ASSESSMENT OF NATIONAL AGEING POLICY 2003 ON THE PROVISION OF FREE HEALTH SERVICES TO OLDER PEOPLE IN TANZANIA: THE CASE OF BAGAMOYO DISTRICT

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A DISSERTATION SUBMITED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN SOCIAL WORK OF THE OPEN UNIVERSITY OF TANZANIA

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CERTIFICATION

The undersigned certify that he has read and hereby recommend for acceptance of the Open University of Tanzania a dissertation titled *"Assessment of National Ageing a Policy on the Provision of Free Health Services to Older People in Tanzania The case of Bagamoyo District in Coast Region, Tanzania"* in partial fulfillment of the requirements for the degree of Master of Arts in Social Work of the Open University of Tanzania.

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……..

Date

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DECLARATION

I, Philipina Boniphace Kagaruki, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

……

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…….

Date

DEDICATION

This dissertation is dedicated to my lovely mother the late Mrs. Maria Majella Boniphace, May your soul rest in peace. Amen.

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ABSTRACT

This study aimed at assessing National Ageing Policy 2003 on free health services provision to older people. It specifically identified the health services which are freely provided to older people and those which are not freely provided. The study adopted an evaluation research design with a sample size of 60 respondents whereas 30 of them were obtained through purposive sampling technique and 30 were obtained through simple random sampling technique. Interview, questionnaire and observation were used to collect primary data. Documentary review was also used in searching various facts. Indeed both qualitative and quantitative were used. The general objective of the study was to assess the National Ageing Policy 2003 on provision of free health services to older people in Tanzania. On the other hand specific objectives were: to examine the extent at which free health services are provided to older people, to explore the understanding of implementers on National Ageing Policy 2003, to examine economic factors that hinder accessibility to free health services provision among the older people and to assess the bureaucratic processes that affect effective provision of free health services to older people. The study revealed that the objective of providing free health services to older people aged 60 years and above as it was stated in the National ageing policy 2003 is not yet met. Findings show that the common health services which are provided freely are consultation, laboratory test and very rarely required medicine. In this aspect, there are recommendations such as policy dissemination, sufficient fund allocation for policy implementation and training to health services providers concerning health services provision to older people.

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LIST OF ABREVIATIONS AND ACRONYMS

AIDS	Acquired Immune – Deficiency Syndrome
ACHRID	Associated Consultants in Human Resources and Institutional Development
CB-CCT	Community Based Conditional Cash Transfer
CHF	Community Health Fund
EU	European Union
HIV	Human immunodeficiency Virus
HBC	Home Based Care
LHRC	Legal and Human Rights Centre.
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MIPAA	Madrid International Plan of Action on Ageing
MOH:	Ministry of Health
NSPF	National Social Protection Fund
NAP	National Ageing Policy
NMSF	National Mult Sectoral Strategic Framework
OVC	Orphan and Vulnerable Children.
PLHIV	People Living with HIV/AIDS
SOC-PRO	Social Protection
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund Transfer
URT	United Republic of Tanzania
WHO	World Health Organization
WEO	Ward Executive Officer

CHAPTER ONE

1.0 INTRODUCTION TO THE STUDY

1.1 Overview

This chapter attempts to set the research problem by providing necessary background information to the research problem. The chapter highlights issues related to ageing policy as far as free health service provision to older people is concerned. It is organized into seven sections namely the introduction, background to the problem, statement of the problem, main objective, and specific objectives of the study, research questions and significance of the study.

1.2 Background to the Problem

The Tanzania National Ageing Policy 2003 (NAP) states that, the twentieth century has witnessed the increase in the number of older people. According to available statistics, Tanzania with an estimated total population of 33,500,000 has about 1.4 million older people (total per cent of the total population) aged sixty years and above. This figure will increase to 8.3 million (10 percent of the total population) by the year 2050 (URT 2003). These demographic projections do not correspond with the plans and existing programs to address the needs of older people. As a consequence the majority of older people continue to live at risk in the face of object poverty and lacking social protection. Social and economic disintegration process tend to exclude a high number of older people from social participation and expose them to high vulnerable living conditions (Rwegoshora *et al.*, 2003)

Approximately 90% of older people live in rural areas of the country and they are in object poverty and they depend on family support networks. It is recognized that

traditional social security systems are evolving, attenuating and rapidly disappearing due to pressures from urbanization, and rural-urban migration. This kind of modernization process led the older generation into lack of support and social protection from the young generation who immigrate into urban areas to look for jobs and leave the older with their grandchildren who are of less help. As a result the formal relationship in the family and the society in general has changed as older people are no longer playing a vital role in the life of the community, consequently the young people do not show respect to older people and often times despise them. (Rwegoshora *et al.,* 2003, URT 2003).

Moreover, the intergenerational poverty cycle is exacerbated by HIV/AIDS, which has resulted in older people caring for their sick and dying children and their grandchildren. In Tanzania 14% of all children are orphans, of which 53% are cared for by grandparents. Families struggle to meet the cost of schooling with the result that increasing numbers of orphans and vulnerable children (OVCs) are unable to access primary education. (Minja, 2011) However the effect of HIV pandemic are devastating on sexually active age groups but little has been done to explore its effect on older people yet it is the older generation which plays particularly important role of caring for people affected with HIV/AIDS in general and orphaned children in particular. (Rwegoshora *et al.,* 2003) HIV/AIDS is taking away the lives of the majority of young people hence intergenerational poverty cycle as it reduces man power to produce and rise the family economy and hence the entire community.

Diseases are another serious challenge that older people face and need proper interventions of the government and other stakeholders. Most diseases correlate with

age, the risk of disease increases with age as do the consequences and many of these are because of immune system wear down and their capacity to heal slow. As people grow older health is threatened due to this obviously affect work that older people can do and how long they can do it The incidence of heart diseases, diabetes, cancer, arthritis, rheumatism, cataracts, osteoporosis, lumbago and type II diabetes, strokes hernias and dementia etc. increases with age. At the same time, biological resistance decreases with age (EU 2004-2007, Maro, 2010).

The majority of people becomes old with poor health due to poor life styles and poor nutrition during their childhood; women heavy work load and frequent pregnancies. (URT, 2003) Older people are still being denied their right to accessible and appropriate healthcare. Healthcare systems are not being adapted to take into account population ageing. Primary healthcare services are rarely age-friendly. (Help Age International, 2011) The net result is that elderly people experience a higher rate of illness and injury than any other age group, this and other causes of ill health which prevent older people from meeting their basic needs (Maro, 2010).

During the celebration of the International year of elderly people (1999) the government committed itself to put into place the National Ageing Policy. Within the spirit of Madrid International Plan of Action for Ageing 2002 the government of Tanzania has on several occasions adopted number of policies, strategies and frameworks such as Health policy, HIV/AIDS Policy and Strategy, Population food and nutrition, social security, MKUKUTA I&II, National Social Protection Fund (NSPF), National Health Insurance Fund, National Social Protection Framework to

mention but a few which address in various ways issues of older people, of the important document is the National Ageing Policy of 2003 which was specifically the first ever political document on older people in Tanzania, The document is a clear demonstration of government resolve to put ageing issues into development agenda of the nation. We are aware that our older people face a number of problems which include poverty, inadequate health services and lack of social protection, caring for orphaned children due to HIV/AIDS, lack of participation in important decisions affecting national development. After Mauritius it is the second country in Africa to have set such a concrete policy on ageing, (URT, 2003**).**

The life situation and circumstances of older people demand for a National policy to guide the provision of services and their participation in the life of the community therefore, The National Ageing Policy 2003 came into being to address the following:

(i) To recognize older people as important resource in National Development.

(ii) To allocate enough resources with the aim of improving service delivery to older people.

(iii) To involve older people in decision-making in matters that concern them and the nation at large.

(iv) To involve older people in income Generation Activities.

(v) To provide legal protection to older people as special group.

The general objective of the policy is to ensure that older people are recognized, provided with basic services and accorded to opportunity to fully participate in the daily life of the community (URT, 2003). While specific objectives are as follows:

(i) To recognize older people as a resource.

(ii) To create a conducive environment for the provision of basic services to older people.

(iii) To allocate resources for older peoples income generation activities and their welfare.

(iv) To empower families for sustained support to older people.

(v) To initiate and sustain programmes that provides older people with the opportunity to participate in economic development initiatives

(vi) To prepare strategies and programs geared towards elimination of negative attitudes and age discrimination.

(vii) To enact laws that promote and protect the welfare of older people

(viii) To ensure that older people receive basic health services.

(ix) To initiate programs that will provide an opportunity for older people to sustain good customs and traditions for the youth in the society.

As far as this study is concerned the concentration will be focusing on the eighth objective which base on ensuring basic health services to older people. The policy states that in order to improve the health status of the older people, the government in collaboration with various stakeholders will ensure the following:

(i) The cost sharing policy shall be revised to adjust the criteria for determining 60 years as a standard age.

(ii) Health personnel receive special training to handle older people

(iii) There is an established mechanism for making follow up on older people's health.

(iv) There is an established mechanism for awareness creation for older people in HIV/AIDS pandemic and care of its victims.

(v) Older people and the public in general are sensitized/mobilized on old age health related problems.

In addition to NAP other sector related documents which in various ways address issues of older and health in particular include policies and strategies on Health, HIV/AIDS, Population food and nutrition, social security, MKUKUTA I & II, National Social Protection Fund (NSPF), National Health Insurance Fund to mention but a few.

National HIV/AIDS policy and strategy, the first national HIV/AIDS policy was developed in 2001 under the coordination of the Tanzania commission for AIDS (TACAIDS) the primary aim of this policy was to enhance effective coordination of the national response to the scourge. The 2001 policy however lacked the involvement of vulnerable groups such as elderly. As the result another policy was issued in 2010 which revealed that older people had been neglected not only in terms of data on people aged 50 years and above but also on how this group was engaged in national response given the fact that in many communities OVC and PLHIV were cared for by older people .It also noted that the elderly faced discrimination in HIV/AIDS services because of wrong held assumptions about their sexual virility and inadequate information. (URT, 2001; URT, 2010).

According to National Health Policy 2007; The revised national health policy of 2007 attempt to address issues that were not tackled clearly in the previous policy

versions 1990 and 2003 the overall objective of 1990 health policy was to improve health and wellbeing of all Tanzanians, with focus on those most at high risk but older people as a special group did not feature anywhere in the policy. The national Health Policy 2003 aimed at providing directions towards improvement and sustainability of health status of all people but without specifically mentioning older people. The revised policy 2007 has gone further to specifically mentioning older people as one of the special groups to benefit health care services in relation to special groups including the older people the policy has categorically highlighted the following:

To strengthen the reproductive health of men and women, people with disabilities youth and older people, to prepare and oversee laws procedures and guideline on cost sharing in health services including exemption on special groups, to prepare better procedures on how to provide curative health services to special groups which deserves exemption, to provide health services on equitable basis and fairly by considering gender and special needs of groups in the society.

MKUKUTA mainstreams the elderly as one of the cross-cutting issues to be handled in its strategy. The provisions of the MKUKUTA are a response to older people's voiced concerns about income, health, water inheritance identity cards, adult education and abuse. It commits to delivering "adequate social protection and the rights of most vulnerable and needy groups with basic needs and services and the reduction of political and social exclusion" There have been two phases of MKUKUTA. In the first phase (2005-2010) the thrust of the strategy focused on

quality and affordability. The underlying objectives were to develop and enforce a comprehensive policy on vulnerability and social protection particularly onto vulnerable groups including elderly. The strategy intended to ensure that eligible elderly people were able to access free medical treatment in public health facilities with acknowledgement from the relevant community concerned. It strove for a 100% of eligible older people to be provided with free medical care and attended by specialized personnel by 2010. In the same vein MKUKUTA II (2011-2016) provisions Endeavour to provide adequate social protection to the vulnerable and needy groups with interventions focusing on orphans and vulnerable children, people with disabilities, the older people among others. (MKUKUTA I, 2005-2010 and MKUKUTA II 2011-2016).

1.3 Statement of the Problem

To ensure effectiveness, accessibility and free health services provision to older people, Tanzania government has taken measures such as formulation of National Health Policy 1990 as revised in 2002 and updated in 2007, National Ageing Policy 2003, Health Sector Strategic plan III of June 2009-July 2015, National HIV/AIDS Policy and strategy (2001 as updated in 2010) , National Poverty Reduction and Economic Growth Strategy (MKUKUTA I 2005-2010 &MKUKUTA II 2011-2016) Social Security Policy 2003, National Social Protection Framework 2008 updated 2010 and revised in 2011, just to mention a few.

Despite all efforts towards improvement of health status to older people in Tanzania, free health services provision is still not accessible to majority of the older people in the country and the quality of health services provision to the older people generally

has never been effective, although it is now nine years since the National Ageing Policy 2003 came into being. This study attempts to find out why accessibility of the free health services to older people remains ineffective in Tanzania despite all efforts done. In order to achieve the goal, the study examined the following variables, policy understanding, health services provision to older people, economic factors that hindering free health services and role of bureaucratic processes in provision of free health services.

1.4 Objectives

1.4.1 Main Objective

The main objective of the research is to assess the National Ageing Policy 2003 on provision of free health services to older people in Tanzania.

1.4.2 Specific Objectives

(ii) To examine the extent at which free health services are provided to older people.

(iii) To explore the level understanding of implementers on National Ageing Policy 2003?

(iv) To examine economic factors that hinder accessibility to free health services provision among the older people.

(v) To assess the role of bureaucratic processes in provision of free health services to older people.

1.4.3 Research Questions

(i) To what extent free health services are provided to older people?

(ii) To what extent do implementers understand the philosophy of accessibility of free health services provision among older people?

(iii) Are there economic factors that hinder effective National Ageing Policy Implementation particularly on older people free health services accessibility?

(iv) How do the available bureaucratic processes affect/facilitate effective provision of free health services to older people?

1.5 Significance of the Study

The study was helpful to the researcher to meet the criteria for partial fulfillment for the award of Masters Degree in Social Work. The study was important as it was thought to contributing to body of knowledge on participatory approach in free health services to older people. Another significance of the study was to provide useful information to researchers, academicians, development planners, policy makers, social welfare officers, health service providers and society themselves so as to enhance its sustainability. In the consideration of the potentiality of free health services to older people, findings are relevant to the understanding as well as implementing free health services and improve the health status of older people.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter presents the review of related literature that has been summarized from different readings on the topic under investigation. It forms the literature of the study in two major parts: namely theoretical part and empirical part. The theoretical literature focuses on: theory guiding a research, health model, definition Health, policy, Social policy and social workers roles, Health services reforms in Tanzania since after independence**.** The empirical literature review focuses on giving a review of relevant literature on the following sub – section: Accessibility of free health services to older people in Tanzania, The impact of HIVAIDS to older people, Awareness of older people on rights, entitlements and policies, Initiatives that has been taken to ensure accessibility to free health services to older people in Tanzania, knowledge gap analysis and finally conceptual framework.

2.2 Theoretical Literature Review

2.2.1 Social Vulnerability Theory

This study is guided by social vulnerability theory. The concept of vulnerability was introduced in the discourse of natural hazards and disaster by O'Keefe Wetgate and Wister (1976), they insisted that social economic conditions are the causes of disaster and there is a greatest loses of lives of many people especially in developing countries due to their incapacity to cope with the situation. Thus current social vulnerability research is a middle range theory and represents an attempt to understand the social conditions that transform a natural hazard (e.g. flood,

earthquake, mass movements etc.) into a social disaster. The concept emphasizes two central themes: Both the causes and the phenomenon of disasters are defined by social processes and structures. Thus it is not only a geo- or biophysical hazard, but rather the social context that is taken into account to understand “natural” disasters (Hewitt 1983). Although different groups of a society may share a similar exposure to a natural hazard, the hazard has varying consequences for these groups, since they have diverging capacities and abilities to handle the impact of a hazard. (Hewitt, 1983).

On the other hand Blaikie (1994) defined vulnerability that it is the capacity of individuals or social group to respond, which is coping with, recover from or adapt to any external stress placed on their livelihood or well- being. Vulnerability or security of any group is determined by the resources availability and by entitlement of individuals and group to call on these resources. Underlying causes of vulnerability include inadequate distribution of resources.

According to Kelly *et al.* (2000), Assessing vulnerability is important component of any attempt to define the magnitude of the threat and it provides the starting point of determination of effective means of promoting remedial action to limit impacts by supporting coping strategies and facilitating adaptation. A successful assessment of consequences for human well-being clearly requires evaluation of the manner in which society is likely to respond through the deployed of coping strategies and measures which promote recovery and in long term adaptation.

On the part of this study the assessment is made on the provision of free health services to older people as far as the National Ageing Policy 2003 is concerned.

Older people are vulnerable due to their age. As they grow older they lose capacity to engage themselves in income generating activities which result them into object poverty. However, older people become vulnerable to different diseases as their body immunity becomes weak to resist diseases. Their vulnerability need to be assessed in order to define magnitude of the threat so as to promote remedial actions in order to provide coping strategies and facilitate adaptation.

2.2.2 Health

Before focusing on health model health is defined as the key concept at this point**,** The English word "health" comes from the Old English word *hale*, meaning "wholeness, a being whole, sound or well,". Medilexicon's medical dictionary define health as *"The state of the organism when it functions optimally without evidence of disease or abnormality" article* 21 may 2009 Walden university, http.//www. medilexicon.com/medicaldictionary.php).

World Health Organization's 1948(WHO's) definition of "health" *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."* WHO says the main determinants to health are**:** Our economy and society *("The social and economic environment"),* Where we live, what is physically around us *("The physical environment")* What we are and what we do *("The person's individual characteristics and behaviors").*

An article in *The Lancet* states that health is not a *"state of complete physical, mental, and social well-being"*. Neither is it *"merely the absence of disease or infirmity"*. The article says the WHO definitions of health will not do in an era

marked by new understandings of disease at molecular, individual, and societal levels.

Health has been defined by different people with different perspectives but for the purpose of meeting the requirement of this study health will be defined as merely the absence of disease or infirmity. No matter how many definitions people try to come up with regarding health, its assessment is still a subjective one.

2.2.3 Availability, Accessibility, Acceptability and Quality Health Model (AAAQ)

This model is originated in the Declaration of the Alma Ata adopted at the international conference on primary health care on 6-12 September 1978. When Dr. Hellen Potts came out with the model in writing on accountability and the rights to highest attainable standard health (2002), referred to the Alma Ata declaration which declares that health is the basic human right and that promotion and protection of the health of the people is essential to sustainable and economic and social development and to better quality of life and the word peace. It also declares that governments have the responsibility for the health of their people which can be fulfilled only by provision of adequate health and social measures. The model states that, the right to the highest attainable standard of health also contains four inter-related and essential elements namely Availability, Accessibility, Acceptability, and Quality. (Potts, H 2002).

2.2.3.1 Availability

Health facilities, goods and services must be available in sufficient quantity within the country. This includes, for example, hospitals, clinics, trained health workers

essential medicines, preventive public health strategies and health promotion as well as underlying determinants, such as safe drinking water and adequate sanitation facilities. Availability is concerned with the physical presence of health facilities. For example, whether there are a sufficient number of health workers and health facilities in rural areas; whether there is a national public health plan; whether there is a health complaints commissioner or similar; whether sexual and reproductive health services are provided (ibid).

2.2.3.2 Accessibility

Health facilities must be accessible to everyone without discrimination, especially the most vulnerable or marginalized people. They must be physically and economically accessible. For example, while a health centre may be available at the local level, people in wheel chairs may not be able to access the centre because of the lack of wheel chair ramps, or the health workers may not speak the same language as the people attending the health centre. If the centre provides no physical access for people with a disability or no one at the centre speaks the local language, the health centre is not accessible, though it may be available. If the health centre charges user fees and those in need cannot pay the fee, the centre is not economically accessible.

Accessibility also includes the right to seek, receive and impart information on health. This latter component Protection and enforcement of the right to seek, receive and impart information on health is a pre-requisite for accountability. Without publicly available health information, monitoring an essential element of the accountability process will be difficult to undertake (ibid).

2.2.3.3 Acceptability

Health facilities must be respectful of medical ethics, culturally appropriate and gender sensitive. For example, medical treatment must be explained in a manner that is understandable to the person who is to receive the treatment. Health workers will need to be aware of cultural sensitivities in the provision of health care; for example, modes of delivery differ with culture. A gender perspective may need to be incorporated into local health facility budgets to identify gender-based gaps in the budget allocation to programmes of the health facility (ibid).

2.2.3.4 Quality

Health facilities must also be scientifically and medically appropriate and of good quality. For example, the provision of a mammography machine to a health centre may not be scientifically and medically appropriate in a situation where resources (human and technical) are scarce and the main health issue for women is cervical cancer. Further, the underlying determinants of health must be appropriate and of good quality. Thus, for example, health education, in addition to hospitals and medicines, must be of good quality. A further important aspect of the right to health ‘is the *participation* of the population in all health-related decision-making at the community, national and international levels. People are entitled to participate in decision- making and policy formulation relating to their health at local, national and international levels. Steps must be taken to develop mechanisms to enable participation to take place. Importantly, effective participation relies in part upon other rights, such as the right to seek, receive and impart health-related information; the right to express views freely; and the right to basic health education. Full

participation on a non-discriminatory basis also requires special attention to sharing information with, and seeking the views of, women and men, as well as the views of disadvantaged people. Participation is essential to the establishment of effective, accessible and easily understood accountability in the context of the right to the highest attainable Standard of health (ibid).

In relation to the study availability of health centers/hospitals/ dispensaries and trained health workers to serve older people is essential in rural and urban areas so as to enable older people to acquire health services and there should be no discrimination, alder people should be treated with special attention putting into consideration that they have got special needs concerning to their age. Health services are not accessible to majority older people as the result their light to health is deprived so the user free charges to special groups like older people is inevitable and older people have to be informed about their rights stated in different policies, strategies and laws. Medical ethics, cultural appropriate and gender sensitivity. Older people are bounded in norms, values and traditional beliefs, health service providers should be aware of acceptability on services they are about to deriver. Older people should be sensitized before health services are provided to them. Moreover quality of health services provided to older people should be considered, for example drugs given to older people should be in good Oder and not provide them expiry drugs because they are old.

2.1.4 Policy

Management definition on policy: The set of basic principles and associated guidelines, formulated and enforced by the governing body of an organization, to

direct and limit its actions in pursuit of long term goals. (http://www.business dictionary.com/definition/policy.html).

To meet the needs of the study policy will be referred to as set of basic principles and associated guidelines formulated and enforced by the governing body of an organization to direct and limit its actions in pursuit short term and long term plans and goals.

2.2.5 Social Policy

Social policy is defined as the study of social services and the welfare state. Social policy looks at the idea of social welfare and its relationship to politics and the society. It also considers detailed issues on policy and administration of social services including housing, education, income maintenance and policies for health. Social policy can also be defined as policy that deals with social issues. Such issues may involve cultures, discrimination against race and gender and diseases that are stigmatized among many others. **(**http://www.ask.com/question/what-is-the-definition-of-social-policy)

2.2.6 Social Policy and Social Workers Roles

National Ageing Policy 2003 is among the social policies which deal with the disadvantaged group namely older people. Social policy reflects a society's agenda for enhancing the wellbeing of societal members. As such it reflects society members shared values, beliefs and attitudes about how the society should care for its members and how it should achieve this mission. Social policy directs the

formulation of social welfare laws and shapes the of social policy programs. It is defined as principles and course of action that influence the overall quality of life as well as circumstance of individuals in group and their intrasocial relationships. Typically, social policy is identified with governmental or public policies that redress inequality in social institutions, improve the quality of life of people who are disadvantaged and provide assistance to people in need. In addition social policies influence private sector services including nonprofit social services agencies and for profit business as they construct administrative policies to guide their day-to-day procedures and operations (Cunningham, 2009).

Social policy is both a process and a product. As a process social policy consist of sequential steps to be followed in problem solving, and as a product social policy are laws, programs, judicial decisions, and administrative directives, social workers must evaluate both process and the products of social policy in order to enhance its effectiveness. As professionals social workers are involved at all stages of social policy formulation. After a social policy is in place and funds of its programmatic implementation become available. Social workers make decision on how to deliver services they design programs to carry out the policy's goal of reaching a specific population to affect some desired change. They develop administrative policies that clearly define roles and tasks and direct the work of agency personnel. Finally they write policy and procedure manuals to communicate expectations responsibilities and outcome measures (ibid).

Implementing related policy in one social system necessitates administering and implements decision in other system as well. Social workers continuously monitor

legislations and the development of other types of policy as well as evaluate related programs and services in order to assess the policy effectiveness and demonstrate accountability. To analyze a policy they examine how well it reaches the target population, measures to what degree it achieves its goals, evaluate its cost effectiveness and determine whether it produced any negative consequences (ibid).

2.3 Empirical Literature Review

2.3.1 Health Services Reforms in Tanzania Since after Independence

Although many people in the developing world the term "health sector reform" may sound like a new policy or ideological terminology, its process and practice in Tanzania are historical. The 1961-67 period was one which focused on correcting problems created by colonial practice where as the system was very segregate and divided in classes as the first class ware for colonialists, second class for Asians and the last for Africans. However, only Africans who were employed in colonial systems were given a chance to be treated (Maghimbi *et al.*, 1998). The Tanzanian government launched the Arusha Declaration in 1967. Under this declaration, all major social and economic sectors were nationalized. In relation to health, one of the purposes of the Arusha Declaration was to ensure universal access to social services to all the citizens, the majority of whom were (as they still are) poor and living in rural areas. This was done on favor of the perceived poor majority and in conformity to the ideology of "socialism and self-reliance" The people regarded as being poor were those who could hardly pay for their essential needs, such as health and education. The Arusha Declaration was followed by the Decentralization Act of 1972. This was aimed, among other objectives, at building regional, district and

village capacity to effectively participate in decision making, planning and implementing activities for their own development, health in particular (Mills et al. 1990; Gilson *et al.,* 1994).

In 1977 the government continued to finance and provide health services free of charge to all citizens seeking care from government health facilities and However, mission health facilities continued to operate as private not-for-profit organizations by charging their patient clients, as they had been doing even before independence (Newbrander and Sacca, 1996; Msamaga *et al.,* 1996);

According to the Ministry of Health (MOH 1997), Due to poor national economic performance, escalating costs of public health care service provision, emergence of pandemic diseases such as HIV/AIDS and changes in patterns of other diseases, the government's ability to continue providing free health services to all citizens decreased. Consequently, establishing other resource bases for financing health services was viewed as a means of improving the availability and quality of health care delivered in the country (MOH, 1994, 1996), as is also advocated elsewhere in the world (World Bank, 1993; Shaw and Ainsworth, 1996).

In July 1993 a cost-sharing policy was launched in the Tanzanian public health sector. User fees began to be implemented in phases at referral, regional, and district hospitals for some services that had previously provided free of charge (Newbrander and Sacca, 1996; Mmbuji *et al.,* 1996). According to the government's health sector reform policy agenda, cost-sharing was planned to be extended to health center and

dispensary levels so that communities would participate in financing their health care needs through formal and informal risk pooling mechanisms Whereas CHF was primarily intended to benefit the majority of the informal sector (e.g., the self-employed), the national health insurance is targeted to formal employees (e.g. civil servants) and some of their dependants (MOH 1994, 1996). Cost sharing is a critical issue which should be looked upon with an open eye as it has negative impact to vulnerable groups including older people. As it is shown area 90% of older people live in rural areas with poor economic status as the consequence they cannot afford to pay for extra costs for health care.

The key question is what changes are necessary at the organizational and process or functional levels of the health sector in order to enhance the performance of the primary health care provision within the districts under decentralized hierarchies. There has also been concern about the contents and direction health sector reforms should take, the level to which they should extend (national, district, or village level), who will benefit from reform, and whether the primary health care guidelines developed by the World Health Organization (WHO) will be effectively and successfully implemented, taking into consideration the capacity of management at various levels in the health sector. (Kamugisha *et al.,* 2000)

2.3.2 Older People

Age classification varied between countries and over time, reflecting in many instances the social class differences or functional ability related to the workforce, but more often than not was a reflection of the current political and economic situation. Many times the definition is linked to the retirement age, which in some

instances, was lower for women than men. Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. The common use of a calendar age to mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous. (Thane, 1978).

On the other hand (Gorman, 2000) states clear that the ageing process is of course a biological reality which has its own dynamic, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age. In the developed world, chronological time plays a paramount role. The age of 60 or 65, roughly equivalent to retirement ages in most developed countries is said to be the beginning of old age. In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people; in some cases it is the loss of roles accompanying physical decline which is significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible." (Gorman, 2000).

2.3.3 Accessibility of Free Health Services to Older People in Tanzania

The difficulties older people experience in meeting their basic needs, and the lack of support, both affect their health. The current health care offered to older people is problematic. Access to free health services is limited, especially to older people,

whose ability to pay for these services is limited as exemption mechanisms for health care services do exist, but their effectiveness is also limited. (URT 2011)

SOC-PRO AGEING study (2003) on social protection which was conducted in Dar Es Salaam (Kingungi village in Temeke Municipality) and Lindi; kinen'gene village the study shows that ,health policy in Tanzania Cleary stipulates that older people should have free access to medical services in government hospitals, health centers and dispensaries. This study shows that it is not the case in Kineg'ene village as 48% of the respondents indicated that they have to pay for their medical treatment only few older manage to pay when they fall sick. Getting money for treatment posed an additional health problem to older people particularly when the respondents revealed that where can they get money for treatment while they have no money to buy food?

The study continues to indicate that many older people live in object poverty so they cannot even get a single penny for transport from their respective homes to hospitals and others are weak to visit clinics on their own, some of them could not afford to have a full meal everyday which makes them increasingly weaker. The study also shows that age limit complications are another obstacle. Many older people are left unattended because of their inability to prove that they are 60 years old or above, which is the acceptable age limit that entitles them for free health care in Tanzania. The same study identifies that while number of problems associated with lack of access to health facilities in rural study site have been documented, accessibility to medical services in the urban context ought to be better due to the coverage of government hospitals and dispensaries in Temeke municipality though it is very difficult when it comes to practical steps in achieving proper health care. It was reported that the only service which old people can get for free were consultation

from the doctor and the prescription of the required medicine whilst the only drug given without charge are cheap pain killers like panadol. (SOC-PRO AGEING 2003)

2.3.4 The Impact of HIVAIDS to Older People

The effects of HIV/AIDS pandemic are devastating on sexually active age groups but little has been done to explore its effects on older people. Yet the older generation prays a particular important role caring for the people affected with HIV in general and orphaned children in particular. In Tanzania 64% out of total number of 2.5 million orphans are living in households headed by a person over the age of 55, and there is a strong tendency that the number of children living with grandparents increases in relation to those living with other relatives. (Help Age international 2004) The older people in this study refused to reveal if they are infected or their children died of HIV/AIDS something which shows stigma that surrounds the whole issue of HIV/ AIDS. (Rwegoshora *et al.,* 2003)

2.3.5 Awareness of Older People on Rights, Entitlements and Policies

Lack of information about accessibility of free health services to older people is a serious barrier which can lead to poor accessibility of free health services to the same. SOC-PRO AGEING study (2003) on social protection which was conducted in Dar es Salaam (Kingungi village in Temeke Municipality) and Lindi; kinen'gene village the study shows that**.** With regards to the existing knowledge of older people on rights entitlements and specific policies which essentially affect them, the overwhelming respondents (89%) in this study shows that they were completely unaware of existing political instruments affecting their lives. By contrast in the urban context knowledge levels were 3 times higher, although gender differences

were as well appalling. In urban setting 47.9% of male respondents showed certain awareness levels, while the proportion of female respondents was only 20.8, thus being 3 times higher than those of their female counter plants in rural. (SOC-PRO AGEING, 2003).

2.2.6 Initiatives that has been Taken to Ensure Accessibility to Free Health Services to Older People in Tanzania

Since old age and ageing is multsectoral National Ageing Policy 2003 cannot be analyzed in isolation rather in relation with other policies and strategies related to older people. This means that the initiatives to address older people issues do not only come from NAP 2003 but also with other policies and strategies. Together with NAP 2003 Tanzania came up with other sector related documents which in various ways address issues of older and health in particular these include policies and strategies on Health, HIV/AIDS, Population food and nutrition, social security, MKUKUTA I&II, to mention but a few. The study conducted by ACHRID in collaboration with Help Age International identified and analyzed older people inclusion policies, strategies and framework in order to extract specific entitlements for older people and their dependants such as Most Vulnerable Children, disabled and people living with HIV/AIDS.

2.3.6.1 National Health Policy 2007 in Relation to Free Health Services Provision to Older People

The study by ACHRID (2011) continues analyzing that the revised National Health Policy 2007 attempts to address issues that were not tackled Cleary in previous policy version of 1990 and 2003. The overall objective of the 1990 Health Policy

was to improve the health and wellbeing of all Tanzanians, with focus on those most at risk but older people as special group did not specifically feature anywhere in the policy. The policy of 2003 aimed at providing direction towards improvement and sustainability of the health status of all people but without specifically mentioning older people.

According to this study, the revised policy has gone further to specifically mentioning older people as one of special group to benefit health care services. Like the previous policy the overall objective of the revised policy is to improve health and wellbeing of all Tanzanians especially those who are at high risk by instituting an effective health services delivery health systems which would address the health needs of all people and consequently increase lifespan of all Tanzanians.

In relation to the special groups including older people the policy has categorically highlighted the following specific statements:

(i) To strengthen the reproductive health of men and women, people with disability youth and elderly.

(ii) To prepare and oversee laws, procedures and guidelines on cost sharing in health services including exemption on special groups.

(iii) To ensure there is parity/equality in provision of health services to all groups of people.

(iv) To prepare better procedures on how to provide curative health services to special groups which deserve exemption.

(v) To provide health services on equitable basis and fairly by considering gender and special needs.

In general term according to the study, the policy has seriously considered the need for provision of health services to older people though implementation feces a number of constraints such as poor health services and medication, as well as reluctance of health care staff and local government officials to adequately deriver to older people their entitled services.

Some policy statement such as ensuring equality in the provision of health services to all groups of people and on equitable basis is a reality of farfetched wish. Implementation of universalized user-free exemption to cover all older people remains challenging. The study analyzed that in principle there is no such a thing like free medical care services as people including older ones have in one way or another to pay for the services either through community health fund or national health insurance fund scheme. Thus the exemption of special groups from paying for health services as stated in the policy is not clearly elaborated to include consultation and medication. In addition even if older people are able to subscribe to Community Health Fund (CHF) or health insurance schemes there might be other specific diseases such as diabetes which are not included in those schemes.

2.3.6.2 National HIV/AIDS Policy and Strategy

This is another area the same study identified and analyzed. The first national HIV and AIDS policy was developed in 2001under the coordination of the Tanzania

Commission for AIDS (TACAIDS) The primary aim of this policy was to enhance effective coordination of the national response to the scourge. In order to provide strategic guidance on how to respond against HIV/AIDS, the National Multi-sectoral Strategic Framework (NMSF) was developed in two phases. The 2001 policy however, lacked involvement of vulnerable groups such as the elderly. Another policy was issued in 2010 which revealed that older people had been neglected not only in terms of data on people aged 50 years and above but also on how this group was engaged in the national response given the fact that in many communities OVC and PLWHIV were cared by the older people. It is also noted that the elderly faced the discrimination in HIV /AIDS services because of wrongly held assumptions about their sexual virility and inadequate information.

The policy strove to address elderly specific needs and roles in National HIV response through the following policy statements.

(i) The government and stakeholders will develop age –sensitive HIV prevention strategies targeting old people.

(ii) The government and stakeholders will develop guidelines which ensure that older care providers of PLWHIV and OVC are empowered to protect themselves and provide appropriate care.

(iii) The government and stakeholders will introduce social protection schemes for the elderly to enhance their ability to handle the effects of HIV and AIDS.

Among the observation made on this policy by the study is that, though the policy stipulates the roles and responsibility of all actors at the village and ward levels these

seem to be mere statements of intent since in most cases the players at those levels are have limited capacity to plan, implement, coordinate and monitor HIV/AIDS response. In the first place they do not have the budget nor the adequate skills to carry out their tasks to carry out the tasks as prescribed in the institutional framework.

Secondly, there is no evidence of collective action plans targeted to older people at the community level and in some areas they are segregated, stigmatized and discriminated especially if they have PLWHIV dependants. Hence the role of protecting vulnerable groups and those infected and affected with HIV/AIDS at that level is simply theoretical. Thirdly, experience shows that the HIV/AIDS committees at community and ward levels are in most cases reactive to externally influenced HIV/AIDS interventions.

While the 2010 policy gives the direction on how to address HIV/AIDS of older elated issues to older people, the HIV/AIDS Act of 2008 does not explicitly state statutory provisions in favor of older people. The legislation refers to special group as vulnerable children, orphans and expectant women and the general term of “every person” only. Additionally, the ongoing National Multisectoral Strategy for HIV/AIDS does not take into account the new policy objective and policy statements in the revised policy. This inconsistency will bring difficulties in implementing statements on ageing in the new 2010 policy. Very little comprehensive research has been conducted in the country, as the result most of the HIV/AIDS programmes implemented in the country lack baseline information on which their activities can be based.

2.3.6.3 National Strategy for Economic Growth and Poverty Reduction

According to the study, MKUKUTA mainstreams the elderly as one of the cross-cutting issues to be handled in its strategy. The provisions of the MKUKUTA are a response to older people's voiced concerns about income, health, water inheritance identity cards, adult education and abuse. It commits to delivering "adequate social protection and the rights of most vulnerable and needy groups with basic needs and services and the reduction of political and social exclusion"

There have been two phases of MKUKUTA. In the first phase (2005-2010) the thrust of the strategy focused on quality and affordability. The underlying objectives were to develop and enforce a comprehensive policy on vulnerability and social protection particularly onto vulnerable groups including elderly. The strategy intended to ensure that eligible elderly people were able to access free medical treatment in public health facilities with acknowledgement from the relevant community concerned. It strove for a 100% of eligible older people to be provided with free medical care and attended by specialized personnel by 2010.

In the same vein MKUKUTA II (2011-2016) provisions endeavor to provide adequate social protection to the vulnerable and needy groups with interventions focusing on orphans and vulnerable children, people with disabilities, the elderly among others. Observation made by the study is that, MKUKUTA refers ageing as a cross cutting issue but in practice it is not accorded deserving magnitude and importance of the sector concerned. Due to this kind of thinking each sector deals with the ageing issue in \ marginalized way. Unlike other crosscutting issues such as

gender, environment and HIV/AIDS which are addressed in a more serious and strategic manner, ageing is simply relegated into a popularly used terminology without a proper institutional home or budget.

The eleven operational strategies for goal 3 in cluster II only focus on capacity development, deployment and retention of health personnel but do not include any strategy on how to improve their delivery to the elderly, which is one of the major shortfalls in the health sector. The operational target for HIV/AIDS and TB in cluster II, Goal 3 lack quantifiable benchmarks for older people who would make it difficult to measure the outcome and impacts of strategies to older people. The strategy on HIV/AIDS prevention awareness and behavior change does not state how the elderly will be covered. In practice such campaign programmes focus on women and youth and the elderly are not specifically targeted as they are lumped into the general public category.

Targeting the poor and vulnerable groups or individuals as proposed under cluster 3 on enhancing good governance and accountability is an extremely complex and painstaking venture especially in the Tanzanian context where poverty is pervasive. This is particularly in a situation where by attributes of ageing are dynamic regular updating and monitoring something which requires heavy investment in terms of finance and human resources. Therefore, the strategy to target eligible older people for cash income transfer in form of social pension cannot be effective so long as a transparent and justifiable mechanism is not in place. Under each cluster key actor are listed without identifying the lead factor who is supposed to coordinate the implementation of the intervention package.

2.4 Knowledge Gap Analysis

From the reviewed literature, numerous studies have been conducted, however most studies have much attached on social protection of older people including health and not particularly on assessment on the National Ageing policy 2003 particularly on accessibility to free health services provision to older people. Moreover most of studies have been conducted in Dar es Salaam and other regions of the country leaving the problem undefined in Bagamoyo District. It is on this ground that this study was thought important to be conducted so as to assess the effectiveness of National Ageing Policy 2003 particularly on free health services provision to older people in Tanzania, specifically in Bagamoyo district.

2.5 Conceptual Framework

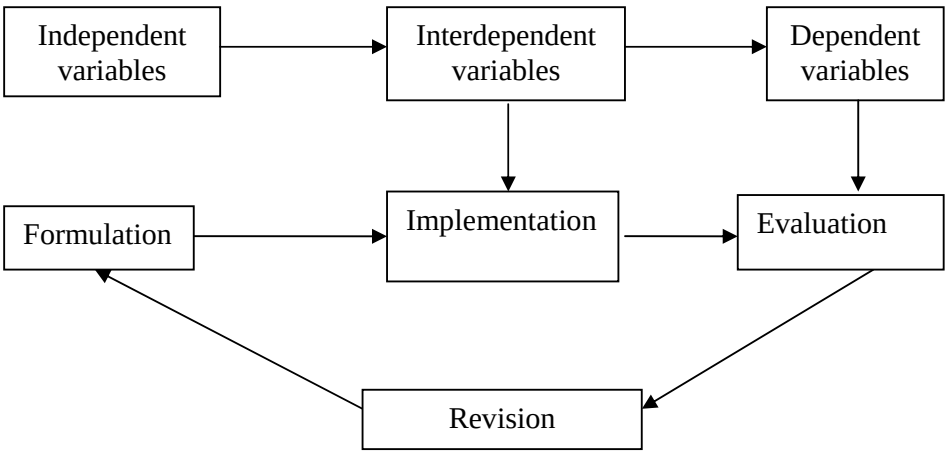

Figure 2. 1: Impediments to Effective Policy Action

Source: Research Data, 2013

2.5.1 Policy Formulation

Policy formulation involves a series of tasks ranging from information gathering to implementation. Formulation of social policy includes identifying problems that

affect social functioning, it define the problem as public issue, analyzing findings and confirming evidence, to provide information to the public, to study alternative solutions, to prepare initiative policy statement that identifies goals, developing supportive organizations structures and political relationships legitimizing policy efforts through public support, constructing the policy and /or program design. The relationships among the actors in policy decisions affect the outcome of the policy at every stage**.**

2.5.2 Policy Implementation

After social police is in place and funds for its programmatic implementation become available; social workers make decisions about how to deliver services. They design programs to carry out the policy's goals of specified population to affect some desired change. They develop administrative policies that clearly define roles and tasks and direct the work of agency personnel and finally they write policy and procedure manuals to communicate expectations, responsibilities and outcome measures. Implementing a social work in one social system necessitates administering and implementing related policy in decision in other system as well.

2.5.3 Policy Evaluation

Social policy is evaluated by reference to their adequacy and effectiveness in attaining certain goals, their economy in the use of scarce resources and their consistency with accepted social values. Evaluation include history of the policy, under study, related policies, describe the problems that the policy would address ,identify the social values and ideological beliefs embedded in the policy, state the goals of the policy, assess the ramification of the policy for the existing health and

human service delivery structure. Assess the effectiveness and efficiency of the implementation of the policy weigh the differential effects of the policy on the diverse population groups and judge the merit of the policy.

2.5.4 Revision

In normal situation policies are supposed to be reviewed periodically at least every three years. It is now nine years since National ageing policy came into being without being revised.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY AND PROCEDURES

3.1 Introduction

This chapter presents the methods and techniques that were used in this study. It covers the methodology used in assessing the National Ageing Policy 2003 on the provision of free health services to older people in Tanzania. These include research design, area of study, and methods of data collection,

3.2 Research Design

A research design is the arrangement of conditions for collecting and analysis of data in a manner that aims to combine relevance to the research purpose with the economy in a procedure (Kothari, 2004). It includes an outline on what a researcher will do from writing the hypothesis and its operational implications to the final analysis of data. The study adopted both qualitative and quantitative approaches. Qualitative information was very important to capture the respondent feelings, perceptions, understandings and opinion concerning ageing policy implementation as far as health services provision is concerned. While quantitative approach was used to capture the number of elderly who access free health services, those who could not access health services, number of aged in the study areas, the average of health services provision.

3.3 Area of the Study

The area of the study was Bagamoyo District which has total of 22, wards 97 villages and 682 “hamlets” The District has three main ethnic groups namely: Wakwere,

Wazigua and Wadoe. The majority of Wakwere occupy the central part of the district which covers Logoba, Msoga Msata, Bwilingu, Pera and Ubenazomozi wards, while the Wazigua occupy the north part of the district at Moino, Mandera, Mkange, Mbwewe and Kibindu wards. In addition, the district is also occupied by Wadoe tribe at Vigwaza, Chalinze and Msata wards. Other ethnicity tribes include Wazaramo who residing at the district headquarters and Maasai who found in Lugoba and Chalinze wards. According to the population and housing census 2012 Bagamoyo has 311,740 where men are 154,198 and women are 157,542. Magomeni ward has the total population of 29,234 where men are 14, 665 and women 14569 this is the second ward in having a big population in Bagamoyo the first being Bwilingu with total population of 35,149 and Miono Ward has a total population of 17,009, where men are 6844 and men 6,896.

However, since it was impossible to study the entire area of Bagamoyo District one village in rural and one hamlet in urban were purposively selected from different wards namely, Masimbani village in Miono among four villages in the ward and Majicost hamlet from Magomeni among 22 hamlets. The area was chosen due to several reasons such as low level of economic development as indigenous are less involved in Income generating activities (older people in particular) which leads them into object poverty, illiteracy of indigenous as a result of not giving priority to education, issues of older people are not priority to planners and implementers as far as the district council is concerned. Another reason is that, no research has been conducted in Bagamoyo concerning assessment on National Ageing policy 2003 particularly on free health services to older people.

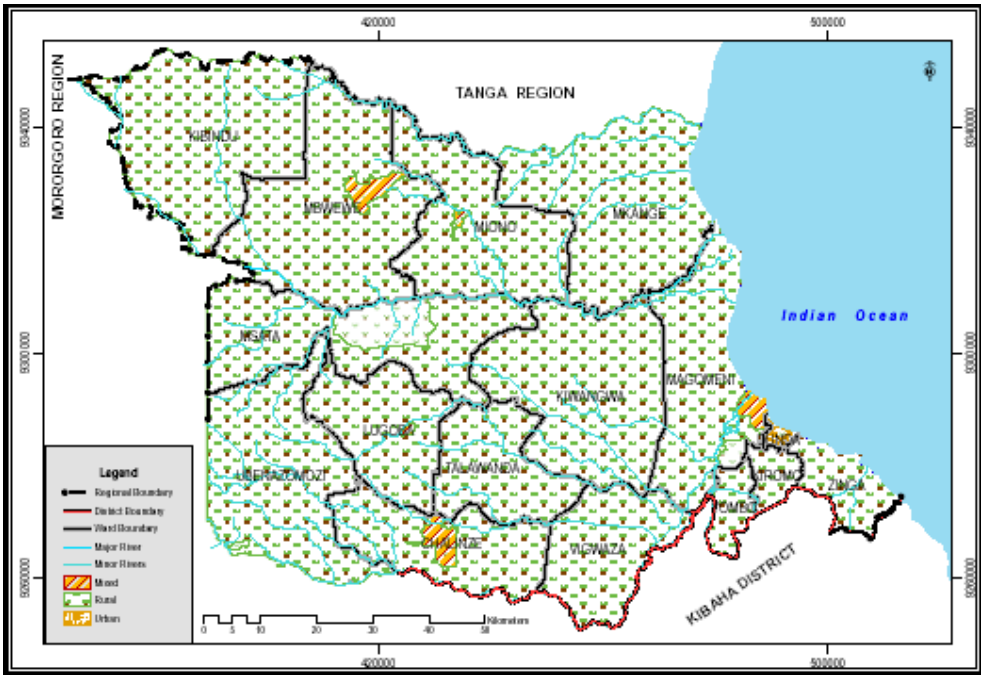

Figure 3.1: Map of Bagamoyo District - Coast Region

Source: Bagamoyo District Executive Director's Office –Land, Natural Resources and Environment Department, (2009)

3.4 Study Population

The population of this study consists of all older people aged 60 years and above, both male and female in Magomeni and Miono wardin Bagamoyo District.

3.3.1 Sampling Frame

The sampling frame is a complete list of all the elements/cases in the population from which your sample will be drawn. Thus a sample frame consists of items from which the sample is to be drawn. It is a complete lists of every unit in the universe (population) (Adam J, 2007) the target population. In conducting this study different groups of people were involved. These include retired older people (who were

government employee and non government employee) non retired older people (government and non government employee), older people were involved because they are the study population who understands the whole situation of the problem under investigation, government officials (social welfare officers, community development officers, ward executive officers and village executive officers) health service providers, Nongovernmental organization officials in Bagamoyo, these were involved in the study due to their expertise and experience.

Social welfare officers were involved in the study due to their expertise and experience in serving older people as the older people desk is found in the social welfare department, on the other side community development officers were involved in the study due to expertise and experience in encouraging people to formulate entrepreneurial groups and provide those groups with soft loans. Health service providers were involved due to their expertise experience as it is their every day duty and responsibility to provide health services to sick people of different ages including older people. Ward executive officers and village executive officers were involved in the study due to their experience as the close leaders to older people at ward and village level. Non-governmental organization officers were involved in the study due to their expertise and experience in serving older people so they come across different challenges in trying to overcome challenges faced by older people Due to large coverage of the study area, the area was clustered and stratified. From each cluster, population was grouped into homogenous groups and then sample was selected from universe. Stratified method tend to serve time budget, and minimizing error (Kothari, 2007).

3.4.2 Sample Size

Sample size refers to the number of items to be selected from the universe to constitute a sample. An optimal sample is the one which fulfills the efficiency, representativeness, reliability and flexibility (Kothari, 2004). The study involved 60 respondents including, 30 older people, 15 government officials (social welfare officers, community development officers, village executive officers, and ward executive officers), 10 health service providers, 5 NGOs officers who are dealing with older people from Bagamoy District. According to Kombo *et al.,* (2009) it is important for the researcher to identify and select respondents that fulfill the questions the researcher is addressing. For example if the study is on the effect of the slum environment of basic education, it is important that majority of the population of the respondents is from the slum environment. It is from this ground that out of 60 respondents 30 respondents are older people.

Table 3.1: Respondents by Groups, Frequency and Percentage

Respondents	Frequency	Percent
Community Development Officers	4	6.7
Social Welfare Officers	5	8.3
Health Service Providers	10	16.7
NGOs Workers	5	8.3
Older People	30	50.0
VEOs	4	6.7
WEOs	2	3.3
Total	**60**	**100.0**

Source: Field data, (2013)

The pre research visit done by the researcher found that there were 5 Social welfare officers and 4 Community Development Officers, the number which was reasonable to be included in the study. On the other side 10 health service providers were purposively selected to represent other health service providers in Bagamoyo as far as population size is usually an estimate.

3.5 Sampling Techniques

3.5.1 Purposive Sampling

It is the decision with regard to which element/item should be included or excluded in the sample is under the control of the researcher. It is sometimes called judgmental sampling this is because the researcher chooses only those elements of which he believes that they will be able to deliver the required data. The major consideration for including a person in a sample is to identify those respondents having expertise or experience about a problem under investigation. (Adam, 2007) It was from this ground that it was used in this study whereby 10 health service providers were (doctors, nurse officers, clinical officers, laboratory technicians) obtained as well as 15government officials (community development officers, social welfare officers, village executive officers and ward executive officers) and 5 NGOs officers dealing with older people. Not only that but also a village and hamlet from two wards were purposively selected.

3.4.2 Simple Random Sampling

Is a probability sampling whereby all members in the population have equal chance of being selected. (Adam, 2007) it was used due to its strength of giving research data that can be generalized to a large population as well as providing equal

opportunity of selection for elements of population (Kothari 2004) 30 older people retired and non retired from government and informal sector were obtained. The aim was to give older people equal chance to participate in the study as the study target improvement of older people's wellbeing. The respondents were obtained by listing down the names of all older people on tags, then the tags were put in the big basket and were mixed thoroughly and one tag by the other were selected without being replaced. When the selected tags reached 30 the names on those 30 tags were the respondents who were involved in the interview to represents other older people who were not picked during the process of selection.

3.6 Methods of Data Collection

3.6.1 Primary Data

Primary data are the ones collected by researcher himself/herself from the field and this is the first hand information (Adam, 2007) Techniques which were employed in primary data collection were: Interviews, questionnaire and observation.

3.6.1.1 Questionnaires

This was done through Multiple questions or statements which was prepared and filled out by the respondents particularly officials to take the required information. Questionnaire was used because a large proportion of the desired information was collected within a short time or limited time and resources. Kidder (1981) argues that the use of questionnaires is of advantage because of economy, limiting interviews bias and possibility of anonymity. Before all, a pilot study was conducted to pre-test questionnaires. Questionnaires included open and closed ended questions.

3.6.1.2 Interviews

The technique involved asking interviewees face to face questions using an interview checklist guideline and filled by the researcher. The method was applied to 30 older people. The rationale for using that method was to obtain data to supplement data obtained through questionnaire method. And this was thought to be a proper method due to the fact that most of older people within the study area did not go to school so reading and writing was a problem and could be an obstacle in data collecting process.

3.5.1.3 Observation

A researcher went around Bagamoyo district hospital the only government hospital that people living in Magomeni ward depend on for medical treatment to observe health services which are provided to elderly, how elderly are treated as well as health conditions of elderly, how long does it take for order people to be attended. Not only that but also the economic status of older people in Miono ward was observed putting into consideration the status of houses they live in and accessibility of having three meals per day. Observed information was recorded by the observer to supplement research findings.

3.6.2 Secondary Data

Relevant information was extracted from various official reports available at Bagamoyo, district hospital, Ward office and hamlet office registration reports and internet. The documentary source of data plays an important role in the disseminating the data in all disciplines (Ndungulu, 2004).

3.7 Data Processing and Data Analysis

Once the questionnaire or other measuring instruments have been administered, the mass of raw data collected must be systematically organized in a manner that facilitates analysis (Mugenda and Mugenda, 1999:155). Before presentation the data collected were processed by editing, classifying and reducing them into homogenous groups and entering them into computer to facilitate tabulation and draw meaningful conclusions. Editing being the process of examining the collected raw data enabled the researcher to detect errors and omissions and to correct those where it was possible. Qualitative data is subjected to content analysis with thematic organization frame work, while the quantitative data from structured questionnaire were statistically analyzed into frequency using SPSS version 16.0; conclusion is based on large number or percentage of findings.

3.8 Duration of the Research

The study was conducted for four months, starting from April to July. 2013, A total of 3,000,000 was budgeted for the whole research activities from the own source.

3.9 Limitation and Delimitation

The limitation of the study was sample. That selected sample unit could not be good representative of the whole population; the result could reduce utility of findings. Involuntary participants could lead to insufficient response or unwillingness to provide required information, respondents could expect to be paid by the researcher in order to provide information. The scarcity of fund and time also was thought to limit a research process. In this study a researcher choose only two wards out of 22

and 60 respondents were good representatives to meet the requirements of the study and meet the obstacle of time and fund, involuntary respondents were sensitized on the importance of the study, it was the duty of the researcher to let the respondents know the truth that there is no any kind of money which could be paid for the study.

3.10 Ethical Issues in Research with Older People

Dealing with special group like older people Tanzania in particular needs to consider certain ethics in relation to the study area. Principles which guided this study were such as: the study did not injure the participants this is derived from “no injure to participants” approach by Babbie (2004). Questions which were asked did not offend any of the respondents. The participants were not forced to provide information without their consent the researcher was responsible to explain clearly to the respondents the purpose and significance of the research so they gave required information on their will. Confidentiality is very crucial, the respondents were assured that the given information are confidential and they will be revealed only to the implementers so as to take action on what will be studied and that their names will not be revealed in any case.

CHAPTER FOUR

4.0 PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 Overview

This study was undertaken to assess the National Ageing policy 2003 on the provision of free health services to older people in Tanzania: Using Bagamoyo as a case study and since it was not easy to study the entire area Magomeni and Miono wards were purposively selected. Chapter four presents the findings as per study objectives and attempt to make a discussion on the findings revealed. The chapter is organized into six sections including introduction, the demographic characteristics of respondents, extent at which free health services are provided to older people, level of understanding of implementers on National Ageing Policy 2003 economic factors that hinder accessibility to free health services provision among the older people, bureaucratic processes that affect/facilitate effective provision of free health services to older people.

4.2 Demographic Characteristics Of Respondents

The demographic characteristics of respondents considered in this section include sex, age, occupation, level of education and working organization.

4.2.1 Sex

The contemplation of this aspect was based on the assumption that it would help the researcher, and other readers, to know the extent to which gender considerations were valued in this study. The sex of respondents is shown in Table 4.1

Table 4.1: Distribution of Respondents by Sex, Frequency and Percentage

Sex	Frequency	Percent
Male	28	46.7
Female	32	53.3
Total	60	100.0

Source: Field Data from Magomeni (Majicoast) and miono (Masimbani), 2013

Table 4.1 indicates that 28 (43.3 %) respondents were males, while 32(53.3%) were females. However the study sample included more females than males because during selection of respondents through simple random sampling technique more tags selected had female names.

4.2.2 Age

The inclusion of age groups of respondents in this study was to help the researcher and the reader to know the most age group that had participated in the present study. The ages of respondents are as shown in Table 4.2.

Table 4. 2: Distribution of Respondents by Age Group, frequency and percentage

Age	Frequency	Percent
25-29	4	6.7
30-39	14	23.3
40-49	4	6.7
50 and above	38	63.3
Total	**60**	**100.0**

Source: Field Data from Magomeni (majicoast hamlet) and Miono (Masimbani Village), 2013

Table 4.2 indicates that 38 (63%) respondents ranged between the age of 50 and above. This was followed by a group of 30 to 39 who were 14 (23%) the group between 25and 29 had 4 respondents (6.7%) the group aged between 40 to 49 years also comprised 4 (6.7%).

4.3 Education Level

The investigation on education level in the study was done because in Tanzania it is assumed that there is a direct correlation between level of education and economic status hence health status can be determined by economic status. The education also entails how a person will be secured as far as health services are concerned. The study finding indicated that 14 respondents which is (23%) have never attended to school.

Table 4.3: Distribution of Respondents by Education Level, Frequency and Percentage

Education Level	Frequency	Percent
Not attended to school	14	23.3
Primary school	14	23.3
Secondary school	6	10.0
Adult education	1	1.7
Tertiary education	25	41.7
Total	**60**	**100.0**

Source: Field Data from Magomeni (majicoast hamlet) and Miono (Masimbani Village), (2013)

As far as this study is concerned Not attended to school refers to those who never, acquired formal education by any means and do not know how to read and write. And primary Education Refers to the basic education that one acquires first before stepping to another level of education. For the purpose of this study primary education ranges from standard one to standard seven. Those who attended primary schools before Tanganyika independence and soon after independence could complete their primary education in standard four. Secondary education has two levels, ordinary and advanced level. Ordinary level is a level of education acquired after completion of primary education where as secondary education is from form one to form four and advanced secondary education consists form five and form six. **Adult education** Is education for adults that is available outside the formal education system. Tertiary education for the purpose of this study combines, certificate holders and graduates at Diploma, degree level, masters' level and others.

4.4 Extent at which Free Health Services are Provided to Older People

The National Ageing Policy of 2003 and the health policy among other things stipulates that older people aged 60 and above are entitled to free health medical services. On the other hand MKUKUTA I (2005-2010) strove for 100% of eligible older people to be provided with free medical care and attended by specialized personnel by 2010. This study wanted to find out whether older people in the selected sample area had access to free medical service. Accessibility was measured by asking respondents several questions. One of them was for the respondents to indicate if health services were freely provided when they visited hospitals/health centre/Dispensaries.

4.4.1 Accessibility

This means easy to get something when required. In this case accessibility refers to easy way to get the medical facilities. The study was conducted in rural areas as part of study area where the infrastructure such as health facilities, and means of transport were poor. In Bagamoyo there is a total of 56 dispensaries under government , 8 private dispensaries ,4 government health centers, 1 private health center and one district hospital widely these facilities are scattered and not every village have a dispensary to allow villagers and older people in particular to access health services.

To this effect respondents were asked if they could easily access medical services, the main variables which were examined included distance from the place of domicile to health facility, ability to pay for transport to the health facility, availability of drugs, friendly atmosphere of the health facilities, ability to pay for medical services. The main thrust of the policy is to provide medical service to older people aged 60 years and above without payment. This was taken into consideration of low level of income among the older people, as they grow older their ability to produce decreases. The problem of distances from residence to hospital/ health centre/ dispensary is shown on Figure 4.1

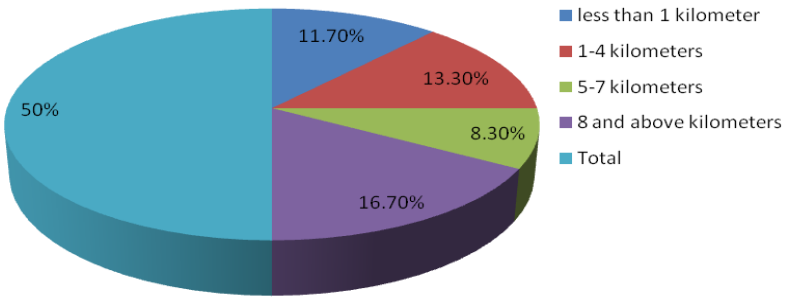

Figure 4.1: Distance from Residence to Dispensary/Health Center/ Hospital and Perentage

Source: Field Data from Magomeni (majicoast hamlet) and Miono (Masimbani Village), 2013

Figure 4.1 Shows that out of 30 respondents 10 (16% out of 50%) had to travel as their residents ranged eight kilometers and above, followed by 8 respondents (13.3) who range 1-4 kilometers, 7 (11.5%) respondents who range less than one kilometer and the last 5(8.3) respondents range from 5-7 kilometers.

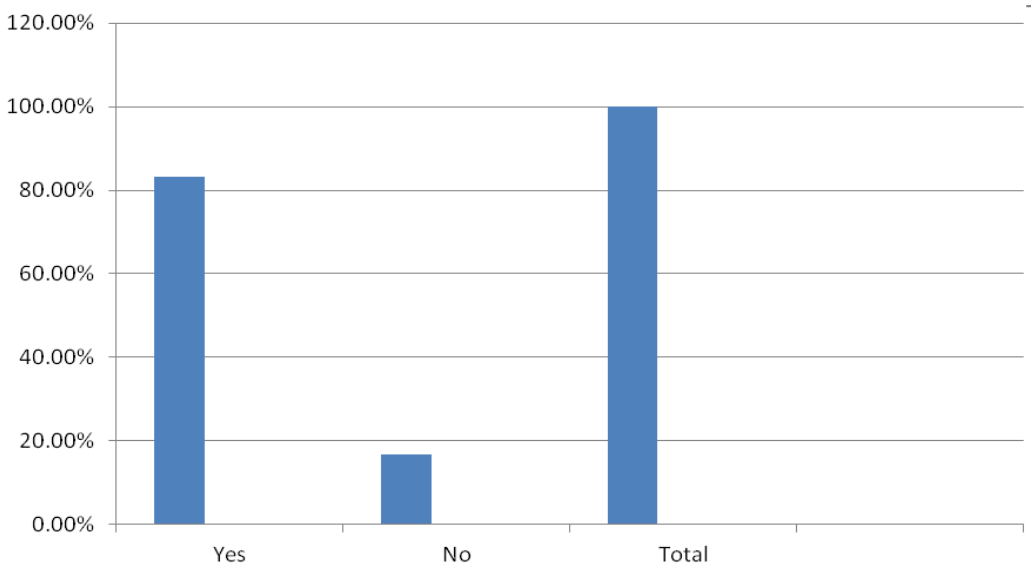

Figure 4. 2: Answers and Percentage on Accessibility to Free Health Services to Older People

Source: Field Data from Magomeni (majicoast hamlet) and Miono (Masimbani Village), (2013)

Figure 4.2 shows that when respondents were interrogated on free health services to be provided to older people 50(83.3%) responded that there is no free health services to older people and 10 (16.7) said there is free health services to older people. Most of the respondents who gave the answer of availability to free health services were health service providers because they are aware that health services to older people aged 60 years and above should be freely provided but also older people who depend on their children to pay health cost do not perceive lack of free health services as a problem.

This is more glaring to older people in rural areas. Respondents who indicated inability to pay as a barrier to access medical services were asked to explain how this was an issue the findings reveal that older people with little or inability to pay were frustrated having traveled a distance only to find a health centre, the cost of drugs were very high for example it was mentioned by one of older person in Masimbani Village.

> *"…….gharama ya kununua dawa ni kubwa ukilinganisha na kutokuwa na kipato. Kwa mtu kama mimi ambaye sina mtu wa kumtegemea dawa inayogharimu tsh.5000 na kuendelea siwezi kuinunua"*

The above narration in summary indicates that for an older person who has no one to depend upon, any drug which exceeds 5000 could not be afforded. Due to this the researcher was curious to find out, what the respondent would be done to overcome such problem given the fact that the government had already committed itself to pay the medical cost to older people. One of the respondents argued that and I quote,

> *"……kama serikali imeamua kwa dhati kugharamia tiba kwa wazee, kwa nini wazee wanaojinuulia dawa wasirudishiwe gharama zao za hospitali au kwa nini serikali isiingie mkataba na maduka ya dawa katika sehemu husika ili wazee wanapougua wapatiwe madawa na wenye maduka wadai malipo hayo serikalini."*

What is recommended by this respondent is that if the government real mean to facilitate free health services to older people it needs to establish a system where older people can access drugs even in private services in case drugs are out of stock and if an older person had incurred any cost to pay for medical service should be refunded by the government.

4.5 Understanding of National Ageing Policy 2003

In measuring the understanding of implementers on National Ageing Policy 2003, the respondents were asked if they are aware of existing National Ageing Policy 2003. The answer of the question was as shown in figure 4.1 below

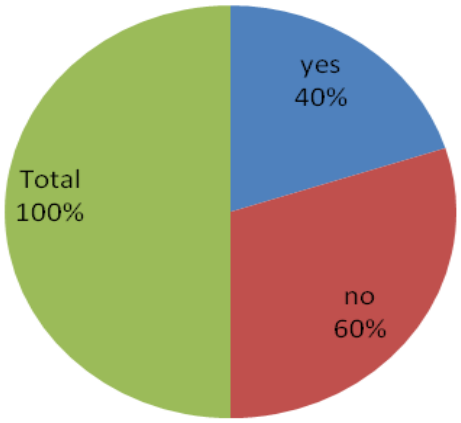

Figure 4.3: Understanding of National Ageing Policy 2003 in Percentages
Source: Field Data from Magomeni (majicoast hamlet) and Miono (Masimbani Village), (2013)

The general impression from the above figure is that the majority of respondents were not aware of the existence of the policy 36 (60%) respondents unaware and 24 (40%) aware. Respondents who were not aware when asked to explain the reasons of not being aware they said their leaders at village and ward level had never informed them about the existence of the policy.

The respondents who indicated that they are aware about the policy indicated that they heard about the policy from the media. One of the respondents for example said he heard from TBC program. Those respondents from the NGO known as Asasi ya wazee Bagamoyo said that (AWABA) had to find and read the policy document so

as to know the rights and entitlements stated in the policy to enable then make a following up on its implementation and advocate it to different stakeholders who are responsible to serve older people in line with sensitizing older people on their rights and entitlements.

When government officials were celebrating older people's day they however indicated that policy document were neither available at village level nor at ward office. It was however noted that respondents who were aware of the policy were either retired public servants who were living in urban areas, those who are working with the NGO which is dealing with older people and the majority were literate. The level of education was therefore another factor which inhibited the accessibility of the information about the policy and interpretation of the policy. According to help age international document, in area where people are aware of the policy (older people) were aware of the existence of the policy the organized themselves and demand their entitlements from the relevant authorities and as far as community development is around generally it becomes clear that the level of understanding/awareness among the general population is a big failure.

The question of awareness was further extended to local government leaders these included village leaders (i.e. chairperson of the village, village executive officers and ward executive officers) among other things there were expected to be well raised with various policies which are important at the grassroots level. They need to possess these policies documents but also have a general knowledge about these policies. And what is expected them from this effect, these leaders were interrogated about their awareness of the policy and whether they had this policy document, the

response from the village leaders indicated that some of them have heard about the policy but they did not have the policy document. In fact some of the leaders have never come across such document. Because of this even the content of the policy were not well understood. That being the case, how do you expect them (leaders) to implement the policy?

A similar response was presented by the ward leaders who also had the same sentiment in as far as having seeing the document and comprehending what was the content of the policy. What does this mean? It means that whereas the government has been trying to formulate policies have not been the other understanding issues was the requirement of the policy which need resources to implement. Some of the activities indicated in the policy need material and financial resources. All in all the role of leaders were not well seen because if they have heard about the policy they have never made any effort to seek information or to get the policy document.

In as far as health service providers are concerned when interrogated indicated that they were aware of the policy from District Medical Office and Regional Medical Office, but they had no proper environments on how to implement it. The implication from these findings is that there are respondents who are aware of the policy but they are not sure of the content and what is to be done. There is also lack of initiatives to look for the policy document; on the other hand older people do not know their entitlements.

4.5 Economic Factors that Limit Proper National Ageing Policy 2003 Implementation Particularly on Accessibility to Free Health Services to Older People

Identifying economic factors limiting proper ageing policy 2003 was the third objective of the study. In this particular objective respondents were asked whether there were any economic factors constraining proper ageing policy implementation on accessibility of free health services to older people. Interrogated 38 (63.7%) Respondents knew that there are economic factors which are barriers to successful free health services to older people where 22 (36.3%) replied that there is no economic factors most of them were those who did not go to school.

The researcher went further interrogating respondents to mention the factors they know the factors mentioned was low income earning, economic crisis, and poor fund allocation. In order to investigate if there is the step taken to overcome mentioned economic constraints respondents were asked if there is any efforts they made to address the challenges and give out the taken steps. Each group of respondents showed an interest to overcome the challenges, the health service providers responded that they have been trying to allocate funds that can suffice free medical treatment to older people but things appear different due to high price of medical facilities which keep on changing every day. They suggest that for older people who are well economically should be sensitized to share cost for their treatment.

Social Welfare Officers and Community Development Officers responded that they have been participating in CB-CCT (Community Based Conditional Cash Transfer)

program which empower poor households to invest in nutrition, health and education. Among beneficiaries are older people aged 60 years and above from poor household for medical checkup even when they are not sick, it was introduced in Bagamoyo in 2009 and in 2013; 11,918 beneficiaries have been reached (TASAF-Bagamoyo Report July 2013). Only 17 villages in Bagamoyo have been reached by the program out of 97 villages. On the part of Non Governmental Organizations, they formulated the association called " Asasi ya wazee Bagamoyo" (AWABA) so as to rise funds which helped to identify the older people in Bagamoyo and the activity is still in progress as well as sensitizing older people to formulate small groups so as to get soft loans to participate in income generating activities. Up to now there is no any activity initiated due to lack of funds to support the movement. Other older people seem to not to have taken any effort on this.

Table 4.4: Answers, Frequency and Percentage on Respondents who Taken Step to Economic Factors Hindering Proper free Health Services to Older People

Answers	Frequency	Percent
Yes	45	75.0
No	15	25.0
Total	**60**	**100.0**

Source: Field Data from Magomeni (Majicoast Hamlet) and Miono (Masimbani Village), (2013)

Table 4.4 shows the frequency and percentage of those who has been taking actions to overcome existing economic factors limiting free health services to older people. In order to have a clear understanding on action taken respondents were asked if they

are taking any initiative where as 45(75.0%) respondents revealed that they have taken effort and 15(25.0%) did not take any initiative. The question of economic factors hindering proper free health services to older people could not be the problem if different stakeholders including older people themselves would come up with initiatives which would lead to proper interventions. For example Community Development Officers in the district council through own source budget provide soft loans to needy groups. The same should be done so as to allow older people to engage themselves in income generating activities to improve their living standard health service in particular.

4.6 Bureaucratic Procedures and its Effect to Effective Provision of Free Health Services to Older People

Bureaucracy refers to the system of official rules and ways of doing things that a company or an organization has especially when these seem to be too complicated. While procedure; simply means a way of doing things; especially the usual or correct way. Bureaucratic procedures are inevitable as it help officials in government or in organization to have a systematic way of performing their duties so as to avoid confusion. Bureaucratic procedures seem to be an obstacle when do not put into consideration the special needs of a particular groups such as older people.

When older people fall sick and go to attend medical treatment they expect to be given a special care and attention because apart from being sick they are old. In order to investigate the effects of bureaucratic procedures to effective provision of free health services to older people, several questions were asked the available

bureaucratic procedures and procedures were uniformly mentioned which are registration, doctor consultation, laboratory test and drug services, the researcher wanted to know how does it affect the clients by asking how long does it take for older people to receive medical treatment when they fall sick. The Figure 4.4 bellow show how many hours they spend in hospital/health centers/ dispensary.

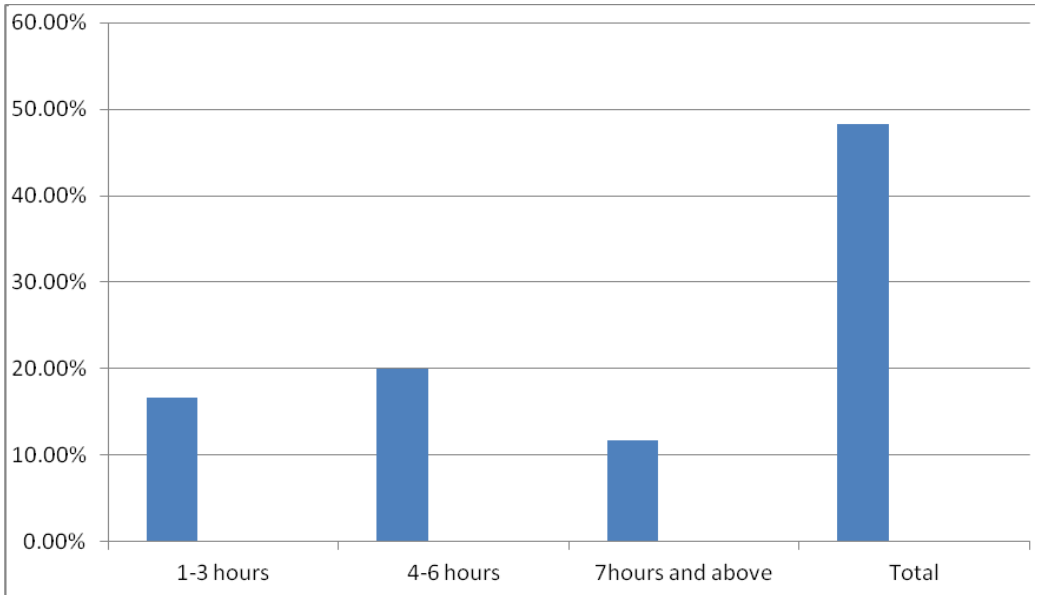

Figure 4.4: Hours Spend in Hospital/Health Centre /Dispensaries Frequency and Percentages

Source: Field Data from Magomeni (Majicoast Hamlet) and Miono (Masimbani Village), (2013)

Figure 4.4 show that 12 (20%) respondents spend 4 to 6 hours a day, followed by 10(16.7%) respondents said that they spend 1to 3 hours, the last group 7(11.7%) respondents revealed that they spend 7 and above hours. The researcher wanted to investigate if there are any administrative arrangements in place to ensure smooth provision of free health services to older people, respondents said that there is no any arrangement in place for the time being but for future plan they think of having

special room to provide health services to older people. Older people were also interrogated if the bureaucratic procedures available are friendly; they said it is a barrier to smooth service as one of older person said from Majicoast hamlet in Magomeni ward:

> "*Mwanangu hili swala la hapa kwenye hospitali limetuchosha. Vijana wenye nguvu wanakuja wanatupita, mimi sina nguvu za kusukumana na vijana. Wahudumu wa afya wanatudharau hawaoni kama wazee tunateseka. Nikiugua nawaza sana kuja hospitali maana nikija ugonjwa unaongezeka nakaa masaa sita wakati mwingine saba nikisubiria huduma. Miguu inaniuma na nina tatizo la sukari. Serikali imetusahau kabisa wazee. Cha kushangaza hata wazee walioko serikalini hawakumbuki wazee wenzao kwamba wanashida, tutakumbukwa na nani sisi"?*

The respondent is very concerned with the bureaucratic procedure on how it has been a barrier to older people, as she explains that she is not strong enough to struggle for quick treatment like youth, she adds; they are tired of the situation at the hospital, heath service providers ignore and stigmatize us very much. It takes a time to make a decision upon coming to the hospital to get treated when I think of the procedures, I become sicker when I visit the hospital as I spend six to seven hours waiting for services. I am diabetic and at the same time have arthritis problem. She is puzzled that even older people who are working in government institutions do not remember their fellow older people who are suffering. She is asking who is going to remember older people?

CHAPTER FIVE

5.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Overview

This chapter presents the summary of the findings, conclusions recommendations and ends by pointing out the direction for future research.

5.2 Summary

The major objective of this study was to assess the National Ageing Policy 2003 on provision of free health services to older people in Tanzania, specifically in Bagamoyo District. The study in particular examined the extent at which free health services are provided to older people, explored the understanding of implementers on National Ageing Policy 2003, examined economic factors that hinder accessibility to free health services provision among the older people, assessed the bureaucratic processes that affect effective provision of free health services to older people and finally came out with possible solutions.

Data were collected from a total of 60 respondents were administered through different data collection methods namely questionnaire and interview, apart from that observation method was also used to collect data, documentary review was also applied to collect documented information to supplement primary data.

Findings revealed that the National Ageing Policy 2003 particularly on free health services provision to older people aged 60 years and above is not yet to be met. This was observed as a result of lack of enough funds to facilitate quality health services, lack of awareness on policy document by implementers, leaders at village and ward

level, older people are not aware of their entitlements which are stated in the policy, poor bureaucratic procedures to serve older people as a special group, and other similar things.

It was also revealed that poverty is a barrier to older people in accessing health services as they fail to pay for the required costs, some health center are located at a distance which require older people to board motor circle but only those who can afford to pay for this dangerous and risky means of transport. In this regard some suggestions such as engaging older people in income generating activities, dissemination of policy soon after formulation, allocation of enough funds so as to support implementation procedures, having a special rooms in place to avoid procedures which cannot be tolerated by older people due to their aging problems, special training to health service providers to serve older people have been put forward to improve the situation.

5.3 Conclusion

This study concludes that free health services to older people as stated in the National Ageing Policy 2003 is not practical. Older people are required to go and seek for medical treatment from the private health centers for those who are able to afford the needed costs and for those who cannot afford continue to suffer. There are also other issues like standing in a queue for a long time waiting for a long time and travelling a long distance seeking for medical services, boarding motor cycle which coasts a lot of money to reach the service station and very risky transport to older people as they cause many accidents. Not only that but also there is poor care of

older people as they are not able to pay cash and therefore viewed an obstacle in generating income as it was revealed that only those who can pay cash can enjoy the services in the hospital. There is therefore a need to follow some recommendations so as to make this situation better.

5.4 Recommendations

The aim of any research is to make investigation whose output will make the researcher suggest some cause of actions. This study has yielded some information from which the researcher would like to make some recommendations by different potential stakeholders, policy makers inclusive. However in order to improve the situation in free health services provision to older people, recommendations has been put forward below:

5.4.1 The First Objective

The first objective of the study was to examine the extent at which free health services are provided to older people from that ground the following are recommendations based on objective one:-

5.4.1.1 Allocation of Sufficient Funds

After a policy is in place and funds of its programmatic implementation become available, Implementers make decision on how to deliver services. They design programs to carry out the policy's goal of reaching a specific population to affect some desired change. During the study 50(83%) respondents said that there are no free health services to older people. The desired change cannot be met without

enough funds to support the movement. Insufficient fund is one of obstacles which result into poor services provision to older people. Allocation of enough funds will solve the issues of inadequate medicine, laboratory facilities and the like. To achieve the mentioned step, The Ministry of Health and Social Welfare in collaboration with NGOs, District Medical Officers, District Council and other stakeholders should ensure that budget for medical facilities are sufficient so as to improve health services provision to older people.

5.4.1.2 Health Personnel should Receive Special Training to Handle Older People

This has been stated in The National Ageing Policy 2003, and it will add value to the health services which are provided to older people. Health personnel will have a greater understanding on the problems which face older people and their special needs together with weaknesses and strength so as to treat them friendly. This can be implemented by having a continuous action plan by the Ministry of Health and Social Welfare to train health personnel to deal with older people. This will be successful only if the same ministry allocates sufficient funds.

5.4.2 Recommendation

The recommendation below is derived from objective two of the study which is concerned with the level of understanding of implementer on National Ageing Policy 2003.

5.4.2.1 Policy Dissemination

As far as the second objective is concerned, 36 (60%) respondents who were interrogated concerning National Ageing Policy 2003 awareness revealed that; they

were not aware of the policy. Basing on that ground social workers and other policy makers should understand that formulating a policy is one step and dissemination of a policy is another step which is very crucial as the chance to help different stakeholders to become aware of the contents within policies and have clear understanding on their roles and responsibilities as well as enabling the targeted group to become sensitized on their entitlements, rights and policies which affect them. Here priority should also be given to rural areas where lack of knowledge seems to be more evident. This can be done by Social Welfare Officers in preparing television and radio programs on the concerned policy, different workshops, seminars and training from national to village level in line with providing policy copies and guidelines to stakeholders. Moreover Non-Governmental organizations are there to supplement initiatives of the government to meet its goals; that being the case social workers have to advocate for financial and material support from NGOs on the process of policy dissemination.

5.4.3 Study Recommendations

The study came out with the recommendations concerning objective number three of the study which is about examining economic factors that hinder accessibility to free health services to older people.

5.4.3.1 Economic Strengthening

Strategic plans should be set to help older people engage in income generating activities. According to the results from the study, it is not always the case that when a person reaches the age of 60 years and above cannot participate in income

generating activities. Older People should be helped to formulate groups and identify activities which are friendly according to their age and can help them to earn something for their wellbeing and not being viewed as a burden. Activities for example are such as poultry and hand crafts (i.e. pottery, ornaments, mats, embroidery and others). This can be done by providing older people with entrepreneurial skills to build capacities of older people which will enable them to participate in income generating activities. Community Development Officers at district level are responsible with providing such kind of skills in line with soft loans to needy groups from village to district level so they should provide such kind of loans and skills to older people too. Generated income will enable older people pay for their medical bills when needed.

5.4.3.2 To Formulate Older People Association

Older people need to have associations so as to help them to have one voice and speak out to fight for their rights especially free health service as stated in the National Ageing Policy 2003 and other related policies and strategies. Social Welfare Officers, Community Development Officers and Non-Governmental Organizations should help to sensitize older people and help them to reach their goals.

5.4.3.3 Identifying Older People as Vulnerable Group

Most of NGOs and Bagamoyo in particular focus on Most Vulnerable Children issues. This situation should change and identify other vulnerable and special groups like older people who need support and intensive care. Action plans by NGOs should include older people issues focusing on improving their well being as vulnerable

group. District Councils should stop putting older issues as the last priority and instead give them first priority so as to solve older people problems.

5.4.3.4 Youth Sensitization on Ageing Process and its Challenges

There is a Swahili slogan which is used by older people in Bagamoyo and I quote *"uzee na kuzeeka nani atakwepa? Labda ufe ukiwa kijana"*

The slogan means that old age and ageing no one can escape, the option can be dying while still young. As far as old age is irreversible this should be the starting point to make the youth aware that one day they will become older and at the time of becoming older they will be not able to produce for their subsistence compared to their past days. In order to have better life at old age they should work hard and start serving some money in line with investing in income generating activities like building houses for rent. Seminars, workshops, trainings, formulating youth clubs can be part and parcel of the way through in creating awareness of youths concerning old age. It is the duty of Social Welfare Officers, Youth Officers, Community Development Officers and NGOs to conduct as well as budgeting for those Seminars, workshops, trainings, formulating youth clubs.

5.4.3.5 Having Special Rooms and Doctors

The fourth objective of the study which is about assessing the role of bureaucratic process and its effects to provision of free health services to older people, 12(20%) of respondent out of 30 respondents complained on spending four to six hours at the hospital or health centre waiting for medical treatment. This is because there are no

any arrangements aiming at smoothening health services to older people. The researcher is of the opinion that management at all government hospitals, dispensaries and health centers should plan of having special rooms and doctors to help older people access health services at a reasonable time without standing in a queue for a long time waiting for services. However, Provision of identity cards, can become a solution to poor implementation of health services, the government of Tanzania have to make sure that free access to medical care will be made available to all older people aged 60 years and above. It is thus essential that older people are provided with identity papers in order to provide their exact age.

5.5 Recommendation for Further Research

It can be stated that there is research gaps in Tanzania as far as older people problems are concerned health problems in particular. Further research should be conducted using other type of research design. Older people health problems are not static they keeps on changing; what is a problem today concerning older person may not be a problem tomorrow. There is a call for research from older people in Bagamoyo. They call for the government to conduct a research to see if what is in the policy is implemented. Assessment research should be conducted in other areas in Tanzania rather than Bagamoyo District. The research can be helpful to gain knowledge on the sufferings that older people encounter concerning health services; hence proper interventions could be put in place to serve older people and improve their wellbeing as far as free health services provisions are concerned.

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APPENDICES

Appendix I: Questionnaire for Health Service Providers

Dear Health Service Providers,

This questionnaire is sent to you in order to request for your cooperation in responding to the questions written below. The purpose is to collect data on " National Ageing Policy 2003 implementation particularly on accessibility of free health services provision to older people " findings for this investigation are for academic purpose and are expected to provide useful information for knowledge for practical application in health services to older people.

Thanks in advance.

A: personal particulars

1. Sex

(a) Female [ ] (b) Male [ ]

2. Age

a) 20-24 [ ] b) 25-29 [ ]

c) 30-39 [ ] d) 40 -49 (e) 50 and above

3. Occupation----------

4. Level of education----------

5. organization----------

B: Extent to which free health services are provided to older people.

6. Do older people access free health services at your hospitals/health centers/ dispensary?

Yes [ ] No [ ]

7. Which services are accessed freely? Please mention _____

_____

_____

_____

8. Which services area not freely accessed? Please mention_____

_____

_____

9. Which diseases mostly affect older people? Please mention_____

_____

_____

_____

10. Are the mentioned diseases treated freely at your hospital/health centre/dispensary?

Yes [ ] No [ ]

11. If "NO" which ones are treated freely and which ones are not treated freely? Please mention_____

_____

_____

12. Is there any cost that sick older people are required to incur for medical treatment?

Yes [ ] No [ ]

13. If “Yes” do older people afford to pay the required cost for medical treatment?

_____

_____

_____

C: Extent to which implementers understand the National Ageing Policy 2003 with particular reference to accessibility to free health services provision to older people.

14. Are you aware of existing National Ageing Policy 2003?

Yes [ ] No [ ]

15. Have you ever come across that policy?

Yes [ ] No [ ]

16. Among other things the policy states that the cost sharing policy shall be revised to adjust the criteria for determining 60 years as standard age to receive free health services. Are you aware of that?

Yes [ ] No [ ]

17. The policy states also that, health services personnel should receive special training to handle older people. Are you aware of these?

Yes [ ] No [ ]

18. Are there health service providers who have been trained to serve older people?

Yes [ ] No [ ]

D: Economic factors that limit proper National Ageing Policy 2003 implementation particularly on accessibility to free health services to older people

19. Is there economic factors constraining proper National Ageing Policy 2003 implementation Particularly on accessibility of free health services to older people?

Yes [ ] No [ ]

20. If "Yes" please mention factors you know.

_____

_____

_____

_____

21. Have you ever taken any effort to address the challenges above?

Yes [ ] No [ ]

22. If "Yes" please mention the efforts you have ever taken to overcome those challenges

_____

_____

_____

E: **Bureaucratic processes and its effect to effective provision of free health services to older people**

23. What are the administrative arrangements do you have in place to ensure smooth provision of free health services to older people? Please mention _____

_____

_____

24. What should be done to ensure smooth free health services provision to older people? Please give your opinion_____

_____

_____

_____

Thank you for your cooperation

Appendix II: Questionnaire To Government Officials

Dear government officials,

This questionnaire is sent to you in order to request for your cooperation in responding to the questions written below. The purpose is to collect data on "National Ageing Policy 2003 implementation particularly on accessibility to free health services provision to older people" findings for this investigation are for academic purpose and are expected to provide useful information for knowledge for practical application in health services to older people?

Thanks in advance.

A: personal particulars

1. Sex

(a) Female [ ] (b) Male [ ]

2. Age

a) 20-24 [ ] b) 25-29 [ ]

c) 30-39 [ ] d) 40 -49 e) 50 and above

3. Occupation----------

4 .Level of education----------

5. Organization----------

B: Extent to which free health services are provided to older people.

6.Do older people access free health services at available hospitals /health centers/dispensaries?

Yes [ ] No [ ]

7. What challenges do older people encounter in accessing free medical treatment? Please mention _____

_____

_____

8. Is there any cost that older people are required to incur for their medical treatment?

Yes [ ] No [ ]

9. If “Yes” Do older people afford to pay required costs for medical treatment?

Yes [ ] No [ ]

10. If “No” what has been done to help them access medical care? Please explain

_____

_____

_____

11. How do older people access identity cards so as to access free health services? Please explain_____

_____

_____

12. What are your roles to make sure that older people receive proper free health care? Please mention_____

_____

_____

_____

C: Extent to which implementers understand the National Ageing Policy 2003 with Particular reference to accessibility to free health services provision to older

13. Are you aware of existing National Ageing Policy 2003?

Yes [ ] No [ ]

14. Have you ever come across that policy?

Yes [ ] No [ ]

15. Among other things the policy states that the cost sharing policy shall be revised to adjust the criteria for determining 60 years as standard age to receive free health services. Are you aware of that?

Yes [ ] No [ ]

16. The policy states also that health services personnel should receive special training to handle older people. Are you aware of that?

Yes [ ] No [ ]

17. Is the attitude of health services providers friendly to sick older people?

Yes [ ] No [ ]

18 which attitudes are not friendly to older people? Please mention_____

_____

_____

D:Economic factors that limit proper National Ageing Policy 2003 implementation particularly on accessibility to free health services to older people

19. Is there economic factors constraining proper National Ageing Policy implementation on accessibility of free health services to older people?

Yes [ ] No [ ]

20. If "Yes" please mention factors you know_____

_____

_____

21. Have you ever taken any effort to address the challenges above?

Yes [ ] No [ ]

22. If "Yes" mention the efforts you have ever taken to overcome those challenges

_____

_____

_____

_____

_____

E: Bureaucratic processes and its effect to effective provision of free health services to older people.

23. Are the bureaucratic procedures available friendly to older people?

Yes [ ] No [ ]

24. If “no” what should be done please explain_____

_____

_____

_____

Thank you for your cooperation

Appendix III: Interview Guide for Elderly

A: personal Particulars

1. Sex

(a) Female [ ] (b) Male [ ]

2. Age

a) 20-24 [ ] b) 25-29 [ ]

c) 30-39 [ ] d) 40 -49 e) 50 and above

3. Occupation----------

4 .Level of education----------

5. Organization----------

B: Extent to which free health services are provided to older people

6. What problems do you have concerning your health status? Please mention……..……

……

7. Where do you get treatment?

---

8. Are you required to pay any cost for your treatment?----------

---

---

9. Do you afford to pay required costs?----------

---

10. What are the attitudes of health service providers towards older people?

---

11. How often do you attend hospital when you fall sick? ----------

---

---

12. How many kilometers are there from your residence to hospital/health centre/Dispensary?

---

13. Do you have to board a bus/motor cycle/ bicycle to hospital/ health centre/ dispensary?

---

14. How much does it cost for you to board a bus/motor cycle/bicycle to hospital/ health centre?

15.How many/ villages hamlets get treated at the same hospital/health centre dispensary?----------

---

16. Are you satisfied by the services which are provided?

---

17. How long does it take you to reach hospital/ health centre/ dispensary?

C: Extent to which implementers understand the National Ageing Policy 2003 with particular reference to accessibility to free health services provision to older people

18. Is there any policy which particularly addresses the issues of older people?

---

19 Have you ever come across that policy?

---

20. Among other things the policy states that the cost sharing policy shall be revised to adjust the criteria for determining 60 years as standard age to free health services, Are you aware of this?

---

21. Is there any importance of having a policy?

D: Economic factors limiting proper Ageing Policy implementation.

22. Is there economic factors constraining proper National Ageing Policy 2003 implementation particularly on accessibility to free health services to older people?

23. If “Yes” please mention factors you know.

---

24. Have you ever taken any effort to address the challenges above?

---

25. What should be done?

E: Bureaucratic processes and its effect to effective provision of free health services to older people.

26. Please mention the bureaucratic procedure you have to go through to receive health services.

---

27. How long does it take you to receive medical treatment in the dispensary/health center/hospital?

a) Less than one hour [ ] b) 1-3 hour [ ] c) 4-6 hours [ ] e) 7 hours and above

28. Are the bureaucratic procedures available friendly to elderly?

---

29. Do you support the existence of available beauroclatic procedures?

---

30. If "no" what should be done please explain----------

Thank you for your cooperation

Appendix IV: Questionnaire for NGOs Officers

Dear NGO Officers

This questionnaire is sent to you in order to request for your cooperation in responding to the questions written below. The purpose is to collect data on "National Ageing Policy implementation particularly on accessibility to health services provision to older people" findings for this investigation are for academic purpose and are expected to provide useful information for knowledge for practical application in health services to elderly.

Thanks in advance.

A: personal particulars

1. Sex

a) Female [ ] b) Male [ ]

2. Age ----------

a) 20-24 [ ] b) 25-29 [ ]

c) 30-39 [ ] d) 40 -49 e) 50 and above

3. Occupation ----------

4. Level of education ----------

5. organization----------

B: Extent to which free health services are provided to older people.

6. Does older people access free health services at available hospital/health centers/dispensary?

Yes [ ] No [ ]

7. What challenges do older people encounter in accessing free medical treatment?

Please mention ----------

8.Are there any cost that older people are required to pay for their medical treatment?

Yes [ ] No [ ]

9. Do older people afford to pay required cost for medical treatment?

Yes [ ] No [ ]

10. If “No” what has been done to help them access medical care? Please explain

---

---

11. How do older people access identity cards so as to access free health services?

Please explain

---

12. What are your roles to make sure that older people receive proper free health care? Please

mention

C: Extent to which implementers understand the National Ageing Policy 2003 with Particular reference to accessibility to free health services provision to older

13. Are you aware of existing National Ageing Policy 2003?

Yes [ ] No [ ]

14. Among other things the policy states that the cost sharing policy shall be revised to adjust the criteria for determining 60 years as standard age. Are you aware of that?

Yes [ ] No [ ]

15.The policy also states that health services personnel receive special training to handle older people, are you aware of that?

Yes [ ] No [ ]

16. Is the attitude of health services providers friendly to sick older people?

Yes [ ] No [ ]

17. Which attitudes are not friendly to older people? Please mention----------

---

D: Economic factors that limit proper National Ageing Policy 2003 implementation particularly on accessibility to free health services to older people

18. Is there economic factors constraining proper National Ageing Policy implementation on accessibility of free health services to older people?

Yes [ ] No [ ]

19 .If “Yes” please mention factors you know.

---

20. Have you ever taken any effort to address the challenges above?

Yes [ ] No [ ]

21. If “Yes” mention the efforts you have ever taken to overcome those challenges

---

E: Bureaucratic processes and its effect to effective provision of free health services to older people.

22. Are the bureaucratic procedures available friendly to elderly?

Yes [ ] No [ ]

23. If “no” what should be done please explain----------

Thank you for your cooperation