Health-seeking behaviour and barriers in accessing medical care among Elderly women in Addis Ababa

By:

Tensae Deneke

Thesis submitted to the Department of Sociology

Presented in Partial Fulfillment of the Requirements for the Masters of Arts in Sociology

Addis Ababa University

Addis Ababa

June 2019

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

This is to certify that the Thesis is prepared by Tensae Deneke, entitled***:*** *Health-seeking behavior and barriers in accessing medical care among elderly women in Addis Ababa* and submitted in partial fulfillment of the requirements for the Masters of Arts in Sociology. Itcomplies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by Advisor

Advisor ___________________ Signature ________________Date ________________

Examiner ____________________ Signature ________________Date _______________

Examiner ____________________ Signature ________________Date ________________

Acknowledgments

First, I would like to thank my God and Virgin Mary for giving me the strength and letting me finish my MA thesis.

Second, I would like to thank my Advisor Professor Getnet Tadele, who has been giving his strong and useful comments throughout the year.

I also I would also like to express my heartfelt gratitude to Helmut Kloos Scholarship Program for the financial aid. I am also thankful to Doctor Helmut Kloos, for the guidance, encouragement and advice he provided throughout the duration of the research.

I am also grateful for the encouragement and tolerance of Eyosyas Kebede. Without his patience and sacrifice at data collection, my job would have undoubtedly been more difficult. I also would like to thank Ato Ephrem Madebo who had helped me a lot in editing my paper.

A special word of thanks also goes to my family for their continuous support and encouragement. Words cannot express how grateful I am to my mother for all of the sacrifices that she has made on my behalf. Every result described in this thesis was accomplished with the help and support of my father. It would not have been impossible to do without the support and guidance of him. I would also like to thank my grandparents. Your prayer for me was what sustained me this far.

I am greatly indebted to the elderly women who participated in the study for giving me their time and stories. Without them, there would be no study.

Abstract

This study was conducted to find out health- seeking behavior of elderly women and their financial coping strategy in Addis Ababa. A qualitative approach was employed to collect and analyze the collected data. Accordingly, in-depth interviews were conducted with 60 elderly women. In addition, key informant interviews were held with ten knowledgeable individuals about the subject under study. The study was started by investigating relevant theories on health-seeking behavior, barriers for health-seeking behavior and coping mechanisms. The study used the health belief model, practice theory, intersectionality theory and buffering social support theory. All these theories validated the findings of the study.

The study shows that elderly women are less likely to seek medical treatment unless they are critically ill. It was reported that elderly women who have relatively secured income and pension, who are educated, employed and married have relatively better health seeking behavior than elderly women who don't have income and pension, who are uneducated, unemployed and widowed. The study also revealed that the majority of the study participants received treatment from modern medical centers, and most of the participants opted to get treated in government hospitals. The participants also used traditional treatments, faith healing practices and homemade remedies to treat their illness. During severe sickness, elderly women used free kebele cards, assistance from community organizations (iddir) and relatives to cover their medical costs.

The government and NGOs should provide free health services to elderly women and also teach them about the causes of illness and treatments in order to increase the use of public health services and reduce their vulnerability to unsafe traditional medicine and even ignorance of their diseases. This thesis paper contributes to this task by exploring the problems associated with health- seeking behavior of elderly women.

Table of Contents

Acknowledgments....i

Abstract....ii

Glossary of local terms....vii

CHAPTER ONE....1

INTRODUCTION....1

1.1.Background of the Study....1

1.2.Statement of the Problem....4

1.3.Objectives of the Study....8

1.3.1.General objective....8

1.3.2.Specific objectives....8

1.4. Scope of the Study....9

1.5. Significance of the Study....9

CHAPTER TWO....10

LITERATURE REVIEW....10

2.1. Definition of health-seeking behavior....10

2.2. Conceptualization and Operationalization....11

2.2.1. Conceptualization....11

2.2.2. Operationalization....12

2.3. Theoretical Orientations and Empirical Evidence on Factors Related to health-seeking behavior of elderly women....12

2.3.1. Self regulation theory and health-seeking behavior of elderly women....13

2.3.2. Health belief model and barriers to health services utilization....18

2.3.3. Intersectionality theory and barriers of health-seeking behavior....22

2.3.4. Buffering social support theory and financial coping mechanisms of elderly women 24
2.4. Studies of health-seeking behavior in Ethiopia 26
2.5. Theoretical Framework of the Study 27
CHAPTER THREE 29
METHODS 29
3.1. Study Site 30
3.1.1. Selection of study sites 30
3.2. Research design 31
3.3. Data sources 31
3.3.1. Primary data 31
3.3.2. Secondary data 32
3.4. Sampling of the study population of elderly women 32
3.5. Key informant interviews 33
3.6. Data collection instruments 33
3.7. Data analysis 33
3.8. Ethical Consideration 34
CHAPTER FOUR 35
DATA ANALYSIS AND INTERPRETATION OF RESULTS 35
4.1. Demographic description of study participants 35
4.2. Illness status 36
4.3. Health- Seeking Behavior of Elderly Women 36
4.3.1. Utilization of Health Facilities 36
4.3.1.1. Utilization of modern health care facilities 37
4.3.1.1.1. Government hospital/clinics: 39

4.3.1.1.2. Private hospitals and clinics 40
4.3.1.2. Utilization of traditional health facilities..41
4.3.1.2.1.Traditional healers 42
4.3.1.2.2.Faith healing 44
4.3.1.2.3. Homemade remedies 46
4.3.1.3.Buying from pharmacies 47
4.3.1.3.1. Previous experience with the illness...48
4.3.1.3.2. Lack of time..49
4.3.2. Taking prescription medicine...49
4.3.2.1. Lack of trust..50
4.3.2.2. Lack of Assistance...50
4.4.Socio-Demographic Barriers..51
4.4.1. Socio-economic barriers...51
4.4.1.1. Income 52
4.4.1.2. Education...53
4.4.1.3. Employment...54
4.4.2.Demographic factors 56
4.4.2.1.Gender 56
4.4.2.2.Age..57
4.4.2.3.Marital status 58
4.4.3.Socio-cultural factors 58
4.4.3.1.Social role...58
4.4.3.2.Cultural beliefs of illness causation..59
4.4.3.3.Cultural and religious norms 61
4.5. Financial Coping Mechanisms...62

4.5.1. Assistance from the community 62

4.5.2. Kebele card 63

4.5.3. Cover costs themselves 64

4.5.4. Home treatment 64

CHAPTER FIVE 65

SUMMARY AND DISCUSSION 65

CHAPTER SIX 73

CONCLUSION 73

Recommendations 77

References viii

Appendix A. Interview Guide for elderly women xxii

Appendix B. Interview Guide for medical practitioners xxv

Appendix C. Interview Guide for kebele administrative xxvii

Appendix C. Interview Guide for NGOs. xxix

List of Table

Table 1: Demographic variables of research participants xxxi

List of Figure

Figure 1 Health-seeking behavior, barriers in accessing medical care and financial coping strategies of elderly women 28

Glossary of local terms

Buda- an evil eye, believed to cause illness.

Iddir- is a traditional 'burial society' primarily established to provide mutual aid in burial matters

Kebele- is the lowest administrative division in Ethiopia.

Mahber - is traditionally a religious feasting association to commemorate various saints or angels every month of the year.

Merigeta- Head of a church's singing group, sometimes engaged in preparing traditional medicine

Senbete- is one of the oldest Orthodox Christianity based association in Ethiopia, in which, every member takes turn to prepare food, drinks and serve at the church on Sundays.

CHAPTER ONE

INTRODUCTION

1.1.Background of the Study

Health and health services utilization are strongly related to age. It is a well-established ground that the prevalence of many diseases increases with age and elderly people often has co-existing medical conditions (Schilp *et al.*, 2012). This requires increased health care utilization (Keene, 2005, Vegda *et al.*, 2009).

Health-seeking behavior involves a decision-making process that is further governed by individual and/or household behavior, community norms and expectations. For this reason, the nature of care seeking varies among the elderly in general and women particular. Moreover, health-seeking behavior of elderly women can be determined and constrained by various factors (Keene, 2005). Studies conducted in Kenya, South Africa and Pakistan identified lack of finance, absence of family support, physical inaccessibility of the official health service providers and practicing quacks as the major factors deterring older people, especially women, from seeking health careservices (Help Age International, 2010). In addition, the under-financed health care systems, the over-stretched health workforces (from doctors to community health workers), poor health management information systems, unreliable supply of medicines, physical barriers to access health care and distance related barriers also contribute to older women's poor access to health care (Waweru,2003). From all these impediments, it appears that financial constraints are the main barrier for elderly women. Since older people cannotbuy health insurance schemes that are commonly available to the better-off and to those who are employed in the formal-sector, they are usually required to pay for almost all the medical treatments they receive (Neme, 2018; Ahmed *et al*., 2001, Mary *et al.,* 2010).

The situation in Ethiopia is not different. Most elderly women have no reliable income sources and adequate public sector pensions for the retired(Neme, 2018) and are vulnerable in the absence of a social security system. The majority of the elderly are engaged in the informal sector where low paying labor-intensive jobs are the norm. Since they have no other option, the elderly continues to work until they become seriously ill or die. However, no matter how long they work, their income hardly meets their basic needs. Older people are forced to stay in these informal jobs because the formal sector has no interest of hiring them, and they have no access to social security (FDRE, 2006).

As a result of societal negative attitude towards women, it is difficult for them to possess property or save money in their name. Many women are engaged in domestic works that have no pension plans, and those who are employed in the formal sector are paid lower salaries compared to their male counterparts because of biases against them. On top of all this social and economic burden on them, women are forced to leave their job on many pretexts, including giving birth. After passing through this kind of agonizing and demeaning life, women enter their retirement age surrounded by poverty (FDRE, 2006). This affects not only their income and wealth but also contributes to poor housing, ill health and personal insecurity. It also affects the health care seeking behavior of elderly people by forcing them to seek traditional health care services or healers rather than going to modern health care facilities (Ahmed et at, 2001, Mary *et al*, 2010).

The low income and pension rate, poor accessibility to health facilities, and failure to disclose their illness to other family and community members forces Ethiopian women to forgo modern health care services and look for traditional medicine (Hayelom, 2018, Amarech 2007, Neme, 2018). Besides, low literacy and higher unemployment rates, the lower social status of women, domestic work burden, and low income also contribute to health problems of Ethiopian elderly women.

There are multiple factors that influence the elderly people's quest for medical care. The perceived severity of old people's health problems is one of the factors affecting health-seeking behavior. In many countries, self-care, including self-treatment (or treatment by family members) is common when the severity of illness is perceived to be low (Foster and Andersen, 2005). Empirical evidence from Bangladesh indicates that people tend to avoid the high cost of allopathic physician services except for severe illness (Neme, 2018). Moreover, income and educational background are cited as key factors for affecting the choice of treatment (Neme, 2018).

Against this background, the study will attempt to explore the health-seeking behavior, barriers in accessing medical care and coping mechanisms of elderly women in Addis Ababa using a qualitative approach. Field research informing the study was conducted with selected elderly women in the age category of 65 and above.

The rationale behind selecting the elderly women as the principal targets of this study is the double vulnerability of elderly women, which is being female and older age. In Ethiopia and many other countries, most deaths occur among people over the age of 65 years (McCracken and Abdullah, 2009). As life expectancy increases, a greater proportion of the overall burden associated with ill health is carried by the older population, increasing the age-linked health inequity (Grundy and Holt, 2001).

Morbidity rates are generally higher among women than men worldwide, including in Ethiopia (population reference bureau, 2007) general level of poor health among older women is often related to women's lack of access to essential resources (such as land), as well as their lower socio-economic status and less focus on the protection of women's right. Largely due to their caring responsibilities at home and traditional sociocultural barriers, most women have less formal education, less employment opportunity, and thus less income than men. Their typically intermittent employment history means the link between lifetime

earnings and pension levels is weaker than if they had an unbroken employment history (Larkin, 2013, Matthews, 2015b).

In addition to low socioeconomic status and access to resources, women also have a lowered autonomy in that they have low decision-making power and are affected by violence and harmful traditional practices (ESPS, 2008, Kishor, 2005).

1.2.Statement of the Problem

It is well-established that the prevalence of diseases increases with age and elderly people often have co-existent medical conditions (Schilp *et al.*, 2012). In Ethiopia, national surveys show that adult women have significantly higher illness rates than adult males (FDRE, 1999). The geriatric population in USA consumes over 30% of all prescriptions and 40% of over-the-counter medications, fill an average of more than 14 different prescription medications per person annually, and take a daily average of five prescription and four over-the-counter medications; Of this group, older women are the greatest consumers of both prescription and non-prescription medications with 23% taking at least five prescription medications. The average number of drugs taken among 70-year-old women increased from 2.8 to 4.0 from 1971 to 2000 (Chiang *et al.,* 2009).

Health problems of the elderly in general and women in particular have been addressed by many researchers. (Chiang *et al.,* 2009; Menard *et al.,* 2008; Hayelom, 2018; Manmeet, 2013; Keene, 2000; Neme, 2018; Ahmed et at, 2001; Mary *et al* 2010 and Waweru, 2003). These researchers studied health-seeking behavior, barriers in accessing medical care and coping strategies of elderly women. For instance, Chiang *et al. (*2009); Schilp *et al*. (2012); Hayelom (2018) and Neme (2018) found that most elderly women took many different types of

medications, including modern medicines obtained from hospitals, clinics or pharmacies, or traditional medicines obtained from shops, friends, or prepared at home.

Regarding the health seeking of women, Aboyade (2016) argued that women are disadvantaged by individual, cultural, social, and institutional factors that impact their access to care. Individual factors, such as early life experiences, gender discrimination and socioeconomic and cultural exclusion are related to a reduced access to modern health care services by elderly women. Gender-based discrimination and stressful circumstances across the life span have resulted in poor health and at the same time less access to health care. Aboyade (2016) describes that because of traditional barriers, women in rural areas are not allowed to visit medical care centers. Despite his description of women's health seeking behavior and its barriers, and his emphasis on the impact of tradition, Aboyade (2016) solely focused only on gender and failed to show how other factors affect women's health.

Other researchers, including Neme, (2018) and Amarech (2007) reported that risk factors such as poverty, lack of education, having no income or property rights, high dependency on males, and social and economic stratification are prominent influences on women's health. Even though Hayelom (2018) and Amarech (2007) conducted health-seeking research, they too failed to show how socio demographic factors impact the health-seeking behavior of the study participants. For instance, Amarech (2007) emphasized mainly financial constraints, and Neme (2018) mentioned all the socio demographic factors, but failed to give a detail account on each of them.

The issue of choice of treatment has also attracted researchers (Hayelom, 2018; Ahmed et at, 2001; Mary *et al* 2010; Neme, 2018; Foster and Andersen, 2005). They found that many ill people tend to cope with their illness by using one of the three major types of health services:

modern, traditional, and faith-based healing services. In several studies, (Hayelom, 2018; Ahmed et at, 2001; Mary *et al* 2010; Akosua, 2017; Neme, 2018; Foster and Andersen, 2005) age, educational level and marital status were the main determinants of coping strategy elderly women patients used. Highly educated patients and patients who have better information about their illness tend to adopt a more active, positive confrontational coping style, which was consistent with other research results. On the other side, patients with lower educational level, lower cognition of their illness, and tended to adopt the negative coping styles of avoidance or acceptance-resignation.

Menberu (2018), on his study about depression in a northwest Ethiopian community reported that a quarter of the participants sought the public health services during illness. The rest used traditional medicine because they either did not have access to the already limited modern mental health care facilities, or because of the stigma associated with mental illness and the cultural belief on its causes. According to that study, females seek professional help 2.8 times more often than men. Though Menberuu discussed coping strategies in detail, he failed to display how cultural beliefs about mental illness affect health-seeking behavior.

Joan (2009), on the other hand, reported that, almost half of her study participants sought treatment at modern centers and subsequently used traditional medicine, and about a quarter of them sought traditional care first before using modern care. Even though Joan's study concludes that most of the study participants prefer modern medical care first, it doesn't point to a reason for such a preference. Besides, her sole dependence on secondary data makes her study less reliable.

Another researcher Anagaw (2014) found that socioeconomic status is the main determinant of adult's choice of treatment during illness. His findings indicate that households with higher education; occupation and income are more likely to seek care in health centers and private or non-government organization (NGOs) clinics than health posts. Delays in care-seeking

behavior and traditional medical usage are apparent mainly for old age-related conditions and among poorer households. Though Anagaw reported that socio economic status impacts coping, he failed to state the reasons for the impact.

In addition to health-seeking behavior and barriers for the medical treatment, the issue of financial coping was also the interest of researchers. (Help Age International, 2013: Prospe 2010; Christine *et al*., 2008; Iffat *et al*., 2016 and Johannes, 2012) they reported that elderly women cope financially using different strategies. Using one's own saving, using son's or daughter's help, selling assets, free medication, community help, loan and borrowing were the most cited ones. Even though the issue of financial coping is addressed by many researchers, to the best of the researcher's knowledge, there is only one study (Help Age International, 2013) in Ethiopia, that describes the financial coping mechanisms; the study was not sufficient and didn't describe the financial coping mechanisms in detail. It mentioned the financial copings and left without describing it.

In general, the above studies (Hayelom, 2018; Ahmed et at, 2001; Mary *et al* 2010; Neme, 2018; Foster and Andersen, 2005; Menberu, 2018 and Anagaw 2014) failed to produce comprehensive assessments. For instance, some of the studies focused only on how traditional factors affect health-seeking and others focused only on the impact of finance, y*et al*l of them failed to simultaneously describe two or more factors in detail. Besides, their study stood short of giving detailed descriptions about the impact of socio demographic factors such as education, income, culture and occupation on health-seeking, and failed to show the relationship between health seeking behavior and women that happen to be old. Moreover, three studies have been carried out by NGOs on the living conditions, food insecurity and poverty of older people in Ethiopia (Help Age International, 2010, 2013; Medhin, 2009) but none of them dealt specifically with health-seeking behavior, barriers from accessing medical care and coping strategies of older women.

To the best of the researcher's knowledge, only few studies (Addisu and Mengistu, 2009; Zinaw *et al*, 2018, Kloos *et al* (1987) and Metadel *et al*, 2017) addressed health seeking behavior in Addis Ababa. The study by Addisu and Mengistu (2009) was mainly focused poor people, on the other hand, the study by Zinaw *et al* (2018) focuses on patients diagnosed with cervical cancer, and the study by Metadel *et al*, (2017) was conducted on children who were under five years old during data collection. Kloos et al. (1987) studied health-seeking behavior of randomly selected households in five *kebeles* in Addis Ababa. Again

Thus, the aim of this study is to fill the gap created by existing studies by examining health-seeking behavior, displaying the impact of socio demographic factors on health-seeking behavior, and show the financial coping mechanisms used by elderly women. The study also aims at giving detail and comprehensive description about each topic and subtopic under investigation.

1.3.Objectives of the Study

1.3.1. General objective

This paper was written with the general objective of exploring health-seeking behavior and coping mechanisms of elderly women in Addis Ababa.

1.3.2. Specific objectives

The specific objectives of the paper are

- ❖ To determine the pattern of health-seeking behavior by elderly women
- ❖ To assess the socio-demographic barriers to access health care by elderly women
- ❖ To examine the financial coping mechanisms of elderly women, use in case of illness

1.4. Scope of the Study

This research was conducted in Addis Ababa, with the aim of exploring health-seeking behavior and financial coping mechanisms of elderly women. Since qualitative research is highly intensive in terms of data and time, a reasonably small sample size may be adequate to manage the research process within the allocated timeframe (Ritchie, Lewis and Elam, 2003). Thus the researcher used sample size of 60, which does not allow the result to be generalized to the whole population of elderly women. In addition, the study is also limited to the qualitative approach and an urban setting in Addis Ababa. The research is also limited to elderly women above the age of 65.

1.5. Significance of the Study

This study was conducted with the aim of exploring health-seeking behavior and coping mechanisms of elderly women in Addis Ababa. Elucidation of the decision-making process by individual women in seeking available, affordable and appropriate health resources, the barriers they face in seeking treatment and their utilization of health resources can provide detailed information on the problems ill elderly women face and provide possible solutions. To this effect, it is hoped that the findings of this study will be considered by planers and social organizations as science-based information concerning health-seeking behavior of elderly women. The study will also provide baseline information for further studies on this topic. The study will also help policy makers and concerned government agents to identify the barriers of accessing medical care by elderly women. Thus, the findings of this study may help concerned parties to design a policy for improving the health situation of elderly women.

CHAPTER TWO

LITERATURE REVIEW

In this chapter, studies conducted in the area of health-seeking behavior of elderly women both at local and international level are reviewed. The chapter begins with a definition of the term health-seeking behavior and is followed by the presentation of theoretical and empirical views of different scholars. Finally, the chapter comes to an end after presenting the theoretical framework of the study.

2.1. Definition of health-seeking behavior

Health-seeking behavior is defined as a "sequence of remedial actions that individuals undertake to rectify perceived ill-health. It is viewed as a process through which individuals acquire and act on information about health, illness, health promotion, and risks related to health. It seeks to construct healthy approaches through every-day practices facilitating the feeling of 'belonging' via spiritual and religious practices and also the use and consumption of materials such as food and forms of treatments and therapies (Caliipe *et al.*, 2013).

In other words, health-seeking behavior is any action of an individual with a perceived health condition or illness who actively seeks an appropriate remedy access to health services. In addition, it is an approach through which people can monitor their body, partially distinguish symptoms and interpret them, look for medical interventions and apply other supportive resources (Edwards, 2016).

In its broadest sense, health behavior includes all behaviors associated with establishing and maintaining a healthy physical and mental state, (primary prevention). Health-seeking behaviors also include behaviors that deal with any digression from the healthy state, such as controlling (secondary prevention) and reducing the impact and progression of an illness (tertiary prevention). It also includes how compliant a patient is with the recommended

treatment, reasons for choice of health care professional and reasons for not seeking help from health care professionals (Edwards, 2016).

In general, it can be argued that health-seeking behavior encompasses decision making about health choices, processes that affect health status, and use of services and an expressed or observed desire to seek treatment and information about health promotion (Caliipe *et al.*, 2013).

2.2. Conceptualization and Operationalization

This section defines some concepts and how the researcher planned to measure those concepts.

2.2.1. Conceptualization

Socioeconomic status-is a combined economic and sociological factor that measures a person's work experience, or a family's and an individual's economic and social position in relation to others; based on income, education, and occupation (Marmot, 2004).

Socio demography-denotes the study of characteristics such as age, gender, sexual orientation, race, religion, income, marital status, birth rate, death rate, average family size, heritage, education and medical history

Elderly-chronological age of 65 years old or older, while those from 65 through 74 years old are referred to as "early elderly" and those over 75 years old as "late elderly" (WHO,2002).

Traditional medicine- refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being (WHO, 2006).

Modern medicine- A system in which medical doctors and other health care professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery(WHO, 2006).

2.2.2. Operationalization

Health seeking behavior: health seeking behavior was measuredby assessing the regular hospital checkups during illness and examining the proper intake of prescription medicine.

Education: Education was measured using categorical variables, by a scale indicating the highest level completed.

Income: Income was assessed by asking elderly women to list all sources of their income including pension, family assistance and so forth.

Occupation: Occupationwas assessed by asking elderly women what their current or most recent occupation is whether it's formal or informal (Any income generating activity). The word occupation was used interchangeably with employment in this study.

2.3. Theoretical Orientations and Empirical Evidence on Factors Related to health-seeking behavior of elderly women

There are a number of theories that attempt to explain elderly women's health-seeking behavior, barriers to accessing medical care and their coping mechanism during illness. From these theories, this study utilizes Andersen and Newman's health belief model (Andersen, 1995; Andersen and Newman 1973), self regulation theory (Leventhal *et al.*, 1980) intersectionality (what is intersectionality, 2017), and social support theory. These theories are also presented in detail with some empirical evidence.

2.3.1. Self regulation theory and health-seeking behavior of elderly women

The researcher used self regulation theory to see the patterns and determinant factors of health-seeking behavior of elderly women. The theory of self-regulation describes elderly women as active agents who are engaged in a dynamic process of first assessing health threats and then using problem-solving strategies to address them (Leventhal *et al*., 1980). Elderly women's choice of medical treatment depends on a health threat, which is based on past, present and newly acquired experiences. The self-regulation model captures the influence of the complex interaction between individual and socio-cultural factors on health behaviors (Nerenz and Leventhal, 1983). The theory was found to be important because of its need to assess individual and socio-cultural factors. The theory also integrates both past and present experience as a contributary factors decision making of seeking medical care. This makes the theory multidimensional. The researcher's interest in assessing contributory factors of health-seeking behavior, which might be past and present situations made the researcher to choose the theory, but the theory was found to be weak because it assumes that health treats are the only contributary factors for seeking medical care.

There are various studies on the extent of health seeking behavior. For instance, it has been argued that in developed countries where acute care and institutional long-term care services are widely available, the use of medical care services by adults rises with age, and per capital expenditures on health care is relatively higher among older groups (Aurelie, 2010).

Empirical evidence shows that many elderly use different types of medications, including modern medicines obtained from the hospitals, clinics or pharmacy and traditional medicines obtained from shops, friends, or prepared personally. Elderly will also attempt to self-medicate or self-treat with folk or home remedies, even though the medical situation may indicate a very different approach (Edwards, 2016; Kloos *et al*. 1987).

In low- and middle-income countries where the number of practitioners of modern medicine is inadequate to meet the health care needs of the population, traditional medicine and its practitioners are an important resource for population health. Compared to modern medicine, traditional medicine is usually more affordable, accessible and acceptable to the communities (Sato, cited in Oyebode, 2016). Studies from many African countries show that the majority of the population uses traditional medicine. The lack of guaranteed health care for the elderly has contributed to poor access and utilization of formal health services (Twumasi, 1975). Other studies pointed that many elderlies could hardly afford the payment of hospital bills and therefore resorted to self-medication or the use of herbal medicine (Archana, 2008).

Studies in Europe, China, Turkey and Africa showed that traditional medicines were used for age related chronic diseases such as hypertension, chronic heart failure, chronic obstructive lung disease, chronic renal impairment, migraine, epilepsy and rheumatoid arthritis, for which no modern medicine or only palliative therapy is available (Mollaoglu and Aciyurt, 2014; Sarina *et al*., 2012 ; Mohamed and Salih, 2014: Buowarib, 2013). Similarly, patients with HIV/AIDS and other difficult-to-treat diseases such as tuberculosis and cancer used traditional healers of holy water than patients with other diseases. It was also found that elderly patients use herbal medicines even though the risk of adverse interactions with modern medicine is high (Birhanas cited in Solomon, 2017).

Next to the type of illness, poverty is another determinant for seeking medical care in Ethiopia. Kloos *et al*. (1987) reported that 30.0% of the sick in low socioeconomic *kebele*s, but only 9.9% in wealthier *kebele*s in Addis Ababa did not use any medical treatment for their last illness. Nearly half of those who did not use medical treatment expected that their illness would go away without treatment while about 32.3% of those who failed to seek medical treatment said they didn’t have money to pay for medical service. The greatest constraints in raising money for medical treatment were experienced before payday around

the end of each month and bureaucratic delays poor people experienced in having their applications for free medical service approved.

Empirical evidence among elderly Malays showed that modern medicine was taken less often than traditional medicine, and a few eldery did not take any medicine at all (Zabidah *et al.,*2005). However, this study failed to uncover reasons for no usage of medicine by the elderly.

A study in the USA revealed that up to 40% of various patient groups take herbal remedies and drugs simultaneously. According to a study in Addis Ababa, nearly half of elderly patients reported they were using herbal medicines even though the risk of adverse interactions in elderly patients is high (Birhanu as cited in Solomon, 2017).

Due to the aforementioned barriers to seeking modern health care, women in Ethiopia often seek modern health care services only after exhausting the traditional remedies and/or holy water. In Addis Ababa, the majority of participants thought that about half of the women seek care from traditional healers first and then seek modern medical care if traditional remedies are ineffective. Those women who do seek treatment from the modern health system often present late in their illness, and then revert back to traditional remedies as modern health care is often unable to provide services for advanced diseases (Birhanu, 2012).

Factors such as education, income, access to resources, and availability of health care play a prominent role in making conventional health care more attractive to the poor. The role socioeconomic factors play in the use of complementary and alternative medicine varies with level of education and income. For instance, several studies indicate that well educated and more affluent are less likely to use complementary and alternative medicine because socio-economic resources facilitate people's access to information, exposure, and ability to pay for modern medicines (Blais, 2000; Kloos *et al*., 1987). A study in Nigeria and Uganda reported

an inverse relationship between socioeconomic status and traditional medicine use. This suggests that low socioeconomic status in society influences the decision to use traditional medicine given the fact that traditional medicine is a low-cost health care option compared with biomedicine (Udezi and Usifoh, 2013; James, 2018).

A study by Kahwa (2009) in Ethiopia suggests that the higher the level of education influences individuals to first seek help from a traditional healer rather than having no treatment. Another study in Konso, by Workneh *et al* (2018) reported that older people believe that illnesses are caused by a range of supernatural forces, including the wrath of God or ancestral spirits, causing them to use culturally prescription treatment. Young and formally educated members of the community attribute causes of diseases to *germitta* (germs) and *factorta* (bacteria) and tend to seek treatment mostly in modern health facilities.

Besides income, education and occupation, it was reported that socio-demographic factors such as age, marital status and gender influence the choice of medical treatment. For instance, a study in Addis Ababa revealed that individuals who never married and those widowed were twice more likely to have first visited a traditional healer than those who are in marital relationship. The same study showed that the separated/divorced were 1.5 times more likely than those who were married to first opt for a traditional healer. Orthodox Christians and Muslims are equally likely to visit traditional healers as the first point of contact for health care rather than having no treatment. Results also reveal that ethnicity is not significant (Kahwa 2009). It was also reported that males notably went less to traditional healer/holy water, while females were more likely to use traditional medicine (Kahwa 2009).

Another study by Kloos *et al*., (1987) reported that teenagers and the elderly are the least likely to use a modern health facility. Probable reasons for lower health care utilization in

older age are the lack of mobility in the elderly or unequal distribution of household resources for health care.

Besides complementary and alternative medical treatments, faith healing also plays an important role in health care. Elders who are spiritual may utilize their beliefs in coping with illness, pain, and life stresses. Empirical evidence in Tanzania found 41% of people with dementia had visited Christian faith healers (FHs). A study conducted In Black Americans also reported the same finding regarding the high use of faith healing practice (Debra, 2006 and Mushi *et al.,* 2014).

The literature reveals that older and less educated people are more likely to use faith healing as compared to educated and younger people. In addition to level of education and age, personal maturation and connection to one's cultural identity influence the scope and utilization of faith healing practices. Utilization of such practices also seems to be more common in the lower socio-economic strata, or where access to other forms of treatment is difficult (Debra, 2006).

A study in East and Southern Africa showed that diseases such as HIV are thought to be caused by supernatural forces for evil deeds, and traditional or faith-based healing was used to complement biomedical care. This was observed among HIV patients who believed they were bewitched or cursed, which could lead to negative interactions of medicines, and providers, although often unknown to them, treated the same HIV patients (Moshabela *et al*, 2017).

The situation is similar in Ethiopia. Many people, especially the elderly, believe that supernatural forces cause all diseases and that holy water in combination with prayer is curative. This belief has traditionally attracted patients with a wide range of diseases to holy spring sites, known as *tsebel* among Orthodox Christians and *zemzem* among Moslems. This

belief continues to generate a strong interest in the use of water from holy springs in conjunction with the use of the cross, holy oil, ash, incense, and prayers by a priest to treat symptoms of AIDS. In addition to the use of holy water for the treatment of AIDS, holy water is preferred over modern medicine for the treatment of mental illness, epilepsy, and several other diseases because they are thought to be more appropriately and effectively treated in the church (Kloos *et al*, 2013). Similarly, Menberu (2018) reported that faith healing is highly preferred by Ethiopians in case of mental illness. It is common to try different alternative traditional and religious health resources before actual health care seeking for symptoms of mental illnesses, including depression. Thirty-one percent of patients sought care from priests/holy water/church. The stigma associated with mental illness and shortage of mental hospitals are major reasons that keep patients from seeking professional help.

2.3.2. Health belief model and barriers to health services utilization

The health belief model views health-seeking behavior as influenced by societal determinants, including social norms, technology, the health service system, including its resources and organization; and individual characteristics(Andersen, 1995; Andersen and Newman 1973). The theory looks at various factors as barriers of health seeking behaviour. The ability of being multidimensional made this theory chosen.

Andersen's model suggests that the health needs of elderly women are a function of their predisposition to use services and their ability to access services and their illness level. The actual use of health services is triggered by needs during illness. The illness level reflects the need to seek medical care. Geofrey *et al* (2018) found that seeking medical care was frequently initiated for illnesses that did not improve or worsened. When an illness was perceived as severe, patients were more likely to visit health centers. Patients who had mild symptoms perceived themselves to be at low risk and were unlikely to seek care. Because of

the low risk perceptions, such patients either depended on self-medication to treat symptoms, or they just ignored their illness and opted to do nothing to it. On the other hand, patients who perceived their disease to be severe, especially those who experienced life-threatening symptoms, are more likely to seek care promptly from hospitals and avoid self-medication. However, Kloos *et al*. (1987) and other authors found that some people used different types of health resources during the same illness episode.

On the other hand, the health belief model describes enabling factors as any condition which permits the elderly to use a health service (Andersen and Newman 1973). In other words, enabling factors are related to the means elderly women have to obtain health services. Such means can be income, access to credit, knowledge about an illness or disease, knowledge about the location of appropriate health services, availability of transportation, and the distance to a service provider. Thus, it can be argued that enabling factors are closely linked to illness and socioeconomic level.

Empirical evidence shows that income is also an important determinant of health insurance status, such that most insured individuals have relatively higher incomes compared to uninsured individuals (Bernard, Banthin andEncinosa 2009). Findings from both developing and developed countries show that old people who are rich have a higher probability of obtaining care when sick, are more likely to be seen by a doctor, and have a higher probability of taking medicines when they are ill than poorer groups. The wealthy spend more on health care, measured in absolute terms, than do poorer groups, but do not devote a consistently higher percentage of their consumption expenditures to health care. On the contrary, the poor elderly, when they do obtain care, spend a greater proportion of their income on treatment than richer households (Aurelie, 2010; Waweru *et al*., 2003; Makinen *et al.* and Taffa *et al.* 2005). Though the studies by (Aurelie 2010; Waweru *et al*., 2003; Makinen *et al.,* and Taffa *et al*. 2005) stated that that poor elderly spend a greater proportion

of their income on treatment than more affluent people, the study by (Aurelie 2010; Waweru *et al*., 2003; Makinen *et al*., and Taffa *et al*. 2005) failed to examine this relationship.

Besides needs and enabling factors, Andersen and Newman's health belief model further describes the predisposing component as characteristics determining the elderly women's inclination to use medical care. Based on personal characteristics, some individuals tend to use more and/or different services than others. These characteristics exist prior to the onset of a certain illness. In particular, socio-demographic factors like age, gender, profession, and education are relevant, but also individual beliefs and attitudes towards health services and knowledge about the illness are part of these factors (Andersen, 1995; Andersen and Newman 1973).

Empirical evidence in developed countries implies that education is an important determinant of health. Higher levels of educational attainment are associated with better health and reduced morbidity and mortality. For instance, the widely cited Marmot Review of England in health inequality research (Marmot, 2010) reported that obtaining a tertiary qualification is associated with increased health and longevity. A pronounced education gradient in health is cited in the literature, suggesting that as level of education increases, so does the likelihood of positive health outcomes. Therefore, education may be an important component in improving the life trajectories of population groups whilst reducing health inequalities that stem from disparities in health-seeking behavior (Edwards, 2016: 11-12). In contrast to this view, a study by Frie, Eikemo and Von Dem Knesebeck (2010) examined the health-seeking behavior of elderly populations in 24 developed European countries and found the opposite effect. According to the findings of these researchers, lower levels of education were indicative of increased health-seeking activity. But the finding failed to show how lower level of education is inversely related to health-seeking behavior.

The dominant findings in the literature from countries in sub-Saharan Africa (Zambia, Kenya, Burkina Faso and Ethiopia) are that, education is strongly related to increased health-seeking behavior among the elderly (Edwards, 2016: 11-12).

Potentially, there are multiple pathways that could explain why education is consistently and strongly associated with higher frequency of health-seeking. Some of the pathways are: increased knowledge of the benefits of preventive health care and awareness of health services, higher receptivity to new health-related information, socialization to interact with formal services outside the home environment and familiarity with modern medical culture (Grosse *et al*., 1989).

Another important determining factor for health seeking behavior is employment status. Employment status is recognized in the literature as one of the most significant determinants of health-seeking behavior. In relation to the association between employment status and health-seeking behavior, international literature examining data from both developed and underdeveloped countries including those in sub-Saharan Africa suggests that being employed is a deterrent to seeking health care services, particularly among lower socio-economic groups who are fearful of losing employment by taking time off work to go to a clinic or hospital(Caldwell *et al*., 2014).In some circumstances, this has resulted in people choosing informal health care providers such as pharmacies who are open until late. A study in Sweden found that being unemployed was associated with a decreased likelihood of going to a health care facility regardless of the need (Ahs *et al*., 2012). But another study in Sweden reported that being unemployed can lead to poorer mental and physical health, which would increase the likelihood of visiting a health practitioner when compared to the employed (Edwards, 2016: 11-13).

Other than socio economic status, marital status was also found to be a major determinant of health-seeking behavior. Studies have reported that there is a negative relationship between

marital status and health services utilization. This is because of either increased utilization of home health care by married adults or improved health of married men and women. Single elderly women are autonomous, and therefore, they frequent health facilities more often than their married counterparts. But on the other hand, single elderly women may be poorer with a lower budget for health care (Aurelie, 2010).

Another study by (Caliipe *et al.,*2013) found that aged women who were divorced or separated and widowers used medical services less frequently. However, aged widows used the services more frequently, which may be explained by the greater longevity of women or by their greater willingness to talk about their health problems and seek medical services, including services for less severe problems, compared with men.

Similar results were found in Norway and China. It was reported that less than half of the older women who were divorced or separated and widowers used medical services less frequently and were less likely to discuss their symptoms with their health care professionals and seek advice from a medical professional. However, since health services are expensive, lack of money and long periods of taking medicine with no improvement made them discontinue using health care services (Obasi, 2013 and Wilkinson 2003). Caliipe *et al.* (2013); Obasi, (2013) and Wilkinson (2003) reported that aged women who were divorced or separated and widowers used medical services less frequently. However, they failed to show how and why separation or divorce affects health care utilization among elderly women. On the contrary, a study among the elderly population in northern India found no significant association between the marital status and health-seeking behavior of elderly women (Sharma, Maztaand Parashar, 2013).

2.3.3. Intersectionality theory and barriers of health-seeking behavior

Intersectionality theory is about the effect of discrimination and disadvantages faced by elderly women. It takes into account elderly women’s overlapping identities and experiences

in order to explain its impact on health-seeking. The theory asserts that elderly women are often disadvantaged by multiple sources of oppression (being female and elderly), which in turn prevents them from seeking medical care (what is intersectionality, 2017). The rationale behind selecting this theory for the research is the characteristics of the study participants. Since the study participants are elderly women who are assumed to be affected both by their age and sex, the theory is useful in assessing the impact of sex and age on health seeking behavior, but the theory would be more attractive if it tries to explain how being old and woman affects ones health seeking behaviour.

Literatures suggest that Elderly women are disadvantaged by individual, cultural, social, and institutional factors that have an impact on their access to health care. Individual factors, such as early life experiences, gender discrimination and socioeconomic exclusion are factors that reduce the elderly women’s access to modern health care service. Gender-based discrimination and stressful circumstances across the life span of elderly women have resulted in poor health and at the same time less access to health care. Other risk factors such as poverty, lack of education, income or property rights, an increasing dependency, and social and economic stratification also have negative influences on elderly women’s health (Amarech, 2007 Mahaini**,** 2008, Khattab, 2000).

Other researchers (Currie and Wiesenberg 2003) also reported how gender has impacted health seeking behavior. The work of the two researchers showsthat women are generally less likely to identify disease symptoms, search for health-related information and feel more restricted in access to health care facilities than men. The authors concluded that this observation is partly because of the relatively lower socioeconomic status, lower social value placed on women by culture, as well as their defined social roles, which make it cumbersome for them to visit health care facilities during the day when they are open.

Other studies further pointed out how health care utilization vary among male and female. Studies in Brazil and Ethiopia showed that ill women used medical services more frequently than men or females without disease It was reported that women regularly visited their doctor for gynecological and obstetric factors abnormalities Additionally, ill women were more aware of health risks than men or their healthy female counterparts because they were more health literate (Caliipe *et al.,* 2013 and Yitagesu, 2018). However, the studies by Caliipe *et al.*, (2013) and Noeline (2013) solely relied on demographic factors and failed to describe how social factors affect the decision making regarding medical care.

2.3.4. Buffering social support theory and financial coping mechanisms of elderly women

In order to study the financial coping mechanism, the study has employed buffering social support theory. According to this theory, Social support is the assistance given for elderly women to enhance their health. This support comes from their social network, which is a pool of different sources such as family, friends, neighbors, coworkers, organizations or even government. The buffering hypothesis, which is part of social support, proposes that social support protects elderly women from health related hardships by influencing them to go to hospital and cope with the illness. The theory describes where the financial assistance came from, and this make the theory use the researcher choose it, but it would be more appropriate if the theory describes how the financial assistance is given.

Empirical evidences from low-income countries suggest that several households incur financial debt or sell household assets to cope with medical care payments (Nitin *et al,* 2004).

A study in India reported that altogether, sources such as borrowings, sale of household assets and contributions from friends and relatives account for 58 and 42% share in total payments for inpatient care in rural and urban India, respectively, n which a significant socioeconomic gradient in the distribution of distressed financing with huge disadvantages

for marginalized sections, particularly females, elderly and economically peripheralized social groups is observed. It was also found that, despite similar socioeconomic background, males are more likely to use borrowings for health care financing than females.

The study further reported that Presence of a significant socioeconomic gradient is apparent with particularly huge disadvantages for the marginalized households who are within lower consumption quintiles. The incidence of borrowing is very high among the lowest consumption quintile. Nevertheless, a significant proportion of borrowing among richer consumption quintiles highlights that financial distress is a key concern even among the better-off sections. Incidence of financial distress is unavoidable to inpatient care seeking cancer and Cardiovascular patients. Households seeking care from private sector hospitals borrow by far more than patients accessing public health care facilities. Most importantly, households report lower incidence of borrowings (39 and 20% in rural and urban areas, respectively) for hospitalization of elderly persons (aged 60 and above). Similarly, among female-headed households, financial contributions from friends and relatives are critical to meet Out of pocket payments on inpatient care (Nadia, 2010).

Another study conducted in different countries reported high rate of assistance from friends, relatives and selling assets and borrowing as well. The study found out that the highest income groups were less likely to borrow and sell assets, but coping mechanisms did not differ strongly among lower income quintiles. In many African countries, except in Burkina Faso, Namibia and Swaziland, households with higher inpatient expenses were significantly more likely to borrow and deplete assets compared to those financing outpatient care or routine medical expenses. In most African countries, the health financing system is too weak to protect households from health shocks. Borrowing and selling assets to finance health care is common (Tazeen *et al.,* 2018).

Another study in Nigeria also found out that the use of own money was also the commonest payment-coping mechanism. Those elderly who are in relatively better economic position had better chance of covering their own medical expenses (Mizanur *et al*.,2013).

2.4. Studies of health-seeking behavior in Ethiopia

The issue of health-seeking behavior has attracted the interest of many researchers in Ethiopia, as noted by Tesfaye (2003); Amarech (2007);Hayelom (2018); Neme (2018); Samuel *et al*. (2018) Menberu *et al.* (2018); Yitagesu *et al.* (2018) and Hailemariam (2012). Samuel *et al*. (2018) argued that health-seeking prevalence was low in southern Ethiopia. He reported that 85.4% of the study participants used few health resources. Moreover, a study by Tesfaye (2003) on demand for curative care in Jimma town reported that level of health status, number of children in the family and the expected maximum benefit from health care providers and respondent's knowledge are significant factors in households' decisions of choosing modern medical treatment. However, Tesfaye failed to show how health status, number of children in the family and the expected maximum utility from health care providers affected health-seeking behavior.

Another study by Amarech (2007) examined the determinants of health care provider choice of urban households of Ethiopia. The study investigated the effects of user fees on the utilization of health care by different segments of socio-economic groups. Amarech's study shows that for a given rise in health care cost, the poor tend to reduce their use health care facilities by far more than the better-off. In other words, an increase in user fee is likely to drive out a larger portion of poor households from receiving medical care. The study also found that the poor are required to pay a significantly greater proportion of their income for health care than the better off for treatment.

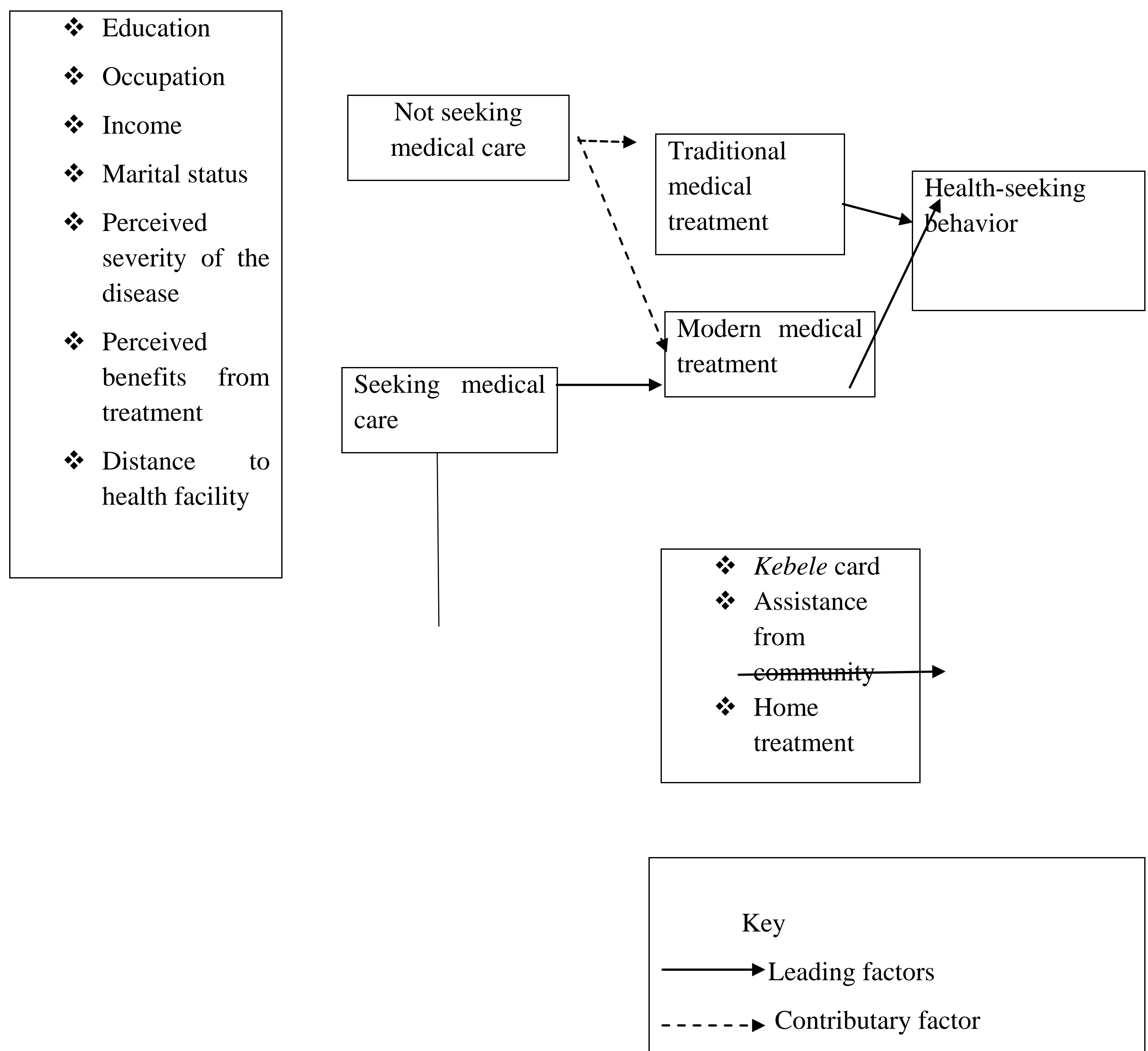
According to HelpAge International (2013), 40.4% of elderly women used financial resources for medical treatment from the following: 40.4% from their own savings or income, 35.8% from their sons or daughters, and 9.4% through loans from “someone”, 8.6% from other relatives, 1.9% each from non-relatives and free medication through their *kebele*s, and 0.5% through begging. This study also found that 35 (60%) of elderly women in Addis Ababa depended on their sons, daughters and their neighbors to accompany them to health facilities.

Based on these studies, the estimated result of the choice of health care providers indicates that patient’s age, the low awareness level about disease and its risk factors, beliefs about diseases, poor access to preventive services, non-affordability of health service, perceived low quality of treatment and assistance from social networks are important factors in the utilization of curative health care. It was also reported that fear of stigma of diseases like cervical cancer, AIDS and mental illness prevents women from seeking medical care (Tesfaye, 2003 Hailemariam, 2012 and Menberu *et al.,* 2018; Kloos, *et al*. 2013).

2.5. Theoretical Framework of the Study

This study had employed a theoretical framework to shape the data collection and analysis. Lisa (2008:873) defined theoretical framework as any empirical or quasi-empirical theory of social and/or psychological processes, at a variety of levels (e.g., grand, mid-range, and explanatory), that can be applied to the understanding of health-seeking behavior of elderly women. Thus, the researcher used a theoretical framework for the guidance of the study and tried to provide a simplified model regarding elderly women’s health-seeking behavior. The model attempts to integrate the different assumptions of the theories indicated in the forgoing discussions.

Figure 1 Health-seeking behavior, barriers in accessing medical care and financial coping strategies of 60 elderly women in Addis Ababa



CHAPTER THREE

METHODS

This study employed a qualitative approach to collect and analyze data needed to address the various objectives of the study. As a result, the study used the constructivism/interpretivism research paradigm. Honebein (1996) describes the constructivism philosophical paradigm as an approach which asserts that elderly women construct their own understanding and knowledge of the world through experiencing things and reflecting on those experiences. It also focuses on exploring the complexity of elderly women's health with a view of gaining in-depth understanding rather than generalizing (Guba, E. and Lincoln, 1994). As a result, the research is grounded in a realist ontology, which rejects the existence of any possible correct reality. Ontologically speaking, cases of elderly women's illness and their health-seeking behavior are absolutely real and there are also various realities constructed by elderly women which in turn allow or prevent them from seeking help and/or use household-based treatment for their illness. The information about health-seeking behavior of the elderly women and their coping strategy was generated and shaped by the perceptions of the participants as well as the researcher. Thus, the reality is subjective and nuanced (Smith, 1983).

The epistemological stance which was used in the study is subjectivism. The researcher tried to subjectively understand health seeking behavior and financial coping of elderly women and to immerse herself in the study setting by interviewing elderly women about their life histories, health-seeking behavior and coping mechanisms, and to objectively analyze available documents. The study also assumed that meaning is embedded in the participants' experiences and that this meaning can be mediated through the researcher's own perceptions (Glasersfeld, 1991).

The methodology of the study was voluntarism. It denotes the assumption that elderly women are the agents of their health-seeking behavior and coping strategies, and that they have some control over seeking or not seeking medical care (Encyclopedia, 1998).

This chapter discusses research methods which were used in the collection and analysis of data. It also presents and explains the study area, research design, data collection and analysis techniques.

3.1. Study Sites

To the best of the researcher's knowledge, there was no full-fledged research on financial coping mechanisms in Addis Ababa. Thus, in order to fill these gaps by producing a research focusing on elder women's health-seeking behavior and financial coping mechanism, the study was conducted in Addis Ababa. Bole, Arada, Nefas Silk, Kirkos, Yeka and Akaki Kaliti subcity were the major study places where data collection took place.

3.1.1. Selection of study sites

Initially, the researcher used purposeful sampling and chooses two sub-cities based on their socio-economic status and the number of health facilities, particularly private clinics and hospitals. The choice has helped the researcher to identify relatively wealthy and poor sub cities and avoid bias. According to United Nations Human Settlement Program (2007), and compared to the other sub cities, Bole Sub-city has the highest socioeconomic status. On the contrary, Arada ranks among the poorest sub cities. With regard to number of health facilities, Bole sub- city is reported to have the largest number of private clinics and hospitals and Arada has fewer health facilities, none of which are private facilities (Addis Ababa City Government, 2017, United Nations Human Settlement Program, 2007). Thus, based on the above information, the researcher selected Arada and Bole sub cities as the main study sites.

Using purposeful sampling, two *Kebele*s, *Woreda* 9 from Bole Sub-city and *woreda* 4 from Arada Sub-city were selected based on socio economic status and number of nearby health

facilities. Since qualitative research is limited to small sample size, only two *kebele*s were selected for the study. Thus, one *kebele* with high socioeconomic status and relatively many nearby health facilities (especially private health facilities, in Bole Sub-city), and one *kebele* with low socioeconomic status and few nearby health facilities (especially private health facilities, in Arada Sub-city) were selected

3.2. Research design

The researcher utilized an exploratory research design to carry out a study on health- seeking behavior and barriers in accessing medical care. "Exploratory research" refers to broad ranging, intentional, systematic data collection designed to maximize discovery of generalizations based on description and direct understanding of an area of social or psychological life" (Stebbins, 2008: 327-328). Thus, an exploratory research method was used to obtain quality and depth information and to acquire a new insight that will help identify issues with regard to health- seeking behavior and barriers in accessing medical care of elderly women.

3.3. Data sources

In order to address its objectives, the study has relayed on both primary and secondary sources of data.

3.3.1. Primary data

The study mainly relayed on qualitative data. Therefore, in-depth interview for elderly and key informant interview method was employed to collect and analyze the data needed to address the objectives of the study. Employing these methods can help the researcher to produce appropriate and in-depth information by collecting information from the target population and knowledgeable individuals about the subject under study using both etic and emic perspectives.

3.3.2. Secondary data

The researcher also used secondary data. A number of books, journals, articles and previously conducted researches were used in order to show what is known about health-seeking behavior, access to medical care and financial coping strategies in case of illness.

3.4. Sampling of the study population of elderly women

The researcher had employed purposive and snowball sampling for the selection of the elderly women and key informants. Purposive sampling is a strategy in which an elderly woman was deliberately selected for relevant information she can provide, which cannot be obtained from other sources. (Babbie 2007:165). The rationale behind selecting this sampling method is to focus on particular health-seeking behavioral characteristics of the elderly women, which enables the researcher to address the research objectives. On the other hand, Snowball sampling is a non probability sampling technique where existing/interviewed elders recruit future elders from among their acquaintances. It is also used to identify populations which are hard to identify. Since the elderly group is small in size and hard to find, snowball sampling was suitable (Goodman, 1961).

*Kebele*s were also selected using purposeful sampling. After the selection of the *kebele*s, individual old woman was selected with the assistance of *kebele* officials and health extension workers. After the women were selected and interviewed in both Sub-cities, they were asked to connect the researcher to their peers.

The number of elderly women was decided when the researcher finds that the point of data saturation was reached. The researcher interviewed 60 women from different sub cities in Addis Ababa. From the total participants, 20 were from Bole, 25 from Arada, six from Yeka, four from Akaki, two from Nifas Silk and three from Kirkos sub-cities.

3.5. Key informant interviews

Besides elderly women, key informants were interviewed for triangulation. Key informants were three *kebele* officials and five medical practitioners from both public (Amoraw and Ras Desta) and private hospitals clinics and health centers (Nova and Ephrata),Professionals who work in “Enredada” and “Tesfa” elder people association and help center; one from each were also the key informants of the study. Medical practitioners and NGO workers were interviewed regarding elderly women’s health- seeking behavior and to assess free medical services for poor women and other women, as well as programs for the elderly, and *kebele* officials were interviewed.

3.6. Data collection instruments

In-depth interview guide was prepared for elderly women and key informants. The instrument was prepared based on the objectives of the study after consulting the extant literature. The researcher used less formal and the structured interview guide, in which the wordings of questions were not predetermined.

3.7. Data analysis

Data analysis for qualitative research generally proceeds from data collection to organizing data in some meaningful form and understanding and analyzing data to interpreting and presenting (Creswell, 2003). Interviews and documentations were arranged and organized into files and folders. This involves transcribing interviews, scanning material, typing up field notes, or sorting and arranging the data into different files depending on the source of information.

The data obtained through in-depth interviews was transcribed verbatim and translated from Amharic into English. Each transcript was given a proper identifying label: name of the interviewee, date and place of interview. After reading the transcripts, the researcher coded the words, quotes and sentences.

The codes were entered on a separate sheet and then grouped into different categories in line with the objectives of the study. This helped the researcher to develop thematic areas of the study. This type of analysis is appropriate for the study as it codes and sorts the data into themes and categories by identifying and analyzing repeating patterns in the data (Bauer, 2000). The researcher also told stories by positioning characters in space and time and /or give order to and make sense of what has occurred, why things are the way they are or have become the way they are using narrative analysis (Riessman, 2008).

3.8. Ethical Consideration

The law and code of ethics of research requires researchers to recognize and consider certain injunctions, namely, never to cause unnecessary or irreversible harm to subjects; hence, the need to secure prior voluntary consent whenever possible; and to never release harmful information about specific individuals that was collected for the purpose of the research (Neuman 2007: 50). As a result, the researcher honored the informant's rights to privacy, confidentiality and free will to participate in the research. Before the start of the study, the research objectives and/or the detail of the study including definition of health seeking behavior were presented to all study participants in Amharic language and their consent was obtained in oral form before the interview and the discussion that followed. The researcher has also gained the participant's consent for photo and sound record. To make the participants comfortable, the researcher used pseudo names throughout the whole research.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION OF RESULTS

This Chapter starts with describing the socio-demographic profile of study participants and is followed by four major sections. The first section presents the illness status of elderly women, which is followed by their health-seeking behavior. The next section consists of barriers that deter elderly women from seeking medical care. The fourth section deals with financial coping mechanisms used by the elderly in case of illness. In all sections, in order to include ethic and emic perspective, data generated from in-depth and key informant interview is presented.

4.1. Demographic description of study participants

The study was conducted with 60 elderly women and 10 key informants. All the study participants were above the age of 65, in which 38 of them were in early elderly period, 18 in middle and the rest four participants were found in late elderly period.

The majority of the study participants were found to have lower income in which 14 participants hadno income, 30 participants hadmonthly income below 2000 and 16 participants were found to have monthly income above 2000.

Regarding educational attainment, 28 of the total participants could not read and write. Whereas, 12 participants can read and write but, not get formal education. Other 12 participants had been in elementary school, but not completed. It was also found that seven participants had completed elementary school but never gone to high school. Only one participant had been in high school and not completed. From the total participants, 11 were self employed and the rest 49 were unemployed during data collection.

The majority (24) of the study participants were residents in Bole Sub-city. Participants who lived in Arada Sub-city were 20 in number. The rest two participants were from Nifas-silk, four from Kirkos eight from Yeka and two from Akaki.

4.2. Illness status

The study documented the major health conditions of elderly women. The most common health problems reported by the participants were heart disease, gastric impairment,vision and hearing impairment, physical injuries such as fractures, dislocation and diabetes and hypertension, flu, sore throat, hearing problems and stress. All of the participants reported that they have been and were affected at least by one of these diseases. Forty participants reported that their illness such as heart disease, diabetics, and hypertension were identified by their doctors and the rest 20 participants reported self-diagnosis of hypertension and heart diseases. Other participants also reported that illnesses such as physical injuries, stress, hearing loss, visual impairment, gastric impairment, flu and sore throat were diagnosed by themselves. On the other hand, 10 participants reported gastric impairment to be identified by medical practitioners.

4.3. Health- Seeking Behavior of Elderly Women

The health-seeking behavior of the elderly was presented by assessing the utilization of health facilities and proper utilization of prescription medicine; the paper presented in the following themes and subthemes.

4.3.1. Utilization of Health Facilities

The study found that elderly women were unlikely to go to hospitals and clinics unless they were critically ill. Almost all (55) of the participants went to the hospital or clinics when they thoughtthat their illness was severe. Even though the perception of illness severity varies from person to person and also from illness to illness, the majority (42) of the respondents reported an inability to move or work, inability to chat with family members, loss of appetite,

increased diabetic symptoms and severe fatigue to be the symptoms of severe illness. The rest 18 participants said that high blood pressure and weight loss to be the symptoms of severe illness.

All of the participants reported that their illness plays a major role in visiting or not visiting health facilities. They reported that they don't go to hospitals for illness they consider as mild. Such illnesses include flu, headache, stomach-ache, and sore throat.

For instance, a key informant, who is a laboratory professional from Amoraw Health Center said that:

> *The majority of our clients are younger groups with the age range of 21 to 55. Older people do not usually seek treatment unless they are in a critical condition or have chronic illness. If we see the case history of older patients, most of them came for diabetics and hypertension check-ups and sometimes for urine and cholesterol testing* (Interview with Kibruyisfa Zekirstos, 8 April 2019).

The above findings show that elderly women did not go to health facilities for an illness which they consider as minor. They are more likely to go to health facilities when they think that it is in a sever stage and when it is chronic. Thus, severity and type of illness was the major contributing factor for visiting or not visiting the health facility.

4.3.1.1. Utilization of modern health care facilities

Among the participants, 42 opted to go to modern health care facilitiesfor illnesses such as diabetes, hypertension, visual impairment, hearing loss and gastric impairment.

A. Effectiveness and reliability

Almost all (38) participants reported that modern health care facilities are more effective and reliable than the traditional healers. The effectiveness and reliability make the participants choose modern treatment. Similar to this finding, w/ro Lula said that:

I used to go to traditional healers when I was young. I don't even know the reason, but I stopped going to traditional healers......traditional healers are not reliable. some of them don't even have a proper address... if medical malpractice happens in modern medical centers, you can sue either the doctor or the hospital, but you can do nothing for a traditional healer...the healer can exile to anywhere.... (Interview with Lula Tariku, 9 April 2019).

Another participant who reported modern medical centers to be effective reported as follows.

Practitioners at the hospitals are effective than traditional healers for us (elderly). Because of our age, we are affected by obvious illnesses....and these illnesses are not treated well by traditional healers......if I have visual impairment, the hospitals examine me and order an eye glass, but what can the traditional healer do.... (Interview with Tseganesh Gidey, 8 April 2019).

The above finding shows that reliability and effectives of modern medical centers makes participants choose modern medical treatment for illnesses considered to be severe. This shows that the previous negative attitude towards modern medicine is being changed.

B. Skills

The participants of the study also reported that modern medical practitioners are well trained than the traditional healers. All of the participants said that the skill of modern medical practitioners makes them opt to be treated in modern medical centers. For instance, w/ro Mestawot said:

Practitioners at the modern hospital are better than the traditional healers; at least they have had longer years of education...majority of traditional healers, but not all don't even have proper training...... (Interview with Mestawot Zinabu, 8 April 2019).

The study also found a variation on choice of health centers among participants who choose the modern health facilities. The variation is further presented below in detail.

4.3.1.1.1. Government hospital/clinics:

As mentioned in the previous section, many (42) of the elderly women preferred to visit modern health facilities for treatment. Among these, 40 women used health care services provided by government hospitals. From these 40 participants, 28 said that they wanted to be treated in government hospitals for diseases which need surgery and for non-emergency diseases. The rest 12 participants reported usage of government hospitals for all health problems regardless of disease and treatment type.

The major reason which made participants choose government clinics was the cost. The participants reported that government hospitals are highly cost-effective compared to private hospitals. From the total participants who wanted to be treated in government hospitals, many (30) of them choose government hospitals because of its relative lower cost for service compared to the private one. For instance, W/ro Lakech's argument strengthens this assertion:

> *The cost for the government and private hospitals are incomparable. You can start from card fees. Patients pay 2 Birr for a visit in government hospitals but a minimum of 50 Birr per visit in private hospitals…..imagine how much you need to pay for a surgery in private clinics and I just did a surgery for free in St Pawlos Hospital…..the huge income difference makes me choose the government hospital …unless I do have very urgent illness, I usually go to government clinics* (Interview with Lakech Banteamlak, 12 April 2019).

This finding shows that the cost of the hospital fee was the contributing factor for choosing the type of health facility. Participants choose government health centers and hospitals for an

illness which are considered to have a higher cost. Besides, the nature of the illness was also contributary factor to the choice of hospitals. Non-emergency cases, in which the participants can wait longer hours, might make the participants utilize government health centers. The choice of government hospitals for non-emergency diseases could be due to the higher queue in government hospitals. The complication of the illness could also be a contributory factor for their choice. The participants also opted to be treated in government hospitals for diseases which they consider as complicated and needs surgical treatment. This was due to the higher trust in the skills of practitioners in government hospitals.

Ten other participants also reported that the quality of the service is the major contributory factor that made them choose government hospitals and clinics. In line with this statement, one of the participants said:

> *Doctors in government hospitals don't work for money. They will treat you well…. they don't ask you to give blood or urine if that is unnecessary…. But if you go to a private clinic, they will order different unnecessary laboratory check-up things for money…. I can say the doctors in government clinics are more responsible* (Interview with Mana Leake, 12 April 2019).

The above finding shows that participants of the study believe that government health centers are more trustworthy than private ones and government hospitals focus more on quality service provision than collecting money. Thus, government health centers could be thought of as a center that is both cost and quality effective and are preferred by women of the study.

4.3.1.1.2. Private hospitals and clinics

The study found out that private hospitals were the choice of some (20) participants. All of the respondents reported that private clinics are fastest for every service than the government. These participants said that the private hospitals consume relatively lower time compared to

government ones. Small number (five) of these participants said that they used private clinics for every disease which refer them to hospitals and the rest 15 reported private hospital usage for emergency diseases. Other participants (eight) also said that the doctors in the private center treat patients more than the government one. They reported that the doctors in private facilities treat patients with better respect than doctors in government facilities. For instance, W/ro Bizunesh said:

> *I prefer to go to private hospitals all the time. You have to wait for at least an hour in government hospitals before seeing the doctor, and if the doctor orders a laboratory test, you will stay the whole day at the hospital. But in private hospitals there is no need to wait such a long time……I don't know why but, I think because the doctors in government hospitals work with too many patients, they are not even polite. They mistreat you...* (Interview with Birtukan Shemsu, 9 April, 2019).

The above finding indicates that participants who can afford private clinics could value their time and comfort more than money. Other than money, time was another important factor for participants. In addition, disease type also determines the choice of hospitals among participants. Participants choose to be treated in private hospitals for emergency disease which is due to the faster service compared to the government one.

4.3.1.2. Utilization of traditional health facilities

The studyfurther found out that participants also chose to be treated by traditional healers such as bone setters (*wogesha)* and *merigetas.* The use of home remedy and holy water, holy oil and holy ashas faith healing was also reported by the participants. For instance, among the participants who opted to go to get treated using indigenous medicine when sick, 18 of them went to traditional healers and 26 to faith healers for treatment.

4.3.1.2.1. Traditional healers

Some of the study participants (12) reported that they went to traditional healers such as bone setters (*wogesha)* and *merigetas.* Most of the participants (10) reported that they usually went to traditional bone setters (*wogesha)* for illness such as fracture and dislocation. On the other hand, eight of the participants reported the use of traditional medicine for all type of illness given by the traditional healer. The lower prices and better treatments made these participants choose traditional medicine.

The study also found out that participants shifted from traditional treatment to modern treatment if they are not cured by the traditional. For instance, five participants again reported the use of modern hospitals if they are not cured by traditional healer for diseases other than physical injuries. Only one participant reported the use of modern hospital for physical injuries if she failed to be cured in modern hospital. The rest participants didn't go to modern health facilities even if they were not cured.

A. Lower prices

The finding uncovered that lower price among traditional healers is one reason for visiting traditional healers. This finding revealed that five elderly women opted to use traditional medicine given by traditional healers for illness such as physical injury and chronic disease. Other four participants reported the use of traditional medicine given by traditional healers for hypertension and diabetics. In relation to this statement, W/ro Alem, said that

> *I don't like going to clinics or hospitals when I am sick. If I get severe illness I will first go to traditional healers and take the medicine with holy water …the medicine you take from traditional healers is strong, but because I take it with holy water, it gives me strength* (Interview with Alem Belete, 15 April 2019).

The above finding shows that, even though government health facilities charge low fees, some elderly women opted to use traditional medicine. Thus, besides the cost, other factors appear to influence elderly women's choice. Elderly women also trust the healing power of traditional healers for physical injuries more than other diseases and other treatments. This could be due to the longer years of experiences by traditional healers on treatments of physical injuries.

It also shows that some of the participants used traditional medicine in line with holy water. Some Elderly women don't only use one form of treatment for their illness but use two or more treatments at a time. This could be due to their fear of side effects of the pharmaceutical drugs. They may want one medicine to minimize or eradicate the effect of the other.

B. Curative

Other than the cost of traditional healers, 12 of the participants reported that the healing power of traditional practitioners is better than the modern hospital. The study also found out that nine participants were more likely to go to traditional healers for treatment once they have known their illness either from modern health centers or even discover by themselves. A few numbers of participants (three) also reported using modern medicine after consulting traditional healers and healed. For instance, a participant, who had been infected by breast cancer reported about traditional medicine as follows:

> *I was diagnosed with breast cancer before nine years and the doctors told me to do surgery, but I refused and went to a traditional healer. He gave me such a strong medicine……. After I took that medicine for long, the wound on my breast started to recede and heal. Then, I went to the hospital for a check-up and the doctor told me that there is no cancer* (Interview with Banchi Temesgen, 16 April, 2019).

But, in contrary to this finding, a key informant from Enredada Elderly Help Center said that:

> *Elderly usually want to get treatment from traditional and religious centers. For instance,I remember an occasion in which one elderly mother got a car accident and refused to get treated in a modern hospital. There is no treatment by traditional healers for this kind accidents, but they won't listen to us……there was also other woman who had been infected by breast cancer and started treatment with traditional healer, we tried to convince her to go to modern hospital but she refused, then at the end of the day she died in a such deplorable way* (Interview with Senait Habtom, 13 April 2019).

The finding showed that, elderly women are more likely to go to modern clinics for checkups (without taking treatment) to check what's wrong with them at the time of illness and after treatment to know what happens after they took treatment from different places. This shows that elderly women trust the results given by modern medical centers, but not want to get treated there.

4.3.1.2.2. Faith healing

The study found out that the participants used prayers, holy ash, holy water and holy oil for chronic illness, hearing deficiencies and visual problems, stress and gastric impairment. The majority of the participants (20) went to holy water for illness such as diabetics, cancer and visual impairment. The study also found out that a few participants (four) went to holy water for all types of illnesses. The finding further revealed that some (ten) of the participants preferred holy water alone for treatment and 16 others used holy water together with traditional and modern medicines. For instance, W/ro Bizuye, who opted to use holy water together with modern medicine, said:

> *Holy water is always in my house and whenever I am sick, I drink that and feel relieved. I also go to church every weekend and shower with holy water to be cured*

from my diabetes……I take medicine for diabetes but I also drink holy water every morning and whenever I feel sick (Interview with Bizuye Masresha, 9 April, 2019).

Another participant who used holy water alone said that

I and my husband started using Saint Urael's holy water after my husband was cured from cancer. Initially he started using chemotherapy and he suffered a lot. He lost much weight and he also used to have severe fatigue. Then, he stopped the chemotherapy and started using holy water…. believe me or not he was cured. Since then, our doctor is Saint Urael. We have never been to a hospital since then (Interview with Lelise Mergiya, 12 April, 2019).

The above findings indicate that majority elderly women are more likely to use holy water for chronic illness. Thiscould be due to the fact that, holy water has no side effect. Its religious value is high and there is high trust in its mouth to mouth testimony. Most importantly, a cure or relief from chronic diseases by holy water is considered as a miracle from above. The news, rather testimonies of such miraculous healings could be transmitted from person to person more often and more quickly than the power of modern medicine healing. As a result, Elderly women could hear such testimonies in their social gathering and may be influenced to use.

The finding also revealed that taking holy water also prevents participants from taking their prescription medicine. Among the 50 participants who did not use prescription medicine properly, three of them didn't even take the prescription medicine because they were taking religious medicine and don't want to mix it with the pharmaceutical drugs. For instance, W/ro Azalech reported as follows:

……I have been told that I have asthma and the doctors warned me to use the medicine whenever it starts. But it has been almost 3 years since I stopped using the

medicine. Whenever it starts, I always drink holy water…. I drink not only for asthma but also for other diseases as well. If I take both the prescription medicine and holy water, I believe that God won't heal me (Interview with Azalech Fantaw 22 April, 2019)

This finding indicates that, even though they go to modern medical centers for checkups and take prescription medicine, elderly women don't actually take the medicine. They rather take holy water, holy oil and holy ash.They could take both modern and religious medicines at the same time because of their spirituality and their lack of trust in modern medicine.

4.3.1.2.3. Homemade remedies

The above findings revealed that the use of traditional medicine. Plants such as *Ocimum lamifolium* (basil or *Demakasie*), *Eucalyptus globules* (eucalyptus leaf or *Bahir zaf kitel*), *Lepidium sativum* (Cress or *Feto*), *Zingibel officinale* (ginger), *Hagenia abyssinica* (*Kosso*) , *Coffea arabica Linn, and Altet*(resin) were among the choices of home treatments by the respondents. It was also found that the majority of the participants (50) used home-made remedy before they looked for any form of treatment. Its availability close to their home and its lower cost is the primary reason why many of the participants reported home-made as their first choice. For instance, the participants reported the use of Eucalyptus *globules* (eucalyptus leaf or *Bahirzaf kitel*) for illness such as flu, *Zingibel officinale* (ginger) and *Hagenia abyssinica* (*Kosso*) for stomach ache, *Coffea arabica Linn.* (Coffee) for headache, *Ocimum lamiifolium* (basil or *Demakasie*) for infections with symptoms of fever, such as sore throat. For instance, W/ro Yewubdar said:

I always get well with the medicines prepared in my home. When I have a stomach ache I eat honey with crushed coffee…. I wash my throat with salt and boiled water

when I have sore throat……everything will be cured. I had never been in a hospital except once for an intestinal infection (Interview with Yewbdar Kore, 16 April 2019).

The above argument shows that elderly women t use homemade remedies for common illnesses such as flu, stomach ache and sore throat whose treatments are assumed to be known and for non-chronic diseases. Elderly women also choose to be treated either in modern hospital or by traditional healers for diseases which need surgical treatment. This could be the inability of home remedies to treat surgical diseases.

The study participants (28) also reported that, for chronic illness such as diabetics, they used home-made remedy and other forms of medicine simultaneously. They reported that they used modern medicine prescription by their doctor together with their home medicines. Similar to this finding, another respondent said that:

I always try to cure myself with my home-made medicine…but if it gets worse, I will go to a clinic. Most of the time I am very talented with homemade medicines and cured before seeing a doctor…If I go to hospital, I will use both the medicine from pharmacy and the one prepared in my home (Interview with Hawa Seid, 13 April 2019).

Twelve of the participants also reported that they discontinued using homemade remedies after they started using pharmaceutical drugs. Five of the participants reported that they will stop homemade remedy if it failed to cure them. Otherwise, they will take both medicines simultaneously. Three participants said that they had stopped their homemade treatment after they were told by their doctors and the rest four participants stopped as a result of fear of clash between the modern medicine with homemade remedy.

4.3.1.3. Buying from pharmacies

It was also found that more than half of the participants (49) opted to use medicines bought from pharmacies for mild diseases. Previous experience with the illness and shortage of time were the main reasons for buying medicine without consulting doctor.

4.3.1.3.1. Previous experience with the illness

The finding also revealed that previous experience of the illness is one factor that made elderly women (22) choose medicines bought from the pharmacy. Participants of the study revealed that they used medicines from pharmacies based on prior prescription by the practitioner (17), based on pharmacist's recommendation (one) and recommendation by relatives or friends who have had the illness and cured or know someone with the same illness (eight). For instance, a participant said:

> *…I always buy gastric medicine from pharmacy without consulting a doctor. The medicine was recommended by my sister, who has strong gastric impairment* (Interview with Beletu Kassa April 13, 2019).

On the other hand, another participant who reported usage of medicine bought from pharmacy said that

> *I am a hypertension patient…. I always buy the medicine from pharmacy without consulting a doctor. Since the medicine is the same there is no need to see a doctor whenever I need to buy*(Interview with Tsehay Zeleke April 18, 2019**).**

Another participant who reported the use of medicine recommended by pharmacist said that

> *When I am sick, I usually go to a neighbor pharmacy and tell the symptom for the illness. Then, he will give me the appropriate medicine* (Interview with Netsanet Yimer, 20 April 2019).

The finding shows that elderly women use previous prescription medicine and buy medicines proposed by family members, friends, and even a pharmacist. This could be because of their

need to save time and money which might be spent on hospital. Elderly women could also trust their families and friends equally with their doctors.

4.3.1.3.2. Lack of time

Because of lack of time, eight elderly women bought medicine from a pharmacy without consulting a doctor. The participants reported that they are engaged in domestic work, *iddir*, shopping, social gathering (coffee ceremony, weeding, funerals, *senbete* and *mahber*), church, taking care of spouse and grandchildren. This busy daily routine deters elderly women from seeking medical care. For instance, W/ro Dusit said that:

> *…I wake up early in the morning and go to church on major holidays…when I came back from church, I will start doing the house work with my niece….our iddir is so big that I might be expected to go to funerals and also have to work for the iddir every time….imagine how much time is left for other stuffs….unless I am very ill, I won't go to hospital on this very crowded daily schedule* (Interview with Dusit Taba, 15 April 2019).

In many cases,elderly women seem to be very busy. Whether they are alone at home or with grandchildren, elderly women are burdened with all household activities. Activities such as cooking, cleaning, babysitting and attend social gathering. These and many other activities keep elderly women busy and force them to skip hospitals, and get their medicine from pharmacies. This shows that elderly women could give priority for their children, grandchildren, spouses and even social gatherings than their health.

4.3.2. Taking prescription medicine

The finding reveals that some elderly women took medicine properly and some didn't. Majority of the participants (50) did not take their medicines properly. From these participants, 32 reported that they stopped taking the medicine when they felt better and the

rest 18 of the participants did not even buy the prescription medicine due to lack of trust of modern medicine, shortage of money and lack of interest. For instance, W/ro Hiwot Amare said that

> *I will automatically stop taking the prescription medicine when I fell well. I don't want to harm my intestine by medicine* (Interview with Hiwot Amare15, April 2019).

4.3.2.1. Lack of trust

Among the participants, ten didn't take prescription medicine properly. They did not take the medicine because they did not trust modern medicine.They reported that the modern medicine is full of side effects. Similar to this, W/ro Enat, a study participant said that:

> *As you know when you a take a medicine prescription for one disease, that disease will be cured for a shorter time, but you will get another disease…thus, rather than being ill by two diseases, I prefer to stick with one* (Interview with Enat Lealem,15 April 2019).

The above finding shows that participants don't have sufficient knowledge about modern medicine.

4.3.2.2. Lack of Assistance

It was also found that elderly women (21) were less likely to take prescription medicine unless they were assisted, or even urged to do so by someone. It was reported that 18 women from the total 38 participants living with children, grandchildren and relatives took the prescription medicine properly in close supervision of their children. Regarding assistance to the elderly, W/ro Senayit, a key informant in Enredada reported as follows:

> *We have volunteers and social workers who assist our elders to take their medicine on time. They also set alarms to remind them if they need to take their medicine at night. But if the women consider the medicine as dangerous or if they think they are well,*

they will stop taking the medicine or don't even start it in the first place…..for example, we had an HIV positive patient who used to take the medicine at the beginning, and after some time our social workers started noticing gradual body loss and checked her room, and they found dozens of medicine under her bed….mostly, HIV patients don't take their medicine. They think that HIV is caused by only unprotected sexual intercourse and are ashamed to have the disease at that age. Thus, they are less likely to take medicine (Interview with Senait Habtom, 13 April 2019).

W/ro Ayalnesh Kiros, a participant of the study said that:

My youngest son always supervises me to take my medicine properly. He always reminds me to take my medicine. If he is not home, he will call to check whether I took or not d (Interview with Ayalnesh Kiros, 15 April 2019).

The findings also indicate that elderly women need some kind of assistance to take prescription medicine on time and they also need help to make sure that they have finished the medicine. The other issue with elderly women is that, they may not know which is which when they have a cocktail of prescription medicine.

4.4. Socio-Demographic Barriers

According to the findings of the study, even though the participants wanted to get modern medical treatment, there were some barriers that prevented them from taking medical treatment. These barriers have been categorized as socio-economic barriers, socio demographic barriers and socio-cultural barriers.

4.4.1. Socio-economic barriers

Elderly women were prevented from both visiting modern medical services and buying medicine because of economic and social barriers. The major socio-economic barriers that were found in this study were income, education and occupation.

4.4.1.1. Income

Most elderly women in this study reported to have no or very little income and from the study participants, 14 of them had no income and 30 had a monthly income below 2000 Birr and the rest 16 participants income lies above 2000Birr per month. The participant's pensionwas also very small (ranging from 175 to 300 Birr per month) which couldn't even cover basic needs. Eighteenof the participants obtained pension from the government. As a result of little or no income and pension, most participants faced difficulties in getting adequate medical care. The participants (five) also reported that they rarely visited hospitals even if they were in critical condition. For instance, a key informant from Enredada elderly center also said:

> *…the majority of the elderly don't have enough pension and for those who receive, the pension is little……now the government has started a new safety net strategy, which provides 170 Birr per month for those who don't have pension and are not receiving aid from any organization. If the elderlieshavechildren, they will receive another 170 Birr for each additional person. The maximum money is given for an elderly who live with four people. …. The amount is still small and needs to be corrected* (Interview with Senait Habtom, 13 April 2019).

Similar to the key informant, W/ro Hawa, participant f the study said that:

> *I was affected by kidney infection two years ago and I was healed after I drunk holy water. Now, even though the pain is gone, I wanted to hear from medical doctors how my kidney is. I also have a strong gastric impairment disease and wanted to have a check-up, but my income is not even sufficient to feed my grandchildren…* (Interview with Hawa Seid, 13 April 2019).

The finding shows that even though women wanted to be treated in modern medical centers their income deter them from seeking medical care. Thus, they could go to other cheaper medical treatment places.

It was also reported that nine of the participants did not take prescription medicine properly because their monthly income was not sufficient to buy medicine. Two participants reported that they won't buy prescription medicine if they did not find it in government pharmacies, and five of them said that they rarely bought prescription medicines from private pharmacies unless they their illness was severe. Lakech's statement strengthens this statement. She reported as follows:

> *These days' medical fees are very expensive. To your surprise, they asked me 730 Birr to make a pair of eyeglasses; they also asked a very large amount of money for a tiny medicine… so if medicines are available, I will buy the prescription medicine from government pharmacies. If not, I don't buy the prescription medicine* (Interview with Lakech Banteamlak, 12 April 2019).

Even though government hospitals and clinics provide free medical examination and treatment, since they don't have enough free medicine, elderly women could be forced to go out and buy medicine from private pharmacies. Thus, if their income is small, they are less likely to buy and use the prescription medicine or could use a small dose than the prescription.

4.4.1.2. Education

The finding reveled that the participants have a different educational background. Twenty-eight of them could not read and write, 12 of them did obtain informal education and can read and write, 12 of them had entered to elementary level education, but not completed. Seven of them completed elementary school, and one completed high school.

Among the participants who could not read and write, only one participant went to hospital and took the prescription medicine properly, even for mild illnesses. It was also reported that only one participant went to hospital even if she thought her illness was not severe, but did not take her prescription medicine properly as prescribed by the doctor. Among the seven participants who did not complete elementary school, three of them went to hospital and only two of them took the prescription medicine properly. From the participant who had been in high school, no onewent to hospital for illness considered to be severe. Similar to this finding, a key informant from Tesfa Elderly Help Center said that:

> *Elderly who had obtained modern education in one or another way have better health-seeking than those who don't. Some of them bring their prescription and ask our recommendation to use or not use and even some ask us to see the dose....it is also easy to convince educated elderly to have checkups in modern clinics and take modern medicines* (Interview with Azmeraw Yirga, 11 April 2019).

The finding shows that educational background is important for convincing elderly women to go to modern clinics and take their medicine properly as well. This could be due to their exposure (even though it's small) to health and medical information in school.

Education was also found to be the contributory factor for choice of medical treatment. It was found that from the 28 participants who cannot read and write, 10 of them went to traditional healers for illnesses such as diabetics, hypertension and gastric. On the other hand, five participants who have enrolled in elementary school went to traditional healers for the same disease. Three participants who completed elementary school went to traditional healers.

4.4.1.3. Employment

Employment was also found to be a major contributory factor for health seeking behavior of elderly women. It was reported that elderly women who were self-employed during data

collection were eleven in number and from among those participants two of them went to modern health centers only for severe illness and one of them took her prescription medicine properly. Forty-nine women were unemployed during the data collection time and from those three went to health centers only for severe illnesses, and only one took her medicines properly. For instance, W/ro Bisrat, who sells vegetables in a market reported as follows:

> *... I can't even turn my face from the market. Since I am selling food, which is demanded every time, I have to be in the market all the time and the business is good……the market is full of vegetable sellers and If I close to mine for a day all my customers will meet another seller, so that I can't get them back so... I don't want to close my shop unless it's serious* (Interview with Bisrat Zeleke, 11 April 2019).

On the contrary, another employed participant said that

> *I have to supervise the workers in my restaurant, but whenever I feel my pressure is up, I will go to a pharmacy to check my blood. I also go to a nearby health center sometimes* (Interview with Shewalem Wassie,11 April 2019).

Participants who were employed could have enough money to go to hospital or pharmacies for a checkup as compared to those who are unemployed, but the finding shows that, some participants who were self-employed didn't go to a hospital for a checkup or treatment because they were afraid of losing income or their job when they go to a hospital. This could be due to the very low income generated from their jobs and losing that job could bring even a worse situation. Thus, they could choose treatments which do not require their physical existence or even to buy medicines from pharmacies on their way home.

4.4.2. Demographic factors

The finding revealed that there are also socio-demographic factors that prevent elderly women from taking medical treatment. Those are gender, age, and marital status. All these factors are listed below as follows.

4.4.2.1.Gender

According to the data from key informants, there is a difference in health-seeking behavior between male and female. The study shows that, compared to men, women were less likely to seek medical care and take prescription medicine. For instance, a key informant from Amoraw Health Center reported as follows:

> *The patients who came in our health center are younger ones, but from the older generation, I can say more than half of them are male* (Interview with Fekadu Tale, 27 April 2019).

Another key informant from Tesfa Elderly Help Center also strengthens the above argument:

> *In our organization, elderly males visit medical centers more than females. I think this might be because of their character. For instance, men move more frequently than women and are stronger than their female counterparts. When it comes to illness, men are able to go to clinics by themselves, but women even face difficulties to walk to the taxi station* (Interview with Azmeraw Yirga, 11 April 2019).

Gender was found to be a cause of variation in the need for medical treatment because gender definitely assigns different roles for the sexes in the house. Almost always women are expected to take care of the children and also are responsible for domestic work and have lower chance of seeking treatment. The restriction in the house to take care of family members could also make elderly women weak and prevents them from going out and see a physician if the hospital is far.

4.4.2.2.Age

The study found out 38 participants in early elderly, 18 in middle and four in late elderly period. Among these participants nine participants were affected by heart disease, five of them were in early old age, and four participants were in the middle old age. Among the 15 participants, who were diabetic patients, eight were in the early elderly period, four middle elderly periods and two in late elderly period. On the other hand, two hypertension patients reported to be with the age range of 65 to 75, five in 76-84 and the rest five participants are above 85. On the other hand, from total 51 participants, all participants who were in late elderly period, 14 middle and 33 early elderly period were affected by visual impairment. Hearing problem was also reported in which three, five and two participants are affected and, fall in late, middle and early elderly period respectively. Other participants who reported to be affected by gastric impairmentwere 23 and from this cohort, nine of them were in early elderly period, nine in middle elderly and five in late elderly. Physical injuries were also found to be a common disease found in all participants. This shows that the age of the participants seems to have been related to their disease type. Stress was also reported by six participants in which, equal numbers were observed in all age periods.

It was also found that, women in their late elderly period are less likely to go to hospitals unless they are in a critical condition. Elderly women in their early period have relatively better hospital visiting record and medical intake habit than those in their middle periods.

The finding also shows that elderly women who are in their middle and late elderly period were more affected by chronic diseases. This could be because of their age. The elderly women above the age of 75 could not go to health centers because of frustration. They could think that they are on their way to death and no need to worry about their health. They could not also take their medicine properly because of their age. They could forget to take their

medicine properly as prescription if they are living by themselves or if their children are not with them during medicine intake.

4.4.2.3.Marital status

Twenty sevenof the 38 married participants stated that their spouses support them to enhance their health-seeking behavior by reminding them to take medicine on time, cover medical expenses, buying prescription medicine and taking them to hospital and controlling their diet. The rest eleven respondents said that they never had spousal support or assistance. For instance, W/ro Fantu said that:

> *It's my husband who always forces me to go to the hospital and holy water when I am sick. I used to have a knee problem and he drove me to holy water every morning before he goes to work. He also took me to the hospital whenever needed..... doctors restricted me from eating bread but I sometimes eat bread when I go to other people house, if my husband watches me eating wheat bread, he will kill me...* (Interview with Fantu Abera, 11 April 2019).

Elderly women need someone to be by their side to take them to a hospital and buy and bring medicine to their home. They are usually busy at home and have very limited or no time to go to hospital, and sometimes they also forgot taking their medicine.

4.4.3. Socio-cultural factors

4.4.3.1.Social role

The study also found out that social life is a major deterring factor for health seeking behavior. Elderly women have a busy life in the house as well as outside the home. It has been found that 12 participants did not obtain medical care because they were busy with their household activities and social life. For instance, W/ro Mana reported that:

I am the only person responsible in the house. I have to take care of my ill husband who has been affected by stroke and is paralyzed. Because he may need something, I can't go out for a second. I usually go out from home when my grandchildren came from school. On that time, I have to go to iddir work, funerals and other places….so if I need to go the hospital or somewhere else, my grandchildren should be at home (Interview with Mana Leake, 12 April 2019).

The finding shows that if elderly women are responsible for taking care of the family, especially very old and young ones, they could be busy and give less time for themselves. This shows that, elderly women could give more priority for their family and social life than their own health.

4.4.3.2.Cultural beliefs of illness causation

The study found out that 13 of the participants did not go to the hospital because of social and cultural circumstances. Both religion and culture influence elderly women to ignore the real causes of illness and think of other supernatural causes. This belief about illness causation was found to be one of the factors that prevent elderly women from seeking medical care. Two participants reported that illness was caused by God and can only be healed by him. For instance, W/ro Sindu said that;

We believe that our God, the creator of every one of us is also the creator of illness and he is also the healer. If Allah didn't want you to live, you won't be healed if you go to America to be treated. Everything is based on his will. But if he wants so you will be healed while you are in your bed. So, I and my families usually pray together when someone is sick. If Allah said then he will be healed and if not, the illness will be worse and even may cause the patient to die (Interview with Sindu Fanata, 21 April, 2019).

The study also found out that the participant's perception about the illness is another factor that prevents the participants from seeking medical care. One participant believed that her illness was caused by "buda". She presented her story as follows:

> *I had been affected by "buda" since my early age. I have a strong headache, stomach ache, back ache and more. Whenever I go to the hospital, they tell me that there is nothing wrong, but I know it's the sprit that disturbs me all the time….so it has been almost ten years since I stopped going to hospitals. The doctors don't know that this evil spirit is playing on me…. I know my illness and I will treat it in my own home* (Interview with Lealem Birhan, 12 April, 2019).

In order to minimize misconceptions regarding the causes and treatment of illness, *Woreda* 9 in Bole Sub-city works on health extension program and gives health related training to all people during home visits. The lessons are called the "16 Packages" and are grouped into three categories, namely family health, disease prevention and control, and hygiene and environmental prevention. These three programs are further subdivided into family planning, maternal newborn and child health, nutrition, vaccination, HIV and sexually transmitted infections, tuberculosis, malaria, first aid, construction and maintenance of sanitary latrines, solid and liquid waste disposal, water supply safety measures, control of insects and rodents, food hygiene and safety, personal hygiene and a healthy home environment.

This training is given to each and every willing individual in the *kebele*. W/rt Tena, a key informant in *Woreda* 9, Bole Sub-city said the following regarding this program:

> *We provide various types of health-related training for the community through our health extension workers; they do house to house training about the 16 packages. Our program is aimed at creating awareness about their health …. Surprisingly, I haven't heard of any resistance from elderly women regarding the training. Sometimes the*

health extension workers report resistance from the society, but none of them is elderly women…. we don't have a separate training for elderly women (Interview with Tena Adamu, 15 April 2019).

Most of the training seems to be irrelevant to the elderly. For instance, family planning, maternal newborn and child health, nutrition and vaccination are generally irrelevant to elderly women. Moreover, the following could not also be that relevant to the elderly. These programs are mainly based on prenatal and antenatal care, which are not the concerns or elderly women. Other programs such first aid, construction and maintenance of sanitary latrines, solid and liquid waste disposal, water supply safety measures, control of insects and rodents, food hygiene and safety, personal hygiene and healthy home environment could not be that relevant for the elderly.

4.4.3.3.Cultural and religious norms

The study found out that cultural and religious norms prevent elderly women from seeking medical treatment. For example, 10 of the participants said that they don't want to be treated by male practitioners because of cultural and religious restriction. W/ro Zebiba's statements strengthen this viewpoint. She said:

My religion doesn't allow me to be touched by men other than my husband. Thus, if my illness requires me to take off my clothes, I don't usually go…. When I gave birth to three of my five of my children, I haven't gone to the hospital because I don't want to be seen by male doctors (Interview with Zebiba Lakew, 12 April 2019).

Another participant, who reported cultural restriction of treatment by male practitioner said that:

One day, I had to check my heart and I went to the clinical room in St. Pawlos Hospital. Then, the nurse (female) told me to take off my clothes. There were about

three doctors in the room and there was only one female nurse. When I refused to take off my clothes, I won't forget how the doctor yelled at me ......after that day, I started hating going to hospitals. I may go if serious thing happens ………………I believe that a women's body should be respected and be hidden. That's why God has created clothes. If it is meant to be seen by everybody like our eye or nose, there was no need to wear a cloth……. (Interview with Birke Daba, 12 April 2019).

The finding shows that culture and religion play a prominent role in determining the choice of elderly women in seeking medical care. This could be due to their high attachment to culture and tradition.

4.5. Financial Coping Mechanisms

According to the study, the participants of the study used different financial coping mechanisms for their illness if the study participants opted to be treated in hospitals. They covered their medical expenses by themselves, assistance from relatives and children, community, *kebele* cards or even treated their illness at their home.

4.5.1. Assistance from the community

It was also revealed that the majority of the respondents get support from the community, 40 of the elderly said that they get support from relatives and children, two from *Iddir*, and five from volunteers including from friends, families and donors. Regarding the financial coping, W/ro Kelem said that:

These days life is becoming tough and tougher, and it is impossible to get medical treatment with pension fee…. since my pension fee is not enough and my children are unable to cover my medical fee, one woman from America covers my medical fees. She pays the medical fee for me and some other elderly (Interview with Kelem Moges, 12 April, 2019).

Regarding W/ro kelem's argument, a key informant from Bole Sub-city woreda 9 stated as follows:

> *…we have listed 13 elderly, who are considered to be poor and connected them with a woman who lives in America. She covers all their medical expenses, provides cloth, food and monthly fund…… as you know iddirs also started covering medical expenses for those who are ill* (Interview with Lamrot Tesfaye, 11 April 2019).

The finding shows that even at times when women wanted to go to modern medical centers, they don't actually go and get the treatment because there is no one to help them. Thus, they could end up using only homemade medicines and religious healings.

4.5.2. Kebele card

The study also found out that using *kebele* cards was one of the coping mechanisms. Among the 42 participants who visited modern medical institutions, 31 had *kebele* cards and received medical treatment for free in government hospitals. Regarding the *kebele* card, a key informant from Woreda 7 stated that

> *We provide a card, which helps them to get free medical treatment from government hospitals. We provide this card for those who have proven their poverty by our social workers and other Woreda staffs and for the residents of the woreda…. the woreda also covers health insurance for the poorest of the poor to be treated in government hospitals* (Interview with Lamrot Tesfaye 11, April 2019).

The finding shows that elderly women need free medical card to be treated for free, but if a woman does not have a *kebele* ID card, she won't get free medical service. The other problem is that if an elderly woman is living in a rented house, her chances of having access to *Iddirs* is small which basically means she can't get the support from *Iddirs*. Thus, they could be forced to see cheaper treatments other than government hospital or even free treatment.

4.5.3. Cover costs themselves

The study further found out that eight of the participants covered their medical expenses out of their own pocket**.** The participants reported that they (three) usually saved money in advance for medical treatments and the other five participants reported that used some of their income for medical treatment. For instance, W/ro Bogalech said that:

I and my husband, usually save money for bad times. We won't use that money unless something bad happens, when we are sick, when our close relatives die and so forth (Interview with Bogalech Tamrat 11, April 2019).

4.5.4. Home treatment

Other than *kebele* cards and paying the bills themselves, home treatment was also found to be a coping mechanism. For instance, two of the participants wanted to treat their current illnesses at home. For instance, W/ro Hawa reported as follows:

> *Whenever I feel sick, I will prepare medicine at home…. I couldn't afford the medical fee. They say the government is free, but you have to pay for the medicine and transportation…. unless my illness is very severe, I won't go to hospital.* (Interview with Hawa Seid, 13 APRIL 2019).

The above finding shows that, participants who couldn't afford to cover their medical expenses either by themselves or by others treat their illness at home.

CHAPTER FIVE

SUMMARY AND DISCUSSION

This section presents the finding of the study in comparison with theories and other studies conducted in Ethiopia as well as outside Ethiopia. For instance, the theory of self-regulation describes elderly women as active agents who are engaged in a dynamic process of first assessing health threats and then using problem-solving strategies to address them (Leventhal *et al*., 1980). Elderly women's choice of medical treatment depends on a health threat, which is based on past, present and newly acquired experiences. Education, income, access to resources, and availability of health care might also be factors for the choice of treatment. The self-regulation model captures the influence of the complex interaction between individual and socio-cultural factors on health behaviors (Nerenz and Leventhal, 1983).

Similar to this theory, the study found out that elderly women were mostly affected by heart disease, gastric impairment, vision and hearing impairment, physical injuries such as fracture, dislocation, diabetes, hypertension, flu, head ache, stress, stomach ache and sore throat. Elderly women's decision to seek medical care whether in hospital or somewhere else depends on the impact of each disease, type of treatment and cost. For instance, the study participants were less likely to go to hospitals for mild illnesses such as flu, headache, stomach-ache, and sore throat; they treated such kinds of illnesses at home. Supporting this finding, a study by Thomas (2016) uncovered thatelderly are less likely to visit health centers for the most common illness such as cough, back complaints, shoulder complaints, knee complaints, and dyspnea.

It was found that, when the participants' decision was getting treatment in modern health centers, more than half of them decided to go to hospitals. This is due to the reliability and efficiency of modern medical centers as compared to the traditional healers. Again, more than

half of the participants who chose to be treated in modern hospital opted to be treated in government clinics because of lower cost and good quality of service provided by government hospitals. The rest of the participants who wanted faster service and better treatment went to private hospitals. In line with this finding, a study conducted in South Africa on non-communicable diseases revealed that more than 75% of the study participants opted to be treated in modern medical center, and most of them wanted to be treated in public clinics found in their district (Aboyade, 2016).

Contrary to the above finding, a study in India showed that, when compared to private hospital, very few people went to government hospital (Sowmya, 2017). Such a variation could be explained by differences in wealth and level of pension payments in Ethiopia and India. The other explanation can be that, India is a middle-income country where health insurance coverage is available to a good segment of the population. This might decrease the need to use government hospital.

The present study also found out that some participants wanted to be treated by traditional healers because traditional healers have better treatments especially in physical injuries and have lower prices than modern health facilities. The finding was supported by Marina (2017). One of the findings of the Marina (2017) was that traditional healing services followed by modern health care are the number one and two options of sick women. The study also found out that the participants trusted traditional healers more than the modern medical practitioners.

In contrary to this finding, a study in South Africaand West Bengal found that, majority of the study participants used no traditional medicine at all, and some used lower level of homemade remedy. Family history use, a recommendation from others and cultural belief were the reported reasons for the use of the home- made medicine (Aboyade, 2016, Satyajit

2004). The scope of the study by Aboyade (2016), which focused only on non-communicable disease, may explain why his study's findings show variation with the current study.

The present study also found out the use of home remedy medicine among participants as a first treatment choice. The lower price, recommendation from others and previous experience made the participants choose homemade remedy before any type of medication.

Besides homemade remedy, faith healing practice was also reported by some of the participants. The option of using holy water as faith healing varies among the participants who wanted to use it alone or in combination with other modern medicine. This finding is consistent with other findings in different countries. For instance, a study in India reported that patients with mental illness used faith healing because of its easy accessibility of the service, good reputation, enough time given for consultation, belief in the system of healing and recommendation by someone (Nitin *et al*., 2014). A study in Ethiopia is also consistent with this finding. The study revealed that the elderly Konso in Ethiopia believed illness to be caused by supernatural forces as a result of violation of social norms. Such illnesses caused by supernatural power are believed to be treated by religious and cultural system (Workneh *et al*., 2018).

The health belief model proposes that health-seeking behavior as influenced by societal determinants, such social norms, technology, the health service system; and individual characteristics(Andersen, 1995; Andersen and Newman 1973).Andersen's model suggests that the health needs of elderly women are a function of their predisposition to use services and their ability to access services and their illness level. The actual use of health services is also triggered by needs during illness.

In line with this theory, the current study found income as the major contributory factor and/or barrier for health-seeking. More than half of the study participants reported having

little or no monthly income. The majority of the participants don't have a pension, and to those who have, its amount is not good enough to pay for basic services. The small amount of money in line with little or no pension hinders many elderly women from going to hospitals and even buying prescription medicine.

In line with this finding, a study conducted in Pakistan reported that income was the major constraint for seeking health. According to this study, elderly women were the most vulnerable group, and compared to elderly men, their financial autonomy decreases as they get older. The lower financial autonomy deters elderly women from seeking medical care. It was also reported that limited financial resources coupled with high cost of health care, morally forces the elderly to give health care priorities to younger members of the family skipping theirs (Abdullah *et al*., 2009).

Other study conducted in Japan also found out that low-income elderly women who have a history of missing regular health check-ups are more likely to postpone upcoming checkups or stop receiving health care (Chiyoe *et al*., 2010)**.** This finding was also supported by the intersectionality theory, which describes the effect of discrimination and disadvantages faced by elderly women. The theory asserts that elderly women are often disadvantaged by multiple sources of oppression (being poor and elderly women), which in turn prevents them from seeking medical care (what is intersectionality, 2017).

The current study also found education to be another restricting factor other than income. The finding discovered that uneducated (who can't read and write) people were less likely to go to modern health centers, and compared to those who have elementary grade education it was also found that uneducated people didn't take their prescription medications properly. In line with this finding, Empirical evidence in developed countries implies that education is an important contributory factor of health. Higher educational levels are associated with better health, and reduced morbidity and mortality. A pronounced education gradient in health is

cited in the literature, suggesting that as the level of education increases, so does the likelihood of positive health outcomes (Edwards, 2016). The same finding was obtained in sub-Saharan Africa countries (Zambia, Kenya, Burkina Faso, and Ethiopia). It was reported that education is strongly associated with increased health-seeking behavior among the elderly (Edwards, 2016: 11-12).

In contrast to this view, a study by Frie, Eikemo and Von Dem Knesebeck (2010) examined the health-seeking behavior of elderly populations in 24 developed European countries and found that, lower levels of education is inversely related to increased health-seeking activities. The difference in the finding might be because of the modernization difference between Europe and Africa.

Other than education, the study also found employment status to be associated with health-seeking behavior. Majority of unemployed participants didn't visit the health center and they took prescription medicine properly less frequently than those employed. Similar to this finding, a study in Sweden found that unemployment is associated with a decreased likelihood of going to a health care facility regardless of the need (Ahs *et al*., 2012). But another study in Sweden reported that being unemployed can lead to poorer mental and physical health, which would increase the need of seeing a health practitioner when compared to the employed (Edwards, 2016: 11-13). The association between mental health and employment status might create variation between the findings.

The current study also found out that some women in the study did not go to hospitals because of the fear of losing their income or job. Similarly, data from both developed and underdeveloped countries including those in sub-Saharan Africa suggest that being employed is a deterrent to seeking health care services, particularly among lower socio-economic groups who are fearful of losing employment by taking time off work to go to a clinic or

hospital. In some circumstances, this has resulted in people choosing informal health care providers such as pharmacies who are open late into the night (Caldwell *et al*., 2014).

Socio-demographic factors were also found to be associated with health seeking behavior. Socio- demographic factors play a major role in deterring elderly women from seeking medical care. For instance, a key informant from Tesfa Elderly Center reported that elderly men have relatively better habits of visiting health care centers as compared to women. Elderly women's confinement to the house and thus few opportunities to leave the home was the reported reason. Moreover, a key informant from Enredada Elderly Center reported that female elderly are less likely to take modern medicine properly as compared to male counterparts. She also reported high traditional medicine usage among females than males. This seems to be true because women are exposed to traditional medicine both inside and outside the home.

In line with this finding, Currie and Wiesenberg (2003) reported that, generally, women's access to health care facilities is more restricted than for men. This might be because of the relatively lower socioeconomic status, the lower social value placed on women by culture, as well as their demanding roles as care takers in the household, which make it difficult for them to visit health care facilities during the day when the facilities are open. But studies conducted in Brazil showed that elderly women used medical services more frequently than men, and women regularly visited their doctor for gynecological and obstetric abnormalities. Additionally, women were more aware of health risks than men or their healthy female counterparts because they were more health literate (Caliipe*et al.*, 2013). The variation in the finding is explained by the sharp difference in the level of education between the Ethiopian and Brazilian women where the latter are well educated and give higher priority to their health. The researcher (Caliipe *et al.*, 2013) also compares its ill elderly women with good

women, which might create a variation with this study, which compares sick elderly women with sick elderly men.

The study also found that the social role of elderly women affected their health-seeking behavior. The study further reported that, besides assuming a good part of the house work, elderly women usually take care of their grandchildren and spouses. It is this pretty much busy schedule of the elderly women that prevents them from seeking medical care anytime they want. This finding was similar to a report by MOLSA (2010). It was reported that in spite of being old, elderly women are also shouldering the responsibility of bringing up and taking care of their grandchildren who lost their parents due to HIV/AIDS and other diseases. They do all these without any payment or support and this has made their life much, more busy, difficult and cumbersome, which further delimits the potential of seeking medical care properly (MOLSA, 2010). This finding was also similar to the study conducted in South Africa in which older women play major roles in the social, cultural and economic spheres of their families and communities. This multi-tasking role prevents many of them from seeking medical care as needed (Aboyade, 2016; Aboderin 2010 and McLare, 2014).

The belief about the causes of illness is another major factor that deters elderly women from seeking medical care in modern health facilities. It was found that the elderly are less likely to visit modern health facilities for an illness which they think is caused by supernatural forces, such as human power, and natural power. In line with this finding, another study in Ethiopia and other countries found out that modern treatment is usually low are for diseases perceived to have supernatural causes (Mesfin, 2017: Iffat *et al*., 2016 and Ong, 2015). They all found that religion has an impact on health seeking behavior.

The study further found out that elderly women use various financial coping mechanisms to get medical treatment. It has been reported that elderly Ethiopian women cover their medical expenses by themselves, assistance from relatives, community, *kebele* cards or even treat

their illness at their home. Similarly, a study by Help Age International 2013:Prospe (2010) and Johannes 2012) reported that elderly women used financial resources for medical treatment from their own savings or income, from their sons or daughters, and through loans from "someone" among other relatives, as well as from non-relatives and through begging (Christine *et al*., 2008). But this study didn't find begging and loan to be coping strategies. Another study (Iffat *et al*., 2016) reported that the majority of the participants used health insurance when they were sick and health insurance was found to be the contributory factor for choosing medical treatment. Participants who had health insurance were less likely to use traditional medicine as compared to those who had no insurance. This study didn't find health insurance as a financial coping mechanism for elderly women, and the reason might be that the health insurance industry in Ethiopia is at its infancy.

CHAPTER SIX

CONCLUSION

The study was generally written with the general aim of exploring health seeking behavior of elderly women, specifically assessing the pattern of health-seeking behavior, determining the socio-demographic barriers to access health care by elderly women and examining the financial coping mechanisms elderly women use in case of illness

In order to meet the objectives, the study has employed in-depth and key informant interview methods. A total of 60 elderly women took part in the study through in-depth interviews. Key informant interviews were held with medical practitioners, *Woreda* officials and NGO professionals. Thus, based on the results of in-depth and key informant interview, this section presents summary of the study's major findings and its conclusion. The conclusion is drawn from analysis of the in-depth and key informant interview finding.

The main indicators of health-seeing behavior in the study were utilization of health care services and taking of prescription medicine properly. The finding revealed that majority of the study participants utilized health centers only for severe illness; they got treated in modern health centers if they decided to get treatment. The study also revealed choice variation among participants who opted to be treated in modern medical center. It was found that the majority of the participants choose to be treated in government hospitals due to its relatively low cost, reliability in quality of treatment and the skill of the practitioners. Private hospitals were also chosen by small participants for emergency diseases, for non-surgical diseases and treatments requiring lower cost. Private hospitals were also chosen by participants because of its relative time taking period and customer management skills by the practitioners.

The study also found that participants used traditional medicine such as traditional healers and faith healing practices. Traditional healers were the choice of participants for illnesses

such as fracture and dislocation. It's relatively low cost, and the healing power of traditional medicine made it more attractive to many participants.

The practice of faith healing such as the use of holy water, holy oil, holy ash andprayer was also found to be the first choice of treatment for some participants. Faith healing is usually preferred for chronic disease such as diabetics, hypertension, hearing deficiencies, visual problem, stress and gastric impairment.

The participants also opted to use medicines prepared in their own house. Homemade remedies were found to be the first choice of treatment for the majority of the participants. Participants initially used home treatments for illnesses they considered as mild. Homemade remedies were also used for chronic illness together with modern medicine prescription by a medical doctor. The study also found out that participants went to either modern health center or traditional healers if they are not cured by home made remedy.

It was also indicated that the study participants simply go to a pharmacy and take over the counter medicine without consulting medical practitioner. It was also found that participant's previous illness experience makes them use medicine bought from pharmacy. Lack of time was also reported to be the contributing factor for making the study participants not to consult a doctor. In addition to lack of time and previous illness experience, participants also use medicine based on prior prescription and recommendation by family, friends and even pharmacist.

Improper medicine intake was also reported among the findings of the study. Some of the participants did not take their prescription medicine properly, because they have no trust on modern medicine. Some other participants also reported that they try to avoid modern medicine as much as they can because they are afraid of its side effects. The use of religious treatments such as holy water, holy ash and holy oil was another reason that prevented elderly

women from taking modern medicine. Elderly women do not want to mix religious medicine with other types of medicine. Lack of assistance was also found to be a barrier for taking prescription medicine properly. The participants are less likely to use their medicine unless they are assisted with someone. In addition, if their income is small, elderly women are less likely to buy the prescription medicine and take as prescription.

The study also revealed that there are several barriers that prevent elderly women from going to hospitals and taking prescription medicine. The barriersare categorized into socio-economic, socio- demographic and socio-cultural categories. The participant's socio-economic status like education, income and occupation play a role in health seeking behavior. For instance, income was found to be the major deterring factor of the participant's heath seeking behavior. Because their income is not enough, participants don't go to hospital for mild disease. Income also deters the participants from buying prescription medicine. In addition to income, education was also found to be associated with health-seeking behavior. Participants with better educational background were more likely to seek medical care as compared to the uneducated or less educated. The study also found out that unemployed participants were also less likely to seek medical care than employed.

Socio demographic factors were also found to be other deterring factors. Gender, age and marital status play a significant role in women's health seeking behavior. For instance; being women by itself was one hindering factor from going to hospitals. Women were also more likely to take traditional medicine than men as reported throughout this study. The finding also revealed that married participants had relatively better health seeking behavior than the widowed. Participants who are in the early old age period have relatively better health seeking behavior than those in middle and late elderly period.

The last barrier found in the study was socio cultural barrier. The social role placed on women together with social responsibility makes the life of the elderly very busy. It was

reported that the participants were expected to take care of domestic work, their grandchildren and spouse. They were also expected to attend social gatherings. These kinds of routines make their life busy and hinder them from going to hospital at the time of need.

Belief about illness causation also plays a major role in preventing elderly women from seeking medical care. If the elderly believe that their illness is caused by supernatural power or any other thing contrary to the scientific explanation, the probability of going to hospitals is small and the likelihood of taking prescription medicine is less.

On top of all the many factors mentioned in this study, culture and religion play a significant role in keeping away elderly women from going to hospitals. Because of these two factors, many of the respondents in the study failed to show their body to male practitioners, and they don't want to go to hospital for illnesses that require body showing.

The study further indicated that, the participants also used various financial coping mechanisms to recover from their illness. The participants cover their medical expenses by themselves and get treated in different hospitals. They also ask assistance from the community if they are unable to cover their cost. They get support from their *iddir,* relatives, children and volunteers. In addition, the government distributes *kebele* cards in its attempt to provide free medical treatment for those who can't cover their medical expenses. The study participants were beneficiaries of such services. The study also found out participants who wanted to treat their illness at home rather than going to modern hospitals.

The study also found similar explanation from theories of the health belief model, intersectionality theory and social support theory. All the theories were similar to the finding of the study. For instance, health belief model states that socio demographic, socio economic and cultural factors affect the health seeking behavior of elderly, in which, the same result was found by the current study**.** Health belief model also states that severity of the illness is a

main factor for health seeing behavior. Similarly, the study also found out that severity of illness is a contributory factor for health seeing behavior of elderly women. Lastly, social support theory also states that social support from different sources protects elderly women from health hazards which was supported by the finding that the support elderly women receive makes them visit health centers.

6.1. Recommendations

The study found out that elderly women don't have sufficient income to cover their medical expenses. It was also found out that elderly women are less likely to go to hospitals and take prescription medicine as a result of lower income. In order to minimize this, the government should strengthen the free medical service program in good quality and quantity.

The probability of getting sick increases as people gets old. Hence, illness and age are directly related. This direct relationship between old age and illness can positively be influenced if government and private clinics design a program that provides free and/or cheap medical checkups and treatment to the elderly on a regular basis. It would also be better if medical practitioners give regular minor checkups for elderly.

The study further uncovered that elderly are affected by hearing and vision problem as a result of their age, but the government doesn't provide free eye glasses and hearing correctives devices. It would be better if the government works with the Non-Governmental Organizations to provide hearing and vision corrective equipment for free to the poorest of the poor and with relatively fair price for those who can afford.

In order to see qualitative change in health seeking behavior of elderly women, the government should increase the amount of pension payments for those who have been in the system and strengthen the safety net program and provide some amount of financial aid on the regular basis for those don't have pension.

The study also found out that elderly women are less likely to take prescribed medicine unless assisted by someone. Thus, Non-Governmental Organizations should train and promote volunteers to help lonely elderly women take their prescription medicine properly.

Utilization of modern health services by of elderly women would also be higher if concerned agencies such as *woredas* provided regular training and awareness creation programs on the causes of major illnesses and their treatment. Learning with the same cohort on similar illness might create noticeable and better result than learning with other cohorts on different issues.

Religious institutions should also teach their adherents to take the religious medicine simultaneously with the prescription modern medicine so that the probability of taking prescription medicine would increase.

References

Abdullah, L., Romaisa , S., Awais, M and Sana, F. (check all references that there is a space between the last name and the initial; see the Aboyade reference for example) (2009).The health seeking behavior of elderly population in a poor-urban community of Karachi Pakistan. *journal of the Pakistan Medical Association* 59(2):89-92 (Retrieved on May 22, 2019 from:

https://www.researchgate.net/publication/24176669_).

Aboyade, O., Beauclair,R., Mbamalu,. Puoane.T and Hughes,G. (2016).Health-seeking behaviors of older black women living with non-communicable diseases in an urban township in South Africa. *BMC Complement Altern Med.* (2) 16: 410. (Retrieved on May 22, 2019 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5078908/).

Addis Ababa City Government. (2017). *Report on Sub Cities.* Retrieved on March 9, (2019) from http://www.addisababa.gov.et/vi/web/guest/yeka-sub-city

Addisu, T and Mengistu, L. (2014). The urban poor and health-seeking behavior: the health care seeking behavior of the 'Poorest of the Poor' in Addis Ababa, Ethiopia. *Global Journal of Human Social Science.* 14(6).

Ahmed, S., Chowdhury, M. and Bhuiya, A. (2001). Micro-credit and emotional well-being: experience of poor rural women from Matlab, Bangladesh. *World Developmentjournal*. 29(11), 57—66.

Ahs, A., Burell, G., and Westerling, R. (2012). Care or not care—that is the question: predictors of health care utilization in relation to employment status. International Journal of Behavioral Medicine. 19(1), 29-38.

Akosua, A. (2014). "Survival Strategies of the Elderly in Rural Ghana." BA. Thesis, University of Ghana.

Amarech, G. (2007). "Challenges of Health care Financing: Economic and Welfare Effects Of User Fees in Urban Ethiopia." MA. Thesis, Addis Ababa University.

Anagaw, D., Ellen, V., Degnet, A. and Zelalem, K. (2014). Health care-seeking behavior in rural Ethiopia: evidence from clinical vignettes. Journal of public medicine. 4(2),77-92. Retrieved on February, 2 from

https://www.researchgate.net/publication/260195331_Health care seeking behavior in rural Ethiopia Evidence from clinical vignettes

Archana, S., Alice, G., Jane, F., Martin, S., Pekka, M., Sebastien, B., Marcel, G. and Michael,M. (2008). Gender differences in the association between morbidity and mortality among middle-aged men and women. American Journal Public Health. 98(12), 2251–2257.Retrieved on January 9, (2019) from https: 10.2105/AJPH.(2006).107912

Aurelie, M. (2010). "Health Care Seeking Behavior in Webuye, Kenya". MA. Thesis, Unversiteit Gent:

Babbie, E. (2007). *Research Methods in Sociology.* Australia: Cenagage Learning.

Bauer, W. (2000). *Classical Content Analysis: A Review in Qualitative Researching with Text, Image and Sound*. London: Sage.

Birhanu, Z., Abdissa ,A., Belachew, T., Deribew, A., Segni, H., Tsu, V., Mulholl, K. and Russell, M. (2012). Health seeking behavior for cervical cancer in Ethiopia: a qualitative study. *International Journal for Equity in Health.* **11**(83) Retrieved January 10, (2019) from

https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-11-83).

Blais, R. (2000). Changes in Characteristics of CAM Users over Time. In: Kelner, M., Wellman, B., Pescosolido, B., Saks, M., editors. *Complementary and Alternative Medicine: Challenge and Change.* Amsterdam: Harwood Academic Publishers

Buowarib, Y. (2013). Diabetic mellitus in developing countries and case series. *Journal of Diabetic Mellitus Insight and Perspective*, 131-148.

Caliope, P., Mario, U., Menon, T. and Aidar, D. (2013). Health services use among elderly people living in the community. *Journal of Revista da Escola de Enfermagem*, 47(1) Retrieved on December 1, (2018) from:

http://www.scielo.br/scielo.php?pid=S008062342013000100027andscript=sci_arttextandtlng=en

Caldwell, K., Rashid, F., and Murthy, S. (2014). The informal health sector and health care seeking behavior of mothers in urban Dhaka slums. Journal of Population Research, 31(2),111-129.

Chiang, S., Gerten, E, and Richter, H. (2009). Pharmacologic management of the older women undergoing surgery. PMC Womens Health, 5(2), 205–219. Retrieved January 9, (2019) from http: 10.2217/17455057.5.2.205.

Creswell, W. (2003). *Research Design: Qualitative, Quantitative and Mixed Approach. (2nd ed.).* India, New Delhi: Sage Publication.

Currie, D. and Wiesenberg, S. (2003). Promoting women's health-seeking behavior: research and the empowerment of women. *Journal ofhealth care woman int,* 24(10), 880-99.

Debra, A. (2006). Indigenous healing practices among rural elderly African Americans. *International Journal of Disability, Development and Education,* 53(4), 433–452

Dole, J., Rhyne, L. and Zeilmann, A. (2000). The influence of ethnicity on use of herbal remedies in elderly Hispanics and non-Hispanic whites. *Journal of America Pharmaceutical Association,* 40:359–365.

Edwards, T. (2016) "Socio-Demographic Determinants of Health-Seeking Behavior among The South African Population: An Analysis of NIDS". MA Thesis, University of KwaZulu-Natal.

Encyclopedia. (1998). *A Dictionary of Sociology.* Oxford University Press. Retrieved on December, 12 (2018) from https://www.encyclopedia.com/history/united-states-and-canada/us-history/voluntarism

Ethiopian Society of Population Studies. (2008). *Gender Inequality and Women's Empowerment: In-Depth Analysis of the Ethiopian Demographic and Health Survey*. Addis Ababa

The Federal Democratic Republic of Ethiopia. (1999). *Report on the (1998) Health and Nutrition Survey.* FDRE, Central Statistical Authority, Addis Ababa.

The Federal Democratic Republic of Ethiopia. (2006). *National Plan of Action on Older Persons.*Ministry of Labor and Social Affairs, Addis Ababa.

Foster, M. and Andersen, G. (2005). *Medical Anthropology*. John Wiley and Sons Inc. USA.

Frie, G., Eikemo, A. and Von, K. (2010). Education and self-reported health care seeking behavior in European welfare regimes: results from the European Social Survey. *International Journal of Public Health, 55*(3), 217-220.

Geofrey, S., Fred, N.,Jean-Pierre V., Rhoda, K., Wanyenze, L and Hilde, B. (2018). Factors influencing compliance and health-seeking behavior for hypertension in Mukono and Buikwe in Uganda: A qualitative Study. *International journal of hypertension,* 1,1-13 Retrieved December 9 from https://www.hindawi.com/journals/ijhy/2018/8307591/

Global Report on Human Settlements. (2007). *Enhancing Urban Safety and Security*. https://www.un.org/ruleoflaw/blog/document/global-report-on-human-settlements-2007- enhancing-urban-safety-and-security/

Goodman, A.(1961). Snowball sampling. *Annals of Mathematical Statistics*, 32, 148-170.

Grosse, N. and Auffrey, C. (1989). Literacy and health status in developing countries. *Annual Review of Public Health*, 10, 281-297.

Guba, E. and Lincoln, Y. (1994). *Competing Paradigms in Qualitative Research. Handbook of Qualitative Research.*ThousandOaks, CA: Sage.

Hailemariam, S., Tessema, F., Asefa, M., Tadesse, H., and Tenkolu, G. (2012). The prevalence of depression and associated factors in Ethiopia: findings from the national health survey. *Int J Ment Health Syst*, 6(1), 23.

Hayelom, M. (*2018).* The socio-economic factors that promote maternal health-seeking behavior among Ethiopian rural women: the case of Raya Alamata district. *Journal of Anatomy andPhysiology*, 8(3), 302. Retrieved December 5, (2018) From https://www.omicsonline.org/open-access/the-socio-economic-factors-that-promote-maternal-health-seeking-behavior-among-ethiopian-rural-women-the-case-of-raya-alamata-dist-2161-0940-1000302-103370.html)

Help Age International. (2010). *The Living Conditions and Vulnerability of Poor Urban Older People in Addis Ababa*. Addis Ababa. Unpublished paper.

Help Age International. (2013). *The State of Health and Ageing in Ethiopia: a Survey of Health Needs and Challenges of Service Provisions*. Addis Ababa: Central Printing Press.

Holman, D. and Borgstrom, E. (2015). Applying social theory to understand health-related behaviors. *Journal of Medical Humanities,* 5, 81-94.Retrieved January 22, (2019) from https: prints.whiterose.ac.uk/91353/3/WRRO_91282.pdf

Honebein, P. (1996). *Seven Goals for the Design of Constructivist Learning Environment.*

Wilson, Brent. G. (Ed.). Constructivist Learning Environments: Case Studies in Instructional Design. Educational Technology Publications. Englewood Cliffs, New Jersey.

Institute of Medicine. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington: National Academies Press.

Jane, R. and Jane, L. (2003). *Qualitative Research Practice: A Guide for Social Science Students and Researchers.* London: Sage Publications.

Johannes, D. (2012). "Health care Seeking Behavior, Barriers in Accessing Medicines, and Coping Strategies in Africa: Evidence from Koboko District". Master's Thesis. Uganda

Jupp, V. (1989). *Methods of Criminological Research*. USA: Routledge.

Kahwa, J. (2009). "Health-Care Seeking Behavior among Terminally Ill Adults in Addis Ababa, Ethiopia." MA Thesis. University of the Witwatersrand.

Keene, J. (2005) and Li, X. (2005). Age and gender differences in health service utilization. *Journal of Public Health (Oxford)*. 27(1):74-9. 28

Khattab, H., Younis, N., Zurayk, H. and Mahaini, R. (2008). Improving maternal health to achieve the millennium development goals in the Eastern Mediterranean region: a youth lens. *Eastern Mediterranean Health Journal*. 12(4) 97–106.

Kishor, S. (2005). A *Focus on Gender: Collected Papers on Gender Using DHS Data.* Calverton: ORC Macro.

Kloos, H., Etea, A., Degefa, A., Aga, H., Solomon, B., Abera, K. and Abegaz, A. (1987). Illness and health behaviour in Addis Ababa and central Ethiopia. *Social Science and Medicine* 25:1003-1019.

Kloos, H., Hailemariam, D., Kaba, M. and Getnet, T. (2013). Traditional medicine and HIV/AIDS in Ethiopia: herbal medicine and faith healing. *Ethiopian Journal of Health Development*. 27:141-155.

Koch, L. (2006). Help-seeking behaviors of women with urinary incontinence: an integrative literature review. *J Midwifery Women's Health*. 51(6) 39-44. Retrieved February 23, (2019) fromhttps://www.scienciddirect.com/science/article/pii/S1526952306003242

Larkin, M**.** **(**2013). *Health Inequalities in the Older Population. Health Variations*: *Health and Well-being across the Life Course*. London: Sage.

Leventhal, H., Meyer, D. and Nerenz, D. (1980). The common sense representation of illness danger. *Journal of Medical Psychology*. New York: Pergamon Press. 2(1) 7–30

Loera, J. Black, S. and Markides, K. (2001). The use of herbal medicine by older Mexican Americans. J *GerontolA Biol Sci Med Sci,* 56(11):714–718.

Mahaini, R. (2008). Improving maternal health to achieve the millennium development goals in the Eastern Mediterranean Region: a youth lens. *Eastern Mediterranean Health Journal* 12(4) 97–106.

Makinen, M., Waters, H., Rauch, M., Almagambetova, N., Bitran, R., Gilson, L., McIntyre, D., Pannarunothai, S., Prieto, A., Ubilla, G. and Ram, S. (2000). Inequalities in health care use and expenditures: empirical data from eight developing countries and countries in transition. *Journal of world health Organ,* 78(1):55-65.

Manmeet, K., Suninder, K., Sodhi, R., Parampreet, K., Jasmik, S and Rajesh, K. (2013). Gender differences in health care seeking behavior of tuberculosis patients in Chandigarh. *The Indian Journal of Tuberculosis*, 60(4):217-222Retrieved December 6, (2018) From http://medind.nic.in/ibr/t13/i4/ibrt13i4p217.pdf

Marmot, M. (2004). The Status Syndrome: How Social Standing Affects Our Health and Longevity. New York: Owl Books.

Marmot, M. (2010). Fair *society, health lives: The Marmot Review Executive summary: Strategic Review of Health in England*. Sage publications. Retrieved January 9, (2019) from http:// fair-society-healthy-lives-executive-summary.pdf

Mary, M. and Mutinda, K. (2010). *Social Protection Status in Developing Countries: The case of Kenya.* ERD Regional Conference on Promoting Resilience through Social Protection in Sub-Saharan Africa. Nairobi.

Matthews, D. (2015b). Sociology in nursing, how gender influences health inequalities.

Nursing Times; 111 (43), 21-23.

McCracken, K. (2012). *Global Health: An Introduction to Current and Future Trends*. London: Routledge.

Medhin, G. (2009). An assessment Report on the Care, Support and Treatment of Older People in Southern Nations Nationalities and People's Regional State (SNNPRS). Unpubished.

Menard, J., Mulfinger, C and Estrade, J. (2008). Pelvic organ prolapse surgery in women aged more than 70 years: a literature review. *Gynecology, Obstetrics and Fertility*, 36:67–73

Menberu, M., Mekonen , T., Azale, T., Ayano, G., Yimer, S., Getnet, A., Belete, A., Kerie, S. and Fekadu, W. (2018). Health Care Seeking Behavior for Depression in Northeast Ethiopia: depression is not considered as illness by more than half of the participants. *BMC Journal*. 17: 34-44. Retrieved January 25, (2019) from https://annals-general-psychiatry.biomedcentral.com/articles/10.1186/s12991-018-0205-3

Metadel, A., Bezatu, M., Worku M., Kloos, H. and Girmay M. (2017). Utilization of health facilities and predictors of health-seeking behavior for under-five children with acute diarrhea in slums of Addis Ababa, Ethiopia: a community-based cross-sectional study. *Journal of Health Population and Nutrition,* 36: 9.

Mollaoglu, M. and Aciyurt, A. (2013). Use of complementary and alternative medicine among patients with chronic diseases. *Acta Clinica Croatica*, 52(2): 181-188.

Mohamed, B. and Salih, M. (2014). Herbal medicine use among patients with type 2 diabetes in North Sudan. Annual Research and Review in Biology, 4(11): 1827-1838

Moshabela, M., Dominic, B., Gabriel, D., Joyce, W., Estelle, M., Morten, S., William, D.,

Kenneth, O., Oliver, B., Janet, S., Victoria, H., and Alison,W. (2017). Traditional healers, faith healers and medical practitioners: the contribution of medical pluralism to bottlenecks along the cascade of care for HIV/AIDS in Eastern and Southern Africa. Sex Transm Infect. 93(3) Retrieved January 18, (2019) fromhttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC5739844/

Mushi, D., Rongai, A., Paddick, S., Dotchin, C., Mtuya, C and Walker, R. (2014). Social representation and practices related to dementia in Hai District of Tanzania . *BMC Public Health.* 14: 260.

Neme, A. (2018). Assessment of factors influencing health-seeking behaviors of elderly in Bilida Kebele, Manna Woreda, Jimma Zone, South West Ethiopia. *Journal of Public Health and Disease Prevention,* Rift Valley University, Department of Nursing, Ethiopia, 1: 103-112

Nerenz, D, Leventhal, H. (1983). Self-regulation theory in chronic illness. Coping with chronic disease research and applications. New York: Academic Press. *Ann Gen Psychiatry.* (2)13–37 (Retrieved on January 27, (2019) from doi: 10.1186/s12991-018-0205-3).

Nitin, M, Sajanjiv, S, Rakesh, K. , and Mamta, S. 2011.Help-seeking behavior of patients with mental health problems visiting a tertiary care center in north India.Indian J Psychiatry. 53(3): 234–238((Retrieved on May 24, 2019 from http://10.4103/0019-5545.86814).

Obasi, Z. (2013). "A Review of the Barriers and Socio-Cultural Factors Influencing the Access to Maternal Health Care Services in Nigeria." MA. Thesis, Helsinki Metropolia University of Applied Sciences: Helsinki.

Oyebode, O. (2016). Use of traditional medicine in middle-income countries: a WHO-SAGE study. *Health Policy and Planning*. 8(1) 984–991. Retrieved February 18, (2019) from https://doi.org/10.1093/heapol/czw022

Population Reference Bureau. (2007). *Gender Disparities in Health and Mortality*. Washington, DC,

Riessman, C. (2008). *Narrative Methods for Human Sciences*, London, England: Sage

Ronald, M. (1995). Revisiting the behavioral model and access to medical care: does it matter? *Journal of Health and Social Behavior.* 36(1):1–10. Retrieved November 27, (2018) from: http://dx.doi.org/10.2307/2137284

Ronald, M. and John, F. (1973). Societal and Individual determinants of medical care utilization in the United States. *Journal of Health and Social Behavior*. 51(1):95-124.

Rouse, J. (2007). "Practice Theory". Division I Faculty Publications. Retrieved February 5,(2019) from https://pdfs.semanticscholar.org/ced8/8f76388295cf061e740d13a93abb36a08262.pdf

Sarina, P., Alivia, M. and Guadagni, P. (2012). Traditional complementary and alternative medical systems and their contributions to personalization, perdition and prevention medicine-person centered medicine. *A Journal of Predictive, Preventive and Personalized Medicine*, 3(15): 1-10.

Samuel, L. Yohannes, S and Habtu, Y. (2018). Health-Seeking Behavior and Associated Factors Among a Community in Southern Ethiopia: Community Based Cross-Sectional Study Guided by Health Belief model. Department of Nursing, Hosanna College of Health Sciences, Hosanna, Ethiopia.

Schilp, J., Kruizenga, H., Wijnhoven, H., Leistra, E., Evers A. and vanBinsbergen J.(2012). High prevalence of under-nutrition in Dutch community-dwelling older individuals. *Journal of Public Medicine*. 28:11-17

Sharma, D., Mazta, S. and Parashar, A. (2013). Morbidity pattern and health-seeking behavior of aged population residing in Shimla Hills of North India: A cross-sectional study. *Med Prim Care, 5*(2), 1-15.

Shivan, K. 2014. Ethical issues relating to faith healing practices in South Asia: a medical perspective. Journal of Clinical Research and Bioethics, 5(4): 605-607 Retrieved December 7, (2018) fromhttps://www.omicsonline.org/open-access/ethical-issues-relating-to-faith-healing- practices in-south-asia-a-medical-perspective-2155-9627.1000190.php?aid=30578).

Smith, J. (1983). Quantitative versus qualitative research: An attempt to clarify the issue, *Journal of Educational Research*, 12(3) 6-13.

Solomon, G. (2017). "Assessment of Concomitant Use of Herbal and Conventional Medicines among Patients with Diabetes in Public Hospitals of Addis Ababa, Ethiopia." MA. Thesis, Addis Ababa University:

Sowmya, B and Saurabh K. 2017. Study on health care seeking behavior among elderly in rural area. *Int J Med Sci Public Health.*6(2): 350-352 (Retrieved on May 23 2018 from: http://10.5455/ijmsph.2017.26072016621).

Stebbins, R. (2008). *Explanatory Research*. The Sage Encyclopedia of Qualitative Research Methods (Vol 1and2). Los Angeles: Sage Publications.

Taffa, N. and Chepngeno, G. (2005). Determinants of health care seeking for childhood illnesses in Nairobi slums. *Trop Med Int Health.*10(3):240-5.

Tesfaye, A. (2003). "The Demand for Curative Health Care in Jimma Town: Choosing Between Health Care Providers". MA. Thesis, Addis Ababa University.

Thomas, F., Jarmila, M., Tobias ,D, and Hagen, S. (2016). For elderly patients GP visits: results of a cross-sectional study.*journal of Clin Interv Aging*. 11: 127–132

Twumasi, P. (1975). *Medical Systems in Ghana.* Tema: Ghana Publishing Corporation.

Usifoh, S. and Udezi, A. social and economic factors influencing the patronage and use of complementary and alternative medicine in Enugu.*Journal of pharmacy and bioresources. 10(*17-24) Retrieved on January 09, (2019) from https://www.researchgate.net/publication/315627467

Vegda, K., Nie, X., Wang, L., Tracy, S., Moineddin, R., and Upshur, R. *(*2009). Trends in health services utilization, medication use, and health conditions among older adults:

a 2-year retrospective chart review in a primary care practice. *BMC Health Services Research*; 9:217.

Waweru, L., Kabiru, E. and Mbithi, J. (2003). Health status and health-seeking behavior of the elderly persons in Dagoretti Division. *East African Medical Journal,* 80: 63-7.

Wilkinson, R and Marmot, M. (2003). *Social Determinants of Health: The Solid Facts. Copenhagen:* World Health Organization.

What is intersectionality, and what does it have to do with me? (2017). Retrieved on January 9, (2019) fromhttps://www.ywboston.org/2017/03/what-is-intersectionality-and-what-does-it-have-to-do-with-me/

WHO (2002). Health Statistics and Information Systems: Proposed Working Definition of an Older Person in Africa for the MDS Project. World Health Organization. Geneva.

Workneh, T.,Emirie , G., Kaba, M., Mekonnen, Y. and Kloos, H. (2017). Perceptions of health and illness among the Konso people of southwestern Ethiopia: persistence and change. *Sex Transm Infect.* 93(3) Retrieved on January 18, (2019) from https://link.springer.com/article/10.1186/s13002-018-0214-y

Yitagesu, H., Samuel, Y. and Tariku, L. (2018). Health-Seeking behavior and its determinants for cervical cancer among women of childbearing age in Hossana Town, Hadiya zone, Southern Ethiopia: community based cross sectional study. *Journal of BMC Public health*. 12(5):44-56 Retrieved on December 17, (2018) from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5857120/

Zabidah, I., Rafeezul, M., Mohd, H., and Kamaruzaman, W.(2005). Usage of traditional medicines among elderly and the prevalence of prednisolone contamination. *Malaysians journal of medical medicine*. 12(2): 50–55. Retrieved on December 6, (2018) from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3349401/

Zinawe, M., Yemane, B, and Dawit, D.(2018). Health-seeking behavior of patients diagnosed with cervical cancer in Addis Ababa, Ethiopia. *Ethiopian journal of health science,*28(2): 111–116. Retrieved November 25, (2018) from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6016345/

Yitagesu, H., Samuel, Y. and Tariku, L. (2018). Health-Seeking Behavior and its Determinants for Cervical Cancer Among Women of Childbearing Age in Hossana Town, Hadiya zone, Southern Ethiopia: community based cross sectional study. (Retrieved on December 17 fromhttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC5857120/)

Zabidah, I., Rafeezul, M., Mohd, H., and Kamaruzaman, W.(2005). Usage of Traditional Medicines Among Elderly and the Prevalence of Prednisolone Contamination. *Malaysians journal of medical medicine*. 12(2): 50–55. (Retrieved on December 6 (2018) from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3349401/)

Zinawe, M., Yemane, B,and Dawit, D.(2018). Health-seeking behavior of patients diagnosed with cervical cancer in Addis Ababa, Ethiopia. *Ethiopian journal of health science,*28(2): 111–116. (Retrieved on November 25, (2018) from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6016345/)

Appendix A. Interview Guide for elderly women

Good morning/afternoon!! First of all, I would like to thank you for your time. My name is Tensae Deneke. I am a student of sociology in Addis Ababa University and I am conducting a study on elderly women's health. I would like to thank you in advance for meeting me today. I am here to kindly request you to participate on the interview, from which a thesis entitled "Health seeking behavior and barriers in accessing medical care" will be formulated.

In our discussion, my aim is to study the health seeking behavior of elderly women, barriers in accessing medical care and the financial coping mechanism. Health seeking behavior is studied by asking few questions on your need to utilize health care and take prescription medicine. The interview would not take more than an hour. If you agree, I will be recording your voice. Since I will use Anonymous name, any information I include in my report does not reveal your personal identity. Besides, everything would be kept confidential and only used for writing report. If you feel uncomfortable, you have a right not to answer the whole or part of the question when you feel like. Thank you!!

A. IDENTIFICATION

1. Interview date

2. Starting time

3. Termination time

1. Demographic information

1.1. Age

1.2. Marital status

1.3. Level of education

1.4. Income

1.5. Occupation

1.6.Sub-city

1.7. *kebele*

2. General questions

1. Illness type (Probing question: Do you have any health problem? If yes, what are those problems?)
2. Whom do you live with?

OBJECTIVE ONE: TO DETERMINE THE PATTERNS OF HEALTH-SEAKING BEHAVIOR BY ELDERLY WOMEN

1. Health seeking behavior (Probing questions: when you have a health problem, what measures do you take? Where do you choose to get treatment? Do you do regular checkups? If not, what do you think is the reason? If yes, how often? For what types of diseases do you immediately go to hospital? Do you buy the prescribed medicine as prescribed by the doctor? If no, why? Do you take the prescribed medicine properly? If you are living with your children/relatives, do they help you to take your medicine?)
2. Type of treatment (Probing questions: where do you usually get treatment when you are sick? For what kind of disease do you go traditional healers? Why do you choose traditional healers for these diseases? For what kind of disease do you go to modern medical care? Why do you choose traditional healers for these diseases? For what kind of disease do you go to religious medicine? Why do you choose traditional healers for these diseases?)
3. What is your first choice of treatment? Why?
4. Choice of modern medical institution (Probing questions: where do you usually get treatment when you are sick? Can you please tell me the reason for that? For what kind of

disease do you go to government health centers? Why? For what kind of disease do you go to private health centers? Why?)

OBJECTIVE TWO: TO ASSESS THE SOCIO-DEMOGRAPHIC BARRIERS TO ACCESS HEALTH CARE BY ELDERLY WOMEN

1. Economic status (Probing questions: what challenges do you encounter in accessing medical care? Can you tell me about your income? Do you think your income is enough to cover your medical expenses? If not, what do you do to get treated?)
2. Marital status (Probing questions: how long have you lived together with your spouse? Does your spouse help you to go to health centers? If yes, How? How about in taking your prescribed medicine?)
3. social role (Probing questions: what is your specific role in the house? Can you please tell me what you always do in your daily routine? Do you think this has affected your health seeking? If yes how?)

OBJECTIVE THREE: TO EXAMINE THE FINANCIAL COPING MECHANISMS OF ELDERLY WOMEN USE IN CASE OF ILLNESS

1. Financial coping during illness (Probing questions: how do you cover your medical expenses when you decide to get treated in government hospitals?)

Appendix B. Interview Guide for medical practitioners

Good morning/afternoon!! First of all I would like to thank you for your time. My name is Tensae Deneke. I am a student of sociology in Addis Ababa University and I am conducting a study on elderly women's health. I would like to thank you in advance for meeting me today. I am here to kindly request you to participate on the interview, from which a thesis entitled "Health seeking behavior and barriers in accessing medical care" will be formulated.

In our discussion, my aim is to study the health seeking behavior of elderly women, barriers in accessing medical care and the financial coping mechanism. The interview would not take more than an hour. If you agree, I will be recording your voice. Since I will use Anonymous name, any information I include in my report does not reveal your personal identity. Besides, everything would be kept confidential and only used for writing report. If you feel uncomfortable, you have a right not to answer the whole or part of the question when you feel like. Thank you!!

A. IDENTIFICATION

1. Interview date

2. Starting time

3. Termination time

OBJECTIVE ONE: TO DETERMINE THE PATTERN OF HEALTH-SEEEKING BEHAVIOR BY ELDERLY WOMEN

1. Health seeking of elderly women (probing question: what is the most common illness faced by the elderly? For what kind of disease do they frequently come for treatment? how many percent of your patients were women above the age 65? How many percent if the visit the hospital/clinic base on their appointments? How many percent of

them did come back after first checkup? How do you describe the utilization of modern health facilities between men and women?)

OBJECTIVE TWO: TO ASSES THE SOCIO-DEMOGRAPHICBARRRIERS TO ACCESS HEALTH CARE BY ELDERLY WOMEN

1. What do you think are some barriers that prevents elderly women to visit medical care? How?

Appendix C. Interview Guide for kebele administrative

Good morning/afternoon!! First of all I would like to thank you for your time. My name is Tensae Deneke. I am a student of sociology in Addis Ababa University and I am conducting a study on elderly women's health. I would like to thank you in advance for meeting me today. I am here to kindly request you to participate on the interview, from which a thesis entitled "Health seeking behavior and barriers in accessing medical care" will be formulated.

In our discussion, my aim is to study the health seeking behavior of elderly women, barriers in accessing medical care and the financial coping mechanism. The interview would not take more than an hour. If you agree, I will be recording your voice. Since I will use Anonymous name, any information I include in my report does not reveal your personal identity. Besides, everything would be kept confidential and only used for writing report. If you feel uncomfortable, you have a right not to answer the whole or part of the question when you feel like. Thank you!!

A. IDENTIFICATION

1. Interview date

2. Starting time

3. Termination time

OBJECTIVE ONE: TO DETRMINE THE PATTERN IF HEALTH-SEEKING BEHAVIOR BY ELDETLY WOMEN

1. Health seeking of elderly women (probing question: Do you have health related trainings for the elderly? If yes, can you please tell me what they are? Do you have health promotion programs for the elderly?).

OBJECTIVE TWO: TO ASSES THE SOCIO-DEMOGRAPHICBARRRIERS TO ACCESS HEALTH CARE BY ELDERLY WOMEN

1. What do you think are some barriers that prevents allows elderly women to visit medical care? How?

OBJECTIVE THREE: TO EXAMINE THE FINANCIAL COPING MECHANISMS OF ELDERLY WOMEN USE IN CASE OF ILLNESS

1. Financial coping mechanism (Do you have social protection program for elderly women? what are those programs? What are the requirements to attend by these programs?What options do you give for poor elderly women who can’t afford their medical fees? Can you please tell me more about it?)

Appendix C. Interview Guide for NGOs.

Good morning/afternoon!! First of all I would like to thank you for your time. My name is Tensae Deneke. I am a student of sociology in Addis Ababa University and I am conducting a study on elderly women's health. I would like to thank you in advance for meeting me today. I am here to kindly request you to participate on the interview, from which a thesis entitled "Health seeking behavior and barriers in accessing medical care" will be formulated.

In our discussion, my aim is to study the health seeking behavior of elderly women, barriers in accessing medical care and the financial coping mechanism. The interview would not take more than an hour. If you agree, I will be recording your voice. Since I will use Anonymous name, any information I include in my report does not reveal your personal identity. Besides, everything would be kept confidential and only used for writing report. If you feel uncomfortable, you have a right not to answer the whole or part of the question when you feel like. Thank you!!

A. IDENTIFICATION

1. Interview date

2. Starting time

3. Termination time

OBJECTIVE ONE: TO DETRMINE THE PATTERN IF HEALTH-SEEKING BEHAVIOR BY ELDETLY WOMEN

1. Health seeking of elderly women (How many elderlies are there in your center? does the women in your center do regular checkups? If yes, how often? If no, why? Where does they usually get treated? do you supervise them to take their prescribed medicine properly? What kinds of treatments do they usually opt? in your center, who is more willing to utilize health center? Male? Female?)

OBJECTIVE TWO: TO ASSES THE SOCIO-DEMOGRAPHICBARRRIERS TO ACCESS HEALTH CARE BY ELDERLY WOMEN

1. What do you think are some barriers that prevents allows elderly women to visit medical care?

2. **OBJECTIVE THREE: TO EXAMINE THE FINANCIAL COPING MECHANISMS OF ELDERLY WOMEN USE IN CASE OF ILLNESS**

1. Financial coping mechanism (Do you have social protection programs for the elderly in your center? If yes, what kinds of health-related social protection do you offer for elderly women? What are the requirements to get these services?)

Table 1: Demographic Variables of Research Participants

ID	Age	Income	Marital status	Educational status	Employment status
Participant 1	79	<2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 2	66	>2000.00 Birr	Married	Completed elementary school	Self employed
Participant 3	71	No income	Widowed	Can read and write, no formal education	Unemployed
Participant 4	74	<2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 5	77	<2000.00 Birr	Widowed	Cannot read and write	Unemployed
Participant 6	77	No income	Married	Cannot read and write	Unemployed
Participant 7	65	<2000.00 Birr	Married	Not completed elementary school	Unemployed
Participant 8	72	<2000.00 Birr	Widowed	Cannot read and write	Unemployed
Participant 9	67	No income	Married	Cannot read and write	Unemployed
Participant 10	70	>2000.00 Birr	Widowed	Not completed elementary school	Unemployed
Participant 11	71	<2000.00 Birr	Married	Can read and write, no formal education	Unemployed
Participant 12	79	No income	Widowed	Completed elementary school	Unemployed

Participant 13	75	>2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 14	87	>2000.00 Birr	Widowed	Can read and write, no formal education	Self employed
Participant 15	66	>2000.00 Birr	Married	Completed elementary school	Self employed
Participant 16	69	<2000.00 Birr	Widowed	Cannot read and write	Unemployed
Participant 17	67	<2000.00 Birr	Widowed	Can read and write, no formal education	Unemployed
Participant 18	89	No income	Widowed	Cannot read and write	Unemployed
Participant 19	68	>2000.00 Birr	Married	Completed elementary school	Self employed
Participant 20	74	<2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 21	68	No income	Married	Not completed elementary school	Unemployed
Participant 22	67	No income	Widowed	Not completed elementary school	Unemployed
Participant 23	80	<2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 24	65	<2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 25	69	>2000.00 Birr	Widowed	Completed elementary school	Self employed
Participant 26	71	<2000.00 Birr	Married	Cannot read and write	Unemployed

Participant 27	72	<2000.00 Birr	Married	Can read and write, no formal education	Unemployed
Participant 28	77	>2000.00 Birr	Widowed	Not completed elementary school	Self employed
Participant 29	75	>2000.00 Birr	Widowed	Can read and write, no formal education	Unemployed
Participant 30	68	No income	Married	Can read and write, no formal education	Unemployed
Participant 31	74	<2000.00 Birr	Widowed	Cannot read and write	Unemployed
Participant 32	80	<2000.00 Birr	Widowed	Cannot read and write	Unemployed
Participant 33	71	<2000.00 Birr	Married	Can read and write, no formal education	Unemployed
Participant 34	71	>2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 35	75	No income	Married	Not completed elementary school	Unemployed
Participant 36	69	<2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 37	74	<2000.00 Birr	Widowed	Not completed elementary school	Unemployed
Participant 38	77	>2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 39	81	<2000.00 Birr	Widowed	Cannot read and write	Unemployed
Participant 40	74	<2000.00 Birr	Married	Not completed	Unemployed

				elementary school	
Participant 41	86	No income	Married	Cannot read and write	Unemployed
Participant 42	68	<2000.00 Birr	Married	Can read and write, no formal education	Self employed
Participant 43	74	>2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 44	67	<2000.00 Birr	Widowed	Can read and write, no formal education	Self employed
Participant 45	75	No income	Married	Not completed elementary school	Unemployed
Participant 46	79	>2000.00 Birr	Widowed	Not completed elementary school	Unemployed
Participant 47	69	No income	Married	Cannot read and write	Unemployed
Participant 48	76	<2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 49	68	<2000.00 Birr	Married	Not completed high school	Self employed
Participant 50	77	>2000.00 Birr	Married	Completed elementary school	Self employed
Participant 51	73	<2000.00 Birr	Married	Not completed elementary school	Unemployed
Participant 52	75	No income	Widowed	Can read and write, no formal education	Unemployed

Participant 53	68	<2000.00 Birr	Widowed	Cannot read and write	Unemployed
Participant 54	72	>2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 55	86	<2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 56	74	<2000.00 Birr	Widowed	Completed elementary school	Self employed
Participant 57	71	>2000.00 Birr	Married	Cannot read and write	Unemployed
Participant 58	73	<2000.00 Birr	Widowed	Can read and write, no formal education	Unemployed
Participant 59	79	No income	Married	Cannot read and write	Unemployed
Participant 60	67	<2000.00 Birr	Married	Not completed elementary school	Unemployed