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ABSTRACT

Objective: **To determine the health status and the health seeking behaviour of the elderly people aged 65 years and above.**
Design: **A descriptive cross sectional study of individuals interviewed through questionnaires and focus groups discussions.**
Setting: **Dagoretti Division, Nairobi Province, Kenya.**
Subjects: **Four hundred non-institutionalised elderly persons.**
Results: **Four hundred people including 276(69%) women and 124(31%) males were interviewed; 44% had no independent source of livelihood and 51% were widowed. The majority 376(92.5%) of the respondents had been sick within the last three months, preceding the study with 111(27.8%) being sick all the time. The prevalent diseases included musculoskeletal (80%), respiratory (68%), sight (44%) and dental conditions(40%). Three hundred and sixteen (79%) of the respondents were functionally independent in activities of daily living. One hundred and sixty one (40.3%) were satisfied with their current way of life while (63%) perceived themselves as healthy, 24.8% of the respondents lived alone. The reported social problems included:- economic dependency (96%), poor housing (76%), loneliness (60%) and feeling not needed (42%) of the respondents. Only 26% were on treatment, lack of money hindered health care access to 73% of the respondents ($p<0.001$). Sixty two per cent of the respondents were buying over-the-counter drugs. Walking was under taken by 217(67%) as a physical exercise, and (26%) of the respondents consumed addictive drugs. The focus groups criticised the lack of health facilities for the elderly in the community.**
Conclusion: **The effects of ageing, low economic status and inadequate access to health care contributed to the elderly poor health status. The use of over-the-counter drugs was indicative of the inefficient health facilities in meeting the health needs of the elderly. The study points out the need to formulate policies that will target on the health needs of the elderly.**

INTRODUCTION

Quality of life changes over life span and health becomes one of the major concerns about old age, for both individuals and society(1). Measures of functioning ability assessed by activities of daily living provide a social definition of health in terms of departure from normal role functions(2,3). With reduced ability to generate resources, the elderly lack basic needs that affect their health status. Where one finds well developed maternal and child health services in the developed countries, a vacuum exist in the elderly health policy(5). Attribution of ill health to ageing, low economic status and negative attitude of health workers towards the care of the elderly are some of the factors associated with delay in seeking health care(6-8).

Large gaps still exist in the knowledge on the health status and health seeking behaviour of the elderly persons especially in Kenya. The results may be used in designing programmes for prevention and management of health problems among the elderly, which would enable them to have a successful ageing.

MATERIALS AND METHODS

This was a descriptive cross-sectional study undertaken in Dagoretti Division in Nairobi province. Four hundred non-institutionalised elderly persons were recruited. Multistage sampling was used and three locations out of a sampling frame of five locations were sampled. A list of all the clusters used during the 1999 census in the three locations was made. A total of 21 clusters were used and all households of elderly persons aged 65 years and above within the selected clusters were identified with the help of community based health workers. A proportion of 70% of the elderly in each cluster was randomly selected using tables of random numbers. Self-reported data on physical impairment and health seeking behaviour were obtained through a questionnaire. Morbidity

among the elderly was assessed through self-reported data on history of illness and functional ability to perform activities of daily living (ADL) (moving, feeding, bathing, dressing and toileting).

Social health status was assessed through living arrangement, interaction pattern, membership to social groups and performing family and society roles.

Psychological health status was assessed through perception of ones health, feeling of being wanted and satisfaction with the current way of life.

Health-seeking behaviour was assessed by inquiring how the respondents managed their health problems, the leisure activities they undertook and their consumption of addictive drugs. For those elderly persons who had problems in communication, the 'caregivers' were interviewed as proxies. Focus group discussions (FGDs) were held with six elderly persons in each location. The FGDs were also conducted with community leaders to discuss issues related to the elderly persons. The interviewers were health workers.

RESULTS

Characteristics of the study population: There were 124(31%) males, females were 276 (69%) of the respondents and 180 (44.9%) fell in the age group 65 - 70 years (Table 1). One hundred and twenty (30%) of the study group were married while 205 (51.3%), were widowed. There was a significant relationship between gender and marital status with more females (83.4%) than males being (16.6%) widowed ($p<0.001$). Those who had no source of income were 175(43.8%). Most of those who were widowed (44%) had no income.

Table 1

Characteristics of the study population

Characteristic or attribute	No.	%
Sex		
Male	124	31
Female	276	69
Age groups		
65-69	180	44.9
70-79	81	20.2
80-89	84	20.9
90+	55	13.7
Marital status		
Widowed	205	51.1
Married	120	29.9
Single	36	9.0
Divorced	39	9.7
Educational level		
None	224	55.9
Primary incomplete	134	33.4
Primary complete	20	5.0
Above Primary	22	5.5
Family size		
None	30	7.5
One	52	13
Two	34	8.5
Three	33	8.2
>Four	251	62.6

Physical health status: The majority of the respondents 376(92.5%) had been sick three months, preceding the interview with 111(27.8%) being sick all the time (Table 2); 57(14.5%) had been hospitalised within one-year prior to the study.

Table 2

Frequency of illness among the elderly

Frequency	Males n=124	%	Females n=276	%	Total	%
Fallen ill in the last 3 months.						
Have not been sick	10	8.06	20	7.4	30	7.5
Five times and more	25	20.16	76	27.5	101	25.2
Always ill	23	18.5	88	31.6	111	27.8
Less than five times	66	53.2	92	33.5	158	39.5

The most common disease conditions were musculo-skeletal conditions 318(79.5%) and respiratory conditions 271(67.8%) with stroke being the least common (0.25%) (Table 3). More males (23%) than females(6%) reported urinary problems ($p<0.001$). Sixty two (23%) of the female respondents were suffering from hypertension. The respondent's associated, musculo-skeletal conditions (49%), respiratory disorders (16%), sight problems (16%) and diabetes (5%) with the aging process.

Three hundred and sixteen (79%) of the respondents were functionally independent in mobility. The elderly and the focus groups discussions (FGDs) indicated mobility as a major determinant of health and functional dependency. ''If you can't move, you die of hunger". This was expressed by most of the group members.

Social health status: Seventy four per cent of the respondents were living with their family members, while 24.8% of the respondents lived alone. Two hundred and twenty two (75%) of the respondents living with someone perceived themselves as healthy. Most of those who were over 70 years were living with someone. Two hundred and thirty seven (59.3%) of the respondents were interacting with their children daily while 21(5.3%) interacted with their children after several years.

Seventy two per cent of the respondents who interacted daily with their family members perceived themselves to be healthy ($p<0.001$).

Sixty per cent of the respondents reported that they were lonely. Perception of loneliness had no significant association with the interaction pattern and living arrangement ($p>0.05$). Two hundred and eighty nine (75%) of the respondents had lost friends through migration and natural attrition while 102(25%),

Table 3

Proportion of the respondents suffering from medical conditions

Ailment	Male		Female		Total	
	No.	%	No.	%	No.	%
Musculoskeletal problems	93	75	226	81.5	319	79.7
Respiratory problems	94	75	176	63.5	270	67.5
Sight problems	62	50	115	41.4	177	44.2
Dental problems	53	42.7	107	38.8	160	40
Digestive problems	50	40.3	82	29	132	33
Hypertension	16	12.9	63	22.8	79	19.7
Urinary problems	29	23	16	5.7	45	11.2
Traumatic injuries	35	28.2	69	55.6	105	26.2
Hearing problems	32	25.8	66	23.9	98	24.5
Diabetes	6	4.8	13	4.7	19	4.75
Heart problems	5	4.0	16	5.8	21	5.25
Skin condition	6	4.8	11	3.9	17	4.25
Neoplastic disease	3	2.4	2	0.5	5	1.25
Mental disorders	3	0.75	2	0.7	5	1.25
Stroke	1	0.8	0	0	1	0.25

maintained them. One hundred and eight (32%) of the respondents belonged to self help groups, while 100(25%) and 30(7%) of respondents belonged to church and peer groups, respectively. Lack of resources affected membership of social groups (p=0.005). Fifty six per cent of the respondents performed various roles for the family and society. Officiating ceremonial duties in the family were done by 13(3.25%) and 26(6.5%) in the society (Table 4).

Table 4

Roles of the elderly in the family and community

Type of duty	In the family		In the community	
	No.	%	No.	%
No duties	175	43.35	319	79.75
Bread winner	160	40	N/A	N/A
Looking after kids	87	21.75	32	8
Making decisions	47	11.75	0	0
Officiating ceremonies	13	3.26	26	6.5
Household duties	117	29.24	N/A	N/A
Counseling youths	87	21.27	0	0

Most of those who had societal roles perceived themselves as healthy. Two hundred and eighty one (70.3%) indicated that they could perform other roles apart from the ones they were currently performing. Two hundred and fifty two (62.8%) wished to operate small business. Gender had no significant association with willingness to perform other roles. The FGDs indicated lack of opportunities for the elderly to utilize their skills. “Being old does not mean we are useless”. I am a herbalist and cured many ailments when I was able to look for these herbs, but I still have the knowledge”. This comment from one of the FGDs members indicated their sentiments.

*Psychological health status:*Two hundred and fifty two (63%) of the respondents perceived them selves as healthy and when they compared themselves with others of their age, 179 (44.8%) rated themselves better. One hundred and sixty one (40.3%) were satisfied with their current way of life. One hundred and sixty one (62%) of the female respondents were dissatisfied with their current way of life compared to 60 (37%) of their male counterparts . Those who felt needed by children were 331(82%) while 280(70%) of the respondents felt needed by the kinsmen. Feeling needed by children was positively associated with self evaluation of good health ($p<0.001$). Gender was significantly associated with self evaluation of health with 244 (73%) of females perceiving themselves as unhealthy compared to 87(26%) of their male counterparts($p<0.001$). Age was negatively associated with evaluation of ones health. The focus group members indicated that the elderly persons were not perceived as useful by the society. “Nobody values an old person” was an unanimous response from all the focus groups. They associated the lack of recognition to their poor social economic status and the declined social norms. More of the elderly persons dissatisfaction was directed to the government which they blamed for not recognising their needs.

Health care seeking behaviour: One hundred and six (26%) of the respondents were currently on medication. Two hundred and forty eight (62%) were buying over-the-counter drugs when they felt a need, while seeing traditional healers accounted for 2% (Table 5). Hypertension, diabetes and stroke were associated with cosmopolitan treatments, while musculoskeletal conditions were associated with traditional treatments.

Table 5

Responses on health seeking behaviour and reasons for not seeking care

Health Management	No.	%
Drugs over the counter	248	62
Treat self with herbs	81	20
Attend public health services	63	41
Private practitioner	36	10
Pray about it	39	9
Traditional healer	9	2
Reasons for not seeking health care		
Lack of money	288	72.5
Disease due to age	27	6.75
Nobody to take me to hospital	27	6.75
Health services too far	13	3.25
Poor attitude of health workers	12	3.0
No faith in health care	5	1.25
Trust God for healing	26	6.5

All the respondents started with self medication and sought outside help when there was no improvement. The reasons given by those not on medication for not taking any action towards their health status included lack of money 288 (72.5%) while five(1.5%) had no faith in health care services (Table 5). Lack of money had a negative association with seeking of health care ($p<0.001$). With advancing age the proportion of those seeking health care reduced.

Two hundred and ninety seven (74%) of the respondents did not take addictive drugs. Twenty one (5.2%) consumed beer while 28(7%) smoked and 54(13%) took snuff. Consumption of these drugs was higher in males (47 %) than females (17%). The leisure activities reported by the respondents included taking walks 276(67%), attending social gatherings 47% while 68(17%) did not participate in any relaxing activities. The frequency of illness and lack of resources prevented 14% of the respondents to participate in leisure activities. Ninety percent of the respondents who perceived themselves as healthy participated in leisure activities ($P<0.001$).

The FGDs indicated frustration in the health facilities. “We are disregarded in favour of the younger persons, we feel pushed to our graves”. They also reported lack of recreational facilities and need for free health facilities for the elderly.

DISCUSSION

The study population was predominantly women and the majority were widowed. This is a result of women’s greater longevity. Widowhood is associated with poverty which increases the health risks as reported also by Oranga (9) and Nordberg (10). The figure of 92.5% reporting various recent problems is much higher than the 68% reported from a rural setting by Waswa(11). Environmental factors (pollution, poor sanitation, congested living arrangement and poor housing) could explain the difference observed since the current study was carried out in a peri-urban setting. Poor ventilation in their houses and the type of cooking fuel used, could explain the high incidence of respiratory conditions reported by the respondents. Unlike in developed countries, stroke, cancers, mental disorders and skin conditions had low prevalence. This could be attributed to life styles and environment of the respondents(1).

The low admission rate reported may indicate that most of these ailments were chronic and hence did not warrant any admission or the diseases were not severe enough to warrant medical attention. The old people also associated illness to ageing process and this affected their health seeking behaviour . Most of the reported conditions were degenerative and increased with advancing age. This is comparable with other studies (1,2,10,11). This is an important observation as most of the health facilities accessible to the elderly persons do not have the services for their degenerative conditions. The incidence of musculoskeletal conditions was found to be higher in females than in males. This was in agreement of the work reported by Saddarth and Brunner(12). In contrast, more males suffered from urinary problems than females, This was in contrast to what was expected since elderly women, particularly multiparous ones, experience incontinence because of relaxed pelvic muscles(13).

The reported illness did not reflect the presence of dependency among the elderly as 79% were independent in mobility . This is further supported by the fact that self-rating of health did not correlate with the reported morbidity. Similar findings have been reported by (2,14). Those who had mobility limiting conditions rated themselves unhealthy. Mobility was indicated as a principal cause of limited quality of life as all the other self-care functions depended on it. This is an important observation since musculoskeletal conditions that were common in the respondents affect mobility. The elderly took walks as preventive measures against ageing process on their mobility. Walking was a feasible preventive measure as one required no skills, or money to participate and had an added advantage of change of environment. Providing recreation amenities, which were lacking, would facilitate health promotion activities to the elderly which would enable them to have successful ageing.

The reduced physical ability, low social economic status and the natural attrition of their contemporaries reduced the persons social contacts. Interaction with family members reduces the feeling of this social isolation. With the prevailing economic strains in Kenya, it is possible that the children had no time for quality interaction with their aged parents, a factor that may explain the reported loneliness among the respondents. Provision of social clubs that the FGDs

were requesting for, would help the elderly develop other relationships for social and psychological well being.

Poverty, widowhood, and the feeling of not being needed made the majority of the respondents dissatisfied with their way of life, which was more pronounced in females than males. The respondents joined social groups to generate income, to facilitate interactions, and for spiritual well being. There was no gender difference in belonging to social groups, contrary to findings in a study carried out in South Africa(3).

The decline in government funding of health services has affected health care delivery system resulting in gap between the demand and supply of these services for all clients but more to the elderly (8). McLigeyo (5) has discussed this bias which is also reflected by the fact that there are no special health services for geriatrics in Kenya. Cost sharing in the health care system has exacerbated the situation given the respondents weak economic status (8, 9). The issue of cost been realised in other countries and the elderly are offered free health services(15-18). Due to economic constrains the families are often unable to provide health care to their elderly relatives. Negative attitude of health workers towards the care of the elderly could be as a result of lack of knowledge to identify those conditions that can be treated effectively and also inadequate resources to treat the degenerative conditions. Kakande *et al*(18) has reported similar findings.

The use of over-the-counter drugs was indicative of the inefficient health facilities in meeting the health needs of the elderly. In contrast to findings reported by Chappel(2) and Kimani(19) very few of the respondents were seeking health care from the traditional healers. This could be as a result of modernization and reduced traditional healers. Okojie(20) has predicted a decreasing number of traditional healers.

Drug consumption was relatively low among the respondents. This differs from the findings of a study carried out by Oranga(9) in Western Kenya. The study area is peri-urban and the traditional rituals where free use of these drugs by the elderly as part of ceremony were rare.

In conclusion this study has shown that the health status of the elderly was poor. The low social economic status among the respondents had a negative impact on their health status as well as their health seeking behaviour. The inadequate access to health care resulted in many of them buying over-the-counter drugs. There is need to organise for free health services, recreational and rehabilitation facilities for the elderly within their community to improve their physical, social and psychological well being.

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