IMPLEMENTATION OF NATIONAL AGEING POLICY IN PROVISION OF FREE HEALTH SERVICES TO OLD PEOPLE IN TANZANIA: A CASE OF MERU DISTRICT COUNCIL

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the Open University of Tanzania a dissertation titled; “Implementation of National Ageing Policy on Provision of Free Health Services to Old People: A Case of Meru District Council” in partial fulfilment for the requirements of the degree of Master of Arts in Monitoring and Evaluation.

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Dr. Hamidu Shungu

(Supervisor)

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DECLARATION

I, Shella Masud Mduba, do hereby declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

……..……...

Signature

……..……..

Date

DEDICATION

This thesis is dedicated to God, the Almighty, who made me strong to persevere to the end of my study while performing my other responsibilities. Regardless how many barriers rose during my study how many times I fall down, Almighty God gave me strength to raise again and again.

It is also dedicated to my family, who gave me support in whatever difficulties happened to me. I also dedicate to my mother, she is no longer with us, I pray for her soul to receive the eternal peace of heaven. She is the one make me strong enough to stay strong whenever possible. Mama we miss you and we wish one day we will meet you and be happy together.

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ABSTRACT

This research was undertaken in Meru district council in Arusha Region is focusing on the implementation of National Ageing Policy in the provision of free health services to old people in Tanzania. Specifically, the study based on the type of health services offered to old people, factors influencing provision of free health services and measures to be taken to influence free health service provision to old people. A triangulation was involved to collect data, that possible technique and tools were applied whenever necessary; which included questionnaire, interview and observation. The respondents were selected randomly, semi-structured interviews and focus group discussion with purposively selected service providers, local leaders and old people were conducted. Findings revealed that, majority of old people in Meru are aware about free health services provision, but the number of elders who have ever received free health services is only 18.8%, while 81.2% had never received any free services. On the other hand, health personnel claim that the Government does not allocate fund for medicine and medical equipment specifically for elderly on time in a small package than required amount. Generally, policy directions are not fully implemented in practice. My study comes up with the suggestions as; Increasing fund allocation (budget), increase number of health personnel, and more consideration should be on health personnel who are professionals on elders. Finally; it is the time now for the Government and all stakeholders to review the Policy implementation by looking success and failure of its implementation so that they can come up with the strategies that can improve the situation.

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LIST OF ABBREVIATIONS AND ACRONYMS

AU/HAI	African Union/ Help Age International
AU-Plan	African Union Policy Framework and Plan of Action on Ageing
CHF	Community Health Fund
DMO	District Medical Officer
HAI	Help Age International
LGA	Local Government Authority
MIPAA	Madrid Plan of Action on Ageing
NAP	National Ageing Policy
O&OD	Opportunities & Obstacles to Development
REPOA	Research on Poverty Alleviation
SAP	Structural Adjustment Programme
SAWATA	Saidia Wazee Tanzania
SPSS	Scientific Package for Social Science
UNDP	United Nations Development Programme
URT	United Republic of Tanzania
VEO	Village Executive Officer
WEO	Ward Executive officer
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background Information

Access to health service is a basic human right regardless of age. States have the primary obligation to protect and promote human rights including provision of health services in order to ensure that every individual is free from diseases therefore, can engage fully in socioeconomic activities towards development (WHO, 2006). The goal of health services provision is to improve health outcomes in the population and to respond to people's expectations, while reducing inequalities in both health and awareness. It is through health service provision that morbidity and mortality will be reduced, hence raising people's life expectancy.

Free health service provision systems vary according to the extent of government involvement in providing care and/or health insurance. In some countries, such as the UK, Spain, Italy and the Nordic countries, the governments have a high degree of involvement in the commissioning or delivery of health care services and access is based on residence rights not on the purchase of insurance (Howse, 2007). As people become old, they physically, mentally and psychologically become weak and they are subjected to frequent attacks of diseases, while they can rarely provide themselves with necessary health services.

It is from this point that, both the United Nations (UN) Universal Declaration of Human Rights – 1948, UN Plan of Action on Ageing – 1981, UN Principles for Older Persons – 1991, UN Proclamation on Ageing– 992, African Union Policy Framework and Plan of Action on Ageing (AU-Plan) - 2002, as well as the Madrid

Plan of Action on Ageing (MIPAA)– 2002 call for old people's care and right to access free health services (Nhongo, 2006).

Free health provision to old aged people in most developed countries started after the Second World War, when the governments realized that health services provision was a basic human right (Howse, 2007). In these countries, all people aged 60 years or more are entitled to free health services from the standard doctor prescription to medication on all types of diseases including sight tests and dental services (Grundy, 2010). In Nepal, health service is delivered without charges (free) to the poor, marginalized, old aged people and disabled, and it was observed that the number of people visiting health centres has increased due to involvement of civil society organizations in awareness raising on people's entitlement to services (Jeevan, 2010).

In Sub Saharan Africa, free health services provision to old aged people aging 60 years and above was initiated by MIPAA and AU-Plan after realizing that old aged people have less access to health services than other aged groups in the society, and that they were lacking access to even basic health care, showing an element of age-related exclusion (UN, 2002), though the initiatives have not solved the problem. In Kenya, it was evidenced that old aged people were experiencing negative attitude and behavior from some health workers. Some old aged people reported that public health providers give unqualified discouraging remarks, for example: "You are not sick, your problem is old age" and were denied with medical treatment (Ochola *et al.* 2000).

Following Independence in 1961, Tanzania adopted free health care provision to all population by abolishing user charges in government health facilities (REPOA, 2004). However, in 1993, Central Government started the health sector reform process in order to reduce government costs. The cost sharing on health service segregated many people especially the poor, old and other marginalized groups on accessing and affording quality health services. Therefore, in 2003, the country adopted the National Aging policy as a strategy advised by the MIPAA and AU-Plan in order to ensure full access to adequate curative and rehabilitative care for older persons.

The National Aging Policy advocates, among other things that there should be proper mechanism to enable an easier identification of people aged 60 years and above so that they could be treated free of charge; and that health staffs especially nurses are to be given training on how to handle the old aged people when in need of health care and health services. Also, The National Strategy for Growth and Reduction of Poverty, mainly referred to as MKUKUTA, now also involves the needs of the old aged people (URT, 2007).

Since the policy implementation, it was reported in 2005 that old aged people were still concerned about the quality of health care they receive, the cost of treatment and medicine, and the distance they travel to services. It is still few number of the old aged people attending various health facilities for treatments received free services (HAI, 2005). In addition, medicines and drugs in public health units were not sufficiently available, leading old aged people to purchase them from private

medical stores (Mongula, 2007). Until 2007, only 15% of them received free treatment. This shows that the problem still persists and it needs more effort to be done to ensure that old aged people are provided with free health services (URT, 2007). Does it mean that old aged people are not aware of the existence of this services, or they don't know on how to apply for the services, or the procedure used to get the service is too complicated for them, or probably they lack the right documents to identify their age to enable them be eligible for the services, or maybe it is the cost to be engaged to reach the health facility itself becomes a constraint.

1.2 Statement of the Problem

The 2003 National Ageing Policy of Tanzania advocates for free health service provision to old aged people (those from 60+ years) from various health facilities, training to be given to health staffs especially nurses on how to handle the old aged people, and availability of proper mechanism to be used to identify people aged 60 years and above (URT, 2003). The government aims to provide free health services to old aged people, such as the adoption of the National Ageing Policy and inclusion of old aged people's needs in MKUKUTA, yet free health service provision to old aged people had not been successfully attained. For instance until 2007 only 15% of old aged people seeking for health services in Tanzania received free treatment, leaving the majority of them without access to the service while facing both social and financial challenges.

In Meru District Council there are 15595 old aged people who are already recognized. Between them only 7006 have identities that can be used in seeking health services. But there are still some problems in the process of getting health

services like shortage of medicine and medical equipment, the processes of getting identity cards that may course elders to luck required services. In this District and may be country wise there no fund allocated for medication to old aged people. It looks like we still have the long way to go so as to achieve the aim of free health provision to old aged people in Meru and Tanzania in general.

1.3 Objectives of the Study

1.3.1 General Objective

Generally, this study intends to evaluate the implementation of Tanzania National Ageing Policy in free health services provision to old aged people in Tanzania.

1.3.2 Specific Objectives

i. To identify the type of health services provided to old aged people
ii. To identify factors influencing the performance of the policy implementation in free health service provision
iii. To explore measures to be taken by development actors to improve the provision of free health service to old aged people.

1.4 Research Questions

i) What type of health services is provided to old aged people?
ii) What are the factors influencing performance of the policy implementation in free health service provision free health service provision?
iii) What are the measures taken by development actors to improve the provision of free health service to old aged people?

1.5 Significance of the Study

The study findings will therefore become a source of information for proposing long-term strategies for enhancing effective and efficient free health services provision to old aged people at local, regional and national level. The study will widen the knowledge especially in planning field, and stimulate other researchers in matters related to older population.

Policy Planners and Ministries; Data given will provide the information on how the Policy should be translated in regional and local areas for the same intended goals where there is implementation of the policy. The results will enable the system to strengthen the Monitoring and Evaluation system to ensure effective and efficient health services are provided to the old aged people.

Old People (Beneficiaries); the results of the study will help the old aged people evaluate the quality of care and services rendered by the health institutions. The results will help old people to access the attitude, skills and relation applied to the aged people. The study also will provide information regarding which type of services should be provided at what level.

Health Department; The results of this study will be used by the Officials of Health Department to improve the health department in provision of health services to aged people. They will foster new ways of enhancing special knowledge, skills and attitude, to health worker when providing services to old aged people.

1.6 Scope of the Study

The study was conducted in Meru district from the sample wards/villages within the District. The study covered old aged people's awareness on their entitlement to free

health services, type of health service provided to old aged people, number of old aged people who receive free health services, frequency of attendance by old aged people to health facility, problems encountered by old aged people when seeking for free health services, and the measures to be taken in ensuring effective health service provision.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the review of related literature that has been critically analyzed from different readings on the topic under investigation. It forms the literature of the study in two major parts: namely theoretical part and empirical part.

2.2 Definition of Key Terms

Old aged people: Specifically for this study, old aged people are those ageing from 60 years and above as stipulated in the Tanzania National Ageing Policy of 2003. In Tanzania an individual is recognized as an older person based on age, responsibilities and his or her status, for example, a leader at his or her work place or in a clan. The elder people we have were either salaried or self-employed or those living in rural areas whose advanced age limits them from active work.

Free health service provision: Is the way in which health inputs are combined to allow the delivery of a series of interventions or health actions without charges to the users (Jeevan, 2010).

Health: The widely agreed definition of health is that of The World Health Organization (WHO) which states that "Health is the state of complete physical mental and social well-being and not merely the absence of disease." Health is thus considered the very center of persons' wellbeing and development. It is an important component of the development process in the sense that it can help or hinder national development, and that other forces of development can add to or detract from health.

Policy: Is a principle or rule to guide decisions and actions in order to achieve rational outcomes.

2.3 Theoretical Literature Review

2.3.1 Social Vulnerability Theory

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

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

On the other hand Blaikie (1994) defined vulnerability that is the incapacity of individuals or social group to respond, which is coping with, recover from or adapt to any external stress placed on their livelihood or well- being. Vulnerability or

security of any group is determined by the resources availability and by entitlement of individuals and group to call on these resources. Underlying causes of vulnerability include inadequate distribution of resources.

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

On the part of this study the assessment is made on the provision of free health services to older people as far as the National Ageing Policy 2003 is concerned. Older people are vulnerable due to their age. As they grow older they lose capacity to engage themselves in income generating activities which result them into object poverty. However, older people become vulnerable to different diseases as their body immunity becomes weak to resist diseases. Their vulnerability need to be assessed in order to define magnitude of the threat so as to promote remedial actions in order to provide coping strategies and facilitate adaptation.

2.3.2 Health

Before focusing on health model health is defined as the key concept at this point, The English word "health" comes from the Old English word hale, meaning "wholeness, a being whole, sound or well,". Medilexicon's medical dictionary

defines health as "The state of the organism when it functions optimally without evidence of disease or abnormality" article 21 may 2009 Walden university, (http.//www. medilexicon.com/medicaldictionary.php), World Health Organization's 1948 (WHO's) definition of "health" "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." WHO says the main determinants to health are: Our economy and society ("The social and economic environment"), Where we live, what is physically around us ("The physical environment") What we are and what we do ("The person's individual characteristics and behaviors"). An article in The Lancet states that health is not a "state of complete physical, mental, and social well - being". Neither is it "merely the absence of disease or infirmity". The article says the WHO definitions of health as; to provide health services on equitable basis and fairly by considering gender and special needs.

In general term according to the study, the policy has seriously considered the need for provision of health services to older people though implementation faces a number of constraints such as poor health services and medication, as well as reluctance of health care staff and local government officials to adequately deriver to older people their entitled services. Some policy statement such as ensuring equality in the provision of health services to all groups of people and on equitable basis is a reality of farfetched wish. Implementation of universalized user-free exemption to cover all older people remains challenging.

2.3.3 National HIV/AIDS Policy and Strategy

Is another area the same study identified and analyzed. The first National HIV and

AIDS policy was developed in 2001 under the coordination of the Tanzania 29 Commission for AIDS (TACAIDS) The primary aim of this policy was to enhance effective coordination of the national response to the scourge. In order to provide strategic guidance on how to respond against HIV/AIDS, the National Multi-sectoral Strategic Framework (NMSF) was developed in two phases. The 2001 policy however, lacked involvement of vulnerable groups such as the elderly.

Another policy was issued in 2010 which revealed that older people had been neglected not only in terms of data on people aged 50 years and above but also on how this group was engaged in the national response given the fact that in many communities OVC and PLWHIV were cared by the older people. It is also noted that the elderly faced the discrimination in HIV /AIDS services because of wrongly held assumptions about their sexual virility and inadequate information. The policy strove to address elderly specific needs and roles in National HIV response through the following policy statements.

i. The government and stakeholders will develop age –sensitive HIV prevention strategies targeting old people.
ii. The government and stakeholders will develop guidelines which ensure that older care providers of PLWHIV and OVC are empowered to protect themselves and provide appropriate care.
iii. The government and stakeholders will introduce social protection schemes for the elderly to enhance their ability to handle the effects of HIV and AIDS. Among the observation made on this policy by the study is that, though the policy stipulates the roles and responsibility of all actors at the village and ward

levels seem to be mere statements of intent since in most cases the players at those levels are have limited capacity to plan, implement, coordinate and monitor HIV/AIDS response.

In the first; Place they do not have the budget nor the adequate skills to carry out their tasks as prescribed in the institutional framework.

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

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

2.3.4 National Strategy for Economic Growth and Poverty Reduction

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

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

Observation made by the study is that, MKUKUTA refers ageing as a cross cutting issue but in practice it is not accorded deserving magnitude and importance of the sector concerned. Due to this kind of thinking each sector deals with the ageing issue in \ marginalized way. Unlike other crosscutting issues such as gender, environment

and HIV/AIDS which are addressed in a more serious and strategic manner, ageing is simply relegated into a popularly used terminology without a proper institutional home or budget. The eleven operational strategies for goal 3 in cluster II only focus on capacity development, deployment and retention of health personnel but do not include any strategy on how to improve their delivery to the elderly, which is one of the major shortfalls in the health sector.

The operational target for HIV/AIDS and TB in cluster II, Goal 3 lack quantifiable benchmarks for older people who would make it difficult to measure the outcome and impacts of strategies to older people. The strategy on HIV/AIDS prevention awareness and behavior change does not state how the elderly will be covered. In practice such campaign programmes focus on women and youth and the elderly are not specifically targeted as they are lumped into the general public category.

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

2.4 Empirical Literature Review

2.4.1 Health Services Reforms in Tanzania Since after Independence

Although many people in the developing world the term “health sector reform” may sound like a new policy or ideological terminology, its process and practice in Tanzania are historical. The 1961-67 period was one which focused on correcting problems created by colonial practice whereas the system was very segregate and divided in classes as the first class ware for colonialists, second class for Asians and the last for Africans. However, only Africans who were employed in colonial systems were given a chance to be treated (Maghimbi *et al.,* 1998).

The Tanzanian government launched the Arusha Declaration in 1967. Under this declaration, all major social and economic sectors were nationalized. In relation to health, one of the purposes of the Arusha Declaration was to ensure universal access to social services to all the citizens, the majority of whom were (as they still are) poor and living in rural areas. This was done on favor of the perceived poor majority and in conformity to the ideology of “socialism and self-reliance” The people regarded as being poor were those who could hardly pay for their essential needs, such as health and education. The Arusha Declaration was followed by the Decentralization Act of 1972. This was aimed, among other objectives, at building regional, district and village capacity to effectively participate in decision making, planning and implementing activities for their own development, health in particular (Mills et al. 1990; Gilson *et al.*, 1994).

In 1977 the government continued to finance and provide health services free of charge to all citizens seeking care from government health facilities and However,

mission health facilities continued to operate as private not-for-profit organizations by charging their patient clients, as they had been doing even before independence (New brander and Sacca, 1996; Msamaga *et al.*, 1996);

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

In July 1993 a cost-sharing policy was launched in the Tanzanian public health sector. User fees began to be implemented in phases at referral, regional, and district hospitals for some services that had previously provided free of charge (New brander and Sacca, 1996; Mmbuji *et al.*, 1996). According to the government's health sector reform policy agenda, cost-sharing was planned to be extended to health center and dispensary levels so that communities would participate in financing their health care needs through formal and informal risk pooling mechanisms Whereas CHF was primarily intended to benefit the majority of the informal sector (e.g., the self employed), the national health insurance is targeted to formal employees (e.g. civil servants) and some of their dependants (MOH 1994, 1996). Cost sharing is a critical issue which should be looked upon with an open eye as it has negative impact to vulnerable groups including older people. As it is shown area 90% of older people

live in rural areas with poor economic status as the consequence they cannot afford to pay for extra costs for health care.

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

2.5 The Concept of Old Age

URT (2003) defines ageing as a biological process which has its own dynamic, largely beyond human control and consists of people with ages nearing or surpassing the average life span of human beings, and thus the end of the human life cycle. It is a multidimensional process of physical, psychological, and social change characterized by the changes in physical appearance such as wrinkles appearing on the face, the graying of hair, slowing down of reactions, followed by restriction of movement and sense organs, and proneness to chronic illnesses. All these require special care and attention from different stakeholders.

UNDP (2007) suggest that, the fact that the average life expectancy in a country like Tanzania is said to be 51 years for men and 52 for women it might not be surprising

that from a European point of view sometimes the question is raised whether there are old aged people in Africa at all. However, URT (2003) added that, old age in a Tanzanian context is a biological process which has its own dynamic, largely beyond human control, and it starts from the age of 60 years and above, roughly equivalent to retirement ages in Tanzania. The policy therefore recognizes old aged people as all those ageing 60 years and above living in rural and urban areas, regardless of their physical ability.

2.6 Meaning of Free Health Service Provision

Jeevan, (2010) defined free health service provision as the way in which health inputs are combined to allow the delivery of a series of interventions or health actions without charges to the users and that, health is a state of complete physical, mental and social well-being. Taking into account that old aged people are neither able to provide themselves with necessary health services, nor to pay for the special treatments they require from various health facilities due to their reduced ability to work for income generation, the combined efforts of private people, government and non government organizations are inevitable to ensure the survival of aged people. It is due to this factor that some developed countries consider free health services as a must and not an option.

Howse, (2007) found that, free health provision to old aged people in most developed countries started after the Second World War, when the governments realized that health services provision was a basic human right. In these countries, all people aged 60 years or more are entitled to free health services from the standard

doctor prescription to medication on all types of diseases including sight tests and dental services.

2.7 Situation of Old Aged People in Africa

HAI (2008) suggest that as people get older, their health care needs change. Old aged people often do not know the clinical effects of ageing, or lack the resources to meet their health care needs. Many of them experience chronic poverty, and this exacerbates the degenerative effects of ageing. In most cases, many old aged people are not accessing to health care due to a number of factors, including: being unable to pay for transport to get to the health centre, or for the medication, lacking the right identity documentation to prove their eligibility for free or subsidized services, being unaware of what they are entitled to, being physically unable to queue for a long time while waiting to be seen, or to take an arduous journey to the health centre by public transport, as well as being geographically isolated from services, with a lack of public transport. These factors are compounded by the fact that health care staff may not be trained in geriatric care, and may discriminate against old aged people.

The majority old aged people especially in rural areas belong to the poorest and most vulnerable groups. Their capacity to satisfy their basic needs reduces as age increases. It is often taken for granted that old aged people in developing countries, Tanzania in particular, are protected and looked after by their families, and given respect by young people. However, HAI (2002) experience indicates that in Tanzania stress and strains of poverty, market forces and changing cultural norms cause family care and respect to often being undermined. The vacuum that was created by the breakdown of the traditional family support system, was neither

sufficiently filled by the individual, by taking early preparations during active life, nor by the government, through the establishment of a substituting social security system.

Kawawani, 2005 concluded that, with the changing structure of society, the older persons have lost their traditional roles and respect. The extreme economic conditions have made economic considerations ever more important. Older persons are thus increasingly marginalized within communities as they are viewed as a waste of scarce resources.

2.8 Free Health Service Provision to Old Aged People in Tanzania

During the years of socialist development strategy in Tanzania health services were available for free to all people. During that period the Government was committed to underwrite both investments and recurrent expenditures on health. Thus building new hospitals, health centers and dispensaries and paying salaries of staff, supplying medicines and equipment and organizing immunization programmes were organized by the Government. Old aged people like any other disadvantaged social categories with little incomes did not have to worry about whether or not they could afford to get access to health services.

This was ended in 1980s after the adoption of Structural Adjustment Programme (SAP), that emphases on cost sharing for service sector including health. Many people especially the poor including the old, were unable to access health services because they could not afford to pay for them. To rectify the situation, in 1995 the government of Tanzania in collaboration with World Bank introduced the

Community Health Fund (CHF). Laterveer *et al* (2004) reported that, the aim of CHF was to improve financial sustainability in health sector and increasing access to health services among rural dwellers. The health fund requires the household to contribute a premium amount per year for the service, with an exemption to the most vulnerable that have to receive free health services. This again strained old aged people little income they have to be spent on health services, at the same time others were left without being served.

According to AU/HAI (2003), the government of Tanzania grasped the need to provide for free health services to all old aged people ageing 60 years and above regardless of their financial ability. This was fuelled by the key supranational policy frameworks which are MIPAA and the AU Plan that emphasized a need for measures to advance health service provision and training in order to ensure effective, fully accessible, prevention, control, management and disability care for age-related non communicable diseases.

Tanzania was the second Nation in Sub Saharan Africa after Mauritius to formulate the National Ageing Policy that advocates for five basic rights for old aged people as; Independence, Participation, Care, Self – fulfillment, and Dignity. Old aged people should be free from diseases, participate in their old development and community development at large, they need to be cared for by their families and the government in terms of providing them with basic services including health, they should be complete physically and mentally so that they can fulfill their dreams and be respected and valued by the community that they have contributions to make

towards national development. All these will be possible if and only if old aged people will have good and satisfying health.

2.9 Role and Importance of the Old Aged People in the Community

Despite the changing socio-economic structures of the African societies, the socioeconomic roles of the old aged people remain very important within the family and the community. It is worth noting however that their roles are often unrewarded and grossly undervalued today. URT (2003) recognizes that, older men and women have played important roles in Tanzanian society and continue to contribute in diverse and dynamic ways at household, community and national levels. Old aged people have contributed to the national economy both directly and indirectly throughout their lives with most (75 per cent) continuing to work well into old age. They are also considered the custodians of culture and history and play a significant role in promoting social cohesion through conflict resolution.

Old aged people, particularly older men, have vast experience of mediating inter-household tensions. Their memories of debts and repayments as well as complex kinship relationships are vital for the social fabric of the community, which relies on a level of social reciprocity. Old women support the extended household and others in the community through caring for young babies and children to enable young women to engage in productive activities This means that old aged people's assets tends to be pooled and invested in the development of younger generations. In this light therefore, the government recognizes the contribution of old aged people, and that it has to ensure that it cares for their health by providing them with free health services.

2.10 Health Problems Related to Old Age

According to United Nations (2002), older populations are deemed to be at high risk of ill-health and disability from age-related chronic non-communicable diseases such as blood pressure, eye problems, malaria, cardiac problems, diabetes, joint pains, kidney infections, cancer, tuberculosis, mental retardation and sweating problems. Once they occur, these diseases may take a long time to heal and they need regularly medical checkups that an old person cannot afford on hi/her own without external support due to limited income. In Sub Saharan Africa older populations are deemed to be at particularly at high risk of ill-health and disability from age-related chronic non-communicable disease, due to a life-time of exposure to conditions of deprivation and a growing prevalence of modifiable chronic non-communicable disease risk factors.

2.11 Institutional Care for Old Aged People

Kawawani (2005) reported that, Tanzania has a small network of care homes for old aged people. This means that many responsibilities to care for the old lies in hands of the family and the community where old aged people lives. However, due to the hardship of life especially in rural areas, many young adults who are responsible on taking care of the old had migrated to urban areas looking for means of survival. The age structure of rural settings is being impacted by the emigration of younger people to urban areas and the return of old aged people to rural environments from urban areas on retirement.

Many young adults who are energetic and main supporters of their families are migrating from their respective rural areas to cities looking for employment due to

poor rural economy. This has changed the tradition role of old men and women of being taken care of and valued as the chief community adviser. Instead of being cared for, old aged people are the care givers to their grand children whose parents have migrated in search of work, or who are ill or have died of HIV/AIDS related illnesses.

2.12 Conceptual Framework

In order to provide free health services, some core inputs such as government policies implementation, health system financing and institution arrangement are necessary. This will influence the type and quality of service provided, qualified and specialized health personnel and the material and equipment availability. However, the individual income status, changing role of old aged people and distance to health facility will determine the accessibility of the services. All these causal and pushing factors if are properly arranged and well implemented, the free provision of health services to old aged people will be possible. Therefore, old aged people will be able to receive timely quality health services, have improved health status, reduced old age morbidity and mortality, as well as raised old age life expectancy. As old aged people are resources in the society, if they live longer they will be utilized fully as potential resources in the development of our nation by contributing their wise ideas towards policy formulation and implementation and institutional arrangements.

A conceptual framework is a narrative outline presentation of variables to be studied and hypothetical relationships between and among them. The conceptual framework of this study is informed by theoretical and empirical literature. The linkages are established between independent variables (socio-economic variables,

quality of health services, respondents' health status, health related variables, and respondents' and health workers' knowledge and attitudes towards free health services to the elderly) and the dependent variable (access to free health services among the elderly). The study was hypothesized that the independent variables have influence on access of the elderly to free health services. It was also hypothesized that socio-economic factors have influence on the health statuses of the elderly.

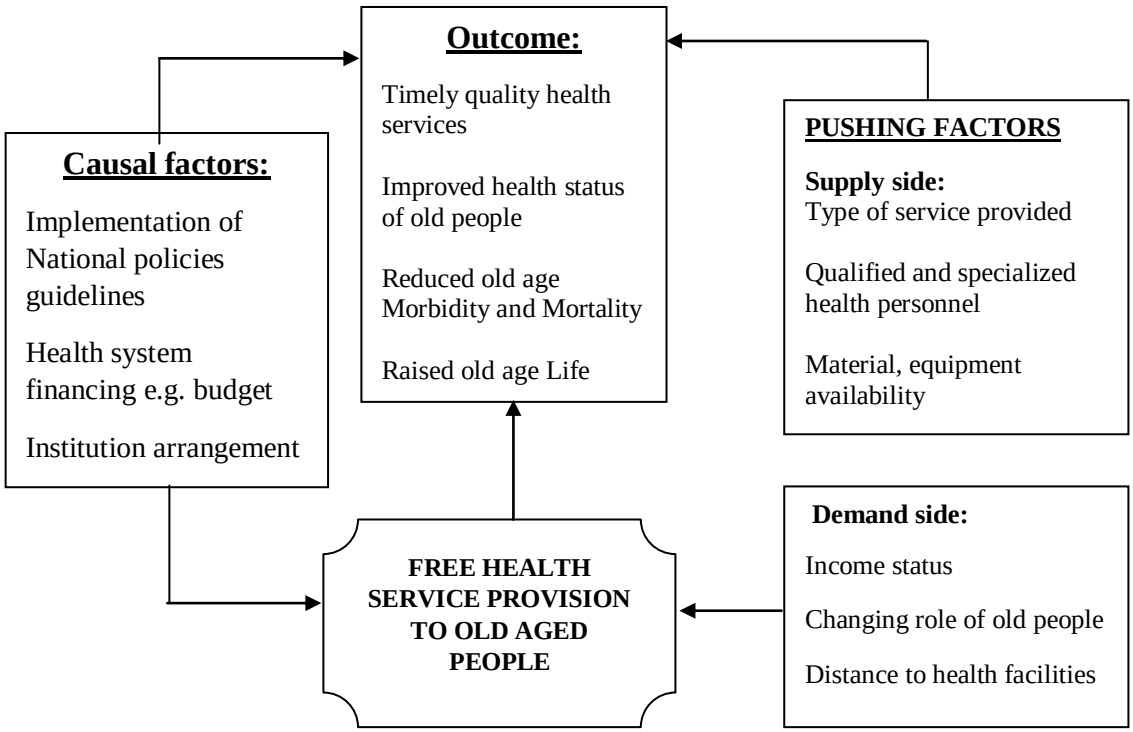

Figure 2.1: Conceptual Framework on Free Health Service Provision to Old Aged People

Source: Research data, 2019

The types of linkages of variables established in the conceptual framework (Fig 2.1) are based on the idea that socio-economic characteristic of the elderly may have positive or negative influence on their health statuses. Hypothetically, it was put forth that the elderly with different socio-economic characteristics do not differ in

their health statuses and that the health status of the elderly is associated with their access to free health services. Figure 2.1: Conceptual framework used for the research showing relationships between and among variables as;

Pushing factors: That influenced by types of Service provided, Qualified and specialized personnel, Material and Equipment availability. The success of this policy depends on good arrangement of Casual Factors like;

i. Implementation of National policies guidelines that needs to provide equal services to old aged people,
ii. Health system financing e.g budget needs enough fund to be allocated to all health facilities in order to insure that they will get services without barriers.
iii. Institution arrangement that needs the institution to create friendly environment and having good preparations that will support free health services to old aged people.

Demand side: Services provided should be equally provided to all old aged people at all levels, regardless of; Income status determines the type of services the one should get, Changing role of old people, Distance to health facilities that may influence access to the health services.

Outcomes;

i. Timely quality health services, improved health status of old people,
ii. Reduced old age Morbidity and Mortality and
iii. Raised old age Life expectancy

Theoretical Perspectives of Access to Free Health Services: The concept of health equity theory according to the Global Equity Gauge Alliance (GEGA) (2003), health equity means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives and all avoidable health inequities, and health disparities must be eliminated. Latts (2008) defines health equity as a means that everyone should, in practice, and not just in theory, be able to access and use appropriate health services. The equity theory by Goddard and Smith (2001) asserts that health services should not only be for the dominant population groups. This implies equitable access and use of health services, given that some people such as the elderly will need more health care than others.

The theory, outlines the factors that may hinder equity health service delivery as low education, lack of information (awareness), age, sex, low income, price of medicines, and spatial factors such as distance from health facilities, that is the closer the health facility the lower the opportunity cost of time, hence more access to health services. It is also argued by the theory and GEGA (2003) that socio-economic characteristics and discrimination to marginalized groups like the elderly may hinder their rights to access health services. Therefore, unless the negative impact of those factors is addressed, it will be difficult to attain equal access and use of health services equally. This theory underpinned this study as the theoretical factors were adapted to the study.

However, the theory does not describe about the individuals like health care professionals and caregivers and relatives who can help call attention to the well-being of the elderly, help empower the elderly to take more control over their health

decisions, bring them to health facilities and hence access free health services. The theory does not show these as one of the factors that may determine the elderly access to free health services. This is a weakness of the theory.

The concept of service quality: The quality of health services has always been found to be an important factor for access to health services. On the other hand, it is pointed out by Bayoumi (2009) that free services encourage providers to deliver only necessary services leading to poor quality of the services. This discourages the health services consumers from attending health facilities. Therefore, even though exemption to health services exists, the quality of the services may remain poor unless there is regular monitoring on the system (Pastory, 2013). Due to this fact, the elderly might not be willing to go for free health services because the poor quality of the services they receive from the health facilities. Therefore, in this study the quality of free health services received by the elderly and its association with access to free health services by the elderly was determined.

The alderfly's knowledge and attitudes Health workers' knowledge and attitudes: It was also hypothesized that the odds of accessing free health services are the same among the elderly with different socio-economic characteristics in the sense that those with poor socio-economic status could have the same or more or less the same access to free health services as their counterparts with relatively good socio-economic status. The idea of service quality in Fig.2.1 express that the quality of health services the elderly received was associated with their access to free health services in the sense that poor health services delivery to the elderly might not meet their health services demand. This might deny them of their right to have health

services they require. Another idea in the conceptual framework is that the elderly and health workers' knowledge and attitudes towards free health service provision to the elderly may be an impediment or impelling factor for the elderly to access free health services. This idea lies in the fact that if the elderly are not well informed about their right to free health services they will not be able to claim for their right.

Also, if they have negative attitude towards the delivery process and the health personnel, they may even not attend the health facilities to seek health services. On the other hand, the health workers may also not have adequate information on the right of the elderly to free health services. This may lead to denial of provision of free health services to the elderly. Negative attitude of health workers towards the elderly also might lead to discrimination against the elderly in the process of health service delivery.

2.13 Information Gap

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

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Design

According to Kothari, (2004), research design guides data collection, measurement and analysis. It is explaining more on what the research design is, in their work, but also is used for planning and 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 because they provide more evidence than a single case and add relevance 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.

3.2 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 so as to establish representatives of what are being studied and conversely to reduce bias. And making inferences from findings based on a sample to a larger population from which that

sample is drawn. The study employed simple random sampling and purposive samplings to get the required sample.

3.3 Selection of the Study Area

The study was conducted in Meru District Council in Arusha Region from twelve wards and their villages. This area is characterized by a social mix of people from different parts of the country. The majority of residents are the Meru who have a relatively average economic and educational status. The District Council has rural characteristics with average housing conditions, and average supply of clean and safe water of 63% access from natural source. The average residents depend on crop farming while experiencing erratic. My study based on twelve wards regarding their characteristics there were two wards Usa River and Akheri) with characteristics of per-urban where there is access of all important social services including better health Facilities and transportation. The other wards are characterized as rural wards with some different difficulties conditions that can be regarded as barriers to access health services to old aged people.

The selection of the study area based on the fact that, the District is having about 51 dispensaries 28 owned by Government and 23 are private's owned. 7 health centers owned by government and 2 hospitals (one is Government owned and the other is private) within these facilities there is need of specialization of health personnel on old aged people related matters, and experiences showed there is inadequate supply of medications. Also, since the implementation of the Tanzania National Ageing policy, no study of this nature had been conducted in the area, making the study important to be undertaken in order to reveal the real situation of old aged people

living in rural-urban settings within the District.

3.4 Geographical Location and Boundaries

Meru District Council lies on the slopes of Mount Meru which is the second highest Mountain in Tanzania after Kilimanjaro that rises up to 14,000 ft. (4516m) above Sea Level. The Council lies between Latitude $3'00^0$ – $3'40^0$ and Longitude 36^0 – 550^0 in the Eastern South of Equator. The district has bimodal type of rainfall i.e. Short rains (*Vuli*) which falls from November to January and long rains (*Masika*) which falls between March to June, that make the district to have two agricultural seasons that receives the Annual rainfall ranging between 500m – 1200 mm and also it experiences the average temperatures of about 25^0C (January – February) and 22^0C (June –August). The district has 11 perennial rivers and 143 springs some of which makes the bases for irrigation, domestic and livestock uses.

3.4.1 Land Area

Meru District covers an area of 1,268.2 square kilometers and about 13% of the total area (163.7 kms^2) is covered by forest reserves. An area of about 813.5 kms^2 (64.1%) is used for agricultural activities, 37.05kms^2 (3%) for grazing, 15kms2 (0.001%) for pasture/fodder, 203.7kms^2 (16%) for National Parks, 5.7kms^2 (0.4%) for water bodies and the remaining area of 44.39kms^2 (3.6%) of land is of settlement and unsuitable land.

3.4.2 Climate and Soils

The dominant climate is tropical-savanna type of climate with clearly rainy and dry

seasons. The mean rainfall ranges 500m – 1200 mm per annum and normally rains starts between mid – October and December, February and ends in May. The distribution of these rains is quite inappropriate for agricultural activities and livestock rearing in the District. The soil of Meru district is relatively fertile as they are of volcanic origin. They are well drained dark sandy loams with favorable moisture holding properties. However, there is soil erosion in Agro- pastoral areas especially in King'ori division.

3.4.3 Agro-Ecological Zones

The district is divided into three agro-ecological zones/belts as follows:

(i) Highland/Upper Belt

This is the Mountainous area which lies between 144m and 1800m above the Sea Level and it has an average rainfall of about 100mm per year. The economic activities are agriculture based on coffee, pyrethrum, and banana and round potatoes.

ii) Middle zone/Belt

The belt rises between 1000m and 1350m above the Sea level receiving the Annual rainfall of 500mm. The major economic activities are Livestock keeping and Agriculture. The crops grown in this belt are coffee, banana, maize, beans, wheat, rice, fruits and horticulture crops.

(iii) Lower Zone/Belt

The belt rises between 800mm to 1000mm above the Sea Level and receiving an average Annual rainfall of about 300mm. Agriculture is the most important activity where by rice, maize, beans, rice, fruits and horticulture crops are produced. (Meru

DC Profile, 2017).

3.5 Study Population

The population of this study was 15595 old aged people both males and females that are available in the District Council. 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, social welfare office and health personnel's 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.

The population of this study is heterogeneous in nature and includes all elder people above 60 years living in different areas in Meru Dostrict, 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

3.5.1 Sample Size and Sampled Population

The size of respondents selected for interview was 161 old aged people of age 60 years and above from different wards as shown in Table 4.1.

Table 4.1: Distribution of Questionnaire by Location and Sex

	Sex		
Ward's name	**Male**	**Female**	**Total**
Usa River	7	9	16
Akheri	6	8	14
Maji ya Chai	4	7	11
Mbuguni	7	8	15
Makiba	6	8	14
Ngarenanyuki	3	6	9
Ngabobo	5	13	18
Nkuanrua	8	7	15
Songoro	5	7	12
Nkoanekoli	6	8	14
Nkoaranga	4	7	11
Imbaseni	5	7	12
Total	**66**	**95**	**161**

Source: Research data, 2019

The number of female respondents exceeds that of males due to the fact that there are more old females in the ward than males, and that it was much easy to allocate them at their residents during the visit than their male counterparts.

3.5.2 Sampling Procedure

Both Probability and Non Probability sampling procedures were used to get the respondents. Old aged people group was purposively selected before the probability process to compose a sample as they were specifically targeted by the study.

3.5.2.1 Probability Sampling

Simple random sampling was used to get old aged men and women, whereby, snoe ball method was employed to classify the respondents by sex. Thereafter, lottery

method was used to select respondents without bias from each cluster. On this exercise village chairs persons and hamlet chairpersons were involved because they are the one knows all the old aged people within their areas.

3.5.2.2 Non - Probability Sampling

Purposive sampling was employed in taking old aged people group and for key informants. The key informant respondents included the DMO, Social Welfare Officer, WEO, VEOs, and health staff members in the study area.

3.6 Data Collection Methods

In this study 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. Therefore, three different data collection methods were applied 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.

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, Also key 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.

3.6.1 Primary Data Collection Methods

Primary data was collected directly from the old aged people using an administered questionnaire to minimize errors and assist most of old aged people who are illiterate. A researcher was introduced to wards, village and hamlets leaders so as get the list of all old aged people in their areas, unfortunately there were no register of old people in most of the areas. so those leaders identified the old aged people they know and the researcher has to follow where the leaders said. In most of the areas the researcher used Snow Ball method of data collection due to lack of old aged register rather than leading the way to old aged people.

3.6.1.1 Literature Reviews

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. Secondary data was extracted from the reports obtained from various government documents available in different offices such as the VEOs, WEOs, Social Welfare Office, and the District Health Department. Other data were abstracted from the internet, books, journals and other publications related to the study. The sources were books, records, reports,

memoranda, agendas, and government administrative and scientific reports on health sector, web pages, newspapers, articles, government publications, official statistics and some NGOs working for the elderly, for example Help Age International.

Interviews: Semi-structured interviews were used to interrogate eighty primary respondents in each village. Also, seven brief interviews were conducted to key respondents to get quantitative data including number of old aged people benefited from the services, and number of health personnel available in the ward. This was obtained from the District Social Welfare officer, Medical officer, Health Personnel, and the VEOs. Table 2 shows the key informant respondents involved in the study.

Table 4.2: Semi-Structured Interview Respondents

Respondents	**Frequency**
District Medical Officer	1
Social welfare officer	1
VEOs/Village Chairperson	8
Health Personnel's	6
Total	**16**

Source: Research data, 2019

Questionnaire: Questionnaires were used to gather information from old aged people and key informant respondents. Administered questionnaires were used to collect information from 161 old aged people in each ward, as shown is the Table 4.1.

3.6.1.2 Focus Group Discussions

This is the source of data whereby respondents discussed in deep about the implementation of Free Health Services to Old People in their areas, (FGD) were conducted only into three wards (Usa River, Ngabobo and Nkoanekoli) because of

time limit and accessibility of the location. These wards used as a sample to represent other wards. But findings were not different as those obtained from other areas during the interview and filling questionnaires. And the exercise succeeded by following a Check-list that were arranged and organized to guide the discussion. All focus group discussion involving four old aged people, one Clinical Officers (COs), one Rural Medical Officer (RMAs) and two Village Executive Officers (VEOs)/Local leaders.

The focus group discussions were suppose to have ten participants regarding their position of representativeness in the community, for the aim of obtaining sentimental feedback from the respondents and to verify generated data obtained during the semi-structured interview. Table 4.3 shows the designation, sex and location of respondents involved in focus group discussion.

Table 4.3: Focus Group Discussion Respondents by Sex and Position Conducted at Usa River, Ngabobo and Nkoanekoli wards

	Sex		**Total**
Respondents	**Males**	**Females**	
Old aged people representatives	2	2	4
Health personnel	2	1	3
Local leaders	1	2	3
Total	**5**	**5**	**10**

Source: Research data, 2019

3.6.1.3 Observations

Observation implies the use of the eyes rather than of the ears and the voice. During data collection in this study, the researcher was making observation when visited to health facilities, 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

3.7 Data Processing, Analysis and Presentation

3.7.1 Data processing

The collected data were edited to detect errors and omissions, classified, coded and entered in a computer for processing using Statical Package for Social Science (SPSS) version 11.5.

3.7.2 Methods of Quantitative Data Analysis

The processed data were analyzed through descriptive statistics methods that are percentage and frequencies.

3.7.3 Methods of Qualitative Data Analysis

Qualitative data were 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

3.7.4 Data Presentation

The analyzed data were presented using tables, figures and pie charts to depict the distribution. Also, the analyzed data were interpreted in order to get the real picture of the problem.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents the results and discussion of the findings in line of the objectives of the study. The organization of the chapter is as follows:

4.2 Socio-Demographic Characteristics of Respondents

The respondent's characteristics including age, sex, and marital status were analyzed as they have direct impact on the study. Table 4.1 shows that, majority (26.1%) of the respondents are at their early old age of 60-65 years old. This cohort is followed by those ageing between 66-70 years that are 19.9%; and those ageing 71-75 years that is 16.8% of the respondents. The number of old aged people decreases by age as it is indicated in Table 4, that only 11.2% of respondents were ageing 81-85 years old, and that it is only 3% of respondents at the age of 91 years and above. The findings also revealed that, 43.5% of the respondents were males and 56.5% were females. This means that there are more females than males. Also, it was found that, 46.6% of the respondents are still married. However, 16.1% respondents were widows while only 11.2% were widowers.

These differences can be explained from a traditional point of view whereby men in African societies have more possibilities of re-marrying when the first spouse dies. It also means that the chance of men being in a marriage status is much more obvious when compared with women who find it difficult to re-marry particularly at old age after death of their spouses. However there are some old aged people about 16.1%

are living along after divorced or separated for some years and the choose to be alone due to their age.

Table 4.1: Age, Sex and Marital Status of Respondents

Variables	**Frequency by Sex**			**Percent**
Age	Male	Female	Total	
60-65	19	23	42	26.1
66-70	14	18	32	19.9
71-75	12	15	27	16.8
76-80	10	14	24	15
81-85	8	10	18	11.2
86-90	5	8	13	8
91+	2	3	5	3
Total	**70**	**91**	**161**	**100**
Sex				**Percent**
Marital status				
Married	75			46.6
Divorced	20			12.4
Separated	22			13.7
Widow	26			16.1
Widower	18			11.2
Total	**161**			**100**

Source: Research data, 2019

Respondent's education and occupation were also analyzed since it was assumed that, there is a relationship between the level of education, economic, and health status of an individual. This reinforces the hypothesis that, individual's health is improved by education, possibly due to having greater access to information on health, better eating habits and self-care.

The study findings as shown in Table 4.2 have revealed that 41.6% of old aged people never attended school, and 28.6% have acquired primary education. However, 10% have attended secondary education and only 18.9% of old aged people managed to attend tertiary education level.

Mainly, 53.4% of old aged people are subsistence farmers as shown in Table 4.2, and 18% are no longer able to engage in physical activities especially those aged 81-85 years and above, and they have to depend on their families to take care of them. The 6.9% of old aged people were either employees or retirees and they depend on their pensions and wages, and also 21.7% engaged in small business. But also 18% percent are not doing anything to support their life than waiting for their relatives to give life support.

Table 4.2: Education and Occupation of Respondents

Variables	Frequency	Percent
Education		
Non formal	67	41.6
Primary	46	28.6
Secondary	16	10
Tertiary	32	19.8
	161	100
Occupation		
Farmer	86	53.4
Retiree	8	5
Employed	3	1.9
Business	35	21.7
None	29	18
	161	100

Source: Research data, 2019

4.3 Type of Health Services Provided to Old Aged People

4.3.1 Curative Health Service

Curative services include consultation, check-up, medication and admission, which need to be provided to old aged people without charges in any government health facility whenever demand arises. Table 4.3 shows that 23% of all old aged people in

different wards had never received any medical services from the health facility, and 77% had ever been to health facilities for different services. Mostly, the main service provided without charges to old aged people are consultations, while check–up and medications are offered to few of them. This implies that, inadequate supply of medicines and equipment's had led most of old aged people to opt for other sources of health services like use of private health facilities, and few of them who attended to health services gets mostly consultation services and choose to pay for the service so as to get better treatment.

Table 4.3: Type of Services Offered

Type of service	Frequency	Percent
Consultation	23	14.2
Check-up	32	19.8
Medication	66	41
Admission	3	2
None of the above	37	23
Total	161	100

Source: Research data, 2019

Due to weakened physical abilities of old aged people and poor living conditions, attendance to health facility increases as one becomes older. This was confirmed by 35% of respondents who attended the health facility more than three times in last year, although they did not receive the required services due to unavailability of medications and equipment's. Lack of medication can lead to an increase of morbidity and mortality among the old aged people as most of them cannot afford buying medicines from private medical stores. This in turn will increase the perpetuation of poverty and good life for every Tanzanian will not be possible.

During the focus group discussion old aged people representative said that the frequency to health facility had currently decreased due to the insufficient services offered to them once they attend to health facilities. The respondents illustrated the situation like this: “most of us cannot attend health facility frequently because the only medicines available and supplied are pain killers that cannot cure what a person is suffering from, yet you have to spend more than three hours waiting for that service”.

4.3.2 Free Health Services

The findings revealed that, 81.3% of the respondents had never received free health services leaving only 18.8% who had ever received free health services for the year 2018. This means that for any type of service delivered to old aged people, the majority have to pay for it, making the free health service provision to old aged people to be not practically done. These findings are supported by URT (2007) which reported that, only 15% of old aged people received free health services from various health facilities. Other researchers like Spiltzer *et al* (2009) reported that, despite the policy directions on free health service provision to old aged people ageing 60 years and above, 22 % of the old aged people who attended various public health facilities received free medical treatments.

The findings show that the number of old aged people benefiting from this policy are very few and has kept on decreasing. Generally, policy directions are not fully implemented leaving complaints and unsatisfactory services to those marginalized who among them are old aged people. Hence, old aged people continue to be subjected to pay medical services in-spite of their financial disabilities, and those

who cannot afford to pay have to find another means of getting treatment including traditional medicine like Maasai medicine as for them one can pay in kind.

4.3.3 Types of Diseases Treated Without Payment

Old aged people in the study area suffer from age-related chronic non-communicable diseases. The common diseases include joint pains, optical problems, malaria, renal failure, as well as liver and kidney problems. Some of these diseases are highly costed and take long time to be healed, hence need more resources to cure them. Table 4.4 shows that, the commonly diseases that are being treated free are pains as stated by 33% of those interviewed, while old aged people related problems like optical and renal failure had been shown by 13% and 46% respectively had other health problems, while 8% said they have no idea about free treatment. The findings imply that the diseases that are highly costly are not provided without charges. This makes old aged people to find other means of getting the required services as per their demand.

Table 4.4: Common Diseases Treated Without Payment

Diseases	Frequency	Percent
Fever	25	15.5
Optical	18	11
Malaria	12	7.5
Renal failure	3	2
Pains	53	33
ARI	37	23
Other	13	8
Total	**161**	**100**

Source: Research data, 2019

These findings are supported by United Nations (2002) who reported that, old aged populations are deemed to be at high risk of ill-health and disability from age-related chronic non-communicable diseases such as blood pressure, eye problems, malaria, cardiac problems, diabetes, joint pains, kidney infections, cancer, tuberculosis, mental retardation and sweating problems. The findings have revealed that most of rural dwellers are believed to be at high risk of ill-health and disability from chronic non-communicable disease such as joint pain, optical and renal failure. Meaning that, these diseases differ according to the environment one lives.

4.3.4 Source of Funds to Pay for Treatment

As most of the diseases are being paid for, old aged people need to have sources of funds that can be used whenever they are need. Table 4.5 demonstrates various sources of fund used by old aged people to pay for health services, whereby 14% of respondents are assisted by their children and relatives. For those whom their families have no ability of assisting them tend to sale their properties so that they can get some money to pay for the required services. This was reported by 45% of the total respondents, while only 13% of the respondents were assisted by the community members.

These entail that, the traditional care for old aged people has now changed and old aged people have to take care of themselves assisted by their families. The challenge is that, the young people whom have the responsibility of taking care of their old aged parents are migrating to urban areas looking for employment due to unstable rural economy. But, upon reaching urban areas they find no jobs to do, hence, cannot get something to send back to their parents as remittances.

The situation has led the old aged people to be more vulnerable in all situations.

Table 4.5: Respondent's Sources of Funds

Source of fund	Frequency	Percent
Assisted by children and relatives	23	14
Use of pension payment	8	5
Sale of asset and crops	72	45
Assisted by the friends and community	21	13
Petty trading	34	21
Casual labour	3	2
None	0	0
Total	**161**	**100**

Source: Research data, 2019

These findings do not correspond with URT (2007) which reported that, 88% of old aged people get help from their immediate family members whenever they are in need; while 38% of them were assisted by their neighbors and friends. Meaning that, apart from family assistance the other reliable source were found to be the community. The findings have revealed that, old aged people are not getting much assistance from the community. Therefore, old aged people especially males have to engage in casual labors, and females are engaging in petty trading such as sale of vegetables so that they can earn money for their survival and pay for health services, and whatever they are earning and whatever little resource they have, are spent on food and health services.

One respondent in research site was quoted saying: "Old aged people do find their own means on how to survive as no one helps them. Most of them do manual labor in order to get money to pay for health services and other basic needs". This fact is supported by Figure 4.1 which shows some old women engaging in selling tomatoes

so that they can earn income for their survival.

Figure 4.1: Old Women on the Left Side Engaging in Petty Trading
Source: King'ori Market

This model of survival of old aged people in the ward suggests that, the low income earned cannot cater for payment of health services, the fact which is also stipulated in the National Ageing Policy (NAP) of 2003.

4.4 Factors Influencing Free Health Service Provision

4.4.1 Influencing Factors to Access Free Health Services

Provision of free health services to old aged people is influenced by the supply side having enough medicines and qualified health staff; proper equipment for check-up; admission facilities; and that, the health facility should be within peoples' reach. On the other side of demand, old aged people are required to have proper identification cards/letters showing their eligibility to the service, and reliable transport to enable them reach the health facility timely.

Figure 4.2 illustrates that, 45% of the respondents found the most influencing factor towards poor free health service provision to be the unavailability of exemption letters as the identification for one to qualify for the service. Other factors are lack of equipment and shortage of health staff as reported by 33.75% and 21.2% of respondents respectively. These imply that not all old aged people in the study are having exemption letters that can enable them to access free health services. Even for those with exemption letters, they are still hindered by lack of equipment and materials as well as shortage of health staff. As a result, much time is spent by old waiting for the services or they have to incur another expense of going to Regional and Private hospitals for further treatment.

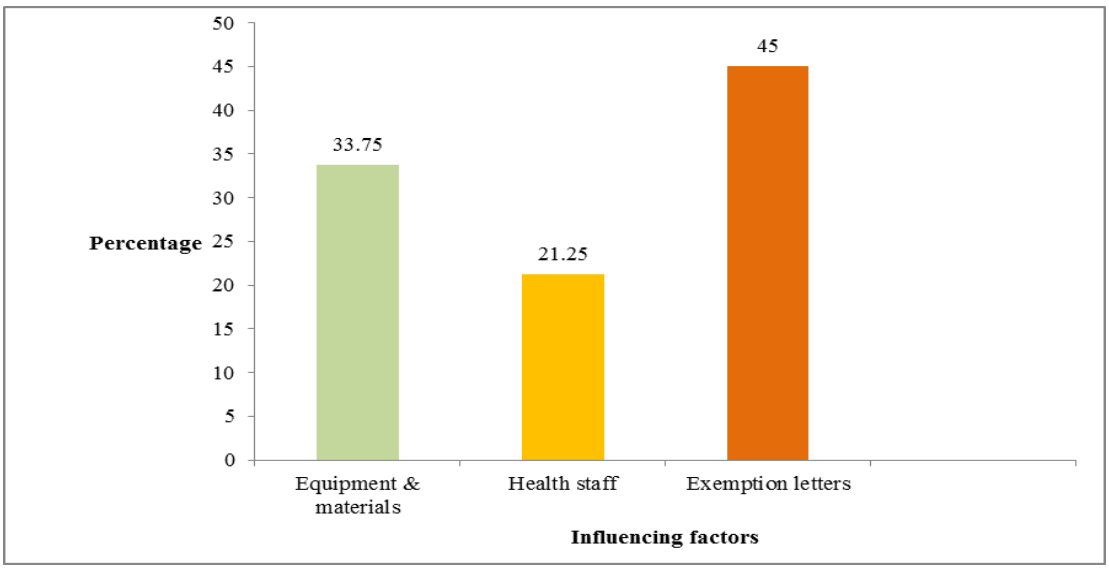

Figure 4.2: Factors Influencing Free Health Service Provision to Old Aged People

Source: Research data, 2019

These findings support what was found by Mongula (2007), who reported that medicines in public health units were not sufficiently available, leading old aged people to purchase them from private medical stores using their own sources of fund.

Exemption letters are officially provided by the Ward Executive Officer (WEO) local leaders as directed by the District Director, because they are the ones who know the ward residents better with the assistance of local village leaders. However, these exemption letters are only provided to some of old aged people and the others are not aware on how to get them. As reported by some of respondents during the interviews. This proves that the majority of old aged people in the study area are not getting free health services as stated by NAP. Apart from the influencing factors, there are also challenges/problems encountered by old aged people when accessing free health services, as indicated in Table 4.6.

Table 4.6: Problems Limiting the Respondent to Access Free Health Service

Limitation	Frequency	Percent
Long distance to health facility	17	10.5
Requested to pay for the service	42	26.3
Unreliable transport	**2**	1
No exemption letters	46	28.7
Long waiting time	54	33.5
Total	**161**	**100**

Source: Research data, 2019

Table 4.6 shows that, the major limitations to access health services are lack of finance as they are requested to pay for the services. This was reported by 26.3% of the respondents. Transport and distance to health facility were reported by some of respondents, because not all the villages have dispensaries but some villages has got a dispensary that is reached within 5km, while public transport is available throughout the year.

Getting money for treatment poses an additional health problem to old aged people, particularly if they frequently become sick, hence, very few old aged people managed to pay for treatment when they felt sick. One respondent reported that it is not possible for her to get money for treatment because she cannot even get money to buy food? The respondent stated that:

> *"Often an older person cannot afford to get money for treatment, yet they cannot be treated till you pay or promise to pay for the service and you will be recorded in the hospital debtor's book for further follow up. Look, if you cannot afford to get money for food, how can you get money for treatment? What remains is just to stay inside the house while being sick and untreated."*

Also, the majority of old aged people interviewed said they lived in abject poverty and were unable to get even a single penny for transport from their respective homes to the District Council hospital where they can get better check-up, while others were too weak to visit the nearby dispensary on their own. Even worse, some of them could not afford to have a full meal everyday which makes them increasingly weaker. This is due to the fact that there is no specific project that targets old aged people in the area. They all depend on small farming while the weather does not support it due to lack of reliable rainfall.

The District Medical Officer (DMO) and other Health Personnel dealing with old aged people confirmed that finance is the major limitation of old aged people to access health services. He said: "Most of old aged people cannot afford to buy the prescribed medications that are not available in the public health facilities. Health services providers are trying to provide services to old aged people as they can, but the problem is supply of medicine from Central Government that is expected to

compensate free treatment to all exempted groups are not delivered on time and sometime they receive just small amount compared to demand of it. However Health personnel said that all exempted groups are the ones who attend to seek for health services more times due to their vulnerability.

4.4.2 Awareness to Entitlement

In order for old aged people to receive free health services, they need to be aware of the service itself and on how they can be eligible to it. Awareness creation in Meru District Council is provided by both the health department in collaboration with wards and villages administration, and the un Fortunately; there is no Non-Government Organization (NGO) dealing with old aged people matters in the area that is known by the communities. The study findings had revealed that, 100% of respondents were aware of their entitlement to free health services regardless they have ever received free services. This means that, as although the majority of old aged people have no formal education, they can get the information at the right time through village offices and meetings, health facilities, and media (Radio, TVs).

These findings are contrary to what was revealed by HAI (2005) who reported that, 30% of old aged people were not aware on how to apply for free health services. While URT (2007) reported 48% of old aged people who were interviewed did not know that they were entitled to free treatment. Therefore, the findings show that since 2005 to date, the awareness creation had been emphasized by respective local authorities in Meru District Council territories. Regardless how many are benefited from the stated services.

4.4.3 Source of Information

Sending information to the community needs various channels of communication that match with the nature of the recepients and their level of education. Various sources of information are used to send and deliver messages regarding their entitlement to free health services to old aged people in the study area. Local leaders in the ward stated that the community was aware on old aged people's entitlement to free health services from village meetings.

Figure 3 shows that 60% of old aged people are receiving information from the village meeting as identified sources, while only 8.8% are getting the information from family, relatives and friends. This means that, policy matters are not forwarded to the community for discussion and clarification during village meetings as it is the only source of information that the majority do depend on. Some people who have the ability to access media like newspapers or own a radio and Television are being informed through media.

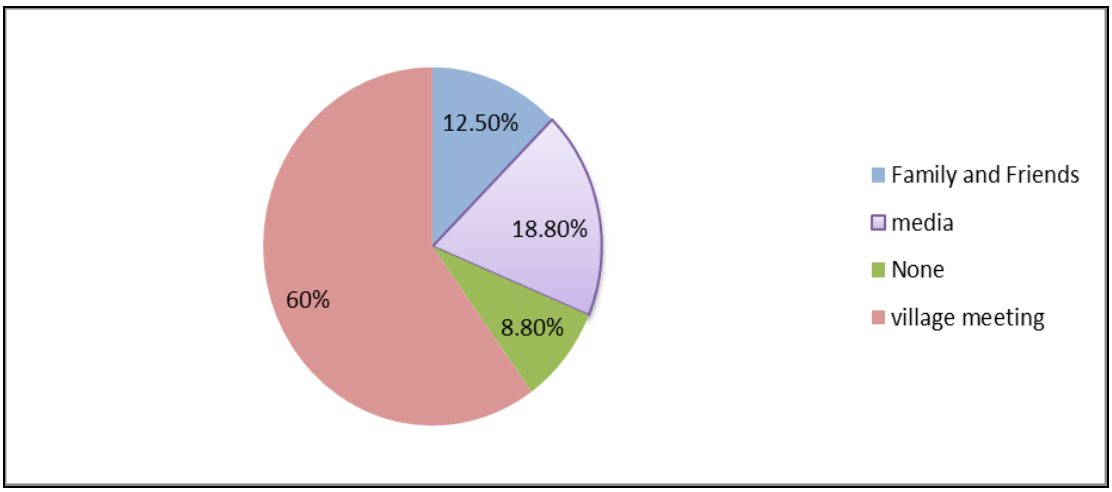

Figure 4.3: Respondents' Sources of Information in Percentage (%)

Source: Research data, 2019

The focus group discussion raised a question of doubt when the old aged people's representatives stated that very little in the ward had been done concerning the information giving on the matter, while the local leaders confirmed to have conducted several meetings. Meru is among the Districts that the sensitization campaigns had been reached and most of old aged peoples are aware of the cervices

4.4.4 Types Of Identity Used to Access Free Health Services

The procedure of getting an exemption card for free health service access involves the welfare committee at hamlet level in each area, which makes the recommendation to the ward executive officer on the matter. The WEO then issues letters for the respective old aged people to grant them an exemption to health services. Once received the letter is valid for life.

According the study, only 17.5% respondents is having exemption cards that enable them to access and receive free health services from any public health facility in the District, while the majority 82.5% are having the letters provided by WEOs but are not accepted as an identity in many public health facilities for free treatment to old aged people. They also stated that, there is no specific procedures followed on who is actually entitled to have an exemption.

During the focus group discussion, it was revealed that the District has directed the village administration to provide exemption letters for those who have been qualified to have them, while they are waiting for the identity card that is prepared by the Council through Social Welfare Officer but the procedures sometimes is boring and discouraging so that some of old aged people are not bothering to find them.

4.5 Measures to Be Taken By Development Partners

The study also aimed at identifying various measures to be taken in order to enhance the provision of free health services to old. Among the identified measures were the need for more health personnel; clear procedures on provision of exemption letters; community awareness creation; having a parliamentary representative; supply of equipment and medicines to dispensaries; and source of fund for old aged people such as pension.

Table 4.7: Suggested Measures to be Taken

Suggested measure	Frequency	Percent
More health personnel needed	25	15.5
Follow clear procedures on provision of exemption letters	32	20
Awareness creation to the community	17	10.5
Have a representative in the Parliament	7	4.3
Establish source of income for old aged people	6	3.7
Total	**161**	**100**

Source: Research data, 2019

Table 10 illustrates that, 46% of old aged people suggested that more medicines and equipment's are needed so that free health services will be provided according to the demand. Another 10.5% of the respondents saw that free health service provision will be possible only if old aged people are aware of their entitlement of this service. The minority 3.7% suggested the establishment of income generating projects so that old aged people could get some income to sustain their livelihood.

This implies that, the provision of free health services will be possible if qualified health personnel are available at the required number; exemption letters are provided to old aged people without bias; policy awareness is created; and dispensaries are

equipped with necessary medicines. Awareness creation is important as it makes the community to understand their entitlements and claim for them. Well-equipped dispensaries will reduce the cost of old aged people to travel to urban area searching for the service.

Also, having a representative of old aged people in the parliament was suggested by 4.3% of all respondents. This is due to the fact that, old people unlike other special groups like youths, women and people with disabilities, that have parliamentary representative, this group is seen as a forgotten generation despite their valuable contributions towards National development. It is through their representative that their matters will be discussed and their rights been provided for. This measure will push the government efforts on matters relating to old aged people including the provision of free health services should be supported by enough supply of medicine and medical equipment for old people.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Overview

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

5.2 Summary of Major Findings

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

Data were collected from a total of 161 respondents were administered through different data collection methods namely questionnaire and interview, apart from that observation method was also used to collect data, documentary review was also applied to collect documented findings revealed that the National Ageing Policy 2003 particularly on free health services provision to older people aged 60 years and above is not yet to be met. This was observed as a result of lack of enough funds to facilitate quality health services, lack of awareness on policy document by implementers, leaders at village and ward level, older people are not aware of their entitlements which are stated in the policy, poor bureaucratic procedures to serve

older people as a special group, and other similar things.

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

5.3 Conclusions and Recommendations

5.3.1 Conclusions

From the discussion of the study findings, access to free health services by old aged people is not properly provided in the study area. The study concludes that:

i. The main health services provided to old aged people without payment are consultation as stated by 14.2% of respondents. The medicines available without payments are mainly pain killers that relives them from pains, while diseases that are common attacking old aged people in the area like optical and renal failure, left to be paid for by the old aged people.
ii. The influencing factors to free health services are lack of exemption letters by the respective old person who requires the services, inadequacy of medications in

public health facilities, and long waiting time due to shortage of health personnel.

iii. Suggested measures were supply of equipment's, medicines, qualified health personnel; provision of exemption letters without biasness; awareness creation; and parliamentary representative.

5.3.2 Recommendations

In order to avoid lack or unavailability of medicines, the Ministry of Health should provide specific budget for old aged people's health related matters instead of generalizing the demand for health services. This will enable old aged people's demand to match with the available supply for it. Hence, the prescribed medications will be received without charges from the nearby public health facility. Also, the Ministry of Health should make sure that training to nurses and service providers are provided regarding how to handle old aged people's health matters with courtesy and sympathy. It is also essential that Local Government Authorities in the respective areas provide exemption letters to all old aged people regardless of their physical abilities, so that they can benefit from free health services as recommended by the policy.

In order for the old aged people to receive free health services, they need to be aware of the service itself. Old aged people should be sensitized on the rights, entitlement and policies affecting them. This should be done by both the Social Welfare and Health departments in each district in collaboration with NGOs dealing with old people matters, and local governments. Here a priority should be given to rural areas

where lack of knowledge seems to be more evident. Information should be provided to them on village meetings as it is the reliable source than media that the majority cannot access and afford.

Like any other special group in the community such as youth, women and people with disabilities, old aged people need to have their representative in the parliament who will forward their respective matters to the government. Advocacy for old aged people parliamentary representative can be undertaken by NGOs and stakeholders dealing with old aged people's matters. This could be an important possibility to ensure that the interests of old aged people are taken on board in the area of planning.

5.3.2.1 Allocation of Sufficient Funds

If we really need to carry out the policy's goal of reaching a specific population to affect some desired change we need to go further in facilitation budget. During the study (83%) respondents said that there are no free health services to older people rather than it is there as business as usual but not in practice. Insufficient fund is one of obstacles which result into poor services provision to older people while the desired change cannot be met without enough funds to support the movement. Therefore allocation of enough funds will solve the issues of inadequate medicine, laboratory facilities. To achieve the mentioned step, The Ministry of Health and Social Welfare in collaboration with NGOs, District Medical Officers, District Council and other stakeholders should ensure that budget for medical facilities are sufficient so as to improve health services provision to older people.

5.3.2.2 Health Personnel Should Receive Special Training to Handle Older People

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

5.3.2.3 Policy Dissemination

60% of respondents who were interrogated concerning National Ageing Policy 2003 awareness revealed that; they are aware of the policy but they don't know procedures on how to get exemption letters identification. Basing on that ground social workers and other policy makers should understand that formulating a policy is one step and dissemination of a policy is another step which is very crucial as the chance to help different stakeholders to become aware of the contents within policies and have clear understanding on their roles and responsibilities as well as enabling the targeted group to become sensitized on their entitlements, rights and policies which affect them.

Here priority should also be given to rural areas where lack of knowledge seems to be more evident. This can be done by Social Welfare Officers in preparing television and radio programs on the concerned policy, different workshops, seminars and training from national to village level in line with providing policy copies and guidelines to stakeholders. Moreover Non-Governmental organizations are there to

supplement initiatives of the government to meet its goals; that being the case social workers have to advocate for financial and material support from NGOs on the process of policy dissemination.

5.3.2.4 Economic Strengthening

Strategic plans should be set to help older people engage in income generating activities. According to the results from the study, it is not always the case that when a person reaches the age of 60 years and above cannot participate in income generating activities. Older People should be helped to formulate groups and identify activities which are friendly according to their age and can help them to earn something for their wellbeing and not being viewed as a burden.

Activities for example are such as poultry and hand crafts (i.e. pottery, ornaments, mats, embroidery and others). This can be done by providing older people with entrepreneurial skills to build capacities of older people which will enable them to participate in income generating activities. Community Development Officers at district level are responsible with providing such kind of skills in line with soft loans to needy groups from village to district level so they should provide such kind of loans and skills to older people too. Generated income will enable older people pay for their medical bills when needed.

5.3.2.5 To Formulate Older People Association

Older people need to have associations so as to help them to have one voice and speak out to fight for their rights especially free health service as stated in the National Ageing Policy 2003 and other related policies and strategies. Social

Welfare Officers, Community Development Officers and Non-Governmental Organizations should help to sensitize older people and help them to reach their goals.

5.3.2.6 Identifying Older People as Vulnerable Group

The community should learn to identify special groups like older people as vulnerable group who need support and intensive care. Action plans by NGOs, and Government should include older people issues focusing on improving their well being as vulnerable group. District Councils should stop putting older issues as the last priority and instead give them first priority so as to solve older people problems.

5.3.2.7 Youth Sensitization on Ageing Process and its Challenges

There is need to create awareness to the youth that one day they will become older and at the time of becoming older they will not be able to produce for their subsistence compared to their past days. In order to have better life at old age they should work hard and start serving some money in line with investing in income generating activities like building houses for rent. Seminars, workshops, trainings, formulating youth clubs can be part and parcel of the way through in creating awareness of youths concerning old age. It is the duty of Social Welfare Officers, Youth Officers, and Community Development Officers and NGOs to conduct as well as budgeting for those Seminars, workshops, trainings, formulating youth clubs.

5.3.2.8 Having Special Rooms and Doctors

Respondents claimed that in many health facilities they use to spend more than four hours waiting for medical treatment. This is because there are no any arrangements

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

5.3.3 Recommendation for Further Research

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

REFERENCES

Abdul, J. (2005). Old aged people treated with disrespect by hospital staff. *J. Am Geriatr Soc.* 60(3), 404-6.

African Union/HelpAgeInternational (AU/HAI) (2003). *The African Policy Framework and Plan of Action on Ageing.* Nairobi: Help Age International Africa regional Development Centre.

Bayoumi T. A. (2009). Interventions to improve medication reconciliation in primary care. Retrieved on 20th March, 2019 from; https://www.ncbi.nlm.nih.gov/pubmed/19737997.

Blaikie,P, Cannon, T. & Wisner, B. (1994). *At risk Natural Hazards Peoples Vulnerability and Disaster.* London: Routledge

Grundy E. & Arie, T. (2010*). The care of old aged people in the United Kingdom: problems, provision and policy.* School of Hygiene & Tropical Medicine, London. A*geing and society,* 26, 105-134.

Helmut, S., Rwegoshora, H. & Mnasi, M. Z. M. (2009). The (Missing) Social Protection for Old aged people in Tanzania: A Comparative Study in Rural and Urban Areas. Carinthia University of Applied Sciences, Austria and the Institute of Social Work, Tanzania.

HelpAge International, (2001). Ageing Issues in Africa: A Summary. Nairobi, Kenya.

Hewitt, K. (1983). *Interpretation of Calamity: From the Viewpoint of Human Ecology.* Boston, Allen.

Howse, K. (2007). Health and social care for old aged people in the UK: a snapshot view working paper 607. Oxford Institute of Ageing Working Papers,

www.ageing.oc.ac.uk.

Help Age International, (2008). *Protecting the rights of Old aged people in Africa.* www.helpage.org/download. Retrieved on 22nd April, 2019.

Insel, P. M. & Walton, T. R. (2002). Core concepts in Health. McGraw-Hill Education, Canada Institute of Ageing, Oxford.

Jeevan, P. (2010). *Free Health Services: Rhetoric or Reality?* www.ridaneoal.org/ index.php. Visited on 16th March, 2019.

Kawawani, N. (2005). Ageing and poverty in Africa and the role of social pensions. Working paper no. 8, International Poverty Centre, UNDP.

Kelly, P. (2000). Toward a sustainable response to climate change in Huxham m. and Sunner D (edds) science and environment decision making, person education Harlow pp-118-141

Laterveer, L., Niessen, L.W., and S. Yazback (2004). *Equity implication in health sector user fee in Tanzania.* Leusden, the Netherlands.

Maghimbi. S, Tungaraza F. Mchonvu A, (1998). *Social Policy and Research Practice in Tanzania, J*ournal of Social Development in Africa, Dar es Salaam Tanzania

Mongula, B. (2007). Poverty Reduction For Old aged people. University of Dar es Salaam, Tanzania.

Msamaga, G. I. Urassa, D. P. & Mujunja, P. G. M (1996). Equity of access to public, private not for Profit and private for profit health facilities in two regions of Tanzania. Final research report submitted to UNICEF, New York (USA) and Ottawa (Canada).

Mwanyangala, M. A., Mayombana, C. & Urassa, H. (2010). *Health status and*

quality of life among older adults in rural Tanzania. Ifakara Health Institute, Morogoro, Tanzania.

Newbrander, W. and Sacca, S. (1996). "*Equity experience in Tanzania: Cost sharing and access to health care for the poor*." Draft report submitted to the Ministry of Health, Tanzania and the USAID Africa Bureau

Nhongo, T. M. (2006). *Age Discrimination in Africa*. International Federation on Ageing Conference, Copenhagen, Denmark.

Ochola, S, Wagah, M. and Omalla, J. N. K. 2000. *An Assessment of the Nutritional Status and Socio-Economic Contributions of the Olderly in Nairobi and Machakos Districts*. Nairobi: HelpAge International – Africa Regional Development Centre.

O'Keefe W. and Wister A. V. (1976). Living Arrangement choices among elderly,

Pastory, W. (2013). Ageism in Tanzania's Health Sector: A reflective inquiry and investigation. *International Journal of Academic Research,* 1(4), 402 -408.

REPOA, *(2004). Tackling Vulnerability, an Approach to Poverty Reduction: A Plain Language Guide to the 2002/03 Tanzania Participatory Poverty Assessment.* Dar es Salaam: Colour Print (T) Ltd.

United Nations (UN), (2002). *Madrid International Plan of Action on Ageing (MIPAA)*. New York: United Nations.

UNDP, (2007). Human Development Report 2007/08: Fighting climate change: human solidarity in a divided world. New York.

URT, (2003). *National Ageing Policy.* Ministry of Labour, Youth development and Sports, Dar es Salaam, Tanzania.

URT, (2007). Views of the people. Tanzanians give their opinions on: Growth and

Reduction of Income Poverty, their quality of life and Social well-being, and governance and Accountability. MKUKUTA Monitoring System: Research and analysis working Ministry of Planning and Development, URT.

WHO, (2006). WHO constitution 45th edition. New York, United States of America.

APPENDICES

Appendix 1 Questionnaire to Primary Respondents

SECTION A: Demographic Characteristics of Respondent

1. Name of respondent: ……..							
2. Village: ……							
3. Age:	60-65	66-70	71-75	76-80	81-85	86-90	91+
4. Sex:	1.Male |__|		2. Female |__|				
5. Marital status:	1.Single		2. Married		3. Divorced	4. Separated	5. Widower
6. Education level:	1.No formal |__|		2.Primary |__|		3.Secondary |__|	4. College+ |__|	
6.1 Description							
7. Occupation:	1.Farmer |__|		2. Business |__|		3. Employed |__|	4. Retired |__|	

SECTION B: HEALTH SERVICE PROVIDED TO OLD AGED PEOPLE

8. Is there any Health facility around you place?

a) YES b) NO |__|

9. If YES what kind of facility?

a) Hospital b) Health Center c) Dispensary |__|

10. Have you ever received free health services?

a) YES b) NO |__|

11. If yes, what type of service? …….....…….....

12. How many times did you attend to the health facility for treatment in the last year?

a). Twice b). Thrice d). More than three times e) Never |__|

13. Did you pay for the services, or you received them without payment?

a). Free b). Paid for the services |__|

14. What type of diseases did you receive free treatment for?

(Mention them) ….....

15. What type of diseases you always pay for? (Mention them) .....….....…….

16. Where did you get money to pay for the services?

a) Assisted by the family b) Used pension payments c) Sale of assets

d) Assistance from the community e) Use of traditional medicines |__|

SECTION C: FACTORS INFLUENCING FREE HEALTH SERVICE PROVISION

17. How far is it from your home in KM?

a) 0-1 km b) 1-3 km c) 3-5 km d) 5+ |__|

18. What means of transport are you using to access the facility?

a) Walking b) Bicycle c) Private motor car d) Public transport |__|

19. Do you normally receive the right health services according to your demand?

a) YES b) NO |__|

20. If NO, what do you think are the reasons?

.....

21. What are the factors influencing free health service provision in this area?

…….....……

22. Which problem do you face when seeking for health services?

…….....……

23. Are you aware that old aged people are entitled to free health services?

a) YES b) NO |__|

24. If yes, where did you get the information from?

a) Village meeting b) Media c) Family and friends d) None |__|

25. What type of identity do you use in accessing free health services?

a) Birth certificate b) Baptism card c) Citizen identity card d) Health insurance e)None |__|

26. What do think about the procedure of obtaining the right identity?

a) GOOD b) POOR |__|

27. How long do you have to wait on a queue before you are able to see a physician for medical prescription and treatment?

a). ½ an hour b). 1 hour c). More than 1 hour |__|

SECTION D: MEASURES TO BE TAKEN

28. What measures do you think should be taken by government and the community to ensure effective and efficiency free health services provision to old aged people in the country?.....

Appendix 2: Checklist for District Medical Officer

Title of respondent ……..…….....……

Place of work ……..…….....……....

1. What health services are provided to old aged people without payment in the District Council?

.....

2. What do you think are the problems facing old aged people in accessing free health services in the District Council?

.....

3. What challenges do you face in making sure that free health services are provided to old aged people?

.....……..……

4. What is the District's expenditure for free health service to the old aged people?

.....

5. Do you think the budget allocation is enough for delivery of adequate health services compared to the demand for it in the Municipal?

a) YES b) NO |__|

6. If NO, what measures are taken by the district to ensure the provision of this service to old aged people?

……...…….....……

7. Is there any means to verify that a person is above 60 years so that (s) he/she can qualify for free health services apart from birth certificates? .....……

8. What do you do if an old person comes without any age verification document?

…….....……

9. Are there special Physicians to take care of the old aged people's health problems in the District health facility?

a) YES 2. NO |__|

10. If NO, what measures are taken to make sure that old aged people are attended by qualified and specialized personnel? ……

11. Suggest measures to be taken by government and the community to ensure that free health services are provided to all old aged people in the country…….

Appendix 3 Official Questionnaire to Health Service Providers in the Wards

1. Title of respondent …….....…….

2. Name of health center …….....….....……

3. What diseases are commonly reported at the center by old aged people? .....

4. Are all these diseases treated without charges?

a). YES b). NO |__|

5. If No, how do you assist those who cannot afford to pay for medical expenses?

…….....……

6. Mention the diseases that are not treated freely to old aged people.

a)…….... b)…….....……c)……d).....……

7. Why are these diseases not treated without payment? …….....……

8. How many health personnel are available in this centre? .....

9. Are there any professional training related to care of old aged people's health challenges provided to health?

a). YES b). NO |__|

10. If YES, how many of you had received that kind of training? .....

12. Basing on the time above, how many patients can you attend per day? .....

13. What challenges do you get in providing health services to old aged people?

..…….....……

14. Suggest measures to be taken .....

Appendix 4 Official Questionnaire to Local Leaders

1. Title of respondent …….....……..

2. Village name …….....……

3. How many old aged people (ageing 60 years and above) are there in the ward/village? .....

4. Among them, how many are: Females ……..… Males….....……

5. Where do they get health services from?

a) Health centre b) Traditional healers c) Both |__|

6. How many health facilities are there in the area? .....

7. Do you think these facilities are enough to cater for the community demand?

a). YES b) NO |__|

8. Are there any Non-Governmental Organizations (NGOs) dealing with provision of health services to old aged people in the ward/village?

a). YES b) NO |__|

9. If YES, mention them ….....……

10. Which services are offered by these NGOs? …….....…….

11. What is people's response towards these NGOs in ensuring that the intended service reaches the target group?

a). GOOD b). FAIR c). BAD |__|

12. Is the community aware on free health services?

a) YES b) NO |__|

13. If YES, where did you get the information from?

a) Friend b) Relative c) Seminar/meeting |__|

14. If NO, what measures have you taken to ensure that old aged people are aware and that old aged people are provided with free health services?…….....
15. How do old aged people get necessary document to prove their age so that they can be entitled with the free health service? …….....……
16. What do you do if an old person will be denied the service due to lack of age identity document? ….....……
17. What do you think about the community perception towards free health service to old aged people in the area?

1. GOOD 2. FAIR 2. BAD |__|

18. If BAD give reasons ……..……
19. Suggest measures to be taken .....

Appendix 5: Checklist for Focus Group Discussion

SECTION A: Background information:

Date: …….....…… Time: …….....……

Name of facilitator: .....……..

Ward: …… District: …… Region: .....

Number of respondents: …….....……

SECTION B: Introduction:

1. When was free health service provision to old aged people introduced in this area? …….

2. What type of services are provided without payment? .....

3. What are the procedures used for one to qualify for the service? .....

4. What are the problems that old aged people encounter when seeking for free health services? …….....

5. Are there any efforts taken by the government to ensure adequate provision of free health services to old aged people in the area? …….....……

SECTION C: Conclusion:

6. What measures do you think should be taken by government to ensure effective and efficiency free health services provision to old aged people in the country?

.....