (Geissler et al., 2000). Economic status determines the ability of a person or a family as a whole to satisfy their need(s) for healthcare. Cost can be a major barrier in seeking appropriate healthcare. Not only the consultation fee or the expenditure incurred on medicines count but also the fare spent to reach the facility and hence the total amount spent for treatment turns out to be cumbersome. Therefore, household economics limit the choice and opportunity of health seeking (World Bank, 2002).

Access to a primary healthcare facility is projected as a basic social right (UN, 2001). In developing countries, the effect of distance on service use becomes stronger when combined with the shortage of transportation and with poor roads, which inevitably contribute towards increased costs of visits. Availability of the transport, physical distance of the facility and time taken to reach the facility can undoubtedly influence the health-seeking behaviour and health service utilization.

Ladha et al, (2009), conducted a cross-sectional study to present socio-demographic characteristics and health seeking behaviour of the elderly in a peri-urban community in Karachi, Pakistan. The study targeted a population aged 65 or above and a total of 438 respondents were interviewed. Frequencies and Chi square values were calculated for different variables using SPSS. The study

found that the major deterring factor which provided hindrance in seeking health care was financial constraint. This made elderly women, the most vulnerable group as they had less financial autonomy as compared to elderly men. Lack of self care was the second most common deterring factor, this might reflect that in face of limited financial resources and expensive health care elderly women give health of younger members of the family priority and do not seek health for themselves. The researchers concluded that elderly women, mostly illiterate and economically deprived, were the most dependent and thus vulnerable population. The elderly population of this peri-urban community had financial constraints in seeking health care. This study investigated the determining factors of health-seeking behavior in Karachi, with emphasis on Diabetes Mellitus and Hypertension. This researcher's study is similarly investigated health-seeking behavior in Githiga Location with the exception of emphasis on any single ailment.

## **2.6 Summary of Literature Review**

From the literature, it was noted that health cannot be dealt with solely by the Ministry of Health. There is need to incorporate other ministries such as agriculture, transport, education among others, if health approach is to be pro-poor. Also to be considered are gender and age in order to make health services consumer-friendly. While the government may be the key health service

provider, there are other stakeholders who substitute government efforts both formally and informally.

The factors affecting health-seeking behaviour are influenced by local environment but there are similarities cutting across the globe such as culture, women's autonomy, economic factors as well as accessibility to health facilities.

The qualitative design is chiefly used to carry out most of the studies in health-seeking behaviour with questionnaires and FGDs as main instruments. The conclusion that there is need for better understanding of behavioural factors and for developing strategies that take these into account is not in contention. What differs is the study group which varies from one study to the other.

Health status is determined by income and social status; social support networks; education; employment and working conditions; physical environments, biology and genetic endowment, personal health practices and coping skills, health services and gender. In addition to traditional health status indicators (death, disease and disability), a population health approach has established other indicators related to mental and social well-being, quality of life, life satisfaction, income, employment and working conditions, education among others.

Health-seeking behaviour of mothers with young children was determined by the availability of health facilities, user fees, satisfaction with services, difficulty to reach the facilities and belief in traditional medicine. The main health-seeking behaviour is to consult the nearest health facility or health personnel together as well as using traditional medicine or herbs.

In Vietnam, the main factor contributing to delay in seeking treatment among women was described as fear of social isolation from the family or the community, while that among men was described as fear of individual costs of diagnosis and treatment

Elderly women were found to be the most vulnerable group as they had less financial autonomy compared to elderly men. This resulted in lack of self care and gave priority to the health of others.

The study conducted on the elderly people in Dagoretti was conducted in an urban setting and there is room for a similar study in a rural area. Social support could affect health through physiological and/or behavioural pathway hence the need to determine the sources of support – spouse, children, other relatives and so on. The support could be emotional or tangible aid such as providing assistance with household tasks, transportation or financial assistance. This study identified

factors which may contribute to health-seeking behaviour by the elderly people in a rural setting.

Among the factors determining health-seeking behaviour was poor socio-economic status, lack of physical accessibility, cultural beliefs and perceptions, low literacy level, health illiteracy and gender.

## **2.7 Theoretical Framework**

This study was guided by the Social Cognitive Theory (SCT) as propounded by Bandura (1986) and which stemmed from the Social Learning Theory. Social cognitive theory provides a framework for understanding, predicting, and changing human behavior. The theory identifies human behaviour as an interaction of personal factors, behaviour, and the environment.

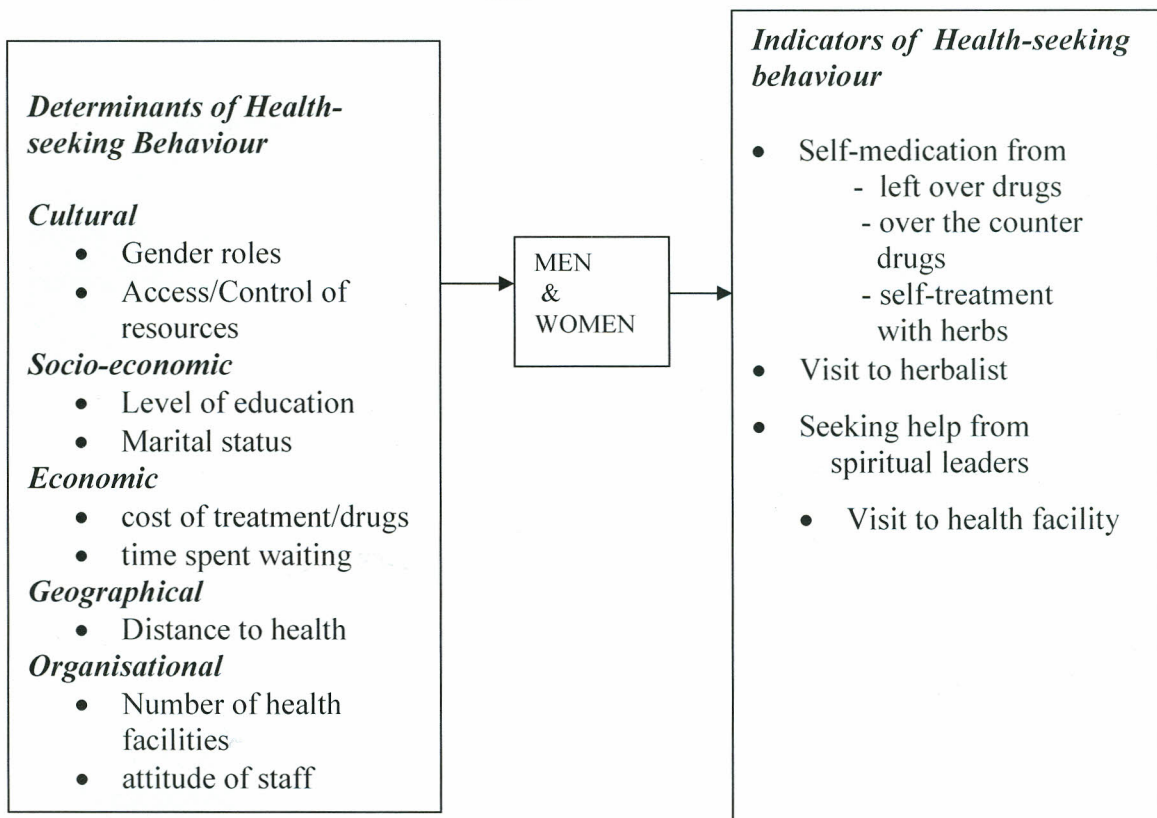
Humans can learn by observing others, in addition to learning by participating in an act personally (called vicarious learning). This tenet explains the human ability to learn not only from direct experience, but also from observation of others. The information obtained is coded into symbols and used as a guide for future action. Vicarious learning is important in that it enables humans to form patterns of behaviour quickly and avoiding mistakes. This theory is important in matters of health as it explains how men and women are socialized to accept the standards and values of their society. It can therefore, be used for intervention

techniques such as modelling, skill training such as reasoning and social skills, as well as contracting with others. However, it has its limitations in that it is too complex which makes it difficult to operationalize. Furthermore, many applications of SCT focus on self-efficacy too much at the expense of other constructs.

Individuals are most likely to model behaviour observed by significant others they identify with. Identification with others is a function of the degree to which a person is perceived to be similar to them. The personal behaviour influences one's thoughts, emotions, and biological properties as well as one's actions (Bandura, 1986). For example, a person's expectations, beliefs, self-perceptions, goals and intentions give shape and direction to behaviour. In the case of health-seeking behaviour, a person who perceives himself as tough will behave in a way to confirm this belief. If succumbing to illness and seeking help is viewed as weakness, chances are that the person will not seek help. SCT, however, has limitations. It views an individual as a rational decision-maker who reviews available information systematically to form behaviour and intentions. This is not the case as some people may have psychological and emotional deficiencies.

An interaction also occurs between the environment and personal characteristics (Bandura, 1986). In this process, human expectations, beliefs and cognitive competencies are developed and modified by social influences and physical

structures within the environment. In addition, humans evoke different reactions from their social environment as a result of their characteristics, such as age, race and sex. This is relevant to this study as it showed that women and men over 60 years of age reacted to factors which impacted on their health-seeking behaviours. It emerged that due to their gender roles, women failed to seek for treatment once a week viewing it as too often. A larger percentage sought treatment monthly. The gender roles are dictated by the society in which people live according to age. The reactions evoked by the elderly in response to the healthcare providers were also expected of their age. According to Bandura (1986), social environment can influence the way people react to situations, according to sex and gender. The dependent variable was health-seeking behaviour while the independent variables included gender roles, access/control of resources, number of health facilities, distance to health facility, level of education of client, attitude of health workers towards the elderly patients, as well as efficiency of facility. Efficiency was measured by availability of staff, drugs and general management of the health centres. Observed behaviour included self-medication, visit to herbalist, or visiting health facility. This is expounded by the following conceptual framework.



**Fig.2.1 Determinants of health-seeking behaviour**

Determinants of health-seeking behaviour comprise the independent variables and influence the way men and women seek help when sick. These include gender roles, access/control of resources, number of health facilities, distance to health facility; level of education of client, attitude of health workers towards the elderly patients as well as efficiency of facility. The arrow from the independent variables and pointing to the men and women indicate they are the health seekers. The behaviour they display is shown by the arrow pointing to health-seeking behavior

and is the dependent variable. Expected behaviour can be self-medication, visit to herbalist, seeking help from spiritual leaders, visit to health facility or just doing nothing.

## CHAPTER THREE

### METHODOLOGY

#### 3.0 Introduction

This chapter describes the methodology that was adopted in this study. It comprises the research design, target population, sample and sampling procedures that were used, data collection instruments and their administration on the respondents as well as the data analysis procedure.

#### 3.1 Study Design

This was a descriptive cross-sectional study whose purpose was to provide information on the health-seeking behaviour of elderly people in Githiga Location.

#### 3.2 Study Variables

Table 3.1: Variables of the Study

DEPENDENT VARIABLE	INDEPENDENT VARIABLES
Health-seeking Indicators: -Visit to health centres -Visiting traditional healers -Self medication with herbs -Visiting fortune tellers -Consulting spiritual healers -Buying drugs from shops/chemists	<ul style="list-style-type: none"><li>• Gender Roles</li><li>• Income</li><li>• Number of health facilities</li><li>• Distance to health facility</li><li>• Level of education</li><li>• Attitude of health workers</li><li>• Efficiency of facility</li><li>- Availability of staff and drugs</li></ul>

### **3.3 Study Area**

The study was carried out in Githiga Location of Githunguri District in Central Province (Appendix IV). The location is situated 36 km to the East of Nairobi City and is an agricultural area with tea as cash crop. Most of the tea is grown in large -estates which formerly belonged to European settlers. Some tea estates have since been acquired by African landlords who hire the people from the location as tea pickers. Majority of the people however, are peasant farmers with small pieces of land on which they grow some tea, keep cows and grow subsistence crops for own consumption. Some also grow vegetables for the local market. Githiga is densely populated and the land has been extensively subdivided rendering large-scale agricultural activities impossible.

The location has three sub-locations with a population of about 23,000 distributed as follows: Matuguta (4,000), Githiga (6,000), Gathangari (6,500 and Gitiha (6,500). This area was selected because of the diversity of the population. There are about 12,000 women and 11,000 men with the general level of education being Kenya African Primary Education. There are two government health centres which are about 15 kilometres apart. There are also several private clinics and chemists located at the shopping centres as well as traditional herbalists.

### **3.4 Study Population**

The study population comprised elderly women and men in the location. Also, targeted were health officers in the two centres together with private practitioners operating in the selected sub-locations.

### **3.5 Sample Size and Sampling Technique**

The process involved simple random sampling in determining the location in which to carry out the study. Githiga Location was sampled out of three locations in Ikinu Division. Purposive sampling was employed in determining the population to be interviewed whereby 26 women and 27 men aged 60 years and above were included in the study. Further, eight healthcare givers were purposively selected to take part in the study. In addition, there were three private institutions and two chemists. The researcher decided to include all of them since there were too few to take some and leave others.

### **3.6 Research Instruments**

The research was conducted using semi-structured guided questionnaires for the elderly respondents. These facilitated probing to elicit detailed information. Health officials in the centres, private practitioners and pharmacists were issued with interview guides. Observation checklists were used in homes and health facilities, to confirm the information given in the questionnaires and structured interview schedule. This is in conformity with what Saunders et al, (2003) who argue that using multi-instruments in data collection enhances data collection and credibility of the results.

### **3.7 Pre-testing of Instruments**

The instruments were pilot-tested on six respondents from the sub-locations outside the study area. These included three women and three men who had similar characteristics as the study population. The purpose of pre-testing the instruments was to ensure that items in the questionnaires were stated clearly and gave the same meaning to all respondents. This provided a trial run for the data collection and ensured reliability and validity and consequently led to the translation of the questionnaire into Gikuyu, the local language.

### **3.8 Data Collection**

Respondents from the selected women and men were interviewed in a face-to-face setting. The researcher sought their consent before the interviews were done and assured respondents of the confidentiality of their responses. They were also assured that their names will not appear on the questionnaires where their answers were recorded. The questionnaire was translated into Gikuyu for the convenience of the illiterate ones. Results were obtained using both primary and secondary data. The primary data was obtained using a structured questionnaire with women and men aged 60 years and above. Health officials, private practitioners and chemists were issued with key informant interview guides which were collected later. Observance of the attendance of both men and women as well as the health services also formed primary data. Secondary data were obtained from

examination of attendance register, reference books and magazines from the library as well as journals from the internet.

### **3.9 Data Analysis**

Quantitative data collected were analyzed using the Statistical Package for Social Sciences (SPSS). It was used to establish the presence or absence of relationships between variables. Descriptive statistics was used to describe and organize data. Means were used to summarize data. Data was presented in the form of frequency distribution, distribution tables and graphs.

### **3.10 Ethical Considerations**

Clearance for the research was sought from Kenyatta University and from Provincial Administration. The purpose of the study was explained to all potential participants so as to get an informed verbal consent. When interviewee gave verbal consent, interview proceeded. They were assured of confidentiality of their responses through interviewing them in confidence and also asking them not to include their names on the questionnaires. That way, nobody would identify the respondent.

## CHAPTER FOUR

### DISCUSSION OF FINDINGS

#### 4.0 Introduction

This chapter presents the findings of the study which are discussed under the following categories mainly on the basis of study objectives:

- Socio-economic characteristics of the respondents
- Characteristics of the study population.
- Health status of the study population.
- Health-seeking behaviour displayed by the respondents.
- Challenges faced in the process of seeking treatment.

#### 4.1 Socio-economic Characteristic of the Respondents

In order to determine the socio-economic characteristics of the respondents, interviews were conducted using an interview schedule shown in appendix 1. The researcher's aim was to find out the socio-economic characteristics of the respondents and how these influence health-seeking behavior. This study involved elderly people both male and female and their health-seeking behaviour from a rural setup. The total number of respondents were 53, 26 of whom were female and 27 were male. Other characteristics are as presented in Table 4.1.

Out of the 53 interviewed, there were 14 females and 17 males within the 60-69 age group. Those in the 70-79 age group were 10 females and 8 males whereas 1

female and 3 males were above 80 years. Table 4.1 summarises the socio-economic characteristics of the respondents.

**Table 4.1: Socio-economic Characteristics of the Study Population**

Characteristic		Female		Male		Total	
		<i>Number</i>	%	<i>Number</i>	%	<i>Number</i>	%
Gender		26	40.9	27	50.1	53	100
Age	60-69	14	26.6	17	32.3	31	58.9
	70-79	10	19.0	8	13.6	18	32.6
	Above 80	1	1.9	3	5.7	4	7.5
Marital Status	Single	1	1.9	-	0	1	1.9
	Married	14	26.6	25	47.2	39	73.8
	Separated	1	1.9	-	0	1	1.9
	Widow	9	17.0	-	0	9	17.0
	Widower	-	0	2	3.8	2	3.8
Education Level	None	5	9.8	3	5.1	8	14.9
	Primary	13	24.7	13	24.7	26	59.4
	Secondary	6	11.8	10	19.0	16	30.8
	Post-Sec	1	1.9	2	3.8	3	5.7
Source of Income	Farming	17	32.3	16	30.4	31	62.7
	Business	3	5.9	3	5.9	6	11.8
	Relative	-	0	5	9.8	5	9.8
	Others	4	7.6	7	13.3	11	20.9

#### **4.1.1 Distribution of respondents by Gender, Age and Marital Status**

The study involved elderly people both male and female. Table 4.1 indicates that of the 53 elderly people were interviewed, 26 (40.9%) were female and 27 (50.1%) were male. They were categorized into three age groups: there were 14 females and 17 males within the 60-69 age group, 10 females and 8 males in the 70-79 age group and 1 female and 3 males above 80 years. As indicted above, 73.8% of the correspondents were married, 14 (26/6%) of them females and 25 (47.2%) male. There were 11 20.8%) who were widowed, 9 (17.0%) of whom were female while 2 (2%) were male.

Marital status was observed to influence variables related to health-seeking behavior. These variables included sources of income and time. As household heads, males determined how much money was allocated to family needs, including health. They also controlled time in regard to the household duties allocation. Those duties traditionally allocated to females were many and repetition thus taking up a lot of time sidelining health matters.

#### **4.1.2 Education Levels**

The majority of respondents (59%) had attained eight years (primary level) of education. Those with primary education comprised equal numbers (13) of females and males. However, there were more men (19%) with secondary education than women (11.8%). Similarly, of those with post-secondary education, 3.8% were men as opposed to 1.9% women. The level of respondents,

education tended to influence and determine the health-seeking behavior, especially the frequency of visits to health centres. This is in agreement with a document to review progress made on implementation of Beijing Platform for Action, (Arifin, 2009) which asserts that older women are more disadvantaged than men. Their disadvantages occur throughout life, whether in the family, health, education and labour market.

#### **4.1.3 Occupation of Respondents**

The respondents' occupation is an important variable as it tends to influence the nature and amount of income and subsequently the ability to adequately cater for needs, in this case, health. Most of the respondents were involved in both farming and businesses their source of income. Of those relying on farming (62.7%), the percentage of females was 32.3% while that of the males 30.4%. Similarly, the number of males engaged in business was equivalent to that of females (5.9%) in the same occupation. However, it should be observed that majority (14) of the females out of those interviewed (26) were married and therefore under the headship of their husbands. Consequently, their income was not under their control but that of their husbands. This had implication on health-seeking behavior as the females needed to ask for money for their own use including visiting health centres.

Most (87.4%) of the respondents stayed with other relatives especially their sons, as shown in Table 4.1. It is customary for sons in most African customs to build

homes and live at their parents' home as opposed to daughters who are expected to marry and move away to their matrimonial home. These relatives influenced health-seeking behaviour as they contributed both time and money towards this.

#### 4.2 Health Status and Ailments of the Study Population

This section describes the self-reported health status of the respondents which was indicated by the values of good, fair and poor. The percentage of elderly reporting poor health was higher for females than males. This notwithstanding, the females continued with their chores despite their health status arguing that as long as one is able to perform their activities, there was no cause for alarm. According to WHO (2002), being able to perform daily chores without help in old age is an indicator of 'good' health. Table 4.2 shows the status of the respondents as per their own admission.

**Table 4.2: Self-rated Status of Elderly Women and Men in Githiga**

<b>Self-rated Status</b>	Good	Fair	Poor	Total
<b>Men</b>	7	13	7	27
<b>Women</b>	4	10	2	26

Of the 27 males interviewed, almost half (13) reported being in fair health. By fair, they meant that they were neither incapacitated nor were they in perfect health. They reported occasional aches and pains which, they felt, did not need

treatment. Equal numbers of males (7) were in good and poor health respectively. Of the 7 in poor health, 3 had diabetes while 4 had ulcers and needed regular visits to health facilities.

Out of the 26 females interviewed, the majority (10) were in fair health while 4 claimed to be in good health. These two groups went about doing their daily activities with occasional visits to health facilities as need arises. The 2 who were in poor health had heart conditions and therefore incapacitated.

About 43.7% of the respondents did not report any chronic disease. Of these, 26.6% were female with 17.1% being male. This is in agreement with Arifin (2009), who found that due to division of labour by gender, women are more likely than men to have health, economic or security problems.

The high percentage of respondents not reporting chronic diseases could be because of the respondents living in a rural area where they have access to fresh foods from the farms. These foods included home-grown fruits, vegetables and legumes which could be found in almost all homesteads. They were therefore cheaply available in the local market place. A study by Baghurst et al (1999) indicated the protective effects of fruits and vegetables against a number of diseases including cancer, diabetes and hypertension. Similarly, a joint FAO/WHO Expert Consultation on diet, nutrition and the prevention of chronic

diseases, recommended the intake of fruit and vegetables for the prevention of chronic diseases such as heart disease, cancer, diabetes and obesity, as well as for the prevention and alleviation of several micronutrient deficiencies (WHO, 2003). Other ailments reported by the respondents are summarized in Table 4.3 by gender, numbers and percentages.

**Table 4.3: Ailments reported by the respondents**

Disease	Females		Males		Total	
	Number	(%)	Number	(%)	Number	(%)
None	14	26.6	9	17.1	23	43.7
Diabetes	3	5.7	3	5.7	6	11.4
Ulcers	1	1.9	4	7.6	5	9.5
Blood pressure	2	3.8	2	3.8	4	7.4
Joint pains	2	3.8	2	3.8	4	7.4
Asthma	0	0	2	3.8	2	3.8
Heart condition	2	3.8	0	0	2	3.8
Arthritis	0	0	1	1.9	1	1.9
Chest problem	0	0	1	1.9	1	1.9
Stroke	0	0	1	1.9	1	1.9
Cough	1	1.9	0	0	1	1.9
Hearing	1	1.9	0	0	1	1.9

Diabetes seemed to affect both males and females equally (5.7% for both males and female) while more males (7.6%) than females (1.9) reported stomach ulcers. This is supported by Cohen (2006, Diabetes, 2002), who found that there are high incidents of diabetes and stomach ulcers among the elderly. Less number of people knew they were diabetics; maybe due to ignorance and non-availability of investigations and screening (Ladha et al (2009).

Blood pressure and joint pains affected both women and men equally with each condition affecting 3.8% of the respondents. This is contrary to Sook (2006) who observed that elderly women complained of types of pain (leg pain, arthritis, lumbago, headache) more than elderly men. Ladha et al (2009) found hypertension to be more prevalent among women as compared to men, the ratio being 1:2.

Other ailments that the elderly complained about were asthma, affecting 3.8% of the males with no females reporting the condition. Arthritis was reported by 3.9% of the males with no female cases. There were 1.9% of males complaining of chest pains, with no female complainants. Similarly, 1.9% of the males reported to have suffered a stroke with no females suffering from the same condition. The fact that there were no females with chest pains or stroke could either they were reluctant to disclose these conditions or that the females were more physically active than males due to their many gender roles. This assertion is supported by an article on 10 reasons why men die younger than women, aquatic biologist Anjili (2009) gave limited household responsibilities one reason. He explained that in their quest to carry out household chores, women sharpen their skills and are more physically alert and apt in responding to family needs, making them fit.

The reverse, however was the case with heart conditions which seemed to affect more women (3.8%) than men who did not report any heart problem. According to Murray and Lopez (1996), cardiovascular disease is by far the leading cause of death at older ages in developing countries. Their study attributed nearly 46 percent of all deaths among females aged 60 and over in developing countries in the early 1990s to cardiovascular disease, while the corresponding figure for older males was 42 percent.

#### **4.3 Health Seeking-behaviour of the respondents**

The study area had various facilities available for seeking treatment. These included two government health centres, private clinics and pharmacies as well as traditional herbalists. However, majority of the respondents (78.4%) sought treatment from the health centre. Out of these, 35.3% were women and 43.1% were men. This can be attributed to the health centres' proximity to the study area. Table 4.4 shows the percentage of the respondents who sought for health upkeep in these facilities as well as the frequency of the visits.

**Table 4.4: Health-seeking Behaviour**

<b>Health Facilities</b>	<b>Female</b>	<b>Percentage %</b>	<b>Male</b>	<b>Percentage %</b>	<b>Total</b>	<b>Percentage %</b>
Health centers	18	35.3	22	43.1	40	78.4
District hospital	6	11.8	4	7.8	10	19.6
Herbs	1	1.9	-	0	1	1.9
Private hospital	-	0	1	1.9	1	1.9
<b>Frequency</b>	<b>Female</b>	<b>Percentage %</b>	<b>Male</b>	<b>Percentage %</b>	<b>Total</b>	<b>Percentage %</b>
Monthly	9	30.0	8	26.7	17	56.7
Rarely	6	20.0	6	20.0	12	40.0
Weekly	-	0	1	1.9	1	1.9

More than half of the study population sought treatment monthly and apart from seeking treatment of chronic diseases with more women (30%) than men (26.7) falling under this category. More women tended to delay seeking treatment to once a month citing their multiple gender roles. These roles included tending the garden, feeding and milking animals, fetching water, cooking, cleaning and looking after sick relatives.

More men (17%) than women (12.8%) sought treatment for ailments like coughs and flu. It was observed that women tended to ignore ailments they considered

'minor' resulting in more men seeking treatment for the same as opposed to the women.

Of the 69.2% who catered for their own health expense, 44.2% were men and 25% were women while 13.5% women relied on their relatives as compared to 7.7% men. More women (7.7%) also depended on their spouses for support to get treatment as opposed to only 1.9% men. More men were able to cater for their own health expenses, and therefore were able to get treatment more frequently. With more women depending on either their spouses or relatives for support to get treatment, their behavior necessarily depended on other people's generosity or willingness to give them money for treatment.

Family members in this study are reported to play an important role in the dynamics of seeking health care by the elderly individuals. Elderly women in particular are reported to be in a vulnerable situation due to their dependence on the male family members (Rahman 2000). In the present study, in some cases, family members and even friends played an additional role in facilitating the treatment process of the older persons by accompanying them to health facilities.

#### **4.4 Factors Influencing Health-seeking Behaviour**

Multiple factors influence elderly people's choice and use of health care services in the study area. These included gender, age, level of income, level of education,

facilities and lack of company while on visit to health facilities especially those living alone as discussed below Table 4.5 summarises these factors.

**Table 4.5. Factors influencing health-seeking behavior**

		Female	%	Male	%	Total	%
Source of Income	Farming	17	32.3	16	30.4	31	62.7
	Business	3	5.9	3	5.9	6	11.8
	Relative	-	0	5	9.8	5	9.8
	Others	4	7.6	7	13.3	11	20.9
Living with	Relative	22	41.8	24	45.6	46	87.4
	Alone	1	1.9	2	3.8	3	5.1
Catering for health expenses	Self	13	25.0	23	44.2	36	69.2
	Relatives	7	13.5	4	7.7	11	21.2
	Spouse	4	7.7	1	1.9	5	9.6

**Age:**

The study further established that increase with age led to decrease in seeking treatment. This can be attributed to low levels of income and mobility as one grows old. This finding is in agreement with work reported earlier by Waweru et al. (2003). Table 4.6 shows the relationship between age of the respondents and frequency in seeking treatment.

**Table 4.6: Relationship between age and frequency of health-seeking treatment**

Frequency		Seeking Treatment			Total
		weekly	monthly	rarely	
Age	60 - 69	2	10	7	19
	70 - 79	1	5	3	9
	above 80	1	1	2	3
<b>Total</b>		4	16	12	32

More women 43.1% than men 35.3% thought “old age” is an explanation of “ill-health”. A study from the United States has also shown that older people equated lower physical health with ageing, as a result placing less importance on seeking health care (Sarkisian et al. 2002). Respondents in the current study were resigned to the belief that illness in old age was a normal state of affairs which needed no treatment.

**Time:**

Some respondents walked long distances to reach the health facilities and they gave this as a reason for not seeking treatment regularly as it consumed a lot of their time. This is collaborated by a similar finding which showed that access to health facilities, (including distance and terrain) and financial barriers hamper seeking help for health problems (Warren, 2010). As most of the elderly engage

in farming, waiting for long hours at the health centres also discouraged some from seeking treatment regularly for fear of wasting time.

**Income:**

Lack of financial independence was another factor given that most of the elderly persons relied on themselves to cater for health expenses. A large percentage (21.1%) are not self-reliant as they depend on their sons, meaning the decision to seek treatment was being made for them.

**Gender:**

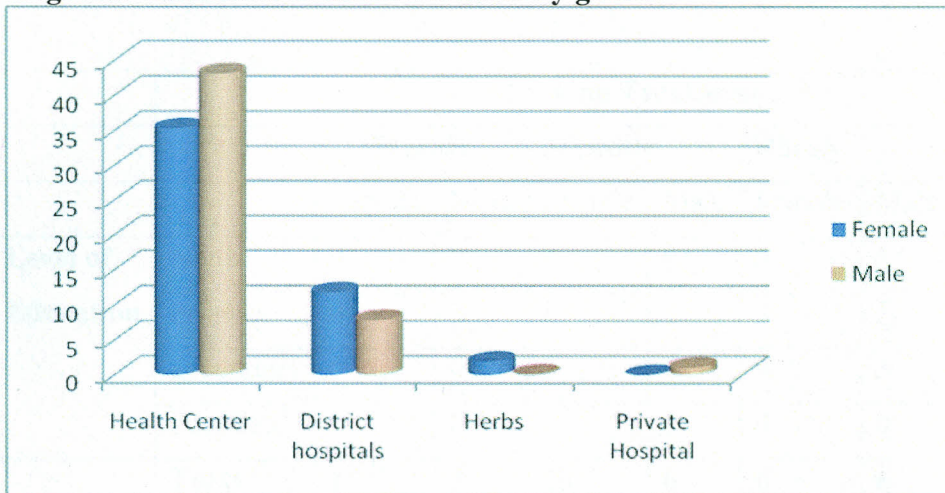
A greater percentage of men (42%) were capable of taking care of their health expenses whereas only 26% of women were self-reliant. The figure also shows that more women were dependent on either relatives (16%) or spouses (5%) compared to men at 5% and 1% respectively. These findings are similar to a study that found that the major deterring factor which provided hindrance in seeking health care was financial constraint. This made elderly women, the most vulnerable group as they had less financial autonomy as compared to elderly men (Ladha et al., 2009). Empirical evidence from Bangladesh and elsewhere indicates that socio-economic status is a strong determinant of health-seeking behaviour (Ahmed et al., 2003), even among the elderly (Ahmed et al. 2005). Similarly in this study, financing health care for an elderly individual is found to be one of the crucial deciding factors of whether or not to seek treatment, and what type of treatment to seek.

**Preference of Facilities:**

Another factor influencing health-seeking behavior was preference for government-sponsored facilities. Figure 4.1 gives a summary of health facilities and the preference respondents show for each of them. Most of the respondents (75.0%) visited health centres as compared to other facilities due to the proximity of the health centres to the study area. Of these, 35% were women with 40% being men.

The District hospital is in Kiambu town a distance of fifteen kilometres away. It appears that those who prefer government facilities would opt for the health centres which are nearer.

**Fig. 4.1: Utilization of health facilities by gender**



Less than 5% of the females used herbs and an equally small percentage of the males sought help from private hospitals.

### Level of Education:

Of the 32 respondents who responded to the question on level of education, 6 did not have any education. Of these, 5 were female with only 1 male. This is in agreement with Arifin (2009) who asserts that older women are more disadvantaged than men whether in the family, health, education and labour market. The highest level of education of majority of women was primary education. Majority of those women seeking treatment (6) had primary level of education with only one male at this level. Table 4.7 illustrates the relationship between education and seeking treatment.

**Table 4.7 Level of education and seeking treatment by gender**

		Seeking Treatment						Total
		Weekly		Monthly		Rarely		
		Female	Male	Female	Male	Female	Male	
Level of Education	None	0	0	2	0	3	1	6
	Primary	0	3	6	1	3	2	15
	Secondary	0	0	2	4	0	3	9
	Post Sec.	1	0	0	1	0	0	2
Total		1	3	10	6	6	6	32

The men on the other hand had secondary level of education and 4 of them sought treatment monthly. Monthly treatment seemed to strike a balance between weekly treatment and rarely and hence acceptably frequent. None of the respondents who did not have basic (primary) education sought treatment weekly.

It can be concluded that the level of education affected one's health-seeking behaviour with the more learned a respondent, the more he/she sought treatment. This concurs with the findings that people who cannot read or understand the words used to describe health problems, diagnostic tests, medications and directions for care may experience confusion in negotiating the health care system, and are significantly handicapped in the tasks of self-care or caring for family members (Levin-Zamir & Peterburg, 2001)

#### 4.5 Challenges

Table 4.8 shows some of the challenges faced at the health centres.

**Table 4.8: Challenges of health-seeking behavior**

Factor	Female	Male	Total
Waiting too long	13 (28.2%)	13 (28.2%)	26 (56.5%)
Uncomfortable with younger staff	4 (8.7%)	6 (13.0%)	10 (21.7%)
Comfortable with both gender	19 (37.2%)	16 (31.4%)	35 (68.6%)
Lack of drugs	3 (6.6%)	6 (13.0%)	9 (19.6%)
Lack of company	- (0%)	1 (2.2%)	1 (2.2%)

#### Waiting for long:

It is evident that waiting for too long was especially a major challenge to a big percentage (56.5%). Equal percentages of women (28.2% ) and men (28.2% )

were in agreement on this issue. It came out from the discussions that waiting on queues for long prevented the elderly, especially women, from seeking treatment as often as they should since they do not want to waste time.

### **Service by Care givers:**

A larger percentage of men (13%) than women (8.7%) reported feeling uncomfortable dealing with the younger staff and expressed preference for mature medical personnel.

About 37% of the women were comfortable with both male and female service providers while 31% of the men felt the same way. These percentages show that the gender of service- providers did not matter to the elderly as long as they received proper care as shown in Table 4.9.

The attitude of staff at the health facilities seemed to disturb the elderly with more men than women wanting to be attended by the more mature staff. Both men and women lamented that the younger staff were indifferent and less attentive to their needs and tended to waste time talking as patients queued outside.

### **Lack of Drugs:**

More males (6) than female (3) cited lack of drugs and the health centres as a challenge. This is expected considering that more males than females had greater access and control over the household resources.

## CHAPTER FIVE

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 5.0 Introduction

This chapter presents summary of the findings, the conclusions arrived at as well as the recommendations.

#### 5.1 Summary of the Findings

The 53 respondents were aged between 60 and 80, the highest number (19) being in the 60-69 age group. Of these, the majority (39) were married. Education levels were low because 34 of the 53 respondents had 8 years of education or less. More than half of these (18) were female. The main occupation was farming and business.

The elderly females were in poorer health compared to the males. Despite this, they were struggling to perform their day to day activities. The males, though in better health compared to the females, performed fewer activities.

Among the health facilities used were government health centres and private clinics. Government health centres were the most frequently used with a higher percentage of men (43.1%) making use of the facility than women (35.3%). The

reason given for this behavior was that the health centres were accessible as they could be reached by public transport or on foot.

A higher percentage of women delayed their visits to health facility to once a month, citing the many gender roles that required their attention. On the other hand, more men sought treatment than women weekly as their gender roles were less demanding and more flexible.

The factors that influenced the health seeking behavior of the men and women included income, gender, distance to available health facilities and level of education. Low economic status among the respondents had a negative impact on their health status as well as health-seeking characteristics. More women relied on their relatives more than the men and sought treatment less than men who were more self-reliant.

It was observed that the men had both access and control of the available resources which were land, animals, and cash crops. Having control over the land meant it was managed the way they wanted and the animals kept and crops planted were of their choice. Money obtained from these was controlled by men as head of the households. The women picked tea and fed the animals and also tended land where they planted vegetables for sale and cultivated subsistence crops for consumption. They were not paid for their labour but relied on what

their spouses or relatives gave the, as well as on cash obtained from sale of subsistence crops.

Gender disparities were observed with elderly women being the most disadvantaged. Elderly women were observed to have more roles than their male counterparts which disallowed them to visit health centres as frequently as their male counterparts.

Challenges faced in the process served as disincentives to health-seeking behavior. Time wasted waiting on queues at government health centres was foremost on the list of the challenges cited as preventing the elderly people from seeking treatment.

## **5.2 Conclusion**

Based on the data collected and analysed in this study, the researcher arrived at several conclusions:

The elderly were very sensitive and required special handling. However so long as they were treated with respect, gender of health-care givers did not seem to matter.elderly.

Most elderly people preferred government-sponsored facilities and would not go elsewhere if assured of getting drugs there.

While health seeking behavior was dependent on several factors, the most prominent were gender and income. Gender dictated the roles and responsibilities for both males and females and consequent time that the roles consume at the expense of other needs like visiting health facilities. Gender also dictated how the household income was to be allocated to various need, including health. The females were the losers in either case as they had more roles and were more dependent on other people for time off and income.

The challenges were more personal than communal. While walking to health centres was a hindrance to some due to poor health, to others it was the time it took to walk which they required to perform other duties.

The attitude of most elderly towards recreation is that it was expensive and a waste of time. This seemed to change when they understood that taking a regular walk was simple and refreshing.

### 5.3. RECOMMENDATIONS

- The service providers should ensure that the elderly are given priority to avoid waiting in long queues. This will not only save time but also encourage them to visit health facilities as need arises. While it may not be possible to have elderly people treated by mature health workers all the time, this could be considered.
- The government and other stakeholders should organize free medical camps which will not only bring the services nearer to the elderly but also sensitize them on the need to seek regular treatment.
- The health workers in the health facilities should ensure that there is adequate drugs in stock so that the elderly can access them easily without having to resort to non-prescription drugs at the pharmacies.
- The health providers can use fora such as chief's 'barazas', women groups or and religious meetings to sensitize the elderly on the need for recreation as most seemed to see it as expensive or a waste of time. This need not be the case as recreation can be as cheap as taking a walk. However, recreational facilities like social clubs could be set up by the community, probably using CDF kitty.

#### 5.4 Further Studies:

Based on the results of the study, the following recommendations have been made for further research:

- i) Similar studies could be replicated using larger samples and different localities.
- ii) A study could be done targeting a different group in society, for example the youth.
- iii) A comparative study could be done, involving elderly people in urban and in rural areas.

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**APPENDICES**

**Appendix 1A**

**QUESTIONNAIRE FOR WOMEN AND MEN 60 YEARS AND ABOVE**

The questions will be read to the respondent (where necessary) and the responses recorded.

Questionnaire No.....Location.....

Sub-location.....Gender F  M

1. Age ( )
  
2. Marital status?
  - a) Single ( )
  - b) Married ( )
  - c) Divorced ( )
  - d) Separated ( )
  - e) Widow ( )
  - f) Widower ( )
  
3. Level of education?
  - a) none ( )
  - a) primary ( )
  - b) secondary ( )
  - c) post-secondary ( )
  - d) other .....
  
4. Source of income? .....
  
5. Occupation of your spouse?.....
  
6. Who is responsible for the household income?
  - a) Self ( )
  - b) Spouse ( )
  - c) Other ( )
  
7. Do you have any other people living with you?  
.....

8. How can you describe your health?
- a) Good
  - b) Fair
  - c) Poor
9. What do you do when you fell unwell?
- a) Lie down
  - b) Take painkillers available in the house
  - c) Boil some herbs
  - d) Seek treatment
10. If you take the first three options above and they do not work, what further action do you (if any).
9. Do you have a chronic illness?
- a) Asthma ( )
  - b) Heart condition ( )
  - c) Diabetes ( )
  - d) Arthritis ( )
  - e) Other .....
10. How often do you seek treatment for the chronic condition? (specify as in 10 above).
- a) Weekly ( )
  - b) Monthly ( )
  - c) Rarely ( )
  - d) Never ( )
11. Other than the chronic ailments what other ailments do you suffer from?  
.....
12. Where do you go to seek treatment? (specify for which ailment)  
.....
13. Who supports you in health-seeking?

- a) Self ( )
- b) Spouse ( )
- c) Other (specify).....

14. Do you take the drugs as prescribed?

- a) Yes ( )
- b) No ( )

15. Do you take alcohol/smoke cigarettes?

- a) Alcohol Yes ( ) No ( )
- b) Cigarettes Yes ( ) No ( )
- c) Both ( ) tick if yes

16. What is your form of recreation? (please explain)

-----

17. Do you punctually keep doctors appointments?

- a) yes ( ) (b) no ( )

18. If No, why not

- a) Distance ( )
- b) Not Happy With The Service ( )
- c) Busy At Home ( )
- d) No Money ( )
- e) Other ( )

19. Are you happy with the staff at the health centre/private clinic?

- (a) Yes ( ) (b) No ( )

20. If no, what problems do you have with them?

.....  
 .....

21. Are you more comfortable with healthcare providers who are your gender? (a) Yes ( ) (b) No ( )

22. If yes, why and if no, why not?

23. What challenges do elderly people in health facilities face? (probe for gender specific challenges)

.....  
.....

24. What change would you like to see in health services in regard to care giving to the elderly? Explain. (probe for gender specific recommendations)

**Appendix 1B**

**HOUSEHOLD INTERVIEW SCHEDULE FOR WOMEN AND MEN  
AGED 60 YEARS AND ABOVE (Translated into Gikuyu)**

The questions will be read to the respondent (where necessary) and the responses recorded.

Questionnaire No.....Location.....Sub-location.....

Ituura..... Mundurume (M)  Mutumia (F)

1. Wina Miaka iigana ( )
2. Niuhikite/niuhanitie
  - a) Ndihikite/ndihikanitie
  - b) Wi muthuri/mutumia
  - c) Ni mutiganite kahinda kanini
  - d) Ni mutiganite biu
  - e) Wi wa ndigwa
3. Uthomete miaka iigana cukuru
  - a) Ndiri na githomo kia marua
  - b) Githomo kia muthingi
  - c) Cekondari
  - d) Iguru wa cekondari
  - e) Kingi .....
4. Urutaga uteithio wa mbeca ku  
.....
5. Muthuri/mutumia waku arutaga wira uriku?  
.....
6. Nu urugamagirira mbeca cia mucii wanyu?  
(a) we mwene (b) muthuri/mutumia waku (c) andu angi
7. Kuri andu angi muikaraga nao gwaku?  
.....
8. Ugima waku wa mwiri ungiuga uhana atia
  - d) Ni mwega
  - e) Ni uigananiirie
  - f) Ti mwega

9. Ni ikinya ririku woyawa rira utekuigua mwiri wega?
- Gukoma hanini
  - Kumeria ndawa cia ruo iria
  - Gutherukia ndawa cia miti
  - Gucaria uteithio wa rigitarai
10. Ungioya makinya mambere matatu monanithio hau iguru na wage kuigua wega-ri, wi ikinyi ringi woyaga?
9. Wina murimu uguthinagia wa kahinda karaya?
- Athima
  - Murimu wa ngoro
  - Murimu wa cukari
  - Murimu wa marungo
  - Mirimu ingi .....
10. Murimu wa ihinda iraya-ri, wethaga uteiithio wa rigitari maita maigana?
- O kiumia
  - O mweri
  - Ti kaingi
  - ndithiaga
11. Tiga murimu wa ihinda iraya-ri, niuruaraga tumirimu tungi?  
.....
12. Uthondekagirio ku? (tariria kuria uthondekagiruo mirimu ngurani, kwa muhiano, 'homa, nganyua miti, matihia, ngathii kwa ndagitari')  
.....  
.....
13. Nuu urugamagirira mibango igii gwetha urigitani?
- We Mwene
  - Muthuri/mutumia waku

- c) Andu angi (magwete).....
14. Ni unyuaga ndawa kuringana na uria wathituo ni murigitani?  
 (a) Ii (b) Aca
15. Ni unyuaga njohi/kugucia thigara?  
 a) Njohi Ii ( ) Aca ( )  
 b) Thigara Ii ( ) Aca ( )  
 c) Cieri ( ) ikira tiki akori ni cieri
16. Ni maundu mariku wikaga ma gwikenia? (Tariria)  
 -----
16. Ni uhingagia giathi gia gucoka kwi murigitani kurorwo?  
 a) Ii (b) Aca
17. Akoruo nduigaga kiriko-ri, itumi ni iriku?  
 a) Ni kuraihu  
 b) Ndukenagio ni urigitani wao  
 c) Wira muindi mucii  
 d) Kuaga mbia
18. Ni uiganagira na aruti a wira a thibitari iria uthiaga?  
 a) Ii (b) Aca
19. Angikoruo nduiganagira, ni ihingica iriku wonaga kuma kuri-o?  
 .....
20. Ungikenio ni kurigituo ni murigitani wa muthemba waku –( mutumia kana mundurume)  
 (a) Ii ( ) (b) Aca ( )
21. Heana itumi ciakurega

.....  
.....  
22. Ni moritu mariku ucemanagia namo ta mundu mukuri megii urigitani?  
(geria gutigithura moritu ma arume kuma kuri ma atumia)

.....  
.....  
23. Ni kii ungienda gicenjio kuringana na uria andu akuru marigitagu?  
(thuthuria maundu ma arume ngurani na ma atumia)

## Appendix 2

### INTERVIEW GUIDE FOR SERVICE PROVIDERS

My name is Janet. I am a student at Kenyatta University undertaking Masters degree in Gender and Development Studies. I am carrying out this research as partial fulfilment for the award of the degree. Thank you for taking time to go through this interview guide and provide me with information. Please do not include your name. Information gathered herein is for academic purposes only and will be treated with utmost confidentiality.

1. What is your age? Under 20
- 20-30
- 30-40
- 50 and above

1. What is your gender

- 1 Female
- 2 Male

3. What is your profession? (choose all that apply)

- 1 Doctor
- 2 Nurse
- 3 Social worker
- 4 Volunteer
- 5 Other (specify)
- 6 .....

4. For how long have you worked in this health centre? (specify)

Years/months

5. How many elderly patients does your centre attend to daily on average?

women

men

6. What are the frequent ailments by gender?

Female	Male

7. What challenges do you encounter at the centre/private clinic serving the elderly?

Female	Male

8. Do you think elderly patients make adequate use of this facility?

Yes  No

9. If No, what in your opinion, are the reasons.

.....  
 .....

10. Are the elderly patients who come here accompanied?

Women	Men
Most	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Few	
All	

11. Among the elderly men and women, who mostly turn up for appointments as requested by health officer?

Women  Men

12. Who are likely to default more?

Females  Males

13. What reasons do they give for defaulting on the appointments?

Women	Men

14. What do you think needs to be done to make the services more attractive and effective to the elderly patients? Please use back if you need more space.

Women	Men

### Appendix 3

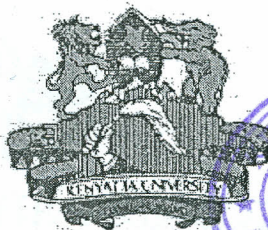
#### OBSERVATION CHECKLIST

##### 1. Homes

- Assess the health and social-economic status  
.....
- What are the gender roles of man/woman in the home?  
.....
- What is the occupation of the elderly?  
.....
- Disabilities  
.....

##### 2. Health centres/private clinic

- Facilities in the centre/private clinic  
.....  
.....
- Condition the facility is in (clean, etc)  
.....
- Attitude of health workers to elderly patients (kind, rude etc)  
.....
- How elderly patients react to health workers  
.....
- Health worker/patient rapport (complaints, etc)  
.....



**KENYATTA UNIVERSITY**  
**DEPARTMENT OF GENDER & DEVELOPMENT STUDIES**

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P. O. BOX 43844 – 00100  
NAIROBI

Tel: 8710901 ext. 3501

11<sup>th</sup> May 2010

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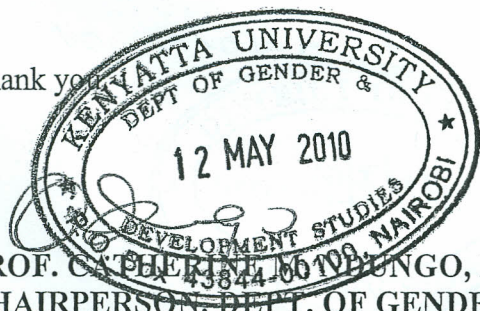
TO WHOM IT MAY CONCERN

REF: JANET MUNGAI NDUTA C50/10802/2008

This is to certify that **Janet Mungai Nduta** Reg. No. **C50/10802/08** is a Master of Arts in Gender and Development Studies Student at Kenyatta University. She has completed her first year of study successfully and she is now in her second year. She is expected to carry out research as part of her studies.

The purpose of this letter is to request you to accord her the necessary assistance to enable her collect data for the purpose of her research project.

Thank you



**PROF. CATHERINE MUNGAI MUNGO, PH.D**  
**CHAIRPERSON, DEPT. OF GENDER & DEV. STUDIES**



OFFICE OF THE PRESIDENT  
PROVINCIAL ADMINISTRATION AND INTERNAL SECURITY  
GITHUNGURI DISTRICT

TELE FAX: 0202302510

When Replying please quote

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OFFICE OF THE DISTRICT OFFICER  
IKINU DIVISION  
P O BOX 33-00216  
GITHUNGURI

20-5-2010

ALL ASSISTANT CHIEFS

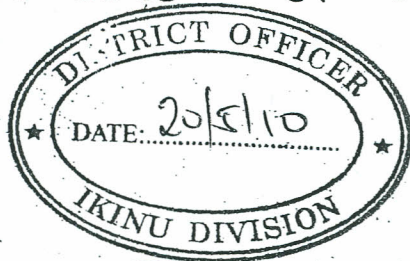
GITHIGA LOCATION

RE: AUTHORITY TO RESEARCH

The above subject refers:

Mrs Janet Mungai Njira Reg No - CS010802/08  
a student of Kenyatta University will be conducting  
a research on health seeking behaviour of  
women and men at Githiga location between  
20-5-2010 to 15-6-2010.

You're hereby required to grant her necessary  
support to enable her accomplish her objectives



*[Handwritten signature]*

J. A. RAITEMO  
District Officer  
IKINU DIVISION

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