



FACTORS THAT INFLUENCE ELDERS WITH MOBILITY IMPAIRMENT TO UTILIZE MEDICAL REHABILITATION SERVICES

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ABSTRACT

The elderly population continually grows globally, necessitating health systems that cater to their needs, including medical rehabilitation since they are more susceptible to being mobility impaired which has been linked to a reduced quality of life for the elderly, rendering them reliant on others for basic daily life needs. Lack of rehabilitation for an impairment can lead to disability but most African countries struggle to provide rehabilitation services for people with diverse impairments so this leaves elders with mobility impairment at a great disadvantage. The study aims to identify the factors that influence mobility impaired elders to utilize medical rehabilitation services in the Ho Municipality of Ghana.

METHODOLOGY: A qualitative study with 25 subjects purposively sampled were interviewed at the Ho Regional Hospital, and results analysis were carried out thematically. 5 rehabilitation therapists were interviewed on challenges faced when administering medical rehabilitation services provided at the facility while 20 elders with mobility impairment were interviewed on considerations before using medical rehabilitations of the facility. Nvivo version 12 was used to evaluate the analysis.

RESULTS: Organizational challenges like not enough skilled workers created more workload for the rehabilitation therapists. The elders with mobility impairment identified personal and environmental factors affected their use of the services.

RECOMMENDATION: The study suggests that specialized health facilities for elders with need to be established with a focus on diverse medical rehabilitative services for those with mobility impairment. Comprehensive courses must also be designed to train skilled therapists to fill working positions that these new facets will create.

KEYWORDS: Physiotherapy, Mobility Impairment, Elders, Medical Rehabilitation Services, Rehabilitation Therapy.

1.0 INTRODUCTION

Ageing is assumed to be associated with increased health care expenditures but the association is also viewed as a diversion from important issues (Hazra, Rudisill, & Gulliford, 2018). One of the signs of aging is the gradual loss of mobility which can be truly cumbersome as it is negatively linked with disability, poor health outcomes which heavily impacts the quality of living (Billot et al., 2020). For elders with impairments, the path to social participation can be uneasy (Raymond, 2019). Persons with disabilities are one of the marginalized groups in society who encounter challenges in all spheres of life, including accessing healthcare (Imoro, 2015). Preventive health care and early health intervention, along with an impaired physical environment, potentially slow down or even reverse the disablement process (Owusu-Ansah & Akanig-ba, 2021). Their reduced bodily functions, relatively weak socioeconomic backgrounds, structural barriers, unsuitable transport system and psychological abuse all combine to restrict access to advanced medical services (Owusu-Ansah et al., 2021). Tailored interventions that tackle the needs of people with mobility impairment are needed to further moderate their risk to other serious illnesses like Cardiovascular diseases. (Wilby, 2019).

At the moment, there are voluminous unmet health needs for rehabilitation services which are expected to increase due to increased life expectancy in Africa (Geberemichael et al., 2019). Access to healthcare in Africa manifests in several aspects, including geographical location, accessibility, affordability, availability, and acceptability (O'Donnell, 2007). The absence of essential strategies in advocacy and consumer groups, a national policy, experts at academic, medical and academic levels has landed Ghana's rehabilitation system in jeopardy (Tinney, Chiodo, Haig, & Wiredu, 2007). Some challenges the Ghanaian medical rehabilitation system faced were identified to be associated with availability and stability of therapy equipment, geographical location, quality of service and exclusion of persons with disability in intervention creation (Christian et al., 2016). Another study identified more diverse impediments to rehabilitation services in Ghana to be high medication bills, transportation constraints, extended waiting periods,



forgetfulness about appointment, limited education on rehabilitation, insufficient communal backing and defected communication with healthcare providers (Baatiema et al., 2021).

Access to quality and timely medical rehabilitation services is essential to the health and well-being of all individuals, with no exception to elders, especially those with mobility impairment. A well-planned medical rehabilitation program should be one that targets nullification of obstacles that generally pertain to availability, affordability and accessibility in order to meet the health needs of mobility-impaired elders.

Comprehensive and accessible rehabilitation services can enable people like elders with mobility impairment to regain their independence and aid their participation in their community and workplace (Allen et al., 2022). There has been a decline in the perception of the importance of rehabilitation but then, there is still the need for maintenance of interventions with the focus, on for example, mobility (Macnaughton, Vianya- Estopa, & Latham, 2022) The elderly population in Ghana has been practically deserted to be cared for by the family meanwhile systematic groundwork to command the years ahead have not been clearly mapped out (Saeed, Xicang, Yawson, Nguah, & Nsowah-Nuamah, 2015). The Livelihood Empowerment Against Poverty (LEAP) and National Health Insurance Scheme (NHIS), both of which have components intended for aged, were found to rather exclude the elderly due to insufficient funds, poor targeting, and inaccurate implementation and evaluation of data which made these well-designed programs lose their focus and merit. (Alidu, Dankyi, & Tsiboe-Darko, 2016)

Older adults rely on the NHIS more than their younger counterparts but rehabilitation services and assistive devices are not covered and right from registration for the scheme, elders with mobility impairments face exclusion as they may have to travel for that (Van der Wielen, Channon, & Falkingham, 2018). This has contributed to the numerous challenges that persons with disabilities encounter in accessing healthcare at health facilities (Inclusion Ghana, 2013).

Governments of developing countries like Ghana need not to underestimate the threat of the phenomenon of population ageing but rather, acknowledge and tackle challenges countless research have highlighted, in order to better manage the anticipated doom (Mba, 2010). The Ho Municipal is one of the 261 Metropolitan, Municipal and District Assemblies (MMDAs) in Ghana, and forms part of the 18 Municipalities and Districts in the Volta Region. The Municipality is also the Administrative capital of the People of the Volta Region. At the regional level, curative services are delivered at regional hospitals and public health services are delivered by the public health division of these regional hospitals in addition to supervision and management support of the districts and sub-districts (Adataro et al., 2018). Financial access and quality coverage were deduced as the main issues slowing down access to health services in the Volta Region for both tracer indicators (Sheff et al., 2020).

2.0 LITERATURE REVIEW

Health is becoming a more prominent focus of aid to Sub-Saharan African countries (Leo, 2013). Deaton and Tortora (2015) conducted a survey to find out how Sub-Saharan Africans see their well-being, health, and healthcare systems. The residents of the region have a worse sense of well-being than those in any other part of the world. The same may be said about how Sub-Saharan Africans view their healthcare system. Nonetheless, many in the region believe that improving health care should not be a top priority for their governments (Gyasi & Lulin, 2022). In Sub-Saharan Africa, the world's poorest and youngest region, little attention has been paid to the challenges of old age (Sakuma & Yamaguchi, 2013). Referenced to a study about two decades ago, Sub-Saharan Africa is a continent with a population of 788 million people, many of whom live in poverty and are afflicted by wars and according to the findings of this study, a person with a handicap in Sub-Saharan Africa has a 0% probability of encountering a physician who specializes in an appropriate treatment (Haig, Im, Adewole, Nelson, & Krabak, 2009). In 2019, Saka, Oosthuizen, and Nlooto (2019) reported an estimate of 46 million individuals aged 60 and up living in Sub-Saharan Africa, which includes 48 of Africa's 54 nations but excludes northern Africa. By 2050, this figure is expected to have more than doubled, suggesting that the area would have the greatest growth rate of older persons in the world during this time period.

There is a large body of evidence demonstrating the effectiveness and cost-effectiveness of medical rehabilitation in restoring independence and productivity to people with disabilities (Cardenas, Haselkorn, McElligott, Gnatz, & Rehabilitation, 2001). The focus on achieving a specified health worker density was advised to address human resources for primary health care in Sub-Saharan Africa by Willcox et al. (2015). This is due to the fact that governments and funders that concentrated on educating more physicians, nurses, and midwives did not achieve the promised results in terms of enhancing primary care recruitment and retention.

However, the most compelling argument for including the elderly in current plans for improved human and economic well-being in Sub-Saharan Africa is that, contrary to popular belief, older Africans play critical roles in achieving Basic Developmental Goals (Lowsky, Olshansky, Bhattacharya, Goldman, & Sciences, 2014). Aboderin and Beard (2015) also gave the obvious relevance of older Africans' physical and mental health to be achieving basic development goals, and therefore, their burden of illness and likely unequal access to needed care would give strong economic and social reasons for action.

Moreover, traditional and spiritual beliefs are claimed to play a significant role in defining health or ill-health, accepting a health condition, choosing a treatment approach, and the outcome of treatment, particularly in Africa. Spiritual and traditional reliefs are



having an increasing impact on perceptions of stroke and mobility among older adults in Sub-Saharan Africa, which has implications for stroke rehabilitation success in the region, as suggested in a study by (Nweke, Eze, & Research, 2019). A review that recruited studies done on slum dwellers in Sub-Saharan Africa who are older raised mobility problems as issues which were common among the elderly in these slums. The report accounted for 9.5% of older slum inhabitants in Kenya and over 97 per cent of older slum dwellers in South Africa. Older slum inhabitants who were sick, fragile, and elderly were more likely than others to report mobility issues and the need for walking aids (Alaazi, Menon, & Stafinski, 2021). Importantly, bridging the gap between medical conceptions of health and more global dimensions of well-being among older persons in Sub-Saharan Africa still needs to be done.

Over the past two decades, more than one million people in Ghana have become disabled, with nearly 95 per cent of them not having access to rehabilitation services and facilities (Kendall, Buys, Larner, & rehabilitation, 2000). In 2007, there was a report of a lack of inpatient rehabilitation facilities in Ghana, which was later confirmed. Physical medicine and rehabilitation specialists were also in short supply in the country. There were only two retired occupational therapists and one retired speech-language pathologist to be found in the city's capital. The country's approximately 20 - 30 physical therapists received the majority of their training in Eastern Europe during the Cold War, and they had less than 10 years of service left on average before they were required to retire at the age of 60, on average (Tinney, Chiodo, Haig, Wiredu, & rehabilitation, 2007).

The findings of a 2011 study revealed that the majority of people admitted to a sophisticated trauma unit in Ghana were discharged without receiving adequate rehabilitation services and that the degree to which they were disabled could be measured using the L.I.F.E (Language Independent Functional Evaluation) even while they were still sick and, in the hospital, (Christian, González-Fernández, Mayer, & Haig, 2011). Christian and colleagues published the first study data on Ghana's rehabilitation infrastructure, human resources, and interventions in 2016, marking a significant milestone in the country's history (2016). Significant human resource constraints were discovered as a result of the findings, as hospital-based rehabilitation treatments were primarily provided by 20 physiotherapists and 21 physiotherapy assistants across the nine participating sites. It was discovered that no rehabilitation physicians were employed at any of the facilities evaluated. Therapy for musculoskeletal deficits was carried out using current evidence-based methods, whereas neurologic rehabilitative techniques were restricted to physical rather than sensory-motor modalities in the majority of cases.

Recent studies have discussed patient-centeredness as an increasingly important factor in health care. In medical rehabilitation, it is considered a critical quality and outcome criterion, necessitating the implementation of patient-centered care policies and services in the field of practice. Tinney et al. (2007) discuss the importance of medical rehabilitation leadership and how it can be achieved effectively. If something external begins, it must be effective and quickly replaced by someone who possesses the necessary knowledge and skills. Providing the national and medical leadership necessary to manage the resource allocation process for all levels of rehabilitative care and training required in a comprehensive care system is critical. This individual will need to have extensive experience in medical rehabilitation. This physician will be responsible for setting the tone for team management in an acute care setting. This individual will also benefit from leadership development. According to the authors, in a small country, a medical rehabilitation expert from an academic medical center will lobby the Ministry of Health for rehabilitation resources, which will be provided by the government.

According to the 2010 World Report on Disability, over one billion individuals, the majority of whom are persons with disabilities (PWDs) and older adults, use one or more assistive technology devices (ATDs) (Organization, 2011). A recent study by Alqahtani et al. (2021) on ATDs concluded that, modern advancements in mobility technology, including robotics, intelligent systems, exoskeletons, prostheses, and orthoses, have significantly increased involvement in desired daily activities for millions of people with disabilities and the elderly.

Throughout an evaluation by Needham et al. (2010), the lack of access to rehabilitation staff was obvious and this meant that, more physiotherapy and occupational therapy staff might achieve more. Cultural concerns was raised in a review by Sosnowski, Lin, Mitchell, and White (2015) that challenged the implementation of daily rehabilitation interventions as routine practice in our critical care units. The authors concluded that, critical care nurses are in a unique position to influence change in their organizations, ensuring that early rehabilitation methods are accepted and followed. Nevertheless, understanding the interaction between the environment and mobility in older persons is critical for both prevention and rehabilitation of mobility impairment. Certain aspects of the environment appear to hinder community mobility in older persons more than others, and a diminished capacity to handle important environmental demands on mobility appears to be a feature of mobility handicap in older adults as outlined by Shumway-Cook et al. (2002).

The global population of older individuals is growing, which has substantial consequences for social isolation and loneliness (Alpert & Practice, 2017). Findings from Alpert and Practice suggested that varied therapies for older persons who feel social isolation and loneliness are necessary because data on social support and group-based activities provided social contact, indicating an improvement in this public health issue.



3.0 METHODOLOGY

The research was conducted using a qualitative methodology. This study was conducted at Ho Teaching Hospital in Ho, formerly Volta Regional Hospital and popularly known as “Trafalgar”, located in the Volta region.

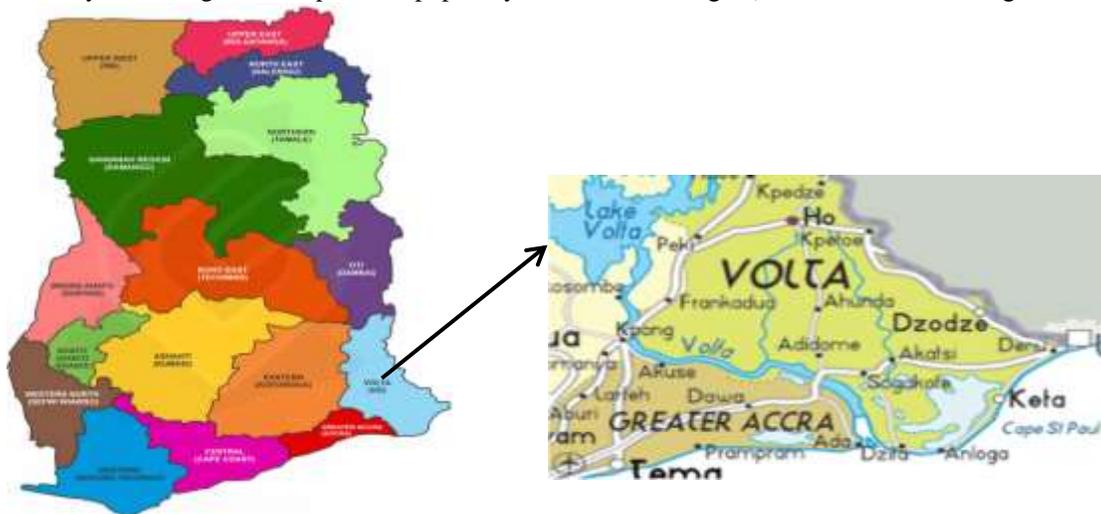


Figure 1 Map of Ho Extracted from the Map of Ghana

This study was conducted at the Volta Regional Hospital which boasts of an ultra-modern 340-bed referral specialist hospital for the region's district and primary healthcare facilities and beyond. The hospital's facilities and services include a well-organized Out Patient Department (OPD), Radiology and Imaging, Surgical services including day case surgery and Orthopedics, Obstetrics and Gynecology, including Neonatal Intensive Care, Eye, Ear, Nose, and Throat, Laboratory and Blood Transfusion services, Mortuary, Pharmacy, Pediatric Care, Internal Medicine and Psychiatry, Health information services, catering.

The population in this study consists of mobility-impaired elders and rehabilitation therapists of the Volta regional Hospital and all participants in the study were chosen purposefully in order to focus on specific characteristics of a particular population to better answer questions about medical rehabilitation for mobility-impaired elders. The elders with mobility impairment were involved in the study because they would have the perfect insight on things they considered before utilizing medical rehabilitation studies. Rehabilitation therapists were included in this study because they are the ones who provide rehabilitation services. A total of 25 people were interviewed (5 therapists and 20 mobility-impaired elders). The criteria for inclusion for the elders were: those who were more than 60 years old, mobility impaired and currently receiving rehabilitation treatment at Ho Teaching Hospital. For the healthcare professionals, inclusion criteria were those who work within the physiotherapist unit of the Ho Teaching Hospital. Exclusion criteria were as follows: Mobility impaired persons not more than 60 years and for the health workers, it was those in other units other than Physiotherapy, as that was the unit the hospital stated was where rehabilitation for mobility impairments were undertaken. The mobility impaired elders, and therapists were recruited to help researchers answer their questions. A total of 25 people were interviewed (5 therapists and 20 mobility impaired elders).

To ensure validity, the semi-structured interview guide was carefully framed by the researcher and double checked by the researcher's supervisor before they were administered. The basis of the validity was to ensure that the right questions are asked without ambiguity and minimize bias in the study as much as possible. At the Ho Municipal Hospital, interview guides were pretested with five (5) people, of which three were mobility impaired elders, and two (2) rehabilitation therapists in this group, all of whom worked together to test and refine the instrument before it was used in the final study. The research relied solely on primary sources of information. The information was gathered by the researcher, who two field assistants assisted in their efforts, one a graduate student from the University of Health Allied Science (UHAS) in Ho and the other from the Kwame Nkrumah University of Science and Technology (KNUST).

The thematic analysis developed by Creswell (2009) was used: the first step is to organize the data into different categories based on the information sources. The information provided by participants during in-depth interviews was recorded and later transcribed in accordance with the thematic steps outlined above. Lists of items with a reoccurring pattern were generated from the data, and these lists were then reduced to categories, which were then further subdivided into segments of data that share a common category or code



were discovered. A thorough description of the results was followed by a series of dialogues connected with each theme in support of increasing dependability. Nvivo version 12 was used to evaluate the analysis. Member checking was incorporated as a means of establishing credibility, as the researcher distributed final themes and supporting dialogue to participants in order to elicit feedback from them.

For ethical consideration, the Ho Teaching Hospital's Committee on Ethical Approval granted permission to conduct the study. Informed consent forms had to be signed or thumb-printed by the participants after they had been read out in the local language and their questions had been adequately answered by the research team. Individuals' personal information was replaced with unique reference codes to ensure anonymity and confidentiality. With the permission of the interviewees, the interviews were recorded on tape.

4.0 RESULT AND DISCUSSION

Information on the demographic characteristics of mobility impaired elders and medical therapists was sought. The mobility impaired elders were 60 years and above, most males. Also, most of them were pensioners or retired persons, with secondary and tertiary levels of education. For the rehabilitation therapists used in the study, there were at least 20 years, with tertiary levels of education. They have also worked on mobility impaired elders at the hospitals for at least 3 years. Also, most of them were males and were mainly physiotherapists. The proceeding session provides the study results according to the four specific objectives as presented.

In Table 1, information on the age distribution of the mobility impaired elders considered in the study showed that 35% were between 61 to 65 years. This was followed by 25% for those 66 to 70 years. The least was 5% for those 80 years and above. This shows that the respondents used in the study qualify to be used for purposes and that they can provide the needed responses for the study. Also, 65% of the elderly were males, while the remaining were females. Concerning the elders' type of work, the majority (85%) of them were white and blue-collar workers, with the least being farmers. Also, most of them (about 65%) were educated, while the remaining had primary or no education. On the instrumental activities of daily living (IADL), it was observed that most of them were independent (70%). Respectively, 20% and 10% were partially dependent and dependent. Concerning the economic status of the elderly persons used in the study, it was revealed that 65% do not have enough money. Only 5% of them had enough money for all their needs. 40% of the elderly persons stated that their mobility impairment was a result of a stroke, while 20% and 15% were impaired by fractures and amputations, respectively. Arthritis and obesity accounted for the cause of impairment for the remaining percentage. Finally, half of them (50%) had moderate chronic pain intensity in their condition's intensity of chronic pains. Furthermore, 35% for those with severe intensity, with the least being 15% for the mild intensity of chronic pains.

Table 1 Demographic Characteristics of the Mobility Impaired Elders.

| Characteristics | Frequency | Percentage (%) |
|------------------------------------|-----------|----------------|
| <i>Age Distribution (in years)</i> | | |
| 61–65 | 7 | 35.0 |
| 66–70 | 5 | 25.0 |
| 71–75 | 4 | 20.0 |
| 76–80 | 3 | 15.0 |
| 80 and above | 1 | 5.0 |
| <i>Gender</i> | | |
| Male | 13 | 65.0 |
| Female | 7 | 35.0 |
| <i>Type of work</i> | | |
| Blue-collar worker | 8 | 40.0 |
| White-collar worker | 9 | 45.0 |
| Farmer | 1 | 5.0 |
| Others | 2 | 10.0 |
| <i>Educational level</i> | | |
| Primary/lack of education | 8 | 40.0 |
| Vocational | 2 | 10.0 |
| Secondary | 7 | 35.0 |
| Bachelor | 3 | 15.0 |

**Instrumental activities of daily living**

| | | |
|---------------------|----|------|
| Independent | 14 | 70.0 |
| Partially dependent | 4 | 20.0 |
| Dependent | 2 | 10.0 |

Economic Status

| | | |
|--|----|------|
| Enough money for all needs | 1 | 5.0 |
| Enough money to make a living, but not for all needs | 6 | 30.0 |
| Not enough money | 13 | 65.0 |

Cause of impairment

| | | |
|------------|---|------|
| Fracture | 4 | 20.0 |
| Amputation | 3 | 15.0 |
| Stroke | 8 | 40.0 |
| Arthritis | 4 | 20.0 |
| Obesity | 1 | 5.0 |

Chronic Pain Intensity:

| | | |
|----------|----|------|
| Mild | 3 | 15.0 |
| Moderate | 10 | 50.0 |
| Severe | 7 | 35.0 |

Table 2 Demographic Characteristics of Rehabilitation Therapists

| Demography of Therapists | Frequency | Percentage (%) |
|------------------------------------|-----------|----------------|
| Age Distribution (in years) | | |
| 20-29 | 2 | 40.0 |
| 30-39 | 2 | 40.0 |
| 40-49 | 1 | 20.0 |
| Gender | | |
| Male | 3 | 60.0 |
| Female | 2 | 40.0 |
| Educational Level | | |
| Undergraduate Degree | 4 | 80.0 |
| Master's degree | 1 | 20.0 |
| Rank | | |
| Head of Department | 2 | 40.0 |
| Attending Physician | 2 | 40.0 |
| Fellow | 1 | 20.0 |
| Number of Years in Service | | |
| Less than 3 years | 2 | 40.0 |
| At least 3 years | 3 | 60.0 |

Information on the age distribution of the therapists in Table 2 showed that 40% each were between 20 to 29 years and 30 to 39 years. The least was 10% for those 40 to 49 years. Thus, majority (80%) of the rehabilitation therapists were between 20 to 39 years. Also, all the rehabilitation therapists were males, with first degrees. The majority (80%) of the ranks were Heads of Department and Attending Physicians. Finally, on the number of years in service, 60% of them have been working as rehabilitation therapists on the issues of mobility impaired elders for 3 years or more. That is, they have more than 2 years of experience on the job. This is very good



for a study such as this. This is because they were able to provide responses based on their long-time service in the organization of concern.

4.1 Factors Influencing Utilization of Medical Rehabilitation

Concerning the factors influencing the utilization of medical rehabilitation by mobility-impaired elders, the results indicate that all the mobility impaired elders interviewed in one way or the other. In particular, the mobility impaired elders understood the factors influencing the utilization of medical rehabilitation as the barriers to effective utilization of medical rehabilitation facilities by the elderly with such conditions. For instance, one mobility-impaired elder particularly stated that he utilizes the medical rehabilitation at the facility because:

It is a public hospital, and most health personnel are very experienced, educated, open-minded, and better than other places I visited.

In terms of the cost of the services, he lamented the non-coverage of the Nation Insurance Scheme, especially not taking care of certain medicines they need. A study by (Pishkhani, Dalvandi, Ebadi, & Hosseini, 2019) concur that most rehabilitation services in Iran were not fully covered by insurance and that significantly had an effect on the devotion to rehabilitation at the long run He specifically mentioned that:

Not really, not really, you know, I am on pension and health insurance does not cover most of the things so, with the little money I have, expensive drugs are being bought with it.

He ended with commenting on the accessibility of such services by stating categorically that:

Average, because coming in, I experienced challenges before I could see the therapist

Another mobility-impaired elder also stated and explained the factors influencing him to go for such services as:

It is not far from my house, and whenever I go there, they are so nice to me, sociable and amicable. Also, it is not that bad. I wish medicines and other things could be taken care of. It is also because if you have a condition that has to lead to a particular department when you go there, they take good care of you. It is also because it is close to where I live and it is a big hospital, and I think they have qualified and experienced doctors and nurses.

In summary and based on the results, the factors influencing the utilization of medical rehabilitation by mobility-impaired elders can be grouped into two. Those as a result of the mobility impaired elders themselves (personal factors) and those emanating from the environment (environmental factors) in which they found themselves. The personal factors include (age, education, income or socioeconomic status, motivation, attitudes and degree of disability, among others) and the environmental factors include identified include (accessible physical environment, accessible services, availability of caring family, attitude of health professionals, accessible transport, cost of services, waiting hours, availability of services, distance to the facility, accessible information, among others). That is, the factors the mobility impaired elders consider before attending the hospital are personal and environmental factors, and these are meaningfully linked to their utilization of physical rehabilitation services at the hospital. The International Classification of Functioning, Disability and Health (ICF) model reported personal and environmental factors as facilitators or barriers to utilizing rehabilitation services (Organization, 2001)). Hence, the findings in the current study are congruent to the descriptions and classifications given by WHO in 2001. Also, in support of the assertion, LaPlante and Kaye (2010) provided an overview of the data on Wheeled Mobility Use, which included a profile of demographics and trends in the use of Mobility Impaired Equipment (Wheeled Mobility) and accessibility in the community in the United States of America (LaPlante & Kaye, 2010). There is some evidence to suggest that the degree of mobility difficulty, as well as other personal factors such as gender, race and income, public financing policies, accessibility of the home and built environment, the availability of and use of other mobility aids, and the availability of personal assistance, appear to determine the situational use and efficacy of WME for people who use WME.

4.2 Knowledge of Mobility Impaired Elders on Medical Rehabilitation

On the knowledge of mobility-impaired elders on medical rehabilitation, when it comes to the length of time they had the condition, they all have knowledge of that. That is, they know the length of time or duration within which they had the condition as well as the major or main cause of their conditions. For instance, once stated:

I had an accident, and the bone in my left leg got fractured, which led to my inability to walk, and since then, I have been unable to walk.

Another respondent stated:

Stroke. I had a mild stroke.

But in all these, it was observed that the health of these mobility-impaired elders is very prime to them. One of them specifically stated:

If I want to live long on earth, I have to take very good care of my health.



Another one also added that:

Growing up, I did not pay a lot of attention to my health. It was getting to the latter part that I started falling sick, and I knew health was very important and since then, I have been up to date on my health issues and concerns.

In summary, with respect to the knowledge of mobility-impaired elders on medical rehabilitation, the study indicated that when it comes to the length of time they had the condition, they all have knowledge of that. That is, they know the length of time or duration within which they had the condition as well as the major or main cause of their conditions. But in all these, it was observed that the health of these mobility-impaired elders is very prime to them.

4.3 Current Care for Medical Rehabilitation

Regarding the current care for medical rehabilitation for mobility-impaired elders at the hospital, the study showed that there are basically two kinds of services these groups of people access. These are physiological or assistive and medical services. Some assistive services or devices include hearing aids, mobility aids, low vision devices, or any assistive device. For medical rehabilitation, they include treatment/surgery, diagnosis, access to, or ever received rehabilitation, received therapy (physical, occupational, speech and language). That is, in the aspect of condition that the patients may be having, especially the elderly, they come with some conditions that affect their balancing and ability to walk. Also, on the availability of policies on the care of mobility-impaired elders, it was seen that the respondents do not have much to say about these policies. One of them has this to say:

There is not much that I can speak of because the policy passed recently was on accessibility. Also, recently, pensioners have been given some money at the various Assemblies, but I do not know how far those have been implemented as well.

The respondents identified a few challenges as the ones that the institution faces in meeting the needs of the mobility impaired elderly. Some of them are:

Usually is based on the assessment and the needs. The assisting devices that the elderly would need as well as the number of personnel trained in that field that the facility would have, are not adequate.

The respondents finally mentioned that to improve elderly care:

A lot of policies need to be passed and implemented. In as much as that is done, a few non-governmental organizations can also establish or promote a field of health care delivery by providing health services to the needs, especially the elderly, so that at the end of the day, they can be integrated into the society and their worth would be felt.

In conclusion, the study showed that there are basically two kinds of services these groups of people access. These are physiological or assistive and medical services. This grounded the findings of researchers (Tinney, Chiodo, Haig, & Wiredu, 2007) when their results showed the absence of occupational therapists and the presence of a few prosthetics, orthotists, and physical therapists, and speech therapists highlighted the fact that Ghana has practically no medical rehabilitation.

4.4 Provision of Resources and Equipment for Medical Rehabilitation

The respondents were of the view that health facilities that provide rehabilitative services are not bad adequate. That is, when it comes to the facility having approved and adequate equipment to manage patients, the respondents were of the view that the facilities and equipment situation at the Ho Hospital in respect of mobility-impaired elders' rehabilitation was not bad. However, unfavorable comments were passed when they were asked about the adequacy of the number of trained human resources available:

.....no because it does not meet the demands because currently, we suffer. That is, instead of attending to about 10 patients a day, you have to attend to more, so you get exhausted, resulting in the rescheduling of patients. Also, due to the inadequate number of trained human resources, patients do not enjoy their benefits to the fullest. This is because, for example, a patient who is supposed to come for three rehabilitation sessions in the course of the week is being reduced.

This very statement supports the study that limited provider ability remains a significant disruption in necessary care (Carvalho, Bettger, & Goode, 2017). However, when it comes to the facility having approved and adequate equipment to manage patients, the respondents were of the view that the facilities and equipment situation at the Ho Hospital in respect of mobility-impaired elders' rehabilitation is not bad. One of them stated that:

Currently, I would rate it on a scale of 80%. They've improved since I came in here. They are on track, so I think they would do more.

In support of this statement, another respondent mentioned that this is because of the nature of the hospital in question. He stated:

It is a 50/50 thing. This is because it depends on the facility's level as it is a Regional, District Hospital, Polyclinic, CHPS compound, among others. For example, in a Regional Hospital, there are adequate services and resources, but in District Hospitals, it falls below and so on.

Carvalho et al. (2017) also named geographical location as a barrier to access to medical rehab services, and this statement proves that too (Carvalho et al., 2017). On what the respondents thought could be done to improve the provision of healthcare for mobility-impaired persons, it was suggested that incorporating mobile health into current healthcare models of rehabilitative care can decrease



hospital visits and provide a longer duration of care. Another stated that care homes should be engaged and encouraged. He stated that:

Very well, Care homes should be engaged and encouraged because they play a very major role by providing a holistic health service to the elderly in the aspect of medical rehabilitation, where they need to be referred as well as community-based rehabilitation which deals with social integration. So, when the elderly is being attended to health-wise, they are also integrated into society, making their worth also felt in the community.

The results of Shakespeare et al. (2009) are consistent with this study. They stated and explained in their study that rehabilitative specialists are hard to come by, and rehabilitation programs are typically more expensive to administer than general healthcare programs, as suggested (Shakespeare, Iezzoni, & Groce, 2009). Researchers (Carvalho et al., 2017) also noted in their study that, even in locations in New England where a very high concentration of physiotherapists was recorded, there were still regions in each locality with these professions below the national average.

Table 3: Summaries of factors that influence the utilization of medical rehabilitation by respondents

| THEME | RESPONDENTS | |
|--|--|--|
| | Rehabilitation Therapists | Mobility Impaired Elders |
| AVAILABILITY OF MEDICAL REHAB SERVICES | <ul style="list-style-type: none"> • They can only provide physiotherapy even though some clients obviously need more than that. e.g., hydrotherapy, speech therapy • The services provided cater to everybody else and not specifically elders with mobility impairment. • The facility doesn't design assistive devices. | <ul style="list-style-type: none"> • They can only provide physiotherapy even though some clients obviously need more than that. e.g., hydrotherapy, speech therapy. • The decorum of the therapists • Referrals are needed before you can access the physio center |
| EQUIPMENT AND ASSISTIVE DEVICES | <ul style="list-style-type: none"> • Lack of specific equipment. • Lack of beneficial assistive devices like prosthetic limbs • Stress on equipment since a lot of people use the few available equipment and this cause the equipment to wear and teach easily • The few technological equipment that break down can cost a lot and take days to fix. • Patients have to fund their acquisition of assistive devices. • Donations | <ul style="list-style-type: none"> • Some assistive devices are not readily available for purchase • The health facility provides assistive devices for ease of movement around the facility. • Some assistive devices are expensive but the NHIS doesn't cover that. • Lots of other patients come to use the few equipment available and it can't get to their turn sometimes. • Some equipment are always broken down. • Some assistive devices are uncomfortable to use. |
| SKILLED PERSONNEL | <ul style="list-style-type: none"> • Not enough physiotherapists. • Unavailability of certified skilled personnel in other areas of medical rehabilitation. • Unavailability of specified assistive device designers. | <ul style="list-style-type: none"> • Distance of the hospital from their homes • Transportation could be a hustle in case one uses an assistive like a wheelchair. • Costly and time consuming in case one lived far from the hospital. This could prevent them from coming to the hospital three times a week |
| THE CLIENT'S IMPAIRMENT | <ul style="list-style-type: none"> • The level of mobility impairment of an elderly client in terms of severity. | <ul style="list-style-type: none"> • The level of mobility impairment of an elderly client in terms of severity. |



5.0 CONCLUSION AND RECOMMENDATION

Concerning the knowledge of mobility impaired elders on medical rehabilitation, the study indicated that when it comes to the length of time they had the condition, they all have knowledge of that. That is, they know the length of time or duration within which they had the condition as well as the major or main cause of their conditions.

The factors the mobility impaired elders considered before attending the hospital are personal and environmental factors, and these are meaningfully linked to their utilization of medical rehabilitation services at the hospital. The study showed that there are basically two kinds of services these group of person access. These are physiological or assistive and physiotherapy. The respondents were of the view that health facilities that provide rehabilitative services are adequate. Still, unfavorable comments were passed when they were asked about the adequacy of the number of trained human resources available.

The government should establish community-based rehabilitation (CBR) programs within the community and provide rehabilitation services in primary health care facilities to reduce transport costs and increase accessibility to the services. Given the increasing number of people with disabilities, it appears that the task of sensitizing healthcare professionals, policymakers and the public about the available rehabilitative services is of paramount importance.

Therefore, the government and other relevant stake holders should increase sensitization and awareness of rehabilitation services to people with physical disabilities, healthcare professionals and the general public, provide more education opportunities to people with physical disabilities, establish a public funding mechanism targeting people with physical disabilities, integrate basic rehabilitation services within the existing health care service delivery and establish community based rehabilitation centers to increase access to rehabilitation services. Here is the need for government to develop community based rehabilitation (CBR) programs and centers within the community to provide primary medical rehabilitation services in order to make rehabilitation services inclusive and accessible to all.

Investments in health facilities to create other forms of medical rehabilitation services can be done. Comprehensive courses must also be designed to train skilled therapists to fill working positions that these new facets will create. Specialized health institutions need to be established to care specifically for medical rehabilitation, focusing on the elderly. Centers that manufacture assistive devices should also be established to make assistive devices quickly obtainable with ease. Educational health campaigns need to be undertaken to sensitize individuals on medical rehabilitation for elders.

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