# RESPONSIVENESS OF HEALTH CARE SYSTEMS ON ELDERLY OPTIMAL AGEING IN RURAL KENYA: THE CASE OF RACHUONYO NORTH SUB-COUNTY OF HOMA BAY COUNTY.

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**RESEARCH THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE CONFERMENT OF THE DEGREE OF DOCTOR OF PHILOSOPHY IN SOCIOLOGY IN THE DEPARTMENT OF HUMANITIES AND SOCIAL SCIENCES, RONGO UNIVERSITY**

## DECLARATION

I the undersigned, do declare that this research thesis is my original work and to the best of my knowledge has not been submitted or presented for examination in any other university or institution of higher learning. All literature reviewed has been acknowledged as required.

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## DEDICATION

This thesis is dedicated to my wife Hellen and all my children: Elizabeth, Erick, Tabitha, Georgina and Donald; and the elderly whom we serve by the will of creation.

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## TABLE OF CONTENTS

## LIST OF FIGURES

## LIST OF TABLES

## LIST OF APPENDICES

## ABBREVIATIONS/ACRONYMS

| | |
|---|---|
| FGDs | : Focus Group Discussions |
| HCIPD | : Homa Bay County Integrated Development Plan |
| IMCI | : Integrated Management of Childhood Illnesses. |
| NACOSTI | : National Commission for Science, Technology and Innovation |
| SSA | : Sub Saharan Africa. |
| UDHR | : Universal Declaration of Human Rights |
| UN | : United Nations. |
| UK | : United Kingdom |
| UNFPA | : United Nations Population Fund. |
| UNDESA | : United Nations, Department of Economic and Social Affairs Population Division |
| UNECA | : United Nations Economic Commission for Africa Centre for Gender and Social Development |
| APHRC | : African Population and Health Research Center |
| WHO | : World Health Organization. |

## OPERATIONAL DEFINITIONS

Ageing : Multidimensional process of an individual growing older marked by physical, psychological and social changes.

Elderly : A person aged 60 years and above.

Health System : The organizations, institutions and resources that are devoted to Producing health actions.

Optimal Ageing : The capacity of an individual to function across many domains- physical, functional, cognitive, emotional, social, and spiritual to one's satisfaction
despite one's health status.

Responsiveness of Health System: Ability of health system to offer high quality care that reflects how well the system responds to the population's legitimate expectation regarding Non-medical (relational) aspects of health-care.

Health Care Service Provider : A trained health staff to offer care service to clients and patients.

Vulnerable Populations : People who cannot comfortably or safely anticipate, access and use standard resources, resist, cope with, and recover from impact of adversity.

## ABSTRACT

Optimal aging in the elderly has become an important concept globally due to increasing number of people aged 60 years and above and their subsequent pressure on health services. The elderly, expectant mothers and children below five years comprise the world vulnerable population. In Kenya, unlike the Western world, only the expectant mothers and children below 5 years have special health care service guides, thus leaving the elderly on routine health care system. This study investigated the influence of health systems responsiveness on optimal ageing of the elderly in rural Kenya, Rachuonyo north sub-county of Homa Bay county. Specifically, the study sought to determine the level of optimal aging among the elderly, establish the influence of respect for persons in caring for the elderly on elderly optimal ageing, determine the influence of implementation of the concept of client orientation in caring for the elderly on elderly optimal ageing, evaluate the influence of Health System preparedness to care for the elderly on elderly optimal ageing. The study was guided by Systems theory. A conceptual framework showing the relationship between health system responsiveness and optimal aging was adopted. The study employed a descriptive cross-sectional explorative survey. Semi-structured questionnaires, interviews and focus group discussions were used as methods of data collection. Study population was 10,033 elderly and sample size of 385 was determined by Taro Yamane's formula with margin of error of 5%. Respondents were obtained by using cluster and purposive sampling methods. Further 45 Key Informants and five 10 focus group discussion members were obtained by purposive sampling method. Reliability of the questionnaire was determined by Cronbach alpha which ascertained at least 0.7 in all subscales. Validity was determined by expert supervisors and by piloting. Quantitative data was analyzed using mean, correlation and regression while qualitative data was analyzed thematically in which concepts were identified and emerging themes generated. In a Likert scale of 1to 5, the study established that there was moderate level of optimal ageing with mean response of2.61, ($r = .247$; $p < 0.05$), there was positive correlation ($r = .247$;$p < 0.05$) between observance of respect for persons and elderly optimal ageing, there was positive correlation ($r = .534$; $p < 0.05$) between implementation of the concept of client orientation and optimal ageing and there was positive correlation ($r = .447$; $p < 0.05$)between health system preparedness and elderly optimal ageing. The study revealed that health system accounts for 56% of the variances in optimal aging of the elderly in the study area. In conclusion, the study established that elderly experience moderate aging due to multiple morbidity associated factors; there was statistically significant influence of implementation of client orientation in caring for the elderly on elderly optimal ageing however, majority of the elderly expressed marked resentments over respect accorded to them by health staff; there was statistically significant influence of implementation of the concept of client orientation in caring for the elderly on optimal ageing but there was inadequate understanding of the elderly on the potentials and challenges of the health systems. Finally, there was statistically significant positive effect of Health Systems preparedness on elderly optimal ageing and that currently health service providers practice with general health care knowledge. The study recommended the use of specific elderly care service guide, sensitization of health care service provider to the observance of respect for persons, positive interactive sessions between health care service provider and the elderly, specialized training of health care service providers to care for the elderly and further study on how to improve on the observance of respect for persons in caring for the elderly.

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background of the Study

The consistent global increase in the number of the elderly i.e. from 901 million in 2015 to a projected 1.4 billion by 2030 has had impact on all human institutions but has had no corresponding categorized health care service responses among many nations particularly the developing nations, Bhattacharyya, (2015); (United Nations Population Fund [UNFPA], 2012); Gachuhi and Kiemo, 2005). The increase is causing worldwide strain on resources specifically health services and the mechanisms to adequately address health problems and risk factors of old-age (United Nations, Department of Economic and Social Affairs, [UNDESA], 2015). This decreases elderly potential for optimal ageing (Beard, Biggs, Bloom, Fried, Hogan, Kalache, and Olshansky, 2012; Mubila, 2012). The strain compromises among others, the social aspect of health-care with respect to the elements of health systems responsiveness (*respect for persons*, capturing ethical aspects of interaction with the health system which includes: dignity, confidentiality and autonomy; *client orientation* which gauges consumer satisfaction in terms of prompt attention, quality of basic amenities, access to social supports network, and choice of health providers) and preparedness(staff training and deployment) to care for the elderly (World Health Organization [WHO], 2007, 2000; Hsu, 2006).

Optimal aging which is a desired virtue in longevity, is the capacity of an individual to function across many domains: physical, functional, cognitive, emotional, social, and spiritual to one's satisfaction in spite of one's medical conditions (Smith, 2007; Appendix 1). Worldwide, the elderly, the expectant mothers and children aged below 5 years are

considered as vulnerable populations (Center for Disease Control [CDC], 2012; Velkoff et al. 2007), that is people who need special attention or additional assistance to cope with life.

In the Kenya health system, the delivery of health services to expectant mothers and children below 5 years is guided by specific care service guides, the "Focused Antenatal Care (FANC)" and "Integrated Management of Childhood Illnesses (IMCI)" respectively (Appendix 2). This is because these two cohorts have unique care needs that go beyond the scope of general care which is guided by the Medical model (Green, Carrillo and Betancourt, 2002). The impact of this specific care has had improved health outcomes for mothers and children marked by reductions in ill-health and deaths (Kenya National Bureau of Statistics [KNBS], 2014; Appendix 3). Managing care for the elderly lack such focused care provision despite them being among the vulnerable populations (UNFPA, 2012). The absence of such focused care for the elderly in Kenya indicate a need to investigate how the health system care for the elderly in the context of health system responsiveness and preparedness. It is against this background that the study sought to investigate the responsiveness of health care system on elderly optimal aging in Rachuonyo North Sub-county of Homa Bay County, Kenya.

### 1.2 Statement of the Problem

Globally, the elements of health system responsiveness are inalienable components for optimizing clients' well-being against 'legitimate'' universal expectations (Hsu 2006; De Silvia et al., 2000). In sub-Saharan Africa, non-responsiveness of health systems due to limited health resources, weak health systems, space social network and prevalence of poverty, could be contributing to non-optimal ageing (UNDESA, 2015) and as a result,

most health programs lack targeted care to the elderly. Optimal aging accounts for the differences within and between individuals in terms of adaptation to stressors, therefore, promotion of optimal aging for the elderly is beneficial to both an individual and the society. The increasing population of the elderly globally, regionally and locally, requires a corresponding responsive health care service delivery being that they are among the vulnerable demographics. However, due to limited health resources, weak health systems, sparse and stretched social safety nets and prevalence of poverty, most health programs lack focused care provision for the elderly. Reports from the office of Kenya Demographic Health Survey, Rachuonyo sub-county, has recorded an increase of38% of elderly population between 2014 – 2017 and now top the other sub counties with number of the elderly (KNBS and SID, 2016; Ministry of Labour and Social Protection, Homa Bay County, 2016; table 3.1). In light of this increase and the absence of care service guide for the elderly, the study sought to investigate health systems responsiveness to the care of the elderly towards optimal aging in Rachuonyo North Sub-County of Homa Bay county, Kenya. Previous studies addressing issues of the elderly i.e. Kabole et al (2015) focused on social context of abuse of the elderly in Emuhaya District, Dwele (2015), focused on elderly support centers in western Kenya, Gondi (2009) focused on status and implementation of national policy on ageing in Kenya, Ojwang et al., (2010) focused on nurses' impoliteness as an impediment to patients' rights in selected Kenyan hospitals.

### 1.3 Purpose of the Study

The purpose of the study was to investigate the responsiveness of health systems on optimal ageing of the elderly in rural Kenya, the case of Rachuonyo North Sub-county of Homa Bay County.

### 1.3.1 Objectives of the Study

1. To determine the level of optimal aging among the elderly in Rachuonyo North Sub County.
2. To establish the influence of respect for persons in caring for the elderly on elderly optimal ageing in Rachuonyo North Sub County.
3. To determine the influence of implementation of the concept of client orientation in caring for the elderly on elderly optimal ageing in Rachuonyo North Sub County of Homa Bay County
4. To Evaluate the influence of Health System preparedness to care for the elderly on elderly optimal ageing in Rachuonyo North Sub County of Homa Bay County

## 1.4 Research Question and Hypothesis

### 1.4.1 Research Question

What is the level of optimal aging among the elderly in Rachuonyo North Sub County of Homa Bay county

### 1.4.2 Research Hypothesis

Ho: There is no statistically significant influence of observance of respect for persons in caring for the elderly on elderly optimal ageing in Rachuonyo North Sub County.

Ho: There is no statistically significant influence of implementation of the concept of client orientation in caring for the elderly on elderly optimal ageing in Rachuonyo North Sub County of Homa Bay County.

Ho: There is no statistically significant influence of Health System preparedness to care for the elderly on elderly optimal ageing in Rachuonyo North Sub County of Homa Bay County.

### 1.5 Justification of the Study

Among the fundamental objectives of health system is to improve health of the population by responding to people's expectations (WHO, 2000). Changes are needed around the globe to adapt health systems to serve the increasing number of the elderly and to maximize their health and well-being (UNDESA, 2015). The elderly being among the vulnerable population and whose number has had marked consistent increase in Rachuonyo North Sub County by 38% between 2014 and 2016 (Ministry of Labour and Social Protection, Homa Bay County, 2016), are receiving health care services in environments meant for the non-vulnerable populations. In light of the existing Kenyan health policy that structured health services to six population groups, (the cohorts), and being that the elderly lack care service guide, the study is justified to investigate how health system care of the elderly in Rachuonyo North-Sub County. Previous studies in Kenya focusing on elderly have not explicitly addressed the health systems responsiveness to the elderly. For example, Kabole et al (2015) focused on social context of abuse of the elderly in Emuhaya District, Dwele (2015), focused on elderly support centers in western Kenya, Gondi (2009) focused on status and implementation of national policy on ageing in Kenya, Ojwang et al., (2010) focused on nurses' impoliteness as an impediment to patients' rights in selected Kenyan hospitals.

## 1.6 Significance of the Study

The study would inform policy on the current state of care for the elderly so as to make research based informed decision in planning care for the elderly. The study would also lead to improved health service delivery to the elderly through adequate resource mobilization, social integration and ease of choice of providers. The overall benefit would be optimal aging which capacitate the elderly to take active role in self-care and also to benefit the nation through their rich experiences and virtues (Gupta, Satpathy, Chandra, and Patel, 2014) and (Government of Canada [GoC], 2012). It would nurture harmonious relationship between health care service providers and the elderly by creating good relationship which facilitate uptake of health services (KNCHR, 2009). Finally, the study would contribute new knowledge to enrich care services to meet the complex social aspects of care for the elderly.

## 1.7 Scope of the Study

The study was geographically confined to the topic of the survey: the responsiveness of the health system and specifically the social relation non-medical aspect of health care to the elderly. Demographically it was limited to the 385 elderly who had received health care services at the sub-county health facilities managed by the County government and private health care providers who participated as main respondents. The study also targeted 45 health care service providers working in Rachuonyo North Sub County health facilities as Key Informants. Methodically it was limited to exploratory descriptive cross-sectional survey using semi-structure questionnaire, interview schedules and Focus group discussion guides with observations as ongoing integral aspect. Geographically the study was limited to Rachuonyo North Sub County of Homa Bay County in Kenya.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Introduction

This chapter presents a review of relevant literature and the current knowledge on health system responsiveness and optimal ageing on care of the elderly. The reviews are guided by the objectives of the study and the hypotheses and take the thematic approach. The review is approached from the global to Africa, Kenya and to the study area. The review also presents the theories that underpin the study and a structured conceptual framework that shows the relationship of the variables.

## 2.2 Health System and Optimal Ageing

Health system include all the organizations, institutions and resources that are devoted to produce health actions (WHO, 2000). The objectives of health system are to improve health of the population; respond to people's expectations and to provide financial protection against the costs of ill-health (Audu, Bako, Abdullahi, Omole and Avidime, 2014). Responsiveness is the system's ability to offer high quality care that reflects how well the system responds to the population's legitimate expectation (individual's beliefs regarding desired outcomes): to be treated physically and psychologically to meet or not meet the non-medical enhancing social aspects of care (Peltzer and Mafuya, 2012). The elements of health system are discussed under two broad classifications: respect for persons (dignity, confidentiality and autonomy) and client orientation (prompt attention, amenities of adequate quality, access to social support network and choice of provider).

Optimal aging is the capacity of an individual to function across many domains: physical, functional, cognitive, emotional, social, and spiritual to one's satisfaction despite one's health status (Smith, 2007). The concept includes the elements of satisfaction: social satisfaction, social participation, social function, social resources and active engagement with life. It differs from successful aging which focuses on absence of disease and disability, high cognitive and physical functioning, and active engagement with life (Donnellan, 2015).

A recent assessment by the World Health Organization (WHO) (2015 in UNDESA, 2015) warns that health systems around the world are falling short with respect to meeting the needs of older persons. The report summarizes the present situation thus "Current public-health approaches to population ageing have clearly been ineffective. Health of older people is not keeping up with increasing longevity; marked health inequities are apparent in the health status of older people; current health systems are poorly aligned to the care that older populations require even in high-income countries; long-term care models are both inadequate and unsustainable; and physical and social environments present multiple barriers and disincentives to both health and participation (p. 18). Thus, changes are needed around the globe to continue to adapt health systems to serve a growing number and proportion of older persons and to maximize health and well-being at all ages".

### 2.2.1 Objective 1: Level of Optimal ageing of the elderly.

Levels of optimal ageing in the elderly as in other population groups is a product of multifactor agents of which health care is one. Longevity predisposes people to live with physical impairments acquired either in old age or early in life and since age periods have

no supremacy over the gains and losses of developmental changes across life-span, it is essential for human actions and personal initiative to keep this balance favorable (Aboderin 2010). A reflection of Cicero (44 B.C.) argument in his essay "De enectute" states that if old age, is approached properly, it gives opportunities for positive change and productive functioning, however, the American Psychological Association ([APA], 2012) commented that as older people today live longer, they experience the hidden problem of exploitation and neglect which impact negatively on their psychological stability. According to UNDESA (2015) and WHO, (2007), the elderly in low and middle-income countries do not experience optimal aging as compared to adults in other age groups.

In Sub Saharan Africa (SSA) Aboderin (2015) reveal that health-care services are deficient in their responsiveness to the needs of the elderly therefore jeopardizes the process of elderly optimal ageing. In Kenya as in many other countries, the custodian of health is the ministry health (KDHS, 2014), however, its supportive mechanisms for elderly optimal ageing transcend the confines of the ministry alone. This suggest that optimal ageing could be achieved through multidisciplinary approach as spelt out by Smith, (2008).

The impact of global increase of the elderly which was projected at 56 percent increase from 901 million in 2015 to a projected 1.4 billion by 2030, is being felt in all human institutions globally according to a study in Europe (PEW, 2014) and a global study report (UNFPA, 2012). This is due to lack of corresponding categorized responses necessary for empowerment (Beales, 2012).In examining the problem of income inequality in Africa Mubila (2012) asserts that developing nations feel the impact of the

elderly increase in the context of poverty and unpreparedness. Poverty is multidimensional and, in most instances, it includes deprivation in knowledge, decline in life expectancy and in quality of life. Poverty relates to lack of material needs signifying deficiency of social, economic and cultural rights, which are important and vital for survival and or well-being especially for the elderly. In a report on status and implementation of national policy on ageing in Gondi, (2009) highlight that Kenya poverty index stand at 52.6% and is worse among the rural communities.

The strain of the increasing number of the elderly on health resources affect services and the mechanisms to address the accompanying health problems and risk factors of old age (Help Age, 2013; Mubila, 2012). Specifically, it jeopardizes, the social aspect of health-care with respect to elderly optimal ageing Gondi (2009), and (WHO, 2007). According to UNDESA (2015), the elderly in low and middle-income countries do not experience optimal aging as compared to adults in other age groups. In Kenya, studies by Kabole et al (2013) and HelpAge (2001) revealed lack of responsiveness in Kenya health system to the elderly in many forms under different circumstances and places including the hospitals. In this study, the investigator has however not met any literature on the elderly in the study area except for their number.

The common life stressors in old age are often associated with changes in life. These could be due to aging processes such as functional loss, changes in family, and the economic factors. A report on Africa demographic trends (Mubila, 2012), affirms that aging population face a set of challenges linked to many long-term conditions which preclude elderly optimal aging. A study in Nigeria revealed that 42% of health service are sought because of ageing processes (Audu, 2014).

According to World report (UNDESA, 2015), the leading cause of disability in females includes depressive disorder, hearing loss, back and neck pains, mental confusion, and painful joints. In men the leading cause of disability include hearing loss, back and neck pain, falls, lung diseases, and blood sugar disease. The report further points that elderly in low and middle-income countries do not experience optimal aging. The findings of the report reflect Miller et al. (1999) that majority of the elderly suffer varied multi-morbidity conditions and that delay to address them often have far reaching consequences.

A study in Kenya by Kabole et al., (2013), found that old age diseases are assumed by the elderly and taken to be normal accompaniments of ageing, as a result, there is laxity in seeking for treatment. In Brazil, Chaves (2009) found out that a responsive health system can reduce cognitive decline and improve wellbeing among the elderly. The report further revealed that confidants and family income were protective factors for optimal aging. Virtues of optimal ageing include among others positive emotions, absence of feeling of loneliness, social desirability, intellectual functioning, maintenance of valued leisure activities, undertaking activities of daily living such as washing, bathing, dressing up, cooking with or without minimal assistance.

According to Smith (2010), the realization of optimal aging for the elderly could be achieved through various approaches including biological (exercise, nutrition, sleep, avoidance of disease causing agents, early treatment of diseases, cognitive stimulation among others); psychological (attitude, stress management, resilience); social (support, activities, spirituality, sex); functional (strength balance, flexibility); Societal(health education, chronic diseases self-management training, access to information, community service, environmental design, health policies and insurance). Specifically taking regular

exercise, eating breakfast, avoiding smoking, sleeping at least seven hours, maintaining moderate weight. These finding are consistent with that of a survey conducted in England (Doyle, DuBosle, Ellingson, Guinn, and & McCurdy, 2010) that good respiratory function is a good predictor of optimal aging, being physically active protect against long term illnesses, being resilient enables the elderly to adapt, purposeful activities by the elderly creates a feeling of acceptance and being valued and that personal and societal planning for involvement of older people is central to optimal ageing. The report concludes that older people should be encouraged to take opportunities for personal development, and engagement with society. Since most of the manifestations of ill-health in the elderly are often salient and occur at the home environment where the family or community support system is the most likely first-hand help, there is need for health system to actively link families in the care of the elderly. This view is supported by Franklin (2013), who in assessing potentially inappropriate medication in elderly in the UK health system, castigated inappropriate medication effects in the elderly due to poor social supervision.

Older persons in good health enjoy greater sense of personal wellbeing and can participate in economic, social, cultural and political life. On the other hand, poor health reduces the capacity of older persons to generate income, curtail their productivity and compels them to depend on other people. In a WHO report on a framework for measuring responsiveness, De Silvia, (2009) maintained that patient satisfaction with non-medical aspects of care, is often associated with better compliance with treatment instructions, prompt seeking of care and a better understanding and retention of medical information.

### 2.2.2 Objective 2: Influence of observance of respect for persons on elderly optimal ageing.

Respect for persons was reviewed in the context of dignity, confidentiality and autonomy in caring for the elderly.

**(i) Observance of Dignity of the Elderly by Health care service providers.**

Dignity as a philosophical, religious and ethical concept has its origin in the Latin word "dignus" meaning worthy or honorable. It is a human right concept about feeling and being treated or regarded as important and valuable in relation to others (Clark, 2010). Dignity bridges law, ethics and politics and is a core basic principle of most human rights treaties (Ojwang, Ogutu, and Matu, 2013; Kenya National Commission for Human Rights [KNCHR], 2009; Sweet, 2007).

In its application in human relations, Gwenda, (2007) point that it is an objective right and a subjective multi-dimensional concept, with different cultural interpretations and shared meanings. Dignity consists of many overlapping aspects relating to a sense of who one is, the identities as a member of cultural, ethnic or religious group which ultimately culminate to a sense of self-worth. It is connected to the self-concept and self-esteem such that the extent to which a person is treated with or without dignity can give rise to an acute or chronic emotional effect.

Recognition of dignity is an inherent and inalienable rights of every individual and is the foundation of freedom, justice and peace. In general, dignity is the culmination of the power of inclusion (promotion of involvement); value (engendering respect); and appreciation (identity, effective communication, person centered care). Conceptually,

dignity is a crucial notion in building and sustaining a human environment in which an individual feel included, valued, and appreciated (Pearson, Jeffrey and Rodger, 2012).
In the developed nations when the elderly are treated with dignity, they experience raised sense of self-worth and self-esteem and as a result comply with management of their conditions. In Wales, Gwenda (2007) emphasizes that acknowledging a person's dignity contributes to a sense of good health, wellbeing and independence. The manner in which care provider interact with the elderly (find the right way to talk with them, assesses care requirements effectively, respond to their needs and fears positively, and treat them with respect) has profound effect on that person's life.

Good listening and talking to the elderly is possibly the point where dignity in care begins. Once rapport develops, care providers would begin to see the whole person, and the foundation of dignified care would be built. This helps to enhance, built and sustain the elderly confidence, independence of thought and action, and to be determined to remain as active as possible (Galloway, 2013).In reviewing the definition and concept of dignity Clark (2010) pointed that in the contrary, elderly would display emotional reactions marked by among others resentment, anxiety, humiliation, embarrassment, loss of self-esteem and depression all with diverse negative psychological impact.

In health-care settings, observance of dignity in the care of the elderly is unique because the relationship between care-providers and the elderly plays a big role towards latter optimal aging This was highlighted in a thesis by Falk, (2013) while reviewing elder abuse in Illinois, Pearson et al. (2012) in reviewing health systems in Europe; and Velkoff et al. (2007) in a study on population Aging in Sub-Saharan Africa: Demographic Dimensions. Reports from the Inspection and Reviews across the United

Kingdom and from the Institute of Medicine (IOM, 2001) in Washington DC revealed immense divide between what is known to be good health care and the actual care that people receive. The elderly expressed concern of being neglected or ignored while receiving care, being cared for in mixed sex bays and wards that accommodate both men and women, made to feel worthless or a nuisance, feeling that their privacy is not respected, being fed and not assisted to feed, forced to use a commode or incontinence pads rather than being provided with a wheelchair then supported to use the bathroom, disrespectful attitude from care providers or being addressed in disrespectful ways; being provided with bibs intended for babies rather than a napkin while being assisted to eat; having to eat with fingers rather than helped to eat with knife and fork, having no care provider support for eating, food being taken away before meal is completed, being rushed and not listened to, being treated more as an object than a person; not being asked about their preferences.

A study in England by Cairns et al., (2013) and by Pearson et, al. (2012) revealed that in Europe, lack of dignity, respect and age discrimination for the elderly are among the common vices in health and social care settings whose effects are damaging to both individuals and society. Stereotyping of the elderly as passive and dependent, erodes individuals' the sense of self-worth. People aged over 70 years are persistently seen as incapable and pitiable. There is disregard for the elderly preferences and aspirations in the design and delivery of services. In whatever form indignity is expressed, the effects may be negative even in the absence of the long-term diseases which are common in this age group (American Psychological Association [APA], 2012).

In terms of personnel, a study evaluating causes of poor care for the elderly in England (Age UK, 2013) indicated the need for enough care providers to give personalized care rather than few who rush to complete tasks. Studies in Europe and America on management decisions for the elderly also indicated that there is the tendency to deprive older persons' some treatment solely because of their age without any justification (Alvarez-Fernandez, Bernal-Lopez, Cabeo, Manuel, Cristobal, 2015).

Africa is however responding to the elderly with mixed reactions though skewed towards ageism. In a WHO global study of 35 countries, observance of dignity in health-care delivery had an average score with Nigeria scoring 5.59 out of 10 ten (55.9%) (De Silvia *et al.*, 2009) and 5.41 out of 10 (54.1%) (Shafiu, et al 2013). Mubila, (2012) pointed that Africa's elderly faces different set of challenges marked by long-term physical and mental disability and varied chronic conditions that increases the needs for holistic care to realize optimal ageing, yet health systems in most African nations are weak and unable to adequately address these health problems holistically. The social safety nets are sparse and over-stretched with marked poverty particularly among elderly-headed households.

According to Cairns et al, (2013), the full implementation of the MIPPAA resolution has remained challenging to most African nations leading to inadequate care for the elderly. Governments are urged to take lead and set positive debate about the ageing society, to celebrate their contribution, build rather than cast them as a problem to be solved.

Observance of dignified care in health institutions may be looked at in three different levels.

Level One addresses the personal responsibility that each care provider has in the provision of dignified care and challenge to poor practice. Level two considers the

leadership at the ward or unit in-charges and institutional boards with regard to integration of institutional and national policies. Level three looks at the wider context of how services are commissioned, the role of professional bodies, universities and client's rights. Integral to these levels is the building of caring families and communities and the recognition of the social and economic contributions of the elderly to the communities (Dwele, 2012; HelpAge, 2001).

A survey conducted in Kenya health facilities reveals deplorable undignified treatment by care providers across all age cohorts and take the aspects of the physical, psychological, financial, and neglect (HelpAge, 2001). Acts of neglect, abusive language, and delayed care are among the key pointers. It is reported by Gondi (2009) that elderly often declines or resent in-patient admission because of poor attitude of the care provider towards them and because it is impossible to get needed care due to insufficient care providers. The elderly feels rejected viewing the hospital as no good place to be left in. Some elderly who accept admission are often conditionally compromised.

The Kenya National Commission on Human Rights (KNCHR, 2009) report reveals that the rights of older persons including challenges faced by Kenyans as they grow old remain a neglected issue left to the focus of few NGOs with hardly any government intervention and support. One of the most critical tenets of human rights is the protection against discrimination yet the situation confronted as one grows old in Kenya is discrimination with resultant dehumanization. There seems to be a shared understanding and agreement that growing old is a pathway to deserved oblivion. It is a palpable neglect and discrimination that leads to exclusion both in terms of public affairs dialogue and resource allocation which places older persons in jeopardy (Aboderin, 2010).

In Western Kenya, many elder lies feel that they have no place in the society among other things (Dwele, 2012). With ageism being internalized, it is unlikely to end age-prejudice which is maintained in conformity to social norms and practices into which people are socialized. It is also unlikely to get dignified care in health facilities.

In terms of home care, a significant number of the elderly are discharged and continue to receive non-professional health care or need practical help at home to get back on their feet. In Kenya, most of the older persons suffer from poor health which limits their participation in social, economic and political lives and are unable to access proper nutrition which further increase their health risk. They lack income to access appropriate health service, health personnel have negative attitude towards them, drugs are often not available and, in some cases, they are unable to access health services due to long distances to health facilities This was the gist of the result by Ojwang *et al.*,(2013) in a study on Nurses' impoliteness as an impediment to patients' rights in selected Kenyan hospitals.

In conclusion, Factors that maintain or adversely affect dignity in care according to Galloway (2013) are associated with the physical environment and the culture of the organization (Place), the nature and conduct of care activities (Processes) and the attitudes and behavior of care provider and others (People). Dignity in care for the elderly is compromised relatively in both developed and developing countries. Promoting dignity in care involve providing care in settings which supports and enhances rather than undermines the elderly person's self-worth. Health system should therefore have a workforce that is sensitive to dignified care of the elderly.

**(ii) Observance of Confidentiality of the Elderly by Health care service providers.**

Concerns about personal privacy in health informatics is an old concept rooted in the patient-provider relationship which is traced back to the fourth century BC and in the Oath of Hippocrates. A duty of confidence arises when one person discloses information to another in circumstances where it is reasonable to expect that the information exchanged will be held in confidence (Burlison 2016).

Confidentiality is both a legal requirement and an ethical obligation and is foundational to privacy in health service delivery. Before many professionals enter into their practice, they take vows to honor the related ethical rules which include vows to hold certain communications confidential and not repeatable under any circumstance. Professions that adhere to such vows include among others, health, law, and liturgy. The vow is so sacred that breeching it such that individual suffers damage (i.e. reputation, mental or financial), often attract legal and or professional sanctions (Kenyan Constitution, 2016; Brodnik et al, 2012; Cymru, 2005).

The fundamental elements which underpin confidentiality are nature of the information, nature of encounter and nature of disclosure. Information that identify patients/clients must not be disclosed or used without the individual's explicit consent except in cases of strong public interest or legal justification. Individual consent implies that the patient (owner of the information) has full understanding of the content, context and the repercussions of divulging information. Strong public interests protect the population from the likely risks if the information is concealed. Legal justification is where in the justice of law, the information about a patient can be divulged even without consent.

Health service consumers entrust care providers with sensitive information on their health conditions and related personal matters in search for treatment, advice and support. They do so in confidence and with legitimate expectation that their privacy would be protected (Burlison, 2016; Valerie, 2014; AHIMA, 2011). Confidentiality as an element of health-systems responsiveness requires health-care providers to keep patients' information private unless consent to release that information is given or except under conditional circumstances i.e. when not doing so would endanger other people (Parsons 2012). Health information managers serve as the stewards for accuracy, completeness, confidentiality, privacy and security of personal records (Washington, 2010).

Health service to the elderly involves prolonged close contact since their ailments are often chronic and complicated necessitating extensive disclosure of personal information on social relationships, interests, habits, behaviors and finance (Levine, 2013). Health-care provider should therefore strive to comply with the ethical behavioral requirements for confidentiality.

In health care settings, patient information may be used for a number of reasons including managing care, assessing the effectiveness of care, adjudicating payment claims, managing population health, measuring and improving health status, marketing pharmaceutical and health products, supporting medical practice, conducting health research, performing oversight activities i.e. credentialing, accreditation, licensing, fraud investigations; tracking and protecting public health, supporting law enforcement, confirming hiring decisions. Public attention however tends to concentrate on security issues associated with wrongful, unauthorized disclosure of information which health-care organizations must implement specific tools, policies, and procedures to address.

In the Americas, both federal and state laws authorized disclosure of records for a variety of purposes including fraud and abuse investigations, public health, peer review, accreditation, and licensing. The nature of identifiable information may be in written, electronic or simply held in the memory of care providers. Specifically, they include clinical information of diagnosis, treatment, images, audiotape, the patient's doctor, the facility and any other information that may be used to identify patients directly or indirectly (McArt, 2010).

From the recent past, advances in electronic technology now facilitate public awareness such that control of personal information may transcend safe boundary. People are anxious about the rapid pace at which information is exchanged therefore are eager to see control measures in managing personal information. Those who use health information are ultimately anxious to ensure that necessary restraints (i.e. privacy protection Act), do not unduly interfere with their function.

The threat to personal privacy arises from the concept of medicalization which perpetuate perceived false health benefits of advertisement. These include marketing and oversight that use personal health information for commercial advantage and pharmaceutical companies which rely on prescription to target customers who might be interested in their new products or services. Baby formula manufacturers often use hospital admissions data to target new mothers. While consumers could conceivably benefit from this unsolicited information, many privacy advocates object to the availability of this information without patient's consent.

The model proposed by Wales Health System (Cymru 2005) to improve confidentiality in services delivery has four elements presented in an acronym "PIPI" which stand for

protect, inform, provide choice and improve. Protect involve safe procedures, accurate and consistent recording, and safe keeping of information; Inform ensures that individuals are aware of how their information is used i.e. may be recorded or shared for efficiency and relevance of service. The elderly should be made to understand the concept of confidentiality and disclosure to alleviate possible apprehension related to un-consented divulging of information. In Kenya this aspect is taken care of by the "Service Charter" displayed in county health facilities. Its applicability may however be limited to the literate elderly who visit health facilities in uncompromised state. Provide choice allow individuals to decide, where appropriate, whether their information can be disclosed or used in particular ways. Improve always look for better ways to protect, inform, and provide choice. Healthcare system should therefore empower care-provider on managing confidentiality in cases of uncertainty by put mechanism for, and acting appropriately on feedbacks.

Confidentiality has been debated in various national constitutions worldwide: The Universal Declaration on Human Rights 1948, European Convention on Human Rights 1950 and 2003; Council of Europe Convention on Data Protection 1981; Convention on Human Rights & Biomedicine 1997; Data Protection Act 1988 and 2003; Freedom of Information Act 1997-2003; Convention on Human Rights Act 2003; Common Law and the Lisbon Treaty.

Concerns about the confidentiality of health information are widespread. This raises the questions about how to protect the confidentiality of information that passes into the domains of secondary and tertiary users. In certain circumstances like mental disorientation (common in the elderly) or unconsciousness, patient may lack the

competence to conceive their rights in relation to confidential information. This however, does not absolve care providers from the duty of confidence. If legal requirements are to be met and the trust of patients and service users is to be retained, it is essential that health systems provide confidential services.

The health information management (HIM) profession and the American Health Information Management Association (AHIMA) believe that confidentiality, privacy, and security are essential features of viable health record which fosters trust in health-providers (AHIMA 2007). In terms of versatility, electronic information is more easily manipulated, widely linked and highly portable. In this regard, computers can increase the ability to create, use, store, transfer, protect, disguise, and track the disclosure of information. With such power, breaches of confidentiality can inadvertently occur in the process (Cymru 2005). Among the nations that have enacted strict policies, procedures, and penalties to address confidentiality in health care are Canada, New Zealand, and the European Union.

In practice, individualized values must be honored in line with the health conditions, personal information and family circumstances. The extent to which information is to be treated should be established with the client because what is sensitive to one person may not be to another and these should be circumstantially debated. Privacy is a personal right attached to an individual who owns the information and have a right to know where and why the information is used. Violation of that right can undermine the fundamental trust for clinical relationship. It emerged that when patients' rights are denied, patients resort to retaliation by violating the dignity of the nurses. This jeopardized the envisaged

mutual support in the nurse-patient relationship and compromised patient satisfaction (Almalki, Alzahrany and Alharthi, 2016).

Distrust of a health system would undermine even the most beneficial goals, for example, clinical research will have little value if the credibility of data is in question. People would not be honest with information on such issues like genetic predispositions, unhealthy behaviors or stigmatizing diseases. Factors upon which fair information practices are based include openness and transparency in which people should know what records exist about them, how the records are maintained, where they can get the records, and how to use the information; access and correction where individuals should be able to view and amend their records to correct errors; data quality which should be timely, accurate, relevant, and complete for the purpose; collection limitation which should be fairly lawful; disclosure limitation such that those who have access to personal information should not disclose it without due consent or legal authority; use limitations to purposes specified at the time of collection; reasonable secure security system; accountability to ethical principles of adherence by record-keepers (Levine 2013).

Organizations should have policies and procedures to discourage gossip, keep people from looking at or disclosing records inappropriately. The common issues surrounding confidentiality are patients' access to their information, access of information beyond the realm of health care, segregating information, and research. Controlling access of others to information raises the questions of who should have access to personal information, how much access should they have, what is the purposes for access, who should control that access and how. In general, any use of health information is appropriate as long as it

has been authorized by an informed patient. In reality, people often authorize disclosures of their information without fully understanding what they are allowing.

In Kenya, management of patient's record is under the care of health records managers and is protected by the constitution. It is addressed by "the Access to information Act No 31" contained in the Kenya Gazette Supplement No. 152 (Acts No. 31) of 7th September 2016. The Law Society of Kenya state that since the medical records are part of a person's private life, every patient or client has right to have medical information and treatment confidential between health-care professional and the patient and thus disclosure of records without patient's consent is a breach of the law except where it is allowed by statute or is in public interest. The duty of confidentiality shall be maintained even after a patient's death (Law Society of Kenya 2012). A study in Kenya points that the elderly are apprehensive in keeping appointment date because of fear of lack of keeping their ailments confidential. This results in a diminishing faith in the medical establishment and the rise of alternative medical philosophies and practices (Green 2002) and (AHIMA, 2007).

**(iii) Autonomy in the care of the of the Elderly**

The term autonomy refers to a universal ethical principle of freedom which is reflected in most health-related professional codes (Andersen and Puggaard, 2008). The term has its origin in the Greek word "autonomia" from autonomos literally" having its own law: autos for self and momos for law. It is a concept that expresses the idea that persons should direct their own actions and be free from coercion or undue influences. Deeper insight which incorporates concepts of critical reflections and negotiations expands the meaning and application to include informed decision making (Eileen et al. 2014;

Andresen et al. 2008). In principle, autonomy is the ability of competent individuals to make decisions over their own lives and includes but not limited to freedom to make decisions about health and living arrangements among others. In order for autonomy to be meaningful, a competent individual's decision should be respected even when those decisions conflict with what others believe to be reasonable or even if the patient decides not to follow health-care advice.

Autonomy touches almost all sectors of social life but has profound effects on health practice where it is expressed in the doctrine of informed consent which defines a set of patient rights and reciprocal obligations from health professionals. Enhancing patient autonomy therefore means helping them to make their own decisions (Beales, 2012). In this context, it is incorporating the elderly as active participants in decision making towards optimal aging.

According to Stiggelbout, Molewijk, Otten, Timmermans, Bockel and Kievit, (2004) descriptive medical decision-making literatures view autonomy as a decision-making dimension of the patient role, a critical reflection of what one wants to be or how one wants to act in line with one's norms and values "the good life''. On the positive side, autonomy supports criticisms of ageism, social attitudes and practices that limit the freedom of or relegate elders to a secondary social status and the elimination or modification of age-based discrimination. It equally advocates the idea that elders in retirement should remain active and be engaged in decision makings. It has introduced into gerontology a focus on individuals who are regarded as independent of other social structures but who have the capacity for independence, self-directed, deliberations, and

decision-making. These virtues preeminent the positive implications of autonomy for optimal aging.

In the context of health care, autonomy is recognized as a fundamental principle in bioethics in which a competent individual is able to rationally decide which medically indicated procedures are appropriate for them (Andersen 2008). This morally obligates health professionals to provide patients with accurate and complete information to make informed decision. On the contrary, there is widespread insensitiveness of health-care providers to the application of autonomy in service delivery. By castigating the social implications of autonomy by the American society Agich (2002) comment thus

> "As a society, we have ignored the material and social conditions that are required for autonomy to flourish. We have allowed autonomy thwarting institutions to dominate the care of the infirm and the sick old. Rather than building autonomy-sustaining institutions, long-term care of elders has accepted a medical paradigm of service delivery rather than a paradigm of providing an environment suitable for sustaining a compromised autonomy". Care providers often ignore autonomy as a concept for patient's participation and therefore negate client's power for participatory ownership by dominating decision making and planning processes" pg. 4.

In a study by Ameneh et al., (2011), clients expressed concern over health care service provider looking down upon their decision-making power. The report says, "'They think that doctors are the only ones who know everything.... Of course, we may not be literate but we know what works and what does not……. When they consider us as low-class people they don't even ask for our participation"

According to Brent (2014), social care workers have unique opportunity to promote good mental health and wellbeing for people to enable them to take active roles in making their choices. It is therefore important to find ways of supporting people towards their own empowerment and to take initiatives. This will often involve working in partnership with people to support them in making decisions based on their lived experiences, needs, preferences and ambitions.

From the normative perspectives, Stiggelbout et al (2004) outline six moral relational aspects of patient autonomy. The four applicable to health care include the liberal legal concept, liberal individualist concept, autonomy as critical reflection and actual autonomy as identification, the liberal legal concept directed towards those who care for the patient, stresses ‘‘freedom from’’ interference by others and demand respect for patient’s integrity. The liberal individualist concept assumes that patients are rational and reasonable agents who act intentionally with understanding and without external controlling influences for their actions. As a critical reflection, autonomy gives room for conscious submission to some form of external authority (physician, religion, leader, etc.). This concept relegates patient power to physician’s decision on treatment so that the paternalistic physician play a role after critical reflection on patient’s preferences. Actual autonomy is an approach which promote dependence as patients identifies with the decision already made.

Concern about whether age, physical and mental illnesses of old-age erode the power to make informed decision. Literature indicates that old-age alone does not preclude a patient from ability to give consent however, since a large number of elderly patients suffer from debilitating mental illnesses, obtaining consent can become a challenge.

Debates on whether elderly with dementia (ailment of progressive memory impairment) are capable of making rational decisions have not been fruitful. In such cases it would be rational to take the beneficence approach by care provider to play paternalistic role and decide for the patient (Dymek, Atchison, Harrell and Marson, 2001; Auerswald, 1997).

The other factor to consider is whether age and illness makes elderly patients vulnerable to coercion by health-care provider and/or family members into making decisions. Since a significant percentage of the elderly is vulnerable due to various factors (poverty, inadequate education about medical matters, physical and mental impairment), conditions of ill-health and old-age can contribute to helplessness which in turn can subject the elderly to undue influence by others.

Decision-making by the elderly is a complex process that should be based on comprehensive assessment as a tool to weigh the risks and benefits of treatment. In many cases co-morbidity, functional capacity, patient wishes and cognitive status are more determinant of patient survival and quality of life than the actual process to be treated. These should form the framework supporting therapeutic decisions (Alvarez et al. 2015).In evaluating elder care in nursing homes Falk (2013) emphasize that residents have the right to refuse any service, medicine, food, etc. but it is the responsibility of the health care service provider to educate them about their options. In some cases, courts usually demand for sufficient evidence that the elderly in question is unable to manage life decisions before a guardian is constitutionally appointed (Florida Statute Chapter 765-Part II) to make medical decisions and pursue elderly best interests (Andersen 2008). Where family members differ about the best course of care for their elderly relative, the care provider is mandated to resolve the dispute. Check points (i.e. periodic report to

local court) are often in place to guard against weaknesses and draw back associated with guardianship and surrogacy. Although family members might believe that their elderly decision is misguided, the choices are to be respected so long as the steps for obtaining valid informed consent have been followed properly.

In Western Australia, Henderson, (2003) found that nurses considered patient involvement as an interference in the nurse's duties, and that majority of nurses were unwilling to share their decision-making with patients. This creates a sense of exclusion, resulting in little input by patients. In South Africa and China autonomy ranked lowest among the elements of health systems responsiveness and is identified as priority area for actions to improve health services (Kowal, Naidoo, Williams and Chatterji, 2011). In Nigeria, Shafiu et al (2013) revealed that providers in public institutions involved clients less in decision-making than those in private institutions. Males were relatively more involved than females. In North America and Europe, informative model see patients as consumer who is in the best position to judge what is in his/her own interest, and thus views the health care provider mainly as providers of information.

In Kenya, health care service provider is viewed as authoritarian benefactor while the patient is considered vulnerable and subservient. Authoritarianism often curtail claim to rights despite growing international consensus that all patients have a fundamental right to autonomy among other elements of care services. A human rights approach calls for an accommodative provider-patient relationship which ideally guarantee the patient the right to autonomy, expression, self-determination, information, attention, and non-discrimination (Ojwang et al. 2013). The greater percentage of health workforce in the

Kenyan health facilities is the nurse whose shortage contributes to the negative authoritarian attitude occasionally manifested.

Among the unsatisfactory strategies cited for autonomy include withholding and failure to explain information. The most complaints is that nurses do not explain procedures but are quick to blame the un-informed patient. This violates patient's right to be informed unconditionally (Kenyan charter of patients' rights). Another unsatisfactory strategy is forcefulness and over-determination, not caring whether patient is ready for a procedure (i.e. dressing). A patient reported an accusation by a nurse who quarreled and said that the patient lacked respect instead of explaining the intended procedure. Poor communication is also cited in a case where nurse carelessly told the patient's relatives that his condition (tuberculosis) was contagious; hence it was up to them to approach patient's isolation room. This ignored the patients' right to preserve self-esteem, violated objectification in which an actor is treated like a thing and not a person thereby forcing an actor to humble oneself by compromising closely held beliefs. Ignoring and dismissing patients' concerns is another reported unsatisfactory strategy. Patients reported nurses' dominance and control over interactions. The report indicated that nurses were harsh and did not want to listen to patient's explanation. All they wanted was a "yes" or "no." (Ojwang *et al.*, 2013).

A case is cited in America where a relative report thus "My sister, who was in severe abdominal pain, asked me to accompany her to the Emergency Room of a major New York City medical center. We waited and waited and finally a triage nurse told my sister to follow her into a room. I got up to join her, but the nurse stood in my way, saying, "You can't come with her. My sister said, "But I want her with me." No way. I should

have insisted but I had learned from my long experience with my late husband that a family member who raises questions or challenges a nurse quickly gets labeled as a pest or an even nastier epithet, and I did not want to jeopardize my sister's care"

The act of dismissing, ignoring, or discounting the patients' perceptions, concerns, needs, and feelings violated the right to express opinions freely on matters related to their treatment. This is also specified in the Kenyan charter of patients' rights.

A host of undignified cases cited in a study by Ojwang et al (2013) points the degree to which patient's autonomous participation in care planning and service delivery is unlikely. In England the following sentiments were expressed by the elderly and their caring relatives: "She was left to lie in her excrement and urine"; "An old boy about 90 had wet himself. On changing him, they left him lying on the bed (naked), curtains all open" "I was both shocked and appalled at the callous attitude of the nurses in the ward"; "my mum's dignity was nonexistent in their eyes". "There were problems with preserving dignity and individuality when meeting patients' essential needs"; "The GP just says `confused.' She never explained it". Although patients find themselves in confinement due to their health conditions, acts that humiliate them and limit their fundamental rights are undesirable. The same study also highlighted acts of good practice that may enhance patient participatory contribution for self-care services. Nzinga et al. (2013) highlights the need to train senior and mid-level hospital managers in two key areas that may have impacts on patient's autonomy. As mentors/coach and as strategists/negotiator, the former encompasses goal settings, therapist and motivator. The latter encompasses information managers, communicator, decision maker and problem solver. For hospital managers to be effective, they should be empathic, emotionally

intelligent, approachable, and have the ability to put people at ease. They also need to have rapport that invites people to come to them with problems, questions and suggestions. In assessing the health services for the elderly in England, Lothian et al (2001) point that maintaining high standards of autonomy in health is a global problem but the key to tackling poor attitudes by health care providers towards the elderly is through training. Understanding the concept of autonomy facilitate recognition of potentially oppressive health regimens, support the development of respectful relationships that enable patients to develop and exercise self-governance skills.

In view of the above observations it is evident that observance of autonomy is invariably compromised globally in the care of the elderly. The evidence suggests that observance of autonomy stems from the elements of attitude and tackling negative attitudes through exposure and education can be of great help. Experiencing autonomy is recognized to promote health and well-being but it is hampered by perceived lack of control by health care providers. Health promotion strategies for the elderly are of prime concern and therefore giving them adequate information empowers them to make informed choices about their care. In Kenya senior and midlevel hospital managers need adequate preparation as mentors, strategists and negotiators so as to be sensitive to elderly autonomy. In conclusion, the elderly rarely gets involved in decision making about their care

### 2.2.3 Objective 3: Influence of client orientation on elderly optimal ageing.

The concept of client orientation is discussed by considering the second set of health systems responsiveness: prompt attention, amenities of quality, access to social support network and client

choice of care provider.

**(1). Prompt Attention**

Prompt attention in this study considered access to care and waiting periods for treatment. Promptness in attending to health needs of a client has much impact on subsequent and follow-up

care. Lack of prompt attention to the care needs of the elderly is attributed in part to inadequate number of care providers; lack of supervision; delays in administrative processes and settling of claims (Mohammed, De Allegri, Suleman, Babale, Sauerborn and Dong, 2011;Bosl 2007, Valentine 2003) the facility factor which in the case of Nigeria, Ghana and South-Africa refers to the type of health facility, inadequate number of personnel, lack of training for care provider, insufficient triage by care provider, and high ratios of elder to caregiver (National Center for research [NCR], 2005).

Falk (2013) in a review of care in nursing homes, identified six common factors contributing to late attention to the elderly. These includes low job satisfaction, poor attitude towards the elderly, burnout, stressful work environment and drug/alcohol abuse. Public providers performed poorly in prompt attention compared to private providers. This is attributed to booking appointments without specifying patient's consultation time for a particular day, high patient numbers exceeding capacity of the facilities, poor quality of public services, especially poor attitude of providers and

bad interpersonal relationships (Adesanya, 2012; Jehu, Aryeetey, Agyepong, Spaan and Baltussen, 2012). In a study by Shafiu, Bermejo, Souares, Sauerborn and Dong, (2013) the element of prompt attention was poorly rated in Nigeria. Among the previous suggestions to promote and enhance prompt attention were that health systems should ensure that clients receive the necessary services within appropriate period of time and active monitoring of service delivery. Elderly value prompt attention because it leads to better health outcomes by allaying fears and concerns that come with long waiting and also prevent their conditions from getting worse. A study in Ghana revealed that the mean expected maximum waiting time for seeking medical help were longer, averaging 1 hour especially at the dispensary or when going for an injection. Main complains about health care providers to the elderly were rudeness, unfriendliness, unapproachable, impatience, and lack of respect (Turkson, 2009). In Mozambique, longer waiting times were found to be significantly associated with lower satisfaction scores among patients. In Kenya, a study by Muriithi, (2013) revealed that patients can wait for a long time at a facility if waiting time is correlated with unobservable or measured quality. The marginal benefit that a patient gets from waiting time is a function of the interaction between trust and waiting time. Individuals might prefer to wait for treatment from a health provider they trust. Secondly, there is no direct opportunity cost for a seriously sick person. For low income groups, waiting time in a public facility, where user fees are low, can be taken as a boost to the net income after paying the user fees. This implies that the marginal net benefit from waiting time will be higher at a health facility with a low cost of treatment. In conclusion, waiting time is partly dictated by the financial cost met by the health care service provider.

**(ii). Amenities of quality in elderly care**

According to Valentine *et al.,* (2003) and the World Health Organization (2000) reports, quality of basic amenities imply that health facilities have clean surroundings, regular procedures for cleaning and maintenance of hospital buildings and premises, adequate furniture, sufficient ventilation, clean water, clean toilets, clean linen, healthy and edible food. clean waiting rooms, toilet facilities, and examination rooms. Prevention measures, involving non-personal prevention activities such as cleaning public areas, spraying insecticide, preventing mosquito breeding in wastelands are some of the activities that also considered under the quality of basic amenities. This concept is not limited to health care facilities but relate to the health system as a whole, which encompasses interactions with the health system in one's workplace, school, community and at home. In a study to understand the ground realities of health-care facilities in Odisha India, Gupta, Satpathy, Chandra, Patnaik, and Patel, (2014) indicated that amenity is not restricted to adequate buildings and roads for the hospitals but also includes basic needs such as equipment for surgery, qualified doctors, surgical theatres, nursing care providers, electricity, power backup, beds for patients, patient attendants, water supply, ventilation provision, security, pollution and noise-free environments, easy accessibility, communication facility, canteens, 24-hour availability of doctors and nursing care provider, trained and computer literate nursing, supporting care provider and financial leverage.

A study by Bhandari (2006) on India's social infrastructure revealed that education and health services are characterized by inadequate and inferior infrastructure; poor public service delivery; lack of quality choices for consumers; and lack of access especially for the poor due to a high dependence on relatively expensive services. These were

attributed in part to inadequate attention to the rapidly increasing population among others.

By spelling the policy framework for people-centred health care, WHO (2007) reiterated the need for a conducive and comfortable environment for both people receiving health care and for health practitioners. The report specifically identifies comfortable environment, safety, access to social, emotional and spiritual support, waiting rooms and other public spaces within the premises of health care facilities, education and risk management policies.

The infrastructure in the private sector is comparatively much better than state-run hospitals and, in some cases, is at par with international standards. However, the medical facilities of private hospitals are unreachable for much of the population and especially the underprivileged sections of society.

A report by European Union (EU) reveal that citizens are often confronted with informal payments for health services such that vulnerable groups who are less protected against informal payments are most likely to forego treatment or to experience catastrophic, impoverishing effects of such payments (Seychell and Hackbart, 2013). This implies that public providers need to improve the quality of their basic facilities so that they can retain and attract clients.

**(iii). Access to Social Support by elderly**

Social support includes real or perceived resources provided by others that enable a person to feel cared for, valued, and part of a network of communication and mutual obligations.

Social support is critical for those elderly who rely on family, friends, or organizations to assist with activities of daily living, provide companionship, and care for their well-being. By having a socially engaging environment geared towards individual's capabilities, the elderly can be kept calm and happy and the strains on caregivers can be reduced (Falk, 2013). According to the United Nations resolution 46/91 of 1991, older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.

In many developing countries the impact of industrialization, urbanization and westernization eroded, weakened, and disintegrated the once cohesive family and community focused care networks that formerly provided support to the elderly (Miller, 1999). This rendered the role of family system ineffective.

According to Population reference bureau, (2011); Keyes, Michalec, Kobau, Zahran, Zack, and Simoes, (2005), there is an association between increased levels of social support and reduced risk for physical disease, mental illness, and mortality.

In a hospital setting according to Levine (2013), social support may entail regular visits by relatives and friends' provision of food and other consumables by relatives and friends, if not provided by the hospital religious practices that do not prove a hindrance to hospital activities or hurt the sensibilities of other individuals.

In the United States (US), Houston home care (Levine, 2013) state that more complications can arise if an elderly person has undergone any serious medical condition and does not receive variety of social support or home health care services. Having a positive social lifestyle can increase the psychological and physical well-being thus

lowers the amount of stress, and helps to treat issues such as anxiety or depression. It is therefore important to support self-awareness as well, not just physical presence or conversation.

A few useful activities suggested to help the elderly improve their quality of life include taking up hobbies, exercise groups, reading clubs, writing and singing groups. The elderly should be included in the planning and choosing ways to find self-awareness activities that are relevant to their needs, interests, background, and culture (C & S Healthcare Services, 2016). This agrees with a documentary that an important aspect of providing coordinated care to the elderly is sharing information among stakeholders and designing care plan with all practitioners liaising together. The Texas based Houston Home Health Care providers have in place licensed staff that assist the elderly to find community resource, motivate self-awareness activities, and provide caring assistance with daily needs of individuals.

Age UK (2013) strongly emphasize and recommend the need for continuity of care after the elderly is discharged. This would ensure that health care service provider check on the client once they are at home and also assess the outcomes of the person's care.

People receiving social support have the same rights as anyone else and in some situations may have additional legal support and protection. However, many people who need care and support often experience discrimination and stigma which can be psychologically detrimental to their health.

Historically, many people who use social care services have been wrongly excluded from making decisions for themselves simply because of their poor health conditions or disability. Social care workers play an important role in promoting equality and ensuring

that people who use social care services are supported to make decisions about their own care and lifestyle.

In Japan care giver support groups are a great way to share difficulties and to find people who are going through the same experiences. In most support groups, one is able to talk and listen to others talk about their problems. This offers platform for reciprocal help in which one get to learn that people experience similar problems and that the knowledge of the other caregivers can be invaluable especially if they are caring for someone with the same health condition (Silverpages, 2015).

Social support workers can promote good health and wellbeing of the elderly by delivering timely, flexible and responsive support which addresses their fluctuating needs(Brent, 2014). Some developed nations (the USA, Europe, Japan, and Australia) have made a breakthrough with care for the elderly because their health-care system is packaged to integrate all supportive social networks (Veras, 2015, Counsell et al 2007). Kabole, Kioli, and Onkware, (2013) lament that old age in many African countries is a nightmare and a tale of woes because the elderly are vulnerable to social isolation thereby endangering their health with resulting poor optimal aging.

In many parts of SSA, the elderly who need keen attention to care have double role as care seekers and as care givers. They take care of their orphaned grand children from the effect of HIV/AIDS and also take care of their unemployed adult children who are in turn parents in some cases (HelpAge International, 2013). This situation calls for the need for social support to the elderly to be able to experience optimal aging. Alvarez-Fernandez, Bernal-Lopez, Cabeo, Manuel, Cristobal, (2015) proposes a sensitive model for early identification of risks weakening and prediction of social indicators to monitor health and

not the disease. Once the risk is identified, the priority would be early rehabilitation to reduce the impact of chronic conditions. Such care model which is sensitive to predictive social indicators of health would be cost-effective. The model would ease the current strain experienced by health facilities in caring for the elderly by anticipating adversities and maintaining functional capacities at family or community level. An active social integration would be key in managing deviations. Any contemporary policy for the health sector should enhance healthy aging by maintaining and improving functional capacity, disease prevention and recovery of health. Optimal aging is feasible with a comprehensive preventive approach that associates epidemiological reflections and planning health actions (Veras, 2015).

Among the factors that call for change on the model of care for the elderly are social and education aspects that encourage self-care, promote mutual-help and enhance active participation of the elderly in community and health-care programs. Brent (2014), assert that being involved in activities and having personal abilities and strengths recognized can be beneficial to the elderly by promoting their wellbeing. Activities in such groups should be matched with the elderly skills, abilities and interests. To actualize the above, an overly demanding or stressful activities should be avoided because they can be harmful to the elderly overall health and wellbeing. The goal is that all be winners: the elderly, which extends their quality of life; the family members, who have longer living with an active and participatory loved one; and health systems, which avoid repeated and costly hospitalizations. In as much as encouraging and supporting people to remain active and to do the things they like doing can help to improve health and wellbeing, there is risk that people being supported by social care services may experience total or partial

loss of independence and choice. This can lead to deterioration in self-esteem with subsequent poor health. An important aspect of developing confidence of the elderly is to support and empower them to recognize and build on their existing strengths, skills and abilities in an attempt to overcome this state.

Key qualities which promote health and wellbeing of those supported include empathy, non-judgmental, consistency, integrity, collaborative approach to make decisions and provide care and support. Information from the qualitative response of the questionnaires, the FGDs (all the five sites) and the Key Informants (Nurse at Kangir Dispensary, Kendu Sub County hospital), revealed lack of social integration of the elderly by the Kenya health system. The elderly are poorly integrated through the formal health system into a social network. Since overall health can be influenced by multiple factors, including a person's psychological, behavioral, and social well-being, multi-agency working is crucial to social care support for the elderly.

**(iv) Client choice of Care provider**

Choice with regard to institution and individual providing care is importto health system users. The ability to choose between care providers becomes increasingly important as the other aspects of responsiveness are met. The cost of providing choice of care provider is most severe for countries with constrained human resource (De Silvia *et al.*, 2013; Bosl, 2007).

Choice of provider in this study considered elderly choice for care personnel to provide services and also, the health facility to go for services. Choice of care providers assures that clients have the freedom to consult health care providers of their wish for services among the available options.

The right to choose provider is exercised at the point where the patient is able to make a meaningful, informed choice and the provider is contracted to provide the required health care service. Choice plays a key role in improving the delivery of quality health services which contributes to better outcomes. In terms of the personnel to offer services, the provider needs to consider its role in ensuring that the patients receive their legal right to choose the provider and the consultant-led or professional-led team which provide care and treatment. Health care providers who know that patients have a choice tend to offer quality care services to their clients with empathy (Valentine et al. 2003). A study in Nairobi, Kenya by Muriithi, (2013) on the determinants of health-seeking behavior, revealed that patients' trust in the health providers is a significant determinant of the demand for health care. Increasing trust increases the likelihood of choosing all other healthcare providers relative to self-treatment. The implication of this is that the more trusting the relationship that the provider builds with their patients, the higher the probability of a visit to that provider in the event of ailments. Trust in the care provider has a positive impact on the psychological stability of the elderly which contribute to optimal aging.

In England, enabling patients to make choices about their care is central to the National Health System (NHS) policy (NHS, 2014). In Massachusetts Americas, patient's right to freely choose provider of services is guaranteed in some insurance i.e. Medicare, Medicaid programs where the right to choose is a condition for the hospital to participate. The condition requires that the patient be informed of their right to choose a post-hospitalization care provider; the hospital must provide the full list from which the patient may choose that provider and that the hospital must disclose any agency in which

a hospital has a financial interest. Failure to meet these conditions; coercion or remuneration to choose a particular provider is violation of patients' rights and illegal according to federal and state law (Markette, 2012). This finding mirrors those of Thompson (2003) in Kazakhstan; Hsiech and Lin (1997) in Taiwan that the information available about health services is a key determinant of health facility choice. It should be noted that for the elderly who in most cases have chronic conditions that only need palliative care, supplier-induced (medicalization) demand can occur due to advertisements for unnecessary treatments. In Nigeria, Audu, Bako, Abdullahi, Umar, Nanben, and Avidime, (2014) add staff attitude and economic cost to be other factors determining the choice.

In terms of choice of health-facility, factors such as accessibility, availability of services, appropriateness of services, cost of care, waiting periods and homeliness which often differ in public and private health facilities tend to influence choice (Bosl, 2007).

In a London study of patient's choice, factors likely to be considered by those who positively exercised choice of care provider were perceptions of hospital cleanliness, low levels of hospital-acquired infection, good quality of care, short waiting time, travel time, travel costs, the reputation of the hospital and where follow up care would be provided. In Ghana (Boachie, 2015), choice of health facility was based on availability of essential drugs (53.63%) and doctors (39.92%), distance or proximity (49.60%), provider reputation (39.52%), waiting time (39.92), additional charges (37.10%), and recommendations (48.79%). It is important that interpretable information on the quality of care and personal support in making choices is made available to all patients, particularly those who are less educated. A study in Brazil (Bosl, 2007), factors that can

predispose a population to increased or decreased utilization of health care services include socio-economic status (SES), physician supply, policies and beliefs of a nation, risk behaviour of a population, and health status. It is believed that SES has significant influence on utilization behaviour because of its effect on aspects such as need, recognition, and response to symptoms; knowledge of disease; motivation to get well; and access or choice of health services. It is documented that persons of lower SES experience greater degree of disease and mortality. In China, Xiong (2014) point that poor financial condition is one of the main reasons restricting the elderly to seek medical services.

Physician supply is not as multifaceted as SES. Its relationships with health care utilization is that an increase in the proportion of doctors available or access to doctors in a community consistently results in an increase in health care utilization. This indicates that many patients will use or be encouraged to use services when the physician services are made available and homely. Government policies and the value system of a country are yet other factors that may have direct effect on health care utilization. Such was the case for Canada which provide more access to health care for persons of lower SES. The elderly being among the vulnerable could benefit from some care cost exemptions just as the Cohort 1 and 2 based on a national policy. In terms of status, the elderly who chose private provider over public provider should achieve better health outcomes after controlling for other determining variables (Bosl, 2007). This agrees with previous studies that users of private providers are usually more contented with their choice of providers than those with public providers. Victor *et al*. (2012) in their study of northwest European countries and the USA concluded that different patients make

different choices in different situations. Comparative information seems to have a relatively limited influence on the choices made by many patients who base their decisions on a variety of both provider and outcome characteristics. The assumptions made in health policy about patient choice may therefore be an oversimplification of reality. In terms of proximity, studies by Mwabu, Ainsworth, and Nyamete, (1993): Kenya; Cisse (2011): Cote d'Ivoir revealed that distance has a significant and negative impact on the choice of a health facility. Increasing distance increases the likelihood of a household opting for self-treatment rather.

any of the formal health providers. The negative impact of distance is higher at the public facilities. In conclusion, the elderly in Rachuonyo North Sub County of Homa bay county have limited choice for health care service provider due to the available options. Their choice for the facility is dictated by factors which in most cases are beyond their capacity.

### 2.2.4 Objective 4: Influence of Health System preparedness on elderly optimal ageing.

Discussion of health systems preparedness to care for the elderly considered training and Staffing of health care provider.

**(i) Training of care provider.**

According to questions for contributions to secretary -general report pursuant general assembly resolution 65/82, the Kenya Ministry of Health had no targeted services for older persons. The curative and primary health services offered by the Ministry are provided within the broader context of the society. The discipline of geriatrics in regions where it is well established, has rich multi-disciplinary history and values all professions for optimizing the well-being and independence of the elderly. Reflections from England

(Brent, 2014), USA (Besser, 2012), Europe (Beauchet, 2012) and New York (Boltz, 2012) agree that geriatric care managers generally have prior training in nursing, social work and gerontology, however their number is inadequate to match the rapid increase in the number of the elderly. According to Silverpages, (2015), training prepares health care service provider to integrate health and psychological care with other needed services such as housing, home care services, nutritional services, assistance with activities of daily living, socialization programs as well as financial and legal planning.

Nearly all physicians have frequent encounters with geriatric patients but few physicians and nurses have adequate training in geriatrics. Many of the ailments afflicting the elderly are priority areas identified as responsive to health promotion and prevention activities. A major focus of training in geriatrics is to minimize the loss of independence associated with functional decline and illness (Rowe & Kahn, 1999). The predominant health problems of the elderly are chronic and are exacerbated by both the normal changes of aging and the increased risk of old age-related illness. Despite this picture, majority of the elderly report themselves to be in good health as measured by level of function and general self-perception of health. It is therefore ideal for health care schools to have mandatory clinical rotations in this discipline. Geriatric management is the process of planning and coordinating care of the elderly who suffer from physical and/or mental impairments to meet their long-term care needs, improve their quality of life, and maintain their independence for as long as possible. It entails working with the elderly and their families in managing various types of health and social care services. These tasks are accomplished by advocating for the clients throughout the care continuum by

combining a working knowledge of health, psychology, human development, family dynamics, and available resources (Tucson, 2011; Cress, 2010).

Working in elderly units requires training that prepares the professional to offer round-the-clock care: days, nights, weekends and holidays; work with varied number of patient's par shift; spend considerable time walking, bending, stretching and standing; guard against potential back injury arising liftings and transfers; follow proper body mechanics and procedures for lifting/moving patients, guard against possible hazards from exposure to chemicals and infectious diseases. In addition, the population cared for will contain patients that are confused, irrational, agitated, or uncooperative, from diagnoses, such as Alzheimer's (Boltz, Capezuti, Fulmer, and Zwicker, 2012).

The first book to give instructions for the care of the aged was the "Canon of Medicine" written by Avicenna in 1025. The book foreshadowed modern gerontology and geriatrics and discussed among others, elderly need for: plenty of sleep, body anointing with oil, exercises, suitable elderly diet and relief of constipation. Among the other earlier pioneers of geriatric instructions were the Arabian physicians: Algizar (circa 898–980) who wrote a book on the medicine and health of the Elderly and discussed sleep disorders, forgetfulness, how to strengthen memory, and a treatise on causes of mortality; Ishaq ibn Hunayn in the 9th century wrote a Treatise on Drugs for Forgetfulness. George Day in 1849 published the Diseases of Advanced Life, one of the first publications on geriatric medicine. (http://www.archive.org/stream/AvicennasCanonOfMedicine). In Europe specifically the United Kingdom, modern geriatrics instructions began with the work Dr. Marjorie Warren who emphasized that rehabilitation in addition to feeding was essential to the care of the elderly who needed systematic diagnosis, treatment, care, and

support. She determined that with correct assessment and treatment, previously bed ridden patients were able to gain some degree of independence. Bernard Isaac later described the giants of geriatric pathology: immobility, instability, incontinence, and impaired intellect as the major categories of impairments into which all common problems of the elderly relates to as they begin to fail. Down the ages care for the elderly has had dwindling challenges with resulting poor care. A study in Europe by Beauchet, (2012) concluded that geriatric education is problematic with specific obstacle being the discrepancy between needs of the elderly and the poorly prepared health system to meet them. This agrees with study findings by the Institute of Medicine in Washington DC (IOM, 2001) which revealed immense divide between what is known to be good health care and the actual care that people receive. Because the combination of multi-morbidity and disability conditions of the elderly requires specific education and care (skill of geriatric medicine and primary care), the study recommended the incorporation of adequate geron to logical training into primary care. In the European countries, the number of geriatricians per 1000 inhabitants is low.

In France a study by Annweiler, (2012) report that training in geriatrics focus on both specialty and sub specialty levels where medical focus on specialty while paramedics focus on nurses, pharmacists, physiotherapists, occupational therapists, neuropsychologists. A study report by Age UK (2013) detailed shocking examples of how the elderly and their families have been let down when hospitals and care homes fail to deliver decent care or treat them with dignity. The report calls for the need of well trainedstaff who are empowered and supported by senior managers to deliver excellent care for the frail older people. This also means listening to and working with patients and

their families to ensure that care is right. Lothian (2001) summarize study results in England and Wales that extensive and continued training is key in tackling poor attitudes by staff towards the elderly. The study reported that more positive attitudes towards older people were found among nurses working in specific elderly care units than among those working in general care units and attributed this to specialized training in gerontology.

In the USA, the field of geriatrics/gerontology has recognized with a consensus what constitutes "geriatric best practice" and to which failure to implement is unacceptable. Consensus by various American geriatric associations on minimum eight domain required of mastery by graduating medical student to care for the elderly include the cognitive and behavioral disorders; medication management; self-care capacity; falls, balance, gait disorders; atypical presentation of disease; palliative care; hospital care for elders, and health care planning and promotion (Williams and Mezey, 2000).

The domains are expanded to assist learners to develop other specific thirty competencies: -

> Recognize one's own and others' attitudes, values, and expectations about aging and their impact on care of the elderly and their families; Adopt the concept of individualized care as the standard of practice with older adults; Communicate effectively, respectfully, and compassionately with the elderly and their families; Recognize that sensation and perception in the elderly are mediated by functional, physical, cognitive, psychological, and social changes common in old age; Incorporate into daily practice valid and reliable tools to assess the functional, physical, cognitive, psychological, social, and spiritual status of the elderly; Assess elderly living environment with special awareness of the functional,

physical, cognitive, psychological, and social changes common in old age; Analyze the effectiveness of community resources in assisting elderly and their families to retain personal goals, maximize function, maintain independence, and live in the least restrictive environment; Assess family knowledge of skills necessary to deliver care to the elderly; Adapt technical skills to meet the functional, physical, cognitive, psychological, social, and endurance capacities of the elderly; Individualize care and prevent morbidity and mortality associated with the use of physical and chemical restraints in the elderly; Prevent or reduce common risk factors that contribute to functional decline, impaired quality of life, and excess disability in the elderly; Establish and follow standards of care to recognize and report elder mistreatment; Apply evidence-based standards to screen, immunize, and promote healthy activities in the elderly; Recognize and manage geriatric syndromes common to the elderly; Recognize the complex interaction of acute and chronic co-morbid conditions common to the elderly; Use technology to enhance elderly function, independence, and safety; Facilitate communication as the elderly transition across and between home, hospital, and nursing home, with a particular focus on the use of technology; Assist the elderly, families, and caregivers to understand and balance “everyday” autonomy and safety decisions; Apply ethical and legal principles to the complex issues that arise in care of the elderly; Appreciate the influence of attitudes, roles, language, culture, race, religion, gender, and lifestyle on how families and assistive personnel provide long-term care to the elderly; Evaluate differing international models of geriatric care; Analyze the impact of an aging society on the health care

system; Evaluate the influence of payer systems on access, availability, and affordability of health care for the elderly; Contrast the opportunities and constraints of supportive living arrangements on the function and independence of the elderly and on their families; Recognize the benefits of interdisciplinary team participation in care of the elderly; Evaluate the utility of complementary and integrative health care practices on health promotion and symptom management for the elderly; Facilitate the elderly active participation in all aspects of their own health care; Involve, educate, and when appropriate, supervise family, friends, and assistive personnel in implementing best practices for the elderly; Ensure quality of care commensurate with the elderly vulnerability and frequency and intensity of care needs; Promote the desirability of quality end-of-life care for the elderly, including pain and symptom management, as essential, desirable, and integral components of health care practice;

The curriculum should have both the didactic and clinical component with a focus on elderly health and deviations from health. The clinical should provide continuity experiences that allow students to follow older patients and their family members using an interdisciplinary team exposure as an integral component. Key course areas include health assessment, adult health, community health, psychiatry and mental health, ethical/legal issues, research, professional issues in health care settings, supportive courses-lifespan development, nutrition, pathophysiology, and pharmacology. Training should have adequate resource backing to be effective (Failla, and Stichler, 2008).

Entry requirements to training for geriatric care is well documented for both medical, paramedical and other allied staff. Geriatricians develop expertise in the aging process,

the impact of aging on illness patterns, drug therapy in seniors, health maintenance, and rehabilitation. They serve in variety of roles including hospital care, long-term care, home care, and terminal care. They are involved in ethics consultations to represent the unique health and diseases patterns seen in seniors. The model of care is heavily focused on working closely with other disciplines: nurses, pharmacists, therapists, and social workers.

Despite this arrangement most practicing nurses have limited preparation in the principles of geriatric care. According to Fleshner (2008), few professional nursing programs prepare their graduates to delegate or supervise; graduates typically lack leadership content and geriatric competencies needed to enable them execute their roles successfully because they have not received formal education in that field. For the practicing nurses (even those with long years of experience), are encouraged by professional organizations to enhance and update their knowledge and maintain clinical competence skills through Continuous Education (CE) programs to be able to provide effective and efficient age-specific care in diverse settings. Continuing education is intended to enable nurses to pursue their professional development, be lifelong learners, and function in their roles safely and proficiently. The sessions take two pathways with different hours modules: the clinical care giver and the trainer. CE programs are more effective when they are constructed to encourage health professionals to take the initiative and direct their own learning. It is reported that nurses who attended these participatory and interactive education programs on geriatric best practices were motivated to make subtle and significant changes to their practice. The collaborative clinical projects, along with

participant interaction and extended mentoring, were the key to lighting the fires of change in their attitudes, beliefs, and confidence levels. (Barba and Fay, 2009).

In Canada, there are two pathways that can be followed in order to work as physician in geriatric settings. Doctors of Medicine (M.D.) can complete a three-year core internal medicine residency program, followed by two years of specialized geriatrics residency training. This pathway leads to certification, and possibly fellowship after several years of supplementary academic training, by the Royal College of Physicians and Surgeons of Canada. Doctors of Medicine can opt for a two-year residency program in family medicine and complete a one-year enhanced skills program in care of the elderly. This post-doctoral pathway is accredited by the College of Family Physicians of Canada. Many universities across Canada also offer gerontology training programs for the general public, such that nurses and other health care professionals can pursue further education in the discipline in order to better understand the process of aging and their role in the presence of older patients and residents.

In India, Geriatrics is a relatively new specialty offering training with few (only four) major institutes providing training. One advantage of in-depth medical school courses in geriatric medicine is that they provide exposure to complex patients with multiple prescriptions. According to Symington (2018) most geriatricians are primary care physicians who desire additional training and skills focused on an older patient population. They are specifically trained in the normal and abnormal physiologic and psychosocial changes associated with aging, and to recognize the differences in presentation of disease relative to normal aging. Upon completion of the training, care

provider is equipped with knowledge and evidence-based innovative approaches that advance best practices in geriatric care.

They gain competency to distinguish between diseases and the effects of normal aging. For example, renal impairment may be a part of aging, but renal failure and urinary incontinence are not. Geriatricians aim to treat diseases that are present and achieve healthy aging. They focus on achieving the patient's highest priorities in the context of multiple chronic conditions, and on preserving function. They recognize the importance of maintaining functional independence in older patients and focus on providing preventive interventions.

The clinical settings in which geriatric medicine is practiced are quite varied. Many geriatricians continue in primary care practice, and geriatrics training uniquely equips clinicians for work in rehabilitation, extended care, and home health settings. Geriatric fellowship training requires one year of training beyond general internal medicine residency, which prepares them for board certification in geriatrics. In America, explosive growth in elderly population is one reason medical school professors and practicing physician’s advice aspiring doctors to learn the basics of geriatric medicine however experts caution that geriatric medicine is among the least lucrative medical specialties, since Medicare provides lower reimbursement rates and also because caring for the elderly is more complex Kowarski (2018).

Lester, the chair of the geriatrics task force at the New York Chapter of the American College of Physicians comment that “One sign that a medical school does not emphasize geriatric medicine enough is that this subject is only taught under the umbrella of a palliative or hospice medicine course” and these basically take the clinical perspectives.

The Mission of the Division of Geriatric Medicine and Gerontology of Johns Hopkins University School of Medicine is to provide the highest level of health care to older adults, and to discover, translate and teach new knowledge through education and research. The goal is to ensure that the quality of care for older adults continues to improve. The division offers a wide range of training in elderly care in which students meets every month to explores issues ranging from social and public policy, research, clinical and education experiences (Durso, 2018). The division has continuous education (CE) in geriatric related topics for healthcare professionals throughout their careers.

Lothian (2001) reported that specialized training in gerontology create positive attitudes towards the elderly among nurses working in elderly care than among those working in acute care settings. Such training would open doors for the elderly to autonomously participate in their care planning and delivery.

Swedish researchers reported that after a year of special education, medical trainees came to view older people with dementia as "unique human beings" rather than "a homogeneous group" and that there is more favorable attitudes towards the care of older people among students attached to a geriatric ward than among those attached to a general ward. Exposure of care provider to the elderly is therefore beneficial. Older students and those with grandparents as role models have been found to have better attitudes towards older people. Several authors have indicated the importance of exposing health care provider to both healthy as well as to the sick elderly. Training and exposure in geriatrics would raise the status of the field through specialization, have a positive impact on attitudes and encourage elderly to seek services in health facilities.

In Israel, Natan, Har-Noy, (2016) observed that the complex role of nurse manager in elderly care encompasses multiple responsibilities, including managing clinical practice, human and supply resources, finances, and regulatory compliance standards, along with personnel and strategic planning. To accomplish this, nurse managers must possess necessary clinical and leadership competencies which include variety of technical, human, conceptual, leadership, and financial management competencies. The highest rated self-reported nurse manager competencies included effective communication, retention strategies, effective discipline, and decision making. Nurses' perception of their managers' competencies in managing conditions of the elderly has been shown to be associated with their job satisfaction (Coomber and Barriball, 2007).

Other studies have identified nurse manager leadership style as having an effect on nurse job satisfaction (Failla & Stichler, 2008; Van der Heever, 2009). Unclear expectations, as well as different perceptions of nurse managers' role, are likely to affect both managers' and staff nurses' performance. Differences in perception concerning the nurse manager role between nurse managers and staff nurses may be a potential conflict between managers and subordinates. Conflicts can also arise if managers experience lack of support from their staff (Carlin & Duffy, 2013). The nursing profession both in Israel and globally, faces both an aging population and a severe shortage of geriatric care nurses (Haron, Levy, Albagli, Rotstein and Riba., 2013). Given this growing imbalance, it is extremely important to create a favorable work environment in order to attract and retain nurses in this field. Among the key issues that hinder staff development are associated with lack of budgeted time for education; few role models; lack, inadequate, or poor learning environment with little emphasis on continuing education, evidence-based

practice and building knowledge skills and competencies; viewing staff development in terms of “mandatories”.

In Japan the Caregivers Training Grant (CTG) provides caregivers with subsidies to attend training to better the care for their elderly’s physical and socio-emotional needs. Regardless of income levels, families or caregivers can tap on an annual training grant of $200, for every care recipient they are taking care of, to attend training programmes approved by the Agency of Integrated Care (AIC) (Silverpages, 2015).

In Kenya the training curriculum for the medical and paramedical care providers for elderly care are deficient in scope and content. From the KII interviews, the coverage of geriatrics at the undergraduate and diploma curricula are only in selected topics in surgery, internal medicine and anaestheology. The programs approved by the regulatory bodies (Kenya Medical Practitioners and Dentists Board and the Nursing Council of Kenya) have no geriatrics as a specialty. The discipline of geriatrics is therefore a wanting necessity because the number of the elderly is rising as mentioned in chapter One. This could be emanating from the insights expressed by Aboderin (2010) on loose policy formulation that is unable to guide detailed program design. Given as an example the report read “decision makers lack clarity about what specific measures are needed to effectively ensure the health of older adults. An example are the provisions on older persons in Kenya’s NHSSP II whose translation has been hindered, among others, by a lack of insight into what older persons’ priority health needs are, and how health or other sectors could appropriately respond to them”.

In Kenya, nurses provide the bulk of direct patient care at all levels of health services delivery. As of mid-2013, the Nursing Council of Kenya (NCK) had approved 83 nursing training institutions of which 53.0% were public, 32.5% were faith-based and 14.5% were private. Training institutions offer programs at the certificate, diploma and degree level and are located in 30 of the Kenya's 47 counties. The nurses are trained at three levels, certificate (enrolled nurse), diploma (registered nurse) and degree (Bachelor of Science in Nursing (BScN). The average tutor student ratio, 1:22 against the recommended 1:10 in government sponsored training colleges demonstrates the need for more faculty. In faith-based and private institutions the ratio of tutor to students is 1:14 and 1:7 respectively.

**(ii) Deployment of Care provider**

Staffing is a function of general organizations management. It is the selection of personnel on the basis of qualifications: knowledge and or skills for related assignment. In a broader concept, staffing is the strategic approach and process that anticipates future needs and situation of an organization and responds to them in advance. Staffing has the deployment component which is a personnel activity that places the selected person in positions to ensure that the labor of the organization is continuous in an optimal relation to the jobs and organizational structure. Staffing has both qualitative and quantitative sides. Deployment on the other hand is matching both the number, qualification and personality structure of human resources to the organizational structure and needs. The purpose of staffing and deployment is to continually ensure optimal performance of the entire organization. Effective staffing and deployment ensure that staff are given work which best suits their skills and aptitudes, staff concentrate on raising the standards of

care and reciprocal learning, minimal disruption of services by planned or incidental staff absence, staff have high levels of morale and work as a team (Villalba-Mora, 2018; Cherie and Berhane, 2005). The challenge to staffing and deployment for geriatric care is compounded by lack of adequate number of trained personnel in the discipline. Some developed countries and almost all developing countries have inadequate number of staffs to care for the elderly. Besser (2012) commented that in the USA, there are not enough health providers who either specialize in geriatric care or who possess the necessary competency of geriatrics knowledge in their practice.

The report express that their small number prevent geriatric nurse specialists from providing care to the elderly who are often at high risk with extremely complex health needs. In addition, because nurses tend to cluster in urban areas, few are available to care for the elderly living in rural areas. According to research by the Agency for Healthcare Research and Quality (AHRQ) and others, hospitals with low nurse staffing levels tend to have higher rates of poor patient outcomes such as pneumonia, shock, cardiac arrest, and urinary tract infections among others, yet increasing staffing levels is not an easy task. The report summarizes the findings of AHRQ-funded and other research on the relationship of nurse staffing levels to adverse patient outcomes as follows: lower levels of hospital nurse staffing are associated with more adverse outcomes (i.e. in-hospital deaths, nosocomial infections, pressure ulcers, falls); patients have higher acuity (ventilator care, tracheostomy care, infection w/ isolation; discharges to the community; focus on reducing re-hospitalizations; primary diagnosis for admission: joint replacement, septicemia, kidney and urinary tract infections, hip and femur procedures, heart failure and shock) yet the skill levels of the nursing staff have declined, higher acuity adds

responsibilities therefore increases nurse workload; avoidable adverse outcomes such as pneumonia raises treatment costs, hiring more RNS does not decrease profits, higher levels of nurse staffing could have positive impact on both quality of care and nurse satisfaction (Stanton, 2004). Staff deployed in geriatric units manage both long term and short-term ill-health cases. Long term cases according to Fleshner (2008) include basically the dementias (Alzheimer's disease and others); frailness; implementation of culture change (person centered care, reducing antipsychotic medication usage). Short term cases include among others cases of increasing acuity.

Staffing and deployment must be sensitive and specific to titles, roles, responsibility, accountability and expectations of the personnel to create good working relationship. It must also consider principles of staff deployment such as promotion, secondment, posting, enhancing staff's learning and working initiative, fostering staff's sense of belonging to the organization. These often translate to staff attitudes towards clients. According to Kenya Nursing workforce, the ratio of nurses to population in Homa Bay County is 100 per 100,000 (Ministry of Health, 2012) thereby reflecting deficiency.

Other factors include effects of staff deployment on the organization: operational cost and change in organizational structure and finally the element of appraisal to bring out staff strengths in terms of ongoing commitment, compassion and caring (Age UK, 2013). A report on Kenya health workforce indicate.

Robert Francis, the Prime Minister for the "Mid Staffordshire National Health System Foundation Trust commented that nurses should be hired and promoted on the basis of having compassion as a vocation, not just academic qualifications (Powell, 2013)

Major challenges to staffing and deployment according to the report are high staff turnover especially the nursing staff, outmoded care delivery systems, task-based nursing, hierarchical management, outmoded education and staff development practices. Staffing and deployment should nurture management principles of shared governance of partnership, equity, accountability, and ownership at the point of service. The advantage of these according to the American Nurses Association, ([ANA], 2006) are longevity of employment, increased employee satisfaction, better safety and healthcare, greater patient satisfaction, shorter lengths of in-patients stay. Those who are happy in their jobs take greater ownership of their decisions and are more vested in-patient outcomes therefore, employees, patients, the organization, and the surrounding communities' benefit from shared governance.

Situations where leadership is effective have realized positive outcomes: improvements in the quality of care, increase in staff retention and job satisfaction, improvements in the organizational and work climate, reductions in the cost of care and successful quality improvement practices. The hierarchical management is castigated by advocates and proponents of shared governance in the USA that it creates barriers to employee autonomy and empowerment and that it can undermine service and quality of care. They point that today's patients are no longer satisfied with directive care but are comfortable with partnership, equity, accountability, and mutual ownership in their healthcare decisions and those of their family members (American Nurses Association, 2006). Given the complexity of information, interpersonal connections and varied nature of elderly ailments, Mitchell, Wynia, Golden, McNellis, Okun, Webb, Rohrbach, and Von and Kohorn, (2012) point that it is not only difficult for one clinician to provide care in

isolation but also potentially harmful. It is therefore safe to work as teams. Team based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers to the extent preferred by each patient to accomplish shared goals within and across settings to achieve coordinated, high-quality care (Naylor, 2010). Five values that characterize the most effective members of high-functioning teams in health care are honesty, discipline, creativity, humility and curiosity. Staffing and deployment should once again be sensitive to these values when placing and assigning personnel. Teams in health care take many forms for example, there are disaster response teams; teams that perform emergency operations; hospital teams caring for acutely ill patients; teams that care for people at home; office-based care teams; geographically disparate teams that care for ambulatory patients; and teams that include the patient and loved ones, as well as a number of supporting health professionals. In health care, teams can therefore be large or small, centralized or dispersed, virtual or face-to-face while their tasks can be focused and brief or broad and lengthy.

The report continues to emphasize that high-performing team is now widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective health care delivery system. The challenge to defining optimal team-based health care are heterogeneity in tasks, patient types, and practice settings. In a global study (the Americas, Asia-Pacific, Europe, the Middle East and Africa) examining business context, talent management practices and human resource (HR) function of staffing, training and development, appraisal, rewards, employee relations, and leadership and succession, Stahl, Björkman, Ferndale, Morris, Paauwe, Stiles, Trevor, Wrigh,(2012) revealed that

businesses need to adjust to shifting demographics and work force preferences, build new capabilities and revitalize their organizations while investing in new technologies, globalizing their operations and contending with new competitors. The study found that the adoption of a set of talent management principles rather than best practices challenges current thinking therefore recommended the use of six talent management principles: alignment with strategy; internal consistency; cultural embeddedness; management involvement; balance of global and local needs; and employer branding through differentiation. In UK healthcare support workers (HSW) carry out a great deal of the hands-on work on a ward yet are not trained professionals. The inquiry recommends that this cadre of staff should have access to training as a motivation and to be safe practitioners.

The deployment data from the Kenya Health Workforce Information System (KHWIS, 2012) maintained by the Nursing Unit, Ministry of Health (MOH), there are 19,591 nurses deployed at 4,187 health facilities across Kenya, including public, parastatal and faith-based facilities. When comparing the ages of nurses employed in the public and faith-based sectors, the faith-based sector employs a higher percentage of younger nurses aged 21-30 years (26%) compared to the public sector (6%), while the public sector employs a higher percentage of nurses aged 51-60 years (28%). Based on deployment data the national nurse to population ratio is 51.5 nurses per 100,000 population. For the deployed nursing workforce, 13% have post-basic training in specialty areas: 10% have post-basic specialization in midwifery; 3% have specialty training in other areas, including psychiatry, ophthalmology, pediatrics, perioperative, anesthesia, critical care, nephrology and accident and emergency. Geriatric care is lacking as a specialty in both

basic and post basic trainings ( ). Despite this deficit, Kenya continues to encourage and Harness private sector for both resources and innovative solutions to improve maternal and child health. Donors in response pledged their support with the result that the Ministry of Health announced a 2014 budget of USD 400 million to reduce maternal and child death, increase the number of skilled healthcare workers and facilities in the country (Gullet, and Chatterjee, 2014).

The recruitment and retention of health care workers to staff the health facilities is the responsibility of the county governments. Regulatory bodies govern the licensure and registration of health care professionals. These include the Kenya Medical Practitioners and Dentists Board, the Nursing Council of Kenya, the Kenya Medical Laboratory Technicians and Technologists Board, the Clinical Officers Council of Kenya, the Pharmacy and Poisons Board, the Kenya Nutritionists and Dieticians Institute, the Radiation Protection Board, and Public Health Officers and Technicians Council among others. Each regulatory body is responsible for upholding ethical and professional standards of practice for their health care. With respect to geriatric care deployment is wanting since there is no specific staff preparation at all levels of training.

## 2.3 Theoretical and Conceptual Framework

### 2.3.1. Systems Theory by Von Bertalanffy (1968)

This is one of the classical theories propounded by Von Bertalanffy. The central theme of System's theory is that a system is a complex of elements which are open to, and interacts with their environments to acquire qualitatively new properties through emergence, thus they are in a continual evolution. Systems thinking places high value on understanding contexts and looking for connections between the parts, actors and

processes of the system. In this context the theory amplifies how the health system nurtures positive relationship through the intervening variables to optimize elderly optimal aging.

Key characteristic of systems thinking is the deliberate, continuous and comprehensive way in application. According to Cordon (2013), system share four common elements: a group of objects or molecules (forces); the relationships and interactions between the groups within their environment; and the function of the elements within the group, that affects the group purpose. The elements are self-regulating and correcting through feedback. The theory views health-care as interventions that nurture positive interactions of the groups. Each perceive the other, the situation, and through communication, set goals together, explore means, and agree on means to achieve them. Systems theory represents a life situation into which a person enters as an active participant. This theory is relevant to this survey because optimal aging results in part to a functional relationship between health system and the elderly.

### 2.3.2. Conceptual Framework

The conceptual framework shows the interacting relationship between the independent variables (elements of the health system and preparedness) and the intervening variables (states in which elderly may be found) to influence the quality of aging. The framework fits into Systems theory in that the interacting elements are meaningful objects that requires respectful handling and have a focus to bring out desired health outcome. The interactions are complex, have processes of determining problem, planning and setting goals by both parties (in this case the health care service provider and the elderly) within the context of the intervening variables and in an enabling environment. At the end of the

process new properties (health status) emerge which allow the elderly to function to satisfaction across many domains or give feedback that necessitate re-planning and or setting of new goals.

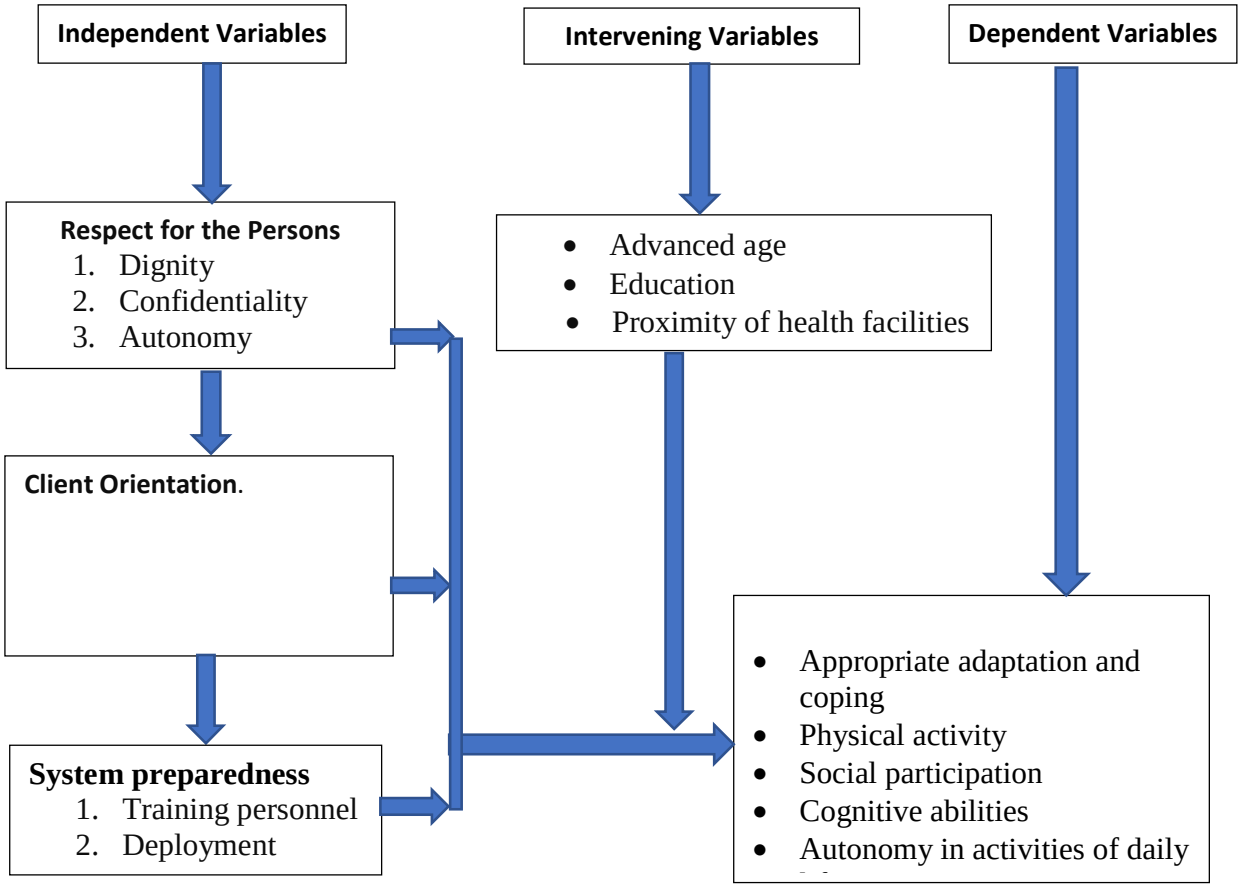


**Figure 1.1: Conceptual Framework**

# CHAPTER THREE

# METHODOLOGY

## 3.1 Introduction

This chapter presents the research design, the study area, target population, inclusion and exclusion criteria, sampling procedures and sampling size, methods of data collection and instruments used, validity and reliability, data analysis, data management and presentation and the ethical considerations each with factors validating their choice in this study.

## 3.2 Research Design

A research design according to Bhattacherjee, (2012) is a comprehensive plan for data collection in an empirical research project, a "blueprint" aimed at answering specific research questions or testing specific hypotheses. According to Musyoki and Mulwa (2011) research it is the plan and structure of investigations so conceived to obtain answers to research questions. Design must specify at least three processes: the instrument development process, sampling process, and data collection process. To Bryman, (2012), research design provides the framework for the collection and analysis of data.

This study adopted an exploratory, descriptive cross-sectional survey because it sought to explore a phenomenon: the experience of the elderly on responsiveness of health system to their care. The exploration aspect of the design explored the perceptions and salient feelings of the elderly on the experiences of their care in health facilities and how they are treated by the general population. The descriptive aspect provided an accurate description of elderly experiences by obtaining answers to "what, where, how and when"

of the phenomenon. This aspect enabled the respondents and the Key informants to describe their feelings on care as experienced in the health facilities and in the community. The cross-section aspect enabled data to be collected across all ages of eligible respondents. The survey aspect of the study enabled the collection of different kinds of information in a quick and at low cost compared to other methods i.e. experimental.

### 3.3 Study Area

The study was carried out in Rachuonyo North Sub-County of Homa Bay County in Kenya. Rachuonyo North Sub-County is located to the North East of Homa Bay county. It is bordered by Winam gulf of Lake Victoria to the North and West, Rangwe and Kasipul Sub Counties to the South and Nyakach of Kisumu County to the East. Administratively, the sub-county covers an area of 412.5 km2 and is compose of seven (7) electoral Wards and Twenty-three (23) locations. The wards were, West Rachuonyo, North Rachuonyo, Central Rachuonyo, Kendu Bay town, Wangchieng', Kanyaluo and Kibiri (Appendix 4 B). It is a uni-ethnic sub county dominated by the Luo with few non-Luo residents as business-men and those on formal employments.

Rachuonyo Sub County was picked for the study because according to Kenya National Bureau of Statistics (KNBS, 2016), the Sub County had the highest number (7,188) of elderly among the other seven (7) out of the 8 sub counties of Homa Bay as shown in Table 3.1, therefore it was necessary to assess the responsiveness of the health system towards this large number.

**Table 3. 1: Population of Elderly in Homa Bay Sub-Counties**

| SUB COUNTIES/ CONSTITUENCIES (Admin/Political) | Number of Elderly |
|---|---|
| KASIPUL | 4,189 |
| KABONDO KASIPUL | 4,439 |
| RACHUONYO NORTH | 7,188 |
| RANGWE | 4,134 |
| HOMA BAY TOWN | 2,664 |
| NDHIWA | 6,242 |
| SUBA NORTH | 3,320 |
| SUBA SOUTH | 3,247 |
| **TOTAL** | **35,421** |

*Source: KNBS and SID, 2016*

### 3.4 Target Population

Target population is a complete set of individuals, cases or objects with some common observable characteristics of a particular nature distinct from other population. According to Mugenda and Mugenda (2010), a population is a well-defined set of people, services, elements and events, a group of things household that are being investigated. The target population in this study were 10,033 elderly in the seven wards of Rachuonyo North Sub-Count, (Homa Bay Integrated Development Plan [HCIDP] 2013). Table 3.2 show the distribution of the elderly in the wards.

**Table 3. 2: Rachuonyo North Ward population of Elderly**

| County Ward | Population | Elderly |
|---|---|---|
| West Rachuonyo | 30,288 | 1614 |
| North Rachuonyo | 27,436 | 1462 |
| Central Rachuonyo | 15,579 | 830 |
| Kendu Bay Town | 23,667 | 1261 |
| Wangchieng | 38,731 | 2064 |
| Kanyaluo | 29,917 | 1595 |
| Kibiri | 22,651 | 1207 |
| **Total** | **188,269** | **10,033** |

*Source: HCIDP 2013 (Pg. 16)*

A sampling frame which was an accessible section of the target population from where a sample could be obtained was determined. The frame was made up of the elderly who had received health care services managed by the County government and private organizations within the sub county.

The study also targeted the health personnel in all health facilities within the sub-county as Key informants. They were people trained to deliver health services and included the medical officers, clinical officers, nurses, pharmaceutical officers (technologists and technicians), physiotherapists, nutritionists, community health workers and social workers attached to health facility (Appendix 5).

### 3.5 Inclusion /Exclusion Criteria

Main respondents comprised the elderly who had received health care services in Rachuonyo North Sub-County for a period not exceeding two (2) years. The 2 years

duration was considered adequate time for vivid reflection of experience of care to qualify respondent's expression. The age was verified by national identity card while the hospital visit was verified by outpatient (OPD) card or any recorded evidence of hospital visit for care services. Participants for Focus Group Discussions were selected based on their experiences as either outpatient, inpatient, surgical or medical treatment clients. Using this background, the investigator compiled a list of elderly characteristics to guide their selection for the discussions. Key Informants were categorized by disciplines as Medical officers and paramedical staff. The exclusion criteria considered the general citizen aged below 60 years and the non-medical and non-paramedical staff.

### 3.6 Sampling Procedure and Size

Sample population was drawn from the Sub-County population of 10,033 elderly. Sample size was determined by using Taro Yamane's formula (Yamane, (1967) which was relevant in this study for getting the desired sample size.

Formula $n = \frac{N}{1+N(e2)}$

n = is the required sample size

N = is population of the elderly (10,033)

e = is the precision level (level of significance). At a precision level of 95% with a ±5 margin of error, the set precision level is 0.05

Using the above formula, the required sample size was calculated as follows:

$$\frac{N}{(1+N(e2)]}$$

$$\frac{10{,}033}{1+10033(0.05)(0.05)}$$

$$\frac{10{,}033}{1+10033 \times 0.0025}$$

$$\frac{10033}{1+25.08}$$

$$\frac{100033}{1+25}$$

$$\frac{10033}{26}$$

Main respondents = 385

The sampling design was Probability, employing random sampling methods of sample selection. The study adopted the already stratified administrative boundaries of the seven electoral wards. Purposive sampling enabled data to be collected from eligible elderly, Key informants who were the routine health service managers at health facilities and at the community level, and also from focus group participants who had the ability to vividly recall the experience of encounter with health care services. According to Kothari (2006) participants for Focus Group discussion are selected purposively because of their ability to explore perceptions, and behaviors being investigated in a target group.

The 385 sampled elderly population was calculated proportionately for each of the seven wards based on ratio of ward population to Sub county population. The outcome was distributed as shown in table 3.3. The Sub - county was clustered into seven (7) electoral wards and twenty-three (23) locations. Each location was allocated the representative number of questionnaires as detailed in Appendix 6.

**Table 3. 3 Rachuonyo North ward population and sample population**

| Ward | Ward Population | Ward elderly population | Sampled Elderly | Locations | No of questionnaires |
|---|---|---|---|---|---|
| West Rachuonyo | 30,288 | 1614 | 62 | 4 | 62 |
| North Rachuonyo | 27,436 | 1462 | 56 | 4 | 56 |
| Central Rachuonyo | 15,579 | 830 | 32 | 3 | 32 |
| Kendu Bay Town | 23,667 | 1261 | 49 | 2 | 49 |
| Wangchieng | 38,731 | 2064 | 79 | 4 | 79 |
| Kanyaluo | 29,917 | 1595 | 61 | 3 | 61 |
| Kibiri | 22,651 | 1207 | 46 | 3 | 46 |
| **Total** | **188,269** | **10,033** | **385** | **23** | **385** |

Source: HCIDP (2013)

### 3.7 Method of Data Collection

The study used mixed method of data collection and obtained both quantitative and qualitative data by use of interviews and focus group discussions. Bhattacherjee, (2012) points that joint use of qualitative and quantitative data may help generate unique insight into a complex social phenomenon that are not available from either type of data alone, and hence, mixed-mode designs that combine qualitative and quantitative data are often highly desirable in social science research. The rationale of using mixed method is that it helped to validate the research study and ensured better results than a single method.

The descriptive data was captured by a five-point Likert scale rated as 1-Strongly Disagree, 2-Disagree, 3=Undecided, 4=Agree, 5=Strongly Agree. The inferential data were captured by the open-ended aspect of the questionnaire. The semi structured

questionnaire was administered by the help of trained research assistants because majority of the respondents were illiterate therefore could not by themselves fill the questionnaire. Data was collected on elderly demographic characteristics, respect for persons, concept of client orientations, and health system preparedness to care for the elderly in regards to optimal ageing. A total of 376 elderly were reached against the expected 385. Open ended questions allowed the interviewer to probe deeper into the initial responses of the closed ended questions in order to gain more detailed insight on the various constructs.

Key Informant Interviews were conducted by the investigator to health personnel who were resourceful persons with professional knowledge, roles and valued insights regarding the phenomenon of study. Key Informants were visited at their various working health facilities. Data collected using KII guide (Appendix 8) addressed the four objective areas: level of optimal aging which captured basically the aspects of morbidity; Observance of Respect for Persons captured the three aspects: dignity, confidentiality, autonomy; Observance of client Orientation captured the four aspects: prompt attention, amenities of adequate quality, access to social support network and choice of care provider; Health System preparedness to care for the elderly captured Staff training and Staff deployment.

Focus group discussion was moderated by the investigator to 10-member groups of mixed gender in five wards of the sub-county (table 3.5). The discussions lasted for a maximum of two hours each. Bhattacherjee, (2012) recommend typically 6 to 10 people at one location for a period of One to Two hours. To ensure, that the interviews probed all relevant issues and that data collection was consistent in all the

interviews, the investigator developed and used guiding questions (Appendix 9) to moderate the discussions. Participants were informed on the subject of discussion before the discussion began to enable them to prepare appropriately. Key areas focused on; dignity, confidentiality, autonomy, promptness of attention, amenities of quality, social support and choice of provider. Focus groups are more suited for exploratory research of which this study was advancing. The mixed gender enhanced discussion by harmonizing perspectives of the phenomena. The interviews were audio recorded and later transcribed. The sites and group characteristics are displayed in Table 3.4.

**Table 3. 4: Summary of the Focus group discussions sites and characteristics group**

| | **Location of the Group** | **Characteristics of the group** | **Status of participants** | **Gender of participants** |
|---|---|---|---|---|
| 1. | Okiki Amayo Health center | Mixed group | Community-based elderly | 6 males<br>4 females |
| 2. | Lower Kamuga Primary School | Mixed group | Community-based elderly | 6 males<br>4 females |
| 3. | Kotieno Gumba SDA Church compound | Mixed group | Community-based elderly | 5 females<br>4 females |
| 4 | Andhoge Chief's camp | Mixed group | Community-based elderly | 6 males<br>4 females |
| 5 | Wadhgone Nyongo Chief's camp | Mixed group | Community-based elderly | 7 males<br>3 females |

*Source Investigator, 2017*

Focus group discussions explored the research questions that were central to the study focus: responsiveness of health care system on elderly optimal aging. The investigator made contextual notes and also audio recorded each focus group discussions in readiness for transcription for analysis.

The field experience met on Focus Group Discussion was high turn out by the elderly for the activity as they expected monetary payment since field work was conducted

immediately after the campaign for general elections which was marked by payment to woe voters. It was also due to anticipated recruitment for the national program for cash transfer allowance. This was overcome by explaining again the purpose of the activity which was basically academic and had no monetary gain.

**Table 3.5: Summary of Methods and Instruments used for Data Collection**

| **Population** | **Size** | **Sampling technique** | **Size** | **Data collection method** | **Instrument /tool** |
|---|---|---|---|---|---|
| Elderly | 10,033 | cluster, multistage &Purposive | 385 | Interviews FGDs | Questionnaires Interview schedule |
| Medical Officers | 5 | Purposive | 2 | Interview | Interview guide |
| Clinical Officers | 31 | Purposive | 10 | Interview | Interview guide |
| Nurses | 121 | Random | 25 | Interview | Interview guide |
| Physiotherapists | 8 | Purposive | 3 | Interview | Interview guide |
| Pharmacists | 10 | Purposive | 5 | Interview | Interview guide |
| Focus group discussion | 10 people in each group | Purposive sampling | 5 | FGD | Guiding questions |

### 3.8 Research Instruments

The tools for data collection were Questionnaires (Appendix7), KII Interview Schedule (Appendix 8), and Focus Group Discussion guide (Appendix 9), and tape recorder for Focus group discussions. Observations were an integral part of the interviews and FGDs while triangulation assisted the study to realize areas of convergence and divergence of different methods such that deficiencies in one method were made up for by the strengths of a different method (Alvi, 2016).

#### 3.8.1 Questionnaire

A semi-structured questionnaire had 102 items (Appendix 7).

The questionnaire was based on the literature review, so it was developed in a deductive way to capture both descriptive and inferential data. The closed-ended questions sketched the objective picture of reality by collecting quantitative data, while the open-ended questions collected qualitative data which clarified and allowed for an interpretation of the participants' reality and experiences. The instrument was piloted and areas that needed adjustments were corrected. In justifying the use questionnaires, Leeds (1980) pointed that a questionnaire is easier to administer to a good number of respondents who respond in private settings. Questionnaire enabled data collection procedures to be applied in a standardized manner. The advantage of semi-structured questionnaire is that it allowed for the flexibility of questions to accommodate respondents understanding. It also allowed the collection of both qualitative and quantitative data.

### 3.8.2 Interview Schedule

The instrument (Appendix 8) was used to obtain data from Key Informants. It spelt out the inclusion criteria for the respondents, brief explanation of the purpose of the study, ethical consideration of consent and confidentiality. It also included age and work experience in terms of years. The instrument guided the investigator to collect data on constructs of Optimal Ageing, respect for persons, client orientation and health system preparedness to care for the elderly. Information from this instrument was used to triangulate for information obtained from the main respondents. Key informant interview is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program or situation (Boyce and Neale, 2006). It is carried out by interviewing persons whose professional roles endows them with in-depth knowledge on an issue (Corbetta, 2003). The advantages of using Key Informant Interviews are that it allows the investigator to reach known people in a short period of time, it is the only method of reaching people whose names and addresses are unknown, involves talking to people at homes, offices, on street, or in shopping malls. Tuckman (1978) and Gall (1996) acknowledged its flexibility since the questions can be repeated and/or the meaning clarified to the interviewee. It however has some drawbacks; there is room for error and bias on the part of the interviewer who may not be able to correctly judge age and race among others, the interviewer may be uncomfortable talking some sensitive issues to elderly.

### 3.8.3 Focus Group Discussion Guide

Focus Group Discussion tool, (Appendix 9) spelt out the inclusion criteria for the respondents, number of participants per group, preliminaries for ground rules. The tool was used by the investigator to guide the discussions on the four objective areas. It enabled the investigator to moderate discussions to obtain data from five sites which had 10 members each composed of mixed gender (Appendix 18). The advantage of using FGD was that it helped to understand people's thoughts and feelings. Its major drawback is that it not generally used for explanatory or descriptive research, it is often costly and generalizing for the sample used may not be easy.

## 3.9 Validity and Reliability of the Instrument

Validity is the degree to which any measurement approach or instrument succeeds in describing or quantifying what it is designed to measure (Weiner, 2007; Kothari, 2004; Golafshani, 2003; Joppe, 2000). Kumar (2011) observes that face and content validity is crucial in ensuring that each question or items on a sub-scale have a logical link with an objective of the study. Amin (2005) portend that the most effective and reliable way of ensuring that a questionnaire meets face and content validity is by relying on expert judgment. Reliability which is the degree to which a measurement technique can be depended upon to secure consistent results on repeated application was also tested. The research instrument is considered to be reliable if it can reproduce consistent results of a study and an accurate representation of the total population over time under a similar methodology (Orodho, 2009; Weiner, 2007; Golafshani, 2003, Joppe, 2000). Exemplified in these citations is the idea of replicability or repeatability of results or observations. Thus Joppe (2000) affirms that variables derived from test instruments are

declared to be reliable only when they provide stable and reliable responses over a repeated administration of the test. In this study reliability of the questionnaires for data collection was tested by assessing the scale's internal consistency (the extent to which they are measuring the common construct).

### 3.9.1 Validity

Validity of the instrument was tested. The investigator relied on the validation of the instruments by two expert study supervisors who gave their views on the comprehensibility, relevance, clarity and applicability of the research instruments. This is in line with Mugenda and Mugenda (1999), that research instruments should be availed by experienced researchers to determine their validity. Validity was also achieved by training the research assistants to understand the context of the study, the content of data collection tool and also to be proficient in administering the tool. This controlled biases that could arise from random errors: inaccurate coding, wrong instructions, interviewee/interviewer fatigue, motivations, interests, or perspectives of the inquirer.

### 3.9.2 Reliability

Reliability was ensured by computing the Cronbach's alpha, the most popular numerical coefficient of reliability (showing how closely related a set of items are as a group), based on the reliability of a test relative to other tests with same number of items, and measuring the same construct of interest, was used in this study. The rule of thumb, as suggested by George and Mallery (2003), classified Cronbach's alpha coefficient values as: > .8 = Excellent; > .7 = Good; > .6 = Acceptable; > .5 = fair; > .4 = Poor and < .3 = Unacceptable.

In the interpretation of the reliability results, it was observed that the closer Cronbach's alpha coefficient is to 1.0, the greater the internal consistency of the items in the scale. It was imperative to calculate and report Cronbach's alpha coefficient for internal consistency reliability for the subscales used in the study. The ten sub-scales used in this study were: Optimal Ageing, Observance of Dignity of the Elderly by Health care service providers, Observance of Confidentiality by Health care service providers, Observance of Autonomy by Health Care Providers, Promptness of Attention by Health care service providers, Amenities of Adequate Quality, Access to Social Support Network, Choice of Health care service providers, Staff Training and Services and Staff Deployment. Computation of the reliability for multi-item opinion items was undertaken separately for all the five subscales in the household questionnaires. Table 3.6 which shows the Cronbach's Alpha for questionnaires reveals that the instruments had adequate reliability for the study.

**Table 3. 4Internal Consistence: Cronbach's Alpha Results for the Questionnaire**

| Scale | No. Items | Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items |
|---|---|---|---|
| Optimal Ageing | 9 | .786 | .757 |
| Observance of Dignity of the Elderly | 8 | .716 | .707 |
| Observance of Confidentiality | 6 | .619 | .609 |
| Observance of Autonomy | 5 | .621 | .612 |
| Promptness of Attention | 5 | .633 | .614 |
| Amenities of Adequate Quality | 9 | .781 | .758 |
| Access to Social Support Network | 7 | .718 | .699 |
| Choice of Health care service providers | 5 | .621 | .612 |
| Staff Training and Services | 7 | .619 | .607 |
| Staff Deployment | 5 | .621 | .612 |

All the subscales reached the threshold of Cronbach's alpha of 0.6. The minimum acceptable value of Cronbach's alpha is 0.60 and a maximum expected value is 0.90. All the items of this subscale were retained because none of them exaggeratedly hanged out. It was also noted that all items were `correlated with the total scale to a good degree. A correlation with the total scale of above .90 would have meant that there were redundancy and duplication of items. On the same note, it was established that the internal consistent for the other subscales in the questionnaire were adequate enough for the study. The sub-scale which had the highest internal consistency Cronbach's Alpha value was optimal ageing with nine items having alpha value of 0.786, which was still less than the threshold of 0.9. These findings show that the questionnaires were generally suitable for data collection; because they adequately measured the constructs for which they were intended to measure.

Reliability was also tested by a pilot study conducted after the questionnaire was developed. Piloting was done from a group similar to the target population who were later excluded from participation in the main study. This was to ensure that the tool had a logical flow, the items were presented clearly, and respondents understood and interpreted the questions the same way and finally that the instrument captures good quality information. The draft report was shared with respondents to determine that the captured data accurately represent their realities before final tool was documented. The fine tuning of the individual items was done after piloting, during which time the inputs of the pilot respondents were evaluated and incorporated in rewording of particular items, where necessary. Piloting in research is supported by Bhattacherjee (2012) that it helps to detect potential problems in research design and/or

instrumentation and to ensure that the instruments used in the study are reliable and valid measures of the constructs of interest.

### 3.10: Data Collection Procedure

The chiefs of the twenty-three locations (table 3.3) in the seven Sub-County wards and management of health facilities were informed about the data collection vide letter dated 28th November 2016 (Appendix 11 and 12). The research assistants who were community health workers attached to the health facilities and covering the locations were identified through their leaders. They were trained on the research tool (semi structured questionnaire) to ensure accuracy and efficiency. This included an understanding of their terms of references, the variables the research intended to capture and definition of terms used. A total of 376 (97.9%) out of 385 semi-structured questionnaires (Appendix 7) were administered in all the seven wards to gather data from the elderly in their homes on their experiences with health-care service delivery. Five Focus group discussions were arranged through community health workers and also through the administrative offices of the location chiefs. The discussions were moderated by the investigator using focus group discussion guide (Appendix 9). Additional 45 interviews were conducted by the investigator to Key informants in selected health facilities in the Sub County using the interview guide (appendix 8).

### 3.11: Data Processing, Analysis, Interpretation and Dissemination of results

Data obtained from the respondents were cleaned, validated, coded and finally analyzed using SPSS version 20. The research results were presented using both the descriptive statistics and inferential statistics. Descriptive statistics of mean,

regression, correlation, and anova were used to describe the views of the respondents on each sub-scale, while the inferential statistics through coding, categorizing, concepts and themes helped to make inferences and draw conclusions. In order to determine the mean score response, data was aggregated on a 5 score Likert's scale in the form of; 1= strongly disagree, 2 = disagree, 3 = undecided, 4 = agree and 5 = strongly agree. The scores of all respondents on a given construct were aggregated to give the total score per item. The mean score response was calculated by dividing total score per item by number of respondents per item. The mean scores were then interpreted using the following intervals - 1.00-1.44 = very low level; 1.45 – 2.44 = low level; 2.45 – 3.44 = moderate level; 3.45 – 4.44 = high level; 4.4.5 – 5.00 = very high-level scores respectively.

Statistical tests, Pearson product-moment of correlation and regression analysis were used to investigate the relationship between the variables. Pearson Moment Correlation Coefficient analysis was used to investigate the relationship between observance of respect for persons in Health System, implementations of the concept of client orientation in Health system, Health Systems preparedness in training and elderly optimal ageing. Multiple regression was used to; establish a linear model to investigate how well the set of the independent variables was able to predict the perceived level of optimal ageing among the elderly, to investigate relative contribution of each of the variables and to establish how much unique variance, in the dependent variable, each of the independent variables explained. All tests of significance were computed at $\alpha = 0.05$.

The multiple regression model adopted was formulated as follows:

$Y = \beta 0 + \beta 1X1 + \beta 2X2 + \beta 3X3 + \varepsilon ij$

Where y is the dependent variable

$\beta 0$ is the constant

$\beta 1$, $\beta 2$ and $\beta 3$ are regression coefficients to be computed

$\varepsilon ij$ is the error component with mean zero

Where: Y is Optimal Ageing

X1Observance of respect for persons

X2Client Orientations

X3 Preparedness to Care for the Elderly

The multiple-regression-model also enabled the researcher to know how much unique variance, in the optimal ageing, each of the aspect of health systems responsiveness explained, as suggested by Hair, Anderson, Tatham and Black (1995). However, a diagnostics tests had to be preliminarily performed to ensure that there is no violation of the appropriate assumptions of correlation and multiple regressions.

### 3.12: Ethical Considerations

This study used people as respondents. Kombo and Tromp (2009), pointed that researchers whose subjects are people or animals must consider the conduct of their research, and give attention to the ethical issues associated with carrying out their research. Approval and permission to conduct this study was therefore sought and was granted by the National Council for Science and Technology (NACOSTI), vide letter Ref. No. NACOSTI/P/16/71971/14003(Appendix 13) through the Rongo University School of Post Graduate Studies. NACOSTI further directed a request for permission

by Homa Bay County government which was ultimately granted through by the Ministry of Health Homa Bay County vide letter dated 28th Nov. 2016 (Appendix 14); the Presidency Ministry of Interior and Coordination of National Government Ref No ED12/1VOL.II/164 (Appendix 15); and Ministry of Education Science & Technology State department of Education Ref No MOEST/CDE/HBC/ADM/11/VOL.1/167 (Appendix 16).

The study took into consideration various ethical issues that enhanced the credibility of the research work. They included the ethical principles of **informed consent**, respect for **privacy**, safeguarding **confidentiality** of data and avoiding harm to respondents and researcher. Participants consent for the study was obtained after the nature and circumstances of the study was explained and any relevant cause of apprehension allayed by assurance. The explanation included the purpose and benefits of the study, how information collected would be used and also the maintenance of confidentiality on the data collected and anonymity of the respondents. Participants were informed about their unconditional freedom to discontinue their participation at any point and that this would carry no risk. Consent form for accepting to participate in the study (Appendix 17) was signed by the participants. The forms were collected and kept under safe custody by the investigator.

# CHAPTER FOUR

# FINDINGS, INTERPRETATION AND DISCUSSIONS

## 4.1 Introduction

This chapter presents results of data analysis, interpretation and discussions. Data were collected and processed based on objectives. In chapter One, questionnaire return rate is presented first followed by demographics of respondents which provide the insight of drawing comparisons among respondents and Key Informants. This is followed by analysis of each specific objective stating the findings and presenting the results, interpretation, discussion and making conclusions on each specific objective. The study aimed at establishing observance of the responsiveness of health care systems on optimal aging of the elderly. The findings and discussions were based on the four study objectives and revealed that the health system accounts for 56% in elderly optimal ageing. The clips for Focus Group discussions were recorded at five sites indicated in parenthesis and listed in appendix 17.

## 4.2 Questionnaire Return Rate

Table 4.1, which shows the summary of return rate of questionnaires from the respondents, revealed that the questionnaires were adequate for the study

**Table 4.1. Respondent's Questionnaire Return Rate**

| Respondents | Questionnaires | Questionnaires | Return rate |
|---|---|---|---|
| Elderly | 385 | 376 | 97.7 |
| Total | 385 | 376 | 97.7 |

The study targeted 385 elderly, out of whom 376 were reached by saturation, translating to a response rate of 97.7%. This response rate was sufficient and conforms to Mugenda and Mugenda (2009) specification that a response rate of 60% is adequate for analysis and reporting; a rate of 70% is good and a response rate of 80% and above is excellent. Based on this, the current study's response rate of 97.7% was excellent.

The investigator attributed the excellent questionnaire return rate to the ability of the research assistants who were community health workers working within the locations and were therefore well versed with the geographical topography of the area and were also well trained on the research tool (questionnaire) for efficiency in its administration. It was also due to extra efforts that were made via personal calls and spot-visits by the investigator to remind the research assistants to be diligent with the questionnaires.

### 4.3 Demographic Information

The study sought to investigate the demographic characteristics of the elderly respondents. This information was considered necessary for the determination of whether the respondents were representative sample of the elderly target population for generalization of the results of the study. The demographic information investigated included gender, age, marital status, educational level and income generating activity. The findings and discussions were presented as follows;

#### 4.3.1 Gender of Respondents

From Figure 4.1, it is evident that majority 227 (60.4%) of the elderly were females, with male elderly being only less than four out of ten of the respondents. Given that

the study respondents were selected randomly without any bias to a particular gender, it implied that majority of the elderly in Rachuonyo North Sub County were females. This is not surprising because generally there are more females than males in Kenya as reported by Kimathi, (2009) and Gondi (2009) that majority of older persons in Kenya are women, many of who live in the rural areas (Byl, Punia, Owino, 2013).

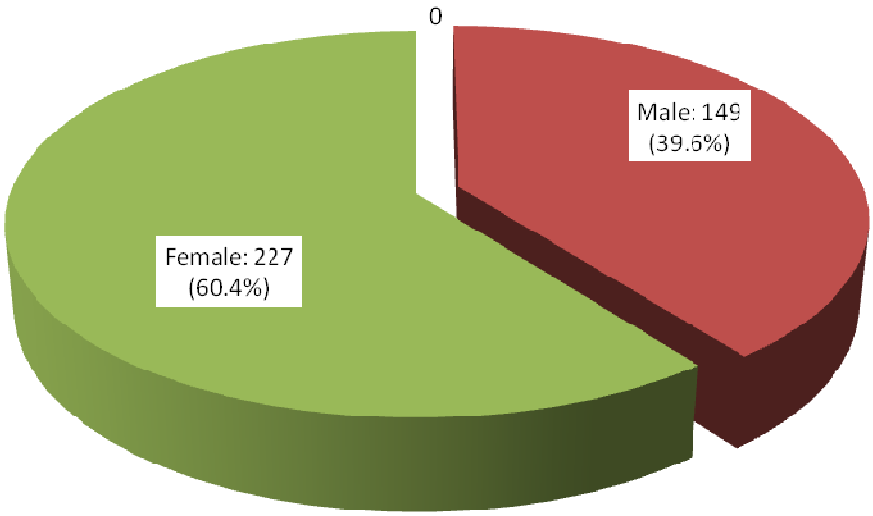


**Figure 4.1: Gender Distribution of Respondents**

The finding also concurred with that of UNDESA, (2015) forecast that three quarter of women aged 60 years and over, worldwide will be living in the developing world where every one in seven persons will be an older woman and that by the year 2014, the number of women outlived men globally by 4.5 years on average and made up 54 per cent of those aged 60 and over and hence ageing is a woman's world.

The investigator therefore concluded that the finding is a true reflection of the contemporary global demographic indicators on the number of females over males. This could be due to the fact that there is relatively high mortality rate among males

than females globally and in the study area. Since both genders were represented in the study, the findings could be generalized to all gender.

### 4.3.2 Age of the Respondents

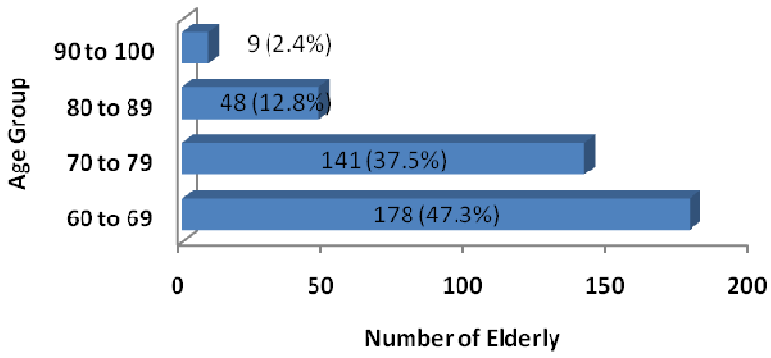


**Figure 4.2: Age Distribution of the Respondents**

On the ages of main respondents (shown in Figure 4.2), the study established that a significant majority 319 (84.8%) of the elderly were in the age group of 60-69 years and 70-79 years. Those who were above 80 years only formed the lowest proportion of the elderly in Rachuonyo North Sub-county, with only 9 (2.4%) of them being aged between 90-100 years. Compared to other world regions, many parts of Africa entered the demographic transition relatively recently, and thus ageing process has just begun with older persons accounted for slightly over 5 per cent of the population in 2014. That proportion is projected to nearly double by 2050. The finding concurs with findings of a study in Kenya by Gondi (2009) that population of Kenya has kept increasing over years with improvement in life expectancy.

The investigator's view is that the demographic trend could be attributed to health complications of old age which could have slowed the aging process in developing nations however these complications started to be sensitive to improvements in public

health interventions of the early 21st century which gave room for the increasing number of the elderly. The findings revealed a statistically negative correlation between age of the elderly and years lived such that as age advances from 60 years, the number of living elderly decreases therefore those who were reached formed a fair representation of the elderly population trend.

### 4.3.3 Marital Status of the Respondents

The study further sought to investigate the marital status of the elderly given that optimal ageing could be influenced by marital status; hence it is important to understand how it was distributed among the respondents. Their findings were presented in Table 4.2 which shows that although majority 206 (54.8%) of the elderly were married, slightly below average number 141 (37.5%) of them were widowed. Only 25 (6.6%) were widowers however, there were few cases of separation.

**Table 4.2.Distribution of Marital Status of the Respondents**

| Status | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| Married | 206 | 54.8 | 54.8 |
| Widow | 141 | 37.5 | 92.3 |
| Widower | 25 | 6.6 | 98.9 |
| Separated | 4 | 1.1 | 100.0 |
| **Total** | **376** | **100.0** | |

The result indicate that life expectancy of women is higher than that for men. This finding mirrors the result of a study by Gondi (2009) that life expectancy is higher in women (60.4) than in men (52.8). The findings further reflect that by UNDESA (2014) that globally forty per cent of the world's older population lives independently, either alone or with a spouse only. While the percentage living independently is

similar by sex, higher female life expectancy means that older women are more likely to live alone (19 per cent) than older men (11 per cent). Independent living is however the dominant living arrangement of older persons in the more developed regions where almost three quarters of them live alone or with a spouse only. As populations continue to age, independent living is expected to become increasingly common among older persons in both the more developed and less developed regions. In the study, area married life is a respected social institution and it translates to supportive co-existence which fosters elderly optimal ageing.

### 4.3.4 Educational Level of the Elderly Respondents

**Table 4.3. Distribution of Elderly Education Level**

| Education Level | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| Primary or none | 328 | 87.2 | 87.2 |
| Secondary | 45 | 12.0 | 99.2 |
| Tertiary College | 2 | .5 | 99.7 |
| University | 1 | .3 | 100.0 |
| Total | 376 | 100.0 | |

Table 4.3 showed that a significant majority 328 (87.2%) of elderly had no formal education or only had primary level of education. Those who attained secondary education were 45 (12.0%), those who attained tertiary/college education or university education only formed less than one out of a hundred 3 (0.8%) of the elderly who took part in the survey. This finding is mirrored by HelpAge (2013) and Aboderin (2010) that there is broad lack of formal education among the elderly in Africa and

SSA respectively. In Kenya it was reported that 77% of women and 40% of men never went to school (KDHS, 2008-2009). Beales (2009) pointed that educational attainment is a key determinant of life-style and the status an individual enjoys in a society, therefore it has strong effect on individuals' attitude towards health behaviors and quality of aging.

The low score by the elderly in achieving formal education could be attributed to the fact that at their prime of age for schooling, schools were few and far placed. It could also mean that since those who turned sixty by the time of survey were born during the colonial era when the quest for education was still low. The implication of illiteracy was reflected in a focus group discussion site 2 where a mother presented to the investigator, a drug prescription given at the hospital and she never collected the drugs because she never got the meaning of that document. The patient continued to suffer despite having the prescription for the drugs.

### 4.3.5 Income Generating Activity of Respondents

The study further sought to determine involvement of elderly in income generating activities as economic boost to their optimal ageing.

**Table 4.4. Distribution of Respondents Income Generating Activity**

| Business Engagement | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| Farming | 271 | 72.1 | 72.1 |
| Business | 57 | 15.2 | 87.2 |
| Teaching | 13 | 3.5 | 90.7 |
| Fishing | 5 | 1.3 | 92.0 |
| Other Activities | 30 | 8.0 | 100.0 |
| **Total** | **376** | **100.0** | |

Table 4.4 showed that, although the elderly are engaged in various economic activities for maintaining livelihood, many of them were engaged in farming and business. This was reflected by the fact that majority 271 (72.1%) indicated that they were doing farming while 57 (15.2%) of them were in other business. Although farming takes a greater percentage of engagements compared with other income generating activities, it is done at peasant level, (HCIDP, 2013).

The investigator attribute this to the fact that the region has one rainy season which cannot support extensive farming. The mixed business engagements included; shop-keeping, supervisions and security officers. A relatively small number 13(3.5%) take up teaching in the various academies within the sub county. The investigator attribute this to possible a response to the Kenya Vision 30 of harnessing talents of high cadre retirees' contribution to development and the United Nations resolutions 46/91 of December 1991 that older persons should have the opportunity to work or to have access to other income generating opportunities. It could also confirm Karpf

(2012)and Matt (2009) assertions that it is the willingness and productivity of an individual that maters and not chronological age.

In a focus group discussion at site 2, (Appendix 17), a female participant observed that whether old or not, women do most domestic chores like cooking, washing, gardening, grazing, and watering domestic animals kept by their husbands.

The involvements of the elderly in income generating activities reflects UN, (2016) and HelpAge (2001) reports that majority of older persons in sub-Saharan Africa have no choice but to continue to work as long as they are physically able and that older men and women in the region are making vital contributions to their families and communities. The finding further mirrors United Nations study on World Population Ageing (UNDESA, 2015) that among people aged 60 years or over globally, 30 per cent of men and 15 per cent of women were active in the labour force, while in developing countries, older men and women were more likely to be active in the labour force. A study in Brazil by Chaves, (2009) on predictors of Normal and Successful Aging Among Urban-Dwelling Elderly Brazilians revealed that income had a protective effect on optimal ageing – the higher the family income the better the aging process.

The investigator observed that socioeconomic roles and contributions of the elderly in various sectors remain important therefore elderly deserve holistic care so as to realize their optimal aging. The various percentage engagement of the elderly in income generating activities indicate that they are not idle against popular belief that they have outlived their usefulness. The findings agree with UNECA (2012) which castigate the notion of stereotyping the elderly as non-productive consumers of resources. This

notion could be detrimental to their potential contributions to inclusive sustainable development. The finding reveals a fair representation of elderly engagement.

In conclusion, the findings revealed that the demographics was representative sample of the elderly target population for generalization of the results of the study.

### 4.4 Objective 1: To determine the level of optimal aging among the elderly.

The study sought to establish the level of optimal ageing in Rachuonyo North Sub County. In order to establish the level of optimal ageing, data was collected through the use of a ten itemed-Likert-scaled questionnaire that was administered to the elderly. The constructs of the items were pivoted on indicators of optimal ageing such as; free of chronic diseases, autonomy in activities of daily living, social participation, only mild cognitive or functional impairment and little or no disability. Using the responses; Strongly Agree (5), Agree (4), Undecided (3), Disagree (2) or Strongly Disagree (1), the elderly responded on the items based on the assessment of their personal experience with the social aspect of care. Rating levels for optimal aging were as follows 1.00-1.44 = very low level; 1.45 – 2.44 = low level; 2.45 – 3.44 = moderate level; 3.45 – 4.44 = high level; 4.4.5 – 5.00 = very high level. The responses were summarized and presented in Table 4.5 which shows that there was moderate level of optimal ageing among the elderly. This finding was mirrored by a mean response of 2.61 (SD=0.43) in the scale of 1 to 5, with most of the constructs indicators rated just barely above moderate level of optimal ageing.

On the construct “I do not have any prolonged health conditions due to my old age status”, Table 4.5 indicated that majority 262 (69.7%) of the elderly had many prolonged health conditions due to their old age status. Therefore, the mean response

of 2.36 (SD=0.56) implied a moderate level of optimal ageing. Equally, the qualitative response in the questionnaire revealed that the elderly in Rachuonyo North Sub-County suffer from varied health conditions.

The investigator attributed this to varied accompanying age-related health conditions which are common in the elderly as reported by Miller et al, (1999).The common health problems that made the elderly to seek health services included; allergy, diarrhea, body pains (backache, painful joints, chest pains, boils, neck stiffness, stomach ache, abdominal pains, muscle pains); body swellings (abdominal, face, knee, eyelids, legs); loss of sensations (side numbness), burning sensation in lower limbs, broken leg, constipation, diabetes, Skin problems (infections, rashes, dog bite, dry skin, burns, wounds); eye problems, hearing problem, high blood pressure (hypertension), HIV/AIDS, dehydration, hotness of the body (fever), body weaknesses, loss of appetite (anorexia), throat problem, loss of voice (aphonia), malaria, meningitis, abdominal ulcer, typhoid, respiratory tract infections (pneumonia, tuberculosis, coughing, asthmatic attacks, difficulty in breathing), urine blockage, uterine problem, vomiting.

It was evident from this list that a sizeable number of ailments were associated with old age, specifically allergy, body pains, loss of sensations, chest pains, breaking bones, skin problems, loss of sight and hearing loss, dehydration, high blood pressure, body weakness and tiredness, loss of appetite, loss of voice, ulcers, urine blockage.The other ailments i.e. malaria, meningitis, typhoid, respiratory tract infections, vomiting were associated with the environment under which the elderly is found (Miller, 1999).

**Table 4.5.: Respondents' Views on Optimal Ageing**

| Indicators of Optimal ageing | 1 | 2 | 3 | 4 | 5 | Mean | SD |
|---|---|---|---|---|---|---|---|
| I do not have any prolonged health conditions due to my old age status. | 124 (33.0%) | 138 (36.7%) | 10 (2.7%) | 62 (16.5%) | 42 (11.2%) | 2.36 | 0.56 |
| I am always in good health and do not suffer disability from age-related chronic non-communicable disease. | 131 (34.8%) | 126 (33.5%) | 16 (4.3%) | 47 (12.5%) | 56 (14.9%) | 2.27 | 0.32 |
| Despite my age I am still able to do most of my things alone and take charge of my family decisions. | 118 (31.4%) | 92 (24.5%) | 18 (4.8%) | 63 (16.8%) | 85 (22.6%) | 2.75 | 0.48 |
| I am fully dependent on the support of young persons in my family to do my things. | 62 (16.5%) | 72 (19.1%) | 26 (6.9%) | 102 (27.1%) | 114 (30.3%) | 2.64 | 0.87 |
| I often have difficulty remembering recent conversations, names or events. | 56 (14.9%) | 58 (15.4%) | 21 (5.6%) | 114 (30.3%) | 127 (33.8%) | 2.47 | 0.78 |
| I am able to take care of myself because I do my basic care needs such as washing, dressing etc. | 108 (28.7%) | 103 (27.4%) | 15 (4.0%) | 74 (19.7%) | 76 (20.2%) | 2.75 | 0.65 |
| I hardly use walking stick or any physical support garget. | 117 (31.1%) | 111 (29.5%) | 18 (4.8%) | 56 (14.9%) | 74 (19.7%) | 2.63 | 0.34 |
| I have limitation in engaging in instrumental activities of daily living such as shopping, lifting and carrying, riding bicycle, driving etc. | 70 (18.6%) | 73 (19.4%) | 20 (5.3%) | 104 (27.7%) | 109 (29.0%) | 2.71 | 1.02 |
| I fully take in social activities such as church, community meetings, funerals, chiefs' meetings etc. | 97 (25%) | 85 (22%) | 14 (3.7%) | 101 (26%) | 79 (21%) | 2.95 | 0.94 |
| Mean Average level of Optimal Ageing among the Elderly | | | | | | 2.61 | 0.43 |

Strongly Disagree (1), Disagree (2), Undecided (3), Agree (4), Strongly Agree (5),

The findings concurred by those by Kabole et al., (2013) in western Kenya that suffering of the elderly included backache joint pain, blurring of vision, reduced hearing, indigestion, heartburn, chronic cough, breathlessness, non-healing wound, dental cavities, giddiness, sleeplessness, lift joint, piles, tumor, loose bladders, dementia and Alzheimer and multiple others. This finding affirms the studies by Mubila (2012) and Mc Murray (2003) that majority of the elderly suffer varied multi-morbidity conditions such that delay to address them may have far reaching negative consequences. A report by UNDESA (2015), indicated that unipolar depressive disorders are a leading cause of disability in females, followed by hearing loss, back and neck pain, dementias(mental disturbance)specifically Alzheimer's, and osteoarthritis. In men, hearing loss is the leading cause of disability, followed by back and neck pain, falls, chronic obstructive pulmonary disease and diabetes mellitus. The report also points that elderly in low and middle-income countries do not experience optimal aging due to diseases conditions.

Since most of the manifestations occur at the home environment where the family or community support system is the most likely first-hand help, there is need for health system to actively link families in the care of the elderly. This view is supported by Franklin (2013), who in assessing potentially inappropriate medication in elderly in the UK health system, castigated inappropriate medication effects in the elderly due to poor social supervision. A reflection of Cicero (44 B.C.) argument in his essay "De enectute" confirmed that if old age, is approached properly, it harbors opportunities for positive change and productive functioning.

On the construct “I am always in good health and do not suffer disability from age-related chronic non-communicable disease”, a total of 103 (27.4%) elderly agreed that they are always in good health and do not suffer disability from age-related chronic non-communicable diseases, but the majority 257 (68.3%) revealed that they are always in bad health and often suffer disability from age-related chronic non-communicable diseases. The mean response of 2.27 (SD=0.32) signified low level of optimal ageing. This mean agreed with the reflections by majority of the Elderly responses. On the contrary, the 103 (27.4%) Elderly who agreed with the construct “I am always in good health and do not suffer disability from age-related chronic non-communicable disease” reflect the results of a study in Kenya by Lasisi (2015), that old age diseases are assumed by the elderly and taken for granted to be normal accompaniments of ageing, as a result, there is laxity in seeking for treatment. It was also reflected in a report of study by Government of Kenya (2014) that 16.7% and 12.7% of the elderly reported feeling sick but declined from seeking health services in the years 2007 and 2013 respectively. In focused group discussions, members confirmed that elderly were often laxed in seeking health care services, as voice recorded at site 1(Appendix 21).

On the constructs “Despite my age I am still able to do most of my things alone and take charge of my family decisions”, the results of the survey showed that quite a significant proportion of the elderly 210 (55.4%) are unable to be fully self-reliant, they mainly depend on other people to meet their daily needs. Only 148 (39.4%) of the elderly who took part in the survey agreed, with certainty, that despite their age they are still able to meet most of their activities of daily living and to take charge of their

family decisions. Therefore, the mean response of 2.75 (SD=0.48) implied a moderate level of optimal ageing.

In regard to the construct “I am fully dependent on the support of young persons in my family to do my things”, many 216 (57.4%) of the respondents accepted that they invariably depend on the support of younger persons in their family to meet their daily needs. The mean response of 2.64 (SD=0.87) implied a moderate level of optimal ageing. It may be concluded that since the elderly often have no option for assistance, they have to undertake these activities personally.

On the construct “I often have difficulty remembering recent conversations, names or events”, majority 241 (64.1%) of the respondents indicated that they often have difficulty remembering recent conversations, names or events with a mean response of 2.47 (SD=0.78). The mean response suggested a moderate level of optimal ageing. It is true that substantial cognitive deterioration over time represents a diagnostic criterion for dementia diseases. Chaves, (2009) attests that cognitive impairment is a common ailment in old age, however, application of a responsive health systems can reduce cognitive decline and improve wellbeing among the elderly.

On the other hand, in regard to the construct “I am able to take care of myself because I do my basic care needs such as washing, dressing etc”. it emerged that quite a respectable proportion 150 (39.9%) of the elderly are able to take care of themselves in regard to their basic care needs such as washing and dressing, translating to mean optimal aging level of 2.75 (SD=0.65), suggesting moderate level of optimal ageing.

In addition, on the construct “I hardly use walking stick or any physical support garget”, 130 (34.6%) of the sampled elderly were found to be able to independently

walk without any support. Majority 228 (60.6%) of them could hardly walk without the help of walking stick or any garget for physical support. The mean response 2.63 (SD=0.34) suggested a moderate level of optimal ageing. It is therefore indicative that a significant number of the elderly do not experience optimal aging in terms of physical fitness thus need assistance.

In terms of the construct "I have limitation in engaging in instrumental activities of daily living such as shopping, lifting and carrying, riding bicycle, driving etc.", the findings of the study established that about average number 213 (56.7%) of the elderly suffer significant decline in physical fitness and robustness therefore are unable to actively engage in physical activities, reflecting an optimal ageing mean score of 2.71 (standard deviation=1.02). For instance, although some 143 (38.0%) of the surveyed elderly denied this fact, a majority 213 (56.6%) of them accepted that they have limitations in engaging in instrumental activities of daily living such as shopping, lifting and carrying etc. The mean response 2.71 (SD=1.02) suggested a moderate level of optimal ageing.

In regards to "Fully taking social activities such as church, community meetings, funeral managements, chiefs' meetings etc. social interactions" it emerged that despite the age, a moderate number 180 (47%) of the elderly were able to interact socially (mean=2.95; standard deviation=0.94). The mean response suggests low level of optimal aging. From all the five FGDs, it emerged that the elderly participates in these activities as opinion leaders.

The investigator observed that good health status is a major goal of development and is also a driver of economic growth and social progress. Older persons in good health

enjoy greater sense of personal wellbeing and can participate in economic, social, cultural and political life. On the other hand, poor health reduces the capacity of older persons to generate income, curtail their productivity and compels them to depend on other people. Elderly in the study area experiences moderate level of optimal ageing due basically to the effects of multimorbidity. This could be mitigated by appropriate uptake of health services which again are a function of economic endowment of the elderly, proximity of health facility, social support network and personal insight and vigor for service uptake.

### 4.5 Objective 2: To establish the influence of respect for persons in caring for the elderly on optimal ageing.

In order to establish whether observance of respect for Persons in caring for the Elderly influences optimal ageing, 5 itemized Likert-scaled questionnaires were used to collect data on the views of respondents on each of the themes; dignity, confidentiality and autonomy. Using the responses; Strongly Agree (5), Agree (4), Undecided (3), Disagree (2) or Strongly Disagree (1), the elderly responded on the items based on the various aspects of observance of respect for persons in caring for the elderly (dignity, confidentiality and autonomy). Data were summarized and presented in Tables 4.6 to 4.8.

Table 4.6 presents mean score for each of the three elements and the overall mean score of 2.49 which translated to moderate level of optimal ageing.

**Table 4.6: Mean Aspects of Observance of respect for persons**

| Aspects of Observance of Respect for Persons | Mean | SD |
|---|---|---|
| Dignity | 2.17 | 0.32 |
| Confidentiality | 2.90 | 067 |
| Autonomy | 2.39 | 0.62 |
| **Overall Mean level** | **2.49** | **0.56** |

### 4.5.1 Observance of Dignity of the Elderly by Health care service providers

Dignity was assessed by evaluating various indicators in the relationship between health-care providers and the elderly as reflected by the latter's experiences while receiving care services.

The indicators assessed specifically were acts of reception and introduction; greetings, body language, acknowledging the elderly, paying attention to the elderly, responses to enquiries, verbal comments about the elderly and commitment to service. Their responses were summarized and presented in Table 4.7.

**Table 4.7: Views of the Elderly on Upholding of their Dignity by Health Care Provider**

| Indicators of Dignity | 1 | 2 | 3 | 4 | 5 | Mean | SD |
|---|---|---|---|---|---|---|---|
| Reception and introduction by health care service provider to the elderly is often welcoming. | 100 (26 %) | 260 (69) | 6 (1.6) | 9 (2.4%) | 1 (0.3) | 1.81 | 0.60 |
| Greetings by health care service provider is warm and friendly | 199 (52.9) | 12 (32) | 26 (6.9) | 19 (5.1%) | 10 (2.7) | 1.72 | 0.98 |
| Health care service providers often display positive body language to the elderly. | 102 (27.1) | 123 (32 %) | 10 (2.7) | 97 (25%) | 44 (11.) | 2.62 | 1.41 |
| Health care service provider often recognizes, appreciate and acknowledge the elderly. | 40 (10.6) | 323 (85%) | 2 (0.5) | 10 (2.7%) | 1 (0.3) | 1.96 | 0.49 |
| Health care service provider often listens and pays attention to elderly. | 33 (8.8%) | 151 (40 %) | 11 (2.9) | 145 (38%) | 36 (9.6) | 3.00 | 1.23 |
| Health care service provider often responds positively to elderly enquiries. | 25 (6.6%) | 163 (43 %) | 5 (1.3) | 167 (44%) | 16 (4.3) | 2.96 | 1.15 |
| Health care service provider often gives prioritized consideration for care to the elderly over other cohorts, where necessary. | 163 (43.4) | 199 (52 %) | 2 (0.5) | 9 (2.4%) | 3 (0.8) | 1.64 | 0.69 |
| Verbal comments by health care service provider to or about the elderly are always encouraging. | 143 (38.0) | 207 (55%) | 17 (4.5) | 7 (1.9%) | 2 (0.5) | 1.72 | 0.68 |
| Health care service provider are always committed to serve the elderly | 32 (8.5%) | 312 (83%) | 6 (1.6) | 21 (5.6%) | 5 (1.3) | 2.08 | 0.66 |
| **Mean average level of dignity upheld by heath providers to the elderly** | | | | | | **2.17** | **0.32** |

Key: 1-Strongly Disagree, 2-Disagree, 3=Undecided, 4=Agree, 5=Strongly Agree and SD-Standard Deviation.

From Table 4.7 it is evident that based on the elderly experience with activities of health facilities in Rachuonyo North Sub-County, the mean average level of dignity

espoused by heath providers to the elderly is generally low. This was reflected by an average response rate of 2.17 (standard deviation=0.32) on a scale of 1 to 5, On the construct “Reception and introduction by health care service provider to the elderly is often welcoming”, majority 360 (95.7%) of the respondents rejected the research assertion.

From the qualitative responses of the questionnaires, majority 340 (90.4%) of the respondents concurred with the statistical findings by rejecting the research assertion. The following statements were made at the various Focus Group discussion sites (Appendix 17) as indicated against the Reponses.

> “*Introduction and greetings by care providers is very rare (1,2,3,4,5). They generally don’t introduce themselves (1,2,3,4,5). I was handled by a person I did not know who commented that there was no business with me because I am an old woman (2), It is always their habit that they don’t introduce themselves but even if it is done it is always in hurry and generally not cordial (4). I expected the doctor and the nurse to introduce themselves before services began but that did not happen. I should be welcomed in the right way and be greeted before starting the treatment (5), the young girl did not welcome me well. They know the reason why they don’t introduce themselves. It is good manners to always do introduction and if possible, it should be made compulsory (4). Introduction is a show of friendship and it should be encouraged. It is very important and people should know one another (4), it is good to know who is attending to you for a follow up. It makes patient to be closer to the doctor and it is meant to set us free with care provider but they always have no time for it (3). It is good manners that someone attending to my life should introduce him/herself to me (1). Being treated by a person you don’t know make one feel bad. If health staff doesnot talk to me then I can buy drugs in the shops. It is not appropriate not to introduce self. I felt bad that I was treated by someone I could not address by name (4). The doctor should*

*identify himself with the patient. It is good when we know one another. Introduction is important as a compliment of drugs given (2). Lack of introduction is equivalent to not welcoming and is discouraging in real sense. It is* important to be treated by a doctor I know and can address by name (2).

The investigator viewed the large number,(360)of respondents who did not agree with the research statement could be an indication of poor attitude held by the staff towards the elderly. It could also be that the elderly often reports late to the health facilities when health care service provider are already preoccupied by the general routine care services. Introduction encourage patients' freedom, comfort and uphold one's dignity.

Only 29 (7.8%) of elderly who took part in the survey agreed with the research statement that reception by health care service provider to the elderly is often welcoming whenever they visit such facilities. From the qualitative aspect of the questionnaire, the following comments were made by the respondents who agreed with the research statement:

*"Health staff were generally receptive. There was warm welcome and good salutation which created a bonding between me and the staff (3). The reception made me feel welcomed at the facility. The nurse introduced herself well before starting treatment (4). Introduction gave me confidence in the care provider (1). It made me feel free and encouraged to explain and give more information on my condition (1). It made me to be sure of the person I was dealing with which was necessary for follow up (4). I felt recognized and good because the environment was homely" (5).*

The investigator's view is that elderly who agreed with the research statement could be attributed to the respondents who received care at the Comprehensive Care Centers (CCC) which handles cases of HIV/AIDS. Services at the Comprehensive Care

Centre begin with health education sessions of which greeting and introduction are preceding components however, in all the five focus group discussions site, participants expressed concern over poor reception which to them is contemptuous and demeaning. The results of the descriptive statistics, the qualitative aspects of the questionnaires, and the focus group discussion agreed that there is a small number of respondents who agreed with, and a large number who did not agree with the research statement that reception (greetings and full introduction) of the elderly by health care service provider is often welcoming. This indicates that elderly population are sensitive to the way they are handled. In Tunisia, strengthening of health system by improving reception and care is a component of the national legislative framework for health (UNCCA, 2009). From the above data it is evident that warm reception is key to good relationship which complement service delivery as a foundation to optimal aging. It should be promoted, nurtured and maintained by health care service provider.

On the construct "Greetings by health care service provider is warm and friendly", more than a half 211 (84.9%) of the respondents strongly refuted the claim. The following key statements were recorded from the qualitative aspect of the questionnaires: -

> *"Health staff rarely greet but are quick to ask what my problem was immediately I came into the room. They are concerned with your sickness than your relationship with them: they go direct to what took me there and ask "Mama what is your problem?" I think the health care providers want to be pleased by the clients in order to serve. They don't even greet people. This is not what they were trained to do. I need to be received in a good way. They should improve".*

In all the five FGDs it was expressed that greeting is often *"old age, wasting drugs"*. A small number, 29 (7.8%), mean 1.72 (SD= 0.98) however agreed with the research assertion that greeting by health care service provider if friendly.

In terms of using body language, 141 (37.5%) of the respondents agreed that health care service providers occasionally display positive body language to them. The key statement supporting this were: -

> *"The staff give positive gestures sometimes using the hands and sometimes the face, when the health care service provider does not respond to your question and just walk away, it means that something is wrong with my condition (2). I asked for the direction of the toilet and the care provider pointed in the direction uninterestedly" (3).*

In FGD site 2 a participant commented that "Action speaks louder than words" hold true in some non-verbal communications. Health care service provider should care much about their body language because findings reveal that the elderly are keen to note and interpret meanings communicated non-verbally.

In terms recognition and appreciation of the elderly for their effort to seek health care services, the construct scored a mean of 1.96 (SD=0.49), suggestive of low level of optimal aging. The descriptive responses indicated that only 11 (3.0%) of the elderly accepted that health care service providers often recognize, appreciate and acknowledge the elderly for their effort to seek health services. Significant majority 363 (96.5%) however disagreed with that research assertion.

In all the five focused group discussions (Appendix 17), it was repeatedly reported that the elderly are seen as a bother to health services. This finding concurs with the study in Kenya by HelpAge (2001) and Kabole et al (2013) that the elderly are seen as a bother in health service delivery. On the contrary, at site 2, one retiree clinical officer operating a private clinic within the community was praised for recognizing and appreciating clients for seeking health services. The investigator interpreted this finding to reflect negative notion about the elderly. Elderly, like any other citizen deserve dignified health service delivery since health care is a human right(KNCHR, 2009) which should be provided in a respectful humane way.

With respect to health care service provider listening and paying attention to elderly, the construct mirrored a mean of 3.00 (Standard deviation = 1.23) suggestive of optimal ageing. From the descriptive statistics, it emerged that close to a half 184 (49.0%) of the elderly who had sought health care services in the health care facilities disagreed with the research assertion. Key statements from the qualitative aspect of the questionnaire which concurred with research assertion included the following: -

> *"Some health care providers were a bit polite, they responded well and were ready to listen to problem and sympathize as if they were also feeling the pain. "There was room for free conversation, attention to clients, encouragement and good care; my disease needed slow conversation and I was given time to express myself; the care provider took time to understand my story, he was keen to my status however some of them underrated me because I appeared dirty and weak from my sickness; despite this, we interacted well with the provider and got good treatment; this has made me feel good and free to express myself. I was not neglected or underrated as a patient with HIV/AIDS. I was given respect which is equivalent to my age and finally despite their busy schedule the care providers did their best to serve me, the reception was warm*

*and proper direction was given for service flow, handling was respectful and I felt free and welcome".*

A slightly less than half, 179 (47.6%) of the respondents disagreed with the research statement that health care service provider listens and pays attention to the elderly. Key statements extracted from the qualitative aspect of the questionnaire included the following:

*"The doctor who attended to me refused to understand me and I think they need to do it better and create good relationship with clients. We did not understand one another until another staff intervened. They are always in hurry to clear the line. It appears that they know what one is suffering from even before you are asked about the problem".*

From all the FGDs it emerged that not all health care service provider listens and pay attention to the elderly. Key statements include: -

*"Some ask few questions and before you give the whole story about your illness, you are handed over the drug prescription" (2,3,4)*

The findings on poor listening and poor attention to the elderly reflects the works of Falk et al. (2013), Aboderin, (2013) and HelpAge International, (2001) indicating that poor attention to the elderly is a common issue in health care. According to Galloway (2013), one of the dimensions for delivering high-quality care services that respect people's dignity is to listen and support them to express their needs and wants.

The investigator interpreted the findings to reflect a popular belief that kept on featuring in responses that elderly are wasting drugs. Communication in health care is pivotal to health care service because it may attract or drive away clients. Poor

listening specifically by health care providers should be discouraged because it could drive a way the already vulnerable elderly from utilizing health facilities appropriately. In terms of "Response to elderly enquiries", the construct attracted a mean of 2.96 (SD 1.15, suggestive of moderate level of optimal ageing.

The descriptive statistics revealed that a sizeable proportion 183 (48.7%) of the respondents indicated that health care service provider often responds positively to elderly enquiries and nearly a half, 183 (48.7%) of the respondents expressed satisfaction on how health care service providers responds to them when they seek assistance in the health facilities.

In a Focus group discussion, a female participant in site 4 expressed satisfaction on how well she was handled by a health care service provider when she went for treatment however in the contrary participants who disagreed with the research assertion (sites 2,4,5) stressed that the young health care service providers are very stubborn towards being sent. The investigator interpreted this finding to be an issue of attitude towards the elderly. On the construct "prioritized consideration to receive care services" the construct attracted a mean score of 1.64 with a standard deviation of 0.6, translating to low level of optimal ageing.

The descriptive statistics revealed that 12 (3.2%) of the main respondents accepted that they are usually given prioritized consideration for care over other patients but a significant majority 364 (96.8%) of the respondents disagreed with the assertion.

From the qualitative responses of the questionnaire, it emerged that majority 370 (98.4%) of respondents disagreed with the research assertion that the elderly are given prioritized consideration for care. Key statements to this effect were that;

> *"Sisters and doctors did not care about us, the elderly, they just see you there and it took more time waiting to be served while they went around serving other people".*

Another respondent felt that he was wasting health care service provider time for seeing young children and mothers. Further, one respondent thought that people in-charges of the health facilities value the lives of the younger people than the elderly in society.

From the focus group discussions there was the general feeling that elderly are not given prioritized consideration for care by health care service provider (sites 1, 2, 3, 5). Among their comments were that services in that health center begins at around 10 am when clients have accumulated. When health care service provider begins to call names, they don't check to identify those who may need urgent attention or follow the order of first come first served. The health care service provider often smuggles forward the people they know and leave even the very sick on the waiting bench. One female participant in FGD site 5 confessed that she will never go to that health facility again unless taken when unconscious" A male participant at a FGD site no (2) expressed how at one point he thought his age would give him a ticket for prioritized care but that did not work. He was told to wait in the line for his turn. He lamented that it is a burden to stand for long, leave alone sitting and that waiting this long may make one to forego treatment even while suffering.

The investigator interpreted this finding to be a justification for the need for specific department to care for the elderly. The elderly should be given priority by the triage nurse in situations with long waiting queues.

On the construct verbal comments by health care service provider to or about the elderly are always encouraging", the construct attracted a mean score of 1.72(SD=0.68) was suggestive of low level of optimal aging. The descriptive statistics revealed that 350 (93.1%) of elderly disagreed with the assertion. Key dissenting statements from the qualitative aspects of the questionnaire included:

> *"Care providers have no respect for the elderly; I was negatively talked to. The man told me that I am old and suffering from old age and that is wasting drugs. They never talked to me well as a patient. They were not polite when addressing patients, they talked to people ruthlessly. Sometimes they failed to talk to me and I felt as if I was not wanted. Sometimes they talked in a manner that does not show respect. I thought I had done something wrong to her, she said that I am old, should relax, because I am sickling from old age; that my complaints are signs of old age. They are not friendly*

From FGDs participants chorused that verbal comments are discouraging and that they are told that they are wasting drugs. The number of clients were too many and the line was too long so the way they talked to us, the elderly depended on the mood of care provider based on the long line. Specific comments were:

> "Care provider used arrogant words in their talk (2,3,5). The care provider did not talk to us properly looking at my age (5). One said, I have given you Panadol- go home and get enough food to eat (4); I felt that care provider should talk to me in a caring way to give me hope in life (3), They sometimes use English language which I do not understand, They blamed me of my condition- that is how I broke my leg, the elderly need respect because of their age: most of the care provider are the ages of our children, and if they cannot take my condition as a disease then let them take me back home and die in my house (4). The talks at the health-care facility do not motivate me as a patient, I felt bad and discouraged, they don't prepare patients psychologically, therefore I felt like I was being harassed, I don't feel comfortable with them,

they undermined me and they did not even greet me (5). I felt bad they don't receive patients in good way and the money they took was too much". Some support care providers talk too bad about patients (4). I felt bad and thought being harassed because of old age" (5).

Key statements from qualitative aspects of the questionnaire that concurred with the small number 26 (6.9%) of descriptive statistics responses were that: -

> "The nurse talked nicely to me but the doctor attending to me did not talk in good tone, they need to address patient politely and use a language which could be understood".

On the issue of commitment to care for the elderly, the construct attracted a mean score of 2.08 (SD=0.66) suggestive of low level of optimal aging.

From the descriptive statistics, it emerged that 344 (91.5%) of the elderly believed that health care service providers are always never committed to serving the elderly.

From the qualitative responses of the questionnaire, the comments by those who disagreed with the research assertion included the following: -

> *"There is reluctance in serving the elderly and some care providers don't look deeply into problem, they don't have time for the elderly and they say we are stubborn; Sometimes they share their stories when patients are waiting; There was the overwhelming power of the ward cleaner who removed those who came to see me in the ward by using watchman who is not sensitive to patients. This did not go well with me. They don't take their time for us because we are old and too slow, we annoy them because we repeat words. People fear the elderly because of their complications, they don't pay much attention to our complaints". They just treated me without testing. They should test me first before giving treatment.*

From all the five FGDs (Appendix 17), it emerged that health care service provider do not take enough time to examine elderly clients, they often make poor comments that

these are old age conditions. In some cases, they exercise nepotism by ushering their preferred clients (most often the young ladies by male health care service provider) whom they spend much time discussing non-sickness issues (FGD site 2). A male participant in FGD site 4 was so disappointed and said that the behaviour of some of the young health care service provider would only bring them curse.

From FGD site 5, the following issues came out:

> *"the hospital put money first. Majority need monetary bribe on top of the hospital fee in order to attend to client. I have been to many of these hospitals. If you give money then quality of care changes. Elderly are viewed as trash that should be thrown a way. They don't know that it is us,the elderly who have made them reach where they are even reaching the hospital where they are working. I was asked, what took me to the hospital at my age? There is also the issue of influence so that even the few good health care service providers at last get influenced by the bad ones."*

On the contrary, a female participant in FGD site 4 who agreed with the research assertion, said that some health care service providers are committed to serve the elderly. Her comments were that

> *"There are some sisters who are very good and concerned. There is one who was concerned with my condition. She did everything to my satisfaction but at the long end I was given only Aspirin and sleep-inducing drugs and my condition never improved".*

A similar compliment was made by a male participant in FGD site no 2 who was impressed by services he received for his eye problem however he said that these were visiting eye specialists so they could behave well because they were visitors.

**Discussion on dignity.**

The investigator interpreted these results to mean that there could be a possibility that health care service providers were being challenged by the health conditions of the elderly. Studies by Levine,(2013) have pointed that globally care for the elderly has been recognized to be challenging to health-care providers. According to Chaves, Camozzato, Eizirik, and Kaye, (2009) there is considerable variation in the effects of aging on healthy individuals, with some people exhibiting extensively altered physiological functions while others shows little or none at all. It would go well to serve with commitment being that the elderly are weak and their health status can change unexpectedly. As given by (Pearson *et al.*, 2012), dignity is a crucial notion in building and sustaining a human environment in which an individual feel included, valued, and appreciated. All the positive responses reflect a study in Wales which emphasized that acknowledging a person's dignity contributes to a sense of good health, wellbeing and independence (Gwenda, 2007).

This helps to enhance, built and sustain the elderly confidence, independence of thought and action, and to be determined to remain as active as possible (Galloway, 2013). Once rapport develops, care providers would begin to see the whole person, and the foundation of dignified care is built. When one's character, sexual orientation, ethnic or cultural heritage is attacked, it is seen as an attack on dignity at personal level. Showing indignity implies that an individual is emotionally or physically, stigmatized, humiliated, neglected, or treated more as an object than a person. Persons discriminated on any ground cannot effectively enjoy their rights i.e. to health, shelter, food and livelihood, protection from abuse, security and dignity. To be able to deliver

dignified care, employers must support care providers through appropriate training, policies and equipments. This enable care providers to objectively plan and deliver dignified care by considering individual preferences after joint discussions. It also promotes client's ownership of the care process which is an element of active participation. In cases where the elderly is not able to dialogue with care provider, the latter must draw on their understanding of inter-subjective dignity and apply their knowledge of cultural and social norms so as to deliver dignified care. In situations where caregivers may need to make judgments in difficult/challenging circumstances, it is essential that they remain objective and rational. When an aspect of dignity may be unavoidably compromised, decision should be dealt with through mutually agreed multidisciplinary team consensus.

Maintaining dignity according to Clark (2010) is not a science but a virtue that relies on understanding, empathy and compassion. In view of the demographic transitions and change in societal norms, the health practitioners need to take account of generational influences and culture to help provide dignified patient-centered care. In addition to respecting the values, attitudes, and beliefs of the elderly, health practitioners need to remember their ethical obligation to provide non-judgmental, personalized care. There is also the need to change the ways services are provided in order to accommodate shift in care by looking at hospital service less from the perspective of diagnosing and treating single illnesses to more from managing long-term conditions with often multiple complex needs. Since Older people tend to stay in hospital much longer compared with the lower age groups, it is necessary that health systems review ways of designing, delivering and monitoring care service so as to

raise older people's expectations of dignity in care. This would enable hospitals to present themselves to older people as places where they are welcomed, valued and where their needs are understood and met (Pearson et al, 2012; UNDESA, 2009). Viewing older people in chronologic terms and biological decline, discussing them as a problem for health and social care service, a crisis that cannot be afforded, is unfair and such constitute ageism which often marginalize the elderly, strip them of responsibility, power and ultimately their dignity (Tracey, Gendron, Welleford, Inker and White, 2016). In conclusion, observance of dignity tends to be compromised globally and is rooted in the discrimination and neglect towards the elderly. The finding revealed that observance of dignity of the elderly by Health care service providers in Rachuonyo North Sub-County is wanting.

### 4.5.2. Observance of Confidentiality by Health care service providers

Confidentiality was assessed by evaluating how information on elderly illness was kept and released or shared; the elderly understanding of the legal implications of confidentiality and the conduct of health care procedures. The views of respondents were captured on how free they were in expressing their feelings without fear that what they said would be divulged in any context, that is such communication would be kept confidentially. The element earned a mean of 2.90 (SD=0.67) attracting moderate level of optimal ageing. Their views were summarized in Table 4.8.

In upholding of confidentiality of health information by care providers in caring for the elderly for optimal ageing, the descriptive statistics revealed that it is above average.

On the construct “The health care staff keeps the information about sickness of the elderly in secret”, the mean response of 2.13 (SD=0.99) was suggestive of low level of optimal aging.

**Table 4.8: Views of the Elderly on Upholding Confidentiality in caring for the elderly for optimal ageing**

| **Indicators of Confidentiality** | **1** | **2** | **3** | **4** | **5** | **Mean** | **SD** |
|---|---|---|---|---|---|---|---|
| The health care service provider keeps the information about sickness of the elderly in secret. | 95(25%) | 202 (53.7%) | 20 (5.3%) | 55 (14.6%) | 4 (1.1%) | 2.13 | 0.99 |
| The information on sickness of the elderly could sometimes be shared with someone else without his/her permission. | 12 (3.2%) | 23 (6.1%) | 20 (5.3%) | 202 (53.7%) | 119 (31%) | 4.05 | 0.95 |
| It is often explained clearly and the elderly understand that information about his/her sickness could sometimes be shared among health care service provider and non-health care service providers without his/her consent. | 35 (9.3%) | 336 (89.4%) | 0 (0.0%) | 5 (1.3%) | 0 (0.0%) | 1.93 | 0.38 |
| Elderly patients do not mind if information of their sickness is shared with someone else without permission. | 48 (12%) | 328 (87.2%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 1.87 | 0.33 |
| Sharing information without permission of the elderly has legal implications. | 0 (0.0%) | 0 (0.0%) | 120 (31%) | 246 (65.4%) | 10 (2.7%) | 3.71 | 0.51 |
| Procedures to elderly are often carried out in privacy. | 0 (0.0%) | 60 (26.0%) | 23 (6.1%) | 252 (67.0%) | 41 (10.%) | 3.73 | 0.86 |
| Mean average level of confidentiality upheld by heath providers | | | | | | 2.90 | 0.67 |

Key: 1-Strongly Disagree, 2-Disagree, 3=Undecided, 4=Agree, 5=Strongly Agree and SD-Standard Deviation.

297 (79%) of the respondents did not agree with the statement of the construct; 59 (15.7%) agreed with the statement and 20(5.3%) were undecided about the statement.

From the qualitative aspect of the questionnaire, the following statements were made

> "Issues of confidentiality should be improved for the elderly because privacy level is low; they talked carelessly thinking I don't understand English; I have never been handled in ways that respect my privacy", they don't handle us well to guarantee confidentiality; some officers don't keep our secret to them; they don't observe privacy and don't respect confidentiality; some people are careless in their manner of talking; the same way he talked to me is the same way he may tell other people;

From the Focus Group Discussions, the following sentiments were raised

> *you cannot trust everybody on earth, confidentiality is compromised because of the large number of patients health care service provider are attending to (2,3,4,5), keeping information confidential depends on the workload for the care-provider (1,2,4,5); Doctor talked in loud tone that even those who were outside could hear (2,3,4,5); Some shout at patients; they see us as people they should not respect their privacy(4)*

On the contrary, the Key informants maintained that they observe professional obligations on maintaining secrecy of patients' records.

The investigator interpreted these results to mean that the elderly were apprehensive about confidentiality of their health conditions. Sources of information that can identify a patient according to McArt (2010)but in the scope of this study include the health care service provider. Talking to the elderly in tones that transcend the acceptable space, constitute divulging the information. However, improving the quality of the building and other infrastructures in some health facilities mayfavor maintenance of confidentiality.

On the construct "The information on sickness of the elderly could sometimes be shared with someone else without his/her permission", the mean response 4.05 (SD=0.95) was suggestive of high level of optimal aging. The descriptive statistics revealed that a large number 321(85.3%) of the respondents agreed with the statement of the construct. From the qualitative response of the questionnaire the following statements concurred with findings of the descriptive statistics.

> "The information about my sickness was shared with other people in my absence and I got to know; they gave the information to my grandchild but they didn't ask me; They sometimes tell other people the disease I am suffering from without my knowledge; The result of my examination was shared with a neighbor who took me to hospital; I once hear villagers talking about my status; My grandchild told me one day that she heard the doctor say that I have strong malaria; I heard the villagers say that the disease I am suffering from is very strong; Sometimes they shared my problem with other care providers. It is important for my care to consult with their colleagues if the health care service provider is not sure about my case. It can be shared if there is need among the health care service provider; if sharing the information is for the benefit of my treatment; it can be shared with my family; it can be shared if those close to me must know

From the FGDs, the following statements were aired

> *You find someone coming to you and telling you about your condition and wonders where is the source (1,2,4,5); One may tell you that your sickness is the same as mine and you don't know how he/she got to know your condition(2,4); I suspect that other patients may get unauthorized information on my condition (1,2,3,4,5). They could talk to other care providers about me (1,2,3,4,5).*

The investigator observed that information about elderly sickness is often given out without authorization. Participants did not appreciate the idea of their condition being

given to other health care service provider except for consultative management. It is therefore important that communication about patients be confined within professional limits. On the construct "It is often explained clearly and the elderly understand that information about his/her sickness could sometimes be shared among health care service provider and non-health care service providers without his/her consent" attracted a mean response of 1.93 (SD=0.38) was suggestive of low level of optimal aging.

The descriptive statistics revealed that a large number 371(98.7%) of the respondents disagreed with the statement of the construct and only 5(1.3%) agreed with the statement. On the issue of the "Elderly patients do not mind if information of their sickness is shared with someone else without permission", attracted a mean of 1.87 (SD =0.33) translating to low level of optimal ageing. From the descriptive statistics 376 (100%), respondents disagreed with the research statement that elderly do not mind their health conditions being shared without permission.

The following statements were extracted from the qualitative aspect of the questionnaire

> *"The mode the information was given was not private, I don't trust the way it was given to me, I don't trust their way of doing things, Other patients could hear what I am being told, from my talks with my friends I got to suspect that they know my condition, I cannot assure myself that the secrecy was 100%. I suspect that the information reached other people, somebody might have heard when I was told of my disease, I did not trust the way it was given to me, it was not secret/private, no privacy, and Just spoke out the result without considering the privacy, Service was not good, and how they talked to us was not good. I think they leak patient information and they talk among themselves. Not all of them just a few. They talk behind our backs. They often disclose the problem to spouse. Some rush you that turn I want to inject you. I think it*

*depends on health care service provider judgment on how to disclose the condition*

From all the five FGD sites participants strongly expressed minding about information about their ailments leaking out. Although they agreed that they don't receive information from health care service provider, but hold the belief that information often get into public domain after the death of an individual.

From the Key informants, it emerged that issue of confidentiality is invariably compromised. They however majored their discussion on keeping health records confidential but were not keen on verbal information. A few disagreed with the research statement that health care service provider keeps information confidential on the ground of language barrier. It came out that most of the elderly usually mind if information on their sickness is shared with someone else without permission.

The construct "Sharing information without permission of the elderly has legal implications' attracted a mean score of 3.71 (SD= 0.51) suggestive of moderate level of optimal ageing.

The descriptive statistics revealed that most 256 (68.1%) of the elderly were not aware of the legal implications of sharing information without authorization, 120 (31.9%) of the respondents were not sure on the legal implication of violating their health information confidentiality.

From all the five FGD sites, (Appendix 17), it was established that majority of the participants had no information about the legality of divulging confidential health information without authorization. Few participants however were aware about the

legal implications of divulging information without authorization. The few who were aware were concerned about the protocol involved in getting justice done to offenders.

In terms of procedures to the elderly being conducted in privacy, the construct attracted a mean score of 3.73 (SD=0.86 thus suggestive of moderate level of optimal ageing.

From the descriptive statistics, it was established that more than one out of every four 60 (26.0%) of the elderly confirmed that procedures to elderly are often carried out in privacy. This was translated to a mean of 3.73 level of confidentiality upheld by heath care service providers.

The following statements were received from the qualitative aspect of the questionnaires:

> *"They bring the curtains when they give injection, Tests are conducted privately. The health care service provider talked in low tones that could not be heard by other people outside the room, we had good conversation inside the room, we were only two with the care provider.*

Those with the contrary opinion, 60 (26.0%) had the following statements: -

> *"Some subordinates are allowed in when I am with the nurse in the room. They sometimes handled me in public. There is no special department for the elderly, no private consultation rooms. People walked in and out where we were with the doctor, no privacy steps; they talk open in-front of other patients".*

In discussing the issue of confidentiality and conduct of procedures to the elderly, the investigator observed that although clients trust that health care service provider keeps patient's information in confidence and the elderly have faith in health care service provider because of the belief that patient information is ethically and legally

privileged. Unauthorized disclosure of such information should only be on legal basis for public protection. Care providers in some health facilities have credibly limited patients' information within acceptable confines. There are however cases where confidentiality was breached and information about the elderly leaked out with resulting apprehensions. Findings pointed to inadequate infrastructural and human factors. The infrastructures which are designed to provide room for private consultations and procedures lacked the utilization capacity to facilitate observance of confidentiality. The major issue is lack of elderly specific department. The existing rooms were either too small or inadequately padded to reduce sounds. Utilization is however a matter of administrative creation and with the existing limitations these rooms could be used to best advantage.

The offending human factors raised include health care service provider talking to patients in tones that transcends confidential space, careless talks about patient's conditions, shouting clients' issues instead of talking in privacy; sharing information without authorization, intrusion by other care providers while procures are being conducted and ushering elderly out of the examination room before they are dressed up well are preventable open breaches to confidentiality. Privacy is personal and can be controlled effectively by a care service guide that is sensitive to the psychosocial needs of the elderly. Attitudinal factors such as poor traffic control when consultations and procedures are going on, open talk in front of others; conducting procedures that do not guarantee confidentiality, and seeing elderly as people whose privacy should not be respected could be corrected administratively. Client information should be handled in ways that do not infringe their liberty, assassinate

their character, and should not stigmatize. A care service guide could therefore be necessary to achieve this. The elderly prefers their health information to be handled privately, confidentially and with dignity between doctors, self and the authorized person.

### 4.5.3 Observance of Autonomy by Health Care Providers

The study investigated autonomy through the way the elderly were involved in their care. This was explored by analyzing five constructs in table 4.9. On observance of autonomy by health care service providers attracted a mean score of 2.39 with a standard deviation of 0.62. On the construct "Discussion is often held and agreement reached between heath staff and the elderly on the plan of care to be implemented" the construct attracted a mean score of 2.27 (SD= 0.89).

The descriptive statistics revealed that 105 (28.0%) of the respondents had been involved in discussion with health care service provider and agreement reached on their plan of care to be implemented.

From the qualitative responses of the questionnaires, the respondents who were involved in decision making and felt encouraged and therefore owned the care process had the following comments:

> *"One feels nice being asked about his/her view. I felt good, happy and encouraged when involved in making decision on my care; doctors ask me about my view on the disease and I was happy to give my views, it was very good. The talk brought friendship between me and the doctor. I felt better to ease the treatment; it is good compared to those who don't ask; "They accepted my suggestions and treated me with a lot of respect and care; I felt good about that treatment; we planned on our agreement and it was good; they*

*accommodated my decision and it is working well for my condition; it is my right to participate".*

the FGDs the private health facilities were praised for involving clients or relatives in planning care. A slightly significant majority 226 (60%) of the respondents did not agree with the research statement. From the qualitative aspect of the questionnaire, the following statements were made:

*"Something should be done on this issue; I do suffer because I lack information on my condition; "Based on how I was handled and how I am used to their way of doing things, there is no communication between care provider and patients. I understand their situation so well, it is a protocol not to ask patient how they want to be treated; they don't prepare elderly psychologically before treatment and I was not prepared either, the care providers talked in a tone I could not hear". The health care service provider don't give chance to clients to participate; I was not given chance to participate in deciding how to be treated. I was denied chance to express myself". They talked in a language I did not understand either and they were not interested in my condition, they criticized my condition and I feel shy going back to that hospital. I was refused drugs for my condition".*

**Table 4.9: Views of the Elderly on Upholding of their Autonomy by Health Care Provider**

| Indicators of Autonomy | 1 | 2 | 3 | 4 | 5 | Mean | SD |
|---|---|---|---|---|---|---|---|
| Discussion is often held and agreement reached between heath staff and the elderly on the plan of care to be implemented. | 30 (8.0%) | 196 (52.1%) | 45 (12.0%) | 86 (22.9%) | 19 (5.1%) | 2.27 | 0.84 |
| Suggestion/opinion of the elderly patient is always respected and or accommodated in managing their conditions. | 43 (11.4%) | 199 (52.9%) | 82 (21.8%) | 29 (7.7%) | 23 (6.1%) | 2.05 | 0.31 |
| Health care service provider often asks the elderly patient about their problem, carry out investigations and prescribe treatment. | 34 (9.0%) | 100 (26.6%) | 41 (10.9%) | 175 (46.5%) | 26 (6.9%) | 3.27 | 0.96 |
| Elderly are discharged with clear and adequate information to manage their condition at home. | 48 (12.8%) | 101 (26.9%) | 87 (23.1%) | 86 (22.9%) | 54 (14.4%) | 2.39 | 0.99 |
| Since sickness deny a person the power to make decision, involving the sick elderly in making decision in care planning is not necessary. | 35 (9.3%) | 201 (53.5%) | 46 (12.2%) | 75 (19.9%) | 19 (5.1%) | 2.00 | 0.00 |
| **Mean average level of autonomy upheld by heath providers** | | | | | | **2.39** | **0.62** |

Key: 1-Strongly Disagree, 2-Disagree, 3=Undecided, 4=Agree, 5=Strongly Agree and SD-Standard Deviation.

From all the five sites of FDGs (Appendix 17), participants strongly disagreed with the statements that discussion is often held and agreement reached between heath staff and the elderly on the plan of care to be implemented. Their key comments were that "They accommodate clients' views well but in most cases after the initial investigative questions, the health care service provider works alone in the plan of care".

The investigator interpreted this finding to suggest that it appears that majority of the respondents misinterpreted the initial investigative enquiries by the health care provider to be the plan of care. This is because further interrogation on this proved negative. It also emerged that involvement of the elderly was not exhaustive as one participant pointed that although he was advised to decrease his weight, he was not given the method of how to do it.

According to Ojwang (2013), the most complaints by clients was that nurses do not explain procedures but are quick to blame the un-informed patient. There is also the forcefulness and over-determination, not caring whether patient is ready or is not ready for a procedure (i.e. dressing). A patient reported an accusation by a nurse who quarreled and said that the patient lacked respect instead of explaining the intended procedure.

These findings on low respect for autonomy in health care service delivery is mirrored in literature specifically in Kenya which shows that health care service provider is viewed as authoritarian benefactor while the patient is considered vulnerable and subservient recipient of service (Ojwang et al. 2013).

The use of "Economic Efficiency theory and Psychological theory" is suggested by Stiggelbout *et al.*, (2004), that could give health care service provider direction on involving clients in decision making. In a UN expert meeting report, Beales (2012) asserted that enhancing patient autonomy means helping them to make their own decisions.

On whether suggestion/opinion of the elderly patient is always respected and or accommodated in managing their conditions, close to two-thirds (242) of the respondents commented that health care service providers usually make unilateral decisions and rarely accommodate their suggestions on the management plans for their care. From the qualitative responses of the questionnaires, the following statements were made: -

> "*They think it is a waste of time to ask us our feelings. They don't allow me to take part in making decision on how I want to be treated; as elderly people we believe in interaction. With no interaction there is no comfort, I felt being looked down upon. I expect to share my problem with caregivers then they give advice; care givers don't ask; they just gave me the drugs for my joint pain and that was all. There is no change in my illness - my problem never ends. Having no relative to care for me at the hospital led to bad words thrown to me. There was poor communication, poor care. I was harassed by the way they addressed me. The care providers should remember that nobody goes to get a disease therefore once sick, he/she should be treated well. There is a doctor there whom I think hates me and I also hate the young man together with the way they are doing things. The care provider annoyed me and I was not given time to express myself. I was not given time even by ward cleaner. The subordinates assumed responsibilities which is not theirs. "They don't take their time to talk to us as we want; Patients should be involved in their treatment process; I think care providers should ask me how I want to be*

*treated; I should be asked because I react to some drugs otherwise I feel bad and ignored. Most of them are not interested in knowing your problem. They need to know my feeling on the issue. They don't give us good environment when treating us and they seem not to fully understand old age conditions and diseases. I have never been asked about my view; Even if I am old as I am I wish to be given chance to explain myself; They don't even talk to you, they did not give me time to give my view. I wanted, but failed to be encouraged, so I lost hope".*

From all the five FDGs sites participants disagreed with the statements that discussion is often held and agreement reached between heath staff and the elderly on the plan of care to be implemented. Their comments were that sometimes they accommodate clients' views well but in most cases after the initial investigative questions, the health care service provider works alone in the plan of care. Majority of the respondents interpreted the initial enquiries as involvement in the plan of care".

The following were key sentiments raised from all the five FGDs sites

*"They hate questions from patients, the response to clients' enquiries is poor or negative. Care providers take advantage since they know they are the experts; they have the authority through diagnosis. It is ok since they know what they are doing. They did not take time to talk to me well instead I was just given the drugs", I cannot blame them because they are trained to do that; It is right for them not to ask; May be that is how they are trained; we also don't have chance to ask; They just give me the drugs for my joint pain that is all".*

The investigator interpreted this findings to mirror those by Forouzan et al (2011) where clients expressed concern over health care service provider looking down upon their decision-making power. Clients are reported as saying, "'They think that doctors are the only ones who know everything.... Of course, we may not be literate but we know what

works and what does not....'. 'When they consider us as low-class people they don't even ask for our participation".

The small number 45 (12.0%) of the respondents who were undecided about the research statement, submitted their care to the decision of the care providers. Key statement on this is that "doctors are right so whatever method they use will always be right. Another one did not feel safe asking a doctor on how to be treated".These statements are emphasizing the critical reflection aspect of normative moral aspect of autonomy spelt by Stiggelbout et al (2004) which give room for conscious submission to some form of external authority (physician, religion, leader, etc.). This concept relegates patient power to physician's decision on treatment so that the paternalistic physician play a role after critical reflection on patient's preferences. It is a relational approach which promote dependence as patients identifies with the decision already made.

This is in disregard to the fact that when patients take part in deciding on the care to be adopted they comply well with treatment and subsequently improve faster which is a foundation for optimal aging. The insensitiveness of health care service provider to elderly autonomy is reflecting the concern by Agich (2002) about the American Society by saying "As a society, we have ignored the material and social conditions that are required for autonomy to flourish. We have allowed autonomy thwarting institutions to dominate the care of the infirm and the sick old. Rather than building autonomy-sustaining institutions, long-term care of elders has accepted a medical paradigm of service delivery rather than a paradigm of providing an environment suitable for sustaining a compromised autonomy".

Involving clients in their care decision promotes compliance therefore ignoring autonomy as a concept for patient's participation negate client's power for participatory ownership by dominating decision making and planning processes".

On the issue of routine protocol in the contrary, it emerged that 201 (53.4%) of the elderly who participated in the survey agreed that health care service provider often asks them about their problems, carry out investigations and prescribe treatment which is a confirmation of the implementation of the medical model (mean=3.27; standard deviation=0.96). Medical Model is the traditional approach to the diagnosis and treatment of illness as practiced by physicians in the Western world where the physician focuses on the defect, by asking questions, do investigations and prescribe treatment but rarely explores beyond this.

On the issue of the elderly being given clear information to manage themselves at home, there was sharp division in opinion of the elderly on whether they are usually given clear and adequate information on how to manage their health conditions at home. There were 149 (39.7%) who agreed with the research assertion that they are usually discharged from health care facilities with clear and adequate information on how to manage their condition at home they made the following statements: -

> "I feel good because I can attend to myself, I am encouraged and motivated to manage myself at home; there is need for more health education on the disease because sometimes I forget to take drugs at the right time".

The 220 (58.5%) who disagreed with the research statement that elderly are discharged with clear information to manage their condition at home had the following comments: -

The health care service provider do not take their time to talk to us the way we can understand instead we are just given drugs. It is very bad to lack clear information; Giving clear information should be made available to all clients; I wanted them to tell my wife how to help me manage my condition at home; We should have clear information to enable me manage my condition well at home; I have poor attention but the care provider talk very fast; Need a helper at home to manage my condition; Elderly clients should stay in the facility until they recover; I have no knowledge to use drugs; Time for taking drugs often passes; They need to take their time and explain to me more on how drugs are used; Sometimes I forget the instructions they give; the doctor need to help me at home; they did not explain anything about my sickness; the short information did not satisfy me. I cannot remember well what they told me; they never advised me on what to do; I should have been instructed by the doctor how to protect myself not to be infected again; they were not ready to advise me;" My condition worsen once I am discharged home. They don't like to repeat words for the elderly to understand; I was told to go home and if pain persists then I come back to hospital. They hate questions from patients and even the reply to my questions was not pleasing. In some facilities you are not directed where to go so many clients get confused. They lack knowledge on my skin conditions; there is bad treatment, lack of drugs, language barrier. I was never advised on what to do and never offered me the right treatment"

A vivid example of inadequate information to clients upon discharge is a female participant in FGD site2 whose sister was attended to by health care

> service provider, given drug prescription but she was not told to go and buy the drugs. She carried the prescription home and remain suffering. At the time of the interview it was one month since the sister was discharged from the hospital and was due for next clinic appointment the following day. She still had the prescription (appendix 18).

A vivid example is an incident in New York (Levine, 2013), in which the reporter declined from enquiring about home care instructions of her sister. She said

> "I had learned from my long experience with my late husband that a family member who raises questions or challenges a nurse, quickly gets labeled as a pest or an even nastier epithet, and I did not want to jeopardize my sister's care"

The 7 (1.8%) who were undecided about the research statement that elderly are discharged with clear information to manage their condition at home made the following statements: -

> "I am doubtful of myself; I don't know how much I should be told. Not sure and I am doubtful of myself. I am too old to be taught; "I cannot remember what they told me"

As health care conditions change, patients often move from one setting to another. These transitions often place patients at risk of adverse events. Important information may be lost or mis communicated as responsibility is delivered to new parties. A common transition of care is discharge from the hospital. Discharge typically indicates improvement in a patient's condition so that the patient no longer requires inpatient care. It also means that the patient and family must resume responsibility for the patient's daily activities, diet, medications, and other necessary assistance. Giving

patients and caregivers' self-management support after discharge, reduce readmissions to the hospital and its accompanying costs by empowering home care services. Giving clear information to patients or their home care giver at the time of discharge from the hospital is imperative and should be encouraged as it adds value to optimal aging.

Miller, (1999) pointed that in contrast to physical assessment, psychosocial assessment procedures do not enjoy the same level of acceptance and are not routinely incorporated into the individuals' overall health assessments.

On the issue of whether sickness is believed to deny a person the power to make decision, involving the sick elderly in making decision in care planning is not necessary. The majority 236 (62.8%) of the elderly who faulted the health providers of failing to fully consult with them regarding their health issues rejected the notion portrayed in the research assertion. They had the following statements: -

> "Since I am not consulted, I think they undermine my ability to make good decision; some underestimate our ability to contribute to our care. Involving us in making decision is very necessary. I wonder why they think an elderly person cannot make good decision. It is not my brain which is sick it is my joints so I have the strength to decide well".

Literature indicates that old-age alone does not preclude a patient from ability to give consent however, since a large number of elderly patients suffer from debilitating mental illnesses, obtaining consent can become a challenge. Debates on whether elderly with dementia (ailment of progressive memory impairment) are capable of making rational decisions have not been fruitfully conclusive. In such cases it would be rational to take

the beneficence approach by care provider to play paternalistic role and decide for the patient (Dymek *et al.*, 2001) and (Auerswald, 1997).

Findings from the descriptive statistics, interviews and FGDs agree that observance of autonomy as an element of health systems for optimal aging is wanting in the study area. This finding is similar to that found in America by Agich (2002) which revealed that the American society have ignored the material and social conditions that are required for autonomy to flourish by allowing autonomy thwarting institutions to dominate the care of the infirm and the sick old. Care providers often ignore autonomy for patient's participation and negate client's power for participatory ownership by dominating decision making and planning processes.

In Western Australia Henderson (2003) found that nurses considered patient involvement as an interference in the nurse's duties, and that majority of nurses were unwilling to share their decision-making process with patients. In the contrary, the English National health system (NHS) affirm their commitment to serving the elderly by stating "We take what patients say seriously. We are honest about our point of view and what we can and cannot do" (Galloway, 2013). This is a lived commitment meant to create an understanding between the elderly and the care provider for optimal aging. A study report on European patients' views on the responsiveness of health systems and healthcare providers (Coulter and Jenkinson, 2004) revealed that that many European patients want a more autonomous role in health care decision-making. Policy-makers and clinicians should consider how to narrow the gap between public expectations and patients' experience

By not accommodating views of the elderly in their care, health care service provider are acting against patient's right to information as spelt out in the bill of human rights (Kimathi, 2009). It is also contradicting the objectives of the Kenya Health Policy 2014-2030 (KNBS, 2014) which advocate for a people-centred and participatory approach to health and service interventions.

Decision-making by the elderly is a complex process that should be based on comprehensive assessment as a tool to weigh the risks and benefits of treatment. In many cases co-morbidity, functional capacity, patient wishes and cognitive status are more determinant of patient survival and quality of life than the actual process to be treated. These should form the framework supporting therapeutic decisions (Alvarez et al. 2015). Entwistle, Carter, Cribb, and McCaffery, (2010) conclude by stating that supporting patient autonomy is import for clinician-patient relationships. An overall finding of this study is that the application of the concept of autonomy is wanting in health care service delivery in the study area.

In conclusion the investigator observed that most decisions on care are dictated and or dominated by health care service provider. The findings mirrored those in Europe, South Africa, China and Nigeria where autonomy ranked lowest among the elements of health systems responsiveness and is identified as priority area for actions to improve health services (Shafiu et al 2013; Kowal et al., 2011; Lothian et al., 2001) point that maintaining high standards of autonomy in health is a global problem. A study in Saudi Arabia by Almalki et al., (2016) found that patients were reasonably informed about their illness but treatment options and the duration of treatment were not discussed with all patients. According to De Silvia e al., (2000), consumers of health care often desire

advice, and hence willingly sacrifice their autonomy for the confidence generated by an expert decision.

The study also sought to respond to the research hypothesis;

$H_0$: There is no statistically significant influence of observance of respect for persons in caring for the elderly in Kenya health system on elderly optimal ageing.

In order to establish whether there was any statistically significant influence of observance of respect for persons in caring for the elderly in Kenya health system on elderly optimal ageing, a bivariate Pearson's Product-Moment Coefficient of Correlation between the overall score of observance of respect for persons and overall scores on optimal ageing was computed. The SPSS output Table 4.10 shows the correlation results.

**Table 4.10: Correlation: Observance of Respect for Persons and Elderly Optimal Ageing.**

| | | Observance of Respect for Persons | Optimal Ageing |
|---|---|---|---|
| Observance of respect for persons | Pearson Correlation | 1 | .247** |
| | Sig. (2-tailed) | | .000 |
| | N | 376 | 376 |
| Optimal Ageing | Pearson Correlation | .247** | 1 |
| | Sig. (2-tailed) | .000 | |
| | N | 376 | 376 |

**. Correlation is significant at the 0.01 level (2-tailed).

The output indicates a significant though weak (n=376; r =.247; $p < 0.05$) positive correlation between observance of respect for persons in caring for the elderly in Kenya health system and elderly optimal ageing. Therefore, given that the p-value was less than .05, the null hypothesis which stated that "There is no statistically significant

influence of observance of respect for persons in caring for the elderly on elderly optimal ageing in Rachuonyo North Sub County" was rejected. It was therefore concluded that there is statistically significant positive relationship between observance of respect for persons in caring and elderly optimal aging for the elderly in Rachuonyo North Sub County.

To illustrate this relationship further, a scatter plot was generated as shown in Figure 4.3.

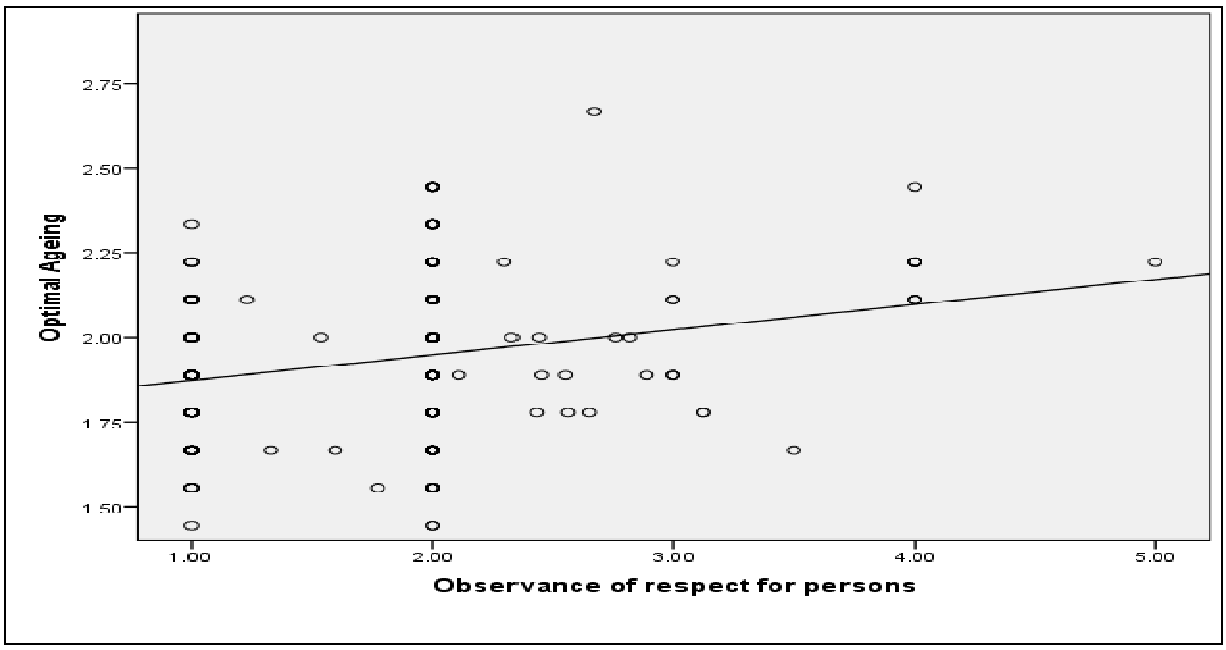


**Figure 4.3: Scatter plot graph: Observance of Respect for Persons on Optimal Ageing.**

From Figure 4.3, the scatter points do not appear to show any relationship between the two variables. Scantly it is shown that the pattern of the dots seems to slope from lower left to upper right, indicating some positive correlation between the variables. The scatter points are not evidently around the line of best fit; no visible pattern is formed signifying that the two data sets were agreeing only to a small extent.

Nonetheless, the line of best fit (trend line) indicates slope from lower left to upper right, cutting across the coordinate points, which implies that at least there are some positive correlation between the two variables.

To estimate the level of influence of observance of respect for persons on elderly optimal ageing, a coefficient of determination was computed. This was done using of regression analysis and the results were as shown in Table 4.11.

**Table 4.11: Summary: Regression Analysis, Respect for Persons on Optimal Ageing.**

| Model | R | R Square | Adjusted Square | R Std. Error of the Estimate | Durbin-Watson |
|---|---|---|---|---|---|
| 1 | .236[a] | .056 | .053 | .20363 | 1.788 |

a. Predictors: (Constant), Observance of respect for persons

b. Dependent Variable: Optimal Ageing

The model shows that level of observance of respect for persons in caring for the elderly in Kenyan health system accounted for 5.6% ($R^2$=.056) of the variation in elderly optimal ageing in Rachuonyo North Sub-County. This was a fairly weak effect of a predictor on the dependent variable.

To determine whether level of observance of respect for persons in caring for the elderly was a significant predictor of optimal ageing, Analysis of Variance (ANOVA) was computed as shown in Table 4.12.

**Table 4.12: ANOVA Influence of Respect for Persons on Elderly Optimal Ageing.**

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | .913 | 1 | .913 | 22.015 | .000[b] |
| | Residual | 15.508 | 374 | .041 | | |
| | Total | 16.421 | 375 | | | |

a. Dependent Variable: Optimal Ageing

b. Predictors: (Constant), Observance of respect for persons

The F-ratio in the ANOVA table (Table 4.12) tests whether the overall regression model is a good fit for the data. The finding of the study reveals that level of observance of respect for persons in caring for the elderly was a significant predictor of optimal ageing, $F(1, 374) = 22.015$, $p < .05$ (i.e., the regression model is a good fit of the data). This means that information on the level of observance of respect for persons in caring for the elderly in Rachuonyo North could be used to significantly predict levels of optimal ageing among elderly.

Further, the study sought to establish the relationship between individual aspects of observance of respect for persons in caring for the elderly and optimal ageing, as indicated in Table 4.13.

**Table 4.13: Correlation: Aspects of Respects for Persons and Optimal ageing**

| | | Dignity | Confidentiality | Autonomy |
|---|---|---|---|---|
| Optimal Ageing | Pearson Correlation | .247** | .508** | .435** |
| | Sig. (2-tailed) | .000 | .000 | .000 |
| | N | 376 | 376 | 376 |

**. Correlation is significant at the 0.01 level (2-tailed).

The findings of the study show that there was statistically significant positive relationship between optimal ageing and all the three aspects (Dignity, Confidentiality and Autonomy) of observance of respect for persons in caring for elderly. However, the strength of the correlations was fairly weak in all the aspects of observance of respects for persons in caring for elderly. For example, observance of confidentiality which had the strongest correlation (n=376, r=.508 and $p < .05$) was just moderately correlated to optimal ageing. The other two aspects of observance of respects for persons in caring for elderly were all weak in strength in their correlation to optimal ageing. Nonetheless, it was worth noting that all aspects of observance of respects had significant positive association with optimal ageing, with more observance of these virtues of respect by health care providers during service provision, it is likely to trigger healthy ageing among the elderly persons.

### 4.6 Objective 3: The influence of implementation of the concept of client orientation in caring for the elderly on elderly optimal ageing.

The influence of the implementations of client orientation in caring for the elderlywas investigated through the use of four sub themes: promptness of attention, adequacy of

quality amenities, access to social support network and choice of health care service provider. A 5 itemized Likert-scaled questionnaire was used to explore the views of respondents on each of the constructs. Using the responses; Strongly Disagree (1), Disagree (2), Undecided (3), Agree (4), and Strongly Agree (5) and rated against the scale on ageing. The element scored a mean of 2.49 (SD= 0.65) thus suggestive of moderate level of optimal ageing. The results are presented in table 4.14.

**Table 4.14: Aspects of Client Orientation**

| **Aspects of Client Orientation** | **Mean** | **SD** |
|---|---|---|
| Prompt Attention | 2.62 | 0.41 |
| Amenities of Quality | 2.56 | 069 |
| Social Support Network | 2.59 | 0.71 |
| Choice of Care Provider | 3.00 | 0.88 |
| **Overall Mean level** | **2.49** | **0.65** |

Result: Reveal moderate influence of level of Observance of Client orientation on optimal aging with mean of 2.49 and SD 0.65

### 4.6.1 Promptness of Attention by Health care service providers

The study sought to investigate promptness of attention which basically addressed the duration elderly take for service delivery. The indicators were assessed, computed and presented as shown in table 4.15. Prompt attention attracted a mean score of 2.62 (SD = 0.41) which was suggestive of moderate level of optimal ageing.

**Table 4.15: Respondents' Views on Promptness of Attention by Health care service providers**

| Indicators of Promptness | 1 | 2 | 3 | 4 | 5 | Mean | SD |
|---|---|---|---|---|---|---|---|
| Time taken by elderly waiting to be attended to is acceptably short by expectation. | 63 (16.8%) | 271 (72.1%) | 21 (5.6%) | 10 (2.7%) | 11 (2.9%) | 1.8 | 0.41 |
| Time taken with the elderly when giving service is enough. | 18 (4.8%) | 312 (83.0%) | 26 (6.9%) | 8 (2.1%) | 12 (3.2%) | 2.0 | 0.33 |
| Time spent by the elderly from admission to hospital till discharge is justified as time well spent. | 26 (6.9%) | 274 (72.9%) | 32 (8.5%) | 18 (4.8%) | 26 (6.9%) | 2.1 | 0.52 |
| Sometimes there is unjustified delay to offer service to the elderly. | 25 (6.6%) | 41 (10.9%) | 32 (8.5%) | 121 (32.2%) | 157 (41.8%) | 3.7 | 0.62 |
| Sometimes there is unjustified hurried service to the elderly. | 30 (8.0%) | 72 (19.1%) | 58 (15.4%) | 137 (36.4%) | 79 (21.0%) | 3.5 | 1.02 |
| Average level of promptness of attention by health care service providers | | | | | | 2.62 | 0.41 |

Key: 1-Strongly Disagree, 2-Disagree, 3-Undecided, 4-Agree, 5-Strongly Agree and SD-Standard Deviation.

On the construct "Time taken by elderly waiting to be attended to is acceptably short by expectation" the descriptive statistics revealed that a significant majority 334 (88.9%) disagreed with research assertion. Only 21 (5.6%) agreed with the statement, the construct attracted a mean of 1.8.

From the FGDs discussions promptness in attending to the elderly was rated as very poor. Comments to this effect included:

> *"The services are poor; no immediate action was taken when I was very sick (1,4). I was seen only in late hours of the day (1,2). I stayed for long with nobody attending to me (1,2): the health staff do not even follow to see the progress of medication (2). The waiting time is worse over the weekend (3,4). The services were poor; the care providers took too long to begin services and were too slow to attend to sick clients who could easily die before treatment (5). The delay to start or implement services creates anxiety and distress (4,5); care providers wait until you talk to them then they ask you of what you want? (4,5) Care providers were insensitive to my weakness to manage long waiting. No immediate action was taken when I was very sick (4, 5). I stayed long hours with nobody attending to me. Waiting on the line for long made me sicker (5); I was forced to lie on the chair waiting for the long line even when I was very sick and they did not care (2). I took almost one hour waiting in the line while I could not sit down and was forced to sleep on the chair; one has to wait for his/her turn to be attended irrespective of age, there was poor working mood of care provider. The doctor saw me but in late hours of the day; there was no immediate action taken to the sick" (1,2,3,4,5)*

A male participant(site 2)stressed how he waited for three hours to get the documents for treatment and that after getting the card he tried to force himself to be seen by the health care service provider but was bitterly sent back to wait in the line. He strongly castigated the insensitiveness of the health care service provider to the sufferings of the elderly. From the same site a female participant expressed how on one of her two visits to the hospital, she was very sick but waited to be seen by the health care service provider for a whole day in vain then she decided to self-prescribe and buy drugs from the nearby

chemist. Another female participant(site 2) explained that there are times when health care service providers donot act promptly even to a very sick client.

On the construct “Time taken with the elderly when giving service is enough”, the descriptive statistics revealed that nearly four out of five 330 (87.8%) of the elderly held the general opinion that the time taken by service provider when giving service is not enough. On the other hand, 20 (5.3%) of the respondents accepted the assumption that time taken by the health care service provider when giving service to the elderly is enough. This attracted a mean score of 2 (SD = 0.33).

From the qualitative aspects of the questionnaire, it emerged that sometimes the health providers take unrealistically short time with the elderly when giving service. In FGD participants in sites 2,3,4 and 5 agreed that health care service providers often rush to clear the clients waiting to be seen. In explaining the scenario, a male participant added that sometimes you can see the reluctance especially among the nurses, who appear to be disinterested in their work. They do their own chatting until they forget the patient. Sometimes you can detect that they are trying to avoid attending to certain conditions like dressing the wound that took me to the hospital. But when the avoidance is inevitable then the service is done superficially. Another male participant lamented over the treatment that was given to his mother whom he took to hospital with wound. On smelling the wound, the nurse just gave me a referral letter to Homa Bay County hospital without looking at the wound. On this there is need to communicate to patients on reason for referral. It could be that the nature of the wound needed care that was beyond the services at that health facility but the client did not understand this. In site 3, a female participant expressed concern on the inattentiveness of healthcare provider to the effect

that a client is handed a drug prescription while still giving history of illness.The findings reflected that of Age UK, (2013) in England that there is need for enough care providers to give personalized care rather than few who rush with clients to complete tasks. This rushing to clear a long list of waiting clients could explain the cause of a prescription that a participant presented during the FGD (site 2) session that was never taken to pharmacy to collect drugs.

On the construct "Time spent on the elderly from admission till discharge is justified as time well spent". From the descriptive statistics it emerged that 300 (89.8%) rejected the statement and only 44 (11.7%) agreed with the statement, the construct earned a mean of 2.1 (SD=0.52).

From FGDs participants strongly asserted that care providers were too slow that an elderly could easily die before due attention is given. They further cautioned that care providers need to take time and examine patients promptly. They also warned that the services offered by the current generation of the young care providers could only earn curses to them, (site 4). On the construct "Sometimes there is unjustified delay to offer service to the elderly".

The descriptive statistics revealed that 278 (74%) agreed with the statement that there is unjustified delay to serve the elderly. Only 66 (17.5) agreed with the statement.

From the qualitative aspect of the questionnaire, the following comments were made: -

> *"There is reluctance of care providers they left me there and talked in English for 1 hour before she came back to attend to me, it seemed that long waiting is a normal protocol in our health facility. They are too slow, there is delays in laboratory tests,*

From FGDs site (5) a female participant lamented that she took a whole day until she decided to leave the facility without treatment. Another one (site 2) added that it took over 4 hours waiting on the line to be attended. The staff take longer than expected to return from lunch break (site 2, 3, 4). It was further established that sometimes there is unjustified hurried service to the elderly by the service providers. In almost all the FGDs it came out that services in public health facilities are poor compared to services in private sector.

This finding concurred with findings by Adesanya (2012) in Nigeria; Jehu et al (2012) in Ghana and Peltzer (2009) in South Africa that public providers performed poorly in prompt attention compared to private providers.

A participant in a study in Kenya (HelpAge, 2001), lamented by saying thus,

> *"We have to queue at district hospitals for long hours and are only treated if we give the clerks some little cash to entice them".*

In Mozambique, longer waiting time was found to be significantly associated with lower satisfaction scores among patients. As one respondent commented,

> *"Sometimes one is feeling very bad but because care providers are insensitive to the condition, he/she has to wait in the line until one's time reaches".*

A study in Ghana (Turkson, 2009) agreed that there were unacceptable longer mean waiting time for seeking medical help which averages to 1 hour especially at the dispensary or when going for an injection. Long waiting is stressful to a sick elderly, make them lose hope and discourages them from using the facility. Being that the elderly are among the vulnerable demographics who have unique health problems and unstable financial status, long waiting could compromise health conditions further.

This finding mirrored a global study by Valentine De Silva, Kawabata, Darby, Murray and Evans, (2003) on access to care and waiting period for treatment.

Health care services should be timely because unwarranted long waiting that does not provide information on the cause of delay is a system defect. On the positive side, prompt attention benefits both the patient and the caregiver by bringing possible positive outcome. Findings on promptness to initiate services is reported in Ghana (Turkson, 2009), as valued by individuals because it often leads to better health outcomes by allaying fears and concerns that come with waiting for treatment. Other studies (Shafiu et al., 2013) in Nigeria, (Falk, 2013) in Illinois; (Adesanya, 2012) in Nigeria; (Mohammed et al.,2011); (National Center for research, 2005) global report; (Valentine et al., 2003) and (WHO, 2000) revealed that prompt attention was rated poorly and was due basically to administrative processes, inadequate number of care providers, poor provider attitude (rude, unfriendly, unapproachable, impatient, disrespect to patients), poor interpersonal relationships, low job satisfaction, burnout, stressful work environment, lack of supervision, inadequate care provider training.

Achievement of prompt attention is often subject to the constraints imposed by limited resources. Geographical accessibility is of particular importance as theability to access health care fast, taking account of distance, availability of transport facilities and terrain, impacts on uncertainty and tension for individuals. In conclusion, prompt attention to the elderly in the study area should be improved possibly by using or improving services of the triage system.

### 4.6.2 Amenities of Adequate Quality

The study investigated the availability and adequacy of amenities in the health facilities on optimal aging of the elderly in Rachuonyo North Sub-County. The responses were computed in percentage frequencies, as shown in Table 4.16

**Table 4.16: Respondents Views on Adequacy of Amenities**

| Indicators | 1 | 2 | 3 | 4 | 5 | Mean | SD |
|---|---|---|---|---|---|---|---|
| Water supply is adequate and safe. | 100 (26.6%) | 60 (16%) | 38 (10.1%) | 58 (15.4%) | 120 (31.9%) | 3.10 | 0.95 |
| Electricity power supply is rarely disturbed. | 172 (45.7%) | 100 (26.6%) | 22 (5.9%) | 66 (17.6%) | 16 (4.3%) | 2.08 | 0.88 |
| Food and eating utensils is adequate for elderly conditions. | 156 (41.5%) | 86 (22.9%) | 36 (9.6%) | 76 (20.2%) | 22 (5.9%) | 2.26 | 0.73 |
| Beddings are adequate for elderly conditions. | 86 (22.9%) | 162 (43.1%) | 40 (10.6%) | 56 (14.9%) | 32 (8.5%) | 2.43 | 1.02 |
| Chairs for visiting relatives are adequate and availed. | 46 (12.2%) | 100 (26.6%) | 48 (12.8%) | 96 (25.5%) | 86 (22.9%) | 3.20 | 0.92 |
| Waiting rooms are available and adequate. | 142 (37.8%) | 112 (29.8%) | 45 (12.0%) | 56 (14.9%) | 21 (5.6%) | 2.21 | 0.89 |
| Toilet facilities are adequate and accessible to the elderly. | 104 (27.2%) | 98 (26.1%) | 32 (8.5%) | 86 (22.9%) | 56 (14.9%) | 2.71 | 0.94 |
| Waste disposal facilities are within reach for the elderly. | 88 (23.4%) | 106 (28.2%) | 56 (14.9%) | 74 (19.7%) | 52 (13.8%) | 2.72 | 0.58 |
| The hospital environment is homely for the elderly. | 134 (35.6%) | 112 (29.8%) | 32 (8.5%) | 56 (14.9%) | 42 (11.2%) | 2.36 | 0.46 |
| **Average level of Adequacy of Amenities** | | | | | | **2.56** | **0.69** |

Key: 1-Strongly Disagree, 2-Disagree, 3-Undecided, 4-Agree, 5-Strongly Agree and SD-Standard Deviation.

Findings of the study established that there was average level of availability and adequacy of amenities by a mean of 2.56 in the scale of 1.0 to 5.0, with most of the constructs scoring between 2.08 and 3.20. however most of the amenities found in health facilities do not meet the levels appropriate for the elderly. On the construct "Water supply is adequate and safe". The descriptive statistics revealed that a sizeable proportion 60 (42.6%) of the respondents disagreed with the research statement.

From the qualitative aspect of the questionnaire, it was established that there is lack clean safe water. The following statements were extracted from the responses.

> "There is lack of safe of clean water, there is no water, there is shortage of water, water is not enough and quality is poor, the region has one long rain season and one short rain season so roof catchment is not a reliable source of water, its supply was quite inadequate and safety not guaranteed, as was indicated by a sizeable proportion"

Those who agreed with the investigator's view that water supply is adequate and safe had the following comments:

> "There is plenty of safe water at the Kendu Adventist hospital; In this health center, water is collected from the roofs into the hospital tanks and is available most parts of the year; The hospital is near the lake so water is not a problem to us".

From the FGDs, the following statements were made

> *"Permanent source of water is far- the lake and the river(1,4, 5);. Water supply is not reliable particularly during dry periods (1,2,3,4,5). Water in most cases is brought by donkey Cats from the nearby river" (3,4,5).*

The investigator observed that taking into consideration the use into which water is put, the situation implies that water quantity and quality is relatively compromised Rachuonyo North Sub County health facilities. The region is traversed by three

permanent rivers Oluch, Kibwon and Miriu, the Northern and Western borders has the southern shore of Winam gulf of Lake Victoria as permanent sources of water.These permanent sources could be used to provide a permanent solution to the provision of good quality water to health facilities.

On the construct “Electricity power supply is rarely disturbed”, the descriptive statistics a sizeable proportion 272 (72.3%) of the respondents rejected the statement therefore confirmed that electricity power supply was often disturbed by blackouts.

From the qualitative responses of the questionnaire, it was established that although most facilities are connected by electric power supply there were instances of power failures. From the key informants it was established that about 90% of the health facilities are connected to electric power supply. The constraints are on standby generators to use during power blackouts. From FGDs, it emerged that power blackout is a key feature that disturb services that depend on its supply specifically laboratory services.

The investigator interpretation on the finding is that high connectivity of electric supply is a milestone in the rural health facilities in the study area because it has improved diagnostic procedures that depends on electric power. The black outs are basically a function of administrative service which should be corrected in time where feasible.

On the Construct” Food and eating utensils is adequate for elderly conditions” the descriptive statistics revealed that, a majority 242 (64.4%) of the respondents rejected the statement while about a quarter 98 (26.1%) of the respondents were satisfied with food served in the health facilities.

From the qualitative aspect of the questionnaire it emerged that food and eating utensils is quite inadequate for elderly conditions. Key features of the deficiency were amount and quality in terms of food and number of eating utensils. In most cases the eating utensils are brought from home. The big problem is that where food is served, it is never sensitive to individual disease conditions. Those who are on special diet are often disadvantaged because they have to get relevant food on individual capacity.

From the Key informants, provision of hospital foods to clients has been affected by the inconsistent disbursement of facility improvement fund and cost sharing fund. The two used to help buy food but of late it is not possible so patients carry their foods from home. At the Sub county hospital food is served based on the scheduled menu and consist of meat, beans, rice, bread (ugali), herrings (Omena), fruits, porridge.

From all the five FGDs following statements were made: -

> *"Food in the health facilities is one type and is therefore not directed to elderly conditions. In site 4 male participants emphasized that health care service providers donot care whether you eat the food or not. They only come and take away whatever is left without enquiring why it is not eaten. Old people have poor appetite but the food served is vegetables which in most cases is just boiled so by looking at it the urge to eat just disappears. Utensils are brought with patient who is admitted and if one does not have it is very hard to be served. The support staff serving food will move a way if you do not avail your dish*

The investigator interpretation of the finding is that the food available in the study region is limited to those that are grown locally. The effect of water hyacinth in the Lake Victoria has drastically reduced fish supply which had consistently supplemented the vegetables served.

On the construct “Beddings are adequate for elderly conditions” the descriptive revealed that 248 (66.0%) of the respondents rejected the statement while 88 (23.4%) accepted the statement.

From the qualitative responses beddings for the inpatients care are not adequate for elderly conditions, as was expressed by more than half of the respondents . From FDGs it emerged that beds are available but sometimes the beds and beddings are shared. Linen are often not adequate for the clients”. The investigator input is that sharing of beds and bed linen is not a safe way of handling the vulnerable elderly who may need additional bedding to maintain the required body temperature. On the constructs “Chairs for visiting relatives are available and adequate. From the descriptive statistics it emerged that 146 (38.8%) of the respondents disagreed with the statement while 182 (48.4%) agreed with the statement.

From the qualitative aspect of the questionnaire it emerged that such facilities as chairs, toilet facilities and waste disposal are not adequate. All FGDs, revealed that chairs are not enough for visiting relatives who in most cases sit on the bed sides. In most cases if a chair is available, it is for the whole ward. The investigator points that visiting a patient in a hospital has great positive psychological impact on recovery and should be encouraged and nurtured by the health facility. On the construct, “Waiting rooms are available and adequate”, the descriptive statistics revealed that a significant number 254 (61.6%)of the respondents rejected the statement while 77 (20.5%) accepted the statement.

From the qualitative aspect of the questionnaire it emerged that there wasgenerally inadequate waiting rooms in the health facilities. Client’s visitors wait along corridors

and under any available tree shade. From all the five FGD sites the health facilities have no waiting place. Visitors in most cases wait outside the facility if it is a fenced facility or they wait along facility corridors or under any available shade, most often under a tree. Although there are scheduled visiting hours, some visitors may arrive earlier because of relative factors such as transport. In terms of the construct "Toilet facilities are adequate and accessible to the elderly", the descriptive statistics revealed that 202 (53.3%) of the respondents rejected the statement while 142 (36%) accepted the statement. From the qualitative aspect of the questionnaire, it emerged that toilet facilities (i.e. pit latrine)are available but not kept clean to expectation. In some facilities they are not adequate or are not accessible to the elderly. More than half of the elderly in the survey were dissatisfied with condition and accessibility of the toilets. The staff toilet on the other hand is clean and often under lock and key.

On the construct "Waste disposal facilities are within reach for the elderly" the descriptive statistics revealed that 194 (51.6%) rejected the statement and 126 (33.5%) accepted the statement. From the qualitative responses of the questionnaire, it came out that waste disposal facilities were not within reach ofthe elderly. From all the Focus Group Discussion sites, it was revealed that each ward has one waste disposal point.
The investigator view is that some health facilities admit low number of clients therefore the waste disposal facilities could serve that limited number however it is imperative that each hospital bed should have an attached waste disposal basket.

On the construct "The hospital environment is homely for the elderly" the descriptive statistics revealed that close to two-thirds 246 (65.4%) of the respondents disagreed with the statement while 98 (26.1%) accepted the statement.

From the qualitative aspect of the questionnaire, it emerged that the hospital environment is not homely.

In FGDs participants strongly rejected the statement claiming that hospital environment is far below home environment and some referred to it as a social jail. They alluded that quality of basic amenities in the health facilities are low; with poorly maintained infrastructure, inadequate facilities and some being inappropriate for elderly use.

The investigator view based on the findings is that health facilities in Rachuonyo North Sub county have deficiency in appropriate amenities for the elderly. The most cited were quality of food, beddings, water, and waitingrooms.It therefore shows that health facilities in the study area do not promote elderly optimal ageing in terms of basic amenities. The result mirrored a study in India (Gupta, 2014) that even after 67 years of independence, people do not have access to basic medical care facilities in the rural areas and to some extent in semi-urban areas also.

### 4.6.3 Access to Social Support Network

The study investigated accessibility of social support network to the elderly by collecting the views of the elderly on how health care environment is socially engaging them in the light of optimal ageing. The responses were computed in frequencies and percentages as shown in Table 4.17 giving a mean of 2.49 (SD-0.71) translating to moderate level of optimal ageing.

**Table 4.17: Respondents Views on Access to Social Support Network**

| Indicators | 1 | 2 | 3 | 4 | 5 | Mean | SD |
|---|---|---|---|---|---|---|---|
| The health care service providerexplores deeply to understands well my social support background. | 76 (20.2%) | 201 (53.5%) | 45 (12.0%) | 33 (8.8%) | 21 (5.6%) | 2.26 | 0.85 |
| I always give adequate information about my social support background. | 21 (5.6%) | 97 (25.8%) | 45 (12.0%) | 193 (51.3%) | 20 (5.3%) | 3.25 | 0.96 |
| The social support at home is adequate for me. | 60 (16.0%) | 165 (43.9%) | 77 (20.5%) | 41 (10.9%) | 33 (8.8%) | 2.53 | 0.45 |
| Apart from the nuclear family, the community also offer support to me. | 102 (27.1%) | 134 (35.6%) | 73 (19.4%) | 52 (13.8%) | 15 (4.0%) | 2.32 | 0.81 |
| The health facility assists me to join support group. | 134 (35. %) | 156 (41. %) | 34 (9.0%) | 18 (4.8%) | 34 (9.0) | 2.10 | 0.80 |
| **Average level of Access to Social Support Network** | | | | | | **2.49** | **0.71** |

Key: 1-Strongly Disagree, 2-Disagree, 3-Undecided, 4-Agree, 5-Strongly Agree and SD-Standard Deviation.

On the construct “The health care service provider explores deeply to understands well the social support background for the elderly”, findings showed that majority 277 (73.7%) of the respondents disagreed with the statement. From the qualitative aspect of the questionnaire, it emerged that health care service providers rarely exploretheir social aspect of care. Those who seem to explore, do not probe deeply to understand well the social support background of the elderly and hence meeting their social expectation becomes difficult.

From all the five sites of FGDs (Appendix 17) there was general agreement that health care service providers rarely advance discussions that explore the state of elderly social support but when attempted, it is superficially or minimally explored to an extent that does not justify decision making. This was also confirmed by the Key Informants that there is minimal exploration of the social background and network available for the elderly.

From the investigator's view, there is an association between increased levels of social support and reduced risk for physical disease, mental illness, and mortality. The fact mirrors Population reference bureau, (2011) and Keyes *et al.,* (2005).

On the construct "The elderly always give adequate information about their social support background" the descriptive statistics showed that 213 (56.6%) of the respondents agreed with the statement while a small proportion 118 (31.4%) disagreed.

From the qualitative aspect of the questionnaire it emerged that the elderly give information about their social network to the extent explored by the health system.

On the construct that "The social support at home is adequate for the elderly", the descriptive statistics revealed that majority 225 (59.9%)of the respondents did not agree that elderly have reliable home social support while a small number 74 (19.7%) of the respondents agreed that their access to social support at home is adequate. The result translates to mean of 2.53 (SD=0.45).

From the qualitative aspect of the questionnaire, it emerged that social support is limited to nuclear family and it is not adequate. From FGDs, it revealed that social support is relative, there is a lot of support during funerals but not for normal existence.

From the investigators point of view, response by the majority reflects a study report in India (Bhattacharyya, 2015),which revealed that inadequate family support account for 57% of problems of the elderly. A United States of America (USA) study (C & S Healthcare Services, 2016) revealed that as people ages, they might not typically think of social support as being a factor in their health but truly, lack of social support affects a person's overall health and quality of life. This may be the perspective view of the 74 (19.7%) of the elderly who agreed that their access to social support at home is adequate for them. In many developing countries the once cohesive family and community focused care networks that formerly provided support to the elderly got eroded, weakened, and disintegrated by the impact of industrialization, urbanization and westernization thereby rendering family care ineffective and as a result, more burden of caring for an increasing population of elder(Miller,1999). The United Nations Population Fund estimates that around 50 million people above the age of 60 accounted for around five percent of Sub-Saharan Africa's population. In the past, most of them turned to their families for help but that practice is becoming less widespread. In many parts of SSA, the elderly who need keen attention to care have double role as care seekers and as care givers as they take care of their orphaned grand children from the effect of HIV/AIDS and also take care of their unemployed adult children who are in turn parents in some cases (HelpAge International, 2013). According to Dwele (2015), many elderlies remain the loneliest, poorest and most neglected people in most Kenyan communities. This situation calls for the need for social support to the elderly to be able to experience optimal aging. The situation could benefit by borrowing from an American study by Levine (2013), that there are an estimated 40-50 million unpaid labour by relatives,

partners and friends who offer family care in the U.S. They provide 80–90% of the long-term care in the community for an aging population with multiple chronic conditions, including Alzheimer's disease and other dementias. Without essential family support, these individuals would require nursing home care, which is not what they or their families want, but which in the context of Rachuonyo Sub County such homes are not available. Equally, in Europe, Age UK (2013), strongly emphasize and recommend the need for continuity of care after the elderly is discharged. This would ensure that the elderly are placed under familiar social assistance for good health outcomes. According to the United Nations principles for older person which was adopted by General Assembly resolution 46/91 of 16 December 1991, the elderly should benefit from family and community care and protection in accordance with each society's system of cultural values.

The family plays an important role in supporting and caring for older persons. Even in the wake of the effects of urbanization, economic pressures and changing social values that have considerably weakened family support structures, younger members of the family need to be sensitized on their obligation to take care of and provide for their older members.

On the construct "Apart from the nuclear family, the community also offer support to the elderly" descriptive statistic found that only 67 (17.8%) of the respondents agreed with the research assertion while majority 236 (62.7%) rejected the statement. of the respondents insisted that they have never enjoyed such community support. Nearly a fifth, 73 (19.4%) of the respondents indicated that they are not aware of the existence of a community support.

From all the five FDGs, specifically at site 2 and site 4, there were general agreement that community support is available but only at the time of death. Death is an end stage of life which in the context of this study is relatively irrelevant to the elderly.

In terms of the construct "The health facility assists the elderly to join support group", the study revealed that 52 (13.8%) of the respondents have been assisted. The group that got the assistance could possibly be from among those attending the Comprehensive Care Centres (CCC), a department that cares for clients suffering from HIV/AIDS. This assistance is in line with study findings in the USA where Texas based Houston Home Health Care providers assist the elderly to find community resources, motivate self-awareness activities, and provide caring assistance with individual's activities of daily living. It is a possible venture that could be borrowed to assist the elderly in the study area to experience optimal aging. In the contrary, a significant majority 290 (77.1%) of the respondents indicated that they have never been assisted by a health facility to join any support group. Participants in all the five FGDs disagreed with the research statement that health facility assist in placing the elderly in support group with an overall poor score. The positive impact of social support is cited by Falk, (2013) in the USA that by having a socially engaging environment geared towards individual's capabilities, the elderly can be kept calm and happy and the strains on caregivers can be reduced; Brent (2014) in England pointed that social support workers can promote good health and wellbeing of the elderly by delivering timely, flexible and responsive support which addresses the fluctuating needs of the elderly; Dwele, (2012) and Help Age, (2001) added that building caring families and communities to offer dignified care to the elderly and the recognition of the social and economic contributions of the elderly to the

communities should be among key activities of health institutions; C & S Healthcare Services, (2016) also commented that having a positive social lifestyle can increase the psychological and physical well-being by lowering amount of stress, anxiety and depression therefore it is important to support self-awareness as well, not just physical presence. In Silver pages, (2015) it is pointed out that training prepares health care service provider to integrate health and psychological care of the elderly with other needed services such as housing, home care services, nutritional services, activities of daily living, socialization programs, as well as financial and legal planning where care plan is tailored for specific circumstances based on individual assessment and continuous monitoring. A study report by Population Reference Bureau, ([PRB,2011) and Keyes *et al.,* (2005) revealed that there is an association between increased levels of social support and reduced risk for physical disease, mental illness, and mortality. In Japan, Silver pages (2015) emphasized that support groups have proved to be a great way to share difficulties and to find people who are going through the same experiences. In light of these findings, it is imperative that the elderly should benefit from social support network to experience optimal aging. According to Veras, (2015), and Counsell, Callahan, Clark, Tu, Buttar, Stump, and Ricketts, (2007), successful stories from some developed nations (the USA, Europe, Japan, and Australia) that made a breakthrough with care for the elderly are that their health systems are packaged to integrate all supportive social networks, for example, in Victoria Australia, programs and services for the elderly are designed to support elderly ability by addressing social participation among other domains. In the contrary, Kabole *et al.,* (2013) lamented that old age in many African countries is a nightmare and a tale of woes because the elderly are vulnerable to social isolation thereby

endangers their health and subsequent quality of aging. Findings in this study, indicates that since most elderly often assume some of the disease manifestations and whereas these manifestations are experienced at the home environment, the family or community support system would be a most likely first-hand help. There is therefore, the need for health system to actively link families in the care of the elderly. In addition, the government of Kenya has employed community health social workers that could actively assist in this aspect. The impact of Social based on its real or perceived resources provided by others that enable a person to feel cared for, valued, and part of a network of communication and mutual obligation (CDC, 2005). It is critical for the elderly who rely on family, friends, or organizations to assist them with activities of daily living, provide companionship, and care for their well-being.

### 4.6.4 Choice of Health care service providers

The study investigated whether the elderly have freedom to make a choice of where to seek treatment and even health care service provider to consult. The responses on the indicators were computed in frequencies and percentage, as shown in Table 4.18 giving a mean of 3.00 (SD =0.88). with all the items ranging between 2.39 to 3.65. Findings of the study show that although a fairly sizeable proportion of the elderly in Rachuonyo North Sub-County have opportunity to make a choice of a health care service provider, majority of them do not enjoy this privilege. Majority 251 (66.8%) of the elderly indicated that they were not aware of their right to choose the health care service provider to treat them however a small number 73 (19.4%) indicated that they were aware. The construct attracted a mean score of 2.39.

**Table 4.18: Respondents Views on Choice of Provider**

| Indicators | 1 | 2 | 3 | 4 | 5 | Mean | SD |
|---|---|---|---|---|---|---|---|
| The elderly are aware of their freedom to choose the health care service provider to treat them. | 83 (22.1) | 168 (44.7) | 52(13.8 %) | 43 (11.4%) | 30 (8.0%) | 2.39 | 0.38 |
| The elderly are aware but have no option to choose the health care service provider to treat them. | 66 (17.6) | 126 (33.5) | 96 25.5%) | 48 (12.8%) | 40 (10%) | 2.65 | 0.77 |
| The elderly are not aware and have no option of choosing the health care service provider to treat them. | 32 (8.5%) | 42 (11.2) | 36 (9.6%) | 180 (47.9%) | 86 (22 %) | 3.65 | 0.98 |
| The elderly often do not choose the health person to treat them. | 56 (14.9) | 27 (7.2%) | 34 (9.0%) | 196 (52.1%) | 63 (16%) | 3.49 | 0.67 |
| The elderly often prefers to be served by staff of the same sex. | 40 (10.6) | 56 (14.9) | 48(12.8 %) | 156 (41.5%) | 76(20%) | 3.46 | 1.02 |
| The elderly often chooses the health facility to attend. | 96 (25.5) | 145 (38.6) | 36 (9.6%) | 67 (17.8%) | 32 (8.5%) | 2.45 | 0.73 |
| Average level of Choice of Provider | | | | | | 3.00 | 0.88 |

Key: 1-Strongly Disagree, 2-Disagree, 3-Undecided, 4-Agree, 5-Strongly Agree and SD-Standard Deviation.

From the qualitative aspect of the questionnaire, it emerged that elderly were invariably not aware of their right to choose health care provider.

From the FGDs, there were mixed heated reactions among participants in all the five FGDs where majority of the participants agreed that they don't know that they have a right to choose the health care service provider to attend to them. It was found that some of the respondents specifically the few enlightened retirees were aware of their rights however all those who participated indicated that they had no option to choose the health

care service provider because their choice was limited to the few available health care service providers. Some expressed that there is a way of silently choosing even if it was not openly echoed. People choose but the problem is the notion of fear of being reprimanded or being sidelined if your preferred health care service provider is not around. It emerged that the elderly holds the notion that choosing a care provider has negative impact on patients care. This was confirmed by heated discussions among participants in all the five FGDs on divergent views. The discussions however settled on the fact that patients are afraid and therefore decline to choose care provider on accounts of fear of victimization where they allude that they might take more time waiting fruitlessly and also fear of neglect or be attended to superficially in case the preferred provider is not available for any reason.

The fear was however confirmed by vivid incidences (site 5) where it was hypothesized that neglect due to jealousy among health care service provider lead to severe medical complications and loss of lives. It emerged that the elderly often prefers to be served by staff of the same gender, as indicated by a majority 232 (61.7%) of the elderly who participated in the survey. From all the five FGDs sites the first reactions were that elderly be served by the health care service provider of the same sex but on further probing the idea got rejected by the majority. The choice on gender preference from the focus group discussion tend to favor choice of male care providers however views showed thin margin on this expert care. It was also established that even though some of the elderly often choose the health facility to attend many 259 (68.9%) of them often do not choose the health person to treat them. The conditions under which choosing a health facility is based are consciousness and experience with the services of the hospital. In

general patients have no choice however there are some diseases such as HIV/AIDS that may force one to choose health facility. Such are stigmatizing diseases and those who contract them prefer to hide.

Choice of care provider is anchored on patients' bill of rights and the Kenya National constitution which recognizes and upholds patient's wish of choice. Among the other bills that offer similar protection is the English National Health System policy (2014). Choices assures that clients have the freedom to consult health care provider of their wish for services among the available options. The right to choose of provider is exercised at the point where the patient is able to make a meaningful, informed choice and the provider is contracted to provide the required health care service. In terms of the personnel to offer services, the provider needs to consider its role in ensuring that the patients receive their legal right to choose of provider and the consultant-led or professional-led team which provide care and treatment. Health care providers who know that patients have a choice tend to offer quality care services to their clients with empathy (Valentine et al. 2003). A study in Nairobi, Kenya (Muriithi, 2013) on the determinants of health-seeking behavior, revealed that patients' trust in the health providers is a significant determinant of the demand for health care. In England, patients' choices about their care is central to the National Health System policy and is supported by the constitution (NHS, 2014). Jealousy and competition among care providers, structural limitation of inadequate number of staff specifically those who are specialized in elderly ailments often compromise elderly right to choose care provider. The elderly choice of facility to go for services did not generate much problem because it is most often a choice of the family. Due to economic factor the first choice is the government over private

health facility because it is relatively cheap. In China poor financial condition is one of the main reasons restricting the elderly from seeking medical services (Xiong, 2014). In Brazil Bosl (2007) point that the elderly who chose private provider over public provider should achieve better health outcomes after controlling for other determining variables. This may have minimal impact in the study area as the number of private providers are almost negligible and the scope of operation is limited. In terms of proximity, some previous studies i.e. Mwabu et al. (1993): Kenya; Cisse (2011): Cote d'Ivoir revealed that distance has a significant and negative impact on the choice of a health facility. Increasing distance increases the likelihood of a household opting for self-treatment rather any of the formal health providers. The negative impact of distance is higher at the public facilities. In this study proximity though an essential determinant, was overtaken by trust in the services expected so FGDs would opt for far facility on the basis of services offered.

**The study sough to respond to research hypothesis**

$H_0$: There is no statistically significant effect of implementation of the concept of client orientation in caring for the elderly in Kenya health system on elderly optimal ageing.

In order to investigate whether there was any statistically significant effect of implementation of the concept of client orientation in caring for the elderly in Kenya health system on elderly optimal ageing. A bivariate Pearson's Product-Moment Coefficient of Correlation was used to establish the relationship between the two variables. The SPSS output Table 4.19 shows the correlation results.

The cost of providing choice of care provider is most severe for countries that are human resource constrained (De Silvia *et al.*, 2013).

From the SPSS output (Table 4.19) it is evident that there was a significant positive correlation (n=376; r =.534; p < 0.05) between implementation of the concept of client orientation in caring for the elderly in Kenya health system on elderly optimal ageing.

**Table 4.19: Correlation: Implementation of Client Orientation and Elderly Optimal Ageing**

| | | Optimal Ageing | Client Orientation |
|---|---|---|---|
| Optimal Ageing | Pearson Correlation | 1 | .534** |
| | Sig. (2-tailed) | | .000 |
| | N | 376 | 376 |
| Client Orientation | Pearson Correlation | .534** | 1 |
| | Sig. (2-tailed) | .000 | |
| | N | 376 | 376 |

**. Correlation is significant at the 0.01 level (2-tailed).

Given that the p-value was less than .05, the null hypothesis that "There is no statistically significant effect implementation of the concept of client orientation in caring for the elderly in Kenya health system on elderly optimal ageing" was rejected. Consequently, a conclusion was made that there is statistically significant positive relationship between implementation of the concept of client orientation in caring for the elderly in the Kenya health system and elderly optimal ageing, with more effective implementation of the concept of client orientation in caring for the elderly associated with improved healthier ageing among the elderly. To further illustrate this relationship, a scatter plot was generated. Creswell (2014) who recommend its use, points out that scatter diagram graphs pairs of numerical data, with one variable on each axis, to look for a relationship between them. Figure 4.4, shows that there was a moderate positive correlation between the two variables; the points tend to fall along the line.

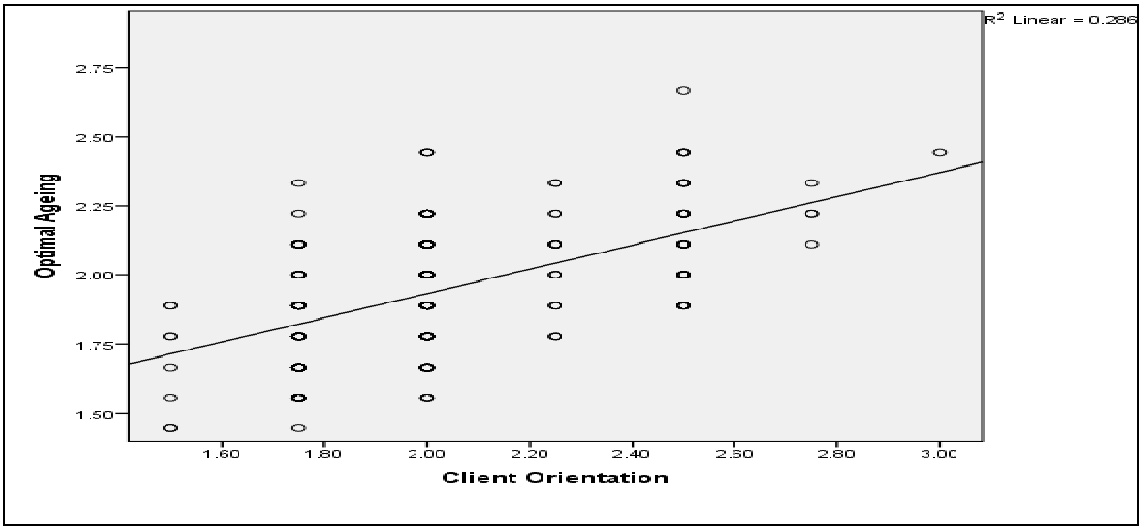


**Figure 4.4: Scatter plot graph: Client Orientation on Optimal Ageing.**

The scatter plot indicates that there was a moderate positive correlation between implementation of the concept of client orientation in caring for the elderly in Rachuonyo North sub-county health services and optimal ageing. This was shown by the pattern of dots which inclines from lower left to upper right, demonstrating a positive correlation between the variables. The trend-line further shows this relationship; the coordinate points are clustered along the line, forming a visible pattern. This means that the relationship was real and not by chance. However, to estimate the level of effect of implementation of the concept of client orientation in caring for the elderly in Rachuonyo North sub-county health services on elderly optimal ageing, a coefficient of determination was computed. This was done using of regression analysis and the results were as shown in Table 4.20.

**Table 4.20: Model Summary on Regression Analysis of Implementation of the Concept of Client Orientation on Optimal Ageing**

| Model | R | R Square | Adjusted Square | R Std. Error of the Estimate | Durbin-Watson |
|---|---|---|---|---|---|
| 1 | .534[a] | .286 | .284 | .17709 | 2.012 |

a. Predictors: (Constant), Client Orientation

b. Dependent Variable: Optimal Ageing

The model shows that level of implementation of the concept of client orientation in caring for the elderly in Rachuonyo North sub-county health services accounted for 28.6% (R2=.286) of the variation in optimal ageing in Rachuonyo North Sub-County. This was a fairly strong effect of a predictor on the dependent variable. On the other hand, to determine whether level of observance of concept of client orientation in caring for the elderly was a significant predictor of optimal ageing, Analysis of Variance (ANOVA) was computed as shown in Table 4.21.

**Table 4.21: ANOVA - Influence of Implementation of the Concept of Client Orientation on Optimal Ageing**

| Model | | Sum of Squares | Df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 4.691 | 1 | 4.691 | 149.577 | .000[b] |
| | Residual | 11.729 | 374 | .031 | | |
| | Total | 16.421 | 375 | | | |

a. Dependent Variable: Optimal Ageing

b. Predictors: (Constant), Client Orientation

Table 4.21 which shows the ANOVA results reveals that the overall regression model is a good fit for the data. It reveals that the level of client orientation for persons in caring for the elderly was a significant predictor of optimal ageing, $F(1, 374) = 149.577$, $p < .05$

(i.e., the regression model is a good fit of the data). This implies that information on the level of client orientation in caring for the elderly in Kenyan health service could be used to significantly predict of optimal ageing levels among elderly persons. In addition, the study sought to establish the relationship between individual aspects of client orientation in caring for the elderly and optimal ageing, as indicated in Table 4.22.

**Table 4.22: Correlation between Aspects of Client Orientation and Optimal Ageing.**

| | | Prompt attention | Amenities | Social support | Choice of provider |
|---|---|---|---|---|---|
| Optimal Ageing | Pearson Correlation | .265** | .349** | .163** | .290** |
| | Sig. (2-tailed) | .000 | .000 | .001 | .000 |
| | N | 376 | 376 | 376 | 376 |

**. Correlation is significant at the 0.01 level (2-tailed).

The findings of the study show that there was statistically significant positive relationship between optimal ageing and all the four aspects (promptness of attention, Adequacy and quality of amenities, access to social support network and choice of health care service provider) of client orientation. However, the strength of the correlations was fairly weak in all the aspects of client orientation in caring for elderly. However, it was shown that all aspects of client orientation had statistically significant positive association to optimal ageing, with appropriate application of client orientation in the provision of health services associated to healthy ageing among the elderly persons.

## 4.7 Objective 4: Influence of Health System preparedness to care for the elderly on elderly optimal ageing

The study investigated the level of preparedness of the health system on optimal ageing of the elderly in caring for the elderly by the use of two sub themes: staff training and staff deployment. A 5 itemized Likert-scaled questionnaire was used and graded as 1-Strongly Disagree, 2-Disagree, 3-Undecided, 4-Agree, 5-Strongly Agree and summarized in tables 4.23 to 4.25. Health system preparedness attracted a mean of 2.58 in a scale of 1 to 5.

**Table 4.23: Aspects of Preparedness of Health System on optimal ageing**

| Aspects of preparedness | Mean | SD |
|---|---|---|
| Training of staff | 2.48 | 0.49 |
| Deployment of Care Provider | 2.67 | 0.23 |
| **Overall Mean level** | **2.58** | **0.37** |

Result: Preparedness has a mean of 2.58 effect on optimal aging.

### 4.7.1 Training of Staff and Services

Training and services as an indication of preparedness to care for the elderlywas investigated by assessing seven constructs that were summarized in percentage frequencies, as shown in Table 4.21.

**Table 4.24: Respondents Views on Staff Training and Services**

| **Indicators** | **1** | **2** | **3** | **4** | **5** | **Mean** | **SD** |
|---|---|---|---|---|---|---|---|
| The non-elderly specific general health departments offer adequate care for the elderly. | 143 (38.0%) | 156 (41.5%) | 37 (9.8%) | 28 (7.4%) | 12 (3.2%) | 1.96 | 0.86 |
| There are no unique requirements to care for the elderly | 204 (54.3%) | 98 (26.1%) | 36 (9.6%) | 30 (8.0%) | 8 (2.1%) | 1.78 | 0.51 |
| As an elderly, I prefer to be attended to by the youthful staff | 56 (14.9%) | 98 (26.1%) | 156 (41.5%) | 45 (12.0%) | 21 (5.6%) | 2.67 | 0.66 |
| From my experience with service delivery, I think staff training is adequate to care for the elderly | 98 (26.1%) | 196 (52.1%) | 48 (12.8%) | 19 (5.1%) | 15 (4.0%) | 2.09 | 0.26 |
| There is need for elderly specific departments in health facilities | 32 (8.5%) | 40 (10.6%) | 60 (16.0%) | 126 (33.5%) | 118 (31.4%) | 3.69 | 0.94 |
| Programs are in place that prepares health care service provider to care for the elderly | 85 (22.6%) | 72 (19.1%) | 156 (41.5%) | 24 (6.4%) | 39 (10.4%) | 2.63 | 0.63 |
| I am strong despite popular beliefs about the elderly | 85 (22.6%) | 152 (40.4%) | 34 (9.0%) | 48 (12.8%) | 57 (15.2%) | 2.57 | 0.73 |
| **Mean average level of staff training and services** | | | | | | **2.48** | **0.49** |

Key: 1-Strongly Disagree, 2-Disagree, 3-Undecided, 4-Agree, 5-Strongly Agree and SD-Standard Deviation.

On the construct “The non-elderly specific general health departments offer adequate care for the elderly”, the descriptive statistics revealed that 299 (79.5%) rejected the statement while a small number 40 (10.6%) accepted the statement. From the qualitative aspect of the questionnaire, it emerged that the elderly were not comfortable with services offered in general wards or units designed for non-vulnerable populations.

From the Key Informants, the study learnt that although the health care service providers have sufficient training, they however lack adequate specialized training to offer elderly specific services. It was learnt that factors such as service in general wards, staff shortage, poor student supervision, poor staff motivation absence of specific care guide to the elderly and generational are contributing factors to poor service to the elderly.

On the construct “There is no unique requirements to care for the elderly” the descriptive statistics revealed that a significant majority 302 (80.4%) rejected the statement while 38 (10.1%) accepted the statement. From the qualitative aspect of the questionnaire it was evident that respondents held a strong belief that elderly have unique needs that require special care. Serving them in general health departments do not meet their unique requirement. From all the five FGDs sites, participants disagreed with the research statement and pointed that their health conditions are unique and the way they respond to them differs from how the younger age groups do.

The investigator input reflects various literatures, i.e. WHO, (2000), Rowe and Kahn (1999, 1997), that elderly have unique old-age health problems and that they feel comfortable to be in their specific departments for commonality. The health problems are the basis upon which the uniqueness in care rests.

On the construct “As an elderly, I prefer to be attended to by the youthful staff” the descriptive statistics revealed that 154 (41.0%) rejected the statement while 66 (17.6%) accepted the statement. From the qualitative aspect of the questionnaire, the elderly prefers to be attended to by staff who have long experience in service.

From FGDs, there were divergent views, those who did not mind and those who minded the working experiences, however those who were sensitive to long working experience of staff had bitter experiences with the youthful generation in caring for the elderly. In FGD site 2 an example was given of an old retiree health care provider who was praised for his keenness in dealing with the elderly in his clinic.

> *“There are many aspects of poor services for example, no immediate action was taken when I was very sick. I stayed for long with nobody attending to me, I was seen only in late hours of the day. These youthful staff engage in social media at the expense of patients suffering. Even they do not follow to see the progress of medication”. The services are good for the young people who can wait for long in the line. The delay in attending to the elderly is worrying to us the elderly. There is no special consideration given to the elderly”.*

The investigator view on the issue of preference for the youthful generation is that supervision should be intensified for those allocated to care for the elderly just as for other patients. In the same line, close to two-thirds 244 (64.9%) of the elderly observed that there is need for specific departments in health facilities to handle their unique health issues. Besides, many of them have general feeling that programs tailored to their unique needs should be put in place to address their ever-varied health related issues.

A qualitative verbal FGD response said:

> *"We can share many of our unique problems and understand one another than when we share wards with our grandchildren or our sons and our daughters" (site2, 4)*

This statistical finding concurs with the views strongly expressed by participants at all the five FGDs that there is need to have elderly sensitive units in the health facilities to offer care that facilitate optimal aging. Treatment in the general wards do not holistically address their health needs adequately. Results of a longitudinal study in the United States supported the hypothesis that disability in the elderly can be postponed through healthier lifestyles (Smith and Mensa, 2003). This can be promoted effectively in elderly specific departments.

On the construct "I am strong despite popular beliefs about the elderly" the descriptive statistics revealed that 237 (63%) disagreed with the statement while 105 (28%) agreed with the statement.

In as much as popular belief has it that elderly are strong people, the study revealed that a significant majority of respondents disagreed with the research statement and hold that the elderly are actually weak people. The participants in site 2 unanimously disagreed with the research statement and maintained that the elderly are weak people. This implies that the elderly deserves special care to experience optimal aging. The above findings concur with those of Falk et al. (2013) who in reviewing services in nursing homes in Illinois, lamented over poor attention given to the elderly. Similar incidences are cited in a global study (Aboderin, 2013) which acted as an eye opener report on care for the elderly. Plsek and Greenhalgh (2001) observed that new conceptual framework that

incorporates a dynamic emergent, creative, and intuitive view of the world must replace traditional approaches to clinical and general service delivery. A study report by Age UK (2013) revealed that the elderly and their families were let down when hospitals and care homes failed to deliver decent care or treat them with dignity. The report recommends training of staff to care for frail older people.

A study in South Africa found low healthcare utilization with higher perceived healthcare responsiveness in private than in public healthcare facilities. Prompt attention, autonomy, communication and access experiences were the identified priority areas for actions to improve responsiveness of healthcare services (Peltzer *et al.*, 2012).

### 4.7.2 Staff Deployment

The study sought to investigate the suitability of staff deployment towards preparedness to care for the elderly as perquisite condition for healthy ageing. The sub-scale was investigated by assessing the views of elderly on the indicators of suitability of staff deployment such as number of staffs, relevance of their training, experience and their attitudes towards the elderly. Their views were summarized in percentage frequencies, as shown in Table 4.22. From Table 4.25, it is evident that the staff deployment of health care service providers in health centres in Rachuonyo North Sub-County is relatively low in regards to specific health needs of the elderly. This was reflected by a mean average of 2.67 (standard deviation=0.23) in the rating scale of 1 to 5 in the level of staff deployment, with many of the items in this subscale rated below 3.0. The finding of this study indicates that there is inadequate number of care providers which contributes to slow or late attention to the elderly. This was mirrored by the fact that more than one out of every two 211 (56.1%) of the surveyed elderly refuted the claim that there is adequate

number of relevantly trained staff to care for the elderly. The finding mirrors sentiments by Harrington, Choiniere, Goldmann, Jacobsen, Lloyd, McGregor and Szebehely, (2012) that without adequately staffed units, care for the elderly is compromised.

**Table 4.25: Respondents Views on Staff Deployment**

| **Indicators** | **1** | **2** | **3** | **4** | **5** | **Mean** | **SD** |
|---|---|---|---|---|---|---|---|
| There is adequate number of trained staff to care for the elderly. | 118 (31.4%) | 93 (24.7%) | 36 (9.6%) | 61 (16.2%) | 68 (18.1%) | 2.65 | 0.71 |
| When elderly need services, a relevantly trained health care service provider is available. | 124 (33.0%) | 77 (20.5%) | 87 (23.1%) | 46 (12.2%) | 42 (11.2%) | 2.48 | 0.56 |
| The elderly often prefers to be served by health care service provider that has long experience in service. | 48 (12.8%) | 76 (20.2%) | 32 (8.5%) | 96 (25.5%) | 124 (33.0%) | 3.46 | 0.86 |
| The health care service provider often have positive attitude towards the elderly. | 121 (32.2%) | 186 (49.5%) | 4 (1.1%) | 45 (12.0%) | 20 (5.3%) | 2.09 | 0.43 |
| **Mean average level of suitability of staff deployment** | | | | | | **2.67** | **0.23** |

Key: 1-Strongly Disagree, 2-Disagree, 3-Undecided, 4-Agree, 5-Strongly Agree and SD-Standard Deviation.

In addition, 201 (53.5%) of them alluded that in many cases when they need services, a relevantly trained health care service provider is not available, which translates to a mean deployment suitability of 2.48 (standard deviation=0.56). Equally, it emerged from the results of the survey that many 220 (58.5%) of the elderly often prefer to be served by health care service provider that has long experience in service. From FGD site 2

participant agreed that they prefer health care service provider who has long years of service experience. A participant gave the example of a Dr. X who was elderly and many elderly people preferred going to his clinic. On further probing and deliberations FGDs weakly accommodated the services of those with short period of service.

On the health providers attitudes towards the elderly, the data revealed that quite a large number 307 (81.6%) of the elderly disagreed with the statement that the care providers often have positive attitude towards them. In assessing the health services for the elderly in England, Lothian et al (2001) point that the key to tackling poor attitudes by care provider towards the elderly is through training. A study report by HelpAge (2001) in Kenya revealed the existence of negative attitude of care provider whose statement reads "older people are a big headache and a waste of scarce resources, the biggest favor you could do to me as an Older People's Organization is to get them out of my hospital" (HelpAge, 2001). A study by Kabole et al (2013) also found that disengagement as a response of a culture implies that the aged are superannuated and therefore should be phased out of life. A small number 65 (17.3%) agreed that care providers often have positive attitude towards them and a smaller number 4(1.1%) were undecided.

*The study sought to test the research hypothesis;*

$H_0$: There is no statistically significant influence of Health System preparedness to care for the elderly on elderly optimal ageing in Rachuonyo North Sub County of Homa Bay County. In order to establish whether there was any statistically significant influence of Health System preparedness to care for the elderly on elderly optimal ageing in Rachuonyo North Sub County of Homa Bay County, a bivariate Pearson's Product-

Moment Coefficient of Correlation, whose result is shown in the SPSS output in Table 4.26, was used to establish the relationship between the two variables.

**Table 4.26: Correlation between Health Systems preparedness to care and Optimal Ageing**

| | | Optimal Ageing | Preparedness to Care for the Elderly |
|---|---|---|---|
| Optimal Ageing | Pearson Correlation | 1 | .447** |
| | Sig. (2-tailed) | | .000 |
| | N | 376 | 376 |
| Preparedness to Care for the Elderly | Pearson Correlation | .447** | 1 |
| | Sig. (2-tailed) | .000 | |
| | N | 376 | 376 |

**. Correlation is significant at the 0.01 level (2-tailed).

Table 4.26 shows that there was a statistically significant positive correlation (n=376; r =.447; $p < 0.05$) between Health Systems preparedness in training and deployment of care providers, and optimal ageing. A p-value of .000 (only 3 dp) means it was far less than .05; hence, the null hypothesis that "There is no statistically significant effect of Health Systems preparedness in training and deployment of care providers to care for the elderly in Rachuonyo North Sub-county" was rejected. Subsequently, a conclusion was reached that there is a statistically significant positive effect of Health Systems preparedness in training and deployment of care providers in caring for the elderly in Kenya health system and optimal ageing, with better Health Systems preparedness in training and deployment of care providers in caring for the elderly associated with improved optimal ageing among the elderly. To further demonstrate this relationship, a scatter plot was generated. Figure 4.5, shows that at least there was some positive correlation between the two variables, as reveled by the trend-line.

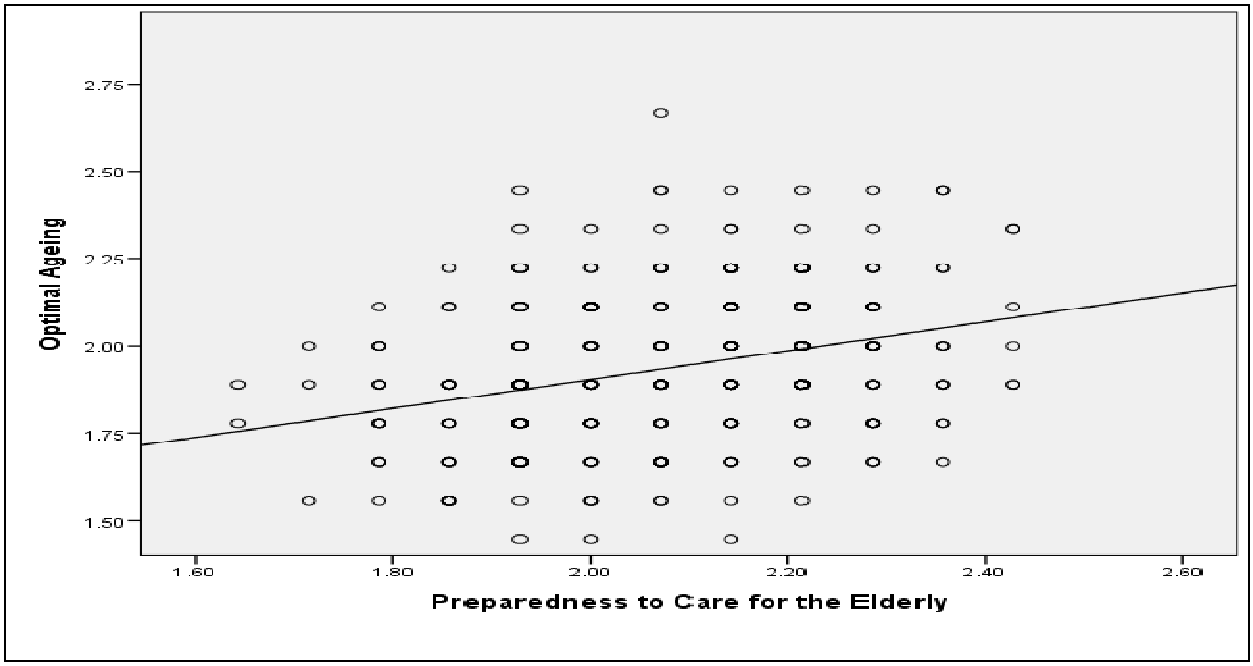


**Figure 4.5: Scatter plot graph: Health Systems preparedness on Optimal Ageing**

The scatter plot reveals that there was some positive correlation between Health Systems preparedness in training and deployment of care providers in Kenya health system and optimal ageing. This was displayed by trend line. The coordinate points appear to cluster along the line, forming almost a visible pattern, implying that the relationship was real and not by chance. On the other hand, to estimate the level of effect of Health Systems preparedness in training and deployment of care providers in caring for the elderly in Kenya health system on optimal ageing, a coefficient of determination was computed using a regression analysis, as shown in Table 4.27.

**Table 4.27: Model Summary on Regression Analysis of Health Systems preparedness in training and deployment of care providers on Optimal Ageing**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .447[a] | .200 | .197 | .18747 |

a. Predictors: (Constant), Preparedness to Care for the Elderly

The model shows that preparedness to Care for the Elderly in Rachuonyo North Sub-County accounted for 20.0% (R2=.200) of the variation in optimal ageing in Rachuonyo North Sub-County. This was a plausible effect of a predictor on the dependent variable. However, to determine whether level of preparedness to care for the elderly was a statistically significant predictor of optimal ageing, Analysis of Variance (ANOVA) was computed as shown in Table 4.28

**Table 4.28: ANOVA - Influence of Preparedness to Care for the Elderly on Optimal Ageing**

| Model | | Sum of Squares | Df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 3.277 | 1 | 3.277 | 93.242 | .000[b] |
| | Residual | 13.144 | 374 | .035 | | |
| | Total | 16.421 | 375 | | | |

a. Dependent Variable: Optimal Ageing

b. Predictors: (Constant), Preparedness to Care for the Elderly

Table 4.25 which show the ANOVA results indicate that the overall regression model is a good fit for the data. This is interpreted to mean that the level of preparedness to Care for the Elderly was a significant predictor of optimal ageing, $F(1, 374) = 93.242$, $p < .05$. This implies that facts on the level of preparedness to care for the Elderly in Kenyan health service could be used to significantly predict the level of optimal ageing among elderly.

In addition, the study sought to establish the relationship between individual aspects of preparedness to care for the elderly in Kenyan health service and optimal ageing, as shown in Table 4.29.

**Table 4.29: Correlation between Aspects of Preparedness to Optimal Ageing.**

| | | Training | Deployment |
|---|---|---|---|
| Optimal Ageing | Pearson Correlation | .385** | .282** |
| | Sig. (2-tailed) | .000 | .000 |
| | N | 376 | 376 |

**. Correlation is significant at the 0.01 level (2-tailed).

The findings of the study show that there was statistically significant positive relationship between optimal ageing and all the two aspects (staff training and services, and staff deployment) of preparedness to care for elderly. Although, there were weak correlations in all the aspects of preparedness to care for the elderly and optimal ageing, they all had statistically significant positive relationship to optimal ageing. This finding implies that

with appropriate preparedness to care for the elderly in terms staff training, services and staff deployment there would be improvement in healthy ageing among the elderly.

### 4.8: Influence of Health Systems Responsiveness to the Care of the Elderly

#### 4.8.1: Multiple Regression Analysis

The study sought to establish a linear model that could be used to describe the optimal level of healthy ageing. This was done by use of standard multiple regression analysis, where all the three independent variables were factored in the model at once. It was suitable because it could help to investigate how well the set of the independent variables was able to predict the level of optimal ageing, in line with the views held by Creswell (2014). The analysis provided information about the relative contribution of each of the variables that make up the model. Each aspect of health systems responsiveness to the care needs of the elderly was evaluated in terms of its predictive power, over and above that offered by all the other independent variables. It enabled the investigator to know how much unique variance, in the dependent variable, each of the predictor explained. Table 4.30 shows the regression analysis model summary output.

**Table 4.30: Regression Analysis Model summary output: Health Systems Responsiveness to Care for the Elderly on elderly optimal ageing.**

| Model | R | R Square | Adjusted R Square | Std. Error of the |
|---|---|---|---|---|
| 1 | .748[a] | .560 | .557 | .13933 |

a. Predictors: (Constant), Preparedness to Care for the Elderly, Client Orientation, Observance of respect for persons

In the model summary (Table 4.30) the "R" column represents the value of R, the multiple correlation coefficients. It is a measure of the quality of the prediction of the dependent variable – optimal ageing. The value of .748 indicates a good level of prediction. However, the value of R Square (.560) indicates how much of the variance in the optimal ageing was explained by Health Systems Responsiveness to the Care for the Elderly. This value expressed as a percentage means that the model explains 56 percentage of the variance in optimal ageing. This is the proportion of variance in the optimal ageing that is explained by Health Systems Responsiveness to the care of the Elderly. It is the proportion of variation accounted for by the regression model above and beyond the mean model. To assess the statistical significance of the result it was necessary to look at the ANOVA results shown in Table 4.31

**Table 4.31: ANOVA- Health Systems Responsiveness to the Care Needs of the Elderly**

| Model | Sum of Squares | | Df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 9.199 | 3 | 3.066 | 157.953 | .000b |
| | Residual | 7.222 | 372 | .019 | | |
| | Total | 16.421 | 375 | | | |

a. Dependent Variable: Optimal Ageing

b. Predictors: (Constant), Preparedness to Care for the Elderly, Client Orientation, Observance of respect for persons

The ANOVA was used to test the null hypothesis that multiple R in the population equals 0. In this case the model reached statistical significance [F (3, 372) =157.953, $R^2$=.560, sig.<.05], implying that the model was highly significant and adequate enough to explain the variance in optimal ageing. In other words, the results show that the studied aspects of Health Systems Responsiveness to the care of the Elderly statistically significantly predict optimal ageing, meaning the regression model is a good fit of the data.

### 4.8.2: Evaluating Contribution of each Predictor

The study sought to investigate the level of contribution of the individual aspects of Health Systems Responsiveness to the care of the Elderly factored in the model in the prediction of optimal ageing. This was shown by the coefficient values in Table 4.32.

**Table 4.32: Coefficient Output: Health Systems Responsiveness to Elderly optimal ageing**

| Model | Unstandardized Coefficients | | Standardized Coefficients | | Sig. | 95.0% Confidence Interval for B | |
|---|---|---|---|---|---|---|---|
| | B | Std. Error | Beta | | | Lower Bound | Upper Bound |
| (Constant) | .450 | .070 | | 6.459 | .013 | .313 | .587 |
| Observance of respect for persons | .100 | .012 | .292 | 8.465 | .011 | .077 | .124 |
| Client Orientation | .437 | .028 | .533 | 15.490 | .021 | .382 | .492 |
| Preparedness to Care for the Elderly | .267 | .020 | .462 | 13.384 | .016 | .228 | .306 |

a. Dependent Variable: Optimal Ageing

From the model it is evident that the three aspects of Health Systems Responsiveness to the care of the Elderly contributed differently in influencing optimal ageing of the elderly in Rachuonyo North Sub-County of Homa Bay County. For example, client orientation had the highest impact on enhancing optimal ageing, while observance of respect for

persons made the least contribution in explaining the variability in the level of optimal ageing. The variable “client orientation” had the largest beta coefficient of .533, implying that it made the strongest unique contribution to explaining the dependent variable. This means that a one standard deviation improvement in client orientation leads to a .533 standard deviation increase in predicted optimal ageing level, with the other variables held constant.

On the contrary, the beta value for “observance of respect for persons” was the lowest at .292, indicating that it made the least contribution to the model; a one standard deviation improvement of observance of respect for the elderly by health care service providers would only leads to a .292 standard deviation improvement in optimal ageing, with the other variables in the model held constant.

However, from the model it was noted that all the aspects of Health Systems Responsiveness to the care of the Elderly made statistically significant ($p<.05$) unique contribution to the model.

It was noted that the total R squared value for the model (.560 or 56.0% explained variance) did not equal to the sum of the R Squared for each as aspect of Health Systems Responsiveness to the care of the Elderly. This was because the part correlation values represented only the unique contribution of each variable, with any overlap or shared variance removed. The total R squared value, however, included the unique variance explained by each variable and also that shared. The predictors were positively correlated (shown by zero-order correlations) hence there were a lot of shared variance that was statistically removed when they were all included in the model.

### 4.8.3 The Regression Model

A regression model for the influence of Health Systems Responsiveness to the care of the Elderly on optimal ageing is shown below.

In this model: $Y = B\ o + B\ 1\ x1 + B\ 2\ x\ 2 + B\ 3\ x\ 3 + \varepsilon$.

Where: Y is Optimal Ageing

X1 Observance of respect for persons

X2 Client Orientations

X3 Preparedness to Care for the Elderly

Optimal level of Ageing was presented by:

Predicted Optimal Ageing =.450UNITS +.100x1UNITS + .437 x 2UNITS + .267x3UNITS + error term

From the equation, the coefficients indicate how much optimal ageing varies with an independent variable when all other independent variables are held constant. For example, the unstandardized coefficient, X1, for observance of respect for persons is equal to .100 means that for each one-unit improvement in observance of respect for persons in the care of the elderly in health care services, there is a corresponding improvement in optimal ageing of .100 units at 95% confidence interval of (.077 .124).

Given that all the predicators had unique significant change in the model, it is concluded that the model was adequate to predict optimal ageing among the elderly in Rachuonyo North Sub-County; it was statistically significant [F (3, 372) =157.953, R2=.560, p <.05]. It was concluded that more than a half (56%) of the variability in optimal ageing is explained by aspect of Health Systems Responsiveness to the Care of the Elderly.

However, other factors (not covered in this regression model) account for about 44% of the variance in optimal ageing

# CHAPTER 5

# SUMMARY, CONCLUSION, AND RECOMMENDATION

## 5.0. Introduction

The study investigated the "Responsiveness of Health care System on Elderly Optimal Ageing" in Rachuonyo North Sub-county of Homa Bay County, Kenya based on four specific objectives. The findings and interpretations of data were presented and discussed in the previous chapter. This chapter summarizes data, draws, conclusions and makes recommendations for policy, practice and future research based on the findings.

## 5.1 Summary of Key Findings

### 5.1.1 Objective 1: Level of Optimal Ageing of the elderly

The key findings were that there was moderate level of optimal ageing among the elderly with a mean response of 2.61 (SD=0.43) as shown in table 4.5, with most of the constructs indicators rated just barely above moderate level in the scale of 1 to 5.Based on demographic data the study revealed that there were more female's elderly, 227 (60.4%) than males, 149 (39.6%) as evidenced by figure 4.1 indicating that Rachuonyo North Sub County has more females than males. Ageing is further shown by the pattern of gender distribution shown in figure 4.2 which suggests that as age advances from 60 years, the number of elderly declines. The study also revealed that majority 206 (54.8%) of the elderly are married as shown in table 4.2 on page 88 thus suggesting that companionship in the elderly is achieved by slightly above average majority. Ageing is again shown by the study in the level of education in table 4.3 that a large percentage 87.2% of the elderly attained primary level schooling or never went to school. The study

finally revealed that all the 376 elderly who participated in the study were involved in a kind of income generating activities as revealed by table 4.4 in page 89 indicating that elderly optimal aging had some economic backup. Finally the study revealed that elderly suffer varied multi-morbidity which impact negatively on their optimal ageing.

### 5.1.2. Objective 2: Influence of Observance of respect for persons on elderly Optimal Ageing

The key findings on the second objective were that there was significant though weak (n=376; r =.247; $p < 0.05$) positive correlation between observance of respect for persons in caring for the elderly in health system and elderly optimal ageing as shown in table 4.10 on page 96. This led to the rejection of null hypothesis stated in page 5. The study further confirmed the positive correlation by the Scatter plot figure 4.3 on page 97 which showed a positive linear inclination of the trendline (the line of best fit) sloping from lower left to upper right cutting across the coordinate points thus indicating some positive correlation between the two variables. On the same note the study found that by regression analysis, observance of respect for persons accounted for 5.6% (R2=0.56) of the variation in elderly optimal ageing of elderly in Rachuonyo North Sub County, which was a fairly weaker predictor effect as displayed in table 4.11 on page 127.The study also revealed through Analysis of variance (ANOVA) that level of observance of respect for persons in caring for the elderly was a significant predictor of optimal ageing, $F(1, 374) = 22.015$, $p < .05$and that information on the level of observance of respect for persons could be used to significantly predict levels of optimal ageing among elderly. This is contained in table 4.12 on page 127. Finally,

in analyzing the contribution of individual aspects of respect for persons through multiple correlation, the study found that there was fairly weak correlation in all the three aspects of respect for person with confidentiality contributing stronger (.508) and dignity contributing weaker (.247) effect as evidenced in table 4.13 on page 128.

### 5.1.1. Objective 3: Influence of implementation of the concept of client orientation on elderly optimal ageing

The third Objective sought to determine the influence of the implementation of the concept of client orientation on optimal aging in Rachuonyo Sub County. The findings were that observance of client orientation had moderate influence on optimal aging with mean of 2.49 and SD 0.65as shown in table 4.14 on page 128.By using a bivariate Pearson's Product-Moment Coefficient of Correlation the study established that there was a significant positive correlation ($n=376$; $r =.534$; $p < 0.05$) between implementation of the concept of client orientation in caring for the elderly in Rachuonyo North Sub County of Homa Bay and elderly optimal ageing as displayed in table 4.19 page (l48). This led to the rejection of the null hypothesis 2, stated in page (5) thus pointing that effective implementation of the concept of client orientation in caring for the elderly is associated with improved healthier ageing of the elderly. The study used Scatter plot whose pattern of inclination illustrated that there was moderate positive relationship between the implementation of the concept of client orientation and elderly optimal ageing. Figure 4.4 on page (?) illustrate a clearer pattern of the relationship with coordinate points clustering around the trend line. The level of effect of client orientation on optimal ageing was estimated through regression analysis and demonstrated through table 4.20, page (?) to account for 28.6% ($R2=.286$)of the variation in optimal ageing in Rachuonyo North

Sub-County. The study further proved through analysis of variance in table 4.22 on page 151 that the overall regression model is a good fit for data and the level of client orientation for persons in caring for the elderly, F (1, 374) = 149.577, p < .05, was a significant predictor for optimal ageing. In analyzing the correlation between the four individual aspects of client orientation on optimal ageing, the study revealed that there was statistically significant though weak positive correlations between optimal ageing and all the four aspects (prompt attention= .265, Amenities =.349, Social support =.163, Choice of provider = .290) as displayed in table 4.22 on page 151. The study confirmed that with appropriate application of client orientation in the provision of health services there was associated healthy ageing among the elderly.

#### 5.2.1.4 Objective 4: Influence of Health System preparedness to care for the elderly on elderly optimal ageing

Objective four sought to evaluate the influence of Health System preparedness to care for the elderly on elderly. The study established that there was statistically significant positive correlation (n=376; r =.447; p < 0.05) between Health Systems preparedness to care for the elderly and optimal ageing as shown in table 4.26 on page 160. This led to the rejection of null hypothesis stated on page 5. The study further used scatter plot which demonstrated this relationship through pattern of inclination from lower left to upper right with coordinate points clustered around trend line as shown in figure 4.5 on page 161. In estimating the level of effect of Health Systems preparedness to care for the elderly on optimal aging, the study did regression analysis, as shown in Table 4.27 on page 162 and revealed that preparedness to Care for the Elderly accounted for 20.0%

(R2=.200) of the variation in optimal ageing in Rachuonyo North Sub-County. This was a plausible effect of a predictor on the dependent variable. The study also revealed through ANOVA that the level of preparedness to care for the elderly, F (1, 374) = 93.242, $p < .05$. was a statistically significant predictor of optimal ageing as shown in table 4.28 on page 162. In establishing the relationship between individual aspects of preparedness to care for the elderly and optimal ageing, the study revealed, as shown in table 4.29 on page 163that there was statistically significant positive relationship between optimal ageing and the two aspects (staff training and deployment) of preparedness to care for elderly. the aspects had statistically significant positive relationship to optimal ageing. This finding implied that with appropriate preparedness to care for the elderly in terms staff training, and deployment there would be improvement in healthy ageing among the elderly. In all the for objectives the study found that that health system account for 56% of optimal ageing of the elderly as shown in table page

**5.3 Conclusion**

Objective 1: To determine the level of optimal aging among the elderly in Rachuonyo North Sub County Homa Bay County, the study concluded that there is moderate level of optimal ageing in the elderly with mean score of 2.61 SD 0.43 possibly attributed to multimorbidity conditions of the elderly.

Objective 2: To establish the influence of respect for persons in caring for the elderly on elderly optimal ageing in Rachuonyo North Sub County, the study concluded that because of the generation gap between the elderly and the youthful generation, the anticipated cordial relationship may not be easily realized. Some comments by health

care service provider towards the elderly, delays to receive services, occasional superficial services to the elderly accounts for the moderate score of respect for persons on elderly optimal aging. There is high expectations by the elderly that health system has potentials to offer responsive health services to meet their legitimate expectations on non-medical aspect of care.

Objective 3: To determine the influence of implementation of the concept of client orientation in caring for the elderly on elderly optimal ageing, the study concluded that there is inadequate understanding by the elderly on the potentials and challenges of the health systems towards their care which make to often view health services to be inappropriate to them. Based on the trends of health system development, most elderly still reflect on the anticipated good past where care services were often free and readily available possibly because there was under usage of health services based on population size and service demand. There is need for the elderly to understand the state of health system and also the health system to understand the expectation of the elderly so that both sides can nurture each other.

Objective 4: To Evaluate the influence of Health System preparedness to care for the elderly on elderly optimal ageing, the study concluded that health care service provider practice with general knowledge of care and as such may not meet the unique needs of the elderly that promote optimal ageing.

## 5.4 Recommendations

Objective 1: To determine the level of optimal aging among the elderly in Rachuonyo North Sub County, the study recommended to national government through the Ministry of health to develop a relevant care service guide for service to the elderly.

Objective 2: To establish the influence of respect for persons in caring for the elderly on elderly optimal ageing in Rachuonyo North Sub County, the study recommended to the national government through the ministry of health that there is need for health care service providers to understand the unique needs of the elderly

Objective 3: To determine the influence of implementation of the concept of client orientation in caring for the elderly on elderly optimal ageing, the study recommended to Homa Bay County health institutions managements and stake holders in the civil society to assist the elderly to understand the potentials and challenges of health system in service delivery.

Objective 4: To Evaluate the influence of Health System preparedness to care for the elderly on elderly optimal ageing, the study recommended for in-service trainings to health care service providers on care of the elderly.

## 5.5 Recommendations for Further Research

Study recommended further study on:

1. Involvement of elderly by health care service provider in the management of their care.
2. Training curriculum for the Medical and Paramedical health care service providers.

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## APPENDICES

### Appendix 1:Optimal Ageing

"Optimal aging," implies that no matter what state of health the person is in, one may still seek to optimize one's capabilities or satisfaction with life. Optimal aging goes beyond good health and longevity. It deals with capacity to function across many domains—physical, functional, cognitive, emotional, social, and spiritual. This capacity is rooted in the concept of adaptation. The many changes of life itself, and the frequently accompanying vicissitudes of illness, functional loss, changes in the family, economic struggles, and other stressors, offer opportunities to adjust and adapt. Optimal aging accounts for the tremendous inter-individual variability and intra-individual plasticity. The adaptation that older adults make to the many challenges of aging involves selection, optimization, and compensation. A person may select certain activities that are most satisfying and meaningful. Behaviors can be modified to optimize performance in these activities. When capacity is lost or reduced, an older person can compensate by choosing different methods of accomplishing the task, or altogether different activities. Optimal aging should be seen from a biopsychosocial viewpoint. It doesn't require the absence of disease or disability. These problems can be viewed as opportunities for growth and development of new capabilities. It utilizes a systems perspective, where lower levels of the system affect higher, and vice-versa. A particularly useful model for explaining the interrelationships of various aspects of the biopsychosocial approach to optimal aging is the health field model (also called the determinants of health model) where all aspects of the disease-health continuum are addressed, including the patient's genetic endowment and behavior, the social environment and support system, the psychological resources and stressors, the physical environment, and the healthcare system. Management of many, if not all, health problems in older persons is significantly affected by a host of other factors. The social support system is critical in rehabilitation outcomes; the physical environment may determine location of the patient; the contributions of genetic endowment are unfolding to be understood. Each of the components interacts with the others in different ways at different times in one's life. The complexity of this dynamic process is great, but it is likely that the interaction of the various components is at the root of optimal aging (Smith 2007, 2008

**Appendix 2 :Extract of MCH Handbook**

## What is MCH Booklet? ; Characteristics

- **Home-based record**
  cf. Facility-based record
- **Covering standard Maternal, Neonatal, and Child health service in the country**
  cf. Specific service monitoring record
- **One book for child from its inception**
  cf. Women's Health Handbook
- **Basic health care information covering Maternal, Neonatal, and Child health including FP in postnatal.**
- **It functions mainly within Health Sector.**
- **Options: Birth Registration form, Child development section.**

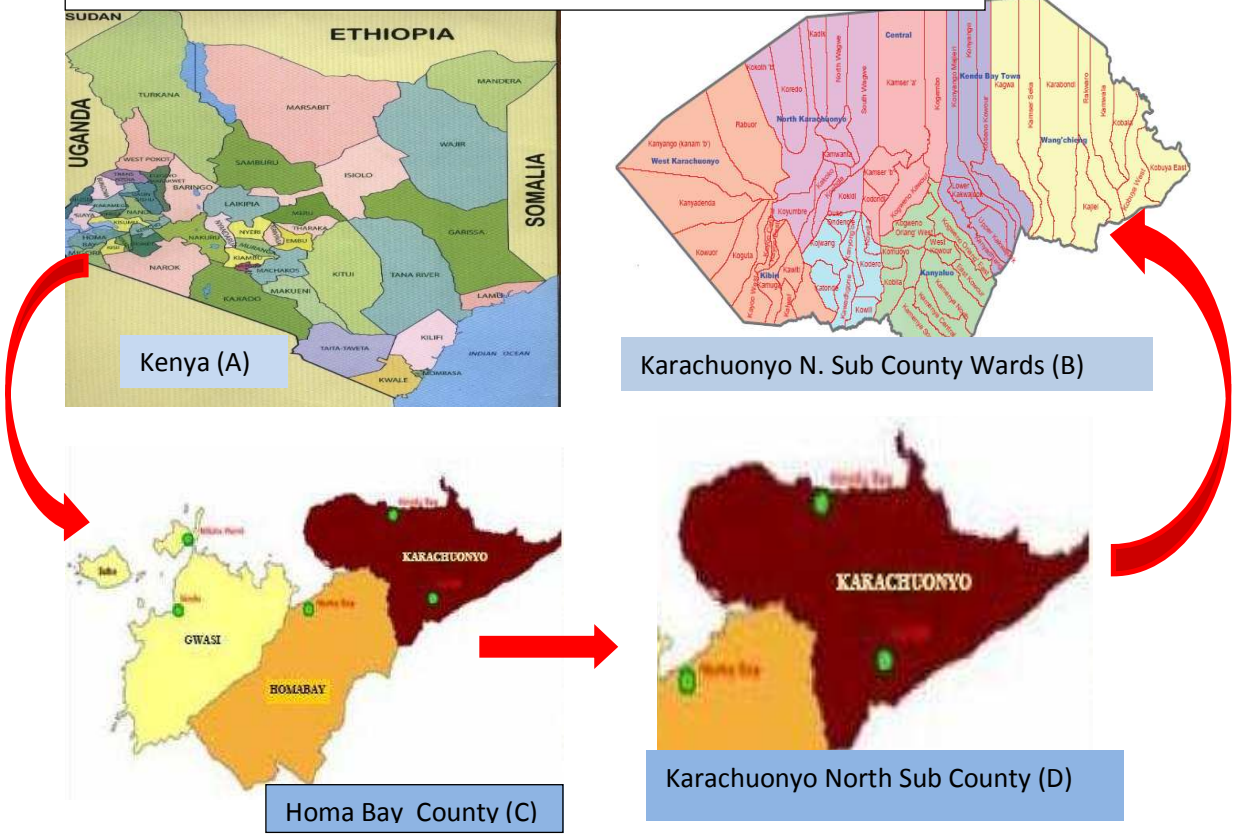
## What is MCH Booklet? ; Objectives

- Several objectives are identified as benefit of MCH handbook (What for?)
  - Monitoring tool
  - Health Education tool
  - Communication tool
  - Referral tool
  - Service Integration tool
  - Other possible functions


**Appendix 3:Early Childhood Mortality rate**

| Years preceding survey | Approximate calendar years | Neonatal mortality | Postneonatal mortality | Infant mortality | Child mortality | Under-5 mortality |
|---|---|---|---|---|---|---|
| 0-4 | 2010-2014 | 22 | 16 | 39 | 14 | 52 |
| 5-9 | 2005-2009 | 24 | 19 | 43 | 18 | 60 |
| 10-14 | 2000-2004 | 26 | 26 | 51 | 30 | 80 |

## Appendix 4:Map of Kenya, Homa Bay and Rachuonyo North Sub-County



**Appendix 5:Staffing Patern of Rachuonyo North Sub County Health Facilities.**

| Health Facility | MO | C.O | Pharm Tec | Nurses | Social workers | Nutr. | Physio/ therapist |
|---|---|---|---|---|---|---|---|
| **A: West Rachuonyo North Ward** | | | | | | | |
| 1. Okiki Amayo HC | 0 | 1 | | 4 | 0 | 0 | 0 |
| 2. Homalime HC | 0 | 2 | | 3 | 0 | 0 | 0 |
| 3. Homa Hills HC (Community) | 0 | 2 | | 2 | 0 | 0 | 0 |
| 4. Kodula dispensary | 0 | 0 | | 2 | 0 | 0 | 0 |
| 5. Ndere dispensary | 0 | 0 | | 2 | 0 | 0 | 0 |
| **B: North Rachuonyo North Ward** | | | | | | | |
| 6. Wagwe Health Centre | 0 | 3 | | 5 | 1 | 0 | 0 |
| 7. Got Oyaro dispensary | 0 | 0 | | 2 | 0 | 0 | 0 |
| 8. Nyaoga dispensary (Community) | 0 | 0 | | 2 | 0 | 0 | 0 |
| 9. Pala dispensary | 0 | | | 1 | | | |
| **C: Central Rachuonyo North Ward** | | | | | | | |
| 10. Kangir dispensary | 0 | 0 | | 2 | 0 | 0 | 0 |
| 11. Ngeta dispensary | 0 | 0 | | 2 | 0 | 0 | 0 |
| 12. Kogweno Oriang dispensary | 0 | 0 | | 2 | 0 | 0 | 0 |
| 13. Oriang SDA dispensary FBO | 0 | 0 | | 2 | 0 | 0 | 0 |
| 14. Simbi dispensary | 0 | 1 | | 2 | 0 | 0 | 0 |
| **D: Kendu Bay Town Ward** | | | | | | | |
| 15. Rachuonyo S.C. Hospital | 1 | 7 | | 23 | 0 | 3 | 1 |
| 16. Kendu Adventist | 3 | 5 | | 34 | 7 | 0 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| hospital FBO | | | | | | | |
| 17. | Kosele dispensary | 0 | 0 | 2 | 0 | 0 | 0 |
| 18. | Nyangajo dispensary | 0 | 0 | 2 | 0 | 0 | 0 |
| 19. | Magao dispensary | 0 | 0 | 1 | 0 | 0 | 0 |
| **E: Wang Chieng' Ward** | | | | | | | |
| 20. | Miriu Health center | 0 | 1 | 4 | 0 | 1 | 0 |
| 21. | Mawego HC FBO | 0 | 0 | 2 | 0 | 0 | 0 |
| 22. | Kobuya dispensary | 0 | 0 | 2 | 0 | 0 | 0 |
| 23. | Kajieyi dispensary | 0 | 0 | 2 | 0 | 0 | 0 |
| 24. | Lela dispensary | 0 | 0 | 2 | 0 | 0 | 0 |
| 25. | Chwowe dispensary | 0 | 1 | 2 | 0 | 0 | 0 |
| 26. | Chuth Ber | 0 | 0 | 2 | 0 | 0 | 0 |
| 27. | Rakwaro dispensary | 0 | 0 | 1 | 0 | 0 | 0 |
| **F: Kanyaluo Ward** | | | | | | | |
| 28. | Adiedo Dispensary | 0 | 2 | 3 | 0 | 0 | 0 |
| 29. | Omboga dispensary | 0 | 1 | 2 | 1 | 1 | 0 |
| 30. | Olando Dispensary | 0 | 1 | 2 | 1 | 1 | 0 |
| 31. | Wikondiek dispensary | 0 | 0 | 2 | 0 | 0 | 0 |
| **G: Kibiri Ward** | | | | | | | |
| 32. | Kandiege Health care center | 0 | 4 | 8 | 0 | 1 | 0 |
| 33. | Raruowa HC FBO | 0 | 0 | 2 | 0 | 0 | 0 |
| 34. | Oriwo dispensary | 0 | 0 | 1 | 0 | 0 | 0 |
| **Total** | | **5** | **31** | **121** | **13** | **8** | **1** |
| **Key Informants** | | **2** | **10** | **23** | **7** | **2** | **1** |
| | | 2 | 10 | 18 | 3 | 2 | |

Source DPHN Office Rachuonyo.

**Appendix 6 :Distribution of Questionnaires Per Locations.**

| **Ward** | **Number of Questionnai** | **Chiefs** | **Locations** | | | |
|---|---|---|---|---|---|---|
| | | | **1** | **2** | **3** | **4** |
| West Karachuonyo | 62 | 4 | Kanam A 16(2x8) | Kanam B 16(2x8) | Kakdhimu East 16(2x8) | Kakdhimu West 14 (2x7) |
| North Karachuonyo | 56 | 4 | Kanjira 14(2x7) | Kobiero 14(2x7) | Kokoth Kataa 14(2x7) | Kokoth Kateng 14(2x7) |
| Central Karachuonyo | 32 | 3 | Kamser Nyakongo 10(2x5) | Central Karachuonyo 10(2x5) | Kogweno Oriang 12(2x6) | |
| Kendu Bay town | 49 | 2 | North Karachuonyo 25(5x5) | North E. Karachuonyo 24(3x8) | | |
| Wangchieng | 79 | 4 | Kobuya 20(4x5) | Rambira 20(4x5) | Karabondi 20(4x 5) | Wangchieng 19(3x 6)+1 |
| Kanyaluo | 61 | 3 | South Kanyaluo 20 (4x5) | West Kanyaluo 20 (4x5) | East Kanyaluo 21(4x5)+1 | |
| Kibiri | 46 | 3 | Koyugi 15(3x5) | Wadhgonenyongo 15 (3x5) | Kanyipir 16(3x5)+1 | |
| **Total** | **385** | **23** | | | | |

**Appendix 7:Questionnaire to Main Respondents**

INVESTIGATING RESPONSIVENESS OF HEALTH CARE SYSTEM ON ELDERLY OPTIMAL AGING IN RACHUONYO NORTH SUB-COUNTY OF HOMA BAY COUNTY, KENYA.

Introduction and Consent

Greetings,

Thank you for availing time for this interview. My name is John Odero, Tel. 0721244792. I am conducting an interview to have an in-depth understanding on how the health system addresses the health care needs of the elderly (people aged 60 years and above) in terms of Dignity, Confidentiality, Autonomy, Prompt attention, Basic care amenities, Access to social Support and choice of health care provider together with System's preparedness to care for this group of persons. **This is part of an academic process** and the information obtained will be used to improve care to assist the elderly to experience optimal ageing. Your experiences and opinions concerning these issues are very important to realize these objectives. All your responses will be anonymous and be kept confidential for this study only. You may decline to participate in the discussion and no penalty will be attached to that.

Do you agree to participate? Yes ……No …….…….

Signature of respondent ……. Health facility Level …….

| **Biographic Data**<br>Indicate by putting a tick in the box for the choice that best describe your experience | | | | | |
|---|---|---|---|---|---|
| | Scores | | | | |
| **Variables** | 1 | 2 | 3 | 4 | 5 |
| 1). Age in years: | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 1). 60 to 69. 2). 70 to 79. 3). 80 to 89. 4). 90 to 100. 5) Over 100 | | | | | |
| 2). Sex 1) Male 2). Female | | | | | |
| 3). Marital Status:<br>1) Married. 2) Widowed. 3). Widower. 4) Separated, 5). Divorced | | | | | |
| 4). Education level:<br>1)Primary2) Secondary3) Tertiary college. 4) University 5). None | | | | | |
| 5). Current engagement: 1). Farming, 2). Business, 3). Teaching, 4). Fishing, Any other | | | | | |
| 6). Religious Affiliation: 1). Christian, 2). Moslem, 3). Buddhism, 4) Hindu, 5). None | | | | | |
| 7). When did you last go the health facility: 1). Last 3 months, 2). Last 6 months, 3). Last 1 yr. 4). Last 11/2 yrs. 5). < 2yr | | | | | |

**Optimal Aging**

The capacity to adapt to changes in life and function across many domains: physical, functional, cognitive, emotional, social, and spiritual etc.Based on your experience with activities of daily living, rate on a scale of 1 to 5, the extent to which the following statements apply to your experience in life.

1=Strongly disagree 2= Disagree 3= Undecided 4= Agree 5= Strongly agree

| | Scores | | | | |
|---|---|---|---|---|---|
| **Activities** | 1 | 2 | 3 | 4 | 5 |
| 8). I do not have any prolonged health conditions due to my old age status | | | | | |
| 9). I am always in good health and do not suffer disability from age-related chronic non-communicable disease. | | | | | |
| 10). Despite my age I am still able to do most of my things alone and take charge of my family decisions. | | | | | |
| 11). I am fully dependent on the support of young persons in my family to do my things. | | | | | |
| 12). I often have difficulty remembering recent conversations, | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| names or events. | | | | | |
| 13). I am able to take care of myself because I do my basic care needs such as washing, dressing etc. | | | | | |
| 14). I hardly use walking stick or any physical support garget. | | | | | |
| 15). I have limitation in engaging in instrumental activities of daily livingsuch as shopping, lifting and carrying, riding bicycle, driving. | | | | | |
| 16). I fully take in social activities such as church, community meetings, funerals, chiefs' meetings etc. | | | | | |
| 17). What problem made you go to health facility? | | | | | |
| **Objective 1: Observance of Respect for Persons** ***(****Dignity, Confidentiality, Autonomy)* | | | | | |
| **1 Dignity**<br><br>Health care service is a need for optimal aging. Based on your experience with activities of health facilities, rate on a scale of 1 to 5 the extent to which the following statements apply to your experience with health care provider in upholding your dignity.<br>1=Strongly disagree 2= Disagree 3= Undecided 4= Agree 5= Strongly agree | | | | | |
| | Score | | | | |
| **Activities** | 1 | 2 | 3 | 4 | 5 |
| 18). I often received welcoming reception from health care service provider | | | | | |
| 19). What comment do you have about the reception and self -introduction? | | | | | |
| 20). I always receive warm and friendly greetings receive from health care service provider | | | | | |
| 21). What comment do you have about the greetings? | | | | | |
| 22). I always receive positive body language from health care | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| service provider. | | | | | |
| 23). I am often recognized and appreciated by health care service provider for seeking health care services. | | | | | |
| 24). What comment do you have about the appreciation and recognition by health care service provider? | | | | | |
| 25). Health care service provider often listens and pays attention to me. | | | | | |
| 26). What comment do you have about listening and paying attention to the elderly by the health care service provider? | | | | | |
| 27). Health care service provider often respond positively to my enquiries. | | | | | |
| 28). Health care service provider often give me prioritized opportunity for care over other cohorts where necessary | | | | | |
| 29). What comment do you have about giving prioritized care to the elderly? | | | | | |
| 30). Verbal comments by health care service provider to or about us the elderly is always encouraging | | | | | |
| 31). What comment do you have about verbal comments by the health care service provider on or about the elderly? | | | | | |
| 32). Health care service provider are always committed to serve us the elderly | | | | | |
| 33). What comment do you have about the commitment of the health care service provider to serve | | | | | |

| |
|---|
| the elderly? |

2 **Confidentiality**

Information on sickness is sensitive to most patients. In a scale of 1 to 5 rate the extent to which the following statements apply in terms of your experience with the health care service to the elderly.
1=Strongly disagree 2= Disagree 3= Undecided 4= Agree 5= Strongly agree

| | Score | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| 34). The health care staff keep the information about my sickness as an elderly in secret | | | | | |
| 35). The information on my sickness the elderly is often shared with relatives without his/her permission | | | | | |
| 36). The information on my sickness as an elderly can be given to none of the relatives without my permission | | | | | |
| 37). The information about our sickness the elderly is often kept in a way that unauthorized person can access it. | | | | | |
| 38). It is often explained clearly and I understand that information about my sickness could sometimes be shared among health care service provider and non-health care service provider without my consent. | | | | | |
| 39). I do not mind if information of my illness is shared with someone else without permission. | | | | | |
| 40). I understand that sharing information without my consent has legal implications | | | | | |
| 41). I often receive information about someone else illness from the health care service provider without that person knowledge | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 42). Procedures to for my condition are often carried out in privacy. | | | | | |
| 43). I understand that health care service provider in a health facility I attended have a right to information about my illness. | | | | | |
| 44). What comment do you have about confidentiality in elderly care? | | | | | |

3 **Autonomy**

When patients take part in deciding on the care to be adopted, they comply well with treatment and subsequently improve faster. Based on your experience in the health care service delivery, rate in a scale of 1 to 5 the extent to which the following statements apply in the involvement of the elderly to make decision about their care.

1=Strongly disagree 2= Disagree 3= Undecided 4= Agree 5= Strongly agree

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 45). Discussion is often held and agreement reached between heath staff I on my care plan. | | | | | |
| 46). My opinion is always respected and or accommodated in managing my conditions | | | | | |
| 47). Health care service provider often ask me about the problem, carry out investigations and prescribe treatment | | | | | |
| 48). I am discharged with clear and adequate information to manage my condition at home | | | | | |
| 49). Since sickness deny a person the power to make decision, involving me in making decision in my care planning is not necessary. | | | | | |
| 50). What is your comment about involvement in decision making about your care. | | | | | |

**Objective 2: Client Orientation (***(prompt attention, amenities of adequate quality, access to social support network and choice of care provider).*

**1. Promptness of attention**

The speed at which the elderly are attended to may have an impact on their health. In a scale of 1 to 5 rate the speed at which following statements apply in terms of your experience with the health care services.

1=Strongly disagree 2= Disagree 3= Undecided 4= Agree 5= Strongly agree

| | **Score** | | | | |
|---|---|---|---|---|---|
| Speed of attention | 1 | 2 | 3 | 4 | 5 |
| 51). Time, I take while waiting to be attended to is acceptably short by expectation. | | | | | |
| 52). The time I take with the health care service provider while receiving service is enough by expectation. | | | | | |
| 53). The time I spend in hospital from admission till discharge is justified as time well spent | | | | | |
| 54). Sometimes I experience unjustified delay to receive services from health care service provider. | | | | | |
| 55). Sometimes I experience unjustified hurried service by health care service provider. | | | | | |
| 56). What is your comment about time taken to be attended to at the health facility | | | | | |

**2 Amenities of adequate quality.**

The comfort of a patient in the health facility is influenced by the supplies that sustain life. In a scale of 1 to 5 indicate the extent to which the comfort of the elderly is assisted by the following factors

1=Strongly disagree 2= Disagree 3= Undecided 4= Agree 1= Strongly agree

| | Scores |
|---|---|

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 57). Water supply is adequate and safe. | | | | | |
| 58). Electricity power supply is rarely disturbed | | | | | |
| 59). Food and eating utensils are adequate for elderly conditions | | | | | |
| 60). Beds and linen are adequate for elderly conditions | | | | | |
| 61). Chairs for visiting relatives are adequate and availed | | | | | |
| 62). Waiting rooms are available and adequate | | | | | |
| 63). Toilet facilities are adequate and accessible. | | | | | |
| 64). Waste disposal facilities are within my reach. | | | | | |
| 65). The hospital environment is homely for me. | | | | | |
| 66). What is your comment about the amenities of the health facility | | | | | |

**3.Access to social support network**

A socially engaging environment may keep the elderly calm and happy and the strains on caregivers reduced. With your experience of community health services, indicate in a scale of 1 to 5 the extent to which the following statements apply

1=Strongly disagree 2= Disagree 3= Undecided 4= Agree5= Strongly agree

| | scores | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| 67). The health care service provider understands well my social support background. | | | | | |
| 68). I always give adequate information about my social support background. | | | | | |
| 69). The social support at home is adequate for me. | | | | | |
| 70). Apart from the nuclear family, the community also offer support to me. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 71). The health facility assists me to join support group. | | | | | |
| 72). What is your view about the community attitude towards the elderly? | | | | | |
| **4 Choice of Provider**<br><br>Patients often have the freedom to make a choice of where to go for treatment and even the health care service provider to consult. As a health care provider, indicate on a scale 1 to 5 the extent to which the following statements apply.<br>1=Strongly disagree 2= Disagree 3= Undecided 4= Agree 5= Strongly agree | | | | | |
| | Scores | | | | |
| | 1 | 2 | 3 | 4 | 5 |
| 73). I am aware of my freedom to choose the health care service provider to treat me | | | | | |
| 74). I am aware but have no option to choose the health care service provider to treat me | | | | | |
| 75). I am not aware and have no option of choosing the health care service provider to treat me | | | | | |
| 76). I do not often choose the health person to treat me | | | | | |
| 77). I often prefer to be served by staff of the same sex | | | | | |
| 78). I often choose the health facility to attend | | | | | |
| 79). What other comments do you have about your choice of care provider | | | | | |
| **Objective 3: Preparedness to Care for the elderly (Staff training; Staff deployment).** | | | | | |
| **1 Staff training and services**<br>Care for the vulnerable elderly need specialized care offered in specific elderly designed units. Based on your experience on health service delivery, rate in a scale of 1 to 5 the extent to which the following statements apply in terms of staff preparedness to care for the elderly. | | | | | |

| 1=Strongly disagree 2= Disagree 3= Undecided 4= Agree 5= Strongly agree | | | | | |
|---|---|---|---|---|---|
| | Scores | | | | |
| | 1 | 2 | 3 | 4 | 5 |
| 80). The non-elderly specific general health departments offer adequate care for the elderly. | | | | | |
| 81). I have no unique requirements as an elderly to deserve special care | | | | | |
| 82). As an elderly, I prefer to be attended to by the youthful staff | | | | | |
| 83). From my experience with service delivery, I think staff training is adequate to care for the elderly | | | | | |
| 84). There is need for elderly specific departments in health facilities | | | | | |
| 85) Programs are in place that prepares health care service provider to care for the elderly | | | | | |
| 86). I am strong despite popular beliefs about the elderly | | | | | |

**2 Staff Deployment**

The comfort of a patient in the health facility is influenced by the supplies that sustain life. In a scale of 1 to 5 indicate the extent to which the comfort of the elderly is assisted by the following factors

| 1=Strongly disagree 2= Disagree 3= Undecided 4= Agree 5= Strongly agree | | | | | |
|---|---|---|---|---|---|
| | Scores | | | | |
| | 1 | 2 | 3 | 4 | 5 |
| 87). There are adequate number of trained staff to care for us the elderly | | | | | |
| 88). When I need health services, a relevantly trained health care service provider is available. | | | | | |
| 89). I often prefer to be served by health care service provider who have long experience in service. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 90). The health care service provider often have positive attitude towards us the elderly. | | | | | |
| 91). Based on the quality of services you receive, what is your view about staff deployment in your care | | | | | |

**Appendix 8:Key Informants Interview Schedule**

**Description Criteria**: Health care service provider working in health facilities in Rachuonyo North Sub County of Homa Bay County

**Inclusion criteria**

Participants must have engaged in the care of the elderly.

**Preliminaries**

Introduction and brief explanation of the purpose of the study

Obtaining consent

Explanation that the information obtained will be kept confidential and used only for the study

Age ---- Work experience in years----------

**Topic One:** Optimal Ageing

Which gender seek health services most

Which are the common complaints of the elderly

What is the frequency of visit to health facility

**Topic Two**

Observance of Respect for Persons ***(****Dignity, Confidentiality, Autonomy)*

To what extent do you think the elderly appreciate the care they receive from this health facility?

How do you feel about the secrecy by which the sickness of the elderly is kept by the health care service provider?

How do you engage the elderly as contributes to their care?

**Topic Three**: Client Orientation*(prompt attention, amenities of adequate quality, access to social support network and choice of care provider).*

How prompt do the health care service provider attend to the elderly as vulnerable population?

How does the health facility play in the elderly social support network?

What is your view in the elderly choosing a preferred health care service provider to serve?

**Topic Four**: **Preparedness to Care for the elderly** ***(****Staff training; Staff deployment).*

In view of vulnerable status of the elderly, how adequate is the training of health care service provider to care for them?

What is your view about the elderly being cared for in a mixed general unit?

What is your view about the attitude of health care service provider towards the elderly?

**Appendix9:Focus Group Discussion Guide**

**Description Criteria**: Persons who have received services in health facilities in Rachuonyo North Sub County of Homa Bay County

**Inclusion criteria**

Participants must have been respondents in the questionnaire survey.

**Number of participants per FGD**: Seven to Ten

**Preliminaries**

Introduction and brief explanation of the purpose of the study

Participants setting of ground rules

Explain that voice recording will be used but the information will be kept confidential and used only for the study

**Topic One:** Observance of Respect for Persons ***(****Dignity, Confidentiality, Autonomy)*

How honorable are you treated when you go to the hospital for treatment?

How do you feel about the secrecy by which your sickness is kept by the health care service provider?

How far do you discuss with health care service provider as a contribution to your care?

**Topic Two**: Client Orientation***((****prompt attention, amenities of adequate quality, access to social support network and choice of care provider).*

How prompt are you attended by health care service provider when you seek health care services

How well did the hospital meet your needs of daily living?

What is the position of your social support network

What is your view in choosing health care service provider to serve you

**Topic Three**: **Preparedness to Care for the elderly *(****Staff training; Staff deployment).*

In view of how the health care service provider handle you, what is your comment about their training

What is your view in being treated in a mixed general unit

What is your view on how the health care service provider regard the elderly

**Appendix 10:Letter to Chiefs**

**28th Nov. 2016**
**From: John Odero Sibuor**
**To the Chief of ……Location**
**Dear Sir/Madam,**
**Greetings**
RE: DATA COLLECTION INTERVIEW IN RACHUONYO NORTH SUB-COUNTY
I am a student at Rongo University pursuing degree in Doctor of Philosophy (PhD) focusing in Health Sociology with emphasis on care for the elderly (people aged 60 years and above). I wish to introduce the data collection exercise that will be conducted in your location as from the month of December 2016. The exercise will take place in Rachuonyo North Sub County of Homa Bay County and is intended to avail data on the experiences of the elderly on the care they receive in the Sub county health facilities.
The interview is strictly an academic entity conducted to fulfill the university requirement for the program. It has no financial gain and no malicious intention.

The research is approved and permitted by the National Commission for Science, Technology and Innovation (NACOSTI) vide letter Ref. No. NACOSTI/P/16/71971/14003; the Presidency Ministry of Interior and Coordination of National Government Ref No ED12/1VOL.II/164; Ministry of Education Science & Technology State department of Education Ref No MOEST/CDE/HBC/ADM/11/VOL.1/167 and the Ministry of Health Homa Bay County.
The purpose of this letter is to inform your office for the necessary assistance in disseminating the same information to the residents.
Thank you for understanding and cooperation in this matter

John Odero Sibuor

Tel. 0721244792.

**Appendix 11: Letter to Health facilities in Rachuonyo Sub County**

**28th Nov. 2016**

**From: John Odero Sibuor**

To the Management of ……..…….……Hospital/Health center/dispensary

Dear Sir/Madam,

Greetings

**RE: DATA COLLECTION INTERVIEW IN RACHUONYO NORTH SUB-COUNTY**

I am a student at Rongo University pursuing degree in Doctor of Philosophy (PhD) focusing in Health Sociology with emphasis on care for the elderly (people aged 60 years and above). I wish to introduce the data collection interview exercise that I will conduct in the health facilities in Rachuonyo North Sub County of Homa Bay County. The exercise will take place in the month of December 2016 and is intended to avail data on the experiences of health care service provider as Key Informants in their work relations with the elderly as their clients for health care.

The interview is strictly an academic entity conducted to fulfill the university requirement for the program. It has no financial gain and no malicious intention.

The research is approved and permitted by the National Commission for Science, Technology and Innovation (NACOSTI) vide letter Ref. No. NACOSTI/P/16/71971/14003; the Presidency Ministry of Interior and Coordination of National Government Ref No ED12/1VOL.II/164; Ministry of Education Science & Technology State department of Education Ref No MOEST/CDE/HBC/ADM/11/VOL.1/167 and the Ministry of Health Homa Bay County.

Your health facility is among those selected for the interview of a few staff (key informants) as per the attached list.

The purpose of this letter is to inform your office for the necessary assistance in disseminating the information to your staff.

Thank you for understanding and cooperation in this matter

John Odero Sibuor

Tel. 0721244792.

**Appendix 12: Research Permit NACOSTI**

**NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION**

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email:dg@nacosti.go.ke
Website: www.nacosti.go.ke
when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:

**NACOSTI/P/16/71971/14003**

**28th October, 2016**

John Odero Sibuor
Rongo University College
P.O. Box 103-40404
**RONGO.**

**RE: RESEARCH AUTHORIZATION**

Following your application for authority to carry out research on ***"An investigation of health systems responsiveness to the care needs of the elderly in Karachuonyo Sub County of Homa Bay County, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Homa Bay County** for the period ending **28th October, 2017.**

You are advised to report to **the County Commissioner and the County Director of Education, Homa Bay County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

**BONIFACE WANYAMA**
**FOR: DIRECTOR-GENERAL/CEO**

Copy to:

The County Commissioner
Homa Bay County.

The County Director of Education
Homa Bay County.

National Commission for Science, Technology and Innovation is ISO 9001:2008 Certified

THIS IS TO CERTIFY THAT:
*MR. JOHN ODERO SIBUOR*
of RONGO UNIVERSITY COLLEGE,
0-40404 RONGO,has been permitted to conduct research in *Homabay County*

on the topic: *AN INVESTIGATION OF HEALTH SYSTEMS RESPONSIVENESS TO THE CARE NEEDS OF THE ELDERLY IN KARACHUONYO SUB-COUNTY OF HOMABAY COUNTY, KENYA.*

for the period ending:
*28th October,2017*

.....
*Applicant's Signature*

Permit No : NACOSTI/P/16/71971/14003
Date Of Issue : 28th October,2016
Fee Recieved :Ksh 2000

.....
*Director General*
*National Commission for Science, Technology & Innovation*

## Appendix 13 : Research Authorization Homa Bay County Ministry of Health

28th Nov. 2016

From: John Odero Sibuor
RONGO UNIVERSITY
P.O. Box 103- 40404
RONGO


To Director Health Services
County Government
HOMA BAY COUNTY.

Dear Sir/Madam

RE: DATA COLLECTION INTERVIEW IN KARACHUONYO SUB-COUNTY

I hereby submit my request to interview health personnel in North Karachuonyo Sub County health facilities on the care services to the elderly (persons aged 60 and above) based on the elements of health systems responsiveness according to the World Health Organization (WHO 2000)

I am a Doctor of Philosophy (PhD) student in Medical Sociology at Rongo University Registration number PSOC/0305/2014

The interview will be conducted strictly as an academic exercise to fulfil the university requirement for the program. It has no financial gain or any malicious intentions. The survey is approved by the National Commission for Science, Technology and Innovation (NACOSTI), the County Commissioner and the County Director of Education- Homa Bay County (documents attached).

The exercise is tentatively intended to take approximately two days in the course of December 2016.

Thanks for understanding and cooperation in this matter

John Odero Sibuor

Tel. 0721244792.

## Appendix 14: Research Authorization Homa Bay County Interior Government

THE PRESIDENCY
MINISTRY OF INTERIOR AND COORDINATION OF NATIONAL GOVERNMENT

Telephone: Homa Bay 22104 or 22105/Fax:22491
E-mail: cc_homabay@yahoo.com
When replying please quote

COUNTY COMMISSIONER
HOMA BAY COUNTY
P. O. BOX 1 – 40300
HOMA BAY

**REF:**ED12/1VOL.II/154

30th November, 2016

Deputy County Commissioner
**Rachuonyo North SUB COUNTY**

**RE: RESEARCH AUTHORIZATION - MR. JOHN ODERO SIBUOR**

The above mentioned person under the auspices of Rongo University has been authorized to carry out a health –related research on ***Health Systems responsiveness to the care needs of the elderly*** in Rachuonyo North Sub-County.

The research which runs for the period ending 28th October, 2017 must observe ethical practices.

J.B ALUODO
For: COUNTY COMMISSIONER
**HOMA BAY COUNTY**

cc.

County Director of Education
**Homabay County**

*Please note our e-mail address: cc_homabay@yahoo.com

**Appendix 15: Research Authorization Homa Bay County Ministry of Education**

# MINISTRY OF EDUCATION SCIENCE & TECHNOLOGY
# STATE DEPARTMENT OF EDUCATION

Telegrams: "SCHOOLING", Homa Bay
Telephone: +254726961531
When replying please quote

*COUNTY DIRECTOR OF EDUCATION OFFICE*
*HOMA BAY COUNTY*
*P.O. BOX 710*
***HOMA BAY.***
**DATE: 1ST NOVEMBER, 2016.**

**REF: MOEST/CDE/HBC/ADM/11/VOL.1/167**

**John Odero Sibuor**
**Rongo University College**
**P.o Box 103-40404**
**RONGO**

**RE: RESEARCH AUTHORIZATION.**

In response to the letter from the National Commission for Science, Technology and Innovation dated 28th September, 2016 giving you authority to carry out the research on ***"An investigation of health systems responsiveness to the care needs of the elderly in Rachuonyo North Sub County of Homa Bay County"*** I hereby give you permission to carry out the research in **Homa Bay County** for the period ending 28th **October, 2017**.

Please submit a copy of your findings both in soft and hard copies to us.

**M. M. NYABUNGA**
**FOR: COUNTY DIRECTOR OF EDUCATION**
**HOMA BAY COUNTY.**

**Appendix 16: Informed Consent Request**

Greetings

This is an invitation to participate in a research study to be conducted by John Odero a PhD student at Rongo University. John hopes to learn about the responsiveness of Kenya health care service delivery to the elderly (person aged 60 years and above) in an attempt to review the existing care service guide used to care for the elderly for optimal ageing.

John hopes that you will contribute to this study which will attempt to influence the separation of services for the elderly from those of general adults, help to nurture and improve the relationship between the care providers and the elderly clients, lead to training and deployment of competent personnel to offer care to the elderly, equip elderly units to address health care concerns holistically, facilitate early identification and subsequent effective management of diseases which translate to optimal aging, enlighten the elderly more on their rights to health care as advocated by the International commission of human rights, inform health care policy in areas of geriatric health, inform health educators and offer guidance on training curriculum for geriatric, lead to the development of culturally relevant model of care, recommend future research in geriatric health care, contribute more knowledge on the care of the elderly.

There is no direct financial compensation provided in return for your participation. If you accept to participate, you are asked to respond to interview questions. The interview will last about one hour and will be audio tapped. Your participation is voluntary and you may withdraw from the study at any time you wish to and that will not affect your relationship with the investigator, your employer or the university.

Any information you give will be treated with confidence and your participation will remain anonymous. There is a possibility that follow up interview may be necessary.

If you have concerns related to your participation in this study or your rights as a research participant, please contact the ethics review committee of Rongo University P.O. Box

103 RONGO. If you have questions about the study itself, contact John Odero on Mobile no 0721244792 or oderojohns@gmail.com.

Your signature indicates that you have read and understood the information given above and that you agree to participate in this study.

Signature……... Date……

**Appendix 17: Focused Group discussions Voice recording clips**

| | Ward | Site | Clip | Participants | |
|---|---|---|---|---|---|
| | | | | Males | Females |
| 1. | *West Rachuonyo North Ward* | *Okiki Amayo health center;* | *20171222105359.3* | 6 | 4 |
| 2. | North Rachuonyo ward (Koredo) | *Lower Kamuga Primary School* | *201711203161048.3* | 6 | 4 |
| 3. | North Rachuonyo Ward (Kanjira) | Oindo Primary school | 20180104112507.3 | 5 | 5 |
| 4. | *Kanyaluo Ward* | *Andhoge chiefs camp* | *01712288105541.3.* | 6 | 4 |
| 5. | *Kibiri Ward* | *Wadhgone Nyongo chiefs camp* | *20171229115832.3.* | 8 | 2 |

**Appendix 18 :Diagnostic Tests**

The assumptions and suitability of the data for the simple correlation, linear and multiple regression analysis were investigated. First, to ensure that the scales of measurement for the data were suitable for multiple regression analysis, the measurements were converted into continuous scale. Other assumptions investigated and ensured include; normality of the data, multi-collinearity, independence, heteroscedasticity and homoscedasticity.

**4.6.1: Normality of the data**

Normality of the data were tested through the use of formal test using Kolmogorov-Smirnov and Shapiro-Wilk tests, as shown in Table 4.15

**Table Tests of Normality**

| Variable | Kolmogorov-Smirnov[a] | | | Shapiro-Wilk | | |
|---|---|---|---|---|---|---|
| | Statistic | df | Sig. | Statistic | df | Sig. |
| Optimal Ageing | .032 | 376 | .076 | .170 | 376 | .120 |
| Observance of Respect for Persons | .076 | 376 | .060 | .029 | 376 | .081 |
| Client Orientation | .025 | 376 | .087 | .383 | 376 | .092 |
| Preparedness to Care for the Elderly | .048 | 376 | .054 | .225 | 376 | .061 |

a. Lilliefors Significance Correction

Table 4.15 shows both Kolmogorov-Smirnov (K-S) and Shapiro-Wilk test results. However, to interpret the normality of the variables Shapiro-Wilk's (W) was used since it is recommended by Garson (2012) for small and medium samples up to $n \leq 2000$. W is comparable to the correlation between a given data and its corresponding normal scores, with W = 1 when their correlation is perfectly normal and W = 0 when there is no correlation at all. This implies that a significantly ($p<.05$) smaller W than 1 means that the normality is not met. Hence, the normality of data is achieved when Shapiro-Wilk (W) >.05. It is evident from Table 4.15 that there was no statistical significant differences (P>.05) noted in any of the variables with their corresponding normal scores, that is, all the variables met the normality condition.

### 4.6.2: Test of Assumptions of Multi-collinearity

The study investigated the assumptions of multi-collinearity; it is unacceptably high level of inter-correlation among the independent variables, in a way that the effects of the independent variables on the dependent variable cannot be separated from each other. This implies that when multi-collinearity exists between variables, relative effects of the determinant variables are exaggerated and therefore unreliable. To test multi-collinearity a correlation matrix was used to check pattern of inter-relationship among the variables in the study, as shown in Table 4.16.

**Table 4.13:Correlation Matrix of the Study's Variables**

| | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| Optimal Ageing (1) | Pearson Correlation | 1 | | | |
| | Sig. (2-tailed) | | | | |
| | N | 376 | | | |
| Observance of Respect for Persons (2) | Pearson Correlation | .742** | 1 | | |
| | Sig. (2-tailed) | .000 | | | |
| | N | 376 | 376 | | |
| Client Orientation (3) | Pearson Correlation | .534** | -.021 | 1 | |
| | Sig. (2-tailed) | .000 | .680 | | |
| | N | 376 | 376 | 376 | |
| Preparedness to Care for the Elderly (4) | Pearson Correlation | .447** | .070 | .021 | 1 |
| | Sig. (2-tailed) | .000 | .175 | .687 | |
| | N | 376 | 376 | 376 | 376 |

**. Correlation is significant at the 0.01 level (2-tailed).

Inter-correlation among the independent variable beyond .08 is a sign of multi-collinearity and should be put to further scrutiny (Gravetter and Wallnau, 2000). Table 4.16 indicates that all the correlation coefficients were less than 0.8 implying that the population data was free of singularity, meaning there was no multi-collinearity. However, Leech, Barrett and Morgan (2005) observe that use of correlation matrix of the variables is not adequate sign of lack multi-collinearity among the variables. Hence, this study further assessed the multi-collinearity issues by examining Tolerance and the

Variance Inflation Factor (VIF) which are two collinearity diagnostic factors. Table 4.17 shows the SPSS output indicating tolerance and Variance Inflation Factors.

**Table 4.14: Tolerance and Variance Inflation Factor (VIF) Statistics**

| Model | | Collinearity Statistics | |
|---|---|---|---|
| | | Tolerance | VIF |
| 1 | Observance of Respect for Persons | .995 | 1.005 |
| | Client Orientation | .999 | 1.001 |
| | Preparedness to Care for the Elderly | .995 | 1.005 |

a. Dependent Variable: Optimal Ageing

Tolerance is the percentage of variance in the predictor that cannot be accounted for by the other predictors. The variable's Tolerance is $1-R^2$, while VIF is its reciprocal. Hence, very small values imply that a predictor is redundant. Tolerance values that are less than .10 and VIF values greater than 10 may merit further examination (Leech, Barrett and Morgan, 2005). A small tolerance value suggests that the variable under consideration is almost a perfect linear combination of the others independent variables already in the equation and that it should not be added to the regression equation. From Table 4.17, it is evident that collinearity conditions were met, given that each of the variables had adequate tolerance (tolerance value > .10) and Variance Inflation Factor (VIF <10); indicating that there was no violation of multi-collinearity assumptions which is a requirement for multiple regression analysis.

**4.6.3:** Test of Independence of Observations

Table 4.18 shows the Durbin Watson test used to check if the assumption of regression that the observations were independent was met.

**Table 4.15: Test of Independence: Model Summary[b]**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Durbin-Watson |
|---|---|---|---|---|---|
| 1 | .750[a] | .562 | .558 | .13906 | 2.202 |

a. Predictors: (Constant), Observance of respect for persons, Client Orientation, Preparedness to Care for the Elderly

b. Dependent Variable: Optimal Ageing

Durbin-Watson is appropriate measure of independence assumptions for multiple regression analysis. Gravetter and Wallnau (2000) suggest that if there is no autocorrelation, the Durbin-Watson statistic should be between 1.5 and 2.5. Table 4.18 shows that the Durbin-Watson statistic was 2.202 which is between 1.5 and 2.5, implies that the data was not auto-correlated, meaning assumption of independence was not violated.

**4.6.4:** Homoscedasticity and Heteroscedasticity

Homoscedasticity is the assumption of ordinary least squares regression that is, the variances of the residuals are homogeneous across levels of the predicted values. It describes a situation in which the error term is the same across all values of the independent variables. A graphical method was used to show this by fitting residuals versus fitted (predicted) values. Gravetter and Wallnau (2000) assert that if the model is well-fitted, there should be no pattern to the residuals plotted against the fitted values. If the variance of the residuals is non-constant then the residual variance is said to be heteroscedastic. Figure 4.3 shows a graph of fitted residuals versus (predicted) values.

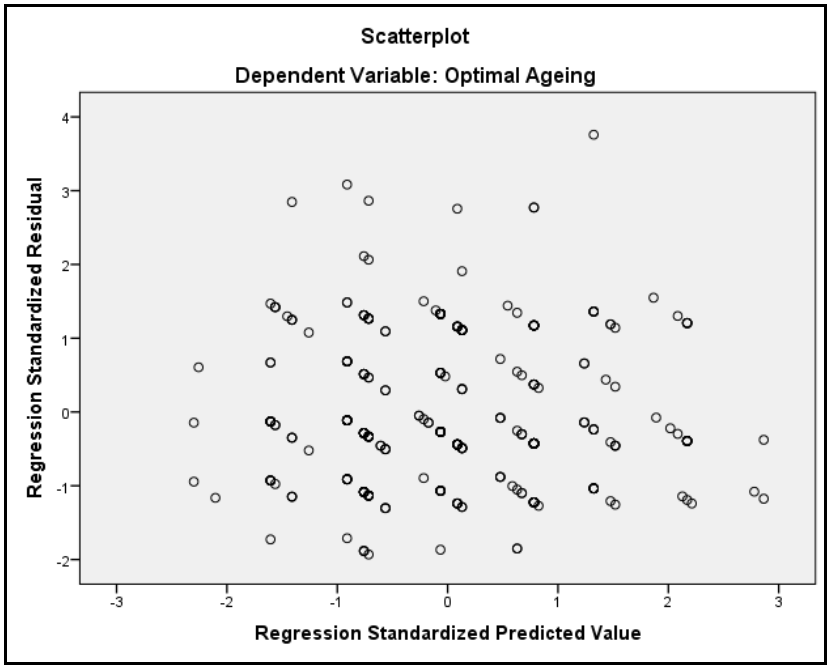



**Figure 4.6:Scatterplot of standardized residuals against standardized predicted values**

Although Figure 4.3 show that the pattern of the data points were getting somehow diagonal orientation pattern, an indication of mild Heteroscedasticity, the data points (residuals) seemly formed a patternless cloud of dots which was a sign of homoscedasticity (Tabachnick & Fidell, 2001). This means that it was assumed that errors were spread out consistently between the variables, indicating that the variance around the regression line was the same for all values of the predictor variables. Hence, the assumption of homoscedasticity, which refers to equal variance of errors across all levels of the independent variables, was not significantly violated.

### 4.6.5: Hypothesis Testing

A parametric test, Pearson Product Moment Correlation Coefficient was computed to test null hypotheses, with scores on aspects of health systems responsiveness as predicator variables and optimal ageing as dependent variable. All the items of each sub-scale which were negatively worded were reversed. The variables were each computed from frequency of responses and converted into continuous scale, where high scale ratings implied high perceived level of the health systems responsiveness and high optimal ageing, and low level of health systems responsiveness implied low optimal aging. The

study used Pearson Moment Correlation analysis because the data were paired observations computed on continuous scale measurement and the relationship between the variables was expected to have linear correlation, which are necessary conditions for the use of Pearson correlation, as recommended by Oso and Onen (2014). In line with the recommendations by Orodho (2012) correlation coefficients values were interpreted as: Values of r between 0.9 and 1.0 as very highly correlated; between 0.7 and 0.8 as highly correlated; between 0.5 and 0.6 as moderately correlated; between 0.3 and 0.4 as a low correlation and correlation coefficients whose magnitude are less than 0.3 as of little if any (linear) correlation.

The prior significant level (p-value) was set at .05, such that if the p-value was less than 0.05, the null hypothesis would be rejected and conclusion reached that a significant difference does exist. If the p-value was larger than 0.05, it would be concluded that a significant difference does not exists.