THE CONTRIBUTION OF INTERNATIONAL NON-GOVERNMENTAL ORGANIZATIONS IN PROMOTING ELDERLY-FRIENDLY HEALTH SERVICES DELIVERY IN TANZANIA: A CASE OF HELPAGE INTERNATIONAL IN MOROGORO MUNICIPALITY

VALENTINE ZACHARIA PAUL

MASTER OF INTERNATIONAL RELATIONS

THE UNIVERSITY OF DODOMA

OCTOBER, 2018

THE CONTRIBUTION OF INTERNATIONAL NON-GOVERNMENTAL ORGANIZATIONS IN PROMOTING ELDERLY-FRIENDLY HEALTH SERVICES DELIVERY IN TANZANIA: A CASE OF HELPAGE INTERNATIONAL IN MOROGORO MUNICIPALITY

BY

VALENTINE ZACHARIA PAUL

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER IN INTERNATIONAL RELATIONS

THE UNIVERSITY OF DODOMA

OCTOBER, 2018

DECLARATION

AND

COPYRIGHT

I, **Valentine Zacharia Paul,** 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.....

CERTIFICATION

The undersigned certifies that he has read and hereby recommends for the acceptance by the University of Dodoma a dissertation entitled ***"The Contribution of International Non-Governmental Organizations in Promoting Elderly-Friendly Health Services Delivery in Tanzania; A Case of HelpAge International in Morogoro Municipality"*** in partial fulfillment of the requirements for the degree of Master of International Relations of The University of Dodoma.

……

Prof. Amukowa Anangwe

(Supervisor)

Date.....

ACKNOWLEDGEMENT

Indeed the entire exercise of writing this dissertation has been full of ups and downs amidst numerous setbacks that threatened the timely completion of this dissertation. Nevertheless, the long and tiresome journey has come to an end, thanks to the ever present support received from various sources without which, I will not have come this far.

My heartfelt gratitude and thanks is to the almighty God for making this journey a reality and a success through the fulfillment of His covenant in the completion of this dissertation journey. I am also grateful to my parents, for their ever enduring support without which, I will not have managed to reach this far. May God grant them long life. Besides, I sincerely acknowledge the support and love of my brothers Mathius Zacharia, Peter Zacharia, Benjamin Zacharia and my sister Maria Zacharia.

I am equally indebted to express my sincere appreciation to my supervisor, Prof. Amukowa Anangwe, for his supportive intellectual guidance and positive criticism throughout the study that has culminated in this dissertation process. May God grant his wishes and continue to guide him in his duties.

I sincerely thank my friends for their patience and moral support. True friends are recognized in times of dire need. I acknowledge the support I received from all friends. Specifically, I could like to thank Makarius Mzampola, Abraham Nyantika, Eugene Gabriel, Tuja Mfinanga my colleague Michael Nicodemus, Gabriel Nicodemus and Frank Sweetbert.

Finally, I am grateful to all the respondents from the Morogoro Municipal Council for their cooperation, valuable inputs and willingness to participate in the interviews. God bless them.

DEDICATION

This work is dedicated to my parents who showed their patience, moral and financial support.

ABSTRACT

This study assessed the contribution of INGOs in promoting elderly-friendly health services delivery in Tanzania: a case of the HelpAge international in Morogoro municipality with three specific objectives, namely to examine the role of INGOs in resource mobilization and funding to improve physical health infrastructure in Tanzania: to investigate the extent of facilitating training of staff in for preventive health to elderly people in Tanzania; and finally to investigate the efficacy of INGOs advocacy in enhancing curative services for elderly people in Tanzania. The study adopted the triangulation research approach by utilizing both quantitative and quality data. A sample size of 43 respondents from Sabasaba (21) and Kilakala (22) wards were involved in this study. The study found that INGOs have a role in providing medicine, medical equipments and medical personnel to target centres. In preventive diseases, INGOs have contributed in providing education to the elderly people through their trained staff on how to prevent diseases. In curative advocacy, INGOs have adopted national and local advocacy strategies including peer educators who champion the rights of elderly people's access to quality and affordable healthcare through the provision of National Health Insurance Fund (NHIF) and Community Health Fund (CHF) cards. The study employed the regime school theory, common international theory, neo-corporatist theory, functionalism theory and liberalism theory were used to guide this study since the selected theories analyse the contribution of INGOs in promoting elderly-friendly health services delivery. The study recommends that the government, NGOs, CSOs and FBOs to invest in infrastructure to cater for elderly-friendly health services. The study suggests that further study to be conducted on the sustainability of local NGOs supporting elderly friendly health care provision without external funding.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ABBREVIATIONS

CBD	Central Business District
CHF	Community Health Funds
CSO	Civil Society Organization
DACOECD	Development Assistance Committee of the Organization for Economic Cooperation and Development
FGD	Focus Group Discussion
GDP	Gross Domestic Product
INGO	International Non-Governmental organization
LGAs	Local Government Authorities
MIPAA	Madrid International Plan of Action on Aging
NAP	National Aging Policy
NGO	Non-Governmental organization
NHIF	National Health Insurance Fund
SADC	Southern African Developing Countries
SPSS	Statistical Package for Social Sciences

CHAPTER ONE

1.1 Introduction

This is a study on the contribution of INGO's in promoting elderly-friendly health services delivery in Tanzania. In fact, INGO's including HelpAge International accord high priority to improve health services of the elderly people. Evidence suggests that INGO's are tools in health services delivery. However, elderly people face many obstacles in obtaining health care services such as mobility, unfriendly physical environments and attitudinal problems which limit older people's access to health services. The purpose of this study was therefore to examine the contribution of INGO's in promoting elderly-friendly health services delivery in Tanzania and to draw implications on possible ways that would be used to reduce obstacles that hinder INGOs' promotion of elderly-friendly health services delivery.

1.2 Background to the Study

The elderly health services depend on the improvements and provision of standard health services in terms of availability, accessibility, quality and equality around the world as their population continues grow at an unprecedented rate. Today, 8.5 percent of people worldwide (617 million) are aged between 65 years and over, this percentage is projected to jump to nearly 17 percent of the world's population by 2050 (1.6 billion) (NIH, 2016). The health of the aging population is one of the most discussed global phenomena in the present century. Madrid International Plan of Action of 2002 on Ageing (MIPAA) adopted during the Second World Assembly on Ageing highlighted the need to consider older persons in development planning emphasizing that older persons should be able to take part in and benefit equitably

from the fruits of development to advance their health and well-being and that societies should provide enabling environments for them to do so (MIPAA, 2002).

Countries with a large population like India have a large number of people now aged 60 years and above (Ministry of Health and Family Welfare of India, 2011) who irrespective of their (elderly people) social economic status, suffer from Non-Communicable Diseases (NCD) that require large quantum of health and social care in old age whereby the management of these chronic diseases is very costly, especially for diseases like cancer, joint replacement, heart surgery neurosurgical procedures (Central Statistics Office of India, 2006).

A report conducted by World Bank (2016) reveals that, in Thailand over 10 percent of the populations in 2015, more than 7 million people were 65 years older. Despite the fact that by 2002 all Thai citizens had been included in the universal health coverage, the report findings indicate that many older people face challenges in using health service. This shows that how the problem of elderly health services delivery has been so crucial even for the developed countries (World Bank, 2016).

According to Taiwan Ministry of Interior (2012), the changes in family and social structure, long term care services have failed to meet the needs and demands of elderly people in Taiwan. Services and health education related to long term care performance needs to meet the trends of time as well. For example 33% of elderly people in Taiwan are illiterate or only graduated from elementary school, these illiterate elderly people often have difficulties in receiving correct health information, which results in barriers seeking medical care and health care.

A study done by Ramesh and Pardeep (2013) however, explained that very little efforts have been made to develop a model of health and social care in tune with the changing needs and time. Developed world has evolved many models for elderly care for example, nursing home care and health insurance. But still this has not achieved the intended rights of elderly people to access health care services, since such models do not exist in India and other many societies.

In Sub-Saharan Africa, the governments have limited financial capability in provision of health services. For instance, Kenya has a prepaid health care coverage of about 25% while 75% of the population do not have any health (insurance) cover and relies fully on out of pockets expenses (Kenya Health Care Federation, 2016). On the other hand, Zimbabwe's per capita allocation for health sector is significantly lower than regional peers at US$ 24.34 against the SADC average of US$ 146.29 (UNICEF, 2016). Therefore the funds which are set aside in the government's budget each year are not sufficient to all the basic requirements needed in generating health centers to enable them to offer standard health services for older people (Pastory, 2013). UNAIDS (Joint UN Programme on HIV/AIDS) has implemented programs in several countries to increase the visibility of older people care givers and document the need for policies and programs for care givers support (UNICEF, 2016).

In Tanzania, according to the 2012 population and Housing Census, out of 44.9 million people, 2.5 million (5.6%) are estimated to be aged between 60 years and above (1.2 million male and 1.3 million female) (NBS, 2013). Furthermore, about 80% of older people in Tanzania are cared by their grandchildren's families. Surprisingly, 2,866 older people have been murdered on allegation of witchcraft in

10 regions over five years with an average of 573 murders a year. Moreover, 96% of the older people do not have a secure income to access health services. Households with elderly care receivers are 22.44% more likely to be poor and food insecure and nearly 60% of death among older people in those households in some districts in Tanzania are due to non-communicable diseases. It is estimated that 5.4% of people aged 50 years and above in Tanzania are living with HIV constituting 15.3% of all people living with the virus (URT, 2016).

Elderly people face many obstacles in obtaining health care services such as mobility (frequently been cited as a critical problem), unfriendly physical environments and attitudinal problems which limit older people's access to health services (Pastory, 2013). Besides, the trainings of health professionals consistently continues to neglect ageing people who experience discrimination and abuse when accessing health services (Brooks et al., 2012). Awareness of older people regarding their own health services status and their entitlement is low in many instances and financial barriers are among key challenges facing elderly populations (Regional Health Forum, 2012).

INGOs these are non-profit organizations. Many of the large INGO's have both components (operational projects and advocacy initiatives) working together within individual countries.

Morris-Suzuki, (2000) and World Bank, (2007) states that, INGOs have the same purpose as the NGOs, but the INGOs are international or global in their scope and they have the outposts around the world to deal with specific issues in many countries which include third world countries. INGO's are formed due to different

purposes such as personal gain or volunteers and supporters. Therefore, INGO's are driven by a range of motivations and values. Some INGOs may be charitable and paternalistic such as relieve suffering, promote the interests of the poor, protect the environment, provide basic social services or undertake community development while others are known to pursue racial or empowerment based approaches as Morris-Suzuki cited an example of NGOs formed for the purpose of pursuing changes such as radicals and seek to explore alternative visions of development and change. The goals of INGOs are generally more closely aligned with those of national policy and it's particularly important to seek ways to support these private providers.

Tanzania adopted the Act No. 24/2002 in the year 2002 which allows INGOs to play a role in promoting health services through giving assistances, an act preceded by the policy statement in 2003 that aimed at providing a clear justification that the government encourages the partnership with public and private sector in order to compliment government efforts in provision of health services to the community (URT, 2016). In Morogoro municipal council where this study was conducted, there are 10,661 older people, of whom 85% are unable to access health services due to financial barriers, poor health facilities and difficulties in receiving correct health information (MMC, 2011). Despite the efforts made by the government of Tanzanian on improving health services by introducing National Ageing Policy (NAP) that was enacted in 2003 aiming to put elderly persons into national development agenda through the provision of free health services in the face of poverty and poor health services (URT, 2011). Still it seems hard for the elderly people to access health services as observed by Pastory (2013) that 70% of his

respondents who were interviewed mentioned provision of health services and quality treatment among public health facilities were determined by patients' age and as results most elderly people fails to acquire timely and quality health services from health attendants as being advocated by NAP services. It's on this basis that this study undertook to examine the contribution of INGOs in promoting elderly-friendly health services delivery in Tanzania by improving health service centers, provision of medicines, trainings and advocacy services.

The global development agenda has shifted markedly over the past three decades, placing different emphases on the relative roles of the state, the market and civil society according to the ideologies supporting the development agenda at each specific time (Hulme, 2013). Large-scale reductions in public expenditures and state-provided services alongside displeasure at the perceived failures of 'top-down' development opened up new spaces for INGO growth and expansion in the 1980s and 1990s. Viewed favorably for their ability to connect with beneficiaries and their role as innovators in working with the poor, INGOs became the new "sweethearts" of development (Barr et al., 2005; Gill, 1997; Hearn, 2007; Murray & Overton, 2011).Therefore little incentive for INGOs to reorient their roles away from service delivery and advocacy toward the building of bridges that are functional to the needs and demands of the civil society groups they aim to support (Nicola et al., 2014).

With respect to development aid, it is too often forgotten that national and international private non-profit organizations and volunteers make a very substantial contribution to development. Recently, the Development Assistance Committee of the Organization for Economic Cooperation and Development (DACOECD) estimated that aid resources handled by non-profit bodies exceed USD $ 1 billion

annually of which at least USD$ 700 million (USD$ 840 million in 1970) was raised from private resources (excluding foundations and missionary societies) for health services (Kjell, 1975; Groom & Paul, 1975). Currently, it is estimated that health expenditure of INGOs in health service is USD$ 1.53 billion (Oliver and Wodon, 2012). More so, for a comparison of aid flows to developing countries, in 1968, some 25,000 people from developed countries were working as volunteers in the low-income countries. This figures had increased five-fold in six years and was then equivalent to nearly a quarter of all technical assistance personnel serving abroad under official programs (Oliver and Wodon, 2012; Tony Blair Faith Foundation, 2014).

The establishment and revision of technical standards is another activity of some INGOs (Groom and Taylor, 1975). The need for standardization of technical equipment and measurement has been one of the driving forces behind the growth of international organization over the past hundred years in improving the quality of health services and it has the side-effect of easing transnational communication in other areas. Although a related activity is the elaboration of professional and ethical codes and norms of operation, for example the World Medical Association is concerned with the ethics of medical doctors globally (Kjell, 1975). In addition, INGOs may focus on many different kinds of targets in order to promote their interest. Sometimes they try to influence national governments, but our impression is that this is practically always done through members in the respective countries (World Bank, 2007). It is clear that as the time goes on elderly populations decreases their ability to perform normal activities and hence unable to produce and doing work by themselves which later on affect their income to the extent that some

depend on the government, INGO's and NGO's as well as relatives to take care of their needs particularly their accessibility to health services (Morris-Suzuki, 2000).

Civil society organizations (CSOs) are tools in health services delivery some of which are institutionalized with activist base, advocacy-focused or service delivery oriented whereby some large and influential whereas others small with little influence. In recent years, transnational, super national, national and local CSOs have played a distinctive policy-shaping role in health along-side governments, market actors, donor organizations, institutionalized social movements and groups of experts in regularly complicated governance structures (Keck and Sikkink, 1998). CSOs generally within the contemporary crisis of health systems and consider their role as a tool of health governance. It also draws attention to the contested theoretical and definitional issues surrounding research and practice on the role of CSOs in the delivery of health care and health advocacy and their place in health systems reform (Giarelli et al., 2018).

It is agreed that CSOs can affect health services negatively or positively, through three main mechanisms: direct provision of services (distinct from the state or as a mouthpiece for government funded programs), engaging in advocacy work (giving voice in to disadvantaged populations) and by providing social capital by offering associational opportunities for individuals with ailments and social problems (Anheier, 2009).

Although CSOs have been playing their role in health service delivery, also it's crucial to recognize the contribution played by INGOs on improving elderly-friendly health services delivery in the world. The role of CSOs and INGOs depends, to a

large extent, on the degree to which they can contribute to the solution of grave world problems (Lewis and Kanji, 2009). Therefore the INGOs and CSOs have played the same role in solving community problems especially flourishing the life of the poor and vulnerable people. They have carried out these particularly in aspects of socio-economic (including, health, education, human rights and so forth), political and culturally. Although in this study we have based in social aspect to health issues.

Administratively, Morogoro Municipality has one division, 29 Wards and 272 streets popularly known as Mitaa (streets) with a population estimate of 387,945 people. The study is about Tanzania but Morogoro Municipality is a case study.

1.3 Statement of the Problem

Older people face many obstacles in obtaining health services. Mobility is frequently cited as a critical problem, because of the remoteness of health facilities and the cost of reaching them (WHO, 2012). Physical environments are not age-friendly in many countries, while attitudinal problems also limit older people's access (Gorman, 2012). The training of health professionals continues to neglect ageing and older people consistently experience discrimination and abuse when accessing health services (Gorman, 2012; WHO, 2012). The awareness of older people themselves regarding their own health status and their entitlements is also low in many instances. Health promotion among older people is neglected in favor of other age groups besides financial barriers.

For instance, in Tanzania, older people reach retirement age after a lifetime of poverty, deprivation and poor access to health care. This situation leaves them with

insufficient personal savings as a consequence of a fragile earning history (Chaton and Rose, 2001; Kimokoti and Hamer, 2008). The situation is worsened by the limited coverage and inadequate benefit payments from formal social security systems (Bailey, 1995; Collin et al., 2000). As a result, majority of older people depend on family support networks, a reality that is well appreciated in most parts of sub-Saharan Africa, although the increasing burden to the extended family have been hindering accessibility to health service delivery due to high costs and inability to accommodate family members (Van de Walle, 2006). Furthermore, it is recognized that traditional social security systems are evolving and rapidly disappearing due to pressures from urbanization, industrialization and HIV/AIDS (Tostensen, 2004). At the same time it is widely reported that older people have more substantial inter-individual variability in health related to age than do younger people (Fialova, and Onder, 2009; Berdard et al., 2007). The health care system spends a small fraction of the budget on treating older adult illness and their access to health care is limited and not a policy priority in most developing countries (Tolman et al., 2000).

Many studies have been conducted on the challenges facing elderly-friendly health services delivery. For instance, Charu et al. (2017) researched on age-friendly health care services in India. The study found that, with ongoing economic development and the consequent changes in family structure and relationships, the elderly lose their relevance and significance in their households and face problems. They are superficially respected, cared for and heard and due to these problems, the aged feel lonely. However, few studies indicate that elderly people suffer more from morbidity and mortality. Similar results were found in another study by Yerpude

(2014) that assessed various health problems and treatment seeking behavior among elderly people in Andhra Pradesh. The study showed that around 68.5 % study subjects were having one or more health problems; 39.42% were suffering from locomotive disorders; followed by respiratory disorders (30.66%); hypertension (27.7%) and visual impairment (25.55%).

Malalika (2016) investigated the implementation of the national ageing policy in Tanzania and the findings were: 59% of respondents showed their dissatisfaction on the services provided by free health services providers, The study further observes that waiting time for Free Health Service affects their access to the services while 92% of them mentioned shortage of drugs especially those relating to elderly related diseases negatively affected access to free health service. In addition, Kagaruki (2013) conducted a study on access to free health services and observed that 48% of the respondents indicated that they had to pay for their medical treatment despites their entitled by National Aging Policy (NAP) to free access to health services. Despite the fact that INGOs' immense involvement in the health sector in Tanzania especially on matters concerning elderly-friendly health services delivery, although areas concerning elderly health should have not been paid more attention. From this basis this research study seeks to examine the contribution of INGOs in promoting elderly-friendly health services delivery in Tanzania by improving health service centers, provision of medicines, trainings and advocacy services.

1.4 Research Objectives

The main objective of this study is to examine the contribution of INGO's in promoting elderly-friendly health services delivery in Tanzania. The main objective will be realized through the following specific objectives:

i. To examine the role of INGOs in resource mobilization and funding to improve physical health infrastructures in Tanzania.
ii. To investigate the extent of facilitating training of staff in preventive health services for the elderly in Tanzania.
iii. To investigate the efficacy of the INGOs advocacy in enhancing curative services for elderly people in Tanzania.

15 Research Questions

i. What are the roles of INGOs in resources mobilization and funding to improve physical health infrastructures in Tanzania?
ii. What is the extent of facilitating training of staff in preventive health services for the elderly in Tanzania?
iii. What is the efficacy of the INGOs advocacy in enhancing curative services for elderly people in Tanzania?

1.6 Significance of the Study

This study will help to provide useful information on contribution of INGO's in promoting elderly-friendly health services delivery. This will help to provide appropriate interventions that can help to improve training of staff in preventive health services for the elderly, INGOs advocacy in enhancing curative services for elderly people and resources mobilization and funding that will improve physical health infrastructures. Further, this knowledge serves as baseline on which future researches will build on. This information will be vital for policy makers, development partners and civil society organizations involved in promoting elderly-friendly health services delivery in many places in Tanzania and other places with similar conditions.

1.7 Chapter summary

This dissertation is divided into five chapters. Chapter one has given a general background to the study. An explanation of the key concepts has been provided and how they have been applied to the study. Also in this chapter statement of the problem has been stated and general objective has been divided into specific objectives later on significance of the study. Chapter two explores the reviewed literature that has been used in demonstrating several understanding to this study. Chapter three presents the methods adopted in this study. Chapter four covers the discussions that are based on three research objectives which include: To examine the role of INGOs in resource mobilization and funding to improve physical health infrastructures in Tanzania; To investigate the extent of facilitating training of staffs in preventive health services for the elderly in Tanzania and to investigate the efficacy of the INGOs advocacy in enhancing curative services for elderly people in Tanzania. Further this chapter addresses the next chapter two that explores literature review based to this study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

According to Amin (2005), literature review involves the systematic identification, location and analysis of documents containing information related to the research problem. This chapter provides the review of literature on the contribution of INGO's in promoting elderly-friendly health services delivery. It includes the theories used as well as the key concepts of the study and their interrelationships.

2.2 Definition of Key Terms

The study presented key terms that were adopted in this study. This section starts with elderly-friendly health services, International Non-Governmental Organization (INGO's), Civil Society Organizations (CSOs) and Resource Mobilization. Others include funding, Physical Health Infrastructures, Training of Staff and advocacy.

2.2.1 Elderly-Friendly Health Service

Elderly-friendly health service refers to the service provided for the development and maintenance of optimal mental, social and physical well-being and function in older adults. This is most likely to be achieved when communities are safe, promote health and well-being, and use health services and community programs to prevent or minimize disease for the older populations (West Virginia Rural Healthy Aging, 2006). Elderly-friendly health service was used in this study to refer to health services provided to people aged 60 years and above taking into account their age specific needs without discriminating them on the basis of their tribe, age, religion, economic or health status.

2.2.2 International Non-Governmental Organization (INGO's)

International Non-Governmental Organization (INGO's): According to World Bank (2007), INGO's are defined on the basis of their primary purpose. Some INGO's are operational (meaning that their purpose is to foster the communities via different projects and operations) while others are advocacies based (which means that their primarily intention is to influence policy-making regarding certain issues).

2.2.3 Civil Society Organizations (CSOs)

Civil Society Organizations refer to organizations legally registered with appropriated statutes, working for the benefit of the populations or in service delivery, sometimes in collaboration with grass-roots organizations (e.g. NGOs, associations) (Maurizio et al., 2009). In addition, civil society organizations are defined as a set of arenas in which social privilege, knowledge and social connections play a role (Giarelli et al., 2018).

2.2.4 Resource Mobilization

Resource Mobilization is a process of getting resources from resource provider, using different mechanisms, to implement an organization's pre-determined goals (Seltzer, 2014). According to HCCC (2018), resource mobilization refers to all activities involved in securing new and additional resources for your organization. Therefore, it involves making better use of and maximizing existing resources. In this study, resources mobilization refers to processes used by local and international non-governmental organizations to secure resources from donors in promoting elderly-friendly health service.

2.2.5 Funding

Funding refers to form of health care financing designed to meet the cost of all or most healthcare needs from a publicly managed fund for elderly people (Blanchette and Tolley, 1997). In addition, the fund may be a not-for-profit trust that pays out for healthcare according to common rules established by the members or by some other democratic form (WHO, 2018). In some countries, the fund is controlled directly by the government or by an agency of the government for the benefit of the elderly people. That distinguishes it from other forms of private medical insurance, the rights of access to which are subject to contractual obligations between an insurer (and his sponsor) and an insurance company, which seeks to make a profit by managing the flow of funds between funders and providers of health care services (Docteur and Oxley, 2003).

2.2.6 Physical Health Infrastructures

Physical Health Infrastructures: Infrastructures are the basic services or social capital of a country or part of it which make economic and social activities possible. In terms of public health, they are the formal and enduring structures that support public health including friendly-elderly health services delivery having both tangible and intangible aspects and existing inside and outside the government sector. They may be directly protective of health as in public sanitation systems or they may support other activities that protect and enhance health (WHO, 2012). More so, physical health infrastructures have many components: physical facilities that make care accessible; laboratory and other support facilities as well as reliable supplies of pharmaceuticals (IZUMI Foundation, 2018). In this study, physical health

infrastructures are facilities that are needed or used by elderly people in accessing health service.

2.2.7 Training of Staff

Training of Staff can play a significant role in determining health care professionals' proficiency with the most recent interventions and technologies. Training programs and policies also have important implications for labor market issues in the health care sector (WHO, 2018). If high quality care is to be maintained, education and training is needed to provide staff with the necessary knowledge and skills to adapt to their changing roles (Ward and Wood, 2000). However, to understand the efficacy of training, it is necessary to consider both patient and staff outcomes especially as training may be enjoyable and change behaviour in trainees, but still have no benefit to patients (Hinrichs, 1976). In this study, training of staff refers to knowledge and skills imparted to doctors, nurses and other health service providers who engage in promoting elderly-friendly health service delivery.

2.2.8 Advocacy

Advocacy is an activity by an individual or group which intends to influence decisions within political, economic, and social systems and institutions (Wagner, 2018). Besides, advocacy can include many activities that a person or organization undertakes including media campaigns, public speaking, commissioning and publishing research or conducting exit poll or the filing of an amicus brief (Obar et al., 2012). On the other hand, advocacy in health services encompasses direct service to the individual or family as well as activities that promote health and access to health care in communities and the larger public. Advocates support and promote the rights of patients in health service arena, facilitate build ability to

improve community health and enhance health policy initiatives focused on available, safe and quality care (IMCQHCA, 2001). In this study, advocacy means INGOs' activities that promote elderly-friendly health service delivery. INGOs advocacy services are best suited to address the challenge of patient-centered care including elderly people in our complex healthcare system.

2.2.9 Efficacy

Efficacy means capability to perform a specific task. It is a dynamic element that influences other concepts such as goals and performance that is influenced with different elements. It plays a role of connecting goals, performance as well as motivation concepts (Erel, 2000). It is related concepts that function as mediating mechanism among these concepts (Bouffard-Bouchard, 1990). In this study, efficacy of the INGOs advocacy means measures used to health service provided to the elderly this may include waiting time as well as health insurance provisions.

2.3 Theoretical Review

The study employed theories as guidelines to achieve its objectives. Common international theory, Regime school theory, Neo-Corporatist theory, Functionalism theory and Liberalism theory were used to guide this study since the selected theories insist on the contribution of INGOs in promoting elderly-friendly health services delivery.

2.3.1 The Regime School Theory

The regime school approach of civil society organization focuses on the nature of the regime and how rules can be made more democratic to create chance for equality in health service delivery to all individuals in the society. (Hyden, 1997) states that

most analysts define CSOs as the realm of the organized social life standing between individual and the state. It recognizes that the consolidation of service delivery to individual may require changes in both state and civil society. The regime school, therefore, tends to be concerned specifically with the constitutional and policy issue of how state-society relations can be organized to promote elderly-friendly health service delivery. A constitution by itself, no matter how ingeniously designed, no matter what admirable formal arrangements of checks and balances, will not limit CSOs to mobilize their resources and funds from external donors. To be effective, constitutions and their policies must improve the physical infrastructures in health sector to the society (Hyden, 1997). They must intertwine state and civil society in ways that permit the effective articulation and aggregation of societal interests that will bring better life to elderly people's health. This advocate for the better improvement in curative service delivered to older people in their societies. Although their position do not treat the state and civil society as standing apart. They are concerned with instituting constitutional and legal mechanisms that had created the past development in our societies (Hyden, 1992).

Scholars of regime transitions are particularly prominent within this school. Some have set the tone for much of this study by evaluating the experiences of transition from authoritarian to democratic rule in the early 1980s relating problems that are facing developing countries particularly in health service delivery. The specific challenges of regime transition in Africa have been discussed by (Bratton and Van de Walle (1994). Some of the literature on governance also falls into this category where elderly and the health of the poor have been paid great attention. (Hyden, 1992), for example, in other side of democratic regime in civil society and social

capital and development discusses the challenges facing African countries in terms of managing regimes, defined as the rules of the political game where states does not consider the interests of the individuals like elderly health services hence CSOs intervene in friendly-health service provision. The difference between the regime and other regime schools of thought is that some concentrates on the framework within which civil society can grow, while the other focuses on its content. Therefore, there is a recognition that while containing state power is important .Also Civil Society Organizations and the state may often be ready to play their role serving the society in either providing training of health professionals to demonstrate better ways of preventing diseases to the elderly-friendly health services. Civil society is not automatically democratic rather democracy create suitable environment for CSOs to conduct the delivery of these services. Many groups may use the relative freedom of civil society to pursue anti-democratic objectives. To the extent that state and civil society are viewed as linked to each other, citizens' rights must be balanced by citizen obligations.

2.3.2 Common international Theory of civil society organizations

According to the common international theory of civil society in service delivery, it is argued that the more developed the country is, the more advanced is its civil society and the more voluntary its labor force becomes. Civil society Organizations utilizes 31 million permanent employees and 219 million voluntary workers who develop ways for resource mobilization and funding in service delivery. CSOs mainly work in the areas of education, health, and social services (Putnam, 1994). From this we can see that civil society has played an increasingly important role in

the improvement of physical health facilities. Scholars of civil society often raise the following arguments:

First, as Tocqueville explained, civil society is part of a wider realm (the associational life). This approach commonly suggests a definitional meaning of civil society that is separate from economic and political society. The basis of this model proposes that civil society operates in a sphere in which social capital is brought into play where targeted group of people are reached. Further, civil society differs from the state in that it provides a forum where individuals like elderly people can participate, are involved and have equal rights to access health service like other human beings. Therefore such voluntary participation of the citizenry builds trust and cooperative spirit in the development process of health service delivery to elderly and the poor people (Putnam et al., 1994).

Second, civil society emphasizes its own positive qualities and values that it advocates. These qualities include an emphasis on specific guaranteed rights in curative health service provision to the elderly such as the freedom of expression, freedom of association, freedom of the people, and economic and freedoms of older people to raise their voices in accessing equal health service . Civil society also practices such values to older people like tolerance, non-discrimination, non-violence, trust, and cooperation to these values. According to this theory, any institution or social mechanism (whether in western society or not) that respects and supports these values, will become a good society and lead to improvement of curative services in which clinical programmes were directed to older people health (Putnam et al.,1994).

Third, it is argued that civil society is a public sphere, meaning it is an entire system that cares for the common interests of its people basing to this study the elderly-friendly health service delivery is the targeted group. In this approach, individuals are free to raise their voices and participate in resolving shared issues, and individual views are not suppressed, provided they serve the common good. CSOs advocacy is the weapon used to protest against elderly people killing and discrimination to access health services. This theory assigns civil society an important role in changing society (Putnam et al., 1994).

Fourth, the state is considered a bureaucratic mechanism that serves the interests of small groups who are easily controlled by interest groups. Thus elderly-friendly health service delivery is demonstrated to the CSOs who can play a role of helping these special groups. Because of this, it is often difficult for the state to resolve problems like the environment, health, and education on a national and international scale. Additionally, in this theory the CSOs facilitate training for staffs in improving preventive diseases that facing elderly people, often neglecting public interest, and as a result, civil society becomes necessary to compensate for the shortcomings of the state. (Edward, 2004)

Therefore, some governments are facing problems such as corruption and ineffective administrative systems, this led CSOs making it difficult to deal with global aging problems like elderly-friendly health service delivery and inter-regional issues.

2.3.3 Neo-Corporatist theory of civil society.

This type of regime comes in different shades, but the general principle behind this is that of integration of interests at the state level. To be sure, this does not apply to

all interests, but participation in state structures is offered at least to the CSOs and other influential interest groups in society. The service delivery carried by CSOs was initially associated with the idea of neo-corporatism. Its prominence can be largely attributed to the simultaneous growth of the welfare state and civil society organization, like the provision of elderly health service delivery from state and CSOs. To manage this kind of economic system, it became necessary for the state to incorporate into its decision-making structures those CSOs could make it succeed or fail (Hyden, 1992).

Although no attempt is typically made to curb the freedom of these organizations, their role in civil society is diminished by their inclination to focus on the structures provided by the state. This makes them accomplish their activity to elderly-friendly health service delivery. This is done through facilitating of training programmes to staff in improving preventive diseases that are facing older people. Some of the most important agents of CSOs are coopted by the state and thus unlikely to act as independently as they otherwise would. As the experiences of many Western European countries (Schmitter and Lehmbruch, 1979) indicate, this type of cooptation has many positive effects, notably that of stabilizing health sector. It also elicits a fairer mobilization and distribution of resources and funds among the principal interest groups like elderly health. Even though the party in power may be politically closer to one of these CSOs, its role in a neo-corporatist system is that of serving as mediator and ensuring that contending forces are balanced.

Although the process of creating a welfare state in countries like those of Western Europe was never completed. As (Collier and Collier, 1991) argue efforts to incorporate the interest of labor in promoting elderly-friendly health service delivery

for improving ways of prevention. Some CSOs in Latin American countries followed very different paths and were never wholly successful in stabilizing social services particularly in health sector. For these reasons, civil society organizations had continued to retain its role as an alternative arena of elderly inclusion in free health services. Although freedom of association and speech has been banned for certain times in these countries, CSOs has never lost its attraction in advocating services for better curative services to the elderly (Nelson, 1989).

2.3.4 The Functionalism Theory

The functionalism perspective emphasizes that good health and effective medical care are essential for a society's ability to function. Ill health impairs ability to perform roles in society, and if too many people are unhealthy, society's functioning and stability suffer. Therefore this was especially true for deaths, because it prevents individuals from fully carrying out all their social roles and thus represents a poor return to society for the various costs of diseases and socialization of the individual who ends up dying early (Parsons, 1951).

The theory suggests that in legitimately sick, several expectations must be met. These expectations are referred as the sick role. First, sick people including elders should not be perceived as having caused their own health problem. Second, sick people including elders must want to get well and if they do not want to get well or worse yet are perceived as faking their illness or malingering after becoming healthier, they are no longer considered legitimately ill by the people who know them or more generally by society itself (Parsons, 1951; Weitz, 2013). Therefore the concept derived from this expectation is that for improving elderly health services

older people may have awareness of health care visitations for checking their health. Third, sick people including elders are expected to have their illness confirmed by a physician or other health-care professional and to follow the professional's instructions in order to become well. If a sick individual fails to do so, she or he again loses the right to achieve the sick role and the aim here is developing the elderly health education provided by health professionals to elderly to be considered to have a several checkups (Parsons, 1951).

However, this perspective has been criticized for several reasons. First, the idea of the sick role applies more to acute (short-term) illness than to chronic (long-term) illness. Although much of the discussion implies a person temporarily enters a sick role and leaves it soon after following adequate medical care, people with chronic illnesses can be locked in a sick role for a very long time or even permanently (Steven, 2011). Second, the theory ignores the fact, that our social backgrounds affect the likelihood of becoming ill and the quality of medical care we receive. Third, Parsons wrote approvingly of the hierarchy implicit in the physician-patient relationship (Buckser, 2009; Weitz, 2013).

In fact, this theory is important because considers the good health and effective medical care are essential for the smooth functioning of elderly people. In relation to the study this theory of functionalism has been emphasizing the importance of good health for society's development. Therefore, it is important for the governments, INGO's and other health institutions to take the responsibilities such as provision of medical equipments and financial aids for the improvement of elderly-friendly health services delivery.

2.3.5 Liberalism Theory

A liberal approach of international relations poses even greater challenges in achieving states interests. Liberals argue that states will pursue not only relative, but also absolute gains (Hughes, 2000). While viewing international institutions as the product of state interests, and thus constrained in what they can achieve when those interest of social conflicts, liberals nevertheless believe that institutions can provide unprecedented opportunities for achieving greater delivery of health services to the poor especially the elderly people through cooperative action (Baylis, 1997). By going beyond describing international relations and seeking to prescribe how states should interact. States through their focus on relative gains, they are nevertheless better able to explain the nature of cooperative institutions such as WHO, HelpAge International, World Vision and so forth (Baylis, 1997).

In the liberal view, state preferences concerning legitimate socio-economic practices shape interstate behavior when their realization imposes significant trans-border externalities particularly in service delivery to other developing countries. From that concern the proper balance between policy coordination and legitimate domestic regulation in service delivery to the poor and vulnerable groups including elderly people are giving rise to even more complex forms of cooperation. Hence regulatory issues play an increasingly important role in international relations in delivery of services to the poor especially elderly-friendly health service delivery through International Non-Governmental organizations including HelpAge International (Moravcsik, 1997). In fact, liberalism approach fits in explaining the contribution of INGO's including HelpAge International in flourishing health of the elderly people. This is because it imposes significant trans-border externalities of INGO's

particularly in service delivery including service delivery for the betterment of the whole societies.

2.4 Empirical Literature Review

This section presents research issues on challenges that led to poor elderly-friendly health service delivery including insufficient of funds, lack of personnel (capacity building), inadequate medical supplies and inadequate health facilities. A number of explanations have been given.

2.4.1 Insufficient of Funds

The cost of health care is not the only barrier to health care access; there are a wide range of factors such as affordability, availability and acceptability barriers, which affect poorer groups most severely. The burden of high and rising health care costs affects elders; the health sector is also a thriving economic sector that serves as a job creator and center for lucrative opportunities that have played a vital role in the nation's economy. Deep-seated cultural, financial and institutional vested interests constitute hurdles to recognize and overcome (James et al., 2016).

INGOs contribute to funds in health services delivery. The main sources of finances for the INGOs are the Government and International Agencies. Kan, (1999) conducted a study in Sri Lanka and found that, the government constituted the main source of funding for elderly-friendly health services delivery undertaken by INGOs constituted 58%. In respect of INGOs and Sub national and Community-Based Organizations sources of funding were more varied, with government funding accounting for 37% and 38% respectively. Other important sources of funds for local government in elderly-friendly health services delivery were the International

Institutions/Donors (16%) and Self-earned sources (16%). On the other hand, government funds for elderly-friendly health services delivery depended more on foreign sources. For Sub-national and Community-based NGOs too these were important sources of funds, with Self-earned finances provided funding for 14%of these INGOs. However, Only 20% of INGOs were satisfied with the current levels of funding.

INGOs may disclose sources of their funding at their own discretion. In reality, most INGOs are generally unwilling to disclose their funding sources and actual expenditures to anybody outside their governing board or executive body, not even to researchers (Kwesiga , 2000). In their study on financing health service through user fee & insurance, concluded that an accountability squeeze was one of the major challenges facing non-profit organizations (Chaw and Ainsworth, 1996).

Gordon and Singer (1995) reported that many countries are looking at ways to reduce health care costs; older people often become the focus of such efforts at cost control. However, there are counter-arguments that question the inevitability of expenditure on health services for older people becoming an unsustainable economic burden. Sandhu et al. (2009) reviewed some data on health services spending as a percentage of GDP as well as its association with population ageing and reported that, the United States spends 14% of GDP on health services, although it is among the lowest of 12 industrialized countries in its percentage of older adults. In contrast, 17.8% of the Swedish people are over 65 years old and it spends 7.5% of GDP on health services (one third less than the United States). Furthermore, the older adults' population in Japan increased by 30% from 1980 to 2010 while there was only a 1.6% increase in the proportion of its GDP that went to general health services

during that period. Nevertheless, in the United States, the increase in the percentage of those aged 65 in the same period was 10% (around one third that of Japan) and health services expenditure went up by 31.5% (World Health Organization, 2013). Therefore, financing issues should therefore not only consider how to generate funds for health care, but also explicitly address the full range of affordability, availability and acceptability barriers to access in order to achieve equitable financing pattern.

2.4.2 Lack of Personnel (Capacity Building)

Change in the knowledge, skills, attitudes and practices of health professionals are critical for improving access to quality health services for older people. The quality and quantity of health care services delivered in public health system is severely limited due to among other things the shortage of sufficient numbers of trained health service workers. For instance, Africa including Tanzania, which has a quarter of the world's disease burden but only 3 percent of its health care workers, is affected the most. Across Africa, elderly patients are often left unattended for days in rudimentary clinics staffed by a single overworked nurse and a few untrained orderlies. Doctors often visit only once every few weeks (Chandran and Lyn, 2008).
INGOs had some trained staff for elderly-friendly health services delivery. The number of trained staff as a percentage of the total staff varied across the INGOs, some with over 75% trained staff to others with less than a quarter. The highest proportion of trained staff was found in the International NGOs (over 75%) while over half (58%) of the INGOs had more than half of trained staff for health education (Tracey, 2015).

In 2008 the Hong Kong Government launched a pilot project called the Integrated Discharge Support Program for Elderly Patients (IDSP) that would provide

education on elderly patients discharge from hospital with 6-8 weeks of follow-up home based services. The results revealed that the pilot project has effectively reduced unplanned readmission to hospitals of elderly patients. Also the family members agreed that the program encouraged the elders to do exercises during the critical period for rehabilitation and the information provided to the care taker was useful and released care taker burden (Lou et al., 2009).

Furthermore, the study conducted by Kan (1999) on work commitment in terms of time expended showed that by and large INGOs worked with a mix of full time and part time health worker (96%). Two INGOs had no full-time staff. All types of INGOs had more full time than part-time health workers. They also operated with a mix of paid and voluntary health workers. Nearly half (48%) of INGOs had more paid than voluntary health workers, with sixteen (32%) employing more than 75% of their staff on a paid basis. Similarly, the major areas of staff training on elderly-friendly health care were the following; the predominant area of training at all levels of staff was the first aid and nursing cluster. Indeed in respect of the INGOs with over 75% of staff trained the major area of training remained First Aid and nursing in 76% of them. Their assessment of training indicated that over half (66%) considered the elderly-friendly health care training provided to their staff to be inadequate.

2.4.3 Inadequate medical supply

Availability of essential medicines in health sector is one of the issues of concern for effective elderly-friendly health service delivery. There are several implications of inadequate and unavailability of medicines, such as unwarranted out-of-pocket

expenditures and consequent indebtedness in some cases. Inadequate of medical supplies is also one of the major reasons for lower utilization of the public and private health systems.

The study is supported by Twaweza survey conducted in 2013 found that 41% of patients including elders were not able to get the medicines they need directly from a public health centers. Tanzanians often have to turn to private pharmacies for medicines due to shortages at public centers. In urban areas this usually means paying a premium for essential medicines that should be available for free or at a discount from public centers, and in rural areas, where private centers are fewer, it often means having to pay for transport and medicine costs or simply going without needed medicines (Twaweza, 2013).

Tucker, (2013) reported that, problems with the supply of medical equipments and materials which is called operational failures disrupt care and waste up to 10% of nurses' workdays and one medical or surgical nursing unit observed, was a chronic shortage of functioning computers-on-wheels which connect to the network and enable doctors and nurses to access patients medical information and to enter notes about care delivery.

Raut-Marathe et al. (2015) conducted a study on causes of medicine shortages in primary health centres. The study found that, several lacunae in the existing indent and supply system of medicines in Maharashtra. Some of the medicines were supplied through multiple sources and yet, these medicines were NIL in stock. Inventory management of the medicines was rather inadequate. Medicine supply system is not demand responsive. Hence, major reforms in the current medicine

indent-supply system are essential to ensure adequate supply of medicines to the patients in the public health system.

Moreover, INGOs have become key players in promoting medical supplies for elderly-friendly health services delivery in developing countries (Lewis and Kanji, 2009). Health INGOs are seen as alternatives to government run health care services by providing medical equipments, because they are considered less hampered by bureaucratic constraints and inefficiencies (Gilson et al., 1994). For instance, in South Sudan, INGOs are the major medical suppliers for elderly-friendly health services delivery. After the collapse of the public health care system during the many years of conflict, INGOs played a major role in the health sector by providing a range of services in accessible areas. In the post-war South Sudan, INGOs continue to provide the bulk of elderly-friendly health services. It is estimated that INGOs are providing about 80% of medical supplies in South Sudan (World Bank, 2007).

2.4.4 Inadequate Health Facilities (Infrastructures)

Elderly-friendly health services delivery will improve, and the burden of infectious disease will be reduced, only if significant investments are made in the infrastructure for providing health care. An adequate health care infrastructure has many components: physical facilities that make care accessible; laboratory and other support facilities such as mechanisms to distribute resources and expertise to people who need them and an adequate system that is capable of providing preventive, diagnostic, and curative care, according to the requirements of the older people

being served. Also many elders arrive to the health facilities very late due to unavailability of transport.

For instance, a study covering 923 public health facilities (hospitals, health centers and dispensaries) conducted by the Ifakara Health Institute (2012) found high levels of stock-outs, only 37% of public hospitals and dispensaries being in stock for any given drug from a set of 14 essential tracer medicines. The study found considerable variation between districts and across medicine types, with somewhat better levels of availability in private facilities and urban (Twaweza, 2013).

USAID, (2017) reported that, inadequate and insufficient healthcare facilities or infrastructures have been a significant roadblock to improve poor healthcare services in Haiti for elders. According to the Ministry of Health, even before the 2010 earthquake, Haiti's healthcare system was not able to respond to the needs for basic healthcare services as the earthquake destroyed 50 healthcare centers as well as the Ministry of Health building. This further limited access and availability of health services for Haitians. The earthquake also destroyed part of primary teaching hospital and disrupted the education of future healthcare professionals (USAID, 2017). INGOs provide significant portions of elderly health care services in Africa and are generally seen as being of high quality. Ghanaian NGOs provide 40% of clinical care needs, 27% of hospital beds and 35% of outpatient services. In Tanzania NGOs provide half of all hospitals and beds and receive half of all curative visits: In Zimbabwe they supply 35% of all hospital beds and 96% of NGO facilities are located in disadvantaged rural areas (Gilson et al., 1997).

2.5 Knowledge gap

The empirical review done revealed that there is a knowledge gap concerning the examination on the contribution of INGO's in promoting elderly-friendly health services delivery. For example, in a study by Gorman (2012) elaborated that despite the governments' efforts on improving elderly health services, much remains to be done and INGOs can play significant roles as stakeholders to governments and INGO's in a number of ways. Non-governmental organizations can assist governments to deliver these commitments, particularly through supporting awareness-raising among health service professionals and older people themselves. Finally, ensuring involvement of older people is critical. It has been noted the role that older people's groups play in strengthening the accountability of health providers to service users and ensuring that the voices of older people are heard in the development of age-friendly health services remains the key challenge for INGOs.

Furthermore, Yeo et al. (2018) showed that, policy tools which allow INGOs to enter into the field in a timely manner, can improve the effectiveness of INGOs' responses in current and future diseases that face people including elders in developing countries where people suffer from inadequate health infrastructure, medical supplies, insufficient of funds, lack of personnel and capacity building.

Therefore, due to inadequate empirical researches for effectiveness of their responding activities, the legitimacy and accountability of international non-profits' engagement in the elderly health services as the critical responders is doubted. This study aims to examine the contribution of INGO's in promoting elderly-friendly

health services delivery in the context of building healthcare infrastructures, providing medical supplies, educating local residents, and training response staffs.

2.6 Conceptual Framework

According to Miles and Huberman, (1994) a conceptual framework is defined as a visual or written product, one that explains either graphically or in narrative form, the key factors, concepts or variables and the supposed relationships among them. The main purpose of conceptual framework is that it is primarily a conception or model of what is out there that you plan to study and of what is going lying on with those things and why a tentative theory of the phenomena that you are going to investigate. The function of this framework is to inform the rest of your design to help you to assess and refine your goals, develop realistic and relevant research questions, select appropriate methods, and identify potential validity threats to your conclusions (Reason and Rigor, 2011).

This conceptual framework is anchored on regime theory. The essence of the theory is to show reflexive contribution between CSOs and state in service delivery.

This theory supports that even in welfare states at the center of analysis the access of health service should be of equality and same standards to all the people without discriminating some classes of the poor while all times fundamentally criticized at times modified, with new regimes added and specific countries moved from ones regime to another. Social democratic regime provides services to its citizen with small standards but a liberal regime seek more capital from its people. Therefore the elderly receive better services from both regimes but with different equality and standards.

2.6.1 The contribution of INGO's

The contribution of INGOs implies many aspects but to this study will focus on these three aspects.

CSOs and Resource mobilization and funding

One of the Civil Society function is developing a plan or strategy for resource mobilization that can lead to creative efforts in using its own local assets to gain support for the organization. With increased competition for scarce grant resources, thinking of, and creating options for new, diverse, and multiple funding streams will help the organization manage its programs (Mechai, 2001; World Bank, 2007). Also in strengthening organizational capacity and deliver benefit to the community. The setup for fundraising in improving health infrastructures requires knowledge of the country's current situation, including legal and tax structures, as well as what kind of fundraising activity that could enabled elderly to easy access for health service around their environment (ABCD, 2005).

Therefore, Successful fundraising efforts of civil society organizations (CSOs) may be supported to strengthen physical health infrastructure. On the other hand, creating innovative and fresh ideas may also inspire people to contribute while many CSOs continue to receive support from external funders; the trend is for this source of income to serve as supplement that is useful, but not one that creates dependency .And from this there will be easier and accessible health services delivery to the elderly people from the strengthening of physical health facilities like provision of medicine and building of infrastructure.

CSOs and facilitation of training of staff

The purpose of this training of staffs by CSOs is to improve treatment outcomes for the elderly health. The aim of CSOs, INGOs and NGOs facilitating training activity is to build the capacity (knowledge, skills and attitudes) of staff to better implement the approach of friendly-health service delivery to the elderly in collaboration with each others like Community Based Organizations (CBOs). In order to reach the unreached and to improve detection and reporting of elderly health problems such as chronic diseases, Tuberculosis (TB) and Blood Pressure (BP), sustainable approaches are needed that go beyond existing health facilities to community structures and individual households in facilitating training of health staffs to demonstrate preventive ways from diseases (WHO, 2014). CSOs or INGOs are often able to engage vulnerable and remote groups effectively to deliver training of health staff to the elderly problems.

Civil Society Organizations emphasizes approaches that foster collaboration between public health officials (staffs) and CSOs staffs that can improve access to and the quality of health services, ultimately contributing to improved health outcomes where training of staffs is prioritized. This specifically focuses on the elderly-friendly health service delivery where it offers trained staff a range of tools from which to choose based on the environment they work in and the objectives they seek to achieve in improving older people's health (Kanthor et al.,2014 ;USAID, 2013). In addition it may also seeks to provide practical mechanisms for how civil society engagement may be achieved in improving elderly-friendly health service delivery in preventive diseases, at the national, sub-national, and community levels.

CSOs and Advocacy

CSOs role on Advocacy in elderly-friendly health services is more taking an ever more central place in health agendas of African countries. It is not possible to have a conversation about public policy now days without someone mentioning civil society (Omungo, 2011). Unfortunately, clarity and rigor are conspicuously absent within Civil Society Organizations in health service. Advocacy for enforcement of Aging policy is called for because of civil society's tendency to concentrate on commercial interests rather than health equity particularly for the elderly and vulnerable groups. (Koh, 2000). A States' first duty towards citizens is to respect the right to health by refraining from adopting laws or measures that directly impinge on implementation of National Aging policy (Network , 2000) Promotion of the responsible exercise of these rights for all people is the fundamental basis for government, NGOs, INGOs and community supported policies and programs. By formulating health policy for the aging people Civil Society Organizations provides norms and networks of trust that can improve the efficiency of society by facilitating coordinated public action through their advocacy methods. Within the global policy process, we found CSOs to strengthen public interest lobbies and balance corporate and market pressures making what is reported as valuable and sometimes essential contribution to successful policy outcomes (Kaulem J, 2007 ; WHO, 2001). Civil society organizations (CSOs) are important stakeholders in policy formulation making processes. It is through CSO networks, state society relations are improved in specific areas of social services particularly in elderly health service delivery.

2.6.2 Elderly-friendly Health Service Delivery

This variable implies different services to the society but to this study will focus on three aspects of elderly-friendly health service delivery.

Improvement of physical health infrastructure

Elderly people aged 60 years and over, in particular those who have increasing levels of frailty, tend to use government and CSOs health services, as the majority cannot afford private healthcare. Older people who have chronic diseases but are functionally independent tend to receive healthcare in outpatient clinics run by the hospital authority, or join screening programs in elderly-friendly health clinics run by the Department of Health and other international NGOs health facilities, while those with increasing frailty are supported by hospital authority. Elderly-friendly health service delivery has improved physical health infrastructure since hospitals are conveniently located and highly accessible, are open 24 hours a day, and are free if the patient cannot afford to pay. Hospital management provides acute and recuperative beds, a geriatric day hospital, and a community geriatric outreach support to older people living at home as well as in residential care homes (HA, 2012).

Although elderly-friendly health service is a key first interface in promotion and maintenance of health of older people in physical health facilities, an assessment of the age-friendliness of service provisions is of critical importance in optimizing health of aging populations (Sixma et al., 2012).

Therefore the specific areas for elderly-friendly health service delivery in health facilities has been improved in, clinic signage and facilities, the physical health infrastructure, such as available seating and space for waiting areas, the consultation process, clinic fees has been lowered, community outreach services, the referral system, increase of health knowledge, medication management, standard of care for

the elderly, feedback system, and communication skills of healthcare staff. This has reduced the mortality rates for older people.

Improved Preventive Health Service for the elderly

Preventive health services are implemented through medical officers of health and their field staff at the district level; additional medical officers focus on mental health and prevention of non-communicable diseases. Elderly-friendly health service delivery has improved preventive services to the older people whereby Health care centers should provide age, gender and culturally appropriate health education and information on health promotion, disease management and medications for older persons as well as their informal careers in older to promote empowerment for health. Also elderly-friendly health service delivery in Health centers has improved where the use of all medications, including complementary therapies such as provision of medicines for preventive diseases. Although clinic programs were improved to demonstrate preventive ways from diseases from elderly people (Sixma HJ et al., 2000; WHO, 2008).

All stakeholders, including older persons, have been part of participatory decision-making mechanisms regarding the organization of the community-based care services. Also information on the operation of the health service delivery to the elderly health center, such as opening hours, fee schedules, medication and investigation charges, and registration procedures has changed in an age-appropriate way. Also comprehensive-fee-charging preventive healthcare services are removed and elderly access free health services (DH, 2012; WHO, 2004). Therefore to ensure elderly-friendly health service delivery government and CSOs published a framework for primary care for older persons, which are predominantly focused on

preventive care/screening rather than on other service provisions. In addition friendly-health service delivery to the older people in later life require a different focus than those at younger ages, with an emphasis on reducing age-associated morbidity and disability and the effects of cumulative disease co-morbidities.

Improved curative services to older people

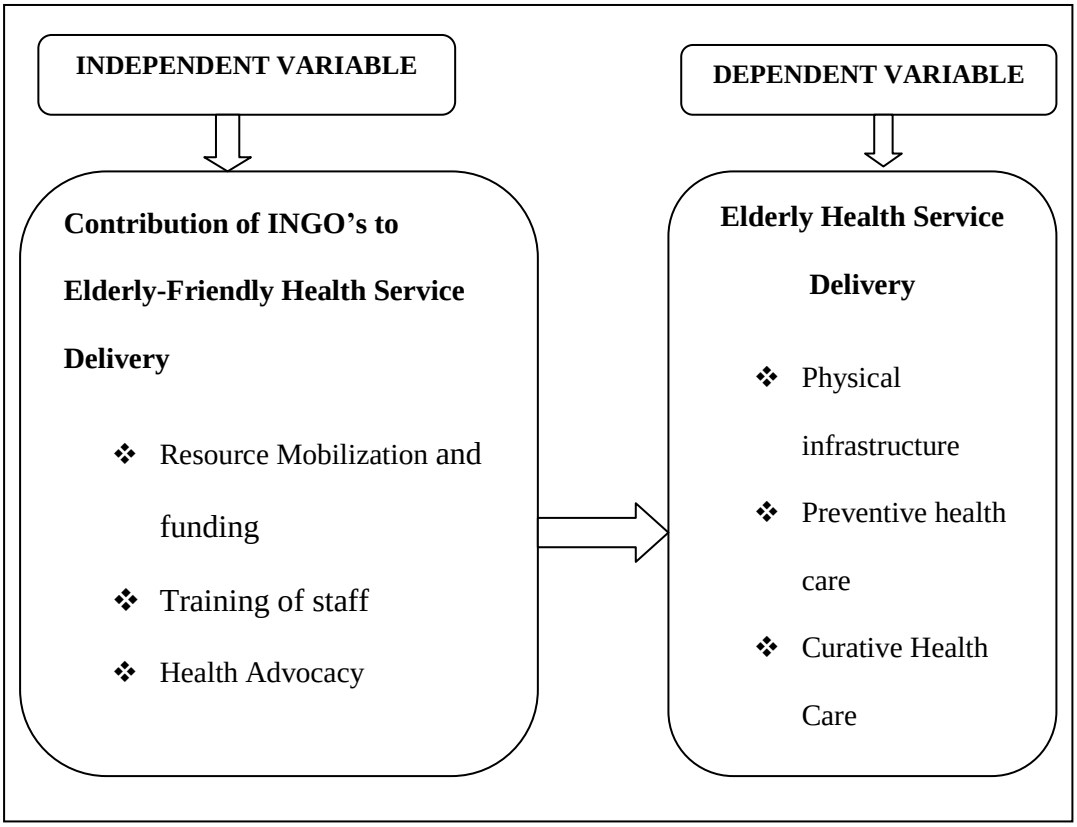
Curative care for the elderly is delivered through the standard primary-to-tertiary health services. Divisional hospitals provide both inpatient and outpatient care and primary medical care units offer only outpatient care with non-specialist doctors and allied staff. Although not specifically aimed at elderly patients, specialist health services such as cancer care, eye care, dental care, cardiology, psychiatric care and disability care and rehabilitation treat patients in the older age bracket this is conducted through advocacy ways. Non-communicable diseases have become one of the leading causes of morbidity, mortality, disability and hospitalization among the older people (Human Rights Commission and HelpAge, 2014). Several planning are in progress to improve provision of health service. Elderly-friendly wards in hospitals, and health clinics for the elderly, are planned at the district level in state-sector health institutions. Establishment of a health institution as a centre of excellence for geriatric care in the country is also in progress. Stroke units have been established in many health institutions in the country and the aim is to establish a stroke unit in each district general hospital and a stroke centre in each province (Policy Analysis and Development Unit, 2013).

Therefore given the growing demands for curative services for the elderly population, it is timely to rethink the health infrastructure to include general

practices to manage curative services in the community and reduce pressures on higher-level services.

Both variables reflect a new conceptual model of healthy ageing that is built around the functional ability of older people to do the things they value, rather than around the absence of disease.

Figure 1: **Conceptual Framework**



Source: Researcher's own illustration, 2018

2.7 Chapter summary

Chapter two has reviewed literature on contribution of International Non-Governmental Organizations in promoting elderly-friendly health service delivery in Tanzania. By using regime theory on supporting this study elderly still face difficulties to accessing health service on time.

The importance of International Non-governmental Organizations (INGOs) in the delivery of services is gaining momentum in increasing the recognition not only to complement government programmes, but also to provide elderly with a choice of service outlets and to create an effective voice in respect to service needs and great expectations. Elderly-friendly health service delivery is not only a national problem but also a global problem and it has persisted despite several initiatives directed to reduce it. Furthermore, Chapter two has laid the foundation for Chapter three that presents the research methodology adopted in this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

According to Kothari (2004), research methodology is a way of systematically solving a research problem. This chapter introduces the methodology adopted in the study. It begins with study area and its description, research design, research approaches, target population and sampling frame. The chapter also covers sampling techniques, sample size, sources and methods of data collection, data processing, analysis and presentation, data analysis, data types/variable collected as well as validity and reliability of study and ethical consideration.

3.2 Study Area

This study was conducted in Morogoro Municipal council, Morogoro Region, Tanzania. The study area was purposively selected because it had more than 7 NGO's handling issues of elderly people (MMC, 2011). Further, two wards were selected Sabasaba and Kilakala wards that were receiving help from HelpAge Tanzania. The wards were chosen purposefully first based on their proximity to the Central Business District (CBD) whereby Sabasaba is relatively close to the CBD while Sabasaba is inclined to the periphery and secondly the based on demographic and infrastructural reasons . For instance Sabasaba was chosen given the fact that the congested population was as a result of the displacements made during the creation of land for the construction of the new city while Kilakala is inaccessible in terms of road network. Morogoro Municipality covers an area of 531 km2 (MMC, 2012).

3.2.1 Description of the Study Area

The Morogoro municipality headquarter is located at latitude 6^0 49‘S and longitude 37^0 40‘E, approximately 195km west of Dar es Salaam. Morogoro experiences an average daily temperature of 300 C with a daily range of about 5^0 C. The minimum temperature is during June to August period when the temperatures goes down to about 16^0 C. The mean relative humidity is about 66% and drops down to as far as 37%. More so, the total average annual rainfall ranges between 821mm to 1,505mm (URT, 2012). Major economic activities include industries of primary and secondary level, subsistence and commercial farming, small scale enterprises and commercial retail as well as wholesale. Administratively, Morogoro Municipality has one division, 29 Wards and 272 streets popularly known as Mitaa (streets) with a population estimate of 387, 945 people (MMC, 2012).

3.3 Research Design

A research design is a plan of action designed to achieve a specific goal (Denscombe, 2010). This study employed a case study method. Case study method refers to an in-depth, detailed study of an individual or a small group of individuals (Benard and Bernad, 2012). The case study method involves observing what happens to or reconstructing the case history of a single participant or group of individuals (for instance, school class or a specific social group) (Macleod, 2018). That is the idiographic approach. Significantly, case studies allow a researcher to investigate a topic in far more detail than might be possible if they were trying to deal with a large number of research participants (nomothetic approach) with the aim of ‘averaging (Carla, 2001).

According to Hayes (2000), the main characteristics of the case study method are as follows; (1) It is a descriptive study, this characteristic can be elaborated as follows; (a) is the data collected constitute descriptions of psychological processes and events and of the contexts in which they occurred also called qualitative data. (b) The main emphasis is always on the construction of verbal descriptions of behavior or experience although quantitative data can be collected. (c) High levels of detail are provided. (2) Narrowly focused and this characteristic can be explained also as follows; (a) typically a case study provides a explanation of only a single individual and sometimes about groups. (b) a case study focuses on a restricted aspect of people such as their psychopathological symptoms. (3) Combines objective and subjective data; these two characteristics can be identified in the following context; (a) the researcher may combine objective and subjective data: all are regarded as valid data as a basis for inferences. (i) The objective explanation of behavior and its context. (ii) Details of the subjective aspect such as feeling, belief, impression and interpretation. In fact, a case study offers a means of attaining an in-depth understanding of the behavior and experience of people

3.3.1 Research Approaches

The study used both quantitative and qualitative approaches. Quantitative approach involves the generation of data in numerical/quantitative form which can be used to answer the question of how much and to what extend also to establish relations and predictions (Marczyk, 2005). Quantitative research approach was used to gather numerical data such as the age of the respondents and number of dependants. This information was supplemented by qualitative data allowing the researcher to obtain additional information that was accidentally omitted from the research questions or

for clarifications. The approaches utilized a combination of data collection methods such as structured interview, observations and Focused Group Discussion,

3.3.2 Target population and Sampling Frame

Population means a group of items that samples are drawn from (Diamantopoulos, 2004). The targeted population for this study was all older people who are vulnerable and benefited from the health services from the HelpAge International. Others included HelpAge officers at Morogoro, Morogoro municipal council officials and community members where HelpAge operates.

The sample frame in this study was older people in their ageing centers and those that were receiving aid from HelpAge. The sample frame was obtained from respective aging centers.

3.4 Sampling Techniques and Sample Size

This section presents sampling techniques and sample size adopted in this study. Sampling techniques included probability and non-probability sampling techniques. The sample size is also presented in this section.

3.4.1 Sampling Techniques

The sampling techniques that was applied in this study was both probability and non-probability sampling in order to obtain respondents from members (older people in ageing centers), government officials and other key informants in the study area (population).

By using probability sampling, each element in the population is given an equal and independent chance of selection (Kumar, 2011). Simple random sampling was used

to select older people who were vulnerable and benefited from the health services supported by HelpAge International and community members. In non-probability sampling, the items of the sample are selected deliberately by the researcher. Purposive sampling was used to select the district, wards, villages and key informants since it enables a researcher to pick sites and respondents who are useful in data collection for research finding.

3.4.2 Sample Size

Sample size for this study comprised of 43 elderly people, who were randomly selected from a sample frame obtained from officials of the two wards from aging centers. The simple size selected was based on Bailey (1998) who affirms that a minimum 30 cases are enough for statistical analysis.

Table 1: Respondent distribution

Participants Category	Number of Respondents
HELPAGE International Officers	03
Elderly People	43
Heads of Ageing Centers	02
Municipal Council Officers	02
Community Members	10
Total	**60**

Source: Researcher's own construction, 2018.

3.5 Sources and Methods of Data Collection

This section presents sources and methods of data collection. Sources of data include primary and secondary sources of data. On the other hand, methods of data collection include survey, interview and Focus Group Discussion (FGDs).

3.5.1 Sources of Data

The study employed both primary and secondary sources of data. Primary data is the first hand information which is collected by a researcher directly from the respondents through interview, observation and survey methods (Kothari, 2004). Primary data was collected from older people and key informants. On the other hand, secondary data is second hand information collected by researchers through reading various written documents which are related to the problem under study (Lincoln & Guba, 2002). The secondary data for this study was obtained from different documents, both published and unpublished like books, journals, reports, newspapers, articles and online sources.

3.5.2 Methods of Data Collection

3.5.2.1 Survey Method

The study adopted the use of a questionnaire as a tool to collect data during the study. A questionnaire is an instrument which consists of a number of questions printed in definite order (Kothari, 2004). A questionnaire containing a set of both open and close-ended questions was used to collect data (Appendix 1). A questionnaire was used since it allows the collection of data from many respondents in a short period of time; it allows respondents to freely respond at their own appropriate time thus grants privacy.

3.5.2.2 Interview Method

Interview guide was used in this study to collect data from key informants in the proposed study area. Interviews were conducted on key informants to obtain in-depth information on the research problem. Interview guides were used in guiding (Appendix 2 &3).

3.5.2.3 Focused Group Discussions (FGDs)

The researcher formed 2 FGDs one from elderly care center of the two care centers involved in the study. Each FGD composed of 6 members drawn from the same care center with total of 12 members. The FGDs were moderated by the researcher in discussing research questions/topics as guided by the use of a check list (Appendix 4). The FGDs were used to collect primary qualitative data since it provides an open, fairly unrestricted forum for individuals to discuss ideas and to clarify each other's impressions and opinions. The researcher employed note taking to collect data from FGDs.

3.6 Data types/variables collected

In order for the researcher to answer the research questions, the following data/variables were gathered from the field per objective. The preliminary information collected include respondents' age, sex, education level, marital status, religion, economic activities, whether respondents had dependents, diseases they receive treatment from HelpAge and alternative ways of treating the diseases that are not treated at HelpAge.

3.7 Data Processing, Analysis and Presentation

3.7.1 Data processing

Data processing implies editing, coding, classification and tabulation of collected data so that they are amenable to analysis (Kothari, 2004). The collected data were processed and verified prior to analysis. Data was edited to detect possible errors and the errors were omitted before coding into numerical and classified to make them amenable for interpretation and then entered into a computer for analysis.

3.7.2 Data Analysis

Data analysis refers to examining what has been collected in a survey or experiment and making deductions and inferences (Kombo & Tromp, 2006). Content analysis was adopted for qualitative data that was collected from FGDs which was grouped into themes, summarized and analyzed manually. On the other hand, the quantitative data collected by questionnaire was coded and processed using the Statistical Package for Social Sciences (SPSS) computer software application version 20. Descriptive statistics in the form of frequencies, percentages, percentages and cross-tabulation was employed.

3.7.3 Data Presentation

Results of the analyzed data are presented in chapter four using tables, figures and word texts. The presentations were interpreted and are provided as findings in the document. The conclusions and recommendations were drawn from the findings and discussion results.

3.8 Validity and Reliability of Study

This section presents validity and reliability of the study. The collected data were edited to eliminate errors and omission done during data collection. This was conducted in order to attain completeness, accuracy and uniformity of the study.

3.8.1 Validity

Validity is the ability of an instrument to measure what is designed to measure (Kumar, 2011). Similarly, Babbie (1989) defines validity as the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration. In other context, validity is the extent to which any measuring instrument measures what it is intended to measure (Thatcher, 2010, p.125). The

reason is to attain the completeness, accuracy and uniformity. In this study, validity was achieved in various ways as suggested by Kothari (2004). Firstly, through carefully formulation of questions and pre-testing of questionnaire and interview guide to make sure that the questions are clear and possible problems are identified earlier so as to find solutions on how to overcome them easily. Secondly, the collected data was edited so as to identify and eliminate errors and omission done during data recording.

3.8.2 Reliability

Reliability of the study is the extent to which other researchers arrive at similar results if undertake study with the same case using exactly the same procedures as the first researcher (Kothari, 2004). Reliability for this study was achieved by pre-testing of the questionnaires and making necessary corrections before the actual data collection. This enabled the researcher to identify possible errors and make necessary changes in questions formulation before the actual data collection exercise. Further, data was collected using the same questionnaire on same category of respondents.

3.9 Ethical Consideration

Ethics is a system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations (Bhattacherjee, 2012). Relevant authorities were conducted for permission to collect data. They include University authorities, Mororgoro district authorities and Morogoro municipal authorities right from the director to the village chairpersons. Informed consent was sought prior to the respondent's participation. Respondents were informed of their right to participate or not, withdraw their participation at any stage

during the interviews and the possible dangers and benefits of engaging in the research study. For confidentiality purposes, the researcher will not disclose directly any information provided in this study to third parties, unless permission has been granted to do so. During analysis and data presentation, the researcher was obliged to avoid biases and reported the findings as they were whether unexpected or negative.

3.10 Chapter Summary

Chapter three presented the research methodology adopted in this study. The Chapter three started with the selection of Morogoro Municipality as a study area and its justification following the consideration of being on contributions of International Non-Governmental Organizations on promoting health service delivery. Furthermore, a case study research design was employed in this study. Research approaches included both qualitative and quantitative research approaches in data collection. Target populations were elderly people and sampling frame constituted elderly people in two wards. Sampling techniques employed in this study were both probability and non-probability sampling techniques. Sample size constituted 60 respondents including 43 elderly, 03 HelpAge international officers, 02 Heads of aging centers, 02 Municipal council officers and 10 community members. Also sources of data included both primary and secondary sources, while methods of data collection included survey, interview and Focus Group Discussion (FGDs) methods. Data analysis was based on content analysis for qualitative data collected from interviews, while quantitative data collection from questionnaire were coded and processed by using SPSS version 20 computer software application. To ensure validity and reliability of the study. Through chapter three the researcher

has demonstrated that challenges in research can be used as opportunities to attain completeness and accuracy of the study. Furthermore, chapter four presents the research findings and discussions.

CHAPTER FOUR

PESENTATION OF RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents and discusses results relating to the subject of study. The discussions are based on research objectives which include: To examine the role of INGOs in resource mobilization and funding to improve physical health infrastructures in Tanzania; To investigate the extent of facilitating training of staffs in preventive health services for the elderly in Tanzania and to investigate the efficacy of the INGOs advocacy in enhancing curative services for elderly people in Tanzania

4.2 Respondents' personal characteristics

The personal characteristics of respondents considered include sex, age, education, marital status and religion.

4.2.1 Sex

The results (Table 2) show that 51.2% respondents were male. The higher proportion of male might be due to death of their wives. This may imply the need for special attention on preventive measures on the diseases that commonly affect men in their old age to reduce curative expenses. In Sabasaba ward, 52.4% respondents were female. The higher proportion of women may imply that older women in the area are widows. This may imply the need for special attention on diseases that affect women in their old age.

Table 2: Respondents' personal characteristics

Variable	Description	Respondents (%)		Overall (%)
		Sabasaba (n = 21)	**Kilakala (n = 22)**	**(N = 43)**
Sex	Male	47.6	54.5	51.2
	Female	52.4	45.5	48.8
Age (years)	60 – 67	19.0	18.2	18.6
	68 – 75	28.8	50.0	39.5
	76 – 83	23.8	13.6	18.6
	84 – 91	23.8	18.2	20.9
	92 – 99	4.8	-	2.3
	Mean (years)	**76**	**74**	**75**
Education	Informal	38.1	40.9	39.5
	Primary	47.6	45.5	46.5
	Secondary	4.8	4.5	4.7
	Tertiary	9.5	9.1	9.3
Religion	Christianity	57.1	59.1	58.1
	Islam	42.9	40.9	41.9
Marital status	Single	4.8	9.1	7.0
	Married	28.6	54.5	41.9
	Divorced	19.0	13.6	16.3
	Widowed	47.6	22.7	34.9

Source: Fieldwork, 2018.

4.2.2 Age

The results (Table 2) show that 39.5% respondents were aged between 68 and 75 years. The reasons might be due to the fact that at that age bracket, most elderly people are strong hence least exposed to opportunistic diseases hence alive or at this age some are widowed, abandoned and hence joining associations/organizations for aid. Those aged between 92 and 99 years (4.8%) were in Sabasaba only. The reason may be associated with better living

standards based on their close proximity to the Central Business District (CBD) hence availability of basic services. This implies that access to basic services may lead to longevity of life.

4.2.3 Education

The results (Table 2) show that majority (86%) had primary education and below this may be due to the since education during those years schools were very few and not easily accessible. This implies the limited understanding on diseases prevention methods thus calling for awareness creation efforts. The proportions of those with primary, secondary and tertiary educations are higher in Sabasaba compared to Kilakala. This might be due to the fact that Sabasaba is more of an urban area than Kilakala hence easy access to education. This implies that the understanding of Sabasaba of disease prevention ways is higher than Kilakala. This calls for additional efforts in training the residents of Kilakala

4.2.4 Religion

The results (Table 2) show that more than half (58.1%) of the respondents in the study area were Christians. This may be associated with the invading of missionaries in the area during colonial period. This may imply different perception on ways to treat and prevent diseases based on religious faith. Therefore different religions may have positive and negative impacts on promoting elderly healthcare delivery.

4.2.5 Marital Status

The overall results (Table 2) show that many (41.9%) of the respondents were married. The reasons might be due to their higher age that requires them to get married according to the African customs and traditions. This implies the presence

of elderly caretakers especially the sick elderly people. The results indicate that (34.9%) respondents were widowed (47.6%) of the respondents in Sabasaba were widowed. This might be associated with HIV/AIDS prevalence in urban area thus affected areas like Sabasaba. This implies the need for the government, organization dealing with elderly issues and other stakeholders to pay special attention to issues affecting elderly people such as health service delivery.

4.3 Respondents' economic activities

4.3.1 Farming

The results (Table 3) show that majority (90.9%) of older people in Kilakala ward were engaged in farming activities compared to Sabasaba (57.1%). The reason might be due to land use conversion in Sabasaba due to urbanization processes. This implies that livelihood interventions and entrepreneur skills in non- farming livelihood activities in Sabasaba should be given a priority in enabling the aged people to cater for their basic needs and health services.

4.3.2 Livestock keeping

The result (Table 3) shows that many (68.2%) respondents in Kilakala were livestock keepers. The higher proportion of livestock keepers in Kilakala compared to Sabasaba may be associated with availability of grazing land in peri-urban areas as opposed to urban areas like Sabasaba. This implies that most elderly people in Kilakala are more likely to have an extra source of income and better dietary supplements than in Sabasaba.

Table 3: Respondents' economic activity

Variable	Description	Respondents (%)		Overall (%)
		Sabasaba (n = 21)	Kilakala (n =22)	(N = 43)
Economic Activity	Farming	57.1	90.9	74.4
	Livestock	47.6	68.2	58.1
	Business	52.4	40.9	46.5
	Employment	4.8	4.5	4.7

Source: Fieldwork, 2018

4.3.3 Business

The results (Table 3) show that those engaged in business activities were almost half (52.4%) in Sabasaba ward. the reason may be due to the availability of infrastructural services like transport, communication and market center in urban areas. This implies that intervention in business will enable the elderly be economically stable hence capable of obtaining basic needs and health serviced.

4.3.4 Employment

The results in (Table 3) show that only (4.7%) respondents were employed. This is because most elderly people had already attained a retirement age. Sabasaba recorded an higher proportion (4.8%) compared to Kilakala (4.5%) This might be due to the available opportunities for employment activities in Sabasaba based on its close proximity to Municipal center (CBD). This implies that relevant stakeholders in providing elderly services should consider Kilakala ward in providing elderly healthcare services and other basic requirements.

4.4 Respondent' dependants

The results (Table 4) show that many (67.4%) elderly people had dependants. This might be due to the migration or death of their children or close relatives leaving behind dependent children or orphans. The burden of taking care of orphans may imply the need for relieving them of other costs such as medication. This calls for urgent provision of government and other stakeholders' intervention to create awareness and provide help to elderly people. Kilakala had a higher proportion (77.3%) compared to Sabasaba ward (57.1%) even though it's located at an urban center. A possible explanation for the higher dependant proportion in Kilakala might be associated with the migration of parents to urban areas in search for jobs leaving behind their children to be taken care by their aging parents or grandparents. Further, the result indicates that many of the respondents (41.9%) have between 1 and 5 children.

Table 4: Respondents' dependant status

Variable	Description	Respondents (%)		Overall (%)
		Sabasaba (n = 21)	Kilakala (n =22)	(N = 43)
Having dependants	Yes	57.1	77.3	67.4
	No	42.9	22.7	32.6
Number of dependants	1 – 5	41.7	59.1	41.9
	5 >	58.3	18.2	25.6

Source: Field Work, 2018

4.5 Roles of INGOs in resources mobilization and funding to improve physical health infrastructure in Tanzania

Specific objective number one was designed to examine the roles of INGOs in resources mobilization and funding to improve physical health infrastructure in Tanzania. This section covers areas of concern, diseases treated by HelpAge International, diseases that are not treated by HelpAge International as well as financial needs and usage.

4.5.1 Areas of concern

The information received from HelpAge officials at the study site indicates that the support they are receiving from donors is directed to two main areas of concern. First, the resources mobilized and funds are directed towards mobilizing older people to facilitate access to equitable and affordable healthcare and secondly, towards advocacy on universal pension reform. HelpAge international has helped them support health facilities deliver age-friendly health services. The organization in partnership with local government of Morogoro has been actively purchasing medicines to two local dispensaries with a view of making available medicines that are directly linked to older persons. To achieve this quest, HelpAge have an annual budget of 12 million shillings that is allocated to the two dispensaries (6 million each) for the purchase of medicines and they occasionally supplies them with medical equipments when need arises. In other cases they cost share medical personnel costs. The Director of one HelpAge center said,

> *Our interest is in elderly health issues; we have been supplying medicine, buying medical equipment and supplying and training*

medical personnel on elderly medical issues to two local dispensaries through the aid of our donors and local well wishers.

The organization has an emergency aid center to treat those who need medical aid urgently before they are transferred to referral hospitals. The organization also comes handy in cases where medical personnel especially those to attend to the elderly people are needed. They achieve this goal through cost sharing with local government in cases of local government dispensaries.

In addition, the organization has its own medical facility where elderly persons from the nearby areas in their center receive medical services.

4.5.2 Diseases treated by HelpAge International

The results Table 5 show the common diseases that are treated at HelpAge International of the fourteen diseases, those with highest proportion of respondent are hereunder discussed. I will undertake to discuss two most prevalent diseases i.e. High Blood Pressure and Eye Loss.

4.5.2.1 High Blood Pressure (HBP)

The results (Table 5) show that (45.5%) of elderly people in Kilakala ward had received High Blood Pressure (HBP) treatments at HelpAge international. The higher proportion might be associated with numerous challenges faced by the elderly people in remote areas compared to urban areas. This calls for urgent measures to help the elderly people in remote areas in matters of stress. This is the case since HBP may weaken the body immunity making most elderly people vulnerable to opportunistic diseases.

Table 5: Diseases treated at HelpAge by respondents

Variable	Description	Respondents (%)		Overall (%)
		Sabasaba (n = 21)	Kilakala (n =22)	(N = 43)
Diseases	**HBP**	19.0	45.5	32.6
	Eye loss	42.9	36.4	39.5
	Arthritis	-	27.3	14.0
	Heart disease	9.5	13.6	11.6
	TB	28.6	-	14.0
	Diabetes	14.3	4.5	9.3
	Cancer	4.8	27.3	16.3
	Asthma	19.0	4.5	11.6
	Iliac	28.6	13.6	20.9
	Parkinson	9.5	9.1	9.3
	Stroke	4.8	18.2	11.6
	Prostate	23.8	9.1	16.3
	Ear	9.5	4.5	7.0
	Amnesia	-	13.6	7.0

Source: Field Work, 2018

4.5.2.2 Eye Loss

The results (Table 5) show that few (42.9%) of elderly in Sabasaba ward reported to have been treated eye loss problems by HelpAge international programme. This is the most prevalent diseases of all the fourteen listed as seen from the table. The higher proportion in Sabasaba might be associated with scarcity and costs of green vegetables and other dietary nutrients necessary to preventing the disorder in towns compared to remote areas. This calls for emphasis on trainings on preventive measures and gardening skills to enable elderly people to obtain cheap dietary compliments to alleviate the problems associated with buying vegetables.

4.5.3 Diseases that are not treated by HelpAge

The result (Table 6) shows options taken in the case of those diseases that are not catered for by HelpAge. The results indicate that 62.8% use their own cash for treatment where by 68.2% of those are from Kilakala. The high proportion of respondents in Kilakala may be associated with alternative income sources such as livestock keeping, farming, business and remittance from employed children in towns.

Table 6: Alternative medication options

Variable	Description	Respondents (%)		Overall (%)
		Sabasaba (n = 21)	Kilakala (n =22)	(N = 43)
Means of treating them	Own cash	57.1	68.2	62.8
	No means	42.9	31.8	37.2

Source: Fieldwork, 2018.

4.5.4 Financial needs and usage

HelpAge International in partnership with local organizations have a stretched budget but manages on the little available. Currently, HelpAge Morogoro has a budget of £ 400,000 annually from HelpAge which was used in various areas of the organization's operations. The usage of the funds is predetermined by both HelpAge and HelpAge partner members at the beginning of each financial year.

4.6 The extent of facilitating training of staff in preventive health services for the elderly in Tanzania

Specific objective number two was designed to investigate the extent of facilitating trainings of staffs in preventive health services for the elderly in Tanzania. This section covers training staffs on health skills for preventive health services and training of elderly people on health skills for preventive health services.

4.6.1 Training of staff on health skills for preventive health services

The contribution of INGO's in the study site was in the areas of, among others, environmental health, sanitation, immunizations, nutrition, control of intoxicants and screenings. These skills were either imparted directly to the doctors, nurses and other health professionals. Besides, trainings considered the community with the aim that the elderly being part of the community, they will benefit in the end. The policy programme of INGOs has two objectives for health education: to "increase public knowledge and understanding on mode of spread and preventive measures of all diseases up to the community level.

More so, environmental health skills/trainings concentrated on proper disposing of refuse such as empty cans that may be a breeding zone for mosquitoes and the clearing of bushes and grass around houses. One of the respondents said:

> *We have been trained on how to prevent malaria and other diseases by keeping older peoples' environment clean. Though sometimes elders are unable to do it but by cooperating with my staff members we carry these responsibilities accordingly from the*

training we acquired. They (INGO) also gave us mosquito nets that we gave them to use at night as an extra protection.

4.6.2 Trainings of elderly people on health skills for preventive health services

Elderly people were involved also in trainings on preventive health services for the elderly people. The result in Table 7 summarizes some of the health skills for preventive health services provided by HelpAge International in Morogoro.

Table 7: Health Skills for preventive services by HelpAge International

Variable	Description	Respondents (%)		Overall (%)
		Sabasaba (n = 21)	Kilakala (n =22)	(N = 43)
Training services	**Exercises**	38.1	72.7	55.8
	Nutrition	47.6	63.6	55.8
	Hygiene	28.6	54.5	41.9
	Immunization	38.1	13.6	25.6
	Screening	34	28	28.7

Source: Field Work, 2018

4.6.2.1 Physical Exercises

The results in Table 7 show that 55.8% of the elderly respondents reported to have received physical exercise trainings and they are practicing in their weekly meetings. They included both men and women in aging groups which were formed to promote healthy lifestyle through regular exercise and tackle harmful practices such as smoking and drinking. The reasons for the physical exercise are to prevent diseases such as high blood pressure, stress and obesity.

An elderly participating in the weekly physical exercise had this to say:

> *Since I started exercising, I am much better now. I don't have depression anymore or high blood pressure. I am also physically fit again. I find comfort in the group. I have company so I don't feel lonely. I also get information about my rights. Now I know I should get free healthcare*.

The established active aging groups provide a forum through which older people share health information and undertake physical exercise, have joint meetings with the NGO health staff to discuss health issues.

4.6.2.2 Nutrition/ Dietary

The results (Table 7) shows that about half (55.8%) reported to have received dietary trainings as a way of preventing diseases. The respondents reported to have been taught on balanced diet coupled with physical exercises. The diseases they reported to have been taught will be prevented include eye loss by eating fresh carrots and green vegetables. One key informant respondent had this to say,

> The *NGOs have taught the elders and the entire community on eating a balanced diet with the aim of preventing nutritional deficiency diseases such as goiter, eye problems and malnutrition that may reduce their immunity to diseases.*

4.6.2.3 Hygiene/Sanitation

The result in Table 7 shows that 41.9% elderly respondents reported that they were taught sanitation measures by HelpAge International. The few respondents'

proportion is due to the fact that most elderly people suffer from memory loss or semi-literate. As noted by HelpAge director

> *The sanitation efforts are individual based and INGO based. On the individual part for instance, elderly people are strictly taught to use pit latrines which were dug and built by* HelpAge *while the NGO has a duty of helping the elderly people in building the pit latrines and at times provide them with soap that will be used in washing hands after using the latrines.*

4.6.2.4 Screening

The results in Table 7 show 28.7% of the respondents reported to have received and attended screening sessions. The few respondent proportions are due to superstitious beliefs by most elderly people given their age. This implies that awareness creation is crucial to prevent diseases such as cancer. Failure to provide necessary awareness will see many elderly people succumbing to preventive diseases. A representative from HelpAge had this to say:

> *HelpAge Tanzania and partner NGOs have been working to improve the prevention of Non Communicable Diseases (NCDs) especially Diabetes, cancer and stroke which are common in advanced age. The organization has been using screening as one method of achieving this goal through the training of health workers in the early diagnosis/screening.*

Table nine gives a summary of results as given by various respondents in the study area. The results indicate that all the sources contacted confirmed that the services related to health indicated as being provided by HelpAge indeed were being

provided despite the fact that the study did not assess the quality of the services provided.

Table 8: Summary of trainings services offered by HelpAge to elderly

Type of training	Respondents (% or tick where applicable)			
	Elderly	Key informants	FGDs	Documentary review
Physical Exercises	55.8	✓	✓	✓
Nutrition	55.8	✓	✓	✓
Hygiene	41.9	✓	✓	✓
Immunization	25.6	✓	✓	✓
Screening	28.7	✓	✓	✓
Control of intoxicants	✓	✓	✓	✓

Source: Fieldwork, 2018

4.7 To investigate the efficacy of the INGOs advocacy in enhancing curative services for elderly people in Tanzania

The objective number three was to investigate the efficacy of the INGOs advocacy in enhancing curative services for elderly people in Tanzania. In fact, the INGOs' participation in advocacy role in enhancing curative services does not only create awareness in order to influence policy process but also the provision of expert services, advice and decision-making in the policy process. Their advocacy will increase efficacy in reducing waiting time for the elderly looking for health service. Also their advocacy will increase better care to the elderly because they have government support for those with health insurance. Through methods of achieving advocacy health workers are now seriously considering elderly health problems. The strategy used to advocate for change in each case by HelpAge has involved a parallel combination of efforts to achieve national-level policy reforms by working

with the central government, along with efforts to achieve change at the local level by engaging local governments and communities of older people. In order for HelpAge to achieve its curative advocacy it has also trained peer educators on issues of concern to older people so that they can put these issues onto the agenda of the councils in their localities. The advocacy and the training of peer educators focuses on the areas discussed hereunder.

4.7.1 Areas of advocacy

HelpAge together with partner members' target areas in older people's issues is best explained by HelpAge official who said:

> *Our advocacy focuses on mobilizing older people to facilitate access to equitable, affordable healthcare and empowering the elderly people to claim their rights and seek protection from violence and discrimination. Further we advocate for the issuance of National Hospital Insurance Fund (NHIF) and Community Health Fund (CHF) medical cover to the elderly and their dependants.*

Health Insurance

The study sought to understand the status of elderly medical cover in the study area. The result (Table 9) shows that about half (53.5%) respondents had no health insurance cover. Most respondents (61.9%) of who contrary to expectations come from Sabasaba ward. The reasons why most people lack health insurance cover might be ignorance, negligence or financial problems. The higher proportion in Sabasaba may be associated with the readily available medical centers in town that

has made elderly people not to bother since they can readily secure medication with no extra costs such as transport as in the case of remote areas like Kilakala ward.

Table 9: Respondents' medical insurance cover status

Variable	Description	Respondents (%)		Overall (%)
		Sabasaba (n = 21)	Kilakala (n =22)	(N = 43)
Health Insurance	Yes	38.1	54.5	46.5
	No	61.9	45.5	53.5

Source: Field Work, 2018

4.7.2 Ways of achieving curative advocacy

Some of the methods used in achieving curative advocacy include training elderly peer educators, public hearings, written presentations, media campaigns and representation in relevant governmental committees. The results in Table 10 show that 82.2% of the respondents are aware of the peer educators as a method used to achieve curative advocacy. This is because the peer educators are chosen among them to represent them in various levels advocating for their rights and agendas then give them feedback.

The result further shows that only 18.7% respondents are aware that the elderly have a representation in government committees. This is because the representative chosen is an influential government retiree preferably a member of government to advocate of elderly issues in various government committees.

Table 10: Methods used by HelpAge to achieve curative advocacy

Type of advocacy	Respondents (% or tick where applicable)			
	Elderly	Key informants	FGDs	Documentary review
Peer educators	82.2	✓	✓	✓
Public hearings	75.7	✓	✓	✓
Written presentations	62.3	✓	✓	✓
Media campaigns	23.4	✓	✓	✓
Representation in government committees	18.7	✓	✓	✓

Source: Fieldwork, 2018

The rest of the sources of data are aware given the fact that key informants and documentary are always informed and updated respectively.

4.7.3 Stakeholders in collaboration and roles played

In order for HelpAge to achieve its objectives in helping vulnerable elderly people in Tanzania and Morogoro in specific, the organization works closely with other stakeholders at various levels. A summary of stakeholders and role played is presented in Table 11.

Table 11: Stakeholders and their role in curative advocacy

Stakeholder	Role played (tick where applicable)			
	Financial	**Personnel**	**Medicine**	**Infrastructure**
Donors	✓	✓	✓	✓
Central Government	✓	✓	✓	✓
Local government	✓	✓	✓	✓
CSOs		✓		✓
Elderly people		✓		
Religious organizations	✓	✓		✓

Source: Fieldwork, 2018

4.7.4 Chapter Summary

Chapter four presented the discussions from the findings that were started by characteristics of respondents in which it has shown that, sex of elderly respondents, age, education level, marital status and religion have effect on contribution of INGOs in promoting elderly-friendly health service delivery. Besides, Specific objective number one was designed to examine the roles of INGOs in resources mobilization and funding to improve physical health infrastructure in Tanzania. This section covers areas of concern, diseases treated by HelpAge International, diseases that are not treated by HelpAge International as well as financial needs and usage. The results on objective one revealed that elderly have benefited from the resources mobilized and funding assistance from INGOs. Objective two has discusses the extent of facilitating training of staff in preventive health services to the elderly people. The results on objective two revealed that elderly diseases have been decreased due to the physical exercises that they have been taught by health staff. Objective three has discusses the efficacy of the INGOs advocacy in enhancing curative services for elderly people. The results on objective three revealed that

elderly issues especially in health were paid greater attention at national and international level in which elderly were served first with free access to health services in health centers with no discriminations as well as they have been provided with health insurance. The following Chapter winds up the dissertation by presenting summary, conclusions and recommendations of the study.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introductions

This study was conducted with the main aim of examining the contribution of International Non-Governmental Organizations in promoting elderly-friendly health services delivery in Tanzania. The conclusion and recommendations made are based on research findings. Further this chapter presents recommendations and areas that need further research.

5.2 Summary of key findings

The study was generally aimed to examine the contribution of INGOs in promoting elderly-friendly health service delivery in Tanzania. First specific objective explored INGOs contribution to resource mobilization and funding in improving physical health infrastructure. Arising from the analysis of data it was revealed that the majority of elderly benefited from INGOs contributions in improving physical health infrastructure that helped them access health services easily and attending screening sessions and medicine provisions, their contributions had impacted elderly health through well improved physical health infrastructure by INGOs. For instance leading to universal health coverage initiatives in resource mobilization and financing mechanisms have paved the way in demonstrating effective processes for effective and meaningful INGOs contributions, and have documented results from the majority the contribution efforts lead to improvements in reaching elderly and vulnerable communities, utilization of funds, and later on health outcomes. About half of the officials noted that INGOs to date in elderly-friendly health service delivery have already yielded positive results, such as the strengthening of health

facilities through medicine provisions and clinical programmes. The majority of officials noted that their competencies in regard to budgeting and proper record keeping had been enhanced to a level where they were able to account for all the monies given to them by donors. However, this ensured proper utilization of resources and funds to the benefit of their client's areas of concern.

This can be concluded that the effective mobilization of resources and funds from external donors and governments have been increasing support in material equipments and funding of projects to health facilities for better improvement of elderly health environment.

The second specific objective numbers explored INGOs contribution to INGOs on facilitating training to staff in improving preventive of diseases to elderly. This had improved preventive ways for the diseases facing elderly people. Majority of elderly people were involved in learning ways of prevention from the trainings of staff and that have been strengthening their physical health keeping their brain active. And where about half of the officials noted that exercises provided by health staff had reduced the mobility from elderly people and keep them understanding from preventive ways of their diseases.

This concluded that trainings of staff have reduced the number of older people who suffered for so long. Through physical exercises have been practicing their make their bodies fit. The aims of establishing this were to promoting healthy lifestyle and keep themselves aware of prevention and managing chronic diseases.

Third specific objective number three explored the efficacy of INGOs advocacy in improving curative services to elderly people. Also from the data analysis one of the

officials noted that the INGOs developed and Strengthened national advocacy through training of peer educators, public hearings, written presentations, national NGOs Coalitions, and Social Medias that lead to accountability efforts in claiming rights to health and protection. From the findings result shows that only 18.7 % were aware that the elderly have a representation in government committees. This had championed for better improvements in curative services to the elderly people. The Partnership for elderly health, the external donors group, as well as other partners, will be at the heart of efforts to strengthen advocacy means for elderly-friendly health services delivery. Country governments must work in partnership with CSOs to operationalize the principles and standards outlined in the implementation of the national aging policy for free access to elderly health services and the need for independent monitoring and accountability must be recognized and prioritized.

This concluded that advocacy has been ensuring the older people acquire quality, standard and equal curative services in health facilities without any discrimination.

5.3 Conclusion

The study concluded that INGOs are highly engaging in promoting elderly-friendly health service delivery. From objective one the study concluded that resource mobilization and funding from INGOs had positively influenced the improvement in physical health infrastructure to elderly-friendly health service delivery though it had not yet covered the problems facing elderly people. For example from the findings the respondents officials reveals that the organization in partnership with local government has been actively purchasing medicines to two local dispensaries with a view of making available medicines that are directly linked to older persons even though it had not reached to the majority older people especially to the rural

areas . Also the organization has an emergency aid center to treat those who need medical aid urgently before they are transferred to referral hospitals in which they have treated elderly from chronic diseases. This has been helping elderly quickly access medical treatment when in risk of dying but to those who are living around town centers.

From objective two the study concluded that training facilitated by INGOs to staff to some extent had improved elderly health from which they have been preventing themselves from diseases. The elderly people in their centers have been taught by health staff to exercise weekly in the aging groups formed to relief stress and share common experiences. But the problem is in the little schedule for the programmes of training provided to the elderly. However elderly are taught balanced diet and regular screening to avoid the dangers of diseases becoming chronic.

Also through training staff older people oftentimes have experienced copying with disasters, and their participation was key to the organization emergency relief progrmames. Although there is adequate crew of staff trained they has been addressing their skills to elderly people through the programme launched by Pfizer for elderly people trainings to ensure the goal of prevention from diseases is attained. One of the key features of this programme was the establishment of staff who will organize the Active Ageing Groups which were formed to promote healthy lifestyle through regular exercise, create platform for improved awareness of prevention and management of chronic conditions and tackling harmful practices such as smoking and drinking. This has not helped much to brighter awareness of understanding different symptoms and how to prevent themselves from diseases due

to the limited time for the training programmes and lack of staff who organize them in such training practices.

From objective three the study concluded that contribution of INGOs advocacy in improving curative services has achieved to some extent the service delivery. Majority of the respondents revealed that from advocacy their issues have been paid great attention in policy debates though this had not yet achieved in all areas where older people lives specifically in rural areas. Majority of the respondents revealed that they can claim to their rights and seek protection from violence and discrimination to some apparatuses that deals with human rights but the problem is lack of such facilities apparatus like courts dealing to our rights in which they can address their issues. Also official respondent noted that the national aging policy was now in implementations.

5.4 Recommendations

The following are the recommendations that should be done in order to increase attention on contributions to elderly-friendly health service delivery:

The recommends that to objective one the Government INGOs, NGOs and other stakeholders should ensure that appropriate levels of care. There should be quality assurance in the hospital, health Centre, drug shops and the informal sector. The quality assurance should be done by the Ministry of health and other international organizations including INGOs, NGOs and and other stakeholders to invest in infrastructure to improve physical health infrastructures for elderly-friendly health care services to cater for the large number of diseases facing elderly people.

The research recommends that the Government INGOs, NGOs and other stakeholders should ensure that appropriate ways of prevention and levels of care to be taken into consideration. There should be quality assurance in the hospital, health Centre, drug shops and the informal sector. The quality assurance should be done by the Ministry of health and other international organizations including INGOs, NGOs and other stakeholders to invest in infrastructure to cater for elderly-friendly health services delivery to cater for the growing number of elderly people.

From the third objective the research recommends that the government, NGOs, CSOs and FBOs should create advocacy and lobbying mechanisms to supplement the health services for the elderly to high donor countries where the National state government cannot afford and has no capacity. To make this efficient the advocacy and lobbying as a tool should be integrated from lower level of Local Government councils health department so as to build expertise that result in to a capacity that helps the government and hospital staff to be able to attract other funding that contributes to enhancing the performance of the elderly-friendly health service delivery that will create general awareness to the community to shun stigmatizing elderly people especially on health matters. Also extension services for the elderly-friendly health services delivery should be increased in rural areas. This will help farmers including women to receive training on post-harvest technologies. The training programs should be also participatory-based so as to understand the actual needs of the rural people.

Further the research recommends that not only the effective implementation of aging policies but also strategic management plans should be well defined with clear reflection on elderly issues. Therefore each task should be effectively performed at all level of units. And other stakeholders should effectively collaborate on policy

formulation. Although there are several studies conducted on elderly issues including access to health services. Elderly health service delivery needs theoretical treatment to achieve better access to quality and standard elderly health service provisions.

5.5 Areas for further studies

The study suggests that further study to be conducted on the effective ways of INGOs resource mobilization and funding in service delivery to the poor.

The study suggests that another area to be conducted on the contribution of INGOs in resource mobilization and funding to elderly in refugees centers.

Another area to be conducted on the transparency and accountability for INGOs resource mobilization and funding to promoting the poor and vulnerable health services delivery.

The study suggests that further study to be conducted on the effectiveness of INGOs staff-care programs and interventions for elderly health service delivery.

Another area suggested for further study to be carried out on the current training of staff care for elderly health service delivery.

The study suggests that further study to be conducted on the INGOs advocacy to promote socio-economic service to the poor. And the roles of INGOs advocacy in promoting fight against discrimination older people.

The study suggests that further study to be conducted on the sustainability of local NGOs supporting elderly friendly health care provision without external funding

REFERENCES

Amin, M.A. (2005). *Social Science research: Conceptions, methodology and analysis*, Kampala,Makerere University press.

Anheier, H. K. (2009). *What kind of nonprofit sector, what kind of society? Comparative policy reflections.* Am. Behav. Sci. 52, 1082e1094.

Asset Based Community Development (ABCD). (2005). *Discovering Community Power: A Guide to Mobilizing Local Assets and Your Organization's Capacity*.

Babbie, E. (1989). *Survey Thinking Theory*.

Bailey, D. K. (1995). *Methods of Social Research. (4th edition)*. The Free Press. New York.

Barr, Abigail, Fafchamps, Marcel, Owens & Trudy. (2005). *The governance of nongovernmental organizations in Uganda*. World Development, 33(4),

Batley, R., & Rose, P. (2011). *Analyzing collaboration between nongovernmental service providers and governments*. Public Administration and Development, 31(4), 230–239

Bédard M, Sacha D & Bruce W. (2007). *The Impact of Cannabis on Driving*. Cannabis; accidents, traffic; alcohol drinking; automobiles.

Bernard, H. R., & Bernard, H. R. (2012). *Social research methods: Qualitative and quantitative approaches*. Sage

Bhatia V, Swami H M, Thakur J S. (2007). A Study of Health Problems and Loneliness among the Elderly in Chandigarh. *Indian Journal of Community Medicine* 32(4): 255-258.

Blanchette and Tolley. (1997). *"Public- and Private-Sector Involvement in Health-Care Systems: A Comparison of OECD Countries*". OECD.

Bouffard-Bouchard. T. (1990). 'Influence of Self-Efficacy on Performance in a Cognitive Task,' *Journal of Social Psychology*.

Bratton M & Nicolas Van de Walle. (1994). *Neo-patrimonial regimes and political transitions in Africa*. World Politics 46.

Bratton M, Beyer P & Van de Walle N. (1994). *International versus domestic pressures for 'democratization' in Africa*. Michigan State University Working Papers on Political Reform in Africa No. 12. East Lansing: Department of Political Science, Michigan State University.

Brooks B.PC & Katherine Leach-Kemon. (2012). *Financing Global Health 2012: The end of the Golden age*? Seattle, WA, Institute for Health Metrics and Evaluation.

Bury G, James D, & Dowling J. (2010). *Survey of Registered Medical Practitioners*. Dublin: Medical Council, Ed.

Carla, W. (2001). *Introducing qualitative research in psychology*. Buckingham: Open University Press.

Central Statistics Office. (2006). *New Delhi: National Sample Survey Organization, Ministry of Statistics and Programme Implementation, Government of India; Mobility, Health Care and the Condition of Aged*. NSSO (64^{th}round) Jan-June 2004.

Charlton R and Mckinnon R. (2001). *Pensions in Development.* Aldershot, UK: Ashgate

Charu K, Neeraj S, & Suhash C. (2017). *India Healthcare Roadmap for 2025*;Health positive attitude.

Cohen L. (1998). *No Aging in India—Alzheimer's, the Bad Family, and Other Modern Things*. Berkeley, CA: University of California.

Collier et al., (1991). *Shaping the political arena*. Princeton, N.J.:Princeton University Press

Collingwood, V. (2006). *Non-governmental organizations, power and legitimacy in international Society.*

Collins KA, Furuyama S & Biggins S. (2004). *Comperative Study| Journal Article Research Support*, Non-U.S Gov't, P.H.S. CSE4

Craven and Hirnle. (2007). *Fundamentals of Nursing. Human Health and Functions (5^{th} ed*). Philadephia. USA.

Creswell, J. W. (2003). *Research Design: Qualitative, Quantitative, and Mixed Method Approaches*. California. Sage Publications. DC: The Word Bank

De-Graft Aikins A, Unwin N, Agyemang C, Allotey P, Campbell C & Arhinful D. (2010). *Tackling Africa's Chronic Diseases Burden: From the Local to the Global*. Globalization and Health, 6,5.

Denscombe, M. (2010). *The Good Research Guide for small-scale social research*

DH. (2012). *Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings*. Hong Kong Department of Health, Government of the Hong Kong Special Administrative Region; 2012. [Accessed September 10, 2018].Available at http://www.pco.gov. hk/english/resource/ professionals _preventive_older_pdf.html. projects, (4thed), The Open University Press, Berkshire, England.

Docteur and Oxley. (2003). *"Health-Care Systems: Lessons from the Reform Experience"*. OECD.

Don, D. S. (2008). *Fixing Health Systems. Contribution: International Development Research Center (Canada)*. Tanzania Wizara ya Afya. IDRC Publisher.

Dozois, E. (2006). *Ageism: A Review of the Literature.*

Edwards, M. (1999). Legitimacy and Values in NGOs and Voluntary Organizations: Some Skeptical Thoughts. In. *International Perspectives on Voluntary Action*. London: Earthscan.

Edwards, M. (2004). *Civil Society. Cambridge*, MA: Polity Press

Erel, D. (2000). *The Concept of Self-Efficacy and Self-Efficacy-Performance Relationship*. Available; https://www.researchgate.net/publication/ 27568576. Accessed July 20, 2018

Fialová D, Onder G. (2009). *Medication errors in elderly people: contributing factors and future perspectives*.Free PMC Article.

Giarelli G, Annandale E, & Ruzza C. (2014). *Introduction: The Role of Civil Society in Health Care Systems Reforms.*

Gill, L. (1997). Power lines: The political context of nongovernmental organization (NGO) activity in El Alto, Bolivia. *Journal of Latin American Anthropology*, 2(2), 144–169.

Gilson et al., (1997). *Should African Governments contract out clinical health services to church providers*?. Eresy Publisher. Ghana.

Globocan et al., (2008). Cancer Incidence and Mortality Worldwide: IARC Cancer. *International Agency for Research on Cancer*. Lyon, France.

Gorman, M. (2012). Ageing and health - an international nongovernmental organization's view. *Regional Health Forum. Vol 16.*

Gramci. (1999). *A summary of philosophic thoughts on civil society in Obien (1978-1985*). OOPEC.

Groom & Paul. (1975) *Functionalism*; *theory and practice in international relations*. London University Press.

HA. (2012). *Hospital Authority Strategic Service Framework for elderly* patients. Hong Kong: Hospital Authority;

Hayes, N. (2000). *Doing Psychological Research. Gathering and analysing data*. Buckingham: Open University Press.

Health Community Capacity Collaborative (HCCC). (2018). What is Resource Mobilization and Why is it so Important? The Johns Hopkins University.

Healthy Aging Network. (2006). *Creating Healthy Communities for an Aging Population.* Minnesota Department of Health.

Hearn, J. (2007). *Roundtable: African NGOs: The new compradors? Development and Change*, 38(6), 1095–1110.

Hegel, G.W.F. (1820). *Elements of the philosophy of right*.

HelpAge International. (2009). *Sauti ya Wazee*. Dar es Salaam. HAI Tanzania.

Heslop A. (1999). *Ageing and Development—Working Paper 3*. London: Department for International Development, Social Development Department.

Hinrichs, J. R. (1976). Personnel training. In M. D. Dunnette (Ed.), *Handbook of industrial and organizational psychology* (pp. 861-888). Chicago, IL: Rand McNally.

Holland, J. and Blackburn J. (1998). *Whose Voice? Participatory Research and Policy Change*. London: Intermediate Technology Development Group (ITDG).

Hsiung-Hung Wang. (2012). *Elderly and Long-term Care Trends and Policy in Taiwan*: *Challenges and Opportunities for Health Care Professionals*. Article available: https://doi.org/10.1016/j.kjms.2012.04002

Hulme, D. (2013). *Poverty and development thinking: Synthesis or uneasy compromise?* BWPI Working Paper 180. Manchester: Brooks World Poverty Institute (24 pages).

Human Rights Commission of Sri Lanka and HelpAge. (2014). Sri Lanka, *Growing old age gracefully*. Colombo: Human Rights Commission of Sri Lanka.

Hyden G. (1997). Civil Society, Social Capital and Development: Dissection of a Complex Discourse, Studies. In: *Comparative International Development Vol.32,no 1*.

Hyden, G. (1992). *Governance and the study of politics*. In G. Hyden and M. Bratton, eds. Governance and politics in Africa. Boulder, CO: Lynne Rienner Publisher.

Institute of Medicine Committee on Quality of Health Care in America. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Quality Chasm Series. Washington, DC: The National Academies Press. ISBN 9780309072809.

Izumi Foundation. (2018). *Health Care Infrastructures.* Available at http://izumi.org/about/how-we-work/health-care-infrastructure/. Accessed 8/11/2018.

James W, O'Hanlon, Barbara, Chee, Grace, Malangalile, Emmanuel, Kimambo & Adeline. (2013). *Private Health Sector Assessment in Tanzania. World Bank Studies*. World Bank Publication.

Kagaruki P. (2013). Assessment of National Ageing Policy 2003 on The Provision of Free Health Services to Older People in Tanzania: The Case of Bagamoyo DistrictA Dissertation Submited In Partial Fulfillment of The Requirements for the Award of the Degree of Master of Arts in Social Work of The Open University Of Tanzania.

Kathor J, Barbara S, Tesfaye D & Lisa T. (2014). *Engaging Civil Society in Health Finance and Governance*:A Guide for Practitioners.

Kaulem, J. (2007). *The role of civil society in social policy Paper Presented at the Side Event "New Consensus on Comprehensive Social Policies.*

Kebede, E. (2004). *The Participation of NGOs/CSOs in the Health Sector Development Program*. Addis Ababa: Christian Relief Development Agency (April).

Keck, M.E and Sikkink, K. (1998). *Activism Beyond Borders*. Cornell University Press, Ithaca, NY.

Kenyan Healthcare Federation. (2016). *Kenya Healthcare Sector:* Opportunities for Dutch life Sciences & Health Sector. The Embassy of Kingdom of the Netherlands. Nairobi.

Kimokoti, R.W., and Hamer, D.H. (2008). *Nutrition, Health, and Aging in Sub-Saharan Africa.* Nutrition Reviews 66 (11).

Kivela S-K, Kesti E, Paivi KS, & Maija L.I. (1992). Abuse *in Older Age: Epidemiological Data from Finland*. Journal of Elder Abuse, 4, 1-18

Kjell, S. (1975). International Nongovernmental Organization and their functions. *International Peace Research Institute.* Oslo.

Koh, H. (2000) Complementarity between international organizations on human rights/the rise of transnational networks as the “third globalization”. *Human rights Law Journal 21:8*

Kombo, K. & Tromp, D. (2006). *Proposal and Thesis Writing: An introduction*. University of Nairobi Press.

Kothari, C. R. (2004). *Research Methodology Methods and Techniques*. India, New age International Publishers.

Kothari, C. R. (2011). *Research Methods and Techniques*, WishwaParackakashan, New Dsselhi.

Layte R. (2012). *Income, deprivation and well-being among older Irish people*. Dublin: National Council for the Elderly.

Lewis and Kanji. (2009). *Non Governmental Organizations and Development*. Meeting on Aging in Africa Ethiopia. London & New York. Routledge Publisher London, England: M E Sharpe

Lou et al., (2009). *A Study Investigating Factors that Affect Long Term Care Use in Hong Kong*. Submitted to Food and Health Bureau Government Secretariat The Government of the Hong Kong Special Administrative Region. Hong Kong.

Macleod, S. (2008). Case Study Method. Available at: https://www.simplypsychology.org/case-study.html. Acessed June 6, 2018

Makuwira, J. J. (2014). *Non-governmental organizations and the poverty reduction agenda: The moral crusaders*. In Routledge global institutions series. Oxon and New York: Routledge

Malalika, M. (2016). Implementation of The National Ageing Policy In Tanzania: What Do Street Level Bureaucrats And Clients Say about Access to Free Health Services by the Elderly Population in Morogoro Municipality? A Dissertation Submitted to the Faculty of Public Administration and Management in Fulfillment of the Requirements for the Degree of Master of Research and Public Policy (MRPP) of Mzumbe University.

Masunzu, D. S. (2007). Old Age Social Security in Tanzania; a Case Study of Kibaha Rural District in Coast Region. Unpublished M.A (DS) Dissertation. Dar es Salaam University.

Maurizio F, Beatriz S. Z & Stefano V. (2009). *"Capitalisation study on Capacity Building Support Programmes for Non-State Actors under the 9th EDF"*. UK.

McGregor, S. (2001). Neo-Liberalism and Health Care. In. *International Journal of Consumer Studies, 25 (2), 82-89.*

Mechai V. (2001). *Strategies to Strengthen NGO Capacity in Resource Mobilization through Business Activities*.

Miles M, Huberman A. (1994) (Eds). *Qualitative data analysis: an expanded source book*. Thousand Oaks. Sage.

MMC, Morogoro Municipal Council. (2011). *Municipal Annual Report*. Morogoro.

Morris-Suzuki, T. (2000). *For and against NGOs.* New Left. Japan.

Msabila D.T & Nalaila S.G. (2013). *Research Proposal and Dissertation Writing: Principles and Practices*. NNP.

Murray, W. E., & Overton, J. D. (2011). *Neoliberalism is dead, long live neoliberalism? Neostructuralism and the international aid regime of the 2000s*. Progress in Development Studies, 11(4), 307–319.

National Council on Ageing and Older People. (2005). *Perception of Ageism in Health and Social Services to Elderly People in Ireland*. Dublin: Grand Canal Quay.

National Programme for the Health Care of the Elderly (NPHCE). (2011). *An Approach Towards Active and Healthy Ageing.* Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. Available: http://www.health.bih.nic.in/Docs/Guidelines-NPHCE.Pdf Accessed on 2018 May. 18

NBS. (2013). *National Bureau of Statistics*: Tanzania.

NELSON, J. (1989). *Fragile coalitions: The politics of economic adjustment*. New Brunswick, N.J.: Transaction Books.

Newton K. (2000). Trust, Social capital, civil society and democracy. *International political science review*. Volume 22(2).

Nicola B, David, H & Michael, E. (2014). *NGOs, States, and Donors Revisited: Still Too Close for Comfort? World Development* Volume 66, February 2015, Pages 707-718 Available: https://doi.org/10.1016/j.worlddev.2014.09.028

NIH. (2016). World's older population grows dramatically. Available: https://www.nih.gov/news-events/news-releases/worlds-older-population-grows-dramatically Last Accessed 9/1/2018

Nordiska A et al., (1998). *Institution Building and Leadership in Africa*. Nordic Africa Institute Publisher.

Nuhemow L. (1986). *Human and Ageing. London*: Academic Press INCT.

Obar, A.J, Cliff L, Paul Z. (2012). "Advocacy 2.0: An Analysis of How Advocacy Groups in the United States Perceive and Use Social Media as Tools for Facilitating Civic Engagement and Collective Action". *Journal of Information Policy. SSRN 1956352* .

Oliver, J & Wodon, Q. (2012). *Playing broken Telephone: Assessing faith-inspired health care provision in Africa*. Development in Practice 22:819-34

Ollila, E. (2005). Restructuring Global Health Policy Making: The Role of Public-Private Partnership. In. *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*. Plagrave Macmillan

Omungo, P. (2011). *A review of the role of civil society in advocacy and lobbying for enforcement of health policy in Kenya*. African Population Studies. Available at: http://aps.journals.ac.za/pub/article/view/257. Accessed June 7, 2017

Pastory, W. (2011). The Effective of Ageism on Provision of Health Services to Elderly People in Tanzania Public Hospitals; the Case of Mwananyamala Hospitals in Dar es Salaam Region. Unpublished M.A (ASP) Dissertation. Dar es Salaam University.

Pastory, W. (2013). Ageism in Tanzania's Health Sector: A Reflective Inquiry and Investigation. *Academic Research International*, 4(1), 402-408

Phoebe L & S. I, Rajan. (2013). *An Ageing India: Perspective, Prospects, and Policies.* Roultledge Publishers.

Policy Analysis and Development Unit. (2013). Ministry of Health, Nutrition and Indigenous Medicine Sri Lanka. *Health Strategic Master Plan 2016–2025 (draft). Volume III: rehabilitation care. Colombo*: Ministry of Health Nutrition and Indigenous Medicine.

Pranitha ,M. (2012). *Ageing and Health in Africa*. Volum 4 of International Perspectives on Ageing. Springer Science & Business Media Publisher.

Ramesh, V and Pardeep, K. (2013). National Program of Health-Care for the Elderly in India: A hope for Healthy Ageing. *International Journal of Preventive Medicine*. MedknowPublication.

Raut-Marathe S, Nilangi S, & Deepali Y. (2015). What Causes Medicine Shortages in Primary Health Centres?: A Case Study of Availability and Supply System of Medicines in Select PHCs from Maharashtra. IIHMR University.

RCHS. (2013). *Preliminary Report of RMNCH Partners Mapping and Resource Tracking 2013*. MHOWAS, Dar es Salaam, Tanzania.

Sandhu, H.S, Gilles E, Marie V.D & Georgia. (2009). "Hyponatremia associated with large-bone fracture in elderly patients". International urology and nephrology 41 (3): 733–7. Available from: https://www.researchgate.net/publication/287697256_Exploring_the_Expectation_and_Perception_of_Healthcare_Needs_of_the_Elderly_in_Ghana_An_Empirical_Analysis. Accessed Apr 30 2018.

Sanga, G. (2013). Challenges Facing Elderly People in Accessing Health Services in Government Health Facilities in Moshi Municipality Area. A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Social Work of the Open University of Tanzania.

Saunders M, Lewis P & Adrian T. (2012). *Research Methods for Business Student*. London. Pearson

Schmitter P.C & Gerhard L. (1979). *Trends towards corporatist intermediation*. London: Sage Publications. EDS.

Seltzer, Judith B. (2014). *"What is Resouce Mobilization"*. *Health Communication Capacity Collaborative. Management Sciences for Health.*

Sen, K. (1993). *Ageing, Health, Social Change and Policy in Developing Countries*. London: London School of Hygiene and Tropical Medicine.*Services in Public Hospitals*: The Case of Temeke, Magomeni And Mwananyamala Hospitals. A Dissertation Submitted In Partial Fulfillment of Requirement for the Award of Master Degree of Arts in Social Work at the Open University of Tanzania

Shaw, R. and Ainsworth, M. (Eds) (1996). *Financing Health Service through User Fees and Insurance*: case study from Sub- Saharan Africa Washington.

Sixma HJ, Joannes J.K, Cretien V.C, & Peter L. (2000). *Quality of care from the perspective of elderly people*. The QUOTE-elderly instrument. Age Ageing; 29(2).

Song Y, Wei M, Xiangren Y, Shumei W, Xiaojie S, Jiming T, Shukang W, Chunmei Z, Bingyin Z, Zhijian X, & Gifty M. (2013). *chronic diseases knowledge and related factors among the elderly in Jinan, China.* PLoS One. 2013; 8:e68599.

Tanzania Directory. (2015). *NGO's in Tanzania.* Available: http://www.123tanzania.com/?module=searchresults&action=index&categories=NGOs .Last accessed 1 Aug.2018.

Tanzania Ministry of Labour, Youth Development and Sports. (2003). *National Ageing Policy*. Available:http://www.tanzania.go.tz/pdf/ NATIONAL%20 AGEING% 20POLICY 20%FINAL%20PAPER. PDF.Accessed 5 Jan. 2018

Tolman, Allard, and Rosen. (2003). "Proximity to Service Providers and Service Utilization among Welfare Recipients: The Interaction of Place and Race." *Journal of Policy Analysis and Management.*

Tony Blair Faith Foundation. (2014). *Global Health & Africa*: *Assessing faith work and Research Priorities.*UK.

Tostensen, A. (2004). *Rural-urban Linkages in Sub-Saharan Africa*. Contemporary debates and implications for Kenyan urban workers in the 21st century. Nairobi: Chr. Michelsen Institute.

Tucker L. (2013). *An Obstacle to Patient-Centered Care. Poor Supply Systems.* Havard Business Review.

Twaweza. (2013). '*Stock out or in stock? Access to medicines in Tanzania'*. Sauti za Wananchi, Brief No.5, September 2013.

UN. (2002). The Madrid International Plan of Action on Ageing (MIPAA) and the Political Declaration was adopted by the Member States of the United Nations at the Second World Assembly on Ageing in April 2002. Available at http://www.un.org/en/events/pastevents/pdfs/Madrid_plan.pdf

UN. (2015). World Population Ageing 2015. Department of Economic and Social Affairs Population Division. New York.

UNICEF. (2016). *Zimbabwe Health and Child care Budget Brief*. Zimbabwe Health Sector.

URT. (2003). *National Ageing Policy.* Tanzania.

URT. (2012). *National Census.* Tanzania.

URT. (2016). Guideline for Developing Annual Health Centre and Dispensary Plans

USAID. (2013). Health Finance and Governance. Expanding Access, Improving Health.

USAID. (2017). *Health Infrastructure Fact Sheet*. USAID.GOV/Haiti.

Van de Walle E, ed. (2006). African Households: Censuses and Surveys.

Wagner. (2018). The Power of Advocacy. Available at; https://www.wisjustice.org/index.cfm?pg=ThePowerofAdvocacy. Accessed October 20, 2018.

Wangwe, S. & Tibandabage, T. (1998). *Transnational Economic and Policy Options in Tanzania. Tanzania Political Economic Series*, 1, Dar es Salaam: Mkuki na Nyota Publisher. West Virginia Rural.

WHO. (2001). Discussion Paper No 1 CSI/2001/DPI Strategic alliances. The role of civil society in health.

WHO. (2014). Training Manual.Curriculum and Guide.Facilitator's Guide.

WHO. (2004). Towards age-friendly primary health care. Geneva: World Health Organization;.

WHO. (2008). Age-friendly Primary Health Care Centre Toolkit. Geneva: World Health Organization.

WHO. (2018). Health Financing for Universal Coverage. Available at http://www.who.int/health_financing/strategy/revenue_collecton/en/. Accessed 8/11/2018.

World Bank. (2007). Small Grants Program: Social Development Department.

World Bank. (2016). *Ageing in Thailand-Addressing Unmet Health needs of the* Elderly *Poor*. World Bank Report Bangkok. Available: www.worldbank.org. Accessed 02 Jan, 2018.

Yeo J, Yoon A.S & Kyujin, J. (2018). The Effectiveness of International Non-Governmental Organizations' Response Operations during Public Health Emergency: Lessons Learned from the 2014 Ebola Outbreak in Sierra Leone. *Int. J. Environ. Res. Public Health 2018*, 15, 650; doi:10.3390/ijerph15040650.

Yerpude, P.N, Keerti, S.J & Mohini, S.J. (2014). A Cross-sectional Study of Health Problems and Health - Seeking Behavior of Aged Population from Rural Area of South India. *International Journal of Health Sciences and Research* 4(3): 29-32. 5.

APPENDICES

Appendix 1: Questionnaire for the elderly people

QUESTINNAIRE FOR THE ELDERLY PEOPLE

I am a Master of Arts student at the University of Dodoma doing a research titled "**THE CONTRIBUTION OF INTERNATIONAL NON-GOVERNMENTAL ORGANIZATIONS (INGOs) IN PROMOTING ELDERLY-FRIENDLY HEALTH SERVICES DELIVERY IN TANZANIA: A CASE OF HELPAGE INTERNATIONAL IN MOROGORO MUNICIPALITY"** with the main objective of examining the contribution of INGOs in promoting elderly-friendly health services delivery in Tanzania. You are among the persons to provide information for this research. Kindly provide this information by answering to the following questions. Please be assured that the information provided will be confidential and used for the purpose of academic only.

SECTION A (Background information of respondent)

Ward……..…… Phone number……

1. Respondent' Name (optional)……
2. Sex i: Male ( ) ii: Female ( )
3. Marital status: i: Single ii: Married iii: Divorced iv: Widowed
4. Age of the respondent……years
5. Place of birth……
6. Length of stay in the area (years)……
7. What is your Education level?

i: None ( ) ii: Primary ( ) iii: Secondary ( )

iv: Diploma ( ) v: Degree ( ) vi: others (mention)……

8. What is your religious denomination?

   I: Christianity ( ) ii: Islamic ( ) iii: others (mention)……

9. What is your major economic activity?

   i: Livestock keeping ( ) ii: Business ( ) iii. Government employee ( )

   iv. Others (mention)……

10. Do you have any dependants currently? Yes ( ) No ( )

11. If yes, how many are they?.....

12. How many of your dependants mentioned in 11 above are schooling?.....

Section B (Medical services)

13. Do you have a health insurance? Yes ( ) No ( )

14. If yes, who pays for it?

    a). Own ( ) b). Government ( ) c). HelpAge ( ) d). Children ( )

15. If No, how do you pay the medical bills?.....

16. If provided health services by HelpAge, what type of diseases are covered?

    ……

    ……

17. How do you manage the diseases that are not covered by HelpAge scheme?....

    ……

    ……

18. Apart from health services (care) what other services do you receive from HelpAge?

    ……

    ……

19. How often do you get the services mentioned in 18 above (frequency)?.....

    ……

20. Which are the most recurring diseases that mostly force you to seek medical help?

    ……

    ……

21. How do you prevent diseases?.....

    ……

    ……

22. Where did you get the skills in disease prevention from?.....

    ……

    ……

THANK YOU FOR YOUR PARTICIPATION

Appendix 2: Questionnaire for key informants (HelpAge)

INTERVIEW GUIDE FOR KEY INFORMANTS (HelpAge)

I am a Master of Arts student at the University of Dodoma doing a research titled "**THE CONTRIBUTION OF INTERNATIONAL NON-GOVERNMENTAL ORGANIZATIONS (INGOs) IN PROMOTING ELDERLY-FRIENDLY HEALTH SERVICES DELIVERY IN TANZANIA: A CASE OF HELPAGE INTERNATIONAL IN MOROGORO MUNICIPALITY"** with the main objective of examining the contribution of INGOs in promoting elderly-friendly health services delivery in Tanzania. You are among the persons to provide information for this research. Kindly provide this information by answering to the following questions. Please be assured that the information provided will be confidential and used for the purpose of academic only.

Section A

Name (optional)…… Phone number……

Organization ……. Position……

1. What is the meaning of the word HELPAGE?.....

   ……

   ……

2. Why did you choose to deal with elderly people?.....

   ……

   ……

3. What are your areas of concern in the elderly people?.....

4. How many elderly members are you serving currently?.....

……

5. How do you recruit new elderly members?.....

……

6. What are the financial needs in your areas of concern?.....

……

……

7. Where do you get cash from to finance your areas of concern?.....
8. Is the cash issued sufficient? Yes ( ) No ( )
9. If No, what do you do in such a situation?.....

……

……

10. Who controls the cash? a). Own ( ) b). Donor(s) ( ) c). Government ()
11. What are other services provided by your organization to the elderly apart from health services?.....

……

……

12. What type of training(s) do you offer to the elderly in your jurisdiction?.....

……

……

13. How often do you offer the training(s)…….
14. Why do you offer the trainings mentioned in 12 above?.....

……

……

……

15. Which diseases that commonly affect the elderly people?.....

……

……

……

16. What are your advocacy areas?.....

……

……

……

17. What curative services does your organization advocate for?.....

……

……

……

18. How do you achieve your curative advocacy services?.....

……

19. Which methods do you use in advocacy services?.....

……

……

20. Which other stakeholders do you collaborate with in providing health services to the elderly people?.....

……

……

21. What are the roles of each stakeholder mentioned in 20 above?.....

……

……

THANK YOU FOR YOUR PARTICIPATION

Appendix 3: Questionnaire for key informants (Municipal officials)

INTERVIEW GUIDE FOR KEY INFORMANTS (Municipal officials)

I am a Master of Arts student at the University of Dodoma doing a research titled "**THE CONTRIBUTION OF INTERNATIONAL NON-GOVERNMENTAL ORGANIZATIONS (INGOs) IN PROMOTING ELDERLY-FRIENDLY HEALTH SERVICES DELIVERY IN TANZANIA: A CASE OF HELPAGE INTERNATIONAL IN MOROGORO MUNICIPALITY"** with the main objective of examining the contribution of INGOs in promoting elderly-friendly health services delivery in Tanzania. You are among the persons to provide information for this research. Kindly provide this information by answering to the following questions. Please be assured that the information provided will be confidential and used for the purpose of academic only.

Name (optional)…….. Phone number……

Organization ……. Position……

1. Which health services do you offer to the elderly people in your area?

   ……

   ……

   ……

2. Which diseases do the elderly people commonly suffer from?

   ……

   ……

   ……

3. What is the population of elderly people in your area?
4. Are all the population mentioned in 3 above included in the health scheme?

   Yes ( ) No ( )

5. Apart from health services what other services do you provide the elderly people?

   ……

   ……....

   .....

6. What type of training(s) do you offer to the elderly in your jurisdiction?.....

   ……

   ……

7. How often do you offer the training(s)……
8. Why do you offer the trainings mentioned in 12 above?.....

   ……

   ……

   ……

9. Which diseases that commonly affect the elderly people?.....

……

……

10. What are your advocacy areas?.....

……

……

11. What curative services does your organization advocate for?.....

……

……

12. How do you achieve your curative advocacy services?.....

……

.....

13. Which methods do you use in advocacy services?.....

……

……

14. Which other stakeholders do you collaborate with in providing health services to the elderly people?.....

……

.....……

15. What are the roles of each stakeholder mentioned in 20 above?.....

THANK TOU FOR YOUR PARTICIPATION

Appendix 4: A checklist for FGDs

A CHECKLIST FOR FOCUSED ROUP DISCUSSIONS

I am a Master of Arts student at the University of Dodoma doing a research titled "**THE CONTRIBUTION OF INTERNATIONAL NON-GOVERNMENTAL ORGANIZATIONS (INGOs) IN PROMOTING ELDERLY-FRIENDLY HEALTH SERVICES DELIVERY IN TANZANIA: A CASE OF HELPAGE INTERNATIONAL IN MOROGORO MUNICIPALITY"** with the main objective of examining the contribution of INGOs in promoting elderly-friendly health services delivery in Tanzania. You are among the persons to provide information for this research. Kindly provide this information by answering to the following questions. Please be assured that the information provided will be confidential and used for the purpose of academic only.

1. Which are the most recurring diseases that mostly force you to seek medical help?
2. How do you prevent diseases?.....
3. Where did you get the skills in disease prevention from?.....
4. What type of training(s) do you offer to the elderly in your jurisdiction?.....
5. Which diseases that commonly affect the elderly people?.....
6. What curative services does your organization advocate for?.....