Human Dignity And Health System In Developing Countries: A Critical Analysis Of The Elderly Persons In Kenya

SIBUOR, J. O., Department of Humanities and Social Sciences, Rongo University, Kenya
OTENGAH, W. A., Department of Humanities and Social Sciences, Rongo University, Kenya

Abstract
This review discusses dignity as a unique concept in health service provisions where relationship with the elderly persons seems to be strained following the demographic transitions of the 21st century which ushered many people into the elderly category thereby increasing demands on health care services in most developing countries. Based on World Health Organization domains, dignity is discussed here as an element of responsiveness of health system in an ongoing research survey that assesses how the health system responds to the care needs of the elderly in Kenya within the existing care package. It is analytically discussed from the existing literature and looks at the relational perspectives between health care providers and the elderly persons. The findings indicate that dignity in care for the elderly persons is compromised globally in developed and developing countries and that in whatever form indignity is expressed, the effects may be fatal even in the absence of the long term diseases common in the elderly persons. When aspects of dignity may be unavoidably compromised, the decisions should be through multidisciplinary team consensus. It is recommended that health care providers should consider generational influences and culture so as to provide dignity sensitive care and should also put more effort in managing long-term multiple conditions which have salient but devastating outcomes. Health care facilities should present themselves as places where elderly persons feel welcomed, valued and where needs are understood and met so as to raise elderly person’s expectations of dignified care. Promoting dignity in care therefore means providing care in settings which supports and enhances rather than underlines the elderly person’s self-worth. The theory of Symbolic interactionism therefore offers the best model to improve implementation of dignity in health care delivery.

Keywords: elderly, dignity, health system, ageism

Introduction
Dignity as a philosophical, religious and ethical concept has its origin in the Latin word “dignus” meaning worthy or honorable. It is a human right concept about feeling and being treated or regarded as important and valuable in relation to others (Clark, 2010). Dignity bridges law, ethics and politics and is a core foundational principle of most human rights treaties (Ojwang et al., 2010; KNCHR, 2009; Sweet, 2007). In its application in human relations, dignity is an objective right and a subjective multi-dimensional concept, with different cultural interpretations and shared meanings. It is connected to the self-concept and self-esteem such that the extent to which a person is treated with or without dignity can give rise to an immediate and long lasting profound emotional effect. In general, dignity is the culmination of the power of inclusion (promotion of involvement, autonomy and independence); value (engendering respect); and appreciation (individual identity, effective communication, person centered care). Conceptually, dignity is a crucial notion in building and sustaining a nurturing human environment in which an individual feels included, valued, and appreciated (Galloway, 2013, Pearson et al, 2012).

Health system refers to all the organizations, institutions and resources that are devoted to producing health actions (MOMS & MOPHS 2011) while responsive health refers to health system which offers high quality care that reflects how well the system responds to the population’s legitimate expectation regarding non-medical health enhancing aspects of health-care of which dignity is a domain according to World Health Organization (Ameneh, 2011).

In health care settings, observance of dignity is unique because the relationship between care providers and the elderly persons seems to be strained as increased number of the latter following the demographic transition of the 21st century places additional demands on care services. This is particularly in the developing nations which are caught un-prepared to meet the additional care needs of this population (Pearson et al., 2015; Pew, 2014; Falk, 2013; Seychell et al., 2013; Dwele, 2012; Mubila, 2012; Ameneh et al. 2011; Abordein, 2010; Matt, 2009; Velkoff et al. 2007). Despite this pressure on health services, the elderly persons still remain to deserve the right to be treated with dignity and also deserve regards for human rights.

In developing nations most studies on elderly persons have focused majorly on their abuse in different contexts (Bhattacharyya, 2015; Atetwe et al., 2013) but have not explicitly addressed the responsiveness of the health systems to the care needs in terms of the elements as

Dignity is discussed here as an element of responsiveness of health systems in an ongoing descriptive research survey in Kenya that assesses how the health system responds to the care needs of the elderly within the context of the existing care package.

Kenya is among the Sub Saharan developing nations situated along the central part of the eastern coast of Africa occupying 582,642 square kilometers. It is nearly bisected into two equal parts by the equator. It lies between longitude 31° East and 41° East and latitude 3° North and 5° South. The country has seven distinct ecological zones based on the rate of precipitation and the nature of the underlying rocks. These zones are important since they influence the sources of livelihood, nature of occupation, settlement patterns, culture, tradition and behavior. Of significance is that 82% of the northern part of the country is semi-arid with some areas being completely arid, while only 18%, predominantly in the south is arable. The population of Kenya is about 47.5 million (49.9 males; 50.1 females) of which about 4.7% are aged above 60 years with a life expectancy of 62 years at birth (UNDESA, 2016). Kenya health system is using a care package based on medical model. Medical model of care is focused on the physical and biologic aspects of specific diseases and conditions thus limited to clinical diagnosis and treatment and as such do not exhaustively address the holistic domains which captures the social relationship in care. In evaluating the Medical Model of care Green, et, al. (2007) comment that the tremendous and changing cultural diversity of our population requires physicians to develop new skills in communication and negotiation with their patients. But managed care constraints, litigation, and growing regulatory pressures have compromised communication and trust between physicians and patients. This, along with the surge in technologic development, has driven the medical system toward a “disease-based” approach to care that views individual as “cases” and undervalues the socio-cultural and humanistic aspects of patient care. The results are a diminishing faith in the medical establishment and the rise of alternative medical philosophies and practices. A medical system that allows physicians to focus on the patient-centered and unique experience of “illness” is an imperative for our time. In emphasizing the rationale for the need of responsive health system, WHO Western Pacific region director comment that the intrinsic goal of health systems are there to serve people, and involves more than an assessment of people’s satisfaction with purely medical care they receive because there are other important aspects that are clearly beyond the realm of biomedicine and specialized models of care where factors such as psychosocial, cultural and broader environmental determinants of health are unduly neglected (Shigeru, 2007). There is therefore need to investigate the responsiveness of the Kenya health system to the care needs of the elderly persons within the context of the existing care package. This is aimed to improve health care to the elderly who are among the vulnerable members of the population.

Conceptual Framework

The conceptual framework shown below has health system as an independent variable with Care package as an intermediate variable and the state of health of the elderly as the dependent variable. When health system organizes the care package to capture the seven elements of responsiveness, then the care consumers who are the elderly person experience robust aging. Robust aging is a state in which an individual enjoys full physiological functioning potential, high level of social contact, good health and vision and few major adverse life events in the past three years.

Health System → Care Package → State of elderly health

- Dignity
- Participatory Involvement
- Respect
- Confidentiality
- Unconditional assistance
- Politeness
- Attentiveness
- Privacy

METHODOLOGY

Data was obtained by reviewing existing literature taking the global, regional and the Kenyan perspectives of care dating back to year 2001 when HelpAge international recommended a need for the establishment of specialist care for the elderly persons. From 2014 hours were devoted to literature search in the various university libraries and archives where internet facilities assisted to reach relevant materials on the subject. Literature on health systems and the elderly were reviewed in the light of the
elements of responsive health care as spelled out by WHO (2000). The review considered the meaning of dignity: definition, origin and the concept- philosophical, religious and ethical. It also considered its application and implications as an element of responsive health systems both in developed and in developing countries. The review critically analyzed dignity in relational perspectives noting the positive and the negative aspects as presented in the previous studies. The basic concept was that care of the elderly persons should be based on the principles of human rights. The contentious points were periodically discussed by the two authors to bring meaningful understandings based on the contemporary national practice in line with the regulatory standards like the Constitution and the regulatory professional boards. The review is based on the systems theory of Von Bertalanffy (1968) whose theme is that a system is a complex of interacting elements and that they are open to, and interacts with their environments in a continual evolution. The theory views health care as interventions that nurtures positive interactions of care providers with clients in which each perceives the other, the situation, and through communication set goals together, explore means, and agree on means to achieve them. Systems theory represents a life situation which a person enters into as an active participant.

Findings And Discussions
Dignity in care for the elderly persons is compromised globally in both developed and developing countries. Although the developed nations have made great strides in terms of structures and policies to the care of the elderly there still exist some elements of neglect in terms of dignified care in the process of implementing these strategies. Reports from the Inspection and Reviews across the United Kingdom (Pearson et al 2012) and from the Institute of Medicine in Washington DC revealed immense divide between what we know to be good health-care and the health care that people actually receive. The report from England indicated that older people are not always afforded the level of dignity and respect they deserve when receiving health and social care service particularly in areas of communication, nutrition and continence.

The elderly expressed concern over feeling neglected or ignored whilst receiving care, being made to feel worthless or a nuisance, feeling that privacy is not respected, being forced to use a commode or incontinence pads rather than being provided with a wheelchair then supported to use the bathroom, disrespectful attitude from staff, being addressed in disrespectful ways, being provided with bibs intended for babies rather than a napkin while assisted to eat, having to eat with fingers rather than helped to eat with knife and fork, having no staff support for eating, food being taken away before meal is completed, being rushed and not listened to (Galloway, 2013; Cairns et al, 2013; Gwenda 2007). Developing nations on the other hand still lag behind in many aspects being that the demographic transition of the 21st century caught them unprepared to meet the additional health challenges that come with this group of people. Mubila (2012) points that Africa’s demographic trends reveal a growing aging population which is expected to accelerate between 2010 and 2030 as more people live to age 65 to account for 4.5% of the population by 2030 from 3.2% in 2010. This population faces a different set of challenges marked by long-term physical and mental disability and varied long-term chronic conditions that will increase the needs for personal care yet average spending on health is low, health care systems in most of Africa are weak and unable to adequately address these emerging health problems. Moreover, the report adds, there is a general lack of broad-based pension systems, while other social safety nets are sparse and stretched.

There is greater prevalence of poverty, particularly among elderly-headed households today than in the past. This is a key emerging policy challenge across most African countries. On its second session I the year 2002, the World Health Assembly adopted the Madrid International Plan of Action on Aging (MIPAA) and the political declaration, a global guiding document with three priority areas one of which is ‘advancing health and well-being into old age’.

In his opening remarks the general secretary challenged all nations of the world to implement the document by saying

“But the real test will be implementation. Each and every one of us, young and old, has a role to play in promoting solidarity between generations, in combating discrimination against older people, and in building a future of security, opportunity and dignity for people of all ages. I urge Member States and, indeed, the entire world to take this issue seriously and to act boldly in finding the right approach to what we already know will be one of the dominant themes of the century” (UN, 2002).

The full implementation of this noble document has remained challenging to African nations leading to inadequate care to the elderly.

In whatever form indignity is expressed, the effects may be fatal even in the absence of the long term diseases which are common in this age group. Factors that maintain or adversely affect dignity in care according to Galloway (2013) are associated with the physical environment and the culture of the organization (Place), the nature and conduct of care activities (Processes) and the attitudes and behavior of staff and others (People).
In a WHO global study of 35 countries, observance of dignity in health care delivery scored an average 5.59 out of 10 (De Silvia et al 2000).

Increase in life expectancy is a positive indicator of good care system, however undignified care of older people does not happen in a vacuum; it is rooted in the discrimination and neglect towards older people in society. Literature reveal that cultural values and belief systems influence norms about family life and structure. A survey by PEW (2013) on attitude towards the elderly revealed that the increasing number of the elderly persons is a world-wide problem with peak concerns in East Asia, where nearly nine-in-ten Japanese, eight-in-ten South Koreans and seven-in-ten Chinese describe aging as a major problem for their countries. In Europe more than half of the public in Germany and Spain indicates that old-age is a major problem. In the Americas one-in-four expresses concern over old age. Africa is however waking up to the grips of aging with mixed reactions though skewed towards ageism.

In developed nations when the elderly are treated with dignity, they experience positive sense of self-worth, their self-esteem is raised and they comply with their management. The way in which staff interact with an older person (assesses care requirements effectively, find the right way to talk with older person, respond to their needs, wants and fears, and treat them with respect) has a profound effect on that person’s life. This helps to sustain and enhance the older person’s self-confidence, independence of thought and action, and determination to remain as active as possible (Pearson et al. 2012). In the contrary, they display emotional reactions which include among others resentment, anxiety, humiliation, embarrassment, loss of self-esteem, anxiety and depression all whose negative impact are diverse and cannot be underestimated (Clark, 2010).

In health care institutions observance of dignified care may be looked at in three different levels. Level One addresses the personal responsibility that each staff has in the provision of dignified care and challenge to poor practice. Level two considers the leadership at the ward or unit in-charges and institutional boards with regard to integration of institutional and national policies. Level three looks at the wider context of how services are commissioned, the role of professional bodies, universities and clients rights and representation. Integral to these levels is the building of caring families and communities to offer dignified care to the elderly persons and the recognition of the social and economic contributions offered by older people to the communities (Dwele, 2012, Nhongo 2001).

Among the factors that contribute to undignified care for the elderly is inadequate staff. A study evaluating causes of poor care for the elderly in England point that there is need for enough staff to provide personalized care rather than few who rush to complete tasks. Helping staff to talk with older people and listen to them is possibly where dignity in care begins and once the rapport develops, care professional begin to see the whole person, and the foundation of dignified care built (Pearson et, al. 2014). Galloway (2013) support that health care system should have a workforce that is equipped to deliver good-quality care.

A study in Europe and America on management decisions for older patients indicates the tendency to deprive older persons’ some treatment solely because of their age without justified associated functional or cognitive disorders. The study found that the framework that support the development of therapeutic decisions making should be based objectively on both comprehensive assessment of patients condition and their wishes (Alvarez-Fernandez, et al. 2015).

A survey on health and social care professionals in England indicated that despite the range of policies and targets focused upon delivering dignity in care for older people, there is evidence that observance of dignity in care is being compromised in some cases. Cairns, et al. (2013) and Galloway (2013) contend that there still exist deep-rooted negative attitudes and behaviors’ towards older people in English health services and they bring to light the following specific instances: being cared for in mixed sex bays and wards that accommodate both men and women; feeling neglected or ignored whilst receiving care; being made to feel worthless or a nuisance; being treated more as an object than a person; generally being rushed and not being listened to; disrespectful attitude from staff or being addressed in disrespectful ways; not being asked about their preferences in terms of dress used; being provided with bibs intended for babies rather than a napkin whilst being helped to eat; having to eat with fingers rather than being helped to eat with a knife and fork.

In developing nations literature on dignity in relation to care for the elderly is focused mostly on abuse. This is a pointer that little survey has been done on the responsiveness of care systems in Sub Saharan Africa. In evaluating the responsiveness of health care service within a health insurance scheme in Nigeria, dignity scored 54.1% as an extremely important responsiveness domain (Shafiu, et al 2013).

Studies in Kenya indicate that health personnel are reported to have negative attitude towards the elderly and behaviors of neglect, abusive language, and delayed care
are among the key pointers. Elderly persons often decline in-patient care because of poor attitude of the health staff and among those who accept admission are conditionally compromised (Atetwe et al. 2013; Dwele, 2012; Gondi, 2009). A confided report in a survey by HelpAge revealed the existence of negative attitude of health care staff whose statement reads “older people are a big headache and a waste of scarce resources, the biggest favor you could do to me as an Older People’s Organization is to get them out of my hospital” (Nhongo, 2001). A study by Atetwe et al (2013) also indicate that disengagement as a response of a culture implies that the aged are superannuated occupationally, and therefore should be phased out of life. With negative attitudes toward aging and the aged becoming internalized, it seems unlikely to believe that age prejudice, some of which are maintained in conformity to social norms and practices to which people are socialized may end. Some of the prevalent outcomes of ageism for elderly people in Kenya as in other parts of the world tend to marginalize, strip elderly of responsibility, power and ultimately their dignity. With such attitudes, it is unlikely to get dignified care in such health facilities. Viewing older people in chronologic terms and biological decline, discussing them as a problem for health and social care service, a crisis that cannot be afforded, is unfair and such constitute ageism. The National Commission on Human Rights report (KNCHR, 2009) reveals that the rights of older persons including challenges faced by Kenyans as they grow old remain a neglected issue left to the focus of few NGOs with hardly any government intervention and support. One of the most critical tenets of human rights is the protection against discrimination yet the situation confronted as one grows old in Kenya is discrimination with resultant dehumanization. There seems to be a shared understanding agreement that growing old is a pathway towards deserved oblivion. A palpable neglect and discrimination that leads to exclusion both in terms of public affairs dialogue and resource allocation places older persons in jeopardy (Dwele, 2012).

A survey conducted in Kenya health facilities reveals deplorable undignified treatment across all care cohorts and take the aspects of the physical, psychological, financial, and neglect perspectives (Hishima project, 2014, Nhongo 2001). Persons discriminated on any ground cannot effectively enjoy their rights i.e. to health, shelter, food and livelihood, protection from abuse, security and dignity. A study by Atetwe et al (2013) reveals similar undignified treatment of the elderly in Kenyan health facilities and that the government has no special policy to care for the elderly. To care for the elderly is a difficult task for which only a few would be willing to sacrifice. Because it was impossible to give extra care needed, due to insufficient staff, the elderly often recent inpatient care as they feel rejected viewing the hospital as no good place to be left in, the report adds.

For care providers to be able to deliver dignified care, their employers must support them through appropriate training and policies. This enables care providers to objectively plan and deliver dignified care by considering individual preferences after discussions with the elderly persons. It also promotes client’s ownership of the care process which is an element of active participation. In cases where the elderly persons are not able to dialogue with staff on how they would like to be cared for, staff must then draw on their understanding of inter-subjective dignity and apply their knowledge of cultural and social norms so as to deliver dignified care. In situations where caregivers may need to make judgments in difficult and challenging circumstances, it is essential that they have knowledge and skills to help them remain rational. When an aspect of dignity may be unavoidably compromised because of urgent need for care or where conflict may arise, decision on care should be dealt with through mutually agreed multidisciplinary team consensus. Maintaining dignity according to Clark (2010) is not a science but a virtue that relies on understanding, empathy and compassion.

In view of the demographic transitions, societal norms change over time, and the healthcare practitioner needs to take account of generational influences and culture to help in providing dignified patient-centered care. In addition to respecting the values, attitudes, and beliefs of older people, the healthcare practitioners needs to remember their ethical obligation to provide non-judgmental, personalized care. There is also the need to change the ways services are provided in order to accommodate shift in care by looking at hospital service less from the perspective of diagnosing and treating single acute illnesses to more from managing long-term conditions with often multiple complex care needs. It is also necessary that health systems review ways of designing, delivering and monitoring care service so as to raise older people’s expectations of dignity in care so that hospitals present themselves to older people as places where they are welcomed, valued and where their needs are understood and met (Pearson et al, 2014; UNDESA, 2009). Older people tend to stay in hospital much longer compared with those aged 15–59. A significant number of older people who enter hospital are discharged and continue to receive care at home or need practical help to get back on their feet. The lack of appropriate health service, health personnel have negative attitude towards them, drugs are not available and in
some cases they are unable to access health services due to long distances to health facilities. In Western Kenya, many elderly persons feel they have no place in the society among other things (Dwele, 2012).

**Proposed Model for dignity in practice**

The model proposed by Clark (2010) is based on the theory of symbolic interactionism “the “ascribed status” in which the self is a process, rather than a structure, that develops through interactions. Self and other are sustained by interactive relations, and it is within and through these relations that concepts of self and other evolve. The model is underpinned by the fact that every law-abiding person has the right to dignity purely because they are human and based on the fact that dignity can be lost even if a person is not aware of it being violated like when an individual has cognitive impairment. In such instances, Clark points that it may only be the

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
</table>

must always and actively seek to engage them in decision making at all stages of their care. Dignity needs to be a core value embedded in practice with care facilities presenting themselves as places where older persons feel welcomed and valued so as to raise their expectations in care. Promoting dignity in care therefore means providing care in settings which supports and enhances rather than undermines the elderly person’s self-worth. The theory of Symbolic interactionism may be helpful in delivering dignity sensitive care to the elderly.

**References**

Summary, Conclusion And Recommendations

The demographic transition of the 21st century has led to increased number of the elderly persons with resulting pressure on health care services. The result is that dignity in caring for the elderly persons is compromised globally in both developed and developing countries but in whatever form indignity is expressed, its effects should not be underestimated because it may be fatal even in the absence of long term diseases common in the elderly. The International declarations on human rights emphasize the observance of dignity for all persons irrespective of age and circumstances under which human relationship exist. Because of demographic transitions, care providers need to consider generational influences and culture so as to provide dignity sensitive care. Health care services should focus less on diagnosing and treating single illnesses but put more effort in managing long-term multiple conditions. Older people need to be cared for holistically by addressing their psychological, social, and physical needs in a culturally sensitive and dignified manner. Completing a person-centered assessment enables the healthcare practitioner to identify the person’s individual needs and preferences in order to inform their plan of care. The older persons needs to be central to their care delivery process, and the healthcare provider

<table>
<thead>
<tr>
<th>Defence</th>
<th>Respect the person and their wishes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Treat each person as a unique human being, with unique values, beliefs, and preferences.</td>
</tr>
<tr>
<td>Gain</td>
<td>Gain information through a holistic assessment to support the delivery of person-centered care</td>
</tr>
<tr>
<td>Name</td>
<td>Refer to people using their preferred form of address</td>
</tr>
<tr>
<td>Information</td>
<td>Provide information and support, and respect informed decision-making.</td>
</tr>
<tr>
<td>Treatment</td>
<td>Treat the whole person, both physically and psychologically</td>
</tr>
<tr>
<td>Yourself</td>
<td>Treat others as you would like your family members to be treated</td>
</tr>
</tbody>
</table>

The dignity model (adapted from Galloway, 2013)
The concept of dignity: meaning and importance of dignified care: findings from a survey of health and social care professionals. 

Clark, J., (2010). *Defining the concept of dignity and developing a model to promote its use in practice.* 


http://www.idealstv.illinois.edu/handle/2142/45280


http://www.esht.nhs.uk/.../GatewayLink.aspx and http://www.oxfordtextbooks.co.uk/orc/hindle/


Heshima Project (2014). *Confronting disrespect and abuse during childbirth in Kenya.* 


http://www.afdb.org/.../afdb/.../


www.who.int/ageing/projects/elder_abuse/alc_ea_ken

Ojwang, B.O., Ogutu, E.A., Matu, P.M. (2010). *Nurses’ impoliteness as an impediment to patients’ rights in selected Kenyan hospitals.* 15; 12(2):101- 


Http://www.pewglobal.org/2014/01/30/attitudes-about-aging-a-global-perspective/


Bhattacharyya,'A. (2015).*Elderly'm'India:'An Issue of Importance.* Advances in Social Sciences Research Journal, 2(6)58B63'.


Wilunda, Boniface, Nawi Ng, and Jennifer Stewart Williams. (2015). *Health and ageing in Nairobi’s...*