THE EXPERIENCES OF THE ELDERLY PEOPLE IN ACCESSING HEALTH CARE SERVICES IN MERU SOUTH DISTRICT OF EASTERN PROVINCE.

SATURNINA ITHIRU MUTEGI
C / 50 / P / 8495 / 00

A Research Project Paper submitted in partial fulfillment for the Degree of Masters of Arts (Medical Sociology) in the department of Sociology, University of Nairobi.

This Project Paper is my original work and has not been presented or submitted in any other University

2005

This Research Project Paper has been Submitted for Examination with my approval as University Supervisor.

MR. BENEAH MUTSOTSO

11/2/05

DATE

TABLE OF CONTENTS

TABLE CONTENTS

ACKNOWLEDEGMENTS

The successful completion of this project paper has left me indebted to many well wishers. First and foremost to my two University supervisors; Professor Nzioka and Mr Mutsotso for their patient encouragement, intellectual and professional guidance. Amidst their other academic duties they availed their time to read and correct my many drafts, to you I say thank you very much and may God bless you forever. To Mercy K. Muthui for her immeasurable support. Mercy gave me inspiration to move on even when things were so difficult and I was at the verge of giving up. Mercy God bless you abundantly. I cannot also forget Mr Korongo who also read, corrected and helped in the organization of this work. To my three research assistants Frida Muthoni, Mageria Migwi and Mbae Chomba, your support made it possible to compile this study. To my daughters Stella, Doris and more Jacqueline who patiently typed my work even at times when she was burdened by her school assignments. To you Jacqueline thank you very much God bless you forever. Above all to my husband Arnold Mutegi for his encouragement, support, patience and love.

DEDICATION

This work is dedicated to four people very special in my life. First my husband Arnold Mutegi, and then to my daughters Stella, Doris and Jacqueline.

ABSTRACT

The study was designed to examine the experiences of the elderly people in trying to access health care services, their common health complaints the understanding and perception of their health problems. The study also tried to find out what the elderly people consider as priority needs in the improvement of their health.

The study hypothesized that lack of knowledge about their old age health problems, their prevention and management makes the elderly people suffer without at times seeking health care services. Lack of proper health facilities and services tailored to meet the specific needs of the elderly in the rural areas aggravates their health problems. Issues of high cost of medical services, the long distance to health facilities, uncomfortable mode of transport and the lack of drugs and other facilities to deal with age related problems were key issues in the health of the elderly.

The study used both qualitative and quantitative research methodologies to collect primary data. Both probability and non-probability sampling designs were used. The specific site of study was purposively sampled .A multi-stage sampling technique was used to select the locations in the division. Then four locations were randomly selected, from each of the selected locations; two sub locations were again selected from which a sample for study was obtained using the snowball method.

The study generated a wealth of information, ideas, opinions and suggestions from the elderly people interviewed. The study clearly showed that the elderly people experienced a lot of problems and challenges in as far

as their health and well being was concerned. The ability to address their health needs was greatly limited by issues of access, availability of drugs and other relevant health services, their income levels, issues of family and social support. The chronic problem associated with aging process, their limited knowledge and understanding of health problems, particularly ways of preventing, managing and mitigating them were a major challenge for the elderly people.

Some of the recommendations made after the study includes;

Where problems of isolation, mobility and physical strength make it difficult to reach or access essential health services, the service providers should think of establishing mobile clinics or home care visiting programmes This could be done by sensitising the existing community groups, churches and other community networks that could easily provide care and support to the elderly.

In health facilities, systems that prioritize or protect the most vulnerable should be developed, e g., designing health services that take into account the physical conditions of the elderly, using priority queuing for the elderly people.

Provision of low cost treatment and support with particular reference to problems of poor vision, dental problems and informing the elderly people about and the management of certain chronic and age related ailments afflicting them.

CHAPTER 1

1. INTRODUCTION AND STATEMENT OF THE PROBLEM

1.1 Background to the study

Statistics presented by the U.N Population Division send out warning signals to prepare for eventualities that the growing population of older persons may present. According to the recent U.N estimates, the population of older people in the world is increasing very fast. From a global population of 260 million in 1950, older people had increased to 600 million in 1999 and the number is expected to rise to 2 billion in 2050. Africa, currently estimated to have just 38 million older people, will have about 212 million in 2050 (Ageing in Africa 2000:100). By 1976 Kenya had 587,983 elderly people, by 1989 they had increased to 1.4 million. It is further estimated that by the year 2020 the number of elderly people in Kenya will be over 2 million (Help Age Kenya situational report 1998).

From these figures a "disturbing problem" emerges. As it becomes clear that the third millennium will have many elderly people, questions like the following emerge;

(i) What will this population ageing imply for developing countries such as Kenya where more than 47% of the total population is languishing in absolute poverty? (Sessional Paper No. 3 1999 -2015).

(ii) As the HIV/AIDS pandemic is taking away the youthful people in many families, the elderly people are once again becoming the

breadwinners of the their families. This is happening at a time when the elderly people themselves need care and support on account of their age. The "disturbing question" then became, what problems and challenges do these elderly people face as they become the "new old mothers and fathers".

Help Age International, a leading global organisation working for and with the disadvantaged older people world wide, says that "despite these U N statistics of older people, issues relating to them have not attracted much attention by policy makers, professionals in various fields, etc". There is very little knowledge about ageing issues needs and problems they face. Information about ageing and the issues of the elderly remain quite sparse. Policy makers also lack the necessary information about issues affecting the older people, resulting in their inability to formulate policies that address the specific needs of the older people (Ageing in Africa 2000:100). Then as Babbie (1995) says "We can't solve our social problems until we understand how they come about and persist. Social science research offers a way of examining and understanding the operations of human social affairs. It provides points of view and technical procedures that uncover things that would otherwise escape our awareness". This again aroused interest on older people and particularly issues relating to their health.

The following questions arose:

(i) How easy is it for older people to access health care services?

(ii) What factors aggravate elderly people's health problems?

(iii) What challenges do they face in trying to address their chronic health problems?

(iv) How could some of their old-age related problems be eased?

Another factor in arousing interest on the health of older people was facts presented by the World Health Organisation Report (W.H.O. 1999:1 and 5). The Report says, "Health is vital to maintain the well-being and quality of life in old age and that health is essential if older people are to continue making active contribution to society". W.H.O continues to state that "although a majority of older people enjoy sound health, lead very active and fulfilling lives, quite a proportion enter old age in a state of ill health. As people reach old age, the report says, "they enter a period in their lives when they are at a higher risk of developing chronic diseases which in turn may result in disability". The Report concludes by painting a gloomy scenario by saying that, "Chronic diseases including cardio-vascular diseases, diabetes, cancer, high blood pressure and depression are predicted to be the main contributors to the burden of disease in the developing countries by the year 2020". These diseases are very prevalent in old age, and so the "disturbing problem" of ageing and health emerges once again. It is with such a scenario in mind that there is a need to target the study on older people's health needs, the challenges and constraints they face in accessing health care.

Finally, Help Age International (2002), was persuasively argued that, although ageing has been recognised as a growing socio-economic phenomenon, lack of data and information on the many issues of older persons remained a problem. It was noted that social gerontology (a study of socio-psychological and socio-economic aspects of ageing) is a field that has not aroused a lot of interest and more so in the developing countries. The

consequence of this is that it has hampered the provision of services to the older people. The workshop noted that while issues such as health, poverty, HIV/AIDS, gender conflict and emergencies continue to be addressed in policy forums, the problems that are specific to the elderly people are often obscure or absent in such debates, and where they feature, the older people are grouped with other vulnerable groups. In other words "while ageing is a major structural issue for the 21st Century, it is marginal in development debates". (State of the World's Older People 2002:2). There was need for research on issues affecting the elderly people is therefore long overdue. Some of the areas highlighted as need research included health, employment and Income security, social security, elderly rights, poverty, food and nutrition.

The fundamental problem is that the elderly population is increasing, largely due to medical advancement. Many scholars may argue that population ageing is not an urgent issue in developing countries such as Kenya. However, according to U.N. Population Division "population ageing" is defined as an increase in the elderly share of the total population, and that a population is described as "an aged population" when the percentage of older people (aged, 65 years and above) exceeds 7%". Kenya's percentage of older people is estimated at 10% (Ageing in Africa 2001). Hence Kenya has an ageing population. While this is known, most elderly people in Kenya are struggling with, among others, poor health, absolute poverty, lack of basic needs, loneliness, isolation and depression.

1:2 Problem statement

Recognition of the importance of conducting research on issues of ageing and the implications for elderly people was provided for at the 1997 World Congress of Gerontology. The need for research on the problems and challenges faced by elderly people was emphasised. The W.H.O International Consultative Meeting on Healthy Ageing and Development held in Kobe, Japan, in September, 1999 noted that "there are wide gaps in the knowledge of healthy ageing and challenges of older people in the developing countries" (W.H.O, Kobe Centre, 2000:4). According to W.H.O (1999), the elderly people if given adequate support can enjoy sound health and lead very active and fulfilling lives. In order to achieve this, there is a need for an investigation into challenges affecting the elderly people in the area of health.

Issues on ageing - particularly as pertains to health, poverty, employment and income security - should be properly addressed and understood as they could present opportunities to help adapt rural socio-economic structures in order to promote sustainable development. Good health is a pre-requisite for socio-economic development of a country. With the foregoing then, issues of health for elderly people become very paramount because poor health means the withdrawal of elderly people from productive activities thus rendering them dependent and becoming very vulnerable. Aspects of ageing related to socio-political economic concerns and responsibilities in the provision of safety nets, rights and ethics in addressing old age problems has not been exhaustively studied. There is need to focus attention on the

needs, problems, and issues affecting the elderly people. Though they constitute a small percentage of the total population, we cannot afford to ignore them.

According to W.H.O International Meeting held in Bangkok, Thailand (July 2001) ageing was recognised as a "Public Social Issue". During the discussion on community health care for older persons, it was noted that it was important to appropriately understand the challenges and problems faced by older persons in the realm of health, so as to help develop systems of health care and welfare provisions that help to cope with the demands and challenges of an ageing population. This was more so because, as the meeting noted, traditional systems of care and support for elderly people that depended upon the extended family system have broken down or if in existence can no longer cope.

It was with the foregoing in mind that a study on the experiences of the elderly people in their attempt to access health care was decided upon. In summary the study will be guided by the following questions;

(i) What are the main health complaints of the elderly people, and what do they know about their prevention, treatment and management?

(ii) What are the experiences of the elderly people as they try to access health care services for their complaints?

(iii) What do the elderly people consider as priority needs in the improvement of their health?

1:3 Objectives of the study

The major objective of this research is to generate information on the experiences of the elderly people in accessing health care services in Meru South District of Eastern Province.

The following are the specific objectives of the study

(i) To identify the common health problems of the elderly people and to assess their perception about these problems

(ii) To find out the experiences of the elderly people in rural areas in trying to access health care services.

(iii) To identify what the elderly people consider as priority needs in the improvement of their health.

1:4 Justification of the study

Until recently very little attention has been given to the ageing issues in developing countries and Kenya in particular. There has been concentration of efforts and resources on issues relating to infancy, the youth, and middle age (Kenya-women and Ageing Report 1985). But now the problems of ageing are surging and thus creating a serious need for research in this field.

Help Age International (2000) notes that one difficulty faced when lobbying for older persons is the lack of information and data about ageing issues in developing countries. So to fill this knowledge gap the study aims to generate information about ageing and health. The information will help to identify the missing link between the provision of health care services and the specific needs of the older persons. It is hoped that this will arouse the interest of students, social workers government officials and non-governmental organisations on the plight of older people as a group with special needs that need to be recognised and addressed.

A draft of African Union Policy Framework and Plan of Action on ageing (drawn in a conference held in Nairobi in Dec. 2001) recommends that: -

(i) "Member states undertake to guarantee the delivery of health care services that meet the specific needs of the older people".

(ii) Member states undertake research to establish the nature and extent of the physical, social and mental health needs of older people with due considerations to promotive, preventative, curative and rehabilitative health issues.

(iii) Ensure that research reflects the different health issues affecting older men and women".

Borrowing from the above, therefore, this study will help to:

(i) Focus on aging and the plight of older people as an important social issue that needs to be recognized and addressed.

(ii) It will help to identify the missing link between the provision of health care services and the older people.

(iii) The study will also help to fill in some knowledge gap by generating information on certain issue on aging.

1:5 Scope

This study is about the challenges and problems that the elderly people experience in trying to address their age related health problems. The study focuses not only on the challenges but also tries to find out whether the perception of their illnesses and the attitude of the health care providers influences the health seeking behaviour of the older persons.

1:6 Definition of key terms

(1) **Aging:** The process of growing old, which begins at conception and continues until death.

(2) **Health:** "Health is the optimum capacity for the effective performance of the roles and tasks for which one has been socialised for" Parsons (1972)

(3) **Elderly People:** Persons 65 years and above.

(4) **Population Ageing:** According to U.N. Population ageing is defined as an increase in the elderly people's share of the total population, and that a population is described as an "aged population" when percentage of older people (65 years and above) exceeds 7%

(5) **Accessing:** Ability to reach or obtain something e.g. healthcare services either physically or financially with ease.

(6) **Challenges:** A difficult situation or task that limit's somebody's ability.

(7) **Chronic illnesses:** A state of being ill over a long period of time (lasting for a prolonged period of time).

(8) **Illness:** A state of not being well or in full physical or mental health.

CHAPTER 2

2. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2:0 Literature review

2:1 Who are the elderly people?

In this study the elderly person will be defined as a person who is 65 years and above. The terms elderly people, older people or the aged will be used interchangeably, and the terms mean one and the same thing. To arrive at this definition two indicators of age have been considered. These are the chronological age and the functional or social age.

Chronological age refers to the number of years a person has lived since birth. In cases where birth dates and registration of births is done, this is the best indicator of age, because the actual number of years lived is known. However in the developing countries, quite a number of the elderly people will not know their actual birth dates. Most elderly people will use approximations associated with certain events e.g. disasters/ calamities, national events or just mere guess work to determine their age. At times individuals may be considered aged if they display such observable functional attributes such as grey hair, stooped posture, failing eyesight etc. The use of functional age is popular in rural areas where chronological age is unknown and the elderly are identified by their functional attributes.

The problem with the functional age is that not every person displays these attributes.

The use of the chronological age whether by known birth dates or by approximation using events has been considered more appropriate in defining the elderly people. Most countries have set age 65 years as the age at which an individual enters old age. Kamwengo (2001:6). Davies (1999) traces the use of age 65 years as an age at which an individual enters old age to the 19th century Germany. Age 65 years was first used in Germany in 1873 to define the age at which a person qualified for public social security. Most other countries followed Germany in using age 65 in retirement regulations Kamwengo (2001:7).

In Kenya the use of age 65 years to define the elderly is a bit problematic because most people retire and become pensionable at age 55 years. The United Nations Population Division adopted and popularised age 60 as the entry point for old age.

However for inter country data comparisons age 65 is used to define the elderly persons. In Zambia for example people retire at 55 years but eligibility for free health services and public welfare assistance is age 65 years. Kamwengo (2001:7).

2:2 Interrelationships between ageing and health

According to Kamwengo (2001:5) aging is a term that "is used to refer to a process of growing old starting at conception and continues until death". The

process involves a series of normal universal and progressive changes which occur throughout the life span. These changes are universal because they occur to all people and are a normal part of human development. The process of aging includes changes in the physiological, psychological and sociological functioning in a persons life. Authors Atchelry (1990), Ferraro (1990) and Cavanaugh (1990) believe that aging is not one process but many processes with positive and negative outcomes.

These positive gains according to Kamwengo include:
More wisdom
More experience
More knowledge about tradition
More law abiding behavior
More skills

While the negative outcomes of aging include:
loss of physical and certain mental capacities
loss of opportunity for employment and income in some cases
greater chances of ill health and isolation

The physiological, psychological and sociological changes that come with the process of ageing, have their impact on the health and well-being of the older persons.

(i) Physiological changes with age

Physiologically the aging process reduces the optimal functioning capacity of most body organs thus rendering the older person to be at a greater chances (risk) of ill health. For example, it is said that as one advances in age there is an increase in the peripheral resistance to blood flow at the rate of 1% annually as a result of the hardening of the arteries and veins. The hardening of the arteries interferes with cardiac functioning. Doctors say that there is an decrease in cardiac output (the amount of blood pumped per minute) by 1& each year between 19 and 86 years. As a result there is a reduction in the ability of the heart to increase its output when faced with stress and so the risk of cardiovascular diseases increases with age Kamwengo(2001:38).

During the aging process a number of changes take place in the muscular-skeletal system and these changes affect the functioning of the elderly person. Muscle cells die and are not replaced, the elasticity of the tendons decreases, there is a decline in bone - mass. Bones become brittle, (due to decreased assimilation of calcium and zinc) lighter and porous thus making them very vulnerable to fractures (Gary 1975, Cavanaugh 1990).

The skin is one of the body organs that clearly shows visible age related changes. As people grow older, there is loss of subcutaneous fat, more in men than women, this results in the skin becoming thin, dry and wrinkled. This loss of the subcutaneous fat is the main contributing factor to the reduction of tolerance to cold by the elderly people. As people age there is also a reduction in cell reproduction leading to a decreased healing of skin related problems Kamwengo (2001:42).

In general there are various physiological changes that occur in all the body organs with increase in age. All these changes lead to a decline in the optimal functioning and thus putting the older person at a higher risk of ill health than a younger person.

(ii) **Psychological changes with age**

Authors Atchelry (1990) Kamwengo (2001) Peterson (1983) all agree that there are a number of psychological changes that impact negatively as an individual advances in age. Kamwengo says that these changes vary from individual to individual and occur at different rtes for different individuals. With age vision becomes blurred and dim. This is as a result of the changes in the eyes, the pupil (which controls the amount of light entering the eye) is reduced in size, its diameter narrows and its flexibility diminishes. (Kline el al 1985:65). All these changes affects the quality of vision. Most older people need optical lenses to control this abnormality. An 80 year old person requires three times as much light as an 18 year old (Peterson 1983).

Other changes in the eyes, that have health implications for the elderly include changes in the eye lenses. The lenses are responsible for focusing light to the retina. With advancing age the lenses loose their elasticity (ability to adjust and focus on nearby objects). This leads to a problem described as Presbyopia. These affects the ability of the individuals to read as reflected by old people holding reading materials at an increased distance with advancing age (Kamwengo 2001:50). Development of cataracts in the eyes is another problem very common among the elderly.

The ear also experiences structural changes with age. These include accumulation of wax in the external canal which can result in loss of hearing, reduction in receptor cells, stiffening of the ossicular chain. The structural changes in the ear result in the reduction in the ability to hear, decline in the ability to understand and discriminate speech, decrease in the speed of hearing.

The decline in the ability of the elderly persons to hear clearly, puts them at a higher risk of accidents, reduced interpersonal communication, paranoid tendencies and depression Kamwengo (2001:51)

(iii) **Mental disorders in old age**

Kamwengo (2001;56) says that there are very many mental disorders that occur in old age. Some are temporary and treatable others are rather permanent and require continued support. Mental disorder may affect the elderly persons social functions.

Some of the mental disorders associated with old age include:

depression

dementia a) multi - infarct dementia

b) Alzheimer's disease

Depression among the elderly people is caused by a number of things among them, age related:

changes in neurotransmitters

worsening physical health

isolations from family members, friends and loss of loved ones

loss of personal possessions

loss of job status and group membership

The loss could be real, threatened or imaginary.

Dementia is a mental disorder which involves a progressive deterioration of mental function. Its is characterised by confusion, poor judgement and forgetfulness. According to Cavanaugh 1990, there are two types of dementia namely

Multi - infarct dementia - caused by many repeated strokes in the brain. It occurs most frequently among the elderly people. Its symptoms are dizziness, headaches, reduced physical and mental vigour, impaired intellectual functioning and memory lapses.

Alzheimer's disease is the most common form of dementia. Alzheimer has three stages:

The first stage is marked by:

forgetfulness

disorientation in time and space

Decline in memory and concentration

Carelessness in dressing and grooming

Insomnia (sleep disturbances)

Decreased ability to learn

The second stage of Alzheimer disease is characterised by:

Difficulty to recognise familiar persons

Poor comprehension

Restlessness

Complete disorientation

Communication difficulties

Memory loss

The third stage is marked by:

Blank facial expression

Irritability

Inability to recognise familiar persons

Loss of appetite

Emaciation

Total dependence

Kamwengo (2001:56 -59)

(iv) Sociological changes with age

Growing old is not only an individuals experience but also a social experience, individuals grow old in a society. From a social context individuals growing old interact with other people in the community and with other social institutions. The needs of individuals growing old should be addressed not only by the individual old person alone but by the society and its institutions.

Growing old comes with a lot of social changes, the society expects the elderly people to behave in particular ways commensurate with their age.

The elderly people too have their own expectations for the family, community and government. For the elderly to cope with the social changes, they need adequate coping mechanisms.

As the theory of disengagement explains, there are significant role changes with ageing. The theory argues that as people grow old "there is a mutual withdrawal between the social context and the ageing person, seen in the decreased interaction or activity outside the primary family group". (Marshall 1986:307).

Societal disengagement depresses most elderly people because when they lose their social roles, they in turn end up losing their social confidence. This is because they are sidelined, are no longer seen as useful points of reference and are at times not treated with the dignity they need and deserve.

2:3 Emphasis for research on elderly issues

Chamber (2002:2) says that the renewed emphasis on poverty reduction and the new focus on the inclusion and participation of those who are weaker and more marginalized should direct more attention to older people who are often isolated, left out, voiceless and their capabilities and needs, need to be better understood. Older people need to become a more significant target of development programmes if the international development target of halving the number of people living in absolute poverty by 2015 is to be achieved.

The HIV/AIDS pandemic is further causing more problems and stress to the elderly people (Help Age International – Global Ageing). Since the

epidemic is hitting working age adults hardest, elderly people are losing the very people they depend on for economic support. The problems of the elderly are further exacerbated by their new second parenting roles that they must play to their grandchildren orphaned by HIV/AIDS. This new parenting roles are assumed by the elderly in the absence of supportive economic resources. This burdens the older persons at a time when they themselves require care and support. Apart form this, older people are excluded from HIV/AIDS education campaigns ignoring the fact that older people could be cares of people with HIV/AIDS or could be sexually active themselves and so at risk of infection. HIV/AIDS awareness campaigns tend to be youth oriented using language that is at times not relevant to older people.

According to U N Population Projections (1998:4) by 2000 older people will number 614 million, and over 62% will be in the developing countries. By 2025 the number will double to 1.2 billion and 72% will be in developing countries, an increase of 22.6%. The rapid increase in the number of older persons in the developing countries will have significant implications for both social and economic development. Specific implications will be in areas such as health care and more so in the ability to provide "effective, accessible and affordable health care for all people". In Kenya the vision for the National Health Strategic Plan Ministry of Health (1999 – 2004 : 7) is "to create an enabling environment for the provision of sustainable and quality health care that is acceptable and accessible to all Kenyans". In its mission statement the Plan states its health goals as, to promote and improve the health status of all Kenyans, to make health services more effective.

accessible and affordable to all Kenyans and to expand the coverage and accessibility of health services for the under served rural communities.

According to the National health Sector Strategic Plan, (1999–2004:8) the national health targets are:

(i) To reduce iron-deficiency anemia in pregnant women by 30%.
(ii) Achieve 90% immunization coverage in children from the current 63%.
(iii) Reduce measles morbidity in children by 95%.
(iv) Eliminate Vitamin A deficiency in children under 5 years.
(v) Increase family planning services from the current 60% to 75%.
(vi) Reduce malaria morbidity and mortality rates by 30%.
(vii) Reduce HIV prevalence rate from by 10% and STD prevalence by 50%.
(viii) Reduce under five morbidity and mortality rates attributed to measles, pneumonia, and diarrhoea, malaria and malnutrition from 70% to 40%.

While these goals and the national health targets mentioned above are very noble, the plan misses a point, while it puts a lot of emphasis on pregnant mothers and children, there is no mention of older people as a target group. And there is no mention of any action against the old age related ailments such as diabetes, high blood pressure ad cardio vascular diseases so prevalent among the older people.

W.H.O (1991:1) says "We are all ageing everyday of life. Good health is vital to maintain wellbeing and quality of life in older age and it is essential if older people are to continue making active contributions to society". It is,

therefore, very important for any state to provide adequate, efficient, accessible and affordable health care and health promotion for older people. Good health for all is a prerequisite for socio-economic development of any country. Older people should not be marginalised in the access to economic resources, may they be in housing, health care or participation in socio-economic life. W.H.O (1991:5) says that, "As more people reach "old age", they also enter a period in their lives when they are at a higher risk of developing chronic diseases which in turn may result in disabilities. Chronic diseases including cardio-vascular diseases, diabetes, high blood pressure and cancer are predicted to be the main contributors to the burden of disease in developing countries by the year 2020". These chronic diseases will make 70% of the health care needs in developing and newly industrialised countries. Older people will form a significant part of this workload. These chronic diseases therefore might pose a serious threat to the future. Solvency of healthcare and social protection systems. The health challenges for developing countries are particularly formidable because of the speed of population aging and prevalence of absolute poverty and infectious diseases. With such a scenario, therefore, it is important for both developed and developing countries to learn and understand how to deal with a new set of health challenges that the growing numbers of elderly people will present (A.B Dey, WHO, 1999:7).

Kaiser (1993:1) says that aging issues are becoming a priority even in developing countries. While population aging has been an area of research and policy formulation in developed countries it has received relatively little attention in developing countries. However given the pressures of poverty, urbanisation, the consequent rural urban migration, economic constraints,

changes in disease patterns, weakening of family bonds and the family support structures, effects of HIV/AIDS pandemic and globalisation, developing countries can no longer afford to ignore issues on population ageing although may be not for the present but for the future. Kimmel (1974:465) says, "perhaps the place to begin with is that lonely, sick and isolated old person who reminds us of what may happen to us if nothing changes and is done as we grow old".

Kimmel (1974:441) in analysing the major social problems faced by the "aged person" says that "Social workers, economists, gerontologists, and all who are concerned with issues of social policy, providing services or planning programmes for the aged recognise some of the problems of the aged such as health, income, housing, nutrition, employment, post retirement roles, spiritual needs and safety". On the health challenges of the aged, Kimmel says that "their increased susceptibility to disease, and the enormous increase in medical and hospital expenses puts these basic necessities out of the financial reach of most aged persons". Kimmel says that regardless of the politics involved in the administration and equitable funding of health care services, it is apparent that more is required for total physical and mental health care than financial resources. Health education is of primary importance and the related task of health assessment is crucial to increase the extent of good health among the aged. Kimmel continues to say that health care services such as occupational rehabilitation and health assessment programmes that tend to be emphasised only for younger persons, should also target the aged not only the urban but also suburban and rural areas. On the mental health of the elderly persons Kimmel says that, since the aged persons are likely to suffer a number of economic and social

losses during the latter years, the elderly require "unrestricted access to adequate mental health care reflecting the varied needs of the elderly persons. It means increased availability of knowledge, workers trained to deal with the emotional problems of the aged and it also means the continued development of innovative in patient and community based treatment programmes" (Kimmel 1974:454).

Yuji (2001) says that "although increased life longevity should be celebrated as one of the great achievements of the 20th Century the consequences of population aging i.e. the increase in the proportion of older people in the population has become a global challenge in the 21st Century. This is a challenge that requires collaborative activities in all domains in order to promote healthy aging".

Mhongo Africa Regional Representative for Help Age International, says that issues on ageing and the elderly persons have not attracted the attention of professionals in various fields, policy makers, scholars and care givers. As a result there exists very little knowledge about ageing issues, needs of the older people and the problems they face. In short, information about ageing remains quite sparse.

2:4 Past studies on ageing issues in kenya

Kithinji (1992) in a study of Old Age in Meru provides an anthropological view of the process of ageing among the Meru. Kithinji notes that the kinship-based support networks that provided care and support for the rural elderly have weakened and are crumbling down. He says that the migration

of the young adults out of the rural areas and the entry of women into the labour force have separated potential primary care givers from their elderly parents. This, in turn, has rendered the elderly persons very vulnerable. Kithinji, however, does not expound the challenges that the elderly get exposed to. This study therefore intends to add more information, particularly on ageing and health.

Khasiani (1987), in a study of the economic well being of older persons in Nairobi, Kakamega and Machakos concluded that the extended family and the systems of mutual obligations towards the older persons are disintegrating and families no longer meet the needs of the older persons adequately. Khasiani, like Kithinji, does not address exhaustively the challenges the older people face after family support and care is eroded. This study aims to identify the problems and challenges the older persons face particularly in the realm of health.

Abilla (1980) says that although health facilities have increased rapidly since independence there is differential distribution of facilities between urban and rural areas. Most African states are faced with inadequate facilities to provide basic health services for their dispersed rural population. Then amidst these rising economic constraints and rising levels of poverty the elderly persons find themselves faced by more challenges in their attempt to access the inadequate health facilities. Abilla does not exhaustively analyse these challenges faced by the elderly. This study therefore, will try to discover and understand the challenges facing the elderly in their attempt to access health care services.

Cattel (1994 : 375) has carried out a wide range of studies on ageing among the Samia of Western Kenya, Cattel talks about the difficult situations facing the elderly people as a result of social changes and modernization. She notes that today the issue of family support for older people is coming more and more in the forefront, particularly as African extended families are becoming stressed by geographic separation, economic pressures, western influence, and socio-economic changes in the 20th Century. While Cattel admits that the elderly in Samia are faced by many challenges, these challenges are however not singled out. This study intends therefore to fill that gap by identifying the health problems and challenges that the elderly people in the rural areas face.

According to a study undertaken in seven sites in Kisumu and Homa Bay Districts in Western Kenya, where the Bamako initiative was first launched in 1987, Oranga notes that poverty is widespread among the rural elderly population and is associated with poor health and the unsatisfactory access to health care. The Bamako initiative called on the UNICEF and WHO to help accelerate the implementation of primary health care at district level, giving priority to women and children. Here we note the implementation of a health care programme that leaves out the vulnerable older people. Oranga notes that the elderly are rarely involved in development and service delivery due largely to lack of knowledge and policies focussing on these "spent shells". Oranga continues to note that widowhood and old age are the most important factors that the poorest within the communities associated with poverty. According to the "poorest survey" a widow scored 44.6%, old age 43.6%, being childless 17.6% . Oranga says that ageing as a biological factor reduces ones physical and mental ability, reduces one's capacity to

generate or own resources such as land, capital, food, and is associated with a myriad of peculiar ill health. And because of this, ageing is a crucial stimulant of poverty in a community. For this reason, therefore, research on issues on ageing should be done to expose the plight of our older people, with an aim of helping them cope with their old age.

Koinange (1996:19) notes that we need to appreciate the health needs of older people. Although ageing is a natural process which we must all expect and prepare ourselves for, complaints and illnesses are common in old age. These complaints, such as poor vision, poor hearing, joint pains, and so on, this limits the ability of the older people to live independently. Koinange says that while the health objectives for older people should be not only to increase the longevity of life, but also to make life more fulfilling, rewarding and not complicated by too many health problems.

Odhiambo in his study of "Causes and effects of institutionalisation as a form of old-age care in Kenya", pays particular attention to the pattern of life in the different homes for the aged and the effects of institutional life for the aged. Although Odhiambo mentions that the problem that beset the aged is "'frailty, poor vision or blindness, inability to resist diseases, their physical deterioration that make them susceptible to diseases", he does not exhaustively address the challenges that these people face in accessing health care services before or in the homes for the aged. This study, therefore, will try to bridge the gaps.

Good health is of vital importance to older people, not only because it improves their quality of life, but also because it enables older people to

continue to work and contribute to their communities (Footsteps; 1999). However he contends that older people who need healthcare may find it difficult to obtain it particularly in rural areas. My study, therefore, will try to identify the problems and challenges facing older people in their attempt to access health services.

Ageing does not necessarily imply ill health. Access to decent living conditions and proper health care throughout a person's life can prevent or delay the onset of undesirable health conditions associated with ageing. If older people maintain good health, they will require less caring by the family members and be able to continue with various activities as they age (Pochun 1998). However with the numerous problems the older people face, Khasiani (1987) notes that the elderly people in Kenya have unique problems. They experience a sense of isolation, poverty, rejection, loneliness, destitution and dependency. These problems then compound together to make accessibility to health care services out of reach for many older persons. The study intends to understand these challenges of older persons with a view to suggesting possible measures that could promote active ageing.

2:5 Theoretical framework

Although there are many theories that have been developed to explain the ageing process, there is no single and universal theory that fully explains the ageing process. The study will borrow from various theoretical frameworks that have been put forward by various social scientists in their attempt to understand and explain the processes of ageing, its many implications and

dimensions. The theories that relate to ageing and will be used as points of reference in this study will be:

(a) Disengagement theory of ageing.

(b) The activity theory of ageing.

2:6 Disengagement theory of ageing

The disengagement theory was developed by Cumming and Henry (1961) after various studies done in Kansas City, U.S.A. The theory argues that certain processes of ageing are universal, inevitable, and developmental. Cumming and Henry found out that there was a marked decline in the amount of social interaction, role activity, ego investment and fulfilment of social obligation with age. The theory postulates that as people grow older "there is a mutual withdrawal between the social context and the ageing person, seen in the decreased interaction or activity outside the primary family group" (Marshall 1986: 307).

The process of disengagement for an older person occurs at two levels. First, there is societal disengagement. This refers to the occupational translocation from remunerative service. This mainly happens through retirement on attaining the mandatory age of 55 years in the Kenya Civil Service or 60 and 65 years in many other countries. This societal disengagement is not gradual but forced through mandatory retirement.

When this happens, it means the retired individual is disengaged by society and is released from most social roles. This mandatory retirement, therefore, means that those who would have wanted to continue working are thrust by

society into a crushing slothness. This then has a very psychological impact on the older person, who sees himself as having lost his worthiness and as a result disengages himself from a society that seems to respect and judge individuals by their employment status. This type of disengagement is referred to as individual or personal disengagement. The old person then becomes retrogressive and becomes less active in the same society that he was once an active participant.

Forced disengagement may have negative effects on the older people. It may affect their morale and self esteem leading to depression and loneliness. With the mandatory retirement, older people lose economic status and sometimes end up being dependant. Societal disengagement depresses most older people because when they lose their social roles, they in turn end up by losing their social confidence. This is because older people are no longer seen as useful points of reference. They are sidelined and are sometimes not treated with the dignity they need and deserve.

However, some people do not disengage and remain active until death. That is why the critics of this theory prefer to use the Activity Theory. Critics of the disengagement theory argue that the theory encourages negative aspects of social policy and negative attitudes towards older people. It marginalizes older people by giving support to ageism and gives the message that older people have little to offer, thus exposing them to a lot of challenges in their older lives.

2:7 Activity theory

This theory is supported mainly by those who disagree with the disengagement theory. It was developed by Robert Havighurst and George Maddox (1963). The theory postulates that there is a positive relationship between activity and life satisfaction. It further suggests that successful ageing is highly dependent on maintaining a high level of activity (Lipman and smith 1968). Therefore, the more activity the aged are engaged in the more satisfied they are likely to be with life. But when those desiring to remain active incur loss of activities, they tend to become lonely and experience feelings of isolation. Maddox says that successful ageing depends on the contribution the elderly people continue to make in both their social and the economic realms. The theory suggests that the greater the loss of activity the slower the life satisfaction Kamwengo (2001:18). To support this both Parker (1982) and Busee (1969) believe that the various activities that the elderly people maintain can revitalise them and maintain their socio-economic well being.

2:8 Research hypothesis

Research hypotheses are important because they act as a guide to the kind of data that must be collected to answer the research questions. Hypotheses help in data collection, organisation and analysis.

Research hypothesis for the topic under study were;-

(i) Lack of knowledge about their old-age related health problems, their prevention and management of these problems makes the elderly people suffer without seeking health care services.

(ii) Lack of proper health facilities and services tailored for the elderly people in the rural areas aggravates their health problems.

(iii) The negative attitude of the health workers towards the complaints of the elderly people sometimes discourages them from seeking health care services.

CHAPTER 3

3. RESEARCH METHODOLOGY

3:1 Introduction

A combination of both primary and secondary data was used in order to give a general view of the challenges faced by elderly people in accessing health care services in the area under study.

Secondary Data:

Secondary data was obtained through desk research in order to get information about the problem. This process involved reviewing various research reports and literature about the elderly people. Information relevant to the problem under study was extracted. Reports and literature by bodies such as the World Health Organization (W.H.O.), Help Age International, a global organization working \for and with disadvantaged older people worldwide, Help Age Kenya, a national organization also working for the elderly, and any other available literature touching on the issues of the elderly persons was critically reviewed. These secondary data helped assess the nature and magnitude of the problem under study.

Primary Data:

Primary data was obtained from actual field research where raw data was collected not only from the elderly people themselves, but also from other key informants, eg the health workers in the area, the provincial administration i.e. the D.O, the chiefs, sub-chiefs and the community development workers. These key informants are usually the custodian of raw official data.

3:2 Research site

The study was carried out in Chuka Division of Meru South District of Eastern province of Kenya. Meru South District is one of the thirteen districts of Eastern Province. It was curved out of the former larger Meru district in 1992. It was initially known as Tharaka-Nithi . However in 1997 it was once again divided into two districts namely Meru-South and Tharaka districts. The total area of Meru-South district is 1,092.9Km^2 and is divided administratively in five divisions namely, Chuka, Magumoni, Mwimbi, Muthambi and Ingambangombe. The five divisions have a total of 25 locations and 76 Sub-locations.

Table 1: Administrative units

Division	Area in km^2	No of locations	No of sub-locations
Chuka *	169.6	6	19
Magumoni	64.2	6	14
Muthambi	84.8	3	10
Mwimbi	203.4	5	21
Ijambagombe	210.4	5	12
Total	**732**	**25**	**76**

Source: District statistical office, Chuka 2001.

Meru South District is very large and it was difficult to cover the entire area with the limited resources available, Chuka Division with an area of 169.6K m^2 was purposively selected. The Division was selected for study for a number of reasons. First no study on ageing and the health of the elderly persons has ever been carried out in the area. Secondly the researcher has a good understanding of the geographical, social economic cultural and political characteristics of the area, also the researcher's knowledge of the local language is an added advantage. Another reason for choosing the study site is that Chuka Division is occupied by a single homogeneous sub ethnic group , who almost share similar socio-economic and cultural traits. Chuka division is also one of the most densely populated divisions in the district with a population density of 334 persons per square kilometre.

Table 2: Population structure of the elderly people by age and sex

Age group	1999		2002		2004		2006		2008	
	M	F	M	F	M	F	M	F	M	F
65 – 69	1280	1450	1327	1503	1359	1540	1392	1577	1426	1615
70 –74	1151	1366	1193	1416	1222	1450	1252	1486	1282	1522
75 –79	795	861	824	893	844	914	865	936	886	959
80+	995	1333	1030	1382	1055	1415	1081	1450	1107	1485
Total	**9,231**		**9,568**		**9,799**		**10,039**		**10,282**	

M = Male

F = Female

Source: District statistical office, Chuka 2001

There is a steady increase in the population of the elderly people in the district. From a population of 9,231 elderly people in 1999 to a projected 10,282 in the year 2008, an increase of about 10.2%. The needs and plight of the elderly people therefore are issues that cannot be easily ignored. The price of neglecting our elderly population will undermine efforts to achieve economic and social developments.

Meru South District has a total population of 212, 982, out of which 18,803 are aged 60 years and above (*District Statistical Office, Chuka 2001),* which is 8.8%, higher than the 7% which is taken as an average population of elderly persons over the total population to describe a population as an ageing population (Ageing in Africa 2001). Hence we can conclude that Meru South District has an adequate population of elderly persons to warrant this study in the area.

The Daily Nation of 5 Dec 2001 stated that there was need to restore hope to the elderly. The local newspaper continued to say, " *Nothing could be more ill advised than ignoring the rights and concerns of the over 2 million people in the country aged 55 years and above. More than ever before the elderly people in Kenya face challenges that pose a real threat to their well being. A lot of time and funds have been spent developing and promoting rights and concerns of children and women, it is time we turned some interest on the elderly people. Their needs and issues have been given very little policy considerations"*

3:3 Research design

Three major social science research designs were used in this study. These were exploratory, descriptive and explanatory research designs. These are commonly used in social science research particularly in research where information is obtained through responses that a sample of individuals give to questions and on topics that very little has been done on Russel (1996:265). Descriptive and exploratory research designs help to discover and test variables with respect to their interrelationship. These methods help to elicit both qualitative and quantitative data, which after organisation and

analysis provides room for generalisations of findings to the entire population.

3.4: The research population

The population in this study was made up of men and women aged 65 years and above living in the rural areas of Chuka Division of Meru South District. This is the standard age limit used by the U.N. Population Division to define older people, and was also adopted by the African Union Plan of Action on Ageing in December 2001. Both the target population and the units of observation were men and women. Women were more than men in the sample, this tallies with the fact that women have a longer life expectancy than men.

3.5: Sampling procedure

Sampling is an important aspect of the research process. It deals with the various methods and techniques of how cases for study are to be selected. In most social science research it is at times impossible to observe the entire population, as a result a representative sample of the population is drawn, studied then generalisation and inferences are made about the entire population. This is why the selection of the sample is a very important part of the research process.

In this study both probability and non-probability sampling techniques were used in the selection of the sample of respondents for observation. A multi-stage sampling technique was used. First as stated earlier by the study was

carried out in Chuka Division of Meru South District of Eastern Province. The Division was purposively sampled by the researcher for the reasons earlier stated.

Chuka Division is administratively divided into six locations namely: Kiangondu, Karingani, Mugwe, Muiru, Gitareni and Kithangani. Using the lottery method four locations were randomly selected, two from the upper zone of the division and two from the lower zone. These zones differ ecologically and economically. The upper zone has more rainfall and therefore tea and coffee are the main cash crops, while the lower zone gets less rainfall and most of the people here are subsistence farmers. These four selected locations become the primary sampling units.

In the next stage, from the four locations selected above, a total of eight sub-locations (two from each location), were picked as the second sampling units. All the sub-locations in the four locations were given an equal chance of being selected. The lottery method was employed to select the eight sub-locations i.e. for each of the locations selected, all the names of the sub-locations were written on pieces of paper and at random two sub-locations were picked from each sub location. There were a total of eight sub-locations from which a sample of respondents for study were obtained.

From each of the sub locations selected, purposive sampling was used to identify one or two elderly persons. Then thereafter the snowball method was used to get the other respondents. The researcher and two assistants interviewed ~60 respondents. The respondents were visited in their homesteads and interviewed. Proper rapport with the respondents was

created so as to make the exercise smooth and efficient, proper self-introductions, explaining the purpose of the research was done.

3.6 : Methods of data collection

In this study four methods of data collection were used. These included, interview schedules, direct observation and documentary materials. Three research assistants were recruited to help in data collection.

(i) **Unstructured Interviews:**

This method of data collection was used to gather information from key informants. These key informants included trained health workers, the local administration i.e the chiefs, sub chiefs, sub area representatives and community development workers. The information collected from these people helped to strengthen information collected from the respondents. These key informants are in most cases the custodians of official raw data and are also knowledgeable on various issues affecting the community.

(ii) **Interview Schedules:**

These was the major method of data collection from the respondents. The advantage of this was that it created personal contact with the respondents thus allowing for flexibility, room for further probing and the observation of personal reactions. This method was used because a number of respondents could not understand English and so the need of the researcher or her assistants to explain the questions. The interview schedules consisted of both open and closed ended questions. Questions pertaining to the respondent age, sex, education, religion, illnesses, their causes and the

utilisation and accessibility of health care facilities, challenges faced in trying to address their health problems and the response of the health workers to their complaints were asked.

(iii) **Direct observation:**

During the interview process in the homes of the respondent, the researcher and the assistants also observed certain things around the home, e.g. state of the homestead, economic activities, the physical appearance of the respondent and anything else that helped the researcher to deduce certain facts about the issues under study.

(iv) **Documentary materials:**

For this study particularly, hospital records, from the health facilities in the area under study were particularly useful. These gave information about the number of elderly people using the health care facilities, the types and commonest problems reported by the elderly people etc.

3:7 Research assistants & time frame.

Three research assistants were recruited to help in data collection. They were recruited from the local area under study because of their familiarity with the area and their knowledge of the local language. Training of the research assistants took place two days. The research was carried out for a period of two weeks.

3:8 Data analysis

Various techniques of data analysis were adopted. Data was analysed using percentages After all the raw data had been collected from the field, data cleansing was done to determine the level of significance of the information given. Data was then sorted and categorised. It was categorised into both qualitative and quantitative data. Qualitative data mainly comprised of the respondents views, opinions, attitudes, expectations and any other responses to the open ended questions of the interview schedule. Quantitative data contained information that had some numerical value.

Both descriptive and inferential statistical methods of data analysis and organisation were used.

CHAPTER 4

4.0 DATA PRESENTATION AND ANALYSIS

This chapter presents the analysis of the research findings using descriptive statistics. The field research produced a wealth of information, experiences, ideas, and opinions from the respondents interviewed. Data is presented by use of percentages in form of tables in a bid to describe the experiences, challenges and perceptions of the respondents.

4.1 Demographic Variables of the respondents

In the study a total of 60 respondents aged 65 years and above were interviewed. Of the 60 respondents, 31(52%) were women and 29(48%) were men as depicted in the table 3 below. The research found out that there were more elderly women than men in the area confirming the fact that women have a longer life expectancy than men do. From the figures shown on table 2 on page 38, it emerges out clearly that there is a steady increase in the population of the elderly people in the district. From a population of 9,231 in 1999 to a projected 10,282 in the year 2008 an increase of about 10.2%. These figures therefore showed that the needs and plight of the older people are issues that cannot be easily ignored.

Table 3: Sex of the respondents

Sex	No of respondents	Percentage
Male	29	48
Female	31	52
Total	**60**	**100**

4.1.2 Marital Status

As Table 4 below shows 34 (57%) of the respondents interviewed were married with living spouses, while 18(30 %) were widowed, only (2%) of the respondents reported having never married.

Table 4: Marital Status of the respondents

Marital Status	No of respondents		Percentage	
	Male	Female	Male	Female
Single	3	5	5	8
Married	19	11	31	25
Widowed	7	15	11	20
Total	**29**	**31**	**47**	53
Grand total	**60**		**100**	

4.1.3: Age of the respondents

As table 5 below shows, 19(32%) respondents interviewed were aged 65-70 years, 16(26%) were 71-75 years, while 16(26%) were 76-80 years and 9(15%) were over 80 years.

Table5: Age of the respondents

Age	No of respondents	Percentage
65-70	19	32
71-75	16	26
76-80	16	26
81+	9	15
Total	**60**	**100**

4.1.4: Education attainment of the respondents

Of the 60 respondents interviewed, 38 (63%) reported having had no formal education, 15 (25%) had received primary education and only 7 (11%) reported having had post- primary education. This level of education explained why a majority of the respondents had very little knowledge and understanding of their health problems.

Table 6: Education attainment

Level of education	No of respondents	Percentage
No education	38	63
Primary	15	25
Post primary	7	12
Total	**60**	**100**

4.2.1: Health and wellbeing of the respondents.

Most of the people interviewed cited health as a priority issue. At an individual level, the capacity to earn or participate in family and community life, as well as a sense of wellbeing are all governed by the health status of the person. From the experiences reported by a majority of the respondents interviewed, the study identified that health problems increase with age while the ability to manage these problems and costs associated with them decreases.

The research identified that even where the older people were currently well and reported to be in relative good health, it was common for them to speak of fear and worry of becoming sick, losing their strength and becoming dependent on others. One elderly woman lamented *", I fear getting sick and needing admission in an hospital. I don't know who would pay for me, my husband is dead, all my children live and work far away and they hardly come to see me and I have no money myself."* Out of the 60 respondents interviewed, 16(26%) expressed this fear and anxiety of ever getting sick. While a few of the respondents reported to be in relative good health, more than 48 (80%) reported two or more chronic health problems.

The needs and issues identified by older people in the study reflected that health problems increased with age, while the ability to cope and manage these problems decreased. An old and widowed woman living with her three grandchildren from her single daughter who works away from home and hardly comes home lamented, *"When I was younger I had more energy and worked hard to feed my family. Now I am old and suffer from joint pains and*

cannot walk long distances .My sons look after their own families and cannot afford to buy medicines for me everytime I get sick."

The research identified that older people tended to generalize their ill health rather than name particular conditions specifically. This reflected lack of information and understanding about their health and issues pertaining to their health, it also reflected the fact that some older people tended not to use health services where such understanding could have been obtained. About 43 (72%) of the interviewees said that they did not know the cause of their ill health. Some attributed their ill health to old age, others to poor nutrition, while a few talked of witchcraft and curses. Some of the elderly people talked of the negative attitudes of some health staff who showed them little respect, made them wait for long periods on long queues or dismissed them without treatment or explaining to them what their problems were, this made some old people to resort to self treatment that is, sometimes buying drugs without prescriptions from the local shops or chemists, or using local herbs and other homemade remedies.

One retired nurse in Ndagani sublocation who occasionally talked to the elderly people at the local P.C.E.A church, about their age related health problems e.g. problems of the prostrate gland in men, eye problems, gynaecological problems in women etc lamented , "*Most of our old people suffer and live with problems that could be treated or managed just because they do not know and that nobody has explained to them about them.*" She explained how she had helped two old men from the village get treatment for their prostrate gland, a condition these old men had lived with for years condemning it on their old age.

It was found out that, while older people reported common illnesses such as malaria, diarhoea, typhoid, respiratory diseases such as common colds, coughs and flu, a wide range of age related and chronic degenerative complaints were also reported by a majority of the older people. The most common complaints reported by elderly people included;

Table 7: Health problems commonly reported

Complaints	**No of Respondents**	**Percentage**
Aching joints	25	41
Poor hearing	18	30
Poor vision	16	26
Backache	9	15
High blood pressure	23	38
Diabetes	12	20
Asthma	7	11
Dental problems	11	18
Problems in passing urine.	9	15
Poor mobility (inability to walk long distance	14	23

Most of interviewees seemed to identify the degenerative effects of advancing age as the major cause of their physical infirmity. They too identified the degenerative effect of old age as the biggest problem affecting older people thus resulting in ill-health for the elderly. Most of the informants stated that this degenerative effects of old age reduced the capacity of the older people to engage in activities required for daily survival, such as farming, food preparation, water and firewood collections, food buying and cooking. This then became a critical factor affecting the health and well-being of the elderly. This became worse when the older person was isolated form people who might meet this gap in their lives e.g. family members and supportive neighbors. One old man nostalgically lamented, " *The days when children used to fetch water and firewood for their grandparents are long gone.*

Although to most elderly people certain conditions were not seen as cases of ill-health, the researcher identified that a majority of them experienced a lot of depression, feelings of neglect, isolation and loneliness This was deduced from the way the elderly people talked. Many talked of decline in family support, breakdown in community structures that cared for the old people, the erosion of tradition values and the emergence of a powerful youth culture that had no respect for the old.

4.2.2: Family care and support.

Most respondents reported no or very scanty care and support from their children or relatives. The study found out that family bonds have been weakened thus impacting negatively on the elderly people. Out of the 60 respondents interviewed, 39 (65%) said that they received no food, clothing

or financial support from their family members, 8 (13%) reported receiving some food support, 7 (12%) reported receiving some clothing, while only 6 (10%) confirmed getting some financial support, but they said that the support was so meager that it was not enough to sustain their needs, particularly now that the cost of living has become very high. These findings seem to collaborate very well with what Khasiani (1987) said " the extended family and the systems of mutual obligations towards the older people, are disintegrating and families no longer meet the needs of the older persons adequately." Cattel (1994) notes that, " Today the issue of family support for older people is coming more and more in the forefront, particularly as African extended families are becoming stressed by geographic separation, economic pressures, western influence and socio- economic changes."

Table 8: Type of support received

Type of support	No of respondents	Percentage
Food	8	13
Clothing	7	12
Financial	6	10
No support	39	65
Total	**60**	**100**

4.2.3: Income and employment

Issues of income were of paramount importance to the elderly people. Lack of adequate income seemed to aggravate the deteriorating state of health among the respondents. A majority of them, 46 (77%) reported having an

income of less than Ksh 1000 per month, 8 (13%) said that they had an income of about Ksh 3000 per month, while only 6 (10%) had an income of Ksh 5000. With these income levels and the present high cost of living, most of the interviewees said that they could not afford most things and particularly the rising cost of health services. About 51(82%) of the respondents said that the high cost of medical services, high cost of transport and their inadequate income, discouraged them from seeking the health services they at times needed. Income therefore was found to present a major challenge in as far as addressing their health needs were concerned.. Only 9(15%) of the respondents interviewed reported having some formal employment, 51(85%) had no employment and depended on subsistence farming. Asked about having any pension , 54 (95%) said that they had none, only 3(5%) had some pension but which was very meager. One old man about 80 years old had this to say, *"I was an agricultural extension worker employed during the colonial period, I retired almost twenty years ago, my pension is only ksh 420, what can this afford when the price of everything has gone up so high?"*

Table 9: Income levels

Amount of income (kshs)	**No of respondents**	**Percentage**
Less than 1000	46	77
1001-3000	8	13
3001-5000	6	10
Total	**60**	**100**

In addition older people seemed to be increasingly affected by the bereavement of their partners, age-mates and their own children. This bereavement was noted to affect the physical, emotional and psychological wellbeing of the elderly people. This feeling of loneliness and isolation seemed to go unacknowledged and unsupported by both the family and the community at large.

An elderly man of about 70 years said " *When I was younger, I worked hard to feed and care for my family. Now that I am old and suffer from joint pains, it is difficult to walk and nobody takes care of me, including my own children. I live alone and feel so useless at home. Since my wife died two years ago not many people have visited me, like now you see it is cold and I have no firewood to make a fire to warm myself.*"

4.2.4: Problems faced in accessing healthcare services

Table 10: Problems encountered

Category label	No of count	Percentage of cases	Percentage of responses
Cost of medical services	42	70	33
Accessibility (distance, mode of transport, cost of transport)	39	65	31
Availability of drugs	35	58	12
Lack of trained staff to handle old peoples problems	26	43	11
Very long time taken to get treatment	33	55	5
Long queues	32	53	7

More than 42(70%) elderly people said that the cost of medical services, problems related to travel and the availability of the relevant services at times discouraged them from seeking the health services they needed. These problems included distance to the nearest health facilities, 21(35%) of the respondents reported living over facility. 5Km from the nearest health facility, 17(28%) between 3-5 Km, 12(20%) between 1-2Km, only 10(17%) of the respondents interviewed reported living less than 1Km from the nearest health

Table 11: Distance to the health centre

Distance Nearest Health Centre	**No of respondents**	**Percentage**
Less than 1km	10	17
1 ——— 2km	12	20
3 ——— 5km	17	28
Over 5km	21	35
Total	**60**	**100**

The research identified that the aging process makes the elderly people to experience a lot of problems and challenges particularly in as far as their health was concerned. This finding is in agreement with Heslop, (1999) who wrote, " a wide range of beliefs, assumptions and stereo-types about older people being dependant, unproductive and weak created a climate in which their problems are misunderstood, undervalued or altogether dismissed as inevitable and irremediable effects of the aging process. Complaints that

otherwise would have attracted attention and treatment at an earlier stage are often dismissed."

Transport cost and the uncomfortable mode of transport was another major complaint of the elderly people. Asked how they got to the health facility when they decided to seek healthcare, 35(58%) said they walked, 13(22%) used public transport the remaining 12(20%) used other types of transport eg being carried on bicycles by relatives. Inadequate and some times complete lack of drugs to treat age related and other chronic problems in most cases discouraged the elderly people from seeking healthcare services. Most of the elderly people interviewed complained of the long queues and the long time taken to get treatment, others reported the negative attitudes of some health workers who showed them little or no respect, at times making them wait for long periods only to dismiss them without treatment.

Table 12: Mode of Transport

Mode of transport	**No of respondents**	**Percentage**
Walking	35	58
Public Transport	13	22
Others (bicyles)	12	20
Total	**60**	**100**

4.2.5. Food and housing:

Problems resulting from hunger, lack of food, poor nutrition and housing problems were also reported as key factors affecting the health and wellbeing of the elderly people. More than two thirds of the respondents interviewed identified food and shelter as key issues in making the elderly people very vulnerable. Problems of hunger and difficulties in maintaining a basic diet was sighted by about 37(61%) of the respondents interviewed. It was very surprising to note that, even in an area like Meru South district, an area "assumed" to be relatively secure in food, high levels of malnutrition among the elderly people was very common. One old man had this to say, *"We only get food when there is enough rain, like now you see rain has failed, crops are withering in the shamba, What are we going to eat?. The government will send us no food because they think we have enough."* Poor nutrition among the elderly people resulted from a number of factors as reported by quite a number of the respondents. These factors included inability to prepare food properly, the loneliness of eating alone, inadequate income, lack of the appropriate food and their dental problems. One old man showed us a half eaten plate of "githeri"(boiled maize and beans) and asked us, " *look at my teeth can I chew this?* The loneliness of eating alone was expressed by one elderly and widowed woman about 75 years old who had this to say, *I live alone, after cooking for a large family and eating together, it is no longer fun to cook for only yourself and to eat alone."* This clearly expresses the importance of living with others, and not in isolation and also the importance of the group to the individual as explained by Durkheim.

4.2.7: Care of grandchildren by the elderly

The study found out that the elderly people are still contributing substantially to the survival of families, particularly in the care and support of grandchildren and at times sick adult family members. In cases where their adult children have died, the old people take up this burden of care with no hope of support. The elderly people were doing this at a time when they themselves required care and support. About 27(45%) of the respondents interviewed were caring for between 1-5 grandchildren or for some sick dependants. For this care of grandchildren a few of them said that they at times received some material or financial support, however to a majority of them they had no support. They found this care sometimes very stressful and physically demanding particularly because their strength and mobility were also declining.

Table 13: Number of elderly people looking after grandchildren:

Looking after grandchildren	**Frequency**	**Percentage**
Yes	33	50
No	27	45
Total	**60**	**100**

4.2.8: HIV/AIDS and the elderly

The study addressed the issue of HIV/AIDS as a problem facing the elderly people. Very few, 9(15%) of the respondents interviewed referred to the pandermic by name or portrayed having some knowledge and little information about the disease. About 43(72%) talked of it very vaguely,

8(13 %) had not even heard about the disease. However the way most of the respondents talked of the death of their sons, daughters and grandchildren, strongly suggested a high prevalence of the virus. An old widowed lady about 75 years, pointing at three graves in the homestead sadly said; " In less than two years I have seen my two sons and my daughter in-law die. Look at all these young children I have to look after, getting enough food to feed them is such a problem for me."

The study revealed that HIV/AIDS awareness campaigns appeared not to place a lot of emphasis on the elderly and they were rarely targeted as a group at risk

In the study the role of the elderly people in managing the impact of HIV/AIDS emerged as a major feature, and a role that was usually taken up without any knowledge, resources or support. The trauma of losing their children to the pandemic and the burden of care left to them , affected them not only emotionally but also economically and physically. One elderly woman about 72 years talked of how devastated she was by the death of her three sons, two daughters in law and two grandsons in a span of three years. She had this to say, "*what do you think it feels to bury your children one after the other. It is very painful. I have four grandchildren to look after, and they are all too young to fend for themselves. I do not have enough money to take them to the hospital when they get sick, and with the shortage of food these days, feeding them is a problem.*"

4.2.8 Suggestions of what could be done

Table 14: Priority needs of the elderly.

Category level	Count	Percentage of responses	Percentage of cases
Provision of free or subsidized drugs	34	61.8	26.8
Provision of good food	33	60.0	26.0
Proper medical checkup	19	34.5	15.0
Home visits	12	21.8	9.4
Make hospitals more accessible to the elderly	11	20.0	8.7
Others(shelter, care & support, security, institutional care	14	32.7	14.2
Total	**127**	**230**	**100.0**

When asked what they thought could be done to improve their situation, the question generated a range of general statements, views, and specific suggestions. These views and suggestions included, the provision of free or subsidized healthcare, (61%) of the respondents cited this as a priority concern for the older people. Poor health resulting from poor nutrition and hunger was an issue that the elderly people felt needed to be addressed More than (60%) talked of the provision of food as being as important as the provision of drugs, (34%) of the respondents felt that there was need for

proper medical checkups for the elderly people. For those unable to get to the health facilities, (21%) of elderly people interviewed suggested that there should be home visits by the healthcare providers. (14%) talked of provision of good shelter and institutional care for the elderly people.

CHAPTER 5

5.0 CONCLUSION AND RECOMMENDATIONS

5:1 Conclusion

This study examined the experiences of the elderly people in as far as accessing healthcare is concerned. The study clearly showed that the elderly people experienced a lot of challenges and problems. The ability of the older people to address their health needs was severely limited by issues of access to, availability of the relevant health services, their income levels, issues of family and social support. The chronic problems associated with the aging process, commonly leading to physical incapacity and sometimes immobility were widely reported by a majority of the elderly people interviewed. The study found that the elderly people had very limited knowledge and understanding of their health problems and ways of managing or mitigating them. Lack of adequate income and other resources meant that the elderly people rarely had the means with which to manage their health problems. A majority of the elderly people reported an increasing breakdown of family and social structures that cared and supported the older people, thus leaving many of them isolated, lonely and marginalized within their own communities

The impact of HIV/AIDS and in particular on the role of the elderly people as careers of the orphans of the pandemic and other sick relatives, emerged as a major factor that adversely affected the health of the elderly people. With the death of their adult sons and daughters, older people are left as the sole careers of their orphaned grandchildren. They are not only supposed to

provide food, clothing, and school fees for these grandchildren, but also to take care of their health needs. This burden of care for the elderly people not only drains them physically, economically but also emotionally. There is a missing link between the concern for the HIV/AIDS orphans and the giving of care and support to their primary cares, namely the elderly grandmothers/fathers.

The perception that the elderly people are cared for and supported by their family members and relatives is a thing that was but no longer is.

5.2 Recommendations

Ways of establishing simple age related clinics and group sessions for issues such as joint-pains, hearing problems, diabetes, high blood pressure, stress and trauma, etc as a means of improving self management of these chronic problems by the elderly people should be sought.

Where problems of isolation, mobility and physical strength make it difficult to reach or access essential services, the service providers should think of establishing mobile clinics or home care visiting programmes This could be done by sensitising the existing community groups, churches and other community networks that could easily provide care and support to the elderly.

In health facilities, systems that prioritize or protect the most vulnerable should be developed, e.g., designing health services that take into account the physical conditions of the elderly, using priority queuing for the elderly people.

Provision of low cost treatment and support with particular reference to problems of poor vision, dental problems and informing the elderly people about and the management of certain chronic and age related ailments afflicting them.

On food and nutrition the study found out that poor nutrition contributes to the poor health of the elderly people, especially in times of food shortages. About 34 (56%) of the respondents interviewed mentioned food as being a critical issue in their livelihood, some said that loss of teeth and other dental problems put restrictions on the types of food they could eat, others even said that they lacked resources such as fuel (firewood), water, as result of inability to walk long distances to fetch the same. Ways of helping the elderly out of this predicament should be addressed by the various stakeholders within the community, e.g. by developing links between bodies such as the churches, non-governmental organizations, various community based groups, schools etc.

Establishment of home visiting programmes, community meals for the elderly either in a church, a school or an elderly day care centre or a place where the old people could meet prepare food, eat tog ether and share some social interaction could be organized, to help in the feeling of isolation which was identified as one of the biggest challenges facing the elderly people and a key factor in defining their level of vulnerability.

Organizations working with the elderly people should network and build links with the government, NGO's, donors and the private sector to promote the inclusion of aging issues in their programmes. The elderly should also be

targeted as a group at risk, their role in caring for the victims and orphans of the pandemic be appreciated.

On HIV/AIDS and the elderly people, dissemination of information needs to be enhanced to enable them know how to protect themselves from infection as they provide care to sick relatives and their orphaned grandchildren. Lobbying is needed among policy makers, the private sector, the donor community and other stakeholders so that the impact of HIV/AIDS on the elderly people is recognized and policies developed to include their issues in development programmes.

In summary and as the Daily Nation of December 5 2002 stated , "*Nothing could be more ill advised than ignoring the rights and concerns of the over 2 million people in the country aged 55 years and above. More than ever before the elderly people in Kenya face challenges that pose a real threat to their wellbeing. A lot of time and funds have been spent developing and promoting rights and concerns of children and women, it is time we turned some interest on the elderly people.*"

W.H.O (1999) also says, "*We are all ageing everyday of life . Good health is vital to maintain the wellbeing and quality of life in old age and is essential if older people are to continue making active contributions to society. It is very important for any state to provide adequate, efficient, accessible and affordable health care and health promotion for the older people. Good health for all is a prerequisite for socio-economic development of any country.*"

BIBLIOGRAPHY

Odhiambo, C (1993): Institutionalisation as a Form of Old Age Care in Kenya Unpublished Thesis University of Nairobi.

Okatcha, Kathleen (1999): HIV/AIDS: Recognising Older Peoples' Needs:Journal of Appropriate Technology Vol. 26, June1999:14, London.

Oranga, H.M (1997): Ageing and Poverty in Rural Kenya: A Community Perception – PhD – East African Medical Journal, Vol. 74, No. 10, October 1997.

Babbie, E (1992): The Practice of Social Research, 6th Edition: Belmont, WadsworthPublishing Co.

Binstock (1985): Handbook on Ageing and the Social Sciences. Van Nostrand Runhold Company Inc.

Cattel, Maria G. (1990):Models of Old Age Among the Samia ofKenya:Family

support for the Elderly:Journal of cross-cultural Gerntology No.51990 Kluver Academic Publishers.

Haber Carole (1983): Beyond Sixty Five : The Dilemma of Old Age in America Cambridge University Press

Hall, Prentice Gelfand D.E and Olsen J.K. (1985): Ageing and Old Age:New Perspectives.

Help Age International (2002): Ageing Issues in Africa

HelpAge International Journal Issue No. (14 March 2002): Ageing in Africa

HelpAge International Report – Ageing and Development:A Summary Survey

HelpAge International (2002): State of the World's Older People

Hull, Nie H. C and Jenkins G. (1975): Statistical Package for SocialSciences.;New York, McGraw Hill.

Kamwengo, M.M. (2001): Ageing and the Elderly in Zambia: Perspectives and Issues Sterling International, New Delhi, India

Khasiani, S (1987): The Role of the Family in Meeting the Social and Economic Needs of the Ageing Population in Kenya.;Genus 43:103-118

Kithinji T. (1987): Problems of Ageing and Retirement: PhD Thesis, Kenyatta University.

Kimmel, Doughlas C. (1974): Adulthood and Ageing: An Interdisciplinary Development View.

Koinange, Wilfred (April 1996): Towards Better Health in Kenya:Kenya Litho, Nairobi.

Libor, Stloukal (May 2001): Rural Population Ageing in Poorer Countries: Possible Implications for Rural Development – F.A.O Women and Population Division.

Marcoux, A (1990): Ageing Rural Population in the Developing Countries: Patterns,Causes and Implications, United Nations Internal conference on Ageing.

Peterson W.A and Quadaguo J. (1980): Health and Ageing: Social Bonds in Later Life: Sage Publications Inc.

Tout, Ken (1989): Ageing in Developing Countries, Oxford University Press,

United Nations General Assembly (Dec. 1991): Principles for Older Persons.

W.H.O Magazine, No. 4, July – August 1997: Ageing and Health: Coping with Old Age

W.H.O (1999): Ageing: Exploring the Myths, Geneva,

Wamalwa, J.M. (March 2000): The Welfare of the Elderly in Contemporary Kenya

Unpublished Thesis – Catholic University.