CHALLENGES OF GOVERNMENT HEALTH SERVICES TO ELDERLY PEOPLE IN TANZANIA: THE CASE OF KINONDONI AND ILALA DISTRICT COUNCILS

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK OF THE OPEN UNIVERSITY OF TANZANIA

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CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by The Open University of Tanzania, a dissertation titled: "***Challenges of Government Health Services to Elderly People in Tanzania: The Case of Kinondoni and Ilala District Councils*** " in partial fulfillment of the requirements for the degree of Master of Social Work (MSW) of the Open University of Tanzania.

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Dr. Hadija Jilala

(Supervisor)

……..

Date

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DECLARATION

I, **Ibrahim Chande Abdu,** do hereby declare that, the contents of this dissertation is a result of my own original knowledge, this work has never been presented for similar purpose or degree awards in any other university.

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Signature

……..…….

Date

DEDICATION

This work is dedicated to my family, my lectures, coordinator and my classmates for their kind support and patience while pursuing my studies.

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I would like to thank God for enabling me to complete this study successfully. I also thank my family for their morally and spiritually support during the whole period of my studies. Their encouragement, advice and support enabled me to successfully conclude this study.

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ABSTRACT

This study investigated the challenges of government health services to Elderly People in Tanzania: The objectives of the study included; i) To examine the government financing for health facilities to elderly people needs in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam, ii) To find out the effect of health policy on the satisfaction of the elderly in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam, iii) To investigate the efficiency of health services provided by government health facilities and their satisfaction to elderly in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam. The study employed a case study design and a sample of 100 respondents involving older people, social workers, doctors and nurses were involved. In terms of sampling procedure, simple random sampling and purposive sampling were used. Simple random sampling was adopted to select older people who visited public hospitals while purposive sampling was used to get doctors, nurses and social workers. Data from questionnaires and interviews was analyzed both quantitatively and qualitatively. Quantitative data were extracted while qualitative data were subjected to content analysis, while, classified and computed using SPSS into frequencies and percentages, and presented in tables and figures. The study revealed that, 58% of the elderly people said that medicines are expensive. This intimates that there is high scarcity of medicines for elderly people in the government health facilities who are exempted to pay, this was due to Government very low financing budget for the health services. 60% 0f the elderly people they don't know about the current healthy policy. This was due to lack access to vital information regarding health services offered on their privileges.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AU	African Union
HIV	Human Immune Virus
HMIS	Health Management Information System
KII	Key Informant Interview
MSW	Master of Social Work
NSGRP	National Strategy for Growth and Reduction of Poverty
OUT	The Open University of Tanzania
SPSS	Statistical Package for Social Sciences
SRS	Simple Random Sampling
SSA	Sub-Saharan Africa
UN	United Nations
UNDP	United Nations Development Program
URT	United Republic of Tanzania
WHO	World Health Organization
HIV	Human Immunodeficiency Virus

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Ageing has emerged as an important policy issue worldwide because of the large increase in the proportion of elder people in the world population. Global projections indicate that, the population of those aged 60 years and above is increasing rapidly. The United Nations (UN) estimates indicated that, in 1950 the number of elder people was 200 million or 8 per cent of the world total population. In 2002, the population of the elderly had increased to about 630 million. Projections further suggest that, the number of elder people aged above 60 years is anticipated to be 1.2 billion in 2025 and 2.0 billion in 2050, (UN 2005, UN Population Division, 2010).

The United Nations (2012) report indicates in 2012 Africa had 42 million elder people, representing 5 percent of the world's population, 8 per cent of which are over 80 years. According to World Health Organization (WHO) 2012reported by the population of the elderly in Africa by 2050 will be 205 million. This is a tremendous increase in the number of elder people which needs proper plans in order to address their varied needs including access to free health care service. The United Nations (UN)and the African Union (AU) have recognized the importance of free health care service to elder people and encourage countries to address this need.

WHO (2011) mentioned the action of addressing health problems in sub-Saharan Africa(SSA) was developed in 2006 basing on health service agreement which was made by 13 African countries in Zambia. Livingston Call for Action recognized

access to free health care services as a basic human right and cash transfers as a highly effective yet under-used development resource in the region (Schubert, *et al.* 2006).

However, despite the large number of the elderly who need health services in Africa, there are no substantial plans and programs to address free health care services for them (Zastraw, 2008). This situation is more complicated in developing countries where the increase of elder people does not match with the available plans and resources to cater for their health needs (UN, 2010). As the number of elder people in Africa continues to increase, particularly those who are aged 60 years and over, there is less growing public policy and service delivery attention to the elder people to ensure their access to the basic necessities of life such as free health care services (Zastraw, 2008).

In line with the above trend, number of elder people in Tanzania continues to increase. The URT (2007) indicates that only 15 percent of the elderly receive free treatment from health service providers in Tanzania. Rutaihwa (1997) and Sembajwa, *et al.* (2009), said the elder people are not able to access free health care services in public hospitals.

Even though, apart from this tremendous increase of elderly people in Africa, it is also noted that, elder people are among the main user of health and social care services in the developing countries, just as they are in most developed countries. Due to their ill-health, older people visit health centers more frequently than younger adults, and are heavier users of both outpatient and inpatient hospital services (Oncology Nursing Society, 2002).

Provision of adequate and access to free health care services to elder people poses great challenges to the Tanzania government. The Tanzania government (2003)

responded to the challenges by creating a National Policy on ageing to set a base for promoting health care for elder people. Apart from the ageing policy, Tanzania formulated the National Strategy for Growth and Reduction of Poverty, mainly referred to as NSGRP, which addressed health care needs of the older people. The target was to reach 40 per cent of older people with effective health care service by 2010 (URT, 2005). However, both the National Health Policy of Tanzania and the Public Service Act of Tanzania recognize 60 years as retirement age (WHO, 2000).

However, in African context elderly is so defined within the context of their families, which are formed by domestic groups, marriages and kin networks. They are also identified by their productive and reproductive roles. Being an elder means that one is shaped by cultural norms and values, and molded and constrained within specific economic, demographic and socio-political systems (Oppong, 2006). Recent research in Africa suggest adopting age 55 and over as a baseline definition of old persons (Ferreira, 2003). Though Sub-Saharan countries have the lowest pace of population ageing in the world, the overall population numbers of old people are on the rise (Oppong, 2006).

The average life expectancy at birth with the exception of the effect of HIV/AIDS is projected to rise from the current 45 years to about 63 years by 2050 (UNPD, 2005). The absolute numbers of older people are expected to rise from 36.6 million to about 141 million in 2050 (UNDP, 2005). In the 2000's, the global population was characterized as more youthful than elderly, hence the rate and pace of ageing is slower than in other parts of the world (Mujahid, 2006). As a result, problems that result from the ageing process have received less focus from policy makers and the

research community than problems that are manifested among the youthful population (Zastraw, 2008). With an ageing population, there has slowly arisen awareness that many older adults in Africa are facing or will face abuse, without the customary expected social safety net (Oppong, 2006).

Africa has a long tradition of being a society that reveres its old citizens. In some traditional societies, older persons have been given respect and honored and they have been women and men undergoing the process of maturation, they are expected to take the roles of advisors, they also guide and support the younger generation right from the family level, society, and national level. It is not old age in years per se that is revered but the maturity and wisdom that comes from a lifetime of experience obtained while raising new generations compounds and many co resident relatives. With the changing realities of daily life, social and economic changes have resulted in rapid urbanization, resulting in exclusion of older person from socio-economic and political affairs at the rural levels (Zastraw, 2008).

The welfare and support of the elderly has always been left in the hands of the extended family networks. The extended family has provided a system of social security which is rapidly eroding due to urbanization, economic recessions, HIV/AIDS epidemics and modernization, leaving the older person vulnerable to abuse (Ferreira, 2005, Mba 2007).

Policies have not had a significant impact on the overall health of the older populations and prevention of Abuse. In Tanzania, the female elderly population is more than that of men. In 2006, the life expectancy at 60 for women was 17 years, but

only 15 years for men (UNDESA, 2006). In 2006 there were 79 men for every 100 women over 60, but only 63 men per 100 women over 80 years. The number of older people in Tanzania over the age of 60 will have increased from about two million in 2006 to over seven million in 2050 (UN, 2006). However, cases of elder abuse especially among women are acknowledged as prevalent in Tanzania and Mozambique (Help Age International, 2002). Annually, 500 witchcraft related killings among elderly women, are reported in Tanzania (Ageing and Development, 2000).

In line with the above evidence from various literature is also reported that, more than 60 per cent of health services are not easily accessible for the majority of elderly people and in most cases, is due to transport cost implication and lack of support from extended families (National Aging Policy 2003.Therefore, from the above facts as reported by various authors, there is a strong need for investigating the challenges facing elderly people in accessing health services in public health facilities. However, there are limited studies that have been conducted in Tanzania that address the elderly challenges particularly on health service accessibility in Kinondoni and Ilala in Dar es Salaam. Therefore, the current study intends to fill the gap by investigation on challenges facing elderly in the context of health accessibility.

1.2 Statement of the Problem

Despite the efforts made by the Tanzania's government in collaboration with private stakeholders (both at local and international levels), in creating health provision strategies and plans, there are mounting evidences showing that older people continue to experience difficulties in accessing adequate and quality free health care services in public hospitals(URT, 2005). Consequently, there is an increase in elderly deaths,

poverty, an increase in variety of diseases to the elderly such as diabetes and stress. In addition, denial hospital treatments, discouragement to attend health facilities for health services, waiting a long time to get health services, decrease of elders support from their families. All these point to one direction, vulnerability and stigma of the elderly(URT, 2005).

The problem of elderly lacking access to health services in Tanzania to a large extent emanate from the fact that they lack access to vital information regarding health services offered on their privileges (Rasch, 2008; African Youth Alliance, 2003). This problem can be addressed only if we have the right kind of data and information of its magnitude, causes and consequences. This understanding can be achieved through a rigorous empirical research, the task the current study sought to address. Therefore, current study uses a mixed-method approach to investigate the challenges of Government Health Services facing the elderly in Kinondoni and Ilala District Councils in Tanzania.

1.3 General Objective of the Study

The general objective of this study was to investigate the challenges of government health services to Elderly People in public hospitals in Dar es Salaam.

1.4 Specific Objectives

(i) To examine the government financing for health facilities to elderly people needs in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam.

(ii) To find out the effect of health policy on the satisfaction of the elderly in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam and

(iii) To investigate the efficiency of health services provided by government health facilities and their satisfaction to elderly in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam.

1.5 General Research Question of the Study

The general research question of this study was; What were the Challenges facing Government Health Services to Elderly People in Tanzania specifically in Kinondoni and Ilala District Councils?

1.5.1 Research Questions

(i) How does government finance health facilities to elderly people needs in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam?

(ii) Does health policy affect the satisfaction of elderly people in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam?

(iii) Does health services provided by government health facilities satisfy the elderly people in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam?

1.6 Significance of the Study

Understanding the Challenges of Government Health Services to Elderly is an important research agenda in Tanzania. This study is important because its findings are useful to the Government of the United Republic of Tanzania through the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEC) in their bid to craft informed policies and strategies regarding the challenges they face in Government Health Services.

Other stakeholders that might gain useful insights in this area include but not limited to development partners, NGOs, and policy makers. In addition, the study findings are useful to health practitioners in building the case to request as many medicines as possible in order to reduce the scarcity of medicines in health facilities as the current study have shown. Also, findings and information obtained from this study cover the existing knowledge gap in the areas of elder people and associated Government Health Services.

Furthermore, researchers may use the findings from this study as a knowledge base in undertaking similar studies in a wider coverage of elder people in addressing challenges facing them in Government Health Services. This helped to raise awareness about the predicaments of elder people, support possible policy interventions and use study recommendations to make decisions.

Lastly, findings from this study increased awareness of the community regarding elder people's right to free health service provision. Also findings are projected to support local authorities, hospital officers and health consultants to have truthful and proper plans which consider health needs of older people.

1.7 Delimitation and Limitations of the Study

This study was only limited to investigate the Challenges of Government Health Services to Elderly People in Tanzania by using the case of Kinondoni and Ilala District Councils. The reasons for choosing this area are because the vulnerability of the aged persons and because of scars health services among the aged persons. The scope of the study was influenced by the limited time and inadequate resources. While

we acknowledge that elderly faces many socio-economic and cultural challenges in their old ages; the study was limited only on the challenges they face in Government Health Services in Tanzania.

1.8 Definition of key concepts

1.8.1 Healthcare

Healthcare is the maintenance or improvement of health via diagnosis, treatments, and prevention of disease, illness, injury, and other physical and mental impairments in human beings (Zastraw, 2008). Healthcare is delivered by health professionals (providers or practitioners) in allied health professions, chiropractic, physicians, physician associates, dentistry, midwifery, nursing, medicine, optometry, pharmacy, psychology, and other health professions (Mba, 2007).

1.8.2 Ageing

The concept of ageing is not universally defined across different people. Researchers have different views regarding the concept. Generally, in developing countries like Tanzania ageing is not defined using the same common terms as those used in developed countries. Ageism refers to the discrimination of elder people perpetuated by prejudice and stereotypes (Butler, 1980).

The consequences of ageism are negative both for society at large and for the individual elder person by negatively influencing the quality of healthcare as well as creating barriers towards implementation of good policies for sustainable development (WHO, 2015). Kozier *et al.* (1992) define ageing in terms of age categories such as,

young old (65-74), the middle old (75-84) and the old-old (over 85). While provide different classification of this group which are independent old, dependent old and oldest old. Pinquart (2001) states that, gerontological studies use the following classification to explain the process of ageing: young-old (60-75) and old-old (75+ years). According to Kapplan, *et al.* (1994) classify elder adults into two groups: young-old (65-74) and old-old (75 years and to the next generation).

1.8.3 Elder Persons

According to Erickson (1963) the elders is “integrity versus despair” whereby elders recognizes that, they are leading the end of life and thus they face many losses of strength, health and family and friends. While Kim (2000) describes elders as another development period that requires significant readjustment. He sees that, there are common similarities between old and adolescent as they both experience biological changes, personal and social expectations and they both perceive major changes in the opportunities available to them. Butler, (1980) most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person, but like many westernized concepts, this does not adapt well to the situation in Africa.

While this definition is somewhat arbitrary, it is many times associated with the age at which one can begin to receive pension benefits. However, Both the National Health Policy of Tanzania and the Public Service Act of Tanzania recognize 60 years as elders and at the retirement age (WHO, 2000). Though, elder people are viewed as frail, burdensome or dependent, despite the fact that these people contribute to society in many ways.

1.8.4 Sociological Perspectives

Brinkmen (1988) propose that the meaning of old age/elderly depends on social structure and thus varies across and space, and Steward (1981) views old age as the time when energy is low, the circle of family and friends diminishes and income reduces. Safari (1985) sees aging as a developmental process beginning with the embryo and ending up in old age and ancestral spirit. However, all the studies failed to identify the exact old age period leaving it to depend on social structure, time and social status transition.

1.8.5 Health Services Accessibility

The degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health care system (Sidney, 1998. Factors influencing this ability include geographic, architectural, transportation, and financial considerations, among others. Accessibility to the elders means that the health care services are unrestricted by barriers such as geography, economy or language. Service standards (James, 2001). Elders feel more comfortable if providers respect their privacy during counseling sessions, examinations and procedures.

Various studies suggest that the older populations are more likely to experience malnutrition, chronic physical and mental conditions, hearing and sight difficulties, depression and dementia (Aboderin, 2010). Elders particularly those who obtain services in secret report higher satisfaction with providers who keep their needs and personal information confidential (Whittaker, 1996). Lack of privacy can violate client's sense of modesty and make it more difficult for them to participate actively in selecting the best alternative in service provision in advocacy (Sidney, 1998).

The health care gaps which are present in low-and middle-income countries have many negative consequences for the health of older people; such as high rates of limitations in functioning as well as negative consequences for their family members. Due to inadequate health care and social care, the poor health of an elder person may force a family member to stop working and stay at home as a caregiver (WHO, 2015).

Distance has been one of the factors constraining elderly health service accessibility. Many elderly cannot easily go to the health facility which are often far apart from the area living, even if public transportation is available for the elderly to travel, long distance may make it difficult to some elderly to obtain services (Lewis, 1995). Some elderly may prefer to travel to more distant facility if they feel that it provide better services, including a range of care options, effective counseling and convenient hours (Hodgins, 2000).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature review both theoretical and empirical drawn from Tanzania and elsewhere in the World. Specifically, the chapter covers the theoretical framework, empirical studies, and it begins by presenting, the theoretical framework, followed by empirical studies, as well as the conceptual framework.

2.2 Theoretical Literature

2.2.1 Theory of Health Empowerment

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The theory of health empowerment is based, in part, on Rogers' Science of Unitary Human Beings particularly influential is Rogers' principle of integrality perspective of human beings as integral with their environment in their daily living and health experience; characterized by pattern, self-organization, diversity and innovative change; and as holding individual values and views about health (Rogers, 1992). Rogers, (1992) noted that, the theory identifies health empowerment as emerging from a synthesis of personal resources and social-contextual resources. Personal resources reflect unique characteristics of older adults such as self-capacity. Social-contextual resources include support from social networks and social service support. Empowerment from this perspective is a dynamic health process that emphasizes "purposefully participating in a process of changing oneself and one's environment, recognizing patterns, and engaging inner resources for well-being. Health empowerment emphasizes facilitating one's awareness of the ability to participate knowingly in health and health care decisions.

The Health Empowerment Theory is a theory-based intervention designed to promote the use of personal resources and social contextual resources with the goal of enhancing well-being in homebound older adults. Health empowerment theory is expressive of a human health pattern of well-being and is viewed as a relational process that emerges from the recognition of personal resources and social contextual resources. This process facilitates purposeful participation in the attainment of health goals and the promotion of individual well-being (Shearer, 2007).

2.2.2 Activity Theory

The Activity Theory occurs when individuals engage in a full day of activities and maintain a level of productivity to age successfully. The activity theory basically says: the more you do, the better you will age (Maddox, 1968). It makes a certain kind of sense, to people who remain active and engaged tend to be happier, healthier, and more in touch with what is going on around them. The same goes for people of any age. Often, the activity theory is dismissed to some degree because it falls a little flat. It not sufficient to just be busy, like the definition states (Quadagno, 2007). You can't wake up every day and do the same thing, like riding a stationary bike, and expect to age well. This theory was taken and used by many program designers for the elderly, who filled elder folks' schedules with busy work and required them to complete tasks. A heightened level of activity is needed, but it needs to be engaging and fulfilling, rather than just busy work (Sana *et* al., 2008). The activity theory, also proposes that successful ageing occurs when elder adults stay active and maintain social interactions. It takes the view that the ageing process is delayed and the quality of life is enhanced when old people remain socially active (Richard, 2006).

The activity theory rose in opposing response to the disengagement theory; however, the theory also fails to consider maintenance of one's mid-life or changes that are made when entering retired or elder life (Vern *etal*, 2009).

2.3 Empirical literature

2.3.1 Global literature Review on Situation of the Elderly and Access to Health care

There has been an increase of elderly persons in the past few years, globally; the percentage of older people is projected to double from 10 per cent in 2000 to 20 per cent in 2050. According to Help Age International, 2013, elder people also often lack access to a steady income, such as pension, or retirement benefit, or salaries from good employment. Even those who do receive pensions will find it difficult to cover their healthcare needs (Hai, 2013).

Half of the disease burden in low and middle-income countries is now from Non-Communicable Diseases (NCD), and these diseases are turning into a global pandemic that threatens the health of a large number of people and their economies (WHO, 2009, WHO, 2011). Although NCD affect elder people of all nations, those in low- and middle-income countries are at peculiarly high risk of NCD (Hai, 2013) In African countries identified under-financing of health systems, over-stretched health workforces, poor health management information systems (HMIS), unreliable supply of medicines, physical barriers to access health-care and distance- related barriers, as the main constraints that contribute to older people’s poor access to health-care services (Hai, 2010).

2.3.2 The Elderly and Access to Health Care in African

Studies conducted in African context have indicated that by 2050, nearly 80 per cent of the world's elder population will be living in less developed countries (UN, 2010). The rise in the number of elder people increases the burden of providing social services, including health-care services, on duty bearers in developing countries, who may be forced to leave much of the needs of these groups of people unaddressed (HAI, 2013).

As the population grows older the demand for health services also increases. In Africa, data on geriatric service provision and utilization is lacking (Joubert, *et al.,* 2006). Most of the studies conducted on the area of elderly and health accessibility suggest that the older population is more likely to experience malnutrition, chronic physical and mental conditions, hearing and sight difficulties, depression and dementia (Abodein, 2010).

For example, studies conducted in Kenya, South Africa and Pakistan identified that lack of finance, absence of family support, physical inaccessibility of health service providers and practicing quacks are the major factors deterring elder people from seeking healthcare services (Ladha, *et al*..,2009, Paxton,2008, Waweru *et al.*, 2003). Under-financing of health systems, over-stretched health workforces (from doctors to community health workers), poor health management information systems, unreliable supply of medicines, incredible time waiting for services, physical barriers to access healthcare and distance-related barriers are other factors that contribute to older people's poor access to healthcare (Help Age International, 2013).

2.3.3 Health Situation to Elder People in Tanzania

A study by Kimokoti (2008) shows that in Tanzania, many elder people reach retirement age after a lifetime of poverty and deprivation, poor access to health care and poor diet. This situation often leaves them with insufficient personal savings as a consequence of a fragile earning history (Chariot, 20001). However, health is the most common problem among the older people in Tanzania. Apart from being vulnerable due to old age and lack of social and economic support from their children, ill health contributes to high vulnerability. For instance, elder people suffer from variety of old age-related health problems such as arthritis, rheumatism, cataracts, strokes, hernias, dementia and many others.

This makes old people to experience frequent forms of ill health which require regular treatment (Tanzania Participatory Poverty Assessment, 2002). Traditionally, Tanzanian and African culture in particular usually valued elder people as a storehouse of knowledge and experience. This routine of honoring the elderly balanced the tendency found in most of the Tanzanian communities whereby old people signified wisdom and blessing from God. As a result, the elderly were seen as pillars and custodians of the Tanzanian culture (Mbwete, 2008). But also, the caring for older people was the responsibility of the whole society including the family.

According to Chapman, (2010) socio-economic factors, urban-rural residence, gender, education, marital status and social networks have been identified as shaping the health status of people over time. Individually, the elderly face numerous barriers in accessing healthcare. Some of the barriers which have been identified include interpersonal relations and communication problems between health providers and

elderly patients and lack of knowledge about services and treatment (Joubert, *et al..*,2006).

For example, a study on health-seeking behavior in Kenya, found out that negative attitudes of healthcare workers were associated with elder people delaying seeking healthcare (Waweru *et al.,* 2003). Consequently, in Tanzania, 40 per cent of elder people reported that the tone language used by medical staff was disrespectful and mocking, while over a third had to wait between 4 and 6 hours in order to see a doctor (HAI, 2008). In South Africa, elder people expressed dissatisfaction with the quality of healthcare at the primary level, including inefficient appointment systems, long waiting times and apparent lack of interest of staff in the health problems of the elderly (Joubert, *et al.*,2006).

Elder people in urban and rural areas revealed that the quality of public healthcare services they received was major concerns including; shortage and unavailability of supporting gears, and perceived lack of respect and sharing of information by health personnel who attended to them (Joubert, *et al.*, 2006). In Kenya, 62 per cent of elder people reported buying over the counter medicines (Waweru *et al.*,2003). This high level of elder people accessing over the counter medicines is indicative of the efficiency of health services in meeting needs of the elderly in developing countries.

These constraints in health service provisions are exacerbated by the shortage of staff trained in the care and treatment of older people. African countries, only a small proportion of health workers have specialist training in management of chronic illness among health workers in generally poor (de-Graft Aikins *et al.,* 2010).

For example, the study on the perceptions and attitudes of medical students towards older patients in Tanzania found that 45 per cent of respondents regarded older people as dependents, unpleasant, unhealthy dull and ugly (Kowal, *et al.*, 2003). It was noted that, only 2 percent of these respondents had attended courses related to ageing, all of which were outside the country.

This study concluded that a lack of geriatric teaching and exposure to geriatric medicine contributes to negative perceptions around the elderly and reduces the quality of services delivered. Economic barriers to accessing services and treatment are often experienced by elder people who lack financial and social support. In Africa, the economic situation of the elderly is closely tied with the overall situation of extended family (Maharaj, 2012). In Kenya, 73 per cent of elder people reported lack of money as hindering their access to healthcare (Waweru *et al.*, 2003). In a qualitative study, titled conditions affecting the elderly in accessing primary health care in urban health care centers of Iran. Reported limitation of distance to health as a barrier of utilizing health care centers by the elderly (Firoozeh, *et al.*, 2009). Alone as a barrier, however, distance does not fully explain accessibility (Bostock, 2001).

Ntihosanzwe (2013) examined challenges facing older people in accessing free health care services in public hospitals taking the case study of Temeke, Magomeni and Mwananyamala hospitals. He employed a case study design and a sample of 80 respondents involving older people, social workers, doctors and nurses. His sample was picked using purposeful sampling and snowballing. His findings show that 58 per cent of older people do not have access to free health care services in public hospitals. Moreover, his findings further show that 87 per cent of respondent complained to have

lack of essential medicines as a major challenge. The study recommends that there is a need to review policies for the elderly together with designing a comprehensive health insurance package for the elderly.

A study by Sanga (2013) examined challenges facing older people in accessing free health care services in government health facilities in Moshi Municipality Area. He employs the questionnaire and semi-structured interviews. His findings show that 85 per cent of the elderly in the sample fail to access important medication in health facilities. And 80 per cent of them also need to have their own window for health services as a strategy to reduce the time waste waiting for the services.

2.4 Existing Knowledge Gap (s)

Despite the existence of rich empirical and theoretical literature on the challenges of government health services to elderly people still there is no improvements. The reviewed literature show that the number of the elderly is increasing at a disproportional level as compared to the expansion and adequacy of health services .It is unfortunate that despite their numeracy and special needs in terms of access to and quality of free health services, literature point out that they have actually been forgotten.

The literature confirms the fact that as age's progress so do the need of special health services to the elderly. The literature have shown that access to free quality health services to the elderly is one among the most critical aspect of their welfare and well-being. Literature point out the existence of various policies aimed at promoting good health to the general public but more so to the elderly as a special group in society.

Yet, the elderly are still failing to access and adequate free health services in public hospitals. This means that these policies much as they are good, they are just in papers and their implementation have posed as a major challenge. Moreover, most of the previous studies have been done in semi-urban or urban areas with more or less homogeneous population of elders. For example, Morogoro, Moshi etc.

The literature reveals that there is a persistent gap and increasing gap between what should be attained and what is available. These gaps exist in areas of knowledge, capacity and resources. No literature has looked at urban society with heterogeneous population like that found in Kinondoni and Ilala Distrits in Dar es Salaam. The current study is set out to fill the existing gap by looking at these two districts taking into account their diversity.

Despite the many empirical studies on health services delivery, these have been done so as if people have homogeneous social-demographic characteristics, and the elderly have not been treated as a special group. Their special needs therefore, have been ignored in literature. Further, literatures regarding healthy issues and challenges facing the elderly have not been adequately dealt with in Dar es Salaam particularly in Kinondoni and Ilala districts. It is also unfortunate that the problem of free health services accessibility among the elderly in Tanzania remain underexplored despite its importance. In addition, the challenges the elderly face when trying to access free Medicare have not been researched enough in Dar es Salaam and hence its literature remain scant.

The difference of this study and the previous study is based on methodology. This study employs questionnaires, purposefully sampling and Key Informant Interviews.

Unlike previous studies, we extend our sample to 100 respondents. Although this sample may not be as representative as one could expect given its size, the fact that we include Key Informant Interviews should address most of the issues not covered in other studies. Moreover, our study involves a heterogeneous population and sample that covers a wide diversity of people. In other studies the methodology aspect is not well covered particularly on the way the sample is picked unlike our study.

This study therefore, seeks to fill the existing knowledge gap of what is not known regarding the challenges of government health services to elderly people on their bid to seek Medicare in urban areas in Tanzania, taking Dar es Salaam as a general case study and Kinondoni and Ilala districts in particular. It is hoped that the empirical findings from this study will inform policy makers, NGOs and the academia on the best policies and strategies to address the problem of the challenges of government health services to elderly people when seeking free Medicare in Tanzania.

2.5 Conceptual Framework

After the review of literatures, the conceptual framework has been developed based on various ideas raised by various authors. Various factors have been raised in various studies that address health service accessibility among elderly. These factors include: elderly' financing packages in public hospitals; policy to elder people from accessing free health care services in public hospitals; and satisfaction among the elderly people on health services provision among the elderly people.

The theory used for analyzing the challenges of government health services to elderly people from government health facilities have been analyzed based on Empowerment

Health Theory. Again, this theory of Health Empowerment characterized by pattern, self-organization, diversity and innovative change; and as holding individual values and views about health (Rogers, 1992).

Rogers, (1992) noted that, the theory identifies health empowerment as emerging from a synthesis of personal resources and social-contextual resources. Personal resources reflect unique characteristics of older adults such as self-capacity. Social-contextual resources include support from social networks and social service support. Empowerment from this perspective is a dynamic health process that emphasizes "purposefully participating in a process of changing oneself and one's environment, recognizing patterns, and engaging inner resources for well-being.

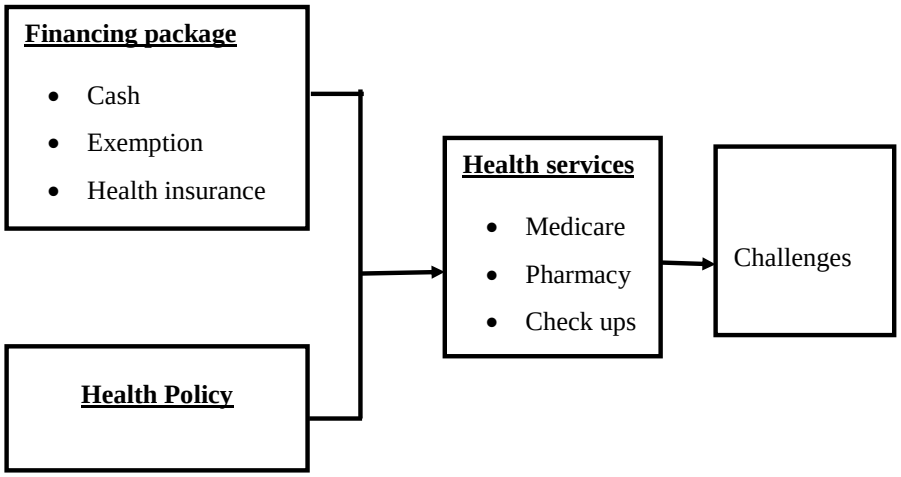

Figure 2.1: Conceptual Framework
Source: Research Data (2017)

Health empowerment emphasizes facilitating one's awareness of the ability to participate knowingly in health and health care decisions. The Health Empowerment theory is a theory-based intervention designed to promote the use of personal

resources and social contextual resources with the goal of enhancing well-being in homebound older adults. Health empowerment theory is expressive of a human health pattern of well-being and is viewed as a relational process that emerges from the recognition of personal resources and social contextual resources. This process facilitates purposeful participation in the attainment of health goals and the promotion of individual well-being (Shearer, 2007).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the research methodology and methods that have been employed in this study. Research methodology relates to grand plan of a particular research project that shows how a researcher intends to conduct the research and how the research is guided against internal and external factors which may influence and undermine its validity and acceptability as a knowledge base (Babbie, 1995). Research methodology is the scientific procedures and processes of studying how research is done scientifically in various steps that are generally adopted by the researcher in studying the selected research problem (Kothari, 2004).

The study also employed qualitative approach as a means of exploring and understanding the meaning of an individual or groups of elderly people, social workers, medical officers, and nurses in accessing health services in government hospitals in Ilala and Kinondoni municipal. The use of this approach enabled the researcher to focus on how these people can have different ways of looking at reality as it concerns with subjective assessment of attitudes, opinions and behavior (Kothari, 2007).

The aim of this chapter is to describe how the study was conducted; it presents research design, study area and rationality, study population, inclusion and exclusion criteria, sampling techniques, sample size determination, data types and sources, data collection techniques, data analysis methods, validity and reliability of data, and lastly ethical considerations.

3.2 Research Design

According to Kothari, (2004), research design guides data collection, measurement and analysis. Highlighting more on what the research design is, in their work. Strauss and Corbin, (1990) advocates that, a research design is plan that shows the approach and strategy of investigation conceived by a researcher in order to maintain relevant data, which fulfills research objectives and answers a set of research questions or tasks.

In this study, multiple holistic case study research design employed as it refers to design that include more than one cases having common specification in data analysis. Following the same line with Yin, (2003) multiple cases use because they provide more evidence than a single case and add confidence to the finding. The study employed quantitative approach and qualitative approach from which data and information were extracted using the structured questionnaires, key informant interviews (KIIs), and observations which are essential. Secondary data and information were extracted from various administrative records in hospitals and government administrative unit's offices.

3.3 Study Area and Rationality

The study was conducted in two public hospitals namely Mwananyamala and Amana in Kinondoni and Ilala Districts respectively in Dar es Salaam region. According to estimates drawn from the Population and Housing Census of 2012 (PHC 2012), there were 5.2 million people living in Dar es Salaam in 2012. Recent estimates show the population to have grown to 5.29 million in 2017 people (NBS, 2017). Moreover, the region covers an area of 1,100 sq. km and it is the most densely populated area in

Tanzania (Tripp, 1997). The region also encompasses a heterogeneous population of different nationalities (Hellela, 2001).

Dar es Salaam was selected because it is the most densely populated and the largest city with multicultural people from Tanzania in particular and the world in general. Moreover, it has complex dynamics and challenges regarding socio-cultural and economic life, particularly for the elderly. The challenges are especially complex to older people who have retired from work with little serving, therefore selection of Dar es Salaam provides good study area of the population in Tanzania since it is composed of heterogeneous population of older people in the country.

In addition, Dar es Salaam has large number of older people compared to other parts of the country (2012 PHC; and World Bank, 2003).According to the 2012 PHC, Kinondoni and Ilala districts have one of the largest population densities in Tanzania. The 2012 PHC shows that the population in Kinondoni and Ilala Districts are respectively 1,775,049 and 1,220,611 people. These people were living in the area of 527 km² and the area of 210km² in that order.

The reasons for selecting these districts and their corresponding hospitals is based on the fact that they are the most visited health facilities at municipal level, and over time are the most blamed regarding poor service delivery do not only the elderly but also to all other patients from different walks of life, according to various media outlets. Moreover, these have been purposely selected for the sake of convenience and cost saving given the small budget in conducting the study.

3.4 Study Population

Kothari, (2008) defines the term population as an entire group, individuals, events or objects having common observable characteristics. It is a group to which results of the study intends to apply Fraenkel, (2000). In addition to what is explained above, Cohen, (2000) defines the term population as a group from which the researcher expects to get useful information and draw conclusions for the study.

For the purpose of this study, the population divided into two groups. First group involved elderly as a targeted group for the study. The second group was social workers, medical officers, and nurses because these are people who regularly interact with elderly when it comes to medical services so they have knowledge and experience about the elderly.

The qualitative nature of this study influenced the choice of population. Moreover, selection of this population based on the belief that they have useful and relevant information related to the study since they directly work in health setting and come in regular contact with elder people. Sometimes getting the correct and complete population of interest becomes quite challenging (Abramson, *et al.*, 1999). The list may be protected by privacy policies or require a lengthy process to attain permissions (www.surveysystem.com/sscal.htm-retrieved on 11th May 2017 at 18:10 hours).

Moreover, there may be no single list detailing the population you are interested in. As a result, it may be difficult and time consuming to bring together numerous sub-lists to create a final list from which you want to select your sample. Many lists will not be in the public domain and their purchase may be expensive; at least in terms of the

research funds of a typical undergraduate or master's level dissertation student. In terms of human populations, some of these populations will be expensive and time consuming to contact, even where a list is available. Assuming that your list has all the contact details of potential participants in the first instance, managing the different ways (e.g., postal, telephone, email) that may be required to contact your sample may be challenging, not forgetting the fact that your sample may also be geographical scattered. In the case of human populations, to avoid potential bias in your sample, you will also need to try and ensure that an adequate proportion of your sample takes part in the research. This may require re-contacting non-respondents, can be very time consuming, or reaching out to new respondents.

The population of this study is heterogeneous in nature and includes all elder people above 60 years living in Ilala and Kinondoni areas, social workers, medical officers, and nurses. The choice of this population is informed by the nature of the study in which the methods employed to each group differs as discussed below. Moreover, it is assumed that these people have either different information or the information they have differs in details and understanding.

3.5 Inclusion and Exclusion Criteria

3.5.1 Inclusion Criteria

The study included the elderly of 60 years of age and above from the two municipalities. The reasons for choosing this age as cut-off is that in Tanzania, the government exemption policy for elderly getting free Medicare is that they should be of that age. Further, this is the recommended age for compulsory retirement and these

are recognized by the government as a special group requiring special government attention in all aspect of social-economic life.

3.5.2 Exclusion Criteria

The exclusion criteria were talking to elderly who had bellow 60 years of age from the two municipalities, the reasons for excluding the age bellow 60 years because this age does not qualify for exception policy, also the age bellow 60 years of age is not recommended age for compulsory retirement and are not recognized by the government as a special group requiring special government attention in all aspect of social-economic life.

3.6 Sampling Techniques

Sampling technique is a definite plan for obtaining sample from a given population. Kothari (2004) defines sampling technique as a procedure that the researcher would adopt to select elements to be included in the sample. Sampling technique lay down the number of elements to be included in the sample. Baker (1999) noted that, there are two major goals that sampling can achieve. The first is to establish representatives of what are being studied and conversely to reduce bias. The second is to be able to make inferences from findings based on a sample to a larger population from which that sample is drawn. Sampling is important in reducing bias in the findings (Veal, 2007; and Flick, 2008). The study employed simple random sampling and purposive samplings to get the required sample.

3.6.1 Simple Random Sampling

According to Kothari (2004), in a random sampling each element has an equal chance of being selected, and the sample so selected is assumed to be more representative.

The study employed simple random sampling to get the respondents. One critical question of interest at this juncture could be why do we use simple random sampling instead other sampling techniques? The answer largely lies on the advantages accrued from using the techniques and these are:

Simple random sampling has many advantages over other sampling techniques, though it is not without limitations. Whilst simple random sampling is one of the 'gold standards' of sampling techniques, it presents many challenges for students conducting dissertation research both at undergraduate and master's level. The aim of using simple random sampling is to reduce the potential for human bias in the selection of elements to be included in the sample. As a result, the simple random sampling provides us with a sample that is highly representative of the population being studied, assuming that there is limited missing data.

Since the units selected for inclusion in the sample are chosen using probabilistic methods, simple random samplingallows the researcher to make generalizations (i.e., statistical inferences)from the sample to the population. This is a major advantage because such generalizations are more likely to be considered to have external validity. The approach also has some disadvantages. A simple random sampling can only be carried out if the list of the population is available and complete.

3.6.2 Purposive Sampling

The researcher also employed purposive sampling or judgmental sampling to obtain the necessary information from the people specialized in dealing with the patients in general and the elderly in particular. These included medical officers, nurses and

Comment [U2]: Why this?

Comment [U3]: Why this?

Comment [U4]: Why this?

Comment [U5]: Why this?

social workers. The reasons for choosing purposive sampling are based on the fact that it served a specific purpose. Mason (2008) argued that, purposive sampling is a set of procedures where the researcher manipulates the analysis, approach and sampling activity interactively during the research process to a much greater extent than in statistical sampling.

In addition, Kothari (2004) pointed out that, purposive sampling is a deliberate selection of particular units of the universe for constituting a sample that represents the universe. Purposive sampling technique was used to select hospital doctors, nurses and other health stakeholders. This is so because there some specific information that cannot be obtained from other members but specific respondent. The researcher used work tittles and relevancy of their positions and knowledge in the health sector in the districts**.**

3.7 Sample Size Determination

According to Bartlett, *et al.,* (2001) defined that, sample size determination is the act of choosing the number of observations or replicates to include in a statistical sample. The sample size is an important feature of any empirical study in which the goal is to make inferences about a population from a sample. Thus, it is important to note that there is no single best way that be used to determine sample size (Singh, 2006).For the purpose of this study, the sample size was determined scientifically and the approach is described here under.

In order to get the required sample size for the elderly, we used the sample size calculator (SSC) retrieved from (www.surveysystem.com/sscal.htm-retrieved on 11th

May /2017 at 03:43 hours). The population size of the elderly amounted to 175 identified from the population list of the elderly who regularly visit the two medical facilities. Assuming the population proportion of 50 per cent (0.5) and confidence level of 95 per cent (corresponds to the confidence interval of 9.8), the sample size is determined as 64 elderly. This number of elders included in the main sample of 100 individual is relatively larger than other categories of respondents largely because this is the main target group for the study and subjects are conveniently available. This sample size is determined automatically by the SSC based on the following mathematical formula:

$$SS = \frac{Z^2 * (P) * (1 - P)}{C^2},$$

Where,

$Z = Z -$ Value (e.g., 1.96 for the 95% Confidence Level)

$P =$ Percentage picking a choice, expressed as decimal (0.5 used for sample size needed).

A standard survey will usually have a confidence level of 95% and margin of error of 5%.

$C =$ Confidence interval, expressed as decimal; (e.g. ± 4).

Table 3.1: Respondents Distribution

Category	Number respondents
Elders	64

NB: The number of key informant interviews were 36 included in the list of respondents for the following criteria bellow:

(i) Medical offices were 6 selected by purposive sapling

(ii) Nurses were 15 selected by purposive sampling

(iii) Social workers were 15 selected by purposive sampling

Therefore the total respondents were 100 for this study.

3.8 Data Types and Sources

3.8.1 Secondary Data Collection

The secondary data are those which have already been collected by someone else and which have already been passed through statistical process (Kothari, 2008). Review of the published and unpublished literature especially those considered more relevant and pertinent to the research problem was undertaken.

The sources were books, records, reports, memoranda, agendas, and government administrative and scientific reports on health sector, webpages, newspapers, articles, government publications, official statistics and some NGOs working for the elderly, for example Help Age International. The secondary data was useful in getting specific information concerning age, frequently of attendance, and types of diseases the quality of services, hospitals reports on matters of elderly' welfare and health policy and regulations.

3.8.2 Primary Data

Primary data are those which are collected afresh and for the first time and thus happen to be original in character (Kothari, 2004). In this study, primary data were collected directly from respondents by means of questionnaires, interviews and on site observations.

3.9 Data Collection Techniques

Given the complexity and heterogeneity nature of the study population, different data collection methods were used. It has been observed in literature that in such studies no single method is adequate in itself in collecting valid and reliable data on a particular problem. Similarly, Bogdan, *et.al,* (2002) observed that, exclusive reliance on one method might bias or distort the researcher's picture of a particular reality.

Therefore, three different data collection techniques were used in order to increase the level of accuracy in data collection. The techniques include questionnaires administration, key informant interviews and observations. Questionnaire was directed to elderly, doctors and social workers. Key informant interview was performed purposely to doctors, nurses and social workers, and observation was performed to all study participants during the entire study.

Comment [U6]: What and why?

This was logical because the sample consisted of three different groups: the elderly; medical practitioners (medical officers and nurses); and social workers. Therefore, the information from the elderly were obtained through the administration of structured questionnaire and interviews, Alsokey informant interviews was used for medical practitioners and social workers. This is important since the researcher wanted to get specific information and experiences of these medical and paramedical practitioners while in their endeavor dealing with the elderly. Such data and information cannot be extracted from the elderly. Moreover, in order to get satisfaction and cross-checking the validity of some information and data, on site observation was necessary and this was done by the researcher in the hospitals and in the field, particularly where social workers engage the elderly.

Comment [U7]: Stop this

3.9.1 Data Collection from Questionnaire

Quantitative data collected using structured closed questionnaire supplied to 100 respondents (elderly, social workers, medical officers, and nurses). As suggested by Leedy, (2001) questionnaires are the best method of assessing the attitude, perceptions, feelings and opinions of selected population sample. Closed questionnaire is generally a series of written questions for which the respondents has to provide the answers (Gay, 2001).

The structured open and closed questionnaires used were comprised summated rating Likert scale proporsed by Resins Likert, (1932). Five-point in the scale used were, *Strongly Disagree, Disagree, I don't know, Agree and Strongly Agree*. Many items in the questionnaire were common for elderly group and for nurses, medical officers, as well as social workers. The instruments used were pilot tested by using *Cronbach's alpha reliability coefficient* and gives the value of 0.8 which was relevant. The results helped in providing clarifications and improvement in some of the items that seemed to be ambiguous in the instrument was able to achieve the research objectives.

3.9.2 Key Informant Interviews (KIIs)

According to Cohen (2001), an interview is regarded as an interchange of views between two or more people on a topic of mutual interest and emphasizes the social situations of research data. It is a research instrument for data collection that involves a collection of data through verbal interaction between the interviewee and the interviewer. Patton (2007) adds that it enables participants to discuss their interpretations of the world in which they live and express how they regard the situation from their own point of view and it is associated with very high response

rate. Wenden (2002) considers that, the general interview guide approach is useful as it ‘allows for in-depth probing while permitting the interviewer to keep the interview within the parameters traced out by the aim of the study’. In this study, semi-structure interviews were used to collect data from elder persons and it was a major means of obtaining deeper information. This technique was purposely selected because it normally provides opportunity to probe further issues that need more information.

Key Informant Interviews (KIIs) involve interviewing people who have particularly informed perspectives on an aspect of the problem/issue being examined. In most cases, 15 to 35 key informants are sufficient for most studies or even less if KIIs are combined with other methods (USAID 1996). KIIs are "qualitative, people selected for their first-hand knowledge about a topic of interest. The interviews are loosely structured, relying on a list of issues to be discussed. KIIs resemble a conversation among acquaintances, allowing a free flow of ideas and information. Interviewers frame questions spontaneously, probe for information and take notes, which are elaborated on later" (USAID 1996).

According to the USAID (1996), a number of situations have proved KIIs data collection approach to be a useful tool and these include: first, when decision-making can be achieved through qualitative and descriptive information; second, when it is important to gain an understanding of the perspectives, behavior and motivations of customers and partners of an activity or intervention in order to explain the shortcomings and successes of an activity or such intervention; third, when generating recommendations is the key purpose; fourth, in order to interpret quantitative data by interviewing key informants about the how and why of the quantitative findings; and

fifth, in order to help frame the issues that are relevant before designing a quantitative study.

KIIs bears several advantages to this option include: they are an affordable way to gain a big picture idea of a situation; the information gathered comes from people who have relevant knowledge and insight; they allow for new and unanticipated issues and ideas to emerge. Despite the advantages that can be accrued from KIIs, several limitations have been identified according to USAID (1996) and these include: there is a potential for the interviewer to unwittingly influence the responses given by informants; there is a potential bias if informants are not selected with care; systematic analysis of a large amount of qualitative data can be time consuming; the validity of the data can sometimes be difficult to prove.

It is thus advisable to the researcher that when formulating study questions, limit the amount to five or fewer, the interview should allow for free discussion by informants, however interviewers should be aware of what questions to ask and topics that should be covered.It is sometimes useful to prepare different guides for different groups of informants when selecting key informants. In selecting key informants make sure to include a wide range of perspectives and points of view, including selecting from different groups of key stakeholders (USAID 1996).

3.9.3 Observations

Observation implies the use of the eyes rather than of the ears and the voice. The researcher is required to be present at the place of interest or data collection(Gay, 2001, Best, *et al.*, 2003). At times, observation affords greater accuracy than other

methods. During data collection in this study, the researcher was making observation, and did not need to depend on other data methods only; but personally, collected data through all the methods mentioned to find out what is really occurring there. The data collected through observation is generally more valid, reliable and convincing. This kind of data collection was used purposely for justifying the responses that were provided by research participants

3.10 Data Analysis Methods

Qualitative data was recorded in interview guides whose content which going to be summarized in a narrative format. Critical analysis of documentary sources and interpretation was made by systematically summarizing the contents. In addition, the background information from the interviews was coded and quantified in frequencies. The tables were used for summarization and presentation of the data. Quantitative data analysis was done by using appropriatesapss.

3.11 Validity and Reliability of Data

This section presents the issue of validity and reliability concerning the data to be collected from respondents in the study area.

3.11.1 Validity of Data

Validity is the instrument capable of measuring what is supposed to measure accurately, effectively and efficiently (Omari, 2011). To improve the validity the researcher will pre-test the questionnaire over a number of people before officially distributing to the participants, this will be achieved through setting standards on constructing questionnaires and interview questions which related to the researcher's

objectives and questions. In this study, interview and questionnaires were generated in conjunctions with the researcher this is to ensure that the interview guides and questionnaires focus on the topic under investigation and the purpose of the study is clearly explained to the respondents and issues of concerned are resolved satisfactorily. The procedures of the key informant interviews and questionnaire were explained to the respondents. Lastly, respondents were assured of anonymity and confidentiality. This encouraged frankness during the interview. On the other hand, the type of data collected through questionnaires, key informant interviews, and observation were valid and reliable. The validity and reliability of data based on the fact that the older persons were the ones to provide the needed information without allowing any third-party intervention and interruptions. Data from questionnaires were supplement gaps that might have occurred due to improper recording of data in documents, since questionnaires allowed a particular person to explain what exactly he/she perceives.

On the other hand, interviews were also providing reliable data because they drew data directly from one to be interviewed expressing his/her ideas. All these techniques improved the quality of data and hence its reliability. The above steps ensured that the multiple sources of data collection such as questionnaires, key informant interviews and observation were conducted under conditions and in an environment acceptable to the respondents and therefore, this ensured that the process and findings are trustworthy and valid.

3.11.2 Reliability of Data

Babbie (2005) describes reliability that, as a condition in which the same results were achieved whenever the same technique is repeated to do the same study. In this study,

the result was achieved by the following means. The anonymity and confidentiality of the respondents was ensured so that they were able to provide information for use strictly for the purpose of the study. A rapport with the respondents was successfully being established during the preliminary fieldwork study.

The relationship of trust with the respondents was built and the credibility of the study was reinforced. And the utilization of trained fieldworker ensured that the discussion level was high where necessary and relevant to the study. To ensure the reliability the researcher was used the triangulation method, the researcher used a number of methods like questionnaire, interview and observation. The similarity of information across the methods will assist the researcher to confirm the consistency of information in the investigation (Babbie, 2005).

3.12 Ethical Considerations

Sullivan (2001) asserts that, social researchers are bound to ethical considerations in their studies. The researcher was observed the rights of all respondents including the information given by respondent which was kept confidential to avoid harming the respondent. In this regard, the researcher was serve the respondents with consent form which was dully filled to confirm his consent and the research directives such as seeking permission from the required offices and officers was thought. Also, all the respondents was respected and the information provided by respondents was kept confidential. The researcher was strictly adhere to the research ethics. Human rights and national policies was observed so as not to violate the scientific standards research producers. Therefore, attention was paid to the rules and regulations of research before and during the actual field.

CHAPTER FOUR

RESEARCH FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter focuses on the data presentation and discussion of the results based on research objectives laid down by this study. The study main objective was to investigate the challenges of government health services to elderly people in Tanzania, taking the case study of Mwananyamala and Amana hospitals in Kinondoni and Ilala districts respectively both in Dar es Salaam. Key aspects in this theme included the government financing for health facilities, health policy and the efficient of health services provided by government health facilities and their satisfaction to elderly.

Heterogeneous sample of 100 participants was interviewed, others observed and later on served with self-administered questionnaire. The respondents included the elderly people who occupy the core of the study, medical practitioners and social workers as health service facilitators in the whole health system of providing the elderly with affordable health services.

4.2 Financing Health Services in Government Hospital

The first objective of the study was to examine the government financing for health facilities to elderly people needs in Mwananyamala (Kinondoni) and Amana (Ilala) hospitals in Dar es Salaam. To meet the requirement of the said objectives key questions presented to the study participants were as follows:

4.2.1 Government Financing Budget for Elderly People

Comment [U8]: I don't understand this?

In order to address issues pertained to elderly accessing medical services in government hospital, the concept of budget financing was invoked in the study in

order to make sense of financial related problems concerning the elderly. Hence two key questions were asked and the results have been presented below followed by an in-depth discussion on the subject.

Among of the very interested question based on government financing budget to all respondentswas:

> "*Do you agree that the government should increase budget for health services, medicines and other treatment for the elderly?*

This question was presented to all study participants namely, the elderly, social workers and medical practitioners. The results are presented in Table 4.1. The results show that, the majority of the respondents (about 85 percent) agreed that the government should increase the budget for health services, medicines and other treatment for elderly. However,10 percent of the respondents did not agree that the government should increase the budget for the said services. Additionally, a small number of respondents (about 5 percent) did not know whether the government should increase the budget or not. For more details let we see the Table below

Table 4.1: Response to Government Increasing Budget for Health Services and Treatment to Elderly People

Response		**Frequency**	**Percent**	**Valid Percent**
Valid	Strongly Agree	65	65.0	65.0
	Agree	20	20.0	20.0
	I Don't Know	5	5.0	5.0
	Disagree	5	5.0	5.0
	Strongly Disagree	5	5.0	5.0
	Total	**100**	**100.0**	**100.0**

Source: Research Data (2017)

Table 4.1reveals that most of respondents agreed that there was a need to increase budget for health and treatment of elderly people. The data is well illustrated on the figure 4.1 below. This helps to precisely present the findings, its interpretation and explanation. However, presenting the results in two different formats reinforces our clearer understanding of the problem under discussion.

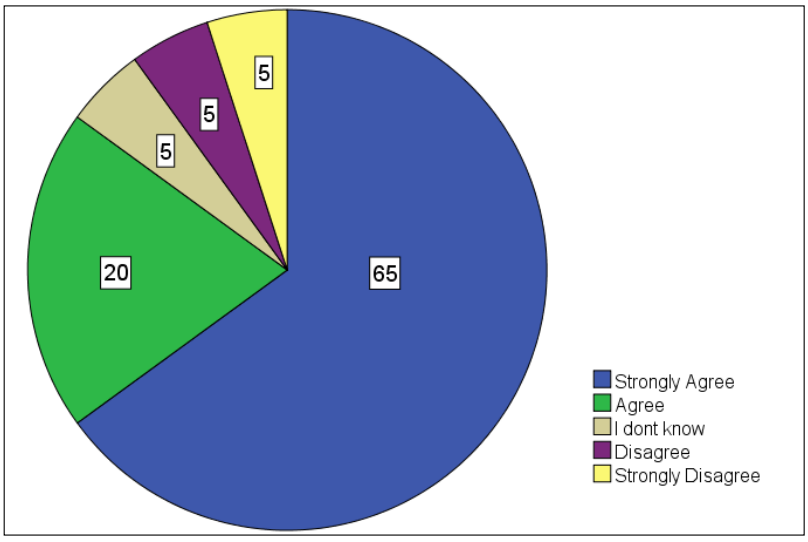

Figure 4.1: Financing

Source: Research Data (2017)

These results point to one direction: that the participants are aware that the government funding of health services for them is inadequate. The findings have shown that budget is still a problem in government hospitals particularly the component focusing on elders. The participants see a shortage of budget as an obstacle to getting better health service. In general, elder people do complain that the budget related problems such as the shortage of medicines and less appealing medical

services have implications for their welfare and the government should do more to improve their life and welfare.

4.2.1.2 Payment of Health Bills to Elderly

The question about the payment of bills was asked to the elderly alone and the logic was that, it is the elderly who are paying their bills through different insurance schemes.

The questions based on Payment of health bills which was very crucial to elderly people was:

> *When you go to the Government hospital to get health care services how do you pay your bills?*

The results show that 62 percent of the respondents paid their bills by cash, 16 percent paid through the National Health Insurance Fund (NHIF). About 14 percent paid by other insurance schemes including the Government Employee Pension Fund (GEPF) and the National Social Security Fund (NSSF). Further, the results show that about 8 percent of the respondents met their government health bills through government exemption schemes. The results are presented in Table 4.2.

Table 4.2: Response to Bill Payment Methods

Response		**Frequency**	**Percent**	**Valid Percent**
Valid	I pay the bills by cash	40	62.5	62.5
	I get medical services by government exemption	5	7.8	7.8
	My bills are paid by national health insurance fund	10	15.6	15.6

	My bills are paid by other insurance funds like GEPF, NSSF	9	14.1	14.1
	Total	**64**	**100.0**	**100.0**

Source: Research Data (2017)

The results in the Table 4.2have also been presented in the Figure4.2below for more precisely illustrations.

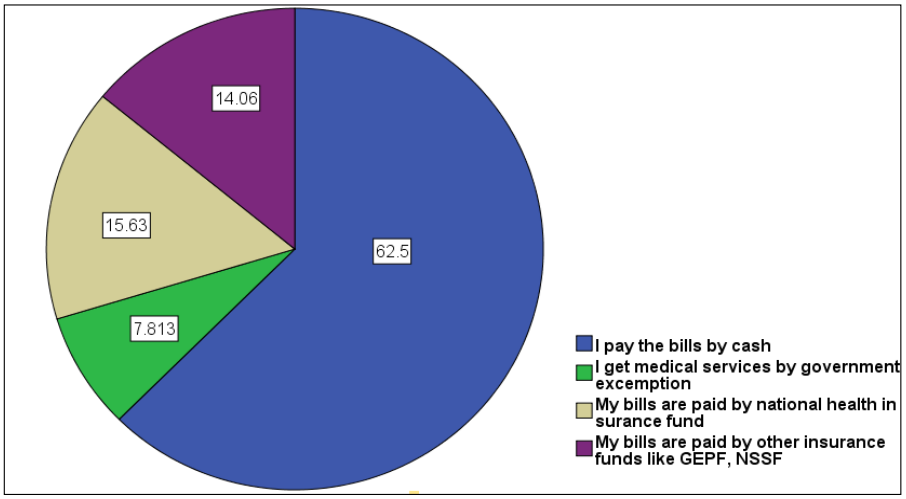

Figure 4.2: Payment of Health Bills

Source: Research Data (2017)

The findings revealed that majority of elderly people preferred to pay their medical services by cash because of poor services. This is because the majority of elderly who possess exemption cards have reported to get unsatisfactory services and were forced to get cash from good Samaritans for the sake of medical treatment. A study by Mansuzu (2007) found that the low level of income is a problem to the old people to afford medical services.

Also during the interview, one respondent had the following to say:

> *……my son, I have no money for medicines. We get poor medical services and it appears that the government has no sincere plans to help*

the elderly. On top of that the government appeared to have no enough resources to support the elderly. The exemption policy for elderly was used as a bait to get popularity and no more. The exempted elderly when they go at the window for medicines they are told that medicines are finished especially for those without an insurance scheme as NHIF(Source: Research data (2017).

Comment [U9]: Hope you interviewed the usi Kiswahili and hope this are in kiswhaili. Show that this is your translation. (My transation form Kiswahili to English language)

4.3 The effect of Health Policy

The second objective of the study was to evaluate the effect of health policy on the satisfaction of the elderly in Kinondoni and Ilala districts. The question was asked to all the study participants (the elderly, medical practitioners and social workers) the question was: *Do you agree that the current health policy on elderly health provision is good?* The results are presented in Table 4.3. The results show that 28 percent of the respondents disagree with the health policy that is good. Also, about 12 percent of the respondents agree that the health policy is good while the remaining 60 per cent were neutral. The table 4.3 illustrate and presents the findings.

Table 4.3: Health Policy

Response		**Frequency**	**Percent**	**Valid Percent**
Valid	Strong Agree	5	5.0	5.0
	Agree	7	7.0	7.0
	I Don't Know	60	60.0	60.0
	Disagree	22	22.0	22.0
	Strong Disagree	6	6.0	6.0
	Total	**100**	**100.0**	**100.0**

Source: Research Data (2017)

The data in the Table 4.3 is also presented in the Figure4.3, for more precisely illustrations. The results point to one direction, that the erdely do not see any good about the health policy. They had the opinon that the health policy has failed to meet their expectations. Old people were expecting better services when they heard that the government is serious about making sure that the erdely get better medical services.

So here there is a need for education so as elderly to have the enough knowledge for policies, because more than fifty percent they don't know whether healthy policy is good or not.

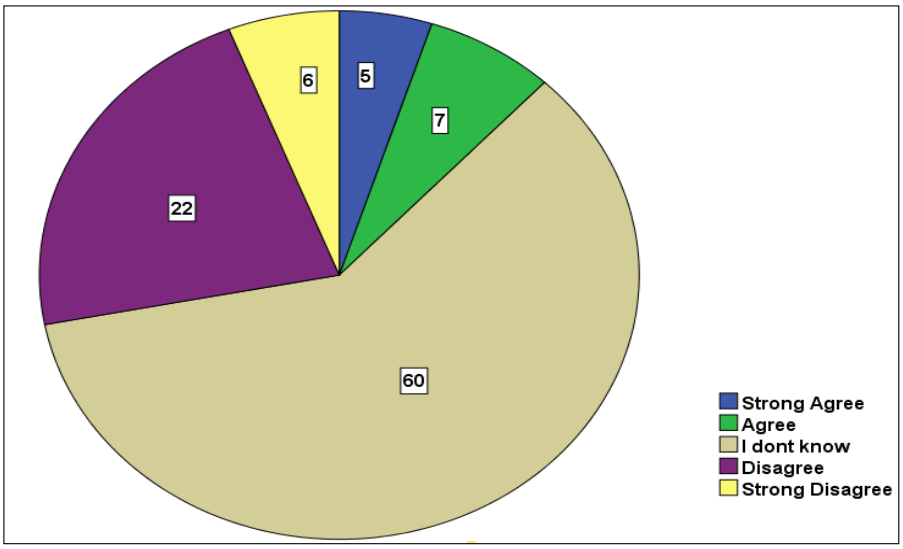

Figure 4.3: Health Policy

Source: Research Data (2017)

Health Policy of Tanzania and the Public Service Act of Tanzania recognize 60 years as elders and at the retirement age (WHO, 2000). Though, elder people are viewed as frail, burdensome or dependent, despite the fact that these people contribute to society in many ways.

4.3.1 Health Policy Problems

Ageing health policy of 2003 states that the elderly who reached 60 years old and full fill those criteria fo getting free healthcare services must get without any unnessessary obstscles, it seems this healthy policy they are there on the paper but are not

implemented effectively to elderly, the question was asked to all respondents *to give their views on which problem confront them the most when they go for health services in government hospitals.*

The Table4.4 revealed that 58 percent of the respondents said that the medicines are expensive. 20 percent of the respondents said that there are fewer health centers in localities and 22 percent said that, they get inadequate health services. See Table 4.4.

Table 4.4: Response to Cost of Medicines

		Frequency	Percent	Valid Percent
Valid	Medicines are Expensive	37	57.8	57.8
	Fewer health centers in localities	13	20.3	20.3
	In adequate health services	14	21.9	21.9
	Total	64	100.0	100.0

Source: Research Data (2017)

The results in the Table 4.4 above have also been presented in the Figure 4.4, for clarification.

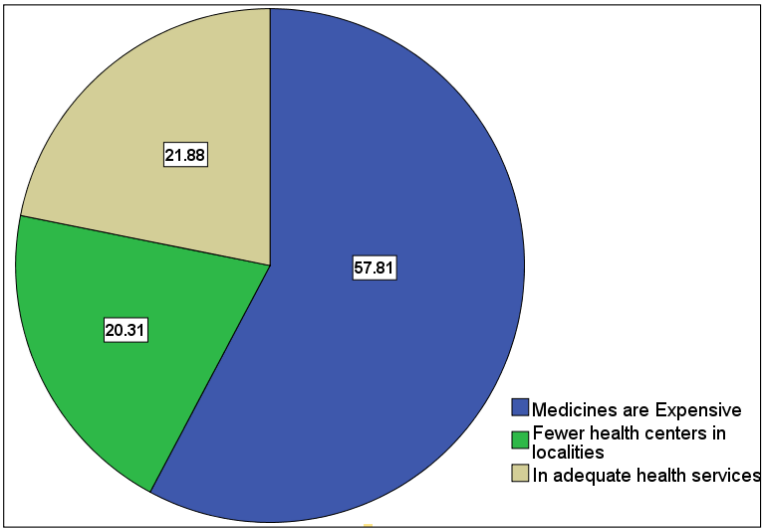

Figure 4.4: **Health Policy Problems**

Source: Research Data (2017)

Thefigure number 4.4 above presents the findings which reveals that, the elderly can no longer comfortably get medical services.A number of problems have stood on the way. Problems such as expensive medicines and distant and fewer health centres have further complicated the situation and above all the services provided by the health centers are inadequate meaning that they are substandard.

4.3.2 Health Services Provision

The third objective of the study was to investigate the efficient of health services provided by government health facilities and their satisfaction to elderly in Kinondoni and Ilala district. The study involved 100 participants to answer the question, *do you agree that the health services that elderly receive from government hospitals are sufficient and satisfactory to you?*

From the Table 4.5the following results were revealed, 10 percent of the respondents agreed that the health services are sufficient. On the other side, 53 percent disagreed that the health services provided are sufficient and the other 37 percent of the respondent were in dilemma neither agreed nor disagreed about the health services provision.

Table 4.5: Health Services Provision

Response		Frequency	Percent	Valid Percent
Valid	Strongly Agree	4	4.0	4.0
	Agree	6	6.0	6.0

	I don’t know	37	37.0	37.0
	Disagree	40	40.0	40.0
	Strongly Disagree	13	13.0	13.0
	Total	**100**	**100.0**	**100.0**

Source: Research Data (2017)

The results in the Table 4.5 above have also been presented in the figure 4.5for more clarifications.

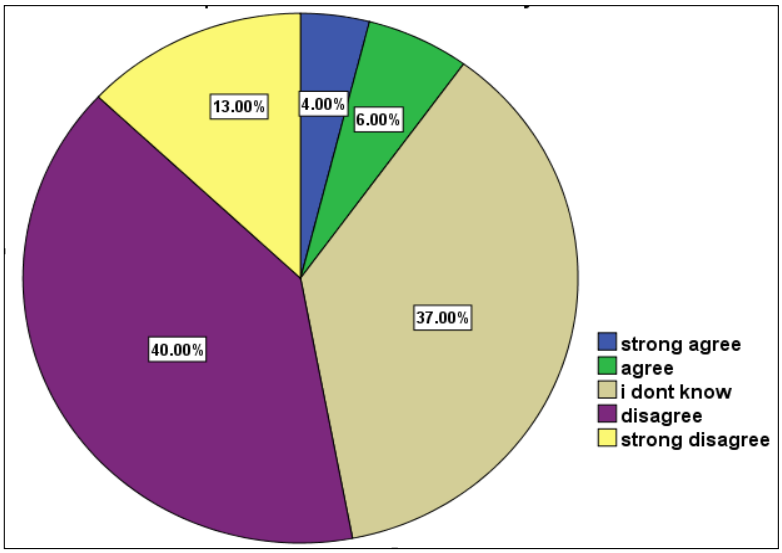

Figure 4.5: Health Services Provision

Source: Research Data (2017)

The findings have revealed that, the erdely are not satsified withthe services provided by the government hospital and a during interview witherdely a lot was unfolded. An old man said the following during an interview:

> *……..we the people of exemption normally get problems because we are told that there is no medicine when we go to the medicine window. Nurses hate us like nobody business. We normally come to the hospital early in the morning but we get services very late.*

There is no any meaningful service we get from here. We come here because we have nowhere to go.(Source: Research data, 2017).

The elderly respondents were also asked about health services like medical treatment/pharmacy and laboratory services are good for them, so as to give their views for future implementations.The results shows that 30 percent of the respondent disagree that services provided to them in terms of medical treatment and pharmacy services is good for them. Further, about 24 percent of the participants are satisfied with the health services provided to them while 47 of the respondent were neutral.The results in Table 4.6illustrate the findings.

Table 4.6: Response to Services Provided in Terms of Medical Treatment and Laboratory Services

Response		Frequency	Percent	Valid Percent
Valid	Strongly Agree	5	7.8	7.8
	Agree	10	15.6	15.6
	I don't know	30	46.9	46.9
	Disagree	15	23.4	23.4
	Strongly Disagree	4	6.3	6.3
	Total	**64**	**100.0**	**100.0**

Source: Research Data (2017)

The results in the Table 4.6is also illustrated in figure4.6 for clarifications

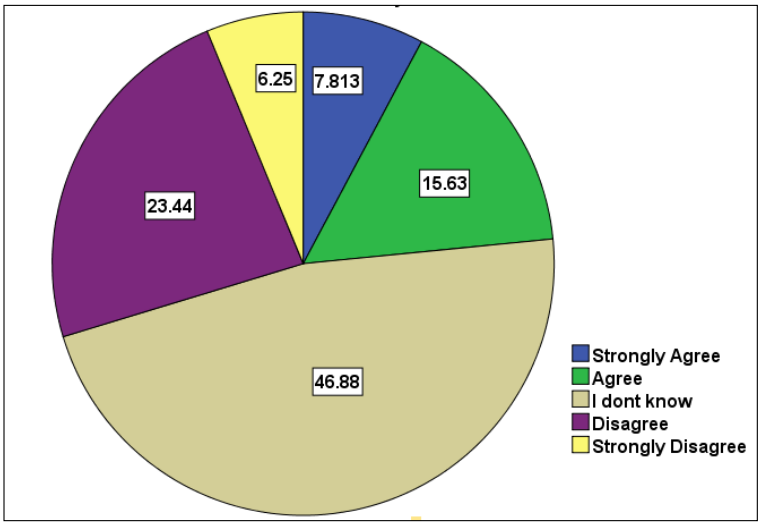

Figure 4.6: **Health Services Provision**

Source: Research Data (2017)

As far as the elderly are concerned the core services in medical treatment such as medical treatment, pharmacy and laboratory services are in bad shape. The whole exercise of providing better services to the elderly has become a white elephant. One respondent said the following during an interview:

> *…….here at government hospital, there is no reasonable medical treatment. People with cash in hand normally get medicices. For those with NHIF card also get medicines because it is a well established insurance scheme and there is a special medical shops for them outside the hospital so easily to get medicines. The problem is for the elderly without insurance cards and hold exepmtion scheme. Doctors or nurses do not want to see them around the medicine window and they are not treat them accordingly due to the environment and it seems not from their heart.* (Source: Research Data 2017).

Also the elderly was asked if they are respected, this was also very important question because this questions based on their service they get but also it imply even their age. *The respondents was asked If they are respected by health services employee such as doctors, nurses and laboratory*.

Table 4.7: Response to Service Provided by Doctors, Nurses and Laboratory

Response		Frequency	Percent	Valid Percent
Valid	Strongly Agree	20	31.3	31.3
	Agree	10	15.6	15.6
	I don't know	10	15.6	15.6
	Disagree	15	23.4	23.4
	Strongly Disagree	9	14.1	14.1
	Total	**64**	**100.0**	**100.0**

Source: Research Data (2017)

The results reveals that, about 47 percent of the respondent agrees that they are respected when they receive medical services in government health facilities. Further, about 37 percent of the respondents disagree with this notion. Again, a sizable percentage of the respondents about 16 percent were in dilemma as they neither agreed nor disagreed with respects of services with respect. See Table 4.7 which presents the findings.

These results is also presented in figure 4.7 below for more illustration.

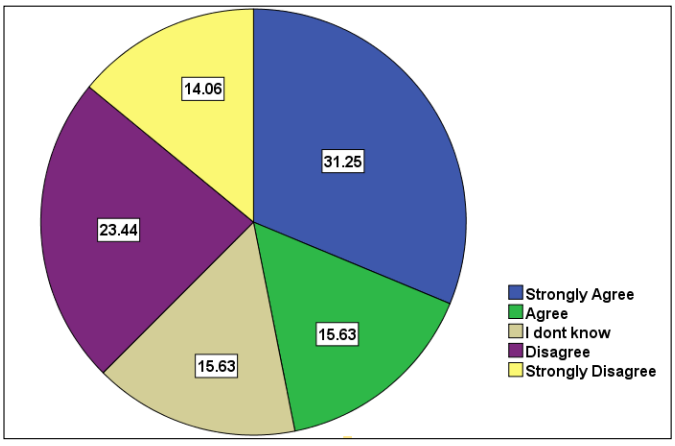

Figure 4.7: **Health Services**

Source: Research Data (2017)

The research findings show that the elderly receive health service without actual respect based on the environment surround. It has been learnt from the study that medical personnel they are not use polite language to the elderly. The nurses especially have a large stake in this respect. Respondent have the opinion that few nurses are very rude to the elderly.

4.3.5 Special Service Window to Elderly

Special window is talk of the hospital based on the health services to elderly According to third objective, the study presented a question on special window which stated that, *do you agree that if the government set aside a special window to provide health services to you elderly people is a good idea?*

From the Table 4.8 below the findings reveal that 84 percent of the respondents agreed that setting a special window is a good idea.10 percent disagreed with that idea and lastly 6 percent of the respondents remained neutral in this question.

Table 4.8: Response on Setting Special service Window to elderly

Response		**Frequency**	**Percent**	**Valid Percent**
Valid	Strongly Agree	50	78.1	78.1
	Agree	4	6.3	6.3
	I don't know	4	6.3	6.3
	Disagree	2	3.1	3.1
	Strongly Disagree	4	6.3	6.3
	Total	**64**	**100.0**	**100.0**

Source: Research Data (2017)

The results in the Table 4.8are also presented in figure4.8 below to get a more cleared

picture of what we have found.

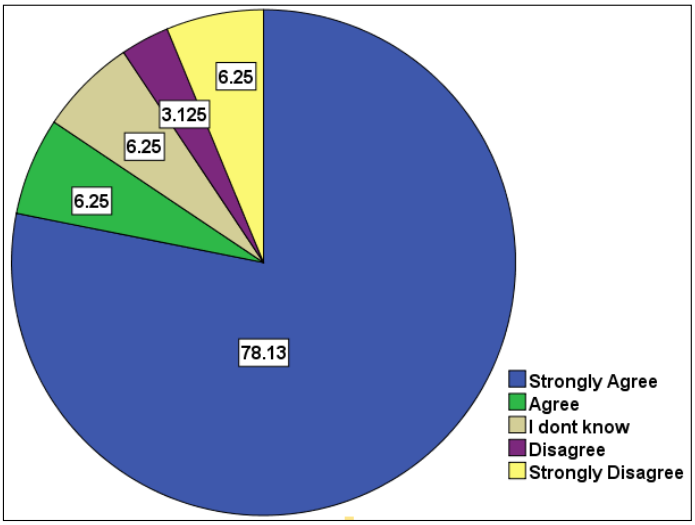

Figure 4.8: Special Window

Source: Research Data (2017)

It has been pointed that, the absence of a special window has caused the elderly to fight with the young in queues for services of which they have no energy to sustain this struggle. So if they get a special window it could be easily for them to get services for the reasonable time and place and hence it could be easily for them to stand in the queues. During the interview the respondents' faces had shown that greater disappointment and one respondent said that:

> *……the way I see it, there is no such policy as exemption policy because we have heard that this policy will give us free medical treatment for elderly above 60 years of age but it has become a problem because it is not implementable. I think an exemption policy is just a show game to maneuver the elderly so that during election time we vote for them.*(Source: Research data 2017).

4.4 Key Informant Interviews Results

In addition to the data analysis above which is typically quantitative, we also had comprehensive discussions with persons in the sample to whom we considered have

key information regarding our problem, so specifically we conducted the Key Informant Interviews. What we learned from them is that, while some few elderly people appreciate the presence of free medication policy for the elderly, many still are not aware of its existence. Moreover, the elderly generally complained about the way the Policy is implemented that the process is lengthy and tedious. According to Social Workers, the elderly are not given due respect and just treatment as their counterpart with Healthy Insurance. We were made to understand that the Social Worker desks receive constant complaints from the elderly regarding the way they are treated. Social Workers had the opinion that education is required to the elderly themselves, medical doctors and nurses about the policy itself and how they should treat the elderly whenever they visit health facilities.

Indeed, the medical doctors and nurses had similar opinions. They informed us that dealing with the elderly is problematic given their ages, background and understanding. Consistent with the Social Workers, these two groups had more or less opinions regarding the health care policy for the elderly. They strongly emphasized the need for a special window for the elderly in health facilitates. This will allow hospitals to have a focus on the elderly as a special group and hence receive due respect and special treatment. For example, the elderly with health insurance receive prompt attention when visiting he health facilities and given medics while these without the insurance do not get immediate attention and in most cases are denied the essential medicine prescribed.

4.5 The Summary

From the results obtained from the field as presented by tables and figures, it has been shown that the elderly are not disputing the idea of exemption policy but they seem to complain about its implementation. The elderly have complained about the absence of special window as they cannot struggle with the young blood for the same. Other complaints include shortage of medicines in health facilities and the use of demoralizing language used by nurses to greater extent and doctors as well.

Exemption right for the elderly seem to offer no added value as far as medical services are concerned, shortage of medicines that accompany with the right of free services has further complicated the situation. The elderly see the whole system of helping them as an ineffective. The issue of delay in getting service has been earmarked, despite the fact that the elderly come to health services early but serious delays have been noted with no the timely service delivery.

It could be that the elderly have no separate system of medical service and they all team up with the young blood however, this may lead to service delay. For example, the elderly with health insurance receive prompt attention when visiting the health facilities and given medics while these without the insurance do not get immediate attention and in most cases are denied the essential drugs prescribed. The outlook is that all elderly be registered in the same insurance scheme to avoid bias, discrimination and stigma. The study employed simple random sampling and purposive samplings to get the required sample and the data method includes both quantitative and qualitative approach.

The outcome of the findings as per chapter four, show that 58% of the elderly people said that medicines are expensive. This intimates that there is high scarcity of medicines for elderly people in the government health services who are exempted to pay, this was due to Government very low financing budget for the health services. 60% 0f the elderly people they don't know about the current healthy policy. This was due to lack access to vital information regarding health services offered on their privileges.

Moreover majority of the respondents by 84% suggested that the government should introduce special window for elderly people. The absence of a special window had caused the elderly to contest with the young in queues, so if they get a special window it could be easily for them to get services for the reasonable time and place and hence it could be easily for them to stand in the queues.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

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5.1 Introduction

This chapter presents summary, conclusion and recommendations of this study for the improvement of the elderly wellbeing. The study intended to investigate challenges of government health services to elderly people in Tanzania. The researcher believes that recommendations put across will be potential and applicable by different stakeholders of health sectors for the aim of improving the delivery of free health care to elderly people in government hospitals.

5.2 Conclusion

The observation obtained from the field concluded that, there are challenges that are encountered by elderly people in Government Health Services in Kinondoni and Ilala district. Despite the efforts made by the government to ensure the elderly access health care services freely and more comfortably, yet this is far from being achieved. The efforts to improve Government Health Services to elderly people have not been fully implemented by the government. Many elderly people still do not have access to free medical service due to several limitations.

The Government must increase the fund to finance health services in public hospitals particularly in Amana and Mwananyamala hospitals because during the research conducted at Amana and Mwananyamala hospitals is shows that the elderly they talked about shortage of medicines and at the same time they talked about high expensive medicines so the government must ensure the availability of enough medicines.

The National Ageing Policy of2003state that, elderly people should access free health service but nothing is implemented, hence, there is a need to review the policy. As the study findings exposes, the government should make deliberate efforts to craft a new mechanism on improving health services delivery for the elderly people including introducing health insurance scheme for elderly people since it provides more coverage even in private health facilities.

5.2 Recommendations

The results findings as presented and discussed above, prompt us to make the following recommendations:

5.2.1 Recommendations for Actions

(i) It is recommended that; the government hospitals should establish special window for elderly people in order to minimize the waiting time. Parallel to this, the government should also employ more medical staff members to trouble spots, redesigning scheduling systems to prioritize elderly people and requiring at least some medical officers to work during the night and weekends so patients don't have to visit to the hospital at the same hours

(ii) The government via the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) should make a follow up to ensure that the National Ageing Policy of 2003 which stipulate the free health service to elderly people is implemented; and the elderly people receive free health services in all government hospitals in Tanzania.

(iii) Hospital infrastructures should be modified in government hospitals to enable the elderly people to be comfortable during the long waits. Elderly people are incapable of queuing for a long time. Modification of infrastructures will facilitate the ease accessibility of health services to elderly people since they lack capacity to wait for a long time.

(iv) The government should increase the availability of important medicines to elderly people as most of the elderly people are suffering from old age disorder diseases.

(v) Laws that do not protect older people; currently, there is no specific law that protect older people. The Parliament of Tanzania should enact Laws that are in favor of elderly people's rights including right to better health services.

5.2.2 Areas for Further Study

This study has looked at the challenges of Government Health Services faced by the elderly when they seek for medical services in government health facilities. Three areas may be of interest for further empirical research in this front.

First, it will be of interest if a study conducted on the examining the challenges facing elderly when seeking medical services in public health facilities but with emphasis on gender disparity. This is so because we suspect the challenges to be different if the gender aspect is included and hence may bring about different results.

Second, it is also worth investigating on the difference in the challenges on accessibility faced by retirees and those who have never been employed before, whether in the public sector or private,

Third, since this study was conducted on small area in urban areas and whose results may not be adequately inferred to the population, next study should be broader in scope within the same urban areas, also there is a need for another study to cover large areas in rural for comparative purposes.

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APPENDICES

Appendix I: Questionnaire on Health Workers and Elderly in Mwananyamala (Kinondoni) and Amana (Ilala) Hospitals in Dar Es Salaam

Question One

Do you agree that, the current health policy on elderly health provisions is good?

a) Strongly agree

b) Agree

c) I don't know

d) Disagree

e) Strongly disagree

Question Two

Do you agree that, the health services that elderly receive from government hospitals are sufficient and satisfactory to you?

f) Strongly agree

g) Agree

h) I don't know

i) Disagree

j) Strongly disagree

Question Three

What is your occupation?

a) Elderly

b) Medical practitioner

c) Social worker

Question Four

What is your gender?

a) Male

b) Female

Question Five

Do you agree that the government should increase budget for health services, medicines and other treatment to the elderly

c) Strongly agree

d) Agree

e) I don’t know

f) Disagree

g) Strongly disagree

Appendix II: Questionnaire on Elderly People in Mwananyamala (Kinondoni) and Amana (Ilala) Hospitals in Dar es Salaam

Question one

When you go to the Government hospital to get health care services how do you pay your bills?

a) I pay the bills by cash

b) I get medical services by Government exemption

c) My bills are paid by national health insurance fund

d) My bills are paid by other insurance fund like GEPF, NSSF ETC

Question Two

Question Four

Which problem confronts you the most when you go for health services in government hospitals?

a. Medicines are expensive
b. Fewer health centers in localities
c. In adequate health services
d. Other specify_____

Question Three

Do you agree that the national health policy for elderly people is good for you?

a) Strongly agree

b) Agree

c) I don't know

d) Disagree

e) Strongly disagree

Question Four

Do you agree that health services like medical treatment, pharmacy and laboratory services are good for you?

a) Strongly agree

b) Agree

c) I don't know

d) Disagree

e) Strongly disagree

Question Five

Do you agree that health service employees like doctors, nurses and laboratory technician gives you services with respect?

a) Strongly agree

b) Agree

c) I don't know

d) Disagree

e) Strongly disagree

Question Six

Do you agree that if the Government set aside a special window to provide health service to you elderly people is a good idea?

a) Strongly agree

b) Agree

c) I don't know

d) Disagree

e) Strongly disagree

Question Seven

Does the Medicare health services provided to you by the Government hospital satisfy your needs?

a) Strongly agree

b) Agree

c) I don't know

d) Disagree

e) Strongly disagree

Question Eight

Do you agree that the government should provide universal health insurance for elderly people?

a) Strongly agree

b) Agree

c) I don't know

d) Disagree

e) Strongly disagree

Question Nine

Do you agree that the government should increase budget for health services, medicines and other treatment to the elderly

a) Strongly agree

b) Agree

c) I don't know

d) Disagree

e) Strongly disagree

Appendix III: Consent Form

THE OPEN UNIVERSITY OF TANZANIA

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

PRINCIPLE INVESTIGATOR: IBRAHIM CHANDE ABDU

PHONE NUMBER: 0713 48 22 46

The purpose of the study: To investigate the challenges facing elderly people in accessing health services provided by government health facilities in Kinondoni and Ilala districts, in Dar es Salaam region, Tanzania. Procedures: I will answer all questions accordingly and participate in interview section. Benefits: There may be no direct benefits to me as a participant in the proposed study but the findings from the study may be beneficial to other elders in my country. Risk and Discomforts: There will be no any risk from the participating from the proposed study apart from time spent Confidentiality: All information obtained in the proposed study will be considered confidential and used only for research purpose. My identity will be kept confidential in so far the laws allows. Right to refuse or withdraw: My participation in the proposed study is entirely voluntary and is free to refuse to take part withdraw at any time.

CONSENT

I……. After considering the explanation of the study and having understood the consent form, I hereby give my informed consent to participate in the study.

Signature……Date……..

Investigators signature……Date…….

Appendix IV: Research Clearance Letter

THE OPEN UNIVERSITY OF TANZANIA

DIRECTORATE OF RESEARCH, PUBLICATIONS, AND POSTGRADUATE STUDIES

P.O. Box 23409 Fax: 255-22-2668759Dar es Salaam, Tanzania,
http://www.out.ac.tz

Tel: 255-22-2666752/2668445 ext.2101
Fax: 255-22-2668759,
E-mail: drpc@out.ac.tz

17/07/2017,

To The Regional Medical Officer

Dar es Salaam Region.

RE: RESEARCH CLEARANCE

The Open University of Tanzania was established by an act of Parliament no. 17 of 1992. The act became operational on the 1st March 1993 by public notes No. 55 in the official Gazette. Act number 7 of 1992 has now been replaced by the Open University of Tanzania charter which is in line the university act of 2005. The charter became operational on 1st January 2007. One of the mission objectives of the university is to generate and apply knowledge through research. For this reason staff and students undertake research activities from time to time.

To facilitate the research function, the vice chancellor of the Open University of Tanzania was empowered to issue a research clearance to both staff and students of the university on behalf of the government of Tanzania and the Tanzania Commission of Science and Technology.

The purpose of this letter is to introduce to you **Mr. Chande Ibrahim Abdu;** a Master student at the Open University of Tanzania. By this letter, **Mr. Chande Ibrahim Abdu** has been granted clearance to conduct research in the country. The title of her research is **"Challenges Facing Elderly People in Accessing Health Services in Government Health Facilities in Tanzania: A Case Study Mwananyamala and Amana Hospital** . The research will be conducted in Kinondoni and Ilala Districts. The period which this permission has been granted is from 17/07/ 2017 to 18/09/2017.

In case you need any further information, please contact:
The Deputy Vice Chancellor (Academic); The Open University of Tanzania; P.O. Box 23409; Dar es Salaam. Tel: 022-2-2668820

We thank you in advance for your cooperation and facilitation of this research activity.
Yours sincerely,

Prof Hossea Rwegoshora

For: VICE CHANCELLOR

OPEN UNIVERSITY OF TANZANIA