THE INFLUENCE OF SOCIO-DEMOGRAPHIC CHARACTERISTICS OF HEALTHCARE WORKERS ON THEIR ATTITUDES TOWARDS OLDER PEOPLE IN NAIROBI, WESTERN AND RIFT VALLEY PROVINCES OF KENYA

BY

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FEBRUARY, 2013

DECLARATION

Declaration by the Candidate

This thesis is my original work and has not been submitted for the award of a degree in any other university. No part of this work may be reproduced without prior permission from the author and/or Moi University.

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DEDICATION

This research work is dedicated to my dear wife Jennifer Jepkoech Kipruto and our lovely children; Sheilla Jebet, Larry Kipkemboi, Jessica Jerotich and Amos-Allan Kipkulei for their resilience and comportment when I was burning the midnight oil to write this thesis.

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ABSTRACT

The purpose of this study was to determine the influence of socio-demographic characteristics of health-care workers on their attitudes towards older people and how it affects their behaviour. The study was based on the theoretical models of Ajzen and Fishbein's Theory of Reasoned Action (1980) and Townsend's Structured Dependency Theory (1981). The study hypothesized based on the assumption that monitoring healthcare workers' attitudes towards older people can serve as a powerful indicator of their behaviour to older people. The *ex post facto* research design was used and the sample was health-care workers in three provinces of the eight provinces of Kenya. A sample of 295 (178 males, 117 females) respondents were assessed on their socio-demographic characteristics and their attitudes toward older people. The sampling methods used were random sampling without replacement in selecting 20 institutions in each province that deal with older people. Respondents were selected using both stratified random sampling and purposive sampling techniques. The 60-item Attitudes Towards Older People Scale (ATOPS) was the main instrument for data collection. The research instrument was pilot-tested to ascertain its reliability yielding a reliability coefficient of 0.76. Research experts reviewed the instrument to establish its validity. Data was analysed using descriptive (frequencies, means, standard deviations and percentages) and inferential statistics (Independent sample t-tests, Chi-square, One-way ANOVA, Coefficient of Contingency and Pearson Product Moment Correlation at 0.05 levels of significance. Results indicated that there were no significant influences of gender, professional occupation, marital status and religious beliefs of healthcare workers on their attitudes towards older people $t(295) = 1.53$, $p > 0.05$. Age, level of education and work experience had a significant impact on the attitudes of healthcare workers towards older people. The results highlighted the importance and urgency of more concerted research to inform the public and organizational policies to better promote and manage care of older people in an ageing society like Kenya. Geriatric curriculum should be developed to correct misunderstandings and improve the attitudes of health care workers toward older people. Further, there is need to explore psychological constructs of ageism across cultures.

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LIST OF ABBREVIATIONS AND ACRONYMS

ATOPS	Attitudes towards Older People Scale
AU	African Union
CBOs	Community Based Organisations
FGDs	Focus Group Discussions
HAK	HelpAge Kenya
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immunity Deficiency Syndrome
MIPAA	Madrid International Plan of Action on Ageing
NGOs	Non-Governmental Organisations
WHO	World Health Organisations

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.0 Background to the Study

In recent years, the world has witnessed a rapid increase in the absolute and relative numbers of older people (defined as 65 years old or over) in both developing and developed countries. According to the United Nations (2009), the total number of older people aged 65 years and over has been increasing at unprecedented rate. In 1980, just prior to the convening of the First World Assembly on Ageing, there were 378 million people in the world aged 65 years and above. In 2010, the figure doubled to 760 million, and it is projected to rise to 2 billion by 2050 (United Nations, 2009).

More than half (414 million) lived in Asia and Europe has 161 million followed by Northern America with 65 million, Latin America and the Caribbean with 59 million and Africa with 55 million and Oceania with 6 million. Although the older population is growing in all parts of the world, most of the increase is taking place in the developing world. On average, 29 million older people will be added to the world's population each year between 2010 and 2025, and over 80% of those will be added in the less developed regions (United Nations, 2009). As a result, the share of the world's population residing in less developed regions will increase from 65% in 2010 to about 80% by the year 2050.

Even though the majority of older people in developing countries still live in rural areas, urbanization is contributing to very rapid growth in the number of older people living in cities. Between 1975 and 2005, the number of urban people aged 60 years or

over nearly quadrupled, and most of the future growth in numbers of older people will take place in urban areas of developing countries (United Nations, 2009).

As the population ages, there will be an increased need for people to work with, and provide care for, older people. This increased need for care of older people will cover the whole range of health care settings, from hospitals to community health care centres and nursing homes (Lin, Bryant & Boldero, 2011). This increased care demand creates the challenge of providing suitable health care services for older people and positive attitudes toward older people.

Currently in Kenya, the older people constitute 5 % of the total population (Help Age Kenya, 2006). Ageing of the Kenyan population has occurred comparatively rapidly in recent years with the aged population predicted to reach 22% (5 million) by the year 2051, double that of 1991 (11%, 1.9 million) (Help Age Kenya). Social developments and ageist stereotypes combined with increases in the aged population have significantly influenced the Kenyan health care system.

The Kenya Government is one of the signatories to the Madrid International Plan of Action on Ageing (MIPAA) adopted in 1982 in Vienna, Austria during the First World Assembly on Ageing. Since then the government is committed to the United Nations principles, which stipulates the rights of older persons to independence, participation, care, self-fulfillment and dignity.

However, despite commitment to the Plan of Action agreed on in 1982, it was noted at the Second World Assembly on Ageing (WAA2) held in Madrid in 2002 that most developing countries, including Kenya, did not take specific steps to domesticate and operationalise the recommendations in the key thematic areas namely, family, social,

welfare, income, security and education (Gondi, 2008). The conference therefore called member states for changes in attitude, policies and practices at all levels in all sectors to implement revised Plan of Action on ageing in the 21st century. Further, at the 38th Ordinary Session of the Assembly of Heads of State and Government of the African Union (AU) held in Durban, South Africa in 2002, the Policy Framework and Plan of Action was approved and this binds member countries to formulate national policies on ageing in order to improve the lives of the continent's older people.

When perceiving fellow human beings, most people are automatically inclined to categorize them along the three dimensions; race, gender and age (Nelson, 2002). This research dealt with the latter and more specifically the phenomenon of ageism.

When ageism was first defined as "the systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for colour and gender" (Butler, 1969), the phenomenon was viewed as something directed at old people only and characterized by negative valence. Ageism has been referred to as the third *ism* of human society following racism and sexism (Butler, 1995).

Ageism has been described as the ultimate prejudice and the last discrimination (Butler, 1995). Unlike other prejudices, ageism is universal as everyone has the potential to become a target of ageism provided they live long enough (Palmore, 2004). Ironically though, it is claimed that many people are still consciously unaware of this relatively recently defined and subtle concept (Palmore, 2001). He stated that his most disturbing finding was that most people knew little about ageing and harboured a number of misconceptions. The implication is that ageism is likely to be reflected in behaviours toward older people due to the negative attitudes resulting

from lack of knowledge and education about older people. The constant propagation of ageism from one generation to the next is not only negative and discriminatory but it also promotes ageist attitudes that become a self-fulfilling prophecy in Kenyan society.

Ageism is a type of prejudice that involves the stereotyping, derogation and discrimination of older people (Butler, 1969). Together with racism and sexism, ageism is one of the most chronic and pervasive forms of prejudice against an easily distinguished minority (Nelson, 2002). Studies have shown that younger people often hold negative attitudes towards older people and view them as senile, asexual, religious, intellectually rigid, isolated, helpless, useless, unproductive, stubborn and 'over the hill' (Palmore, 1990; Palmore 2004). Further, the constant emphasis on youth, beauty, vitality and strength indirectly strengthens the negative aspects of ageing.

Palmore (1990) explained that ageism involves both prejudice and discrimination, both stereotypes and attitudes, and therefore both cognitive and affective processes. Levy and Banaji (2002) speak of ageism as "…feeling, belief, or behaviour in response to an individual's or group's perceived chronological age". Most authors focus on negative views and feelings, but others argue that ageism can also have a positive tone (e.g Glover & Branine, 2001; Palmore, 1990). Butler (1969) was primarily concerned with the deleterious effects of negative stereotypes upon older people. Like sexism and racism, ageism represents discrimination of one group against another, in this case based on age. When applied to older people, it reflects negative attitudes toward them, unfair and false stereotyping, differential medical or

employment treatment, emotional rejection and being seen as worse off financially, physically and socially (Rice, 1992). Older people experience reduced independence, limited decision-making opportunities, increased probability of developing complications, little consideration of their ageing related needs, limited health education and social isolation (Courtney, Tong & Walsh, 2006).

Ageing involves some inevitable decline in biological functioning (McConatha, 2004). However, chronological age alone does not explain the negative psychological and social effects of human ageing. These are more a result of socially constructed values and belief systems denigrating the status of older people. Old age is a natural part of the life cycle and it is possible to live later adult years with a sense of satisfaction and well-being. Contrary to stereotypical views, statistics indicate that the majority of older people are not dependent, sick, or physically disabled (Diener, Dinier & Dinier, 2005).

The quality of care that older people receive is dependent on the attitudes of health care providers and therefore their attitudes toward older people can significantly impact upon the care that older people receive (Stevens & Crouch, 2003). As older persons consume more health care services, health care providers will have to be more aware of the challenges they will face to appropriately care for this segment of the population. For example, care needs to go beyond treatment of older people to include diseases prevention and maintaining function and independence in older people. Healthcare professionals are reported to be particularly susceptible to ageist stereotyping because of their increased exposure to older people. The need for trained social workers in gerontology is critical because older people consume

disproportionately large share of health care and social services (Gellis, Sherman & Lawrence, 2003).

Despite well-intentioned initiatives by the Kenyan government to provide high-quality care and treatment to older people, there is evidence to suggest that widespread ageist attitudes prevail and that ageism is endemic within health and social care services (Palmore, 2001). These negative attitudes and instances of ageism in Kenyan society can become an obstacle to training qualified care providers in elder care.

Due to the continuing ageing of the population, lack of personnel in the field of gerontology and increased health and social service utilization by older people, gerontological education has become critical in health care provision. Older people are perceived by policy makers and society in general as problems requiring considerable attention and resources. Increases in health care costs have been attributed to the increases in the aged population (Courtney, Tong & Walsh, 2006). However, these increases are more closely linked to social and political changes than physiological ageing per se.

The human race is unique amongst the animals in that they continue to live beyond the time when they have relinquished two roles which are vital to other species – the ability to work for a living, and the ability to procreate and nurture new offspring (Scrutton, 1989). Yet this very uniqueness brings with it problems which can be seen in the lives of many elderly people in the Kenyan society.

In African cultures, older people are offered considerable respect within the family and regarded with admiration and respect (Rice, 1992). Traditionally, older people are respected and listened to, and are treated accordingly; for example, it is customary for

everyone to stand up when they enter a room, they are allocated the best seats and they are offered drinks and food before everyone else. They are addressed in soft voices and are not called by their first names, but instead are referred to as father or mother of the oldest son (even if they have a daughter who is older than their son).

Some societies abandoned their enfeebled old. Native American people like the Crow, Creek and Hopi tribes, for example, built special huts away from their homesteads where the old went to die. The Eskimos left the incapacitated elderly in snowbanks or they went off in a kayak. The Siriono community of the Bolivian forest simply left them behind when they moved on in search of food. The Ik of Uganda leave the elderly and the disabled to starve to death (Zastraw & Kirst-Ashman, 2001). Generally, the primary reason for abandoning the elderly is scarce resources.

Various communities in Kenya differ in the role and manner the older persons are regarded and status they are accorded. Most communities respect highly their older generation (Senior citizens) and are treasured and revered as sages and role models. Few communities, however, accord their older persons low esteem and with disrespect. This group regards the aged people as both economic and social burden (Olum, 2009). For instance they argue that a country with high level of older persons turns out to have high dependency ratio caused mainly by the older people. They argue that older people are those citizens who have passed their productive stage and are now more of consumers than producers in economic activities. This has led this group to ignore the older persons. As a result the older people are not being consulted for guidance in; cultural matters, land heritage, setting-up of new homesteads; and, discretely, on few cases involving wife or widow inheritance. Yet older persons have

wide experience and wisdom on family and community matters in general (Olum, 2009) and should be incorporated in decision making.

Considerable cultural differences exist in the status of older men and women. Modernisation theory (Cowgill, 1986) for example, has suggested that a systematic relationship exists between ageing and modernization. According to this theory, older men and women in less technologically advanced societies tend to yield more economic and social power than those in more industrialized countries. However, men and women in these societies are also considered "old" at a younger age than men and women in more technologically developed societies.

There is a wide range of beliefs regarding the social position and status of the aged in the Kenyan society today. The society is youth oriented and deplores growing old by glorifying physical attractiveness and thereby, shortchanges the elderly. Older people are viewed as out of touch with what is happening, and their knowledge is seldom valued or sought. Intellectual ability is sometimes thought to decline with age, even though research show intellectual capacity, barring organic problems, remains essentially unchanged until very late in life (Zastrow and Kirst-Ashman, 2001). Most people dread getting grey hair and wrinkles or becoming bald and are pleased when someone guesses their age to be younger than it actually is. Society places a high value on youthful energy and action.

There are powerful forces in society which tend to denigrate and diminish older people. Some are deeply rooted and irrational as they spring from fears about ageing and death and from the psychological need to distance themselves from selected groups of people (Stevenson, 1989). Public stereotypes of older people are damaging

as they affect how people regard themselves as they grow older and create problems in the achievement of a satisfactory emotional adjustment (Gibson, 1992). Older people are erroneously thought to be senile, resistant to change, inflexible, incompetent and a burden to the young. They generally react to prejudice against them in the same way that racial and ethnic minorities react – by displaying self-hatred and by being self-conscious, sensitive, and defensive about their social and cultural status (Zastrow & Kirst-Ashman, 2001). Individuals who frequently receive negative responses from others eventually tend to come to view themselves negatively. This socially-constructed ageism is a threat to ageing well in the 21st century.

At present, the Kenyan society is still in what might be described as the "apologetic stage" where terms such as "old folk", "old geezer", "fossil", "over the hill", "one foot in the grave" "vultures are circling" are used to refer to older people which are condescending and derogatory. Terms like the "elderly" and the "old" appear to refer to groups rather than recognize the individuality of older people. These perceptions can result in compassion, but also in excessive care, patronizing and pacification of many older people, in other words, discrimination which is negative in its consequences.

Although such customs may be considered to be barbaric and savage, have Kenyans not also abandoned the elderly? As society becomes more industrialized and modern, the elderly loose their economic advantages and their leadership roles in industry and the extended family. Consequently, they loose their status and prestige (Rice, 1992). The changes which industrialization and urbanization imposed on the family structures, combined with the increased life expectancy which medical technology

engendered, has resulted in a crisis in public policy regarding older people (Wood, 1991). Within the new industrial context, older people are regarded as no longer productive and thus devalued. They are urged to retire when they are still productive. With retirement, they loose their status, power, role and self-esteem. The abandonment of the elderly is further indicated by the little action taken to relieve the financial problems of the older people. The dependent elderly population has seen dramatic increase with which existing social policies and institutions are unprepared to deal (Aging, 1997).

It is important that health care workers possess the correct attitudes toward older people and not have ageist attitudes so as to respond to future health and support needs of older people (Doherty, Mitchell & O'Neill, 2011).

1.1 Statement of the Research Problem

Research has indicated that ageism (attitudes towards older people) is quite prevalent in society (Palmore, 2001), possibly even more prevalent than sexism and racism (Banaji, 1999), although it is typically much more difficult to detect (Levy & Banaji, 2002). These facts, coupled with the rise of both the number of older people in society as well as the number of age discrimination claims being filed suggest that more research is needed that explores the construct of ageism and its measurement.

The attitudes of healthcare workers are affected by societal and cultural factors. In most African countries including Kenya, older people generally enjoy more respect because older age is recognized as a source of prestige and honour influenced by the African traditions (Nhongo, 2006). However, there are increasing tensions from younger people in relation to whether they will be able to continue to care for older

family members. This is because there has been a decline in the extended family system and an increase in nuclear families, leaving many older people alone. In addition, industrialization has brought the younger generation to cities further increasing the physical distance between many parents and children (Byun, 1997). Furthermore, the number of women working outside the home has steadily increased.

Traditional social structures in Kenya dictate that the care of parents is predominantly the responsibility of women, in particular the daughter-in-law. Filial piety based on the traditional African philosophy of respect for both the living and the dead has greatly influenced the care system between parents and children and relationships among people (Nhongo, 2006). These tensions have given majority of those who care for older people to experience stress including physical and mental burnout (Kim et al., 2006). They therefore perceive as a negative experience associated with physical and mental challenges and they feel competing tensions from their filial responsibility. As a consequence of these tensions and changing family values, it is becoming more difficult to take care of older people in the home. The demands of employment in a competitive world economy may also pressure families to pass over their caregiving role and place an older family member in a healthcare facility.

The persistence of age-related stereotypes is curious given the existence of considerable evidence that older people are generally as capable as their younger counterparts. Workplace researchers have found chronological age not to be a valid (negative) predictor of performance for many tasks (Cleveland & Landy, 1983). Research on the construct of ageism also appears to be warranted given the potential negative impact of ageism on both individuals and organizations. For individuals,

ageism can lead to ageist discourse, expressed ageist attitudes, and discriminatory practices based on age which have been shown to cause lowered self-efficacy, decreased performance, and stress (Levy, Hausdorff, Hencke, & Wei, 2000). However, despite this evidence, few researchers have investigated ageism, its measurement, its structure, and both individual and group differences in the construct of ageism.

Although ageism also can be aimed at younger age groups, this study was limited to late adulthood. There are similarities between ageism towards young and older people e.g. the inferior position both young and old people have in the power structures of society. However, ageism towards older people seems qualitatively different as it is associated with deterioration and death rather than with the developmental potential of youth. The challenges of youth will be overcome as time goes by, whereas old age will be succeeded by death. The life course takes us all away from the category 'youth' towards the category 'elderly'.

Compared to research on racism and sexism, research on ageism has been neglected (Nelson, 2005). Research on ageism is focused on the causes, the consequences, the concept and the ways in which ageism may be reduced. The study of the causes, the consequences, and prevention has marked the field of research, whereas the socio-demographic basis of attitudes towards older people has basically been ignored.

As people live longer and the number of older persons increases worldwide, it becomes important to understand the factors that influence healthcare workers' attitudes towards older people. Although studies have indicated that later adulthood can be a healthy, productive, and satisfying time of life, ageism or prejudice and

discrimination against older people and a fear of the ageing process, continues to be a widespread phenomenon (McConatha, 2004).

Despite the relatively low numbers of older people in Kenyan society, they are now perceived as a problem. A number of reasons have contributed to this perception. First is the decline of extended family and the fast growth of nuclear family. Similarly in the Kenyan culture, fast growth of nuclear family is increasing dramatically, leaving the older people living alone. In addition, people in this culture prefer individualistic lifestyles and to be free from rigid rules and regulations. Second is the increasing numbers of women, in the past the prime carers for the older people, working outside the home. This change increases the demand for more skillful and experienced healthcare workers who can address and meet the needs of older people. Improving the quality of care provided to older people in Kenyan society is a key issue, as experience and knowledge in taking responsibilities are considered crucial factors for providing optimum care for older people (Help Age, 2001). Healthcare workers are an essential and vital part of the healthcare system involved in the care of older people.

The quality of care provided to older people is directly related to the attitudes that healthcare workers hold towards them (Jacelon, 2002). Positive healthcare workers' attitudes were found to have a positive effect on the health of older people in areas such as attentiveness, connectedness, respectfulness, helpfulness and friendliness (Jacelon, 2002). Educators need to place more emphasis on healthcare workers' attitudes towards older people. This is because the number of older people needing care is increasing while the number of healthcare workers interested in working with

them has declined (Happell, 1999). Negative attitudes towards older people may result in healthcare workers' behaviours that harm older people in their care (Jacelon, 2002). A potentially important component not addressed in previous studies on ageism is the contribution of socio-demographic characteristics of health-care workers to the formation of their perceptions of older people (Menz, Stewart & Oates, 2003). It is likely that an individual's perceptions of older people will be influenced by his or her socio-demographic characteristics. Inaccurate beliefs about the aging process may manifest as negative stereotype of older people. An accurate understanding of the aging process may also influence workers' perceptions of older people. Attitudes towards older people are considered as an important factor in their care (Kalavar, 2001).

As people live longer and the number of older people continues to increase around the world, it becomes increasingly important to provide education and understanding regarding the factors that influence the attitudes of health care workers toward older people as well as how they construct their attitudes towards older people. The purpose of this study was to determine the influence and the relationship of socio-demographic characteristics of health care personnel in Kenya on their attitudes towards older people. Age, gender, level of education, marital status, occupation, religion, and work experience were considered as socio-demographic characteristics. There is need therefore to understand the dominant social contexts and attitudes in which older people live, and the attitudinal impact this has on the lives of older people.

1.2 Research objectives

The main objective of this study was to determine the influence of socio-demographic characteristics on health-care workers' attitudes toward older people (ageism). Specifically, the study attempted to achieve the following objectives:

1. To determine the influence of the socio-demographic characteristics of health-care workers (age, gender, level of education, professional occupation, work experience, marital status and religious belief) on their attitudes towards older people.
2. To determine the relationship between socio-demographic characteristics of healthcare workers (age, gender, level of education, professional occupation, work experience, marital status and religious belief) and their attitudes towards older people.

1.3 Research Questions

There was need to investigate the factors that justify and reinforce ageist attitudes in Kenya. The following were the research questions that this study attempted to answer;

(a) Does age of health care workers influence their attitudes towards older people?

(b) Does gender of health-care workers influence their attitudes towards older people?

(c) Does level of education of health-care workers influence their attitudes towards older people?

(d) Does professional occupation of health-care workers influence their attitudes towards older people?

(e) Does work experience of health-care workers influence their attitudes toward older people?

(f) Does marital status of health-care workers influence their attitudes toward older people?

(g) Does religious belief of health-care workers influence their attitudes toward older people?

1.4 Research Hypotheses

The study tested the following null hypotheses:-

Ho1: There is no significant influence of age of health-care workers on their attitudes toward older people.

Ho2: There is no significant influence of gender of health-care workers on their attitudes toward older people.

Ho3: There is no significant influence of level of education of health-care workers on their attitudes toward older people.

Ho4: There is no significant influence of professional occupation of health-care workers on their attitudes toward older people.

Ho5: There is no significant influence of work experience of health-care workers on their attitudes toward older people.

Ho6: There is no significant influence of marital status of health-care workers on their attitudes toward older people.

Ho7: There is no significant influence of religious belief of health-care workers on their attitudes toward older people.

1.5 Significance of the Study

The findings of the study will help gain greater insights into factors that influence social attitudes of health-care professionals towards older people. It is critical that practitioners working with older people show increased awareness of the process by which older people are demeaned, stigmatized and deprived of choice. The findings of this study will provide guidance for the measurement of ageism and develop educational interventions that will promote interest and training in gerontology. Knowledge of such factors is very important to the government, health practitioners and policy makers because it will help them identify appropriate strategies to change the way society looks at and deals with older people.

The detrimental effects of stereotypes involving perceptions of older people may distort assessment and diminish helping efforts by health care workers to take care of older people (Gilles, Sherman & Lawrence, 2003). Likewise, concurrent with the increase in the proportion of older people in the population, negative stereotypes about older people continue to be pervasive among medical, nursing and college students. These negative attitudes toward older people which exist among human and health care professionals potentially impact the quality of services provided to older people. If health care workers are going to respond to this demographic shift by providing high quality care for older people, they need to be knowledgeable about the health and social problems of older people, be skilled in assessment and treatment and have positive attitudes toward older people.

Another reason why the study was warranted was because research has found that ageism can be reduced (Braithwaite, 2002). Efforts have aimed at both potentially

ageist individuals (e. g. those who have the power to engage in age discrimination such as healthcare workers) and potential victims of age bias (e.g. by not attending to older people's needs because performance seems to decline with age). Other interventions have focused on organization or community climate. Such a strategy attempts to sensitize individuals to the possibility of unconsciously engaging in stereotyping (Braithwaite, 2002), to educate individuals on myths and realities of ageing (Finkelstein et al., 1995), and to emphasize the negative consequences of age bias. This strategy reflects the more general literature on age bias, which has shown that bias can be reduced through education and constructive intergroup contact, including contact of equal status, shared goals, and the support by authorities (Fiske, 2002).

The study of health care providers' attitudes toward older people and the factors that may affect it has a vital role to play in the improvement of service provision for the older people and ultimately the quality of care that older people receive (Courtney, Tong & Walsh, 2000).

In his 2011 report, the Special Rapporteur on the right to health highlighted that failing to recognize older people as rights holders may lead to prejudice and discrimination with profound consequences for the health outcomes of older people (Ageing & Development, 2012). For millions of older people, the discriminatory attitudes of some health workers determine not only the quality of care and treatment of older people may receive but also whether they receive any at all.

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1.6 Justification of the Study

The issue of age discrimination against older people has become a heated topic because a person's lifetime is no longer than ever in most countries (Chen & Wang, 2012). There are several reasons why it is important to examine the attitudes toward older people. The working environment in many countries is where workplace age discrimination against older people may become more epidemic and affect their lives (Kalaver, 2001). Older people have encountered age discrimination from employers where there are often explicit age barriers in job advertisements and less favourable treatment in recruitment, promotion and training. Age discrimination against older people may be perceived as having undesirable characteristics including poor health, an inflexible attitude, resistance to change, or low professional trainability (Taylor & Walker, 1994). There are widespread discriminatory perceptions of older people

including their being less ready to accept new ideas, less adaptable to change, less able to learn new technology and less interested in professional training.

While researchers have investigated college students' attitudes toward older people (Kalaver, 2001, Chen & Wang, 2012), few studies have focused on healthcare providers' attitudes toward older people in Kenya. Therefore, the purpose of this study was to determine the attitudes of health care personnel towards older people in Kenya.

Ageism in our homes, offices and residential care centres creates climates in which old people experience depersonalizing experiences embodied in procedure and routines in these places. Once old people are not viewed as individual adults, the scene is set for insensitive practices. Therefore, the research study will help staff to establish and maintain positive attitudes towards old people in their care by emphasizing their individuality and building upon their competence in daily living. Dominance of institutional maintenance over other goals is made more likely when old people are subject to stereotyping and assumption of competence.

Gibson (1992) observed that ageist traditions in various professions die-hard. It is difficult for some professionals not to see older people as part of charity-receiving populace. He said that people have a long way to go before ageist attitudes are eliminated from the professions. This study aimed to determine the influence of some factors on ageism and address the problem.

Norman (1987) referred to some examples of indignities inflicted on elderly people by professional workers in contemporary practice and called for the need to modify existing attitudes by examining their professional training schemes or programmes.

Absence of adequate counseling provisions for old people has also contributed in part to the increasing levels of pathology in the lives of elderly people. This study therefore offered suitable suggestions to change/improve the training manuals of the various cadres of health-care professionals for better treatment of older people.

Research studies such as this is also valuable to those running residential homes and training health-care professionals at different levels. This is as far as advocacy activities are concerned where older people are to be encouraged to be more vociferous in how they are treated or how residential homes should be run (Wynne-Harley, 1989).

The results of this study recommend an attitude shift by exploring ways to move people and social institutions based on the concept of aging called *conscious aging* (Aging, 1997). This is a way of looking at and experiencing aging that moves beyond cultural obsession with youth toward a respect and need for the wisdom of age. The goal is to change the prevailing view of ageing as something to be feared and improve the quality of life among the aged.

A potentially important component not addressed in previous studies on ageism is the contribution of socio-demographic characteristics of health-care providers to the formation of their perceptions of older people (Menz, Stewart & Oates, 2003). It is likely that an individual's perceptions of older people will be influenced by his or her socio-demographic characteristics. Inaccurate beliefs about the aging process may manifest as negative stereotype of older people. An accurate understanding of the aging process may also influence carers' perceptions of older people. This study adds

to the existing social work and gerontological literature on health care providers' attitudes towards older people.

The aim of the study was to determine whether the findings of previous studies also apply to Kenyan health-care providers and to evaluate whether attitudes toward older people are influenced by the socio-demographic characteristics of health-care providers.

The study provided invaluable information leading to the understanding of socio-demographic characteristics that influence health practitioners' attitudes towards older people.

1.7 Limitations of the Study

Respondents to research instruments may have expressed socially acceptable views and not disclosed their true or perceived attitudes towards older people. Socially desirable responses would have been reported as more positive attitudes toward older people. By using a self-reporting questionnaire, the respondents may have reported what they think the researcher wanted to know rather than the truth and their responses can be idealized to conform to norms that are socially acceptable.

Systematic errors in data collection related to the issue of *social desirability* i.e responding with the socially desirable answer even though it was not a true reflection of the respondents' views or attitudes (Brink & Woods, 1999). The researcher tried to overcome this limitation by reassuring the respondents of their confidentiality.

Because the survey instrument used was a self-reporting measure, the information presented by the participants was based upon their subjective perceptions of older people.

The findings of this study may not be generalized to healthcare professionals in other areas as the different environment and circumstances prevailing in other areas may impact on the attitudes towards older people.

The research instrument used in this study was developed in Western countries and while the researcher used versions that had been modified to be compatible with the Kenyan culture, the attitude items were made easy to interpret in terms of the Kenyan context with the input of research experts and supervisors.

The sample (N=295) was derived from only three provinces of Kenya, so the results reported here may not reflect the Kenyan healthcare workers' population as a whole which may limit generalisability to other provinces across the nation.

1.8 Assumptions of the study

The study assumed that:-

(a) Health-care workers evaluated the attitude items in the data collection instruments appropriately.

(b) The responses provided by respondents were honest responses and reflected their perceived attitudes towards older people.

1.9 Scope of the Study

The focus of this study was on the influence of socio-demographic characteristics of healthcare workers on their attitudes towards older people. Therefore, the findings and generalizations of the study results will only apply to the population of health workers from which the sample of the population studied was drawn.

The scope of the study did not permit an examination of variables such as personal experiences with older people and knowledge of the ageing process which can influence health care workers' attitudes towards older people.

1.10 TheoreticalFramework

Ageism can be viewed as a characteristic of institutions and also as a property of individuals for the sake of conceptual clarity. Authors, who build on the model of stereotypes developed by Eagly (Eagly & Chaiken, 1998), identify three key aspects of ageism: *cognition, affect, and behaviour* (Kite & Wagner, 2002). Humans use categories as cognitive tools for ordering information. Stereotyping are *shortcuts* for perceptual processing regarding categories of people (Palmore, 2003). Under

conditions of incomplete knowledge, stereotyping draws on generalizations about how characteristics or attributes go together.

Ajzen and Fishbein's Theory of Reasoned Action (1980)

According to Ajzen & Fishbein's Theory of Reasoned Action (1980), attitudes influence individual intention toward behaviour as well as intention directly related to behaviour. People with positive attitudes toward specific objects, such as older people, are likely to have favourable beliefs, feelings, and behaviours toward them. Those with negative attitudes are likely to show unfavourable beliefs, feelings and behaviours toward such objects. In short, attitudes induce behaviours in certain directions. Positive feelings are usually accompanied by positive beliefs and then positive behaviours.

Attitudes towards each other are of the utmost importance (Norbergh et al, 2006). In his famous description of the relationship between the "master and slave", Hegel stated that the meeting between two individuals is a struggle that can result in one of them abandoning his or her life to the other. In the care of older people, this can be interpreted as a connection between healthcare workers' attitudes towards older people and their experiences of themselves as carers of older people. There can be a risk of a negative process if the workers view older people as worthless objects which can result in their experiencing their own caring for older people as meaningless and their work as worthless. When their work is so meaningless and worthless, they must be worthless people themselves. This implies our attitudes are of great importance when it comes to the quality of care that older people receive.

Townsend's Structured Dependency Theory (1981)

The study was also conducted within the **Structured Dependence Theory** by Townsend (1981). It conceptualizes the link between old age and dependence as being structured by social laws and organization, by institutions, and by the dominant ideas about the nature of old age. It argues that "society creates the framework of institutions and rules within which the general problems of the elderly emerge and indeed are manufactured".

The theory posits that social forces have effect upon the functioning of old people, upon their morale, and upon their enjoyment of life. Decisions are taken every day, in the management and development of social institutions, which govern the position which the old occupy in national life, and these also contribute powerfully to the public consciousness of different meanings of ageing and old age. It concludes that debilitating characteristics of ageing are in fact social artifacts.

Ageism is endemic in Kenyan society and pervades the thinking, attitudes and expectations of the young and the old alike. The result is that both the older people and their minders accept the socially constructed view of old age, not because that is the "reality" but because the social beliefs are so powerful that they become self-inflicting. This could be attributed to the attitudes that healthcare workers and members of the society hold towards older people. There is a general belief that human behaviour is influenced by attitudes, where attitudes are seen as the "cause" and behaviour as the "effect". Attitudes are acquired and influenced by both social and demographic aspects of the environment.

1.11 Operational Definition of Terms

The study defined operationally the significant terms used as follows:-

Socio-Demographic Characteristics- They referred to community and population properties i.e. age, gender, occupation, level of education, work experience, marital status, and religious belief selected for the study. This data was collected by use of proforma administered to the research respondents (APPENDIX A).

Health Care Workers- They referred to those who nurse and provide for older people in old age homes, nursing homes, residential homes, hospices, day-care centres, psychiatric hospitals, retirement homes and they include nursing students, registered nurses, medical students, medical doctors, social and community workers selected for the study. The aim of this study was to explore the attitudes held by these health care workers towards older people in their care.

Attitude- Is a cognitive association between concept or objects and their evaluations (Eagly & Chaiken, 1992). It is an evaluation of something or someone on a continuum of like to dislike or favourable or favourable. Therefore, attitudes toward older people are usually assessed by asking respondents to indicate the strength of their agreement with both positive and negative statements about older people.

Attitudes are developed and learned as part of the socialization process. If a prevailing attitude is that older people are a surplus commodity, the cognitive component perceives an older person as unneeded and valueless to society.

Attitudes toward Older People (Ageism) – The systematic stereotyping prejudice and/or discrimination against (or to the benefit of) older people because they are

old (Oskamp, 1991). It is used to describe a societal pattern of widely held devaluative attitudes and stereotypes older people (Getz & Pearson, 1988). Like racism and sexism, ageism is presumed to be responsible for social avoidance and segregation, hostile humour, discriminatory practices and policies, and a conviction that older people are a drain on society.

It is a social tendency which assume that old age is a uniform category or condition, that the process of growing old is in some way a regular experience, and that older people constitute a homogenous group by virtue of their age alone (Scrutton, 1989). It denies the old people the right to be viewed and treated as individuals with distinctive and widely varying strengths, weaknesses, and needs as any other age group (Stevenson, 1989). The Kogan's (1961) modified version of Attitudes toward Old People Scale (ATOPS) was used to measure the health-care workers' attitudes towards older people (Appendix A).

Older People – In conformity with United Nations and African Union definitions, it was those people aged 65 years and above. It is a matter of cultural and social construction with floating boundaries but is conventionally accepted as being the period of life beyond the age of 65 years.

1.12 Summary

The main focus of this chapter was to discuss the background to the study, statement of the research problem, research objectives, research hypotheses, justification of the study, assumptions of the study, limitations of the study, scope of the study, significance of the study and theoretical framework of the study.

In the background of the study, it was noted some people believe that the best way to understand the problems of older people is to regard them as a minority group, faced with difficulties similar to those of other minority groups. Discrimination against older people is believed to be based on a bias against visible physical traits (Ageing, 1997). Since the ageing process is viewed negatively, it is natural that the elderly try to appear and act younger. Some spend a tremendous amount of money trying to make themselves look and feel younger. Self-consciousness about one's changing physique is accentuated by society's attitudes. Unfortunately the label "older person" often has negative connotations in Kenya society. It is described as aimless, apathetic, debilitated, disruptive, hypochondriacal, insecure, needing insatiable reassurance, low in self-esteem, sluggish, reclusive and temperamental (Rice, 1992).

The chapter also outlined the statement of the research problem, its purpose and objectives. Theoretical framework was also outlined to bring synergy between the research problem and the existing models on ageing and ageing process. Key terms were

operationally defined so as to allow for specific research concepts to be objectively described. The next chapter focused on literature review so as to compare and contrast research designs and methodologies of previous studies and their strengths and weaknesses so as to benefit of the study.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter consists of a review of related research studies which have been carried out on the impact of socio-demographic characteristics on the attitudes of health-care workers towards older people. This was done for the purpose of examining the weaknesses and strengths of the relevant past studies so that their contributions to the present study can be identified. It also helped to identify the methods of data analyses which the related studies used so as to borrow for the study. The main sources of the literature reviewed included abstracts, e-journals, periodicals, book reviews, research theses, dissertations and encyclopedias. Literature was reviewed under the following sections- Myths about Old Age, "Dominant" Ideology of Old Age, The Genesis of Ageism, The Nature of Ageism, Overview of Ageing Policies in Kenya, Health Care Workers and their Attitudes towards Older People, Gender and Attitudes toward Older People, Age and Attitudes toward Older People, Level of Education and Attitudes toward Older People, Occupation and Attitudes toward Older People, Work Experience and Attitudes toward Older People, Marital Status and Attitudes toward Older People and Religious Belief and Attitudes toward Older People.

2.1 Myths about Old Age

Dixon and Gregory (1987) outlined several different myths about ageism which is increasingly recognized as a powerful influence in developing a stereotype of "old people" which diminishes and undermines their social status. These include:-

(a) **The myth of chronology** – that elderly people are a homogenous group by virtue of their age alone i.e. once your age reaches a "magic number" you automatically become old and part of the group "the elderly".

(b) **Myth of ill health** – that old age automatically involves physical deterioration and that illness in old age is part of normal ageing, not disease processes, and therefore is irreversible and untreatable.

(c) **Myth of mental deterioration** – that elderly people automatically loose their mental faculties, have defective memories and become "senile" (i.e. demented).

(d) **Myth of inflexible personality** – that personality changes with age to become more intolerant, inflexible and conservative.

(e) **Myth of misery** – that elderly people are unhappy with the state of their lives.

(f) **Myth of reflection and isolation** – that society rejects its elderly people and is uncaring towards them, and the elderly people prefer to "disengage" from life i.e. withdraw into themselves. They are neither interested in nor have the capacity for sexual relations.

(g) **Myth of dependence** – that elderly people are not productive members of the society and therefore are inevitably dependent upon others and seen as a burden on the rest of society.

These myths about old age perpetuate the stereotype that older people are perceived and hence aggravating their place in society. They were linked to the research problem as they helped to understand Kenyan healthcare workers' attitudes towards older people based on mythical views of old age.

2.2 "Dominant" Ideology of Old Age

The origin of ageism is rooted in the value that society places on age (Scrutton, 1989). Youth is more highly valued by dominant social attitudes. It is associated with beauty, energy, enthusiasm, vigour, new ideas, innovation, change and progress – all highly valued attributes. The old can offer only experience, competence, loyalty, continuity, security, and reliability to a society that seems to have outgrown such values. The immaturity, rashness and naivety of youth seem so often to be forgotten, along with the role that the experience of age can play in guiding it. Dominant ideology sees the future, and the people of the future, as crucially important, and older people have little role there (Scrutton, 1989). In much the same way that people have learnt to consider commodities with a "value" to be bought and sold, and once they have outlived their value, they too become disposable.

Within the Kenyan society, there exists a body of ideas which can be described as dominant. This "dominant ideology" consists of a complex set of social values which to a considerable extent determines how older people are seen, how they see themselves, and how they function or are allowed to function within the wider social context (Estes, 1996). It is these dominant ideas which establish "structures", the dominant constraints within which older people are forced to live their lives.

Dominant ideology reflects the interests of the most powerful groups in any society (Scrutton, 1989). Laws are passed which not only work in the interest of these groups but often work against the interests of weaker, minority groups i.e. older people hence ageism. This comprises a set of negative attitudes, practices and values, which form a stereotype of the group. Ageism is being increasingly recognized as a powerful

influence, developing a stereotype of “old people” which diminishes and undermines their social status (Dixon and Gregory, 1987).

Ageism has led to a number of personal problems to older people i.e. poverty, malnutrition, low status, roleless status, neglect and elder abuse (Zastrow and Kirst-Ashman, 2001). Older people will learn that to be old is to conform to their stereotypes and accept the ascribed elderly role within the social order. They will take the attitudes they held as young people and internalise them when they reach old age. Thus generation by generation, we perpetuate and intensify such attitudes.

Provisions of care to the older people by family members and the community are vital for the comfort and psychological satisfaction to the older people. However, it has emerged that with the hard life caused by modernization, a number of families and communities tend to ignore the long-standing traditional responsibility and leave only a few people to cater for and take care of the older members of their families and communities. This has resulted in having older people being taken care of in old age homes, home nursing services, foster homes and home help services amongst others. However, a number of care and support centres are not accessible to the majority of the older people due to their costs or room for admission (Olum, 2009).

With the impact of Western cultures that put stress on individualism and mutual respect between generations, the traditional value of elder respect has been shifting (Sung, 2001). It indicated that consulting elders instead of obeying elders has become a prevalent form of elder respect. As more and younger people value reciprocity between generations, consulting elders is widely practiced. Additionally, instead of bending the body forward to greet seniors, juniors now tend to say hello to elders or

shake hands with them (Sung, 2001). Viable intervention strategies must have a basis on multi-sectoral approaches with primary focus on attitudes and the community.

Ageism is endemic in society and resides within all people (Scrutton, 1989). It pervades the thinking, attitudes and expectations of young and old alike. The result is that both the old and their carers accept the socially constructed view of old age, not because that is the "reality" but because the social beliefs are so powerful that they become self-fulfilling. It is not a natural perception that is true and incontrovertible but beliefs which have been developed by dominant social forces over the years. The paradigm of an older person is perhaps the individual living alone, socially isolated, managing on an inadequate income, suffering from poor health, poorly housed, dependent and seen generally as a burden to society (Scrutton, 1989).

Earlier evidence adduced that the attitude and behaviour of some health-care workers towards older people was negative (Ochola et al, 2000). Elderly respondents taking part in Focus Group Discussions (FGDs) in their study reported that public health workers utter discouraging remarks, for example: '*Wewe si mgonjwa, shida yako ni uzee*', translated in English as: "You are not sick, your problem is old age". Some observed that they often hear paramedics discuss how much of a waste of precious drugs that old people receive.

In Kyrgystan, older people report that ambulance services ask for the patient's age and routinely discriminate against people over 50 by not sending an ambulance for anyone who they think is too old. A member of Bishkek said "We have to tell a lie when calling an ambulance" (HelpAge International, 2009). Such discriminatory practices can also be found in post-conflict or humanitarian situations. In northern Uganda,

displaced older people unable to return to their villages were frequently told that they were wasting the doctor's time and that they were not sick, just old.

With the changing structure of society, the older people have lost their traditional roles and respect. The extreme economic conditions have made economic considerations ever more important. Older people are thus increasingly marginalized within communities as they are viewed as a waste of scarce resources (HelpAge International, 2001).

"Dominant" ideology are spurious psychological constructs in which older people are meant to live and this helps perpetuate the self-fulfilling prophecy in older people and the lives they live. It was important for this study as they contribute to the understanding of the attitudes that people hold about older people and more so within the Kenyan context.

2.3 The Genesis of Ageism

The institutionalization of ageism has its roots in the increasingly negative way that people view older people (Nelson, 2002). Older people tend to be marginalized, institutionalized, and stripped of responsibility, power and ultimately their dignity. In most prehistoric and traditional societies, older people were often held in high regard and they were teachers. By virtue of their age and greater experience, they were regarded as wise and they were the custodians of the traditions of their people. In African societies, if one lived beyond 70 years, it was believed he or she was chosen by God for a divine purpose (Nhongo, 2006).

However, attitudes towards older people began to shift dramatically through the advent of the printing press where the culture, tradition and history of a society was

immortalized in books and the status and power older people held as village historians was greatly reduced. Also the industrial revolution demanded great mobility of families in search of jobs and therefore the extended family structure became less adaptive as older people were not as mobile and the jobs were suited for younger and stronger workers. With greater advances in medicine, life expectancy was significantly extended and society with two major developments in civilization was not prepared to deal with this new large population of older people.

Society began to associate old age with negative qualities and older people were regarded as non-contributing burdens on society. These negative attitudes have persisted and increased over time (Palmore, 1999). Older people today are treated as second-class citizens with nothing to offer society. These negative attitudes towards older people have resulted in the rise to ageism which tend to manifest in subtle ways in the daily lives of older people.

2.3.1 Functional Perspective of Ageism

This approach holds that negative attitudes towards older people serve as ego-protective function for the stereotyping individual (Snyder & Meine, 1994). These stereotypes help younger people deny the self-threatening aspects of old age (e.g. that one will become frail and die eventually). When people encounter older people who represent a threat to their self, their perceptions of and behaviours towards the threatening person tend to be more negative. This helps to reduce anxiety associated with considering older people as a future ingroup.

2.3.2 Terror Management Theory (TMT) Approach

This approach suggests that culture and religion are creations that impose order and meaning on the world, and this buffers frightening thoughts of one's own mortality and the seemingly chaotic nature of existence (Solomon, Greenberg & Pyszczynski, 1991). As people grow up, they learn that being good means being protected (parental approval and protection). Therefore, self-esteem becomes an anxiety buffer in that it helps people deny their mortality. Because older people tend to be associated with death, younger people may adopt ageist attitudes and behaviours to distance themselves from older people. This may include blaming older people for their state (e.g, external indicators of old age). Doing this may allow the younger person to deny the realities that they too will eventually become part of that outgroup.

2.4 The Nature of Ageism

As the number of older people increase, the perception grew that they were a burden to society (Butler, 1969). This became widespread as societies moved from agrarian economies, where older men had traditionally owned land to industrialized economies when work was no longer centred in the home and older people lost authority. However, although the status of older persons and attitudes towards them are both historic and economically defined, attitudes towards older people (ageism) are also a reflection of the concerns and fears about the vulnerability and old age that everyone has (Butler, 1969).

Although attitudes towards older people are somewhat based on the social and economic position of the older person in society, ageist stereotypes abound in all societies-both developed and developing that also dictate how older people are viewed

and treated, even when societal agreement for material support of older people is strong (Nelson, 2002). For example, in a United Kingdom study key findings showed that 48% of respondents viewed age discrimination as a serious issue, people of all ages experienced ageism more commonly than any other form of prejudice and that persons over 70 years are perceived as posing a greater threat to society by placing burdens on the economy rather than by affecting others' access to services or way of life (Kimuna, Knox & Zusman, 2005). Many felt that older people are all alike and consider themselves bored, miserable, senile and living in the past. In developing countries with limited financial security coverage in old age, perceptions of older age as a period of life to look forward to is much lower.

2.5 Overview of Policies on Ageing

The Government of Kenya is committed to supporting welfare activities for older people. This is evident from the various policy documents in which the Government has made specific provisions for the needs of the older people. The key policy documents are;

- The 9th National Development Plan (2002-2008)
- Sessional Paper No. 1 of 2000 on National Population Policy
- The New Constitution (2010) of Kenya
- Kenya National Policy on Ageing

2.5.1 The 9th National Development Plan (2002-2008)

In this plan, it is noted that the disintegration of the extended family support system due to urbanization and modernization and poverty have rendered older persons

helpless and sometimes making them more destitute. It is therefore stated that during the planning period, the Government in collaboration with other stakeholders will undertake the following activities; Operationalise the National Policy for Older Persons to ensure proper coordination of all programmes for older persons, Design appropriate capacity building programmes for all the organizations addressing older persons issues, Advocacy programmes to sensitise the public on the needs and rights of the older persons and Mainstreaming ageing issues in the national development planning and budgeting processes.

2.5.2 Sessional Paper No. 1 of 2000 on National Population Policy

The Sessional Paper recognizes that older people present a potential problem in light of the breakdown in societal structures that used to take care of them and the absence of comprehensive support programmes faced by the majority of families. The major challenge with regard to older persons is therefore emphasized to be the provision of basic needs and care by formulating long-term programmes to ensure the socio-economic support and security for the elderly, including creation of private social security programmes and encouraging positive traditional support networks.

2.5.3 The New Constitution (2010) of Kenya

The new constitution has provisions for older people in Article 36. It includes the right of older people to fully participate in the affairs of the society; pursuing their personal development; freedom from all forms of discrimination, exploitation and abuse; live with dignity and respect; and entitlement to reasonable care and assistance of family and state. It is further provided that older members of society have the duty to plan

their retirement, to share their knowledge and skills with others and to remain active in society. It noted the involvement of Help Age Kenya in making representations to the New Constitution (Olum, 2009).

2.5.4 Kenya National Policy on Ageing

The Policy has the overall objective of facilitating the integration and mainstreaming of the needs and concerns of the older people in the national development process. The vision of the policy is to create an environment in which older persons are recognized, respected and empowered to actively and fully participate in society and development. The priority issues covered in the National Policy are laws and rights of older persons; poverty and sustainable development; health and active life; family culture; gender; food security and nutrition; housing and physical amenities; employment and income security and preparation for retirement (Olum, 2009).

It is proposed in the policy document that there will be need for the establishment of a fully-fledged division in the Ministry of Gender and Children Services. Secondly, it is proposed that a National Council for Older Persons be established to spearhead activities in support of older persons in collaboration with other stakeholders. These policy documents explains Kenya government efforts in bringing older people into the mainstream of its development strategies and therefore it was important in this study as it helped to gauge the government's contribution in alleviating the plight of older people (Republic of Kenya, 2003)

2.6 HealthCare Workers and their Attitudes toward Older People

Research studies that have investigated healthcare workers attitudes towards older people have reported contradictory findings. Several research studies investigated healthcare workers' attitudes towards older people in both long-term and acute care settings (Hope 1994, Jacelon, 2002). These research studies indicated healthcare workers' attitudes need to be identified and modified. The majority of the studies attempted to explain healthcare workers' attitudes focused on the characteristics of healthcare workers and their work environment. The most frequent correlates were age (Jacelon, 2002), gender (Slevin, 1991) and education (Jacelon, 2002).

Studies of attitudes toward older people have shown that, on the positive to negative attitude continuum, attitudes towards older people fall at the neutral to negative end. This has been shown in a variety of studies of health care professionals and their attitudes toward older people (Robinson, 1993 & Kane, 1999). The methodologies, attitudinal measures and curricular intervention are highly disparate making it difficult to appraise. Literature reviewed indicated that health care workers generally hold slightly to moderately positive attitudes towards older people despite what appeared to be common knowledge that health care professionals have negative attitudes toward older people (Sainsbury, Wilkinson & Smith, 2004). Most of the articles reviewed reported negative attitudes toward older people. Nurses observed that they prefer working with younger people because older people were 'difficult'. They recommended specialist geriatric facilities not in the spirit of desiring better care for older persons but so as to get the older persons out of their systems. In a confidential interview with the head of one of the hospitals, he confided that "older people are a

big headache and a waste of scarce resources, the biggest favour you can do to me as Older People's researcher is to get them out of my hospital". The research also found major problems related to the scarcity of resources at the hospitals resulting in older people not being prioritised in treatment and care. For instance, it was found that they would sleep on the floor instead of being provided with beds.

Mosher-Ashley & Ball (1999) explored the attitudes of college students toward their ageing and older people. In comparing the attitudes of business, psychology, occupational therapy, and nursing students in the United Students, they found that although older people were seen as knowledgeable and enjoyable to be with, they were perceived as having physical problems and being dependent on others.

Generally, studies of attitudes to aging have found a pessimistic view of later life, and the strength of this opinion is in inverse proportion to the age of the respondent (Stuart-Hamilton, 1998). However, the research methods used in such studies may in some instances tacitly predispose participants to take a more negative view of later life than was perhaps intended. For example, one popular method requires the participant to compare an older and younger person and judge their relative merits, sometimes against an idealized "perfect" person (Netz & Ben-Sira, 1993). There are sound reasons for such a methodology, and it is of course important to study explicit age group comparisons. However, the methodology will also almost force participants into downgrading older people, because they are no longer being seen in terms of their own merits. If an older adult is directly compared on social, financial, mental and physical status with a younger adult, then on the most egalitarian premises, one must conclude

the older adult is worse off. This statement does not in any manner countenance an ageist viewpoint.

There is a large amount of evidence that older people are generally less well regarded by society, many pensioners are in desperate financial straits, and on objective tests, older people in general perform less well on tests of physical and mental functioning (Stuart-Hamilton, 2000). Of course there are strong counter-arguments to this. For example, on a straightforward factual level, a large proportion of older people maintain younger levels of performance; and many older people enjoy a high social status especially in African societies and are financially more secure than many younger people. On a more subjective level, it can also be validly argued that any age group should be judged on its own merits, not on how it compares with others. We would not, for example, criticize children for being less mature than adults. In other words, many old-young differences either are not all-embracing or they do not matter when viewed from another angle. The essence of inviting an explicit comparison is that senescent age change if often made to appear universal and to matter.

Damrosch (1984) also reviewed various studies concerning the attitudes of students and young adults to the sexuality of elderly people, and reports that many of them show that younger people in general are far more tolerant, at least in theory than has been indicated in other literature. This might indicate that prejudices are more prevalent and more deeply rooted in more mature professionals and calls for more research which this study did. He mentioned that the students in his study had already been exposed to some educative influences to liberalise their attitudes to the elderly.

Kramer, Ber and Moore (1989) also focused on medical students' empathy towards their patients in relation to ageing and averred that a process of "dehumanization" takes place as students proceed through their medical studies. They state that while "emphatic listening to patients, responding to their emotional needs, and expressing supportive caring" are the main components of an empathic approach, unfortunately these are often considered a waste of time in the hospital setting and are discouraged by clinical tutors.

There have also been attempts to modify the attitude of medical students towards older people (Smith and Wattis, 1989), but they do not appear to have been effective. More successful have been attempts to modify students' attitudes toward elderly sexuality in general (Damrosch, 1984). This study sought to assess the attitudes of health-care workers towards older people. Marshall (1990) also reported a significant change for the better in public attitudes towards older people since about 1985 in Britain. But Stout (1985) points out specifically that the attitudes towards older people of both the population as a whole and of some members of the health professions are sometimes unhelpful and negative. These contradicting views about attitudes towards older people necessitated this study.

Philpot (1986) compared the traditional and the modern attitudes towards older people in Japan. He found that the roots of respect for elderly people were contained within Japanese culture and religion, and that despite the rapid development of industrialisation and urbanization and the rush for growth, efficiency and change, respect for elderly people has ensured that they have not fallen behind, and old age still retains a certain authority and respect. But Cowgill and Holmes (1972) say that

with advanced industrialisation, people have abandoned these perceptions of old age. They say that the various aspects of the social status of older people have been lowered during the last two centuries. It was the aim of this study to determine the influence of various socio-demographic characteristics of healthcare workers on their attitudes toward older people in the Kenyan society to embellish these various findings on ageism.

2.7 Gender and Attitudes toward Older People

The proportion of women in the population also increases significantly with age (United Nations, 2009). Among the population aged 65 and over, women constituted 54% in 2009, but at the age 80 and above, the population rose to 63%, and continued to increase to 81% among centenarians (United Nations, 2009).

Many older people are women in most cultures (Gibson, 1992). This means that gender-related attitudes affect them as well as those to do with ageing. Attractiveness in women is more closely associated with sexuality and sexuality with youth, than is the case for men. He says that it is socially acceptable for men to marry younger women but not vice versa. Women must not be hairy in the wrong places but men can be bald. Older women are sent daily signals that they must struggle to preserve their attractiveness. It was the objective of this study to find out the influence of gender on the perceptions about older people.

Women, even more than men, tend to be subjected to the negative attitudes associated with age. For example, although women live longer than men, they are considered “old” at a younger age (McConatha, 2004). Women are also socialized to place more value on their appearance than men. As a consequence, women tend to internalize

social and cultural perspectives about their physical selves which may in turn promote shame and anxiety about their ageing bodies resulting in an increase in anxiety about the ageing process. They have more concerns about ageing than men especially in relation to losses associated with physical appearance.

Kogan & Shelton (1962) have discussed the importance of considering gender differences in attitudes towards older people. Although their main finding was that younger participants had more negative beliefs about older people. These researchers also reported that significant age differences were related to the gender of the participants. That is, age differences on two items were found for male participants only, and age differences on three other items were found for female participants only.

Some research has found women to be less ageist than men (Kalavar, 2001). For instance, using primarily female (66%), Caucasian (93%), and young (M=20.2 years, SD=4.9 years) sample of university students (N=200), Kalavar (2001) found evidence that male participants (M=70.6, SD-13.3) possessed greater ageism scores on the Fraboni Scale of Attitude (FSA) than did their female counterparts (M=62.9, SD=14.1). This finding is consistent with that of Fraboni *et al*, (1990) who reported that men (M=61.0, SD=11.6) had significantly greater ageism scores on the FSA than did women (M=56.4, SD=11.8).

Kite & Stockdale (2004) suggested that men generally give lower ratings to older individuals on performance dimensions labeled as ‘competence’ and ‘behavioural intentions’ than do women. However, gender differences were not consistently found across the studies that were examined. Although the evidence supporting a gender effect on ageism scores is somewhat inconclusive, it was hypothesized that women

would display less systematic ageism than would men. Such a finding would be congruent with the work of Deaux (1985) that found women to be more warm, caring, and empathetic, whereas men were more competitive and critical.

The abuse of older persons within the healthcare system in Kenya was observed to be taking a gender dimension (Nhongo, 2006). A social worker at Nanyuki observed that the 60% to 70% of the abandoned older patients were male. This was generally attributed to their having abandoned their families during their youth. The perception is that they squandered their youth and because of that negative attitude they get even less favourable treatment than the abandoned female counterparts. Also, due to traditions (of men keeping emotional distance from their children) and the tendency towards extravagant habits such as alcohol, the children often tend to support their mothers more often and better than their fathers. In the same discussions, the participants also observed that female children were more supportive of their parents than the male ones (Nhongo, 2006).

In a research in Kenya and Zimbabwe, Nhongo & Tewodros (2002) found that the belief in witchcraft was rife with 96.7% of the respondents indicating that they believed in it even when they were Christians. Asked what image immediately came to their minds when they heard the word ‘witch’, 75% said that what came to their mind was the image of an older person.

Reviews of literature on ageism have concluded that older people are evaluated more negatively than young people, particularly when young and older targets are placed in direct comparison with one another (Kite & Johnson, 1988; Kite & Wagner, 2002). Interestingly, older adults are rarely actively disliked; instead they are particularly

liked to be the victims of 'paternalistic prejudice', which stereotypes them as warm, but incompetent (Cuddy & Fiske, 2002). Stereotypes of older people as incompetent may lead, in turn, to discrimination against them in the workplace and other settings like nursing homes. Although always troubling, prejudice against older people is a growing concern due to the rapid growth of Kenya's older population. Projections by the U.S. government predict that the percentage of the American population over the age of 65 will rise from 12.4 Million in 2000 to 19.6 Million in 2030. As such, understanding the causes and consequences of ageism is a pressing and important task. The study intended to determine the influence of gender of health-service workers on their attitudes towards older people.

2.8 Healthcare Workers' Age and Attitudes toward Older people

Studies investigating the effect of age on healthcare workers' attitudes towards older people reported incongruent findings. An early study (Taylor & Hamed, 1978) found that healthcare workers' age did not relate to their attitudes towards older people. A later study (Slevin, 1991) indicated that older healthcare workers had more favourable attitudes and were better informed about older people than younger healthcare workers. However, Herdman (2002) found that older healthcare workers had more negative attitudes towards older people.

Past empirical research has found that younger people are more ageist than older people. That is, younger individuals generally possess more negative attitudes toward the older person than do older counterparts (Bell & Stanfield, 1973a, 1973b). Organizational research has found a similar age effect on attitudes about the aged (Hassell & Perrewe, 1995) as well as an age effect regarding the severity of actions

taken against older workers for performance errors (with younger workers making harsher recommendations).

In contrast, other researchers have indicated that older people are more biased toward their own age group than are younger people (Hellsbusch, Corbin, Thorson, & Stacy, 1994). Given these contradictory findings, the study sought to investigate the influence of age on the healthcare workers attitudes towards older people using the Attitudes Towards Older People Scale (ATOPS). It was hypothesized that younger individuals would be more ageist than would older individuals. The Social Identity Theory (SIT) indicates that individuals are more motivated to perceive their own group in more positive terms relative to out-groups. Indeed, several researchers have used the basic tenets of SIT as a possible explanation for age effects on ageism scores. The Ageism Survey has demonstrated that younger people and men have significantly higher ageism scores than older individuals and women.

Lifshitz (2002) found significant differences among age groups regarding the cognitive component of attitudes towards older people. One hundred per cent (100%) of the young adults ascribed negative characteristics to older people versus 66% of the middle-aged group and 33% of the elderly group. Characteristics were mostly physical and concrete: “walks with a cane”, “has white hair”, “lives in an old-age home”, “in the cemetery”, “dead” and so on. Chi-square analysis of responses to “Do you want to be an old person?” showed that 75% of the young adults answered negatively (“No, I’ll walk with a cane”, “No, I’ll die”, “No, I’ll live in an old age home” and 16% gave a neutral answer (“I don’t care one way or another”). Of the middle-aged group, 66%

gave a negative response (illness and fear of death) and 33% gave a neutral one. One hundred per cent (100%) of the elderly gave a neutral response ("I'm already old").

Regarding responses to "With whom do you prefer to be and to spend time?"', chi-square analysis indicated significant differences between the age groups. Eighty three per cent (83%) of young-adult group prefer young adults and 16% prefer middle-aged people; of the middle-aged group, 57% prefer young adults, 28% prefer middle-aged people and 14% prefer the elderly. In the elderly group, 66% prefer young adults and 33% prefer elderly people.

When asked "What can you do when you are with an old person?", 70% talked about activities for old people (helping them to dress, wash, cross the street, carry heavy items), 12.3% talked about passive activities (watching television together) and 8.3 % talked about sharing activities (conversing, learning, leisure activities).

To the question, "What can old people do for you?", 57% said "they can't do anything", 19% mentioned physical activities ("they can help me dress or wash myself") and 19% said that older people can teach them (Lifshitz, 2002). Studies of health care professionals attitudes towards older people have generally found negative attitudes towards older people, which are more pronounced the younger the respondent (Hellbusch et al, 1994) and generally become more consolidated during training. Adolescents may have negative attitudes of older people because it is an abstract concept and one which is difficult to imagine personally experiencing. Because the majority of their professional exposure to older people will be to unwell older people then this may inevitably shape their attitudes negatively.

In another study, Laditka et al (2004) found that among younger, middle aged and older participants from a college community, female participants were viewed more positively than males by most rater groups. Older groups were viewed more positively by older participants than by other age groups. Older participants had more positive views about their own aging than did participants of the younger and middle aged groups. One study found that a learning activity about ageing can significantly improve students' negative attitudes toward the elderly (VonDras & Lor-Vang, 2004).

In their study on students' perceptions of the aged, Kimuna et al. (2005) found that men and White students tend to consider a younger age as being 'old'. Protestants are less likely to agree that older people are dangerous drivers. White students are more likely to believe older people tend to be dangerous drivers and more likely to agree that most social services are easily accessed by older people. White students are less likely to agree that grown children should allow their older parents to live with them, and they were less likely to agree that the government should take care of older people who are poor.

Salthouse (2004) argued that although there is a sharp decline in cognitive functioning as adults gets older, the impairment rarely impacts everyday functioning. This is because factors such as motivation, persistence, adaptation, and experience inhibit performance declines. Also, many tasks (including job tasks) rarely require the level of cognitive functioning required in laboratory studies of this effect. However, it appears that individuals continue to possess age-related attitudes regarding both people and jobs. An important goal for future research would be to identify the

antecedents of ageist attitudes and the mediating variables explaining how such attitudes lead to age bias.

It was the objective of the study to determine the influence of age on healthcare workers' attitudes towards older people.

2.9 Level of Education and Attitudes toward Older People

The level of education of healthcare workers seems to have an impact on their attitudes towards older people (Kwan & Law, 1994). However, Treharne (1990) reported no significant differences between working nurses and student nurses in their attitudes towards older people. He found that registered nurses held more positive attitudes than nursing students and suggested that educational preparation was a major cultural influence in shaping healthcare workers' attitudes towards older people. After four weeks of intensive education, participating nurses reported more favourable attitudes towards older people. In terms of positive attitudes, it has been noted that higher levels of education in healthcare were accompanied by a greater acknowledgement of the older people's attitudes and wishes (Treharne, 1990). Salmon (1993) reported that registered nurses had more positive attitudes towards older people, higher levels of empathy, and lower burnout than did licensed practical nurses and nursing aides.

Some previous research (McContha & Stevenson, 1982; White, 1982) indicated that the more knowledge nursing staff had on the facts of old age in later life, the more understanding and permissive they were in their professional practice. Glass *et al* (1986) set out to ascertain the extent of knowledge about old age in later life possessed by member of the staff of the nursing homes, and whether such knowledge was related

to their attitudes to the elderly people in their case. They also studied whether socio-demographic characteristics such as age, marital status, general education, nursing education and religious denomination, were significantly related to both knowledge and education on older people.

Somewhat to their surprise they found in their study that the greater the extent of actual knowledge about old age in later life possessed by various members of staff, the lesser the degree of the restrictiveness of their attitudes towards the elderly. While the higher their general education, the more restrictive were their attitudes, this did not go for the level of nursing education, the latter associated with greater understanding of the emotional needs of older people (Gibson, 1992). Restrictiveness of attitude was related to being in a supervisory and administrative position, such positions also going with having a higher level of general education, although not necessarily more nursing education.

Healthcare workers with higher levels of professional education had more positive attitudes toward older people (Hope, 1994). Similar results were obtained from studies in long term care settings for older people (Haight, Christ & Dias, 1994). They found that educational interventions changed health care workers' decision making practices with older people from a "medical-oriented, professional" approach to a "patient choice" approach allowing older people more control over decisions relating to their care and place of residence following discharge. They found significant increases in knowledge and a significant reduction in negative attitudes toward older people following a continuing education programme for all health care workers in long term

care facilities but increased education did not strengthen positive attitudes towards older people.

Increased knowledge about ageing and attitudes toward older people may be related to and significantly influence the quality of care that older people receive. Knowledge about the ageing process did not predict positive attitudes toward older people (Courtney, Tong & Walsh, 2006). Knowledge of ageing by health care workers in acute settings influences their care for older people where they attend to routine observations, medication and technical activities but not attentive to the nutrition, hygiene, elimination, mobility and educational needs of older people which vary from younger people.

Gellis et al. (2003) found that first year Social Work students have already formed a negative impression of older people. Increasing knowledge of aging was a predictor of positive attitudes on the Aging Semantic Differential (ASD) scales, whereas 'plans to work with older people upon graduation' was the only predictor for more positive attitude on all ASD subscales.

Hope's (1994) study suggested that a lower knowledge level of geriatric care may indicate a more negative attitude toward older people. However, using Palmore's Facts of Ageing Quiz (PFAQ) (1977) as an outcome measure, this association was not statistically significant. Lack of knowledge of the ageing process may not affect attitudes toward older people. However, poor knowledge of geriatric care may result in nurses being unable to modify care accordingly, potentially placing older patients at risk.

It was the objective of this study to establish the influence of healthcare workers' level of education on their attitudes towards older people.

2.10 Professional Occupation and Attitudes towards Older People

Attitudes of health care professionals toward older people are significantly influenced by both their current and preferred area of practice. Armstrong-Esther et al (1999) found those preferring to work in geriatrics and rehabilitation had more positive attitudes toward older people than those preferring to care for surgical needs of older people and those under 65 years of age. Interestingly, intensive care nurses were found to be both more knowledgeable about ageing and have more positive attitudes toward older people than medical-surgical nurses. The nature of intensive care patients may explain these nurses' greater knowledge of ageing and positive attitudes toward older people. All intensive care patients are dependent and therefore older intensive care patients' nursing needs may not be perceived as burdensome or different from the needs of other intensive care patients.

In a similar study in Nigeria, Baiyewu et al, (1997) explored attitudes among caregivers living at home with an older person, hospital workers, and the general public. Overall, Nigerians tended to have positive attitudes toward older people. However, caregivers had the most positive attitudes while hospital workers had the most negative. The researchers concluded that negative attitudes toward older people are less salient for those who are emotionally close to the older person. The quality of contact with an older person appears to be influential in determining attitudes toward older people. It suggests that attitudes toward older people may be improved by ensuring favourable contact conditions. They indicate, for example, that nursing

students and physicians who work with older people in medically related situations may develop and maintain more negative attitudes toward them and the ageing process.

Hope (1994) noted that nurses working in acute older people care setting reported more positive attitudes toward older people than nurses in medical settings for older people. Those in the older people care settings may have a preference for working with older people explaining their more positive attitudes. Interestingly, in one study volunteers had more positive attitudes toward older people than nurses, nursing aides and licensed doctors possibly indicating their reason for their work with older people (Brown, 1998).

Similarly, Kogan (1961) and Smith & Wattis (1989) found that although many positive attitudes were reported by nurses, many negative attitudes were also identified. Nurses feel at ease in the presence of older people and find them different, cantankerous and complaining. They also find older people set in their ways and incapable of adjusting to new situations.

Lookinland & Anson (2005) suggest that this may be the result of prolonged exposure to ill and infirm older adults leading to emotional rejection and stereotyping rather than individualisation. This emotional rejection has significant repercussions on the quality of care older people may receive in acute care settings, particularly from nurses who prefer not to work with patients 65 years and older. Many studies have examined the information received by older people on discharge and reported lack of information about their illness, recovery, medication and life rules which could be the result of these ageist or stereotypical attitudes (Armstrong-Esther et al, 1999).

Studies among healthcare professionals showed persistently negative attitudes toward older people regardless of profession, gender and clinical experiences (Cheong, Wong & Koh, 2009). For medical trainees, the existing literature revealed inconsistent results with several studies reporting negative attitudes of medical trainees toward older people particularly first-year medical students while others showed neutral or favourable attitudes towards older people.

Previous research has examined knowledge and attitudes of medical students and college students (Mosher-Ashley & Ball, 1999). However, little attention has been given to health care providers. Reed et al. (1992) compared social work and nursing students on knowledge about ageing, attitudes towards older people and perceived barriers to gerontological education. Findings revealed no significant differences among the two groups on attitudes toward older people. However, both groups reported knowledge deficiencies about ageing. Knowledge scores were related to attitudes and social work students ranked limited experience with older people and lower status of work with older adults as the greatest barriers in gerontological education.

Camel, Cwikel & Galinsky (1992) evaluated the effects of courses in gerontology and geriatrics on changes in attitudes toward older people, knowledge, and work preferences among social work, nursing and medical students. Their results showed that only the social work and nursing students reported an increase in knowledge about ageing although no significant differences were found in attitudes or work preferences among the different groups. However, Mosher-Ashley & Ball (1999) found that

medical students reported more positive attitudes toward older people on post-test measures after exposure to a well-elderly programme.

Other investigators examined the effects of gerontology coursework on college students' attitudes toward older people. Anguillo et al. (1996) found an increase in positive attitudes toward older people during and after completion of the course. After a four-month follow-up revealed that the student attitudes had remained at the increased level. They compared the attitudes toward older people of three cohorts of first-year medical students. They reported that gender and previous exposure to undergraduate courses in geriatrics or nursing homes prior to entering medical school did not affect attitudes toward older people.

Pine (1997) explored the effects of an intergenerational college course on college students' attitudes towards older people. As part of the course, students were required to volunteer in a long-term care facility, conduct an in-depth interview with an older person, and complete a daily journal of experiences. Qualitative analyses of the assignments revealed positive attitudes toward older people.

Previous research also has looked at student exposure and interaction with older people. Dellasega & Curriero (1991) did not find any significant differences in attitudes held about older people between college students who had a lot of contact with older people and those that did not. In contrast, some researchers have found that individuals who had previous experience with older people tend to have slightly less negative attitudes toward older people than those who have no experience.

Previous research showed that medical students have mixed attitude towards older people and a low interest to pursue a career in geriatric care (Cheong, Wong & Koh,

2009). It showed that medical students' positive attitudes toward older people might decrease during their time in medical school. However, there were no definite conclusions on why these decreases occurred. It found that first year medical students had significantly more positive attitudes toward older people than more advanced students.

The results of a number of studies suggest that individual's training to be primary and allied health professionals, including medical students, nurses, psychologists and social work students are reluctant to work with older people (Cummings, Adler, & DeCoster, 2005). Therefore, to ensure that the health care workers meet the increased need for caring for older people, it is important to examine the factors that influence their attitudes toward older people. Research has demonstrated that the factors that increase health care personnel desires to work with older people included positive attitudes toward older people and having rewarding experiences with older people (Cummings, Adler & DeCoster, 2005). For example, among trainee medical students, negative attitudes toward older people were associated with a reluctance to work with them. Similarly, nurses who have negative attitudes towards older people are also less willing to work with them. As a result, it is important that the pervasiveness of negative attitudes toward older people can be determined so that training programmes can be implemented to change these attitudes.

Gellis et al (2003) found that first year Social Work students have already formed a negative impression of older people. Increasing knowledge of ageing was a predictor of positive attitudes toward older people. A learning activity about ageing can significantly improve students' negative attitudes toward older people.

Literature reviewed suggested that nurses in acute care hospitals have overall, slightly positive attitudes towards older people. Hope (1994) compared the attitudes of nurses working in acute care in general medical units to nurses working in acute care in aged care units using Kogan's (1961) Old People Scale (KOPS) .These findings indicated that nurses in both units had positive attitudes towards older people.

A similar result was found in a study of orthopaedic nurses from four different hospitals (Tierney et al. 1998). It confirmed this trend and found that nurses' age, years of nursing experience and qualification level had no bearing on their attitudes toward older people.

Simpson (1984) investigated the attitudes towards older people of clinical psychologists compared with those of medical students, and concluded that the former group were less ageist than the latter. He suggested that the slightly unfavourable view of the elderly, especially by some of the medical students, resulted from a perceived greater likelihood of older people behaving in ways that are viewed as slightly unpleasant.

Penner et al. (2004) discovered that even though nurses may have positive attitudes toward older people, their attitudes toward older people were not as positive and their attitudes toward their own patients were even more negative. Therefore, it is the contention of this study that nurses with slightly to moderately positive attitudes toward older people may indeed have negative attitudes toward older patients in their care. Nurses with negative attitudes toward older people hold stereotypical and ageist attitudes about older people. These negative attitudes might have a significant impact on the quality of care their older patients receive. For example, when older patients are

perceived as cantankerous and complaining then their requests to nurses may not be taken seriously impacting on the care they receive, length of hospitalization and recovery.

In the medical field, health care workers' attitude and professional development is the fifth domain which should be defined as an outcome of higher education (Dent & Harden, 2005). These are apart from knowledge and understanding, generic skills, cognitive skills, and subject-specific skills. Care for the elderly requires specific knowledge, attitudes, and skills that expand across the continuum of medical education from medical school through post-graduate training.

Health-care workers have been reported to demonstrate a variety of negative attitudes towards older people (Baiyewu, et al. 1997 and Cheong, Wong & Koh, 2009). Given the huge increase of older people, most people in every professional field will work with older people in the future and this warrants a study to discover more about health care providers' attitudes toward older people.

It is against this background that the study attempted to investigate the influence of socio-demographic characteristics on healthcare workers' attitudes towards older people in some selected professions that work with old people. Specifically, the following characteristics were investigated i.e. respondent's age, gender, educational level, professional occupation, work experience, marital status and religious belief. The aim of this study was to determine the influence of health workers' socio-demographic characteristics on their attitudes towards older people in Kenya.

2.11 Work Experience and Attitudes towards Older People

Work experience has been shown to influence healthcare workers' attitudes towards older people (Hope, 1994; Sheffler, 1998). They found that several environmental factors influenced healthcare workers' attitudes towards older people. These include type of facility, frequency of staff turnover, staffing patterns, type of facility ownership, facility size and physical environment. Sheffler (1995) suggested that personnel working in long term care settings exhibited paternalistic behaviours towards older people. These behaviours were interpreted as demoralizing and dehumanizing and were viewed as contributory to the myth that older people are helpless and in need of nurturance. In contrast, Hartley et al. (1995) found that initial experience with older people in nursing homes had significantly improved attitudes towards older people. He found that the longer the time healthcare workers spent working with older people, the better their attitudes towards them would be. However, Wright (1988) argued that an increase in the amount of contact with older people leads to less positive attitudes towards them.

2.12 Marital Status and Attitudes towards Older People

Most older men are married, while most older women are not (United Nations, 2009). Instead, older women are likely to be widowed. Worldwide, around 80% of men aged 65 years or over, but under half of women of the same age, currently have a spouse. By region, the proportions of men who are married range from 85% in Africa to 73% in Oceania; for women they range from 52% in Asia to 39% in Africa. In Africa, older men are more than twice as likely as older women to be married. The large differences by gender come about because women usually outlive their husbands, both because of

women's life expectancy and because they tend to marry men older than themselves. In addition, men are more likely than women to remarry after divorce or widowhood (United Nations, 2009).

Marital status affects the attitudes of healthcare workers towards older people and hence the wellbeing of older people. Research shows that being married benefits the healthcare workers as they are less likely to show signs of depression and loneliness and hence positive attitudes towards older people (Kinsella, Kevin & Wan He, 2009).

2.13 Religious Belief and Attitudes toward Older People

Religious belief entails more than just participation in rituals or the acceptance of certain doctrines (Gielen, et al, 2009). As religion is expected to have repercussions on every aspect of life, it can be assumed that religious convictions will influence the healthcare workers' attitudes towards older people and their practice. Personal religious convictions can conflict when healthcare workers have to decide which attitude to adopt or what should be done in a particular situation. The possibility that experience and training of healthcare workers will exercise a more profound influence on their attitudes than religious belief sounds more probable when declining influence and individualisation of religion in present society are taken into consideration (Gielen, et al, 2009).

The centrality of the respect for older people in many religions suggests that religion nurtures positive attitudes towards older people and the attitudes of non-believers towards older people would be much more negative when compared with those of believers (Alshahri, 2002). In several research studies, a statistically significant

difference was found between believers and non-believers concerning attitudes towards older people.

In Eastern cultures such as Saudi Arabia, old age is admired as a holy state of great religious significance (Alshahri, 2002). Young Saudi people are expected to be polite and restrained and even avoid smoking cigarettes or chewing gum when older people are present. In the home environment, an older person usually dictates to the younger family members to look after him or her and satisfy his or her needs.

Islam religion, like many other religions, advocates that the Saudi population should respect and value older people and this has been illustrated in many verses in the Holy Koran (Holy Book of Islam).

2.14 Summary

The literature reviewed showed that most of the studies concentrated on the psycho-cultural factors that influence the workers' attitudes toward older people while none investigated the influence of socio-demographic characteristics of health care workers on their attitudes towards older people. The literature reviewed covered all the independent variables (age, gender, work experience, level of education, professional occupation, religious belief and marital status) in relationship to the dependent variable (health care workers' attitudes toward older people).

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.0 Introduction

This chapter gives a detailed description of the study area, the research design, the study population, the study sample and sampling procedures and data collection instruments. It also outlines the study variables, development of the instruments, data collection procedures, data scoring procedures, data analyses techniques and ethical considerations.

3.1 Description of the Study Area

The study was conducted in three provinces of Kenya namely Nairobi, Western and Rift Valley Provinces (APPENDIX G). The Republic of Kenya has an area of 582,646 square km and is situated in the eastern part of Africa with a population of about 40 million people. There are eight provinces in Kenya namely – Nairobi, Rift Valley, Coast, Western, Central, North-Eastern, Eastern and Nyanza. The three (3) provinces were chosen at random. The selected provinces were sampled by a random process by using a random number table so that each subject in the population had the same probability of being selected for the sample. The three provinces also constituted over 30% of the population hence was found to be representative of the Kenyan population.

3.2 Research Design

A descriptive cross-sectional survey design was carried out for all the levels of Kenya's health care workers in three (3) provinces of Kenya (N=295). The study also employed the *ex post facto* correlational study design. An *ex post facto* research design is a systematic inquiry in which the researcher does not have direct control of independent variables because their manifestations have already occurred or because they are inherently not manipulable and inferences about relationships among variables are, without direct intervention, from concomitant variation of independent and dependent variables (Kerlinger, 1973).

In this research design, direct control of independent variables by a researcher is not possible (Kerlinger, 1973). This is because the socio-demographic characteristics of respondents to be studied have already occurred and therefore could not be controlled by the researcher. This design was found to be appropriate for the study as it allowed the investigation of subsequent relationships among variables. Also, the researcher was able to relate an after-the-fact analysis to an outcome or dependent variable (Kathuri and Pals, 1993).

3.3 The Study Population

The healthcare system in Kenya consists of four sectors: private, public, military, church-based and community healthcare centres. The public healthcare sector provides care to the vast majority of Kenyans at low cost. This study focused primarily on the public healthcare centres.

The target population comprised all (1500) health-care professionals such as social workers, nurses, general practitioners, counselors, priests or parsons, doctors, nursing

and medical students who come into contact with older people. These are personnel who work in hospices, day care centres, residential homes, nursing homes, psychiatric hospitals, foster-care homes, social service departments in the three provinces of Kenya that deal with older people.

3.4 The Sample Size and Sampling Procedures

The sample for this study consisted of two hundred and ninety five (295) respondents (Appendix H). They were healthcare workers in sites (hospitals, residential homes, hospices, nursing homes, psychiatric wards, rehabilitation wards, medical wards, surgical wards etc) in three provinces of Kenya (Nairobi, Rift Valley and Western). The participants were registered nurses, student nurses, social workers, psychiatrists, physiotherapists, Counselors. Priests and Doctors. The inclusion criteria was current professional registration either a registered nurse or psychiatrist and those who have worked in older peoples' settings.

In selecting a representative sample of the population, stratified random sampling and purposive/convenience sampling techniques were used. Stratified sampling is a method of sampling in which the population is divided into strata, such as men and women, and the like, from which random samples are drawn (Kerlinger, 1973). Stratified sampling was chosen because the researcher intended to classify the respondents (health-care workers) into groups according to certain socio-demographic characteristics (mainly gender, age, marital status, level of education, professional occupation, religious belief etc).

Purposive sampling is a form of nonprobability sampling method characterized by the use of judgement and a deliberate effort to obtain representative samples by including

typical areas or groups in a sample (Kerlinger, 1973). Purposive sampling was chosen because the researcher intended to focus on healthcare personnel who come into contact with older people.

A total of 295 usable questionnaires were received achieving a response rate of 65.6% which is comparable to response rate in similar studies of 69% (Hope, 1994) and 57% (Edwards & Aldous, 1996). The sample size was determined by a table (Appendix C) generated by Peter (1994) used in developing a representative sample from a population.

3.5 Data Collection Instruments

Questionnaires were the instruments for data collection (APPENDIX A). A structured, descriptive and non-experimental quantitative design using a self-report questionnaire was used to collect data from a sample of healthcare workers (N=295). The researcher administered a closed-ended items' questionnaire (ATOPS) modified from Kogan's (1961)'s Old People Scale (KOPS) which is the first standardized scale developed to assess the attitudes toward older people in general. This instrument consisted of 60 statements regarding older people. Half of these statements represent negative attitudes and the other half represent positive attitudes towards older people. Participants evaluated these statements on a 5-point Likert scale from 1 'strongly disagree' to 5 'strongly agree'.

The scores on negatively worded items were reverse scored prior to the commencement of analysis. Total scores ranged from 60 (minimum) to 300 (maximum) with high scores indicating more positive attitudes towards older people. The following attitude categorization was used for the study;

60-156- Negative Attitude towards Older People

157-204- Neutral Attitude towards Older People

205-300- Positive Attitude towards Older People

The ATOPS was a self-administered paper and pencil questionnaire which took approximately 30 to 40 minutes to complete and assess attitudes towards older people with respect to both norms and individual differences, stereotypes and misconceptions. The questionnaire began with a section requesting selected socio-demographics and work characteristics information. This section consisted of a checklist and fill in blank type questions. This is a 60-item tool consisting of 30 positively framed and 30 negatively framed statements. The negative statements were reverse scored so that higher scores were to mean more positive attitudes. Respondents were asked to indicate the level to which they agreed with each item on a 5-point scale ranging from "Strongly Agree" to "Strongly Disagree". To obtain a score, the values of the negatively framed statements were reversed and tallied in with the positively framed statements. The range of scores was 60 (minimum) to 300 (maximum) with higher scores representing more positive attitudes toward older people.

The questionnaire was of the 5 point Likert-type as it is the best to measure attitudes (Oppenheim, 1966). The respondents were required to answer all the items by ticking the responses that were appropriate to each one of them. The respondents were asked to agree or disagree on 5-point scale with each statement as it refers to their own beliefs about older people. To obtain frank and honest responses, the respondents were assured of confidentiality.

Part (A) of the ATOPS questionnaire (APPENDIX B) sought sample characteristics regarding biographical and contextual data such as gender, professional occupation, age, level of education, marital status, work experience, and religious belief. Part B of (APPENDIX B) consisted of closed-ended statements (customized ATOPS items) measuring the attitudes of the various health-care professionals towards older people.

3.6 Reliability and Validity of Data Collection Instruments

Reliability and validity of the data collection instruments had to be ascertained so as to give credence and faith in the results obtained and the conclusions drawn from the results. The measures for reliability and validity are as follows;

3.6.1 Reliability of Instruments

Before the research instruments were used for the actual study, their reliability was determined through pre-testing them outside the study area. A sample of twenty (20) health-care professionals commented on the clarity of the questionnaire items drawn from Kisumu District of Nyanza Province of Kenya. The reasons for pretesting were to check for ambiguities that may be inherent in the instruments and also ascertain whether the instruments will elicit the data anticipated. It also helped to measure the internal consistency of the responses and to know whether the items are too easy, complex or comprehensible. Minor adjustments were made following feedback from the health care workers after the pilot study.

Fraboni *et al* (1990) found FSA scores to have adequate internal-consistency reliability with a Cronbach's alpha coefficient of 0.86. The FSA's items were designed to measure three of Allport's (1958) five levels of prejudice as related to

ageism: **Antilocution** (e.g "Many old people just live in the past"), **Avoidance** (e.g "I don't like it when old people try to make conversations with me"), and **Discrimination** (e.g "Most old people should not be trusted to take care of infants").

The ATOPS was tested for reliability by means of the *Cronbach's Alpha coefficient* method of estimating reliability. This is a method of estimating reliability of test scores by use of a single administration of a test and provides a good measure of internal consistency i.e. that the test items are homogenous (Popham, 1967). The reliability co-efficient (Cronbach's a) of the attitude scale (ATOPS) was 0.76. For a newly developed psychosocial instrument, a reliability of 0.76 was considered acceptable.

3.6.2 Validity of the Instruments

The data collection instruments were also tested for content validity by discussing them with supervisors of the study and other members of the teaching staff of Educational Psychology department and also after an extensive literature review and an input from a gerontologist. Content validity is the representativeness or sampling adequacy of the content-the substance, the matter, the topics-of a measuring instrument (Kerlinger, 1973).

Members were asked to rate the relevance of each item in the draft ATOPS questionnaire to measure what it is supposed to measure and elicit anticipated data. Suggestions and advice given were used to modify and improve the items in the data collection instruments.

3.7 Data Collection Procedures

Once the data collection instrument was made valid and reliable, the researcher sought the permission of the Ministry of Higher Education, Science and Technology through the National Council for Science and Technology to conduct the research (APPENDIX F). After permission was granted, the researcher visited the selected institutions to establish rapport and made appointments with those to be interviewed. A participant information letter was provided (APPENDIX A) and the voluntary nature of questionnaire completion was stated.

The researcher solicited the help of three research assistants to administer the questionnaires to the respondents selected for the study. The questionnaires (450) were given personally by the researcher and his research assistants to the respondents and at the same time giving an overview of research objectives, clarifying requirements for filling the questionnaire and answering questions. The number of returned questionnaires (295); 117 from female and 178 male respondents. The participation in the research was voluntary and the respondents were informed about the confidentiality of their personal data and of using the data results only for research purposes. Research assistants were onsite to supervise the completion of the questionnaires at convenient times for the participants over an eight-week period.

3.8 Data Scoring Procedures

The analytic strategy identified socio demographic characteristics of health care workers as independent variables and measures of their attitudes towards older people as the dependent variable. These socio-demographic variables included age, gender, level of education, professional occupation, work experience, marital status and

religious belief. The questionnaires were coded to ensure consistency of analyses and standard schemes were used to compute the scores for ATOPS. Coding was done by assigning the data collected by the questionnaires to categories.

Then tabulation was done by recording the number of responses to the desired categories and then calculating the frequencies of each response as well as means of each statement were computed. The minimum possible sum was 60 and the maximum sum was 300. The neutral values were within the range of 157-204. Attitudes towards older people were categorized into three groups (positive, neutral and negative). The following attitude categorization was used for the study;

(3.5-5.0) 205-300- Positive Attitudes towards Older People

(2.7-3.4) 157-204- Neutral Attitudes towards Older People

(<2.6) 60-156- Negative Attitudes towards Older People

3.9 Data Analyses Procedures

Using an independent sample t-test, socio-demographic profiles of each participant were cross-correlated with scores for each research subject to identify relationships. Ninety five per cent (95%) confidence intervals were generated for important statistics. Healthcare workers' attitudes and characteristics were identified using descriptive statistics. Descriptive statistics were used to describe healthcare workers' characteristics and to examine their effects on their attitudes towards older people.

The influence of healthcare workers' socio-demographic characteristics were examined using one-way ANOVA for variables that measured on dichotomous level

of measurement and Pearson correlation coefficient for variables that measured on continuous level and all statistical tests were set at 0.05 level of significance.

Descriptive and inferential statistics were performed on the Statistical Package for Social Sciences (SPSS Version17.0). The ATOPS was computed by using a 5-point Likert approach in which the more positive attitudes towards older people achieved a higher score. The ATOPS was totaled and cross-referenced to the returned questionnaires to address any errors or misses data coding. Missing data on SPSS was replaced with the midpoint number 2.5, a strategy supported by Palliant (2007).

Descriptive and inferential statistics were used to explore the characteristics of the sample and to examine attitudes towards older people and assess the overall frequency of the occurrence of ageism among health-care workers in Kenya. Data were also summarized using graphic presentations for the interpretation of findings. A post-hoc analysis for further comparisons between groups was executed.

The following statistical techniques were used to analyse data:-

Independent Sample t-test- They were conducted to compare the mean attitude scores across two groups.

Chi-square ($\chi 2$) test- Chi-square analysis was used to compare continuous variables for statistical significance and examine the associations between the frequency of occurrence of ageism and the socio-demographic characteristics of the health-care workers. This tool was appropriate because respondents were classified into various categories based on their attitudes toward older people. The actual and expected frequencies falling in each category were established to compute ($\chi 2$) value. The ($\chi 2$) value was used to determine whether differences in respondents' attitudes

toward older people are statistically significant or not. Chi-square difference tests indicated that the revised three-factor structure with correlated factors was the solution demonstrating the best fit.

Coefficient of Contingency (C) was used as one of the measures of the degree of relation (association) between two ordinally measured variables (attributes). Coefficient of Contingency was an appropriate tool of analysis, since variables (attributes) admit measurement on a nominal scale where classification of responses requires arrangement in 2 or more rows or columns.

Pearson's Correlation Coefficient-Pearson product moment correlation was used to determine the relationship between socio-demographic characteristics (independent variables) of healthcare workers' and their attitudes towards older people (dependent variable). This statistical technique was found valuable.

One-Way ANOVA-One-way Analysis of Variance (ANOVA) with post hoc comparisons was conducted to examine whether attitudes were significantly different between groups of healthcare workers. The effects of healthcare workers' characteristics were examined using ANOVA for variables which have more than two groups in each characteristic. In addition, Levene's test was performed to determine whether the ATOPS questionnaire have homogeneity of variance before conducting both t-test and ANOVA.

3.10 Study Variables

The variables of the study were categorized into:-

- The independent variables (presumed causes)
- The dependent variables (presumed effects).

Independent variables were socio-demographic characteristics of healthcare workers; age, gender, level of education, marital status, religious belief, professional occupation and work experience while the dependent variables were healthcare workers' attitudes toward older people. They were measured by the ATOPS 5 point Likert-type attitude questionnaire. The questionnaire consisted of 60-attitude statements indicating the intensity of attitudes; (Strongly Agree (5), Agree (4), Undecided (3), Disagree (2), and Strongly Disagree (1).

3.11 Ethical Considerations

The study was conducted after obtaining a research permit from the National Council of Science and Technology of the Ministry of Higher Education, Science and Technology of the Kenyan Government (Appendix D). A cover letter explaining the study and verifying participant consent was attached to each questionnaire (APPENDIX A). Participation was strictly voluntary and completion of the questionnaire verified by the participants' informed consent to participate in the study (Appendix A).

The participants were assured of complete confidentiality and their anonymity was preserved. In order to guarantee confidentiality, details were changed so that no participant could be recognized in the research report. Healthcare workers were assured that personal data collected and provided to the researcher would be destroyed when the research was completed and research findings would only be reported in aggregated format.

It took 30-40 minutes for the participants to independently and privately complete the study questionnaire. The data collected was stored securely and made available only to

the researcher and his assistants. Potential respondents were recruited on the basis of their availability after an informed consent was obtained. They received a brief explanation of the purpose and the aim of the study by members of the research team who had no dependent relationship with them, and those who agreed to participate were asked to sign an informed consent form. Participants were also assured that the collected data would be used only for the purposes of the study, and that their decision to withdraw or refusing to participate would not influence their relationship with older people, since all questionnaires preserved their anonymity. Data collection period lasted May to June 2009.

3.12 Summary

In this chapter, research design and methodology and related aspects have been comprehensively described. Data collection instruments and their reliability and validity were narrated and also data collection procedures and ethical considerations were also outlined so as to ensure that the research models used are practical and would generate the knowledge required for the study.

CHAPTER FOUR

DATA PRESENTATION, ANALYSES AND INTERPRETATION

4.0 Introduction

The study determined the influence of socio-demographic characteristics (age, gender, level of education, professional occupation, work experience, marital status and religious belief) of health care workers on their attitudes towards older people. Data collected was analyzed using Independent Sample t-tests, Chi-square tests and One-way ANOVA to test if there were any significant differences in the study hypotheses stated. Pearson Correlation Coefficient was used to test for relationships between the socio-demographic characteristics of healthcare workers and attitudes towards older people. This chapter presents the results of data analysed.

4.1 Socio-Demographic Characteristics of Healthcare Workers

The socio-demographic characteristics of healthcare workers were age, gender, level of education, professional occupation, marital status, work experience and religious belief and they are presented below;

4.1.1 Gender of Respondents

The gender of the professional health care workers were varied during the study as summarized in Figure 4.1. Majority of the respondents 178 (60%) were male and 117(40%) were female. This showed that majority of the personnel were male, hence there was gender disparity in the distribution of professional health care workers during the study.

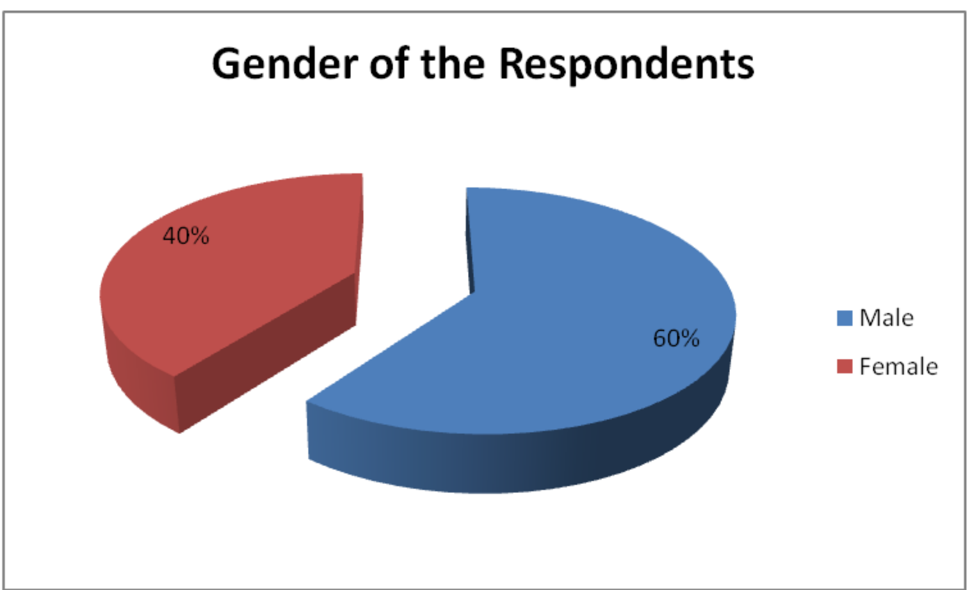

Figure 4.1 Gender of Respondents

4.1.2 Age of Respondents

The age of the professional health care workers were varied during the study as summarized in Figure 4.2.The age of the employees with 94(31.9%) of the employees aged between 41 and 50 years, (81) 27.5% of the aged between 31 and 40 years, with 53(18%) aged between 51 and 55 years, while (48) 16.3% aged between 21 and 30 years and the least 19 (6.4%) aged above 55 years. These findings indicated that majority of the employees were 50 years and below.

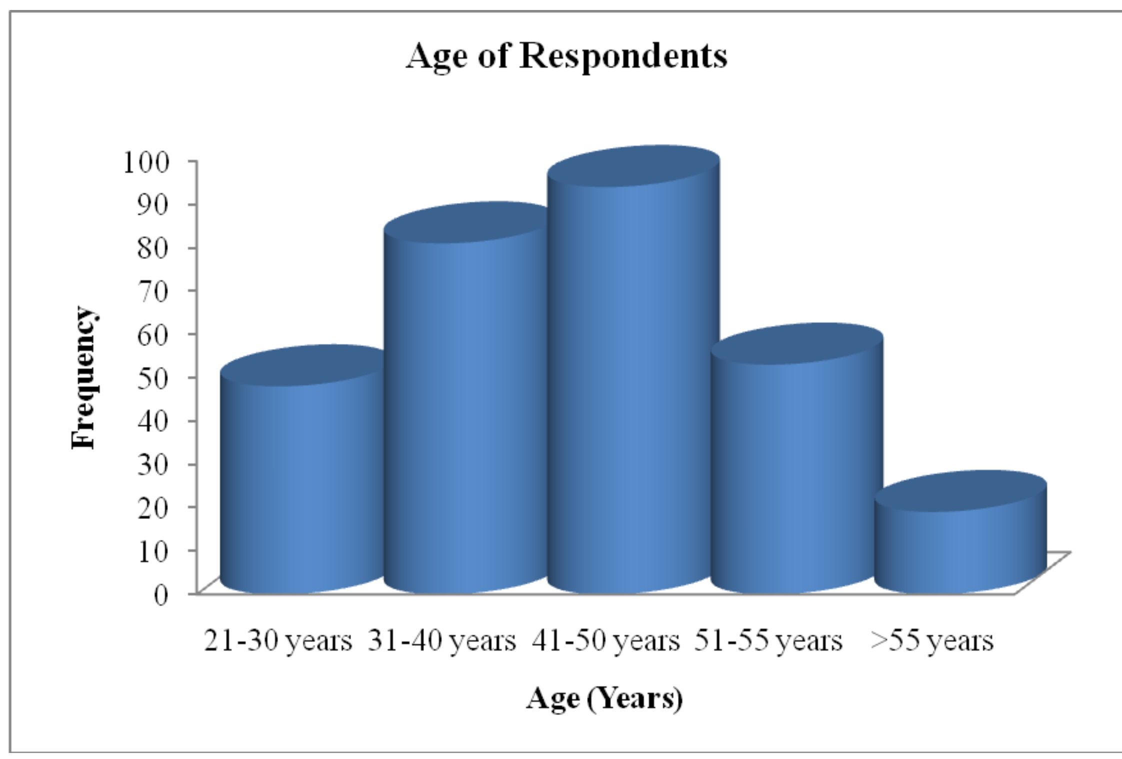

Figure 4.2 Age of Respondents

4.1.3 Marital Status of Respondents

The marital status of the professional health care workers were varied during the study as summarized in Figure 4.3. Most employees 160 (54.2%) were married, with 78(26.4%) single, and the least 57(19.3%) were widowed. This findings indicates that majority of the employees were married.

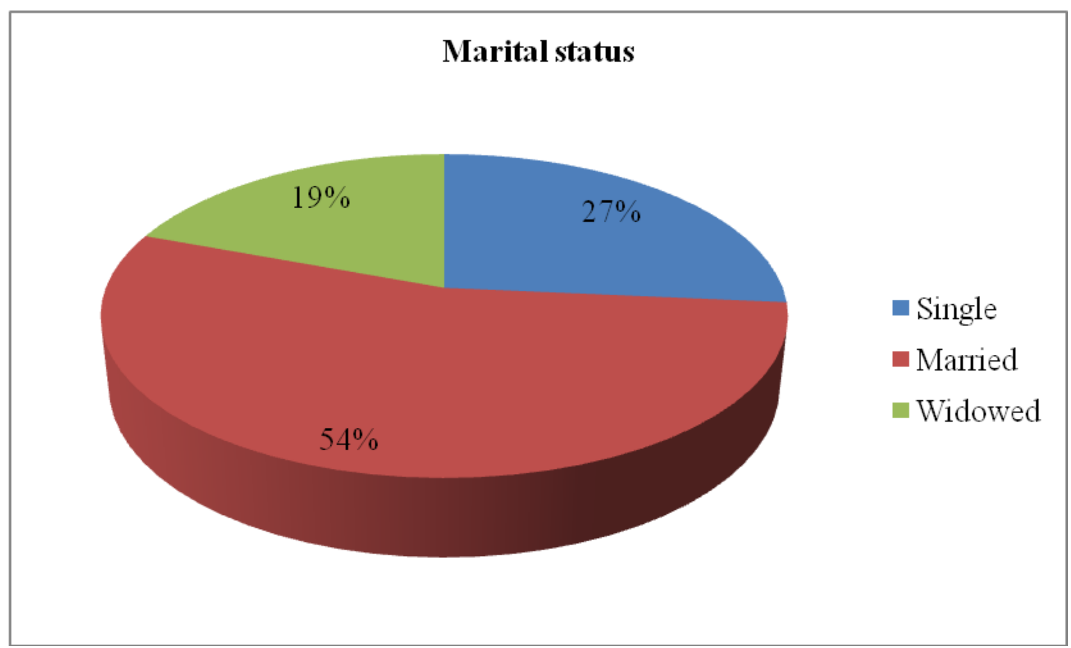

Figure 4.3 Marital Status of Respondents

4.1.4 Level of Education of Respondents

The level of education of the professional health care workers was varied during the study as summarized in Figure 4.1. Most 98 (33.2%) of the employees having Diplomas as their highest education level, with 87 (29.5%) had Degree qualification, with 78(26.4%) having Certificates, while 32(10.8%) had Masters qualification. The findings indicated that a large number of employees had above Diploma level of education, comprising of Diploma, Degree and Masters.

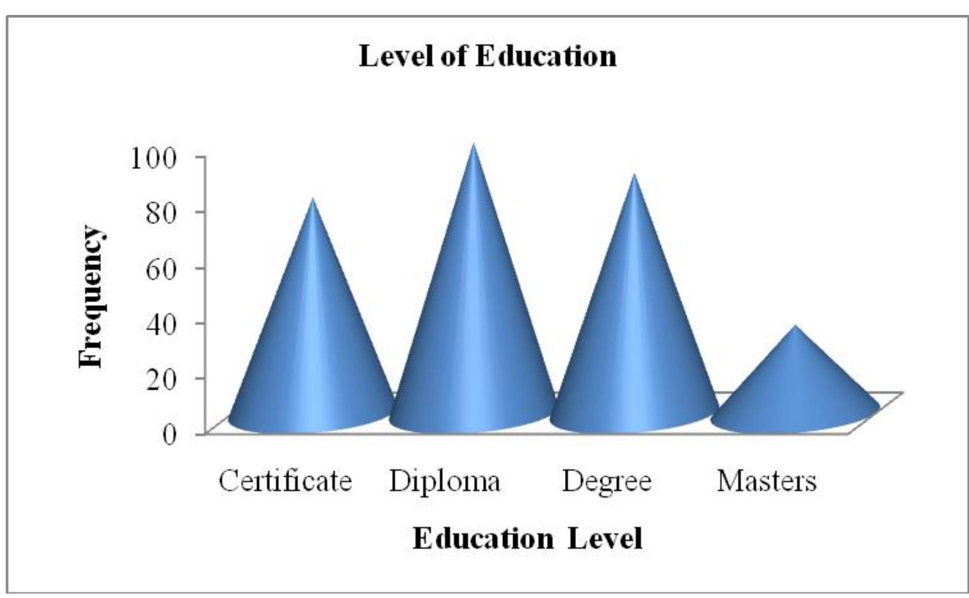

Figure 4.4 Level of Education of Respondents

4.1.5 Religious Beliefs of Respondents

The religious belief of the professional health care workers were varied during the study as summarized in Figure 4.5.The religious beliefs of most of the employees were varied during the study with most of the employees 162(54.9%) as Protestant, with 111(37.6%) were Catholic, while 21(7.1%) were Muslim. The findings indicates that majority of the employees were of the Protestant faith.

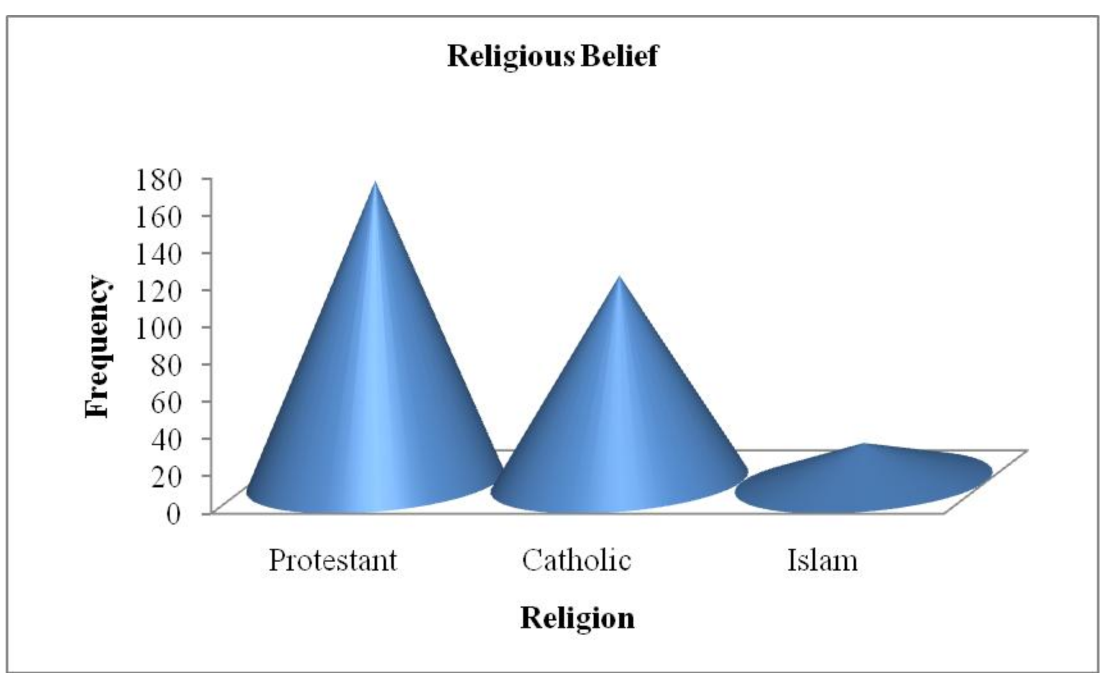

Figure 4.5 Religious Beliefs of Respondents

4.1.6 Work Experience of Respondents

The work experience of the professional health care workers was varied during the study as summarized in Figure 4.6. The working experience 107 (36.3%) employees had worked for between 11 and 15 years, with 90(30.5%) had between 6 and 10 years. However, 54(18.3%) had below 5 years working experience, while 34(11.5%) had between 16 and 20 years and the least 10(3.4%) had above 21 years of work experience. The findings showed that majority of the employees had above 10 years work experience.

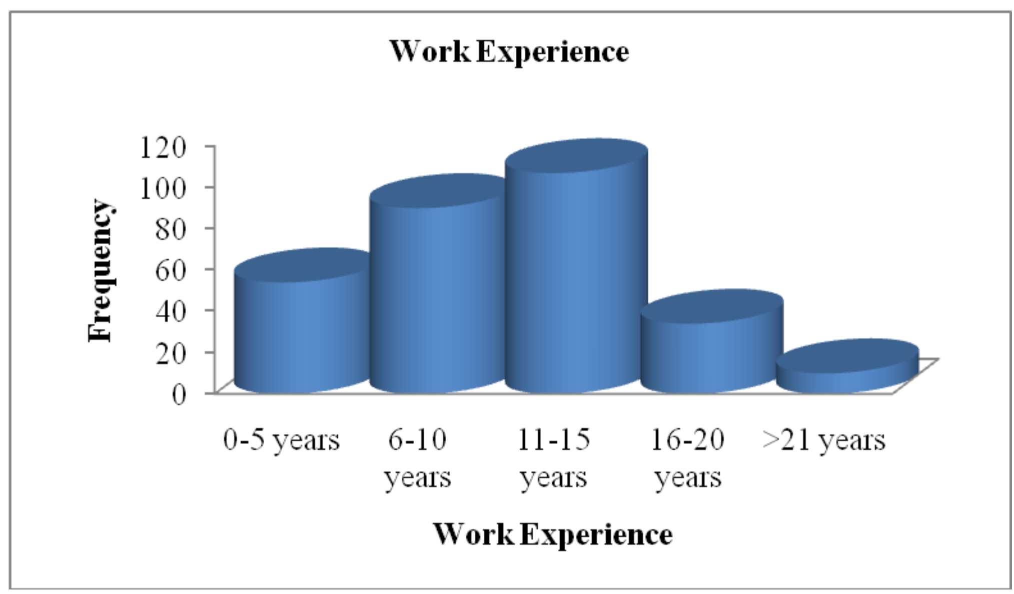

Figure 4.6 Work Experience of Respondents

4.1.7 Professional Occupation of Respondents

The prevalence of healthcare workers occupation was varied during the study as shown in the Table 4.1 below. Seventy (70 or 23.7%) were Community/Social workers, while 57(19.3%) were Nurses/Nutritionists and 31 (10.5%) were Counselors. The least employees comprised of Nursing students, Medical students, Clinical officers, Doctors, Physiotherapists, General practitioners, Priests and Psychiatrist professionals.

Table 4.1 Professional Occupations of Health Care workers

Profession	Frequency	Percent
Nurse/nutritionist	57	19.3
Community/social worker	70	23.7
Nursing student	17	5.8
Medical student	14	4.7
Clinical officer	18	6.1
Doctor	21	7.1
Physiotherapist	25	8.5
General practitioner	9	3.1
Counselor	31	10.5
Priest	16	5.4
Psychiatrist	17	5.8
Total	**295**	**100.0**

4.2 Attitudes Towards Older People

During the study, 60-item Likert-type questionnaire on attitudes of professional health care workers towards older people was used. In each of the statement, a score assigned by the health care workers were computed to get an average score as summarized in Appendix E. The computed scores were summed up to give the overall attitude of the professional health care workers towards the older people. This study examined the attitudes of health care personnel towards older people by using a modified Kogan's

(1961) Attitude Toward Older People Scale (ATOPS) and it was found out that the average attitude score was 3.24, (SD 0.32) as shown in Table 4.2 The score indicated a favourable and positive attitude among Kenyan health care workers towards older people.

Sheffler (1998) found that the mean score achieved by nursing students was 2.24 which is a borderline score. Stuart-Hamilton (2000) and Philpot (1986) also reported mean scores in the borderline range. When the mean score achieved in this study by Kenyan health care workers are compared with those achieved by other studies, they were found to be low. Significantly, there is clear evidence from the attitudes scores achieved by Kenyan health care workers from this study, that they have a more positive attitude toward older people in general.

Due to the critical role of attitudes in influencing health care professionals to work and care for older people, a number of previous studies have explored healthcare workers' attitudes toward older people and the findings of this study support those that have found favourable or positive attitudes among health care workers toward older people (Zakari, 2005; Sainsbury, Wilkinson & Smith, 2004)

Table 4.2 Descriptive Statistics of Attitudes towards Older People

	N	Minimum	Maximum	Mean	Std. Deviation
Attitude	295	2.35	4.05	3.2428	.32052
N	295				

4.3 The Influence of Gender on Health Care Providers' Attitudes towards Older People

The attitudes toward older people were computed from the 60 statements that were used in the study. The male and female average attitudes computed was compared using the cross tabulation. From the study it showed that the mean attitude of male employees was 3.26, SD of .334 and close to that of women 3.22, SD of .30 as shown in Table 4.3. These findings indicate that the attitudes of both male and female health care personnel toward older people were average.

Table 4.3 The Influence of Gender on Attitudes towards Older People

	Frequency	Percent	Minimum	Maximum	Mean	Std. Deviation	Chi-Square Tests
Male	178	60.3	2.42	4.05	3.2551	.33427	χ^2=276.56
Female	117	39.7	2.35	3.87	3.2260	.29947	df=269
Total	295	100.0	**2.35**	**4.05**	**3.2428**	**.32052**	**p=.363**

The cross tabulation was used to evaluate the Contingency Coefficient (C). Since the two variables were deemed to be dependent, contingency coefficient was used to determine if there a strong relationship between the gender of health care workers and their attitudes towards older people. From the results it showed that Contingency Coefficient was .696 and not significant ($p>0.05$). Thus it showed there was no significant relationship between the gender of health care workers and their attitudes towards older people as summarized in Table 4.4.

Table 4.4 Contingency Coefficient on the relationship between Gender and Attitudes towards Older People

		Gender			Chi-Square	Contingency Coefficient (C)
Attitude		**Male**	**Female**	**Total**		
Negative	<2.6	5	4	9	χ^2=277.589	C=.696
Average	2.65-3.4	126	83	209	df =269	Sig.346
Positive	3.45-5.0	47	30	77	Sig.=.346	N =295
Total		**178**	**117**	**295**		

The cross tabulation was used to determine the relationship and association between gender of the professional healthcare workers on their attitudes towards older people. The results showed that there was no significant influence of gender on attitudes towards older people, χ^2 = (276.56), (269) and p=.363 at 5% level of significance. Since the p value is greater than 0.05 this showed that gender of the professional healthcare workers did not influence their attitudes towards older people. From these results, we accept the null hypothesis that there is no significant influence of gender on health-care workers' attitudes toward older people.

The gender influence on health care workers' attitudes were evaluated using a t-test due to the nature of the data since it had only one continuous dependent variable and only one categorical independent variable. An independent sample t-test was used to compare ATOPS mean attitude scores between males (N=178) and females (N=117)

and to randomly assign to one of the two groups. The t-test was calculated to determine if there was any attitude difference between the two gender groups and whether it was statistically significant.

To determine gender influence on attitudes towards older people, the variation was determined using the independent samples t-test as summarized in the Table 4.5. The findings showed that there was no gender variation in the mean attitude of males (3.25, SD=.334) as compared to that of females (3.22, SD=.299). The attitude variation in gender was about the same as the male score**s** do not vary much from the female scores. Difference across gender was not significant (p=.363).

Table 4.5 Group Statistics on Gender influence on Healthcare Workers Attitudes towards Older People

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Attitudes	Male	178	3.2551	.33427	.02505
	Female	117	3.2242	.29883	.02763

The findings showed that there was no statistically significant difference between gender variation in their attitudes towards older people and the differences between gender means are not likely due to chance but are probably due to the IV manipulation. The independent sample t test results showed that the variation in attitudes towards older people had p>0.05 indicating that there is no statistically

significant difference in attitudes of professional health care workers for both males and females as shown in Table 4.6.

An independent-samples t-test was conducted to compare gender influence on professional health care workers' attitudes towards older people. The results confirmed that there was no significant difference in the scores for male and female attitudes towards older people, $t(293) = .811$ $p = .418$. These results suggested that there was no significant variation on the influence of gender on the professional health care workers' attitudes towards older people and the means of males and females did not vary.

Table 4.6 Independent Samples' Test of Gender influence on Healthcare Workers' Attitudes toward Older People

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Attitude	Equal variances assumed	1.231	.268	.811	293	.418	.03097	.03817	-.04415	.10609
	Equal variances not assumed			.830	266.935	.407	.03097	.03730	-.04246	.10440

Less favourable attitudes toward older people among male as compared with female healthcare workers has been noted in other studies (Deaux, 1985; Cammer-Paris et al,

1997; Kite & Stockdale, 2004). They suggested that women may be more attracted to working with older people because of serving in traditional caregiving roles for older people. They found out that women were warm, caring and empathetic towards older people.

The findings of this study did not support the notion that female health care professionals may have favourable attitudes toward older people than do male healthcare workers. It lends further support to other studies that have found that cultural standards and expectations for women tend to associate attractiveness and other positive qualities with a youthful appearance, making women have negative attitudes toward older people (Clark & Hurd, 2002). In this study, gender had no significant influence on the attitudes of healthcare workers towards older people. This finding is consistent with the McConatha (2004) and Anguillo et al. (1996) findings. Male heath care workers had significantly less favourable attitudes toward older people than the female health care workers. This is consistent with the previous studies (Fraboni et al. 1990; Kalaver, 2001; Gellis et al., 2003).

4.4 The Influence of Age of Health Care Workers on their Attitudes towards Older People

The age categories of the professional health care workers were used to compare their attitudes towards older people. The average attitude was computed using the cross tabulation in which the influence of age on attitudes towards older people was done. From the study, it showed that the mean attitude of employees between 21 and 30 years was slightly higher than those of above 55 years as shown in Table 4.7. The findings showed that the attitudes of professional health care workers with 21 and 30

years was 3.34, with SD of .358, those between 31 and 40 years had a mean of 3.25, SD of .278, employees between 41 and 50 had a mean attitude of 3.25, SD of .323 with those workers aged between 51-55 years had a mean attitude towards old age of 3.17, SD of .308 and workers of above 55 years had a mean attitude of 3.18 and SD of .372. These findings indicated that the attitudes of professional health care workers towards older people were average and decreases with increase in age.

Table 4.7 The Influence of Age on Healthcare Workers' Attitudes towards Older People

	Frequency	Percent	Minimum	Maximum	Mean	Std. Deviation	Chi-Square Tests
21-30 years	48	16.3	2.67	4.05	3.3418	.35802	χ^2=1081.72
31-40 years	81	27.5	2.42	4.04	3.2470	.27792	df=1076
41-50 years	94	31.9	2.35	3.97	3.2466	.32299	p=.008
51-55 years	53	18.0	2.50	3.86	3.1656	.30763	
>55 years	19	6.4	2.60	3.99	3.1719	.37208	
Total	**295**	**100.0**	**2.35**	**4.05**	**3.2428**	**.32052**	

The Contingency Coefficient (C) was used to determine if there a strong relationship between the ages of health care workers and their attitudes towards older people. From the results it showed that Contingency Coefficient was .886 and significant ($p<0.05$). Thus it showed there was significant relationship between the age of health care workers and their attitudes towards older people as summarized in Table 4.8.

Table 4.8 Contingency Coefficient on the relationship between Age and Attitudes towards Older People

		Age						Chi-Square	C
Attitude		**21-30 years**	**31-40 years**	**41-50 years**	**51-55 years**	**>55 years**	**Total**		
Negative	<2.6	0	2	3	3	1	**9**	χ^2=1081.7	C=.886
Average	2.65-3.4	29	62	64	39	15	**209**	df =1076	Sig .008
Positive	3.45-5.0	19	17	27	11	3	**77**	Sig.= .008	N =295
Total		**48**	**81**	**94**	**53**	**19**	**295**		

The cross tabulation was used to determine the influence of age of the professional healthcare workers on their attitudes towards older people. The results showed that there was no significant influence of age on their attitudes towards older people, χ^2 = (1081.72), (1076) and p=.008 at 5% level of significance. Since the p value is greater than 0.05, this showed that age of the professional healthcare workers does influence their attitudes towards older people. From these results, we reject the null hypothesis and accept the alternative hypothesis that there is significant influence of age on health-care workers' attitudes toward older people.

The influence of age of healthcare workers on their attitudes toward older people was evaluated using a One-way Analysis of Variance. The use of these methods was attributed to the nature of the data since it has more than one dependent continuous variable or more than two values across the categorical independent variables. A One-

way Analysis of Variance (ANOVA) was used to compare the influence of age of health care workers on their attitudes towards older people.

A One-way Analysis of Variance was conducted to explore the variation in the attitudes of health workers with respect to their ages as shown in Table 4.9. There was weak statistically significant difference at the p>.05 level of significance [F (4, 290) =2.187, p=.000]. Since the influences of age variation were found to be significant, it implies that the means differ more than would be expected by chance alone and despite reaching statistical significance, the actual difference in mean scores between the age groups was quite small.

Table 4.9 One-way ANOVA on the influence of Age on Healthcare workers' Attitudes towards Older People

	Sum of Squares	**Df**	**Mean Square**	**F**	**Sig.**
Between Groups	.884	4	.221	2.187	.071
Within Groups	29.319	290	.101		
Total	30.203	294			

The post hoc tests were performed using the least significant difference on the influence of age groups on their attitudes towards older people as summarized in Table 4.10. From the results, it showed that there was significant difference in attitudes between the workers who were aged between 21 and 30 years and those aged between

51 and 55 years ($p<0.05$) as well as those above 55 years ($p<0.05$). The findings indicate that significant difference occurs between the workers who were aged between 21 and 30 years and those above 50 years.

Table 4.10 Multiple Comparisons on Least Significant Difference on Age and Attitudes towards Older People

(I) Age	(J) Age	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
21-30 years	31-40 years	.09477	.05792	.103	-.0192	.2088
	41-50 years	.09523	.05641	.092	-.0158	.2062
	51-55 years	.17618*	.06335	.006	.0515	.3009
	>55 years	.16992*	.08618	.050	.0003	.3395
31-40 years	21-30 years	-.09477	.05792	.103	-.2088	.0192
	41-50 years	.00046	.04820	.992	-.0944	.0953
	51-55 years	.08141	.05618	.148	-.0292	.1920
	>55 years	.07515	.08105	.355	-.0844	.2347
41-50 years	21-30 years	-.09523	.05641	.092	-.2062	.0158
	31-40 years	-.00046	.04820	.992	-.0953	.0944
	51-55 years	.08095	.05462	.139	-.0265	.1884
	>55 years	.07469	.07998	.351	-.0827	.2321
51-55 years	21-30 years	-.17618*	.06335	.006	-.3009	-.0515
	31-40 years	-.08141	.05618	.148	-.1920	.0292
	41-50 years	-.08095	.05462	.139	-.1884	.0265
	>55 years	-.00626	.08502	.941	-.1736	.1611
>55 years	21-30 years	-.16992*	.08618	.050	-.3395	-.0003
	31-40 years	-.07515	.08105	.355	-.2347	.0844
	41-50 years	-.07469	.07998	.351	-.2321	.0827
	51-55 years	.00626	.08502	.941	-.1611	.1736

*. The mean difference is significant at the 0.05 level.

There was a statistically significant influence of age of healthcare workers on their attitudes toward older people indicating that older workers had more favourable attitudes toward older people. The influence of age on attitudes towards older people is consistent with the hypothesis of this study and the results of other previous studies (Edwards & Aldous, 1996) suggesting that older workers had more favourable attitudes toward older people.

The results of this study are quite in accordance with what Weiss & Maurer (2004) found that older healthcare workers are more likely to have positive attitudes toward older people than younger workers. Younger age was associated with less favourable attitudes towards older people. These findings are consistent with previous studies (Shahidi & Devlen, 1993; Lifshitz, 2002; Hellenbusch, et al. 1994)

In the current study, age did have a significant influence on attitudes of healthcare workers towards older people. This finding is consistent with previous studies that older healthcare workers had positive or favourable attitudes toward older people (Gellis et al., 2003; Laditka et al., 2004). Older healthcare workers were found to have more positive attitudes towards older people than younger healthcare workers.

It was inconsistent with Tierney et al. (1998) who reported that the age of majority of healthcare workers had no significant influence on their attitudes towards older people. On the contrary, Damrosch (1984) found that younger healthcare workers had more positive attitudes towards older people than older workers.

4.5 The Influence of Marital Status of Healthcare Workers on their Attitudes towards Older People

The marital status of the professional health care workers was used to compare their attitudes towards older people. The average attitude was computed using the cross tabulation in which the influence of marital status on attitudes toward older people was done in Table 4.11. From the study, it showed that the mean attitude of single (3.29, SD=.352), married (3.23, SD=.312) and widowed (3.21, SD=.297) workers was almost the same as shown in Table 4.11. The findings indicated that the influence of marital status on the attitudes of professional health care workers towards older people were above average.

Table 4.11 The Influence of Marital Status on Healthcare Workers' Attitudes towards Older People

	Frequency	Percent	Minimum	Maximum	Mean	Std. Deviation	Chi-Square Tests
Single	78	26.4	2.42	4.05	3.2873	.35213	χ^2=833.96
Married	160	54.2	2.35	3.99	3.2320	.31223	df=807
Widowed	57	19.3	2.52	3.90	3.2124	.29670	p=.248
Total	**295**	**100.0**	**2.35**	**4.05**	**3.2428**	**.32052**	

The Contingency Coefficient (C) was used to determine if there is a relationship between the marital status of health care workers and their attitudes towards older people. From the results it showed that Contingency Coefficient was .859 and not significant ($p>0.05$). Thus it showed there was no significant relationship between the

marital status of health care workers and their attitudes towards older people as summarized in Table 4.12.

Table 4.12 Contingency Coefficient on the relationship between Marital Status and Attitudes towards Older People

		Marital Status				**Chi-Square**	**C**
Attitude		Single	Married	Widowed	Total		
Negative	<2.6	2	5	2	9	χ^2=833.96	C=.859
Average	2.65-3.4	52	116	41	209	df =807	Sig =.248
Positive	3.45-5.0	24	39	14	77	Sig.= .248	N =295
Total		78	160	57	295		

The cross tabulation was used to determine the influence of marital status of the professional healthcare workers on their attitudes towards older people. The results showed that there was no significant influence of marital status on attitudes toward older people, χ^2 = (833.96), (807) and p=.248 at 5% level of significance (See Table 4.12). Since the p value is greater than 0.05, this showed that marital status of the professional healthcare workers does not influence their attitudes towards older people. From these results, we accept the null hypothesis that there is no significant influence of marital status of health-care workers' on their attitudes toward older people. This implies that marital status does not have any influence on the healthcare workers' attitudes towards older people.

4.5.1 One-way ANOVA on the influence of Marital Status on Healthcare Workers' Attitudes towards Older People

A One-way Analysis of Variance was conducted to explore the variation in the attitudes of health workers with respect to their marital status as shown in Table 4.13. There was no statistically significant difference at the $p>.05$ level of significance [$F(3, 291) =.957$, $p=.000$]. Since the influence of marital status was found to be insignificant, it implies that the attitude means did not differ much with respect to marital status of the healthcare workers.

Table 4.13 One-way ANOVA on the influence of Marital Status on Healthcare Workers' Attitudes towards Older People

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.295	3	.098	.957	.413
Within Groups	29.908	291	.103		
Total	30.203	294			

Data analysis and interpretation of the influence of marital status on healthcare workers' attitudes towards older people found no significant influence of marital status on attitudes towards older people.

4.6 The Influence of Level of Education of Healthcare Workers on their Attitudes towards Older People

The prevalence rate of highest educational attainment was ascertained in Table 4.14 and it was observed that 33.2% (98) of the healthcare workers were Diploma holders, 29.5% (87) were Degree holders, 26.4 (78) were Certificate holders while 10.8% (32) were Masters degree holders.

The level of education of the professional health care workers was used to compare their attitudes towards older people. The average attitude was computed using the cross tabulation and the influence of level of education on their attitudes toward older people was determined. From the study, it showed that the mean attitude of employees with higher education level was slightly higher than those with lower education level as shown in Table 4.14. The findings showed that the attitudes of professional health care workers with Master’s education level was 3.49, SD of .323, those with Degree had a mean attitude of 3.27, SD of .337, employees with Diploma education had a mean attitude of 3.26, SD of .288 and workers with Certificate level of education level an attitude of 3.19 and SD of .339. The findings indicated that the attitudes of professional health care toward older people were above average and increased with the level of education.

Table 4.14 The Influence of Level of Education of Healthcare workers on their Attitudes towards Older People

	Frequency	**Percent**	**Min**	**Max**	**Mean**	**Std. Deviation**	**Chi-Square Tests**
Certificate	78	26.4	2.42	4.03	3.1937	.33907	χ^2=1116.50
Diploma	98	33.2	2.50	3.97	3.2567	.28799	df=1076
Degree	87	29.5	2.35	4.05	3.2700	.33641	p=.006
Masters	32	10.8	5.75	6.91	3.4944	.32260	
Total	295	100.0	**2.35**	**4.05**	**3.2428**	**.32052**	

The Contingency Coefficient (C) was used to determine if there is a relationship between the level of education of health care workers and their attitudes towards older people. From the results it showed that Contingency Coefficient was .857 and significant ($p<0.05$). Thus it showed there was significant relationship between the level of education of health care workers and their attitudes towards older people as summarized in Table 4.12.

Table 4.15 Contingency Coefficient on the relationship between Level of Education and Attitudes towards Older People

		Level of Education					Chi-Square	C
Attitude		**Certificate**	**Diploma**	**Degree**	**Masters**	**Total**		
Negative	<2.6	0	1	1	0	2	χ^2=814.6	C=.857
Average	2.65-3.4	35	70	72	39	216	df =807	Sig =.005
Positive	3.45-5.0	19	19	34	5	77	Sig.= .005	N =295
Total		**54**	**90**	**107**	**44**	**295**		

The cross tabulation was used to determine the influence of level of education of professional healthcare workers on their attitudes towards older people. The results showed that there was no significant influence of level of education on their attitudes towards older people, χ^2 = (1116.5), (1076) and p=.006 at 5% level of significance. Since the p value is less than 0.05, this showed that the level of education of the professional healthcare workers influenced their attitudes toward older people. From these results, we reject the null hypothesis and accept the alternative that there is significant influence of level of education on health-care workers' attitudes toward older people.

A One-way Analysis of Variance was conducted to explore the variation in the attitude of health workers with respect to their level of education as shown in Table 4.13. There was statistically significant difference at the $p<.05$ level of significance [F (3, 291) =2.187, p=.000]. Since the influences of level of education variation were found

to be significant, it implies that the means differ more than would be expected by chance alone and despite reaching statistical significance, the actual difference in mean scores between the education levels was quite small.

Table 4.16 One-way ANOVA on the influence of Level of Education of Healthcare Workers on their Attitudes towards Older People

	Sum of Squares	**Df**	**Mean Square**	**F**	**Sig.**
Between Groups	1.551	3	.517	5.252	.002
Within Groups	28.652	291	.098		
Total	30.203	294			

The post hoc tests were performed using the least significant difference on the influence of level of education on their attitudes towards older people as summarized in Table 4.14. From the results, it showed that there was significant difference in attitudes towards older people between the Masters, Degree, Diploma and Certificate levels of education ($p<0.05$). The findings indicated that significant differences existed between the levels of education of the healthcare workers and their attitudes towards older people. This implied that the level of education of healthcare workers had a significant influence on their attitudes towards older people.

Table 4.17 Multiple Comparisons on the Influence of Level of Education of Healthcare workers on their Attitudes towards Older People

(I) Professional qualification	(J) Professional qualification	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Certificate	Diploma	.07693	.05401	.155	-.0294	.1832
	Degree	.05583	.05238	.287	-.0473	.1589
	Masters	.24113*	.06373	.000	.1157	.3666
Diploma	Certificate	-.07693	.05401	.155	-.1832	.0294
	Degree	-.02110	.04488	.639	-.1094	.0672
	Masters	.16420*	.05772	.005	.0506	.2778
Degree	Certificate	-.05583	.05238	.287	-.1589	.0473
	Diploma	.02110	.04488	.639	-.0672	.1094
	Masters	.18530*	.05620	.001	.0747	.2959
Masters	Certificate	-.24113*	.06373	.000	-.3666	-.1157
	Diploma	-.16420*	.05772	.005	-.2778	-.0506
	Degree	-.18530*	.05620	.001	-.2959	-.0747

*. The mean difference is significant at the 0.05 level.

4.7 The Influence of Professional Occupation of Healthcare workers on their Attitudes towards Older People

Participants were categorized in 11 groups according to their professional occupations; Nurse/Nutritionist, Community/Social worker, Nursing student, Medical student, Clinical Officer, Doctor, Physiotherapist, General Practitioner, Counsellor, Priest and Psychiatrist. The professional occupation of health care workers was used to compare their attitudes toward older people. The average attitude was computed using the cross tabulation and the professional occupations' influence on attitudes toward older people was determined. From the study, it showed that the mean attitude of nursing students (3.40, SD of .371) was slightly higher than the other professional occupations as shown in Table 4.15. The findings showed that the attitudes of professional occupation health care workers from nurse/nutritionist (3.25) were similar to the mean of community/social worker (3.22), medical student (3.25), clinical officer (3.2), doctor (3.21) and general practitioner (3.25). The mean of physiotherapist was 3.28, SD of .231 and similar to counselor 3.33 with SD of .288. These findings indicated that the attitudes of health care workers towards older people were almost similar toward older people and above average regardless of their professional occupation. Nursing students had a slightly higher attitude scores followed physiotherapists and counselors. However, priests had the lowest attitude scores during the study.

Table 4.18 The Influence of Professional Occupation of Healthcare workers on their Attitudes towards Older People

	Freq	Percent	Minimum	Maximum	Mean	Std. Deviation	Chi-Square Tests
Nurse/Nutritionist	57	19.3	2.52	4.03	3.2493	.32179	χ^2=2725.7
Community/Social worker	70	23.7	2.42	4.04	3.2151	.31612	df=2690
Nursing student	17	5.8	2.76	3.97	3.3967	.37105	p=.310
Medical student	14	4.7	2.81	4.05	3.2493	.33661	
Clinical officer	18	6.1	2.64	3.86	3.1617	.34097	
Doctor	21	7.1	2.64	3.94	3.2050	.39001	
Physiotherapist	25	8.5	2.83	3.67	3.2819	.23105	
General Practitioner	9	3.1	2.96	3.53	3.2483	.18125	
Counselor	31	10.5	2.50	3.87	3.3265	.28763	
Priest	16	5.4	2.60	3.53	3.0748	.29705	
Psychiatrist	17	5.8	2.35	3.86	3.2545	.36646	
Total	**295**	**100.0**	**2.35**	**4.05**	**3.2428**	**.32052**	

The Contingency Coefficient (C) was used to determine if there is a relationship between the professional occupation of health care workers and their attitudes towards older people. From the results it showed that Contingency Coefficient was .950 and not significant ($p>0.05$). Thus it showed there was no significant relationship between

the professional occupation of health care workers and their attitudes towards older people as summarized in Table 4.16.

Table 4.19 Contingency Coefficient on the relationship between Professional Occupations and Attitudes towards Older People

	Professional Occupation											Total
Attitude	**Nurse/ Nutritionist**	**Community/ social worker**	**Nursing student**	**Medical student**	**Clinical officer**	**Doctor**	**Physiotherapist**	**General practitioner**	**Counselor**	**Priest**	**Psychiatrist**	
Negative	1	2	0	0	1	1	0	0	1	2	1	**9**
Average	40	52	9	10	13	14	21	8	19	12	11	**209**
Positive	16	16	8	4	4	6	4	1	11	2	5	**77**
Total	**57**	**70**	**17**	**14**	**18**	**21**	**25**	**9**	**31**	**16**	**17**	**295**

Chi-Square	C
χ^2=2725.78	C=.950
df =2690	Sig .310
Sig.= .310	N =295

The cross tabulation was used to determine the influence of professional occupation on healthcare workers' attitudes towards older people. The results showed that there was no significant influence of professional occupation on their attitudes toward older people, χ^2 = (2725), (2690) and p=.310 at 5% level of significance. Since the p value is greater that 0.05, this showed that the professional occupation healthcare workers did not influence their attitudes toward older people. From these results, we accept the null

hypothesis that there is no significant influence of professional occupation on health-care workers' attitudes toward older people. This implied that professional occupation had no significant influence on healthcare workers' attitudes towards older people.

A One-way between-groups Analysis of Variance was conducted to explore differences in attitudes towards older people between these groups with respect to their professional occupations as shown in Table 4.17. There was no statistically significant difference at the $p>.05$ level of significance [$F (1, 284) =1.30$, $p=.233$]. Since the influences of professional occupation were found to be not significant, it implies that the attitude means do not differ with respect to professional occupations of the healthcare workers.

Table 4.20 One-way ANOVA on the Influence of Professional Occupations of Healthcare workers on their Attitudes toward Older People

Attitude	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1.317	10	.132	1.295	.233
Within Groups	28.887	284	.102		
Total	30.203	294			

4.8 The Influence of Religious Beliefs on Health Care Workers' Attitudes toward Older People

The religion of the professional health care workers was used to compare their attitudes toward older people. The average attitude was computed using the cross tabulation and the influence of religious belief on attitudes toward older people was determined. From the study, it showed that the mean attitude of workers with varied religion was almost the same as shown in Table 4.18. The findings showed that the attitudes of Protestant health care workers was 3.24, SD of .329, Catholics had a mean attitude of 3.26, SD of .303 and Islam's had a mean attitude of 3.20, SD of .347. The findings indicated that the attitudes of health care workers toward older people were above average and similar regardless of their religious beliefs.

Table 4.21 Religious Beliefs and Attitudes toward Older People

	Frequency	Percent	Minimum	Maximum	Mean	Std. Deviation	Chi-Square Tests
Protestant	162	54.9	2.42	4.05	3.2396	.32962	χ^2=829.74
Catholic	111	37.6	2.35	4.03	3.2588	.30267	df=807
Islam	22	7.4	2.67	3.97	3.1858	.34723	p=.282
Total	**295**	**100.0**	**2.35**	**4.05**	**3.2428**	**.32052**	

The Contingency Coefficient (C) was used to determine if there is a relationship between the religious beliefs of health care workers and their attitudes towards older people. From the results it showed that Contingency Coefficient was .860 and not significant ($p>0.05$). Thus it showed there was no significant relationship between the religious beliefs of health care workers and their attitudes towards older people as summarized in Table 4.19.

Table 4.22 Contingency Coefficient on the relationship between Religious Beliefs and Attitudes towards Older People

		Religious Beliefs					Chi-Square	C
Attitude		**Protestant**	**Catholic**	**Islam**	**Others**	**Total**		
Negative	<2.6	1	1	0	0	**2**	χ^2=836.20	C=.860
Average	2.65-3.4	122	78	15	1	**216**	df =807	Sig =.231
Positive	3.45-5.0	39	32	6	0	**77**	Sig.= .231	N =295
Total		**162**	**111**	**21**	**1**	**295**		

The cross tabulation was used to determine the influence of religious beliefs of healthcare workers on their attitudes towards older people. The results showed that there was no significant influence of religion on their attitudes toward older people, χ^2 = (829), (807) and p=.282 at 5% level of significance. Since the p value is greater than 0.05, this showed that the religious beliefs of healthcare workers did not influence their attitudes toward older people. From these results, we accept the null hypothesis that there is no significant influence of religious beliefs of health-care workers on their attitudes toward older people.

A One-way Analysis of Variance was conducted to explore the variations in the attitudes of health workers towards older people with respect to their religious beliefs as shown in Table 4.20. There was no statistically significant difference at the p>.05 level of significance [F (3, 291) =.432, p=.731]. Since the influences of religious beliefs were found to be insignificant, it implies that the attitude means do not differ much with respect to religious affiliations of the healthcare workers.

Table 4.23 One-way ANOVA on the influence of Religious Beliefs on Health Care workers' Attitudes towards Older People

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.134	3	.045	.432	.731
Within Groups	30.070	291	.103		
Total	30.203	294			

Religious beliefs did not influence the healthcare workers' attitudes towards older people. However, a majority of Protestants reported more positive attitudes towards older people (M 4.05) as compared to the maximum mean positive attitudes towards older people as reported by the Catholics (M 4.03) and Muslims (M 3.97) as shown in Table 4.20.

4.9 The Influence of Work Experience on Health Care Workers' Attitudes toward Older People

The work experience of the professional health care workers was used to compare their attitudes towards older people. The average attitude was computed using the cross tabulation and the influence of work experience on attitudes toward older people was determined. From the study, it showed that the mean attitude of employees with low work experience was slightly higher than those with higher experience as shown in Table 4.21. These findings showed that the attitudes of health care workers with

less than 5 years as well as those with 11 to 15 years experience had a mean of 3.27, SD of .340 and .327 respectively. From the study, the workers with 6 and 10 years of experience had a mean attitude of 3.3, SD of .260. Healthcare workers with 6 and 10 years of experience had a mean attitude of 3.3, SD of .260.

The findings showed that the attitudes of health care workers with 16-20 years as well as those with above 21 years of experience had a mean of 3.1, SD of .265 and .339 respectively. The findings indicated that the attitudes of health care workers toward older people with less work experience were slightly higher than those with higher work experience.

Table 4.24 Work Experience and Attitudes toward Older People

	Frequency	**Percent**	**Min**	**Max**	**Mean**	**Std. Deviation**	**Chi-Square Tests**
0-5 years	54	18.3	2.73	4.03	3.2667	.34019	χ^2=1096.3
6-10 years	90	30.5	2.81	3.97	3.3000	.25987	df=1076
11-15 years	107	36.3	2.35	3.87	3.2674	.32639	p=.004
16-20 years	34	11.5	2.64	3.52	3.0743	.26465	
>21 years	10	3.4	2.74	3.45	3.1182	.33913	
Total	**295**	**100.0**	**2.35**	**4.05**	**3.2428**	**.32052**	

The Contingency Coefficient (C) was used to determine if there is a relationship between the work experience of health care workers and their attitudes towards older people. From the results it showed that Contingency Coefficient was .888 and significant ($p<0.05$). Thus it showed there was a significant relationship between the work experience of health care workers and their attitudes towards older people as summarized in Table 4.22.

Table 4.25 Contingency Coefficient on the relationship between Work Experience and Attitudes towards Older People

		Work experience					Total	Chi-Square	C
Attitude		**0-5 years**	**6-10 years**	**11-15 years**	**16-20 years**	**>21 years**			
Negative	<2.6	0	1	1	0	0	**2**	χ^2=1081.72	C=.888
Average	2.65-3.4	35	70	72	30	9	**216**	df =1076	Sig .003
Positive	3.45-5.0	19	19	34	4	1	**77**	Sig.= .004	N =295
Total		**54**	**90**	**107**	**34**	**10**	**295**		

The cross tabulation was used to determine the influence of healthcare workers work experience on their attitudes towards older people. The results showed that there was a significant influence of healthcare workers' work experience on their attitudes toward older people, χ^2 = (1096), (1076) and p=.004 at 5% level of significance. Since the p value was less than 0.05, this showed that the healthcare workers' work experience influenced their attitudes toward older people. From these results, we accept the alternative hypothesis that there is significant influence of healthcare working experience on their attitudes toward older people.

A One-way Analysis of Variance was conducted to explore the variation in the attitudes of health workers with respect to their work experience as shown in Table 4.23. There was statistically significant difference at the p<.05 level of significance [F

(3, 291) =2.187, p=.000]. Since the influences of work experience variation were found to be significant, it implies that the means differ more than would be expected by chance alone and despite reaching statistical significance, the actual difference in mean scores between the working experiences was quite small.

Table 4.26 One-way ANOVA on the influence of Work Experience of Health Care workers' Attitudes toward Older People

	Sum of Squares	**Df**	**Mean Square**	**F**	**Sig.**
Between Groups	1.557	4	.389	3.941	.004
Within Groups	28.646	290	.099		
Total	30.203	294			

The post hoc tests were performed using the least significant difference on the influence of work experience on their attitudes towards older people as summarized in Table 4.24. From the results, it showed that there was significant difference in attitudes between healthcare workers with less than 5 years of work experience to that of having 16 and 20 years and above 21 work experience. The workers with between 6 and 10 years had significant difference to those of between 16 and 20 years. Therefore, the study showed that the healthcare workers who had between 16 and 20 years had significant mean difference to those that were less than 5 years work experience, those with 6 and 10 years and those with between 11 and 15 years. The

findings indicated significant differences between healthcare workers' work experience and their attitudes towards older people.

Table 4.27 Multiple Comparisons on the influence of Work Experience of Health Care workers on their Attitudes towards Older People

	(J) Working experience	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
0-5 years	6-10 years	.07693	.05410	.156	-.0295	.1834
	11-15 years	.05583	.05246	.288	-.0474	.1591
	16-20 years	.23479*	.06881	.001	.0994	.3702
	>21 years	.26270*	.10820	.016	.0497	.4757
6-10 years	0-5 years	-.07693	.05410	.156	-.1834	.0295
	11-15 years	-.02110	.04495	.639	-.1096	.0674
	16-20 years	.15786*	.06327	.013	.0333	.2824
	>21 years	.18577	.10476	.077	-.0204	.3920
11-15 years	0-5 years	-.05583	.05246	.288	-.1591	.0474
	6-10 years	.02110	.04495	.639	-.0674	.1096
	16-20 years	.17895*	.06187	.004	.0572	.3007
	>21 years	.20686*	.10393	.047	.0023	.4114
16-20 years	0-5 years	-.23479*	.06881	.001	-.3702	-.0994
	6-10 years	-.15786*	.06327	.013	-.2824	-.0333
	11-15 years	-.17895*	.06187	.004	-.3007	-.0572
	>21 years	.02791	.11306	.805	-.1946	.2504
>21 years	0-5 years	-.26270*	.10820	.016	-.4757	-.0497
	6-10 years	-.18577	.10476	.077	-.3920	.0204
	11-15 years	-.20686*	.10393	.047	-.4114	-.0023
	16-20 years	-.02791	.11306	.805	-.2504	.1946

*. The mean difference is significant at the 0.05 level.

4.10 Relationship between Socio-Demographic Characteristics of Healthcare Workers' on their Attitudes towards Older People

The Pearson correlation was performed to determine the influence of socio-demographic characteristics of health care workers on their attitudes towards older people as shown in the Table 4.25 below. The age (r=-.155) and working experience

(r=-.183) of the health care workers were identified to have a significant negative influence on health- care workers' attitudes toward older people at 1% level of significance and two tailed. The level of education (r.=.115) of the health care workers was identified to have a significant positive influence on health- care workers' attitudes towards older people at 5% level of significance and two tailed.

However, there was no significant influence identified in the following socio-demographic characteristics (Gender, Religious belief, Professional Occupation and Marital Status) on health care workers' attitude towards older people. From the study, it showed that there was significant positive influence of level of education, age and work experience on healthcare workers' attitudes toward older people. This implied that as the health care workers become more educated, aged, and as they work with older people, their attitudes towards older people becomes positive.

Table 4.28 Pearson Correlation

	Attitude	Gender	Age	MS	EL	PO	PQ	RE	WE
Attitude	1								
Gender	-.044	1							
Age	-.155**	.166**	1						
Marital Status(MS)	-.077	.081	.507**	1					
Educational level(EL)	.115*	-.002	.073	.079	1				
Professional occupation(PO)	-.007	.073	.235**	.147*	.202**	1			
Religious(RE)	-.018	-.028	.040	.028	.161**	.047	.241**	1	
Working experience(WE)	-.183**	.101	.691**	.414**	.054	.226**	.125*	.100	1

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

N=295

4.11 Summary

The study set out to explore the attitudes of healthcare workers toward older people in Kenya. From the data collected from 295 respondents, it was reassuring to find that healthcare workers in Kenya generally held positive attitudes toward older people. The results indicated that gender, professional occupation, marital status and religious belief did not have any significant influence on attitudes scores measured by ATOPS.

These results showed that certain socio-demographic characteristics of healthcare workers did not influence their perceptions of older people. There were no significant differences in gender, professional occupation, marital status and religious beliefs across healthcare workers in Kenya. In contrast, the study did detect significant differences in attitudes scores measured by ATOPS across age, level of education and work experience. The more the healthcare workers advanced in age, the more they are educated and the more years they work the more favourable or positive their attitudes towards older people. In the next chapter, discussions, conclusions and recommendations are made.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter discusses the research findings of the study and draws conclusions from the findings and suggests areas for further research. The major objective of the study was to determine the influence of socio-demographic characteristics of health care workers on their attitudes toward older people. Two hundred and ninety five (295) healthcare workers were asked to report their attitudes towards older people by using the ATOPS technique. The study was guided by the following two objectives;

1) To determine the influence of socio-demographic characteristics (age, gender, level of education, professional occupation, work experience, marital status and religious belief) on health care providers' attitudes toward older people.
2) To determine the relationship between socio-demographic characteristics of healthcare workers (age, gender, level of education, professional occupation, work experience, marital status and religious belief) and their attitudes towards older people.

The findings are discussed under the following headings: Attitudes towards Older People, Age and Attitudes towards Older People, Gender and Attitudes towards Older People, Level of Education and Attitudes towards Older People, Professional Occupation and Attitudes towards Older People, Work Experience and Attitudes

towards Older People, Marital Status and Attitudes towards Older People and Religious Belief and Attitudes towards Older People.

5.1 Socio-Demographic Characteristics and Attitudes towards Older People

The major objective of this study was to determine the influence of socio-demographic characteristics of healthcare workers on their attitudes towards older people. Data analyses and interpretation from the 295 respondents revealed that the majority of Kenyan health care workers had positive attitudes toward older people regardless of their gender, religious status, professional occupation and work experience.

People's attitudes are greatly influenced by cultural values, norms and social structures of the community (Andrews, 1991). Socially, the multigenerational extended family system predominates in Kenya where the vast majority of older people are living in households of four or more people and the norms and traditions of the African culture encourage strong family ties. This might explain healthcare workers' attitudes towards older people in terms of the family impact and role of the social system structure that formulate or influence Kenyan healthcare workers; attitudes towards older people.

One possible reason for this is the observation that respect for older people is a notable tradition among the people of Kenya. This is influenced by traditional African culture that respects the elderly and honour by their offspring. There is a sense of obligation through filial responsibility involving protection, care and financial support toward parents and ancestors.

Another possible reason is that many of the present older people are active within the family arena, such as looking after their grandchildren, cooking and helping to keep

the family traditions alive. This could have the effect of letting the young witness first-hand the active roles and functions older people serve within the family.

The results of the study showed more positive rather than negative attitudes towards older people. This validates a study that found more positive attitudes and stereotypes of older people (Yenerall, 1995). It is possible that such positive views reflect a shift in attitudes towards a more positive stereotype of ageing. This changing attitude could be the result of today's young adults growing up in a more open social climate, in a more diverse society, and in an era of political correctness with more positive images of older adults (Bell, 1992). Thus young adults may be less inclined to 'age-bash'.

The study findings did differ from those which indicated negative attitudes toward older people among health-care workers (Butler, 1969; Moody, 1980; & Palmore 1990).

This could be explained by conservative cognitive biases about the older people that are formed in people. In their perception, older people resemble one another not only in negative physical characteristics but also in personality traits. The respondents could have been threatened by older people, not because of competition over jobs, education or money but rather it seems due to the fear of the older people's unaesthetic appearance and a belief in the distorted information that all older people live in the homes for the aged, take no interest in society and contribute nothing to it. The participants claimed they have nothing in common with older people, do not want to spend time with them, and prefer the company of younger people.

5.2 Age and Attitudes towards Older People

The second objective was to determine the influence of age of healthcare workers on their attitudes towards older people. Data analyses and interpretation revealed that age had a significant influence on the healthcare workers' attitudes towards older people. The study findings established that as healthcare workers age they tend to have more favourable or positive attitudes towards older people. Age of the respondents did correlate with their attitudes towards older people.

Paul et al. (2003) proposed that younger healthcare workers perceived older people negatively as they drain economic resources of the community and do not contribute to the society. Ebersol & Hess (1997) indicated that healthcare workers, particularly nurses who cared for the sick elderly, perceived older people as having numerous problems that negatively affect their perceptions about older people.

The more favourable or positive attitudes towards older people reported by older healthcare workers could be attributed to the fact that they may have had many years of exposure to older people and also that as they age they also come to appreciate the inevitability of their own ageing hence the positive attitudes. Also, it could be that their subsequent in-service training may have introduced them to the nature of the ageing process and curriculum in gerontology.

The study results indicated a relationship between the age of the respondents and their conceptualization of older people. Old age awakens the greatest fears from those furthest away from it. It arouses repugnance and dread in younger health-care providers (ages 20-39) and those in the 40-50 age group. The respondents, especially those in middle age, tended to deny their real age and to prefer the company of

younger adults. In other words, there is an unrealistic self-image with regard with age. These findings concurred with the results of a study by Erickson, Krauss & Seltzer (1989) which reported denial of ageing especially among the younger respondents. There is a tendency to accept advancing age and that awareness and understanding of age and ageing increase with age. Conceptualisation of age and attitudes towards older people in middle-aged and elderly groups of the health-care workers was better than those of younger healthcare workers.

The research findings indicated that a significant negative relationship exists between participants' chronological age and attitudes towards older people scores indicating a tendency for younger healthcare workers to be more ageist than older workers. This finding supports past research that has found similar effects (e. g. Damrosch, 1984; Finkelstein et al. 1995; Lifshitz, 2002;Gellis et al.,2003;) and counters past research that has not detected such an effect (e. g. Hellenbusch et al. 1994; Tierney et al., 1998). In the present study, it was found that a relationship exists between chronological age and attitudes towards older people which is congruent with the research of Kite and Stockdale (2004).

Perhaps the general findings that negative attitudes towards older people are found among younger healthcare workers are a manifestation of out-group derogation (Fiske, 2002). Research in this area has generally found that people are biased in their evaluations, attributions, and expectations of those considered to be out-group members. Consistent with Social Comparison Theory (Festinger, 1954), it is also likely that young people seldom interact with older people and are primarily exposed to people of similar ages. This circumstance can lead to a confined view of older

people, especially because of their relatively rare-and often low-status-portrayal in books and the media (e. g. Whitbourne & Hulicka, 1990).

Although past research work has shown that older persons (as opposed to younger persons) are more prejudiced in general (von Hippel, Silver & Lynch, 2000), the present results suggest that this may not be the case when the focus of the prejudice is one's own group (i.e., older people). When age is the target of prejudice, an opposite effect occurs. That is, younger individuals show more negative attitudes towards older people than do older individuals.

ATOPS scores exhibited significant negative relationships with age of healthcare workers although the strength of these effects was generally weak. Decline in ATOPS scores that is associated with being older becomes less pronounced at the higher end of the age spectrum.

Conceptualisation of old age is influenced by stereotypes (Lifshitz, 2002). Cognitively, respondents focused on physical and practical characteristics only. Older people are seen in negative light ("walks with a cane", "has white hair", "gets sick", "lives in an old-age home", "in the cemetery"). The older the person, the greater his positive characteristics of older people and of the ageing process. Affectively, old age is seen as threatening and frightening. Many respondents expressed intensely fearful feelings about aging; ("I'll die", "I'll live in old-age-home"). Behaviourally, older people are viewed as helpless and useless and old age is characterized by traits typical of Piaget's preoperational stage of cognitive development. This stage includes egocentrism, irreversibility and one-dimensional perception. The respondents were

unable to relate to the multifacetedness of old age and judged older people by their appearance.

5.3 Gender and Attitudes towards Older People

The third objective was to establish the influence of gender of healthcare workers on their attitudes towards older people. Data analysis and interpretation revealed that gender had no influence on their attitudes towards older people.

Contrary to previous studies, the current study failed to show a gender influence on attitudes of healthcare workers towards older people, or perceptions of older people. The only significant difference between male and female students was that female students had more positive attitudes toward older people. This result is consistent with the literature that suggests that female healthcare workers fulfil their caregiver role because they are socialized to enact caring and nurturing roles that include teaching and nursing.

Previous findings indicated that men are more ageist than women (e.g. Fraboni et al., 1990: Kalavar, 2001; Kite & Stockdale, 2004).

This result may be partly due to the females having higher scores on the personality dimension of expressiveness (e.g warmth, caring, empathy), whereas men generally possess higher instrumentality scores (Deaux, 1985). Kalavar (2001) argued that such an effect may be the result of lifespan developmental processes and greater experience with and exposure to older people. Nevertheless, researchers should interpret the gender effect found herein with caution i.e the difference in ageism scores attributed to gender was relatively small (mean difference of 0.17) and could have been affected by a variety of factors, most notably the size of the sample. A gender difference of this

size, though statistically significant, casts some doubt on the pragmatic utility of the present findings. Further research is needed to determine the accuracy and generalisability of the gender-ageism relationship.

The historical socio-economic conditions of Kenya are an important issue in understanding a woman's role in Kenyan society. Women traditionally remained at home to raise children and care for older people while men went to school and sometimes moved long distances in search of jobs to improve their family status. In some instances, women were left with the primary responsibility for child-rearing and caring for older people which might have prevented them from pursuing education and employment opportunities. However, younger generation in Kenya, including women, still uphold the traditional values of the family and women's responsibility to respect older people and encourage empathy and filial responsibility.

As a result of a dramatic increase in the Kenyan population, men started moving long distances looking for jobs, leaving women to take care of their parents. It is considered a responsibility of women who are also responsible for nurturing and taking care of their own children. Consequently, this responsibility may result in female healthcare workers to develop positive attitudes towards older people.

This finding contradicts Slevin (1991)'s findings that male healthcare workers have negative stereotypical responses towards older people.

This may be attributed to the caregiving role allocated to women in most cultures (Baiyewu, et al, 1997). Given that, in general, women are the primary caregivers in the family, even in extended family situations, it is likely that they regularly have more

contacts with older people. This contact may result in more emotional closeness and, subsequently, more positive attitudes toward older people.

As women age, they are more subjected to biases associated with old age than men. Men, on the other hand, are often seen as gaining prestige with age and are considered attractive and powerful in old age despite a lack of a youthful appearance.

Overall, the results of this study are positive and suggest that healthcare workers in Kenya have a reasonably accurate understanding of older people and favourable attitudes towards older people. Thus, the future development of the field of geriatrics is certainly warranted.

5.4 Level of Education and Attitudes towards Older People

The fourth objective was to determine the influence of the level of education of healthcare workers on their attitudes towards older people. Data analysed and interpreted a statistically significant influence of their level of education on their attitudes towards older people.

Consistent with other studies (Anguillo et al, 1996; Shahidi & Devlen, 1993; Hope 1994), the level of education was a predictor of positive attitudes toward older people. This finding suggests attitudes toward older people may be modifiable by increasing the level of education of health care workers. A positive predisposition toward older people can provide a successful base for increasing their knowledge and motivation to consider working with older people. Therefore, curriculum reform is essential to have an impact on improving health care workers' attitudes toward older people. To increase workers' knowledge about older people and sensitise them to the needs of

older people, curriculum interventions must be employed in gerontological programmes.

In this study, the overall attitude scores between the various levels of education of healthcare workers were statistically significant. This might be the result of the overall Kenyan culture of extended families and respect for seniors. The majority of the older people live with their children and grandchildren. Prior exposure to older people has a relationship with the attitudes of workers towards older people. The more older people the healthcare workers knew well, the less the negative attitudes towards older people.

Given that the level of education appeared to have a significant influence on attitudes toward older people, educational institutions in Kenya must provide extensive education programmes on ageing and gerontology. Younger people will have the opportunity to learn about the ageing process and gain more realistic views about later adulthood. These programmes have not yet been provided in Kenya.

The results of this study indicated that workers with higher education report positive attitudes towards older people. These results are important as previous studies have typically found neutral or negative attitudes toward older people (Lovell, 2006; Mosher-Ashley & Ball, 1999).

A possible explanation for more positive attitudes toward older people is that their attitudes toward older people might be affected by their relationship with their grandparents. Previous studies (McKay & Caverly, 2004; Cheong, Wong & Koh, 2009) have found that most grandchildren and first year medical students have positive attachments to their grandparents and generally consider the relationships as important for identity development. In Kenya, it is not uncommon for healthcare

workers to remain in the family home while attending to their jobs. As a result, Kenyan healthcare workers are more likely to spend more time with their grandparents and have closer relationships with their grandparents. These positive relationships with grandparents might explain the finding that the level of education had a significant influence on participants having more positive attitudes toward older people. Given the prevalent belief that older people in Africa enjoy higher status than their Western counterparts, these results are likely to reflect the rapid economic development in these areas and the subsequent dramatic changes in traditional concepts.

Studies have shown that healthcare workers interact more frequently with older people with whom they are able to communicate than with those who have communication problems. However, the finding of this study showed that with increased level of education, the more positive attitudes towards older people. This can be interpreted as indicating that when healthcare workers have positive attitudes towards older people, they regard older people as significant and their existence as important (Norbergh et al. 2006). This indicates that when healthcare workers perceive older people as unique and valuable persons, they experience their work as very important tasks and, thus, older people feel important themselves.

The results indicated also that the educational backgrounds of the health care workers were consistent in terms of gerontological education. On a more practical note, there is clear evidence from this study that there was a high mean positive attitudes toward older people when healthcare workers have higher level of education. The level of education has been identified in previous studies as a predictor for positive attitudes towards older people (Lovell, 2006). The finding that staff with higher education had

significantly higher mean ATOPS scores than those with lower education is particularly interesting in light of the shift in the care of older people as more achieve higher education.

Socially, the extended family system prevails in Kenya (Olum, 2009) where the vast majority of older people are living in households of four or more people and that might affect the health care workers' attitudes toward older people. In keeping with this view, Ochola et al. (2000) reported that where extended family system predominates health care workers hold positive attitudes toward older people. These life experiences of living with older people outside the school context provide useful direction and understanding to shape the health care professionals' positive attitudes and to learn how to care for the older people. These positive attitudes are strongly influenced by Kenya's cultural, social and religious backgrounds as well as family and women's responsibility that health care workers bring to bear in developing positive perceptions toward older people.

No research currently exists to determine the attitudes of health care providers towards older people in their care in Kenya. In contrast to research studies of nurses working in acute care settings that found only mildly positive attitudes toward older people (Tierney et al., 1998; Hope 1994), the attitude score in this study were strongly positive. The fact that health care workers showed much more positive attitudes toward older people may suggest education as a predictor of attitudes towards older people. In addition, positive attitudes toward older people with a higher level of education of health care workers indicating the importance of attitude in learning and knowledge.

5.5 Professional Occupation and Attitudes towards Older People

The fifth objective was to determine the influence of professional occupation of healthcare workers on their attitudes towards older people. Data analysed and interpreted found no significant influence of professional occupation on their attitudes towards older people. The study did not detect a significant difference in ATOPS scores between the various professional occupations of healthcare workers in Kenya.

This finding is in consonance with Carmel, Cwikel & Galinsky (1992) & Reed et al. (1992) who found no significant differences in professional occupations among social work, medical students and nursing students in their attitudes towards older people.

Other studies found significant differences in attitudes towards older people between clinical psychologists, medical students, nurses and physicians (Simpson, 1984; Armstrong-Esther et al., 1999; Baiyewu, et al., 1997 & Cummings, Adler & DeCoster, 2005) while other researchers found neutral to negative attitudes towards older people (Stout, 1985 & Cheong, Wong & Koh, 2009) regardless of their professional occupation.

Attitudes towards older people by healthcare workers can be influenced by the underresourced environments experienced when working with older people. Hope (1994) reported that some of the health care workers for older people had more positive attitudes towards older people.

However, in a study similar to this study's findings, Gallagher et al's (2006) research did not detect a significant difference in attitudes scores across the various professional occupations. Organisational change and ageing demographics may have

mediated towards healthcare workers working with older people without the prevalent prejudices.

Other studies have found that professional occupation affect healthcare workers' attitudes towards older people (Salmon, 1993; Ebersol & Hess, 1997). Nurses who worked in surgical units demonstrated significantly more positive attitudes than those who were working in medical units did. Older people are frequently viewed as helpless, useless, and dependent on others to perform their activities of daily living. Older people in medical units have slower recovery rates and are more dependent on their caregivers than younger patients. This supports Sheffler (1998) and Hartley et al. (1995)'s findings that healthcare workers' professional occupation determined their attitudes towards older people. Greater dependency of older people stimulates and initiates more negative attitudes from healthcare workers towards this age group.

The type of healthcare worker's profession did not significantly influence healthcare workers' attitudes towards older people. In this study, lack of significance may be related to the small sample size.

In this study, no significant ATOPS score differences were found between the various professional occupations which contrast with previous research that reported that healthcare workers hold more negative attitudes towards older people (Gallagher et al. 2006). Perhaps, the professional ethics of healthcare workers in Kenya have led to the more favorable attitudes towards older people.

Also healthcare workers may know the older people they are working with, not only as older person but possibly as a neighbour, distant relative, or a friend. In addition, as

they are embedded in the community, the older person being taken care of is real and likely to be perceived as living independently.

This study finding differ from those of Chumbler, Robbins and Poplawski (1996) who reported that medical students who entered podiatric medical profession for extrinsic reasons (income, prestige and financial security) were more likely to have negative attitudes towards older people. No such association was found in this study, nor was any relationship between their professional occupation and their attitudes towards older people. These conflicting results may be due to differences in the medical profession between the United States and Kenya.

The findings of this study suggest that the professional occupation of healthcare workers do not have any significant influence on their attitudes towards older people. The development of geriatric curriculum should then take the students' and trainees' existing attitudes into account and require the strategies to improve their attitudes and not just their knowledge and clinical skills. Intensive geriatric education may be necessary to develop positive attitudes toward older people.

5.6 Work Experience and Attitudes towards Older People

The sixth objective of this study was to determine the influence of work experience of healthcare workers on their attitudes towards older people. Data analysed and interpreted detected a significant influence of healthcare workers' experience on their attitudes towards older people. Years of experience correlated with healthcare workers' attitudes towards older people. As the number of years of work experience increased, the healthcare workers developed more positive attitudes towards older people.

Socio-psychological theories have emphasized that negative attitudes towards older people are the result of general stereotypes about older people rather than the result of direct negative work experiences of healthcare workers (Ebersol & Hess, 1997). However, Sheffler (1998) and Hartley et al. (1995) concluded that the primary determinant of healthcare workers attitudes towards older people was their work experience with older people rather than their general stereotypes about them. They found that less experienced healthcare workers hold negative stereotypes about, and attitudes towards, older people. They also indicated that younger healthcare workers had more negative attitudes towards older people than their older counterparts.

The relationship between years of work experience and healthcare workers' attitudes can be attributed to the fact that healthcare workers who had more direct experience with older people had a better understanding of their health and social needs. This understanding may influence their attitudes towards older people. Longer work experience in healthcare has been found to accompany greater acknowledgement of older people's attitudes and wishes (Kwan & Law, 1994). Salmon (1993) indicated that healthcare workers who are less knowledgeable about the ageing process are also more likely to have negative attitudes towards older people.

This study is consistent with Hope (1994) who suggested that work exposure to older people correlates positively with healthcare workers' positive attitudes towards older people. This finding is also in line with McConatha (2004) and Zakari (2005) who found significant differences in healthcare workers experience on their attitudes towards older people. They did also find that an increased work experience of healthcare workers was associated with positive attitudes towards older people.

This finding differs from that obtained in the study by Hope (1994) who found generally negative attitudes towards older people regardless of their years of work experience and Tierney et al. (1998) who found no significant influence of years of work experience on healthcare workers' attitudes towards older people.

Lun (2011) and Gellis, Sherman & Lawrence (2003) found that longer working experience for healthcare workers led them to having positive attitudes towards older people which is in line with the findings of this study. This could be attributed to longer years of work experience providing healthcare workers with exposure to the lives and exigencies of older people hence more favourable attitudes towards them. Exposure to working and helping older people could have led to more positive attitudes.

From the findings of this study, it is reasonable to assume that with more positive attitudes towards older people, the quality of care that older people receive will improve and the interaction between an older person and the health worker can be seen as a helping relationship. Positive attitudes may lead to behaviours that enhance older people's satisfaction and promote their health and psychosocial well-being.

5.7 Marital Status and Attitudes towards Older People

The seventh objective of this study was to establish the influence of marital status of healthcare workers on their attitudes towards older people. Data analysed and interpreted found no significant influence of marital status on their attitudes towards older people. Marital status did not significantly influence healthcare workers' attitudes towards older people.

These findings are consistent with Gallagher et al. (2006) study that reported that there was no significant influence of marital status on healthcare workers' attitudes towards older people. Kimuna, Knox & Zusman (2005) and Mosher-Ashley & Ball (1999) reported also that marriage did not significantly influence healthcare workers' attitudes towards older people and their behavior in general.

This finding could be attributed to the traditional African family system where the care and provision for older people was in the hands of both men and women and hence it was taken by both as community responsibility for all regardless of marital status. Marital status was found to be insignificant as may not determine their perceptions towards older people as married, single and widowed may not be a prime factor in determining how they treat and perceive older people.

5.8 Religious Belief and Attitudes towards Older People

The eighth objective of this study was to determine the influence of religious belief of healthcare workers on their attitudes towards older people. Data analysed and interpreted revealed no significant influence of religious belief on their attitudes towards older people.

This finding was contrary to Alshahri (2002) study that reported significant religious influence on healthcare workers' attitudes towards older people. The author averred that religion (Islam) nurtured positive attitudes due to the respect and reverence of older people and the Quran's teachings on the place of older people in their society. Religion may influence individual's attitudes towards older people and affect the ways in which the older person is perceived (Treharne, 1990). Islam, as many other

religions, urges and motivates Kenyan Muslims to respect and value older people. This has been demonstrated in many verses in the Holy Koran.

Several studies seemed to demonstrate the more dominant influence of secular ethics on healthcare workers' workers attitudes towards older people (Hope 1994; Sainsbury, Wilkinson & Smith, 2004). Majority of the healthcare workers stated that they based their attitudes towards older people on secular ethical principles.

However, Protestant healthcare workers showed more positive attitudes towards older people than the Catholic and Muslim healthcare workers. Protestant healthcare workers may have considered religion as important in their profession and hence reported more positive attitudes towards older people and hence less likely to be prejudiced towards the elderly.

The influence of secular professional ethics may explain the non significant difference between healthcare workers' religious belief and their attitudes towards older people though it may not necessarily prove the absence or irrelevance of the influence of religious affiliation on healthcare workers' attitudes towards older people. The influence of religion may be much stronger among members of specific faiths or religious denominations.

The majority of health care workers may have viewed care for older people as driven and influenced by their religious faiths. For that reason, Kenyan health care professionals regarded the care of older people as a role of respect from their religious perspectives. The Islamic and Christian faiths are certainly a major aspect responsible for shaping the Kenyan society and therefore play a significant role in health care workers' work culture and their views toward the care of older people.

The finding that health care workers are more neutral or negative about older people is not synonymous with a belief that they are uncaring. If resources are limited within a health care system, therapeutic treatment beyond palliative care might be better given to younger patients who have a longer remaining lifespan. There is the danger that in presenting findings of non-significant influence on attitudes toward older people, the less favourable attitudes may have not only come from the design of the study but also from the interpretation placed on the results. Within this study, it was observed that the healthcare workers placed a negative view on many physical and mental changes that come with old age yet at the same time felt that older people were wiser and more contented (Dewey's Paradox, 1939).

5.9 Conclusion

The objective of this study was to determine the influence of socio-demographic characteristics of healthcare workers on their attitudes towards older people. The socio-demographic characteristics (age, gender, level of education, professional occupation, work experience, marital status, and religious belief) were the independent variables while attitudes towards older people were the dependent variable.

The study has shown that the vast majority of the participants which included nurses, clinical officers, student nurses, counselors etc hold positive attitudes towards older people. In addition, it was found that studying to a higher level of education appeared to mitigate towards holding more positive attitudes and hence more training of healthcare workers will go a great length in improving the perception of older people. It was revealed that as the healthcare worker ages, the more positive attitudes towards

older people were observed. Also, the longer the period of work experience, the more favourable or positive attitudes were reported by the healthcare personnel.

However, there were no significant influences of gender, marital status, professional qualification and religious belief on the attitudes of healthcare workers in Kenya.

With the global trend towards an increasingly ageing population, it is clear that healthcare workers need to be equipped with the knowledge and skills to fulfill significant roles in responding to future health and support needs of older people. There is need for a serious advocacy for older people to be mainstreamed in the affairs of the Kenyan society so as to combat ageism. Poor health services that older people receive are likely to further reinforce the portrayal of older people as a burden on society. Reports of elder abuse, neglect and substandard care are also a danger of undermining those healthcare workers who are attempting to provide quality care in challenging times.

We are living in an era of continuous improvements in mortality and increased life expectancy due to improved science and technology. Populations are ageing throughout the world including developing countries like Kenya. Investigating the influence of socio-demographic characteristics of healthcare workers on their attitudes towards older people is important as people continue to grow older. As a result of the ageing population, research studies on ageing and ageing process is now the focus of policy makers. These studies provide insight into the health, mortality and care that older people receive.

As Kenya moves towards a Western lifestyle, its society has undergone major social changes. These impact on healthcare workers' attitudes towards older people in terms

of rejection of the principles of the past and adoption of the manifestations of recent modernization. Strategies should be adopted to maintain and strengthen the social system structure in Kenya and enroll healthcare workers in continuing education programmes that address basic gerontological aspects in terms of health and social needs of older people.

From the study findings, there are clear socio-demographic factors of healthcare workers that affect attitudes towards older people and being older tends to give a person a more positive perspective on ageing. From a life course perspective, health care workers' attitudes might also be affected or formed by their previous experiences with aged persons.

The dearth of literature investigating the attitudes of health care workers' towards older people is of great concern as ageing of the Kenyan population continues. In Africa, there has recently been considerable research undertaken on the quality of care provided to residents living in residential care centres (nursing homes, hospices, old age homes etc) (Courtney, Tong & Walsh, 2006).

The present study offered additional psychometric evidence that the ATOPS constitutes a reliable and valid measure of attitudes towards older people. It is hoped that other researchers will find the ATOPS to be a useful instrument for exploring the antecedents and consequences of ageism.

Programmes to combat ageism against self or others and to create a healthier society must address and engage all segments of the Kenyan society. Research has demonstrated that concrete strategies for communicating specifically with older adults can increase the effectiveness of health promotion programmes. Educational models to

improve attitudes regarding the elderly, through information and reinforcement for change, must be encouraged and created. They must involve both health-care professionals and the general public. As a society we must raise awareness about this negative bias and actively promote and participate in programmes that allow dignity, health and autonomy for senior population. Ageism in health care can lead to unequal treatment of the elderly with less preventive care, less screening and an approach to chronic diseases based more on age than on the calculated risk/benefit ratio.

Initiatives to generate health care personnel with positive attitudes toward older people must rely on curricula efforts and field internships in retirement homes, senior centres, hospices etc. Continued innovative teaching models and evaluation efforts will be necessary to determine the type and content of teaching experiences in medical schools that will cultivate positive attitudes towards older people.

The study was the first of its kind to investigate the attitudes of health care workers toward older people in Kenya. The key findings show that even though they had overall positive attitudes toward older people, they have significant knowledge deficits in other socio-demographic characteristics such as professional occupation, gender, religious belief, and marital status.

5.10 Recommendations of the Study

The results of this study are considered as important contribution to the welfare and care of older people as it considered healthcare workers attitudes towards them and this has big impact on the type of care they receive.

On the basis of the findings of this study, the following recommendations are made;

1. There is need to stop viewing old age as a problem, an affliction to be solved by spending billions of shillings on plastic surgery, medical research to extend the lifespan itself and on nursing or retirement homes to isolate the aged. There is need to change the negative attitudes of health-care providers in order to remediate underservice. The concepts suggested by research on attitudes toward older people must be applied to refining our understanding of health-care workers' attitudes towards older people.
2. Need to provide ageing education in the school curriculum for health care providers to dispel myths and fears of ageing and change their attitudes and behaviours toward older people. To make health care professionals aware of how their attitudes toward older people influence their actions/behaviours in relation to older people it is important to focus on geriatric practice and education.
3. There is need for health workers in Kenya to have special training in geriatrics so as appreciate older people as normal human beings seeking medical care like any other patient and that old age ailments are normal and not due to old age.
4. There is need for elevation of the older people's programme into a Division of Older People within the Ministry of Gender and Social Services. This will facilitate advocacy and mainstreaming/integration of ageing issues, needs and concerns of the elderly in the national development process. As a vulnerable group, they require targeted provision of basic services such as housing, access to medicare, recreational facilities and security among others.

5. University medical schools and colleges need to seriously examine their curriculum, methods of teaching and use of enriching class experiences to improve healthcare workers' attitudes towards older people so as better service delivery. The findings of this study offer grounds for giving greater attention to the existence of age bias in healthcare provision in Kenya both in terms of access and the nature of the relationships that emerges.

5.11 Recommendations for Further Research

The study intended to provide insight into the influence of healthcare workers' socio-demographic characteristics on their attitudes towards older people. However, the following suggestions emanating from this study have been proposed for further research;

1. Since this study adopted a quantitative approach, it is suggested that a qualitative research design with in-depth interviews of health care workers in Kenya to seek further clarification and views about their attitudes towards older people. A qualitative research approach is an appropriate method to study a qualitative concept (Phillips, 1995) such as attitudes. Thus, qualitative studies should investigate the essence of attitudes among Kenyan healthcare workers.
2. It would be fruitful for future research to study the psychological construct of ageism across cultures. Such studies should look toward the cross-cultural age bias literature for informative models. Such a pursuit is especially relevant because other countries are in the process of passing legislation outlawing age discrimination.

3. Future research should also investigate the cognitive/antilocution, behavioural/avoidance and affective/discrimination attitudes subscales as defined by Butler (1969).
4. Longitudinal studies are recommended to compare health care workers' attitudes and their level of knowledge of the ageing process after studying courses in gerontology. Such research may provide information concerning the effect of gerontological learning experiences on attitude change.

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APPENDICES

APPENDIX A: CONSENT/INFORMATION LETTER

John Kipruto,
Dept. of Educational Psychology,
Moi University,
P.O. Box 3900,
ELDORET.

Dear Participant,

I am grateful indeed for your acceptance to participate in this study. This questionnaire is designed to find out your views about old age and problems that accompany the ageing process. Your responses will help the society structure social systems that would help alleviate problems of older people.

You are required to provide responses to the items in the questionnaire attached to this letter. Please note that all the information you give will be treated with utmost confidentiality and will not be used for any other purpose other than this study.

Your response is highly appreciated.

Yours sincerely,

JOHN KIPRUTO

APPENDIX B: ATTITUDES TOWARDS OLDER PEOPLE SCALE (ATOPS) QUESTIONNAIRE

Instructions

- Please respond to ALL the items. There is no RIGHT or WRONG response.
- Read the statements carefully and understand before writing your responses.
- In ALL cases provide honest responses that are also pertinent to you.
- Respond to all items by ticking (√) in the blank spaces provided or simply fill in the blanks.
- Do NOT include your name anywhere in this questionnaire.

SECTION A: - SOCIO-DEMOGRAPHIC DATA OF HEALTHCARE WORKERS

First, provide some information about yourself (please tick the correct boxes).

1. Give gender: Male { } Female { }
2. Give your age range: 21-30 { }
   31-40 { }
   41-50 { }
   51-55 { }
   Above 55 { }
3. Indicate your marital status: Single { }
   Married { }
   Widowed { }
   Divorced/Separated { }

   Others (please specify) ______________________________

4. Indicate your professional occupation

- Nurse/Nutritionist { }
- Community/Social worker { }
- Nursing student { }
- Medical student { }
- Clinical officer { }
- Doctor { }
- Physiotherapist { }
- General Practitioner { }
- Counsellor { }
- Priest/Parson { }
- Psychiatrist { }
- Others (Please specify) ___________________________

5. Indicate your level of education/qualification:-

- Certificate { }
- Diploma { }
- Degree { }
- Masters { }
- PhD { }
- Others (Please specify)________________________

6. Indicate your religious belief:-

- Protestant { }
- Catholic { }

- Islam { }
- Others (Please specify)______________________

7. Indicate your years of work experience:-

   0-5 years { }

   6-10 years { }

   11-15 years { }

   16-20 years { }

   21+ { }

SECTION B – ATTITUDES TOWARDS OLDER PEOPLE SCALE (ATOPS)

Go through each item and indicate your feeling or opinion about old people. Tick in the bracket for **SA (Strongly Agree)** if you feel that the statement strongly applies to you, **A (Agree)** if it does not apply so strongly, **U (Undecided)** if you are not sure about it, **D (Disagree)** if does not apply and **SD (Strongly Disagree)** if you strongly feel that it does not apply to you at all.

KEY **SA** - **Strongly Agree**

A - **Agree**

U - **Undecided**

D - **Disagree**

SD - **Strongly Disagree**

NB: Tick only ONE of the choices given.

1. Many old people are stingy and hoard their money and possessions.

   SA { } A { } U { } D { } SD { }

2. Many old people just live in the past.

   SA [ ] A [ ] U [ ] D [ ] SD [ ]

3. Most old people should not be trusted to take care of infants.

   SA [ ] A [ ] U [ ] D [ ] SD [ ]

4. Many old people are happiest when they are with people of their own age.

   SA [ ] A [ ] U [ ] D [ ] SD [ ]

5. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.

   SA [ ] A [ ] U [ ] D [ ] SD [ ]

6. Old people should feel welcome at the social gatherings of young people.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

7. Old people deserve the same rights and freedoms as do other members of our society.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

8. Old people can be very creative.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

9. I would prefer not to live with an old person.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

10. Old people do not need much money to meet their needs.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

11. The majority of old people are senile i.e. disoriented or demented.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

12. It is almost impossible for most old people to learn new things

SA [ ] A [ ] U [ ] D [ ] SD [ ]

13. Most old people are set in their ways and unable to change.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

14. Most old people have no interest in or capacity for sexual activity.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

15. The majority of old people feel miserable and are unhappy because they are old.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

16. Most older people are stubborn, conservative and intolerant to new ideas.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

17. One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

18. Old age is second phase of childhood.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

19. It is impossible to differentiate between illness and natural ageing processes.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

20. Most diseases in old age are not treatable.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

21 Many old people are not interested in making new friends, preferring instead the circle of friends they have had for years.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

22. Most old people spend too much time prying into the affairs of others and giving

unsought advice.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

23. It is foolish to claim that wisdom comes with age.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

24. It is best that old people live where they won't bother anyone.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

25. When you think about it, old people have the same faults as anybody else.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

26. Old people have too much power in business and politics.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

27. Most old people are really no different from anybody else; they are as easy to understand as younger people.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

28. I personally would not want to spend much time with an old person.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

29. There are a few exceptions, but in general most old people are pretty much alike.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

30. Most old people are cheerful, agreeable, and good humoured.

SA [ ] A [ ] U [ ] D [ ] SD [

31. Old age is a period devoid of personal growth and development

SA [ ] A [ ] U [ ] D [ ] SD [ ]

32. Most older people prefer own company and the company of other aged.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

33. Old people are incapable of living their lives without considerable support.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

34. Old people are depressed, docile and old-fashioned.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

35. Majority of all people lack achievement orientation and self confidence.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

36. Most old people get set in their ways and are unable to change.

SA { } A { } U { } D { } SD { }

37. Most old people are capable of new adjustments when the situation demands it.

SA { } A { } U { } D { } SD { }

38. Old people are unable to think, reason and make decisions.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

39. Majority of older people have inadequate incomes and live below the poverty level.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

40. It would probably be better if most old people lived in residential units with people their own age.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

41. Most old people make excessive demands for love and reassurance than anyone else.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

42. Most old people can be irritating because they tell the same stories over and over again.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

43. Teenage suicide is more tragic than suicide among the old.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

44. I sometimes avoid eye contact with old people when I see them.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

45. I don't like it when old people try to make conversations with me.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

46. Complex and interesting conversation cannot be expected from most old people.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

47. Feeling depressed when around old people is probably a common feeling.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

48. Old people should find friends their own age.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

49. The company of most old people is quiet enjoyable.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

50. Most old people bore others by their insistence on talking "about the good old days".

SA [ ] A [ ] U [ ] D [ ] SD [ ]

51. Older people prefer to disengage from life and withdraw into themselves.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

52. Old people have lived beyond their time and have less value.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

53. Older people are best when left alone and socially isolated.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

54. Old people are dependent upon others and are a drain to public funds.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

55. Old people are best kept in institutions to keep them clean, silent and out of sight.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

56. Older people are more susceptible to fatal illness and should not be treated when sick.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

57. Old people are deficient in intelligence and mentally retarded.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

58. It is the fit elderly and not the sick elderly who are the exceptions to ageing.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

59. Older people should not remarry upon death of spouse.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

60. Elderly people are not productive members of our society.

SA [ ] A [ ] U [ ] D [ ] SD [ ]

APPENDIX C: SAMPLING FRAME

Table for determining the sample size (Sampling frame)

Population size	Sample size
10	10
19	19
20	20
40	35
50	45
60	52
70	59
80	66
90	73
100	80
150	108
200	132
250	162
300	169
400	196
1500	306
2000	322
3000	342
4000	351
5000	357
10000	370
20000	377
50000	381
100000	384

Source (Peter, 1994, p. 76)

APPENDIX D: RESEARCH BUDGET

	Description of item	Unit Cost (Kshs)	Total Cost (Kshs)
A.	**Equipment**		
1.	Computer	80,000	80,000
2.	Printer	20,000	20,000
B.	**Stationery & Photocopying**		
1.	Spring files; 10 pcs	30	300
2.	Floppy diskettes: 10 pcs	50	500
3.	Research permit: 1	1,000	1,000
4.	Questionnaire: 5 pgs x 300 copies	3	4,500
5.	Interview schedules: 6pgs x 36 copies	3	648
6.	Proposal: 50pgs x 10 copies	3	1,500
7.	Thesis: 400pgs x 10 copies	3	12,000
8.	Thesis binding: 10 copies	300	3,000
C.	**Data collection**		
1.	Subsistence during piloting (2 days)	3,300	6,600
2.	Transport during piloting (2 days)	1,000	2,000
3.	Subsistence during field work (30 days)	3,300	99,000
4.	Transport during field work (30 days)	1,000	30,000
5.	Supervisors' subsistence during field Work: 10 days x 2 supervisors	6,000	120,000
6.	Research Assistant: 30 days x 3 Assistants	2,000	180,000
		Sub-Total	**428,000**
GRAND TOTAL		**KShs. 551,448 (US $ 6,895)**	

APPENDIX E: DESCRIPTIVE STATISTICS OF ATTITUDES TOWARDS OLDER PEOPLE

	N	*Min*	*Max*	*Mean*	*Std. Deviation*
Many old people are stingy and hoard their money and possessions.	295	1.00	5.00	3.0847	1.47413
Many old people just live in the past.	295	1.00	5.00	2.8983	1.37884
Most old people should not be trusted to take care of infants.	295	1.00	5.00	2.7525	1.37140
Many old people are happiest when they are with people their own age.	295	1.00	5.00	2.7627	1.36201
Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.	295	1.00	5.00	2.7322	1.31170
Old people should feel welcome at the social gatherings of young people.	295	1.00	5.00	3.2034	1.30122
Old people deserve the same rights and freedoms as do other members of our society.	295	1.00	5.00	3.2305	1.26750
Old people can be very creative.	295	1.00	5.00	3.4237	1.47315
I would prefer not to live with an old person.	295	1.00	5.00	3.4949	1.37487
Old people do not need much money to meet their needs.	295	1.00	5.00	3.0373	1.36849
The majority of old people are senile i.e. disoriented or demented.	295	1.00	5.00	2.8068	1.38011
It is almost impossible for most old people to learn new things	295	1.00	5.00	2.7186	1.41138
Most old people are set in their ways and unable to change.	295	1.00	5.00	2.9831	1.40325
Most old people have no interest in or capacity for	295	1.00	5.00	3.0881	1.46815

sexual activity.					
The majority of old people feel miserable and are unhappy because they are old.	295	1.00	5.00	3.1254	1.40257
Most older people are stubborn, conservative and intolerant to new ideas.	295	1.00	5.00	3.1051	1.37487
One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.	295	1.00	5.00	2.9729	1.35248
Old age is second phase of childhood.	295	1.00	5.00	3.1356	1.33577
It is impossible to differentiate between illness and natural ageing processes.	295	1.00	5.00	3.1288	1.29245
Most diseases in old age are not treatable.	295	1.00	5.00	2.8915	1.27579
Many old people are not interested in making new friends, preferring instead the circle of friends they have had for years.	295	1.00	5.00	2.8678	1.23696
Most old people spend too much time prying into the affairs of others and giving unsought advice.	295	1.00	5.00	3.9525	1.20280
It is foolish to claim that wisdom comes with age.	295	1.00	5.00	3.6576	1.47360
It is best that old people live where they won't bother anyone.	295	1.00	5.00	3.1153	1.41671
When you think about it, old people have the same faults as anybody else.	295	1.00	5.00	3.0780	1.43713
Old people have too much power in business and politics.	295	1.00	5.00	3.0068	1.44983
Most old people are really no different from anybody else; they are as easy to understand as younger people.	295	1.00	5.00	3.1492	1.38927

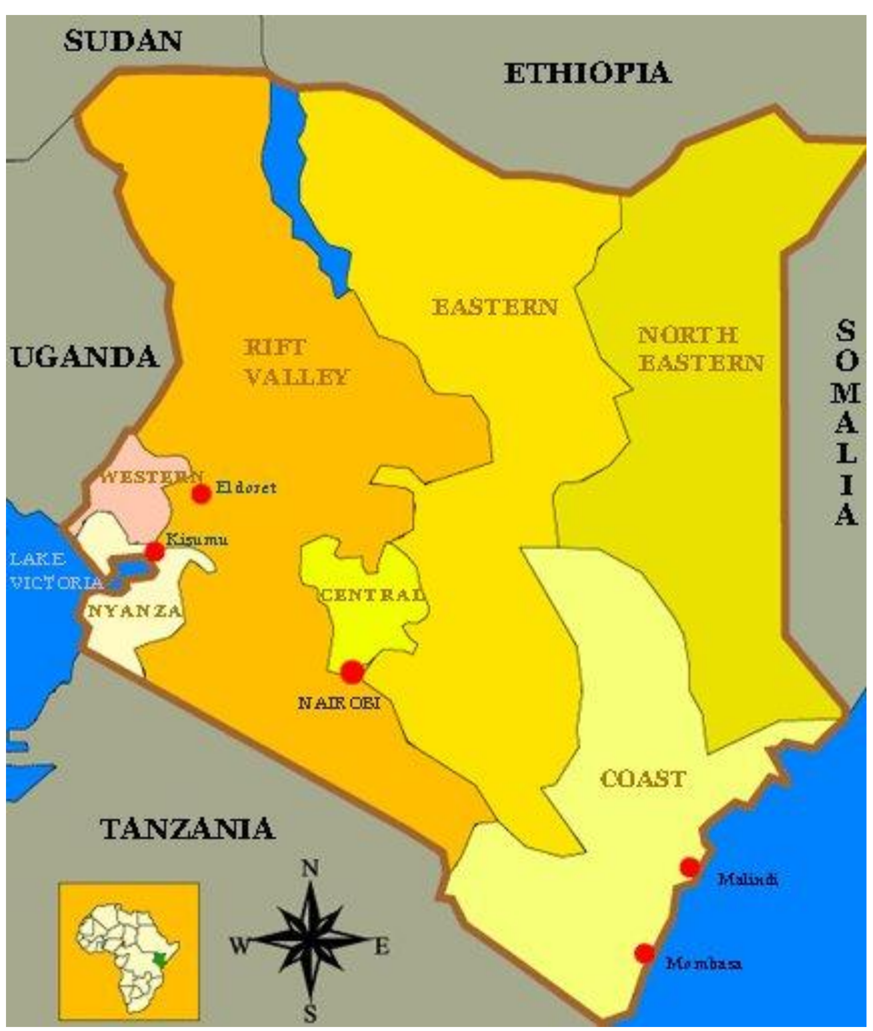
I personally would not want to spend much time with an old person.	295	1.00	5.00	3.1932	1.37518
There are a few exceptions, but in general most old people are pretty much alike.	295	1.00	5.00	3.2102	1.39114
Most old people are cheerful, agreeable, and good humoured.	295	1.00	5.00	3.1492	1.31893
Old age is a period devoid of personal growth and development	295	1.00	5.00	3.2237	1.32125
Most older people prefer own company and the company of other aged.	295	1.00	5.00	3.2136	1.38449
Old people are incapable of living their lives without considerable support.	295	1.00	5.00	3.0983	1.30690
Old people are depressed, docile and old-fashioned.	295	1.00	5.00	3.1153	1.29110
Majority of all people lack achievement orientation and self confidence.	295	1.00	5.00	2.9695	1.19626
Most old people get set in their ways and are unable to change.	295	1.00	5.00	3.6678	1.35205
Most old people are capable of new adjustments when the situation demands it.	295	1.00	5.00	3.7051	1.39160
Old people are unable to think, reason and make decisions.	295	1.00	5.00	3.1932	1.30929
Majority of older people have inadequate incomes and live below the poverty level.	295	1.00	5.00	2.9627	1.40527
It would probably be better if most old people lived in residential units with people their own age.	295	1.00	5.00	2.8508	1.30337
Most old people make excessive demands for love and reassurance than anyone else.	295	1.00	5.00	3.1831	1.39742

Most old people can be irritating because they tell the same stories over and over again.	295	1.00	5.00	3.2915	1.37387
Teenage suicide is more tragic than suicide among the old.	295	1.00	5.00	3.2000	1.36427
I sometimes avoid eye contact with old people when I see them.	295	1.00	5.00	3.0814	1.28842
I don’t like it when old people try to make conversations with me.	295	1.00	5.00	3.0034	1.36899
Complex and interesting conversation cannot be expected from most old people.	295	1.00	5.00	3.1153	1.34022
Feeling depressed when around old people is probably a common feeling.	295	1.00	5.00	3.0780	1.30307
Old people should find friends their own age.	295	1.00	5.00	2.8576	1.22616
The company of most old people is quiet enjoyable.	295	1.00	5.00	3.8271	1.19833
Most old people bore others by their insistence on talking “about the good old days”.	295	1.00	5.00	3.6339	1.22677
Older people prefer to disengage from life and withdraw into themselves.	295	1.00	5.00	3.1424	1.35529
Old people have lived beyond their time and have less value.	295	1.00	5.00	2.9322	1.41017
Older people are best when left alone and socially isolated.	295	1.00	5.00	2.9559	1.36330
Old people are dependent upon others and are a drain to public funds.	295	1.00	5.00	3.1153	1.38023
Old people are best kept in institutions to keep them clean, silent and out of sight.	294	1.00	5.00	3.2075	1.36302
Older people are more susceptible to fatal illness and should not be treated when sick.	295	1.00	5.00	3.2237	1.30049
Old people are deficient in intelligence and mentally retarded.	295	1.00	5.00	3.2576	1.32534
It is the fit elderly and not the sick elderly who are	295	1.00	5.00	3.1593	1.32674

the exceptions to ageing.					
Older people should not remarry upon death of spouse.	295	1.00	5.00	3.1119	1.27949
Elderly people are not productive members of our society.	295	1.00	5.00	2.9458	1.26858
Overall Attitude towards Older People	**295**	**2.35**	**4.05**	**3.2428**	**.32052**

APPENDIX F: RESEARCH PERMIT

APPENDIX G: MAP OF KENYA SHOWING THE STUDY AREA



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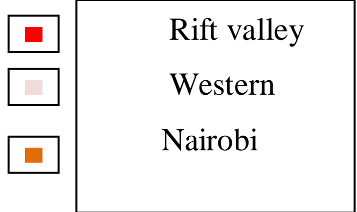
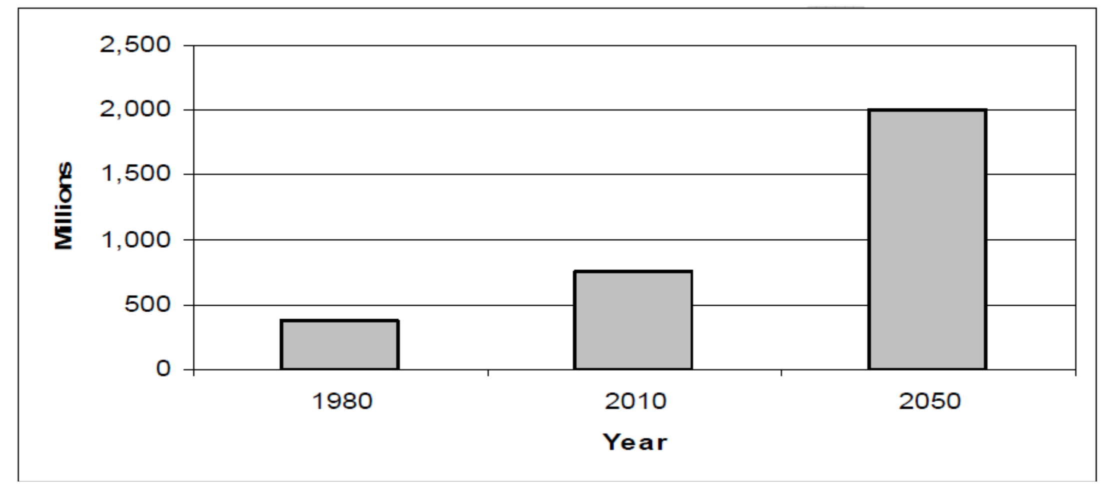


APPENDIX H: HEALTHCARE INSTITUTIONS SAMPLED

Province	**No. of Respondents**	**Total**
Rift Valley	10	
Eldoret Hospital	10	
Eldoret Hospice	8	
MTRH	17	
Kabarnet District Hospital	10	
Nakuru PGH	11	
Kericho District Hospital	7	
Trans-Nzoia District Hospital	5	
Mediheal Hospital	5	
Mercy Hospital-E/Ravine	8	
Kajiado District Hospital	7	
Naivasha District Hospital	6	
Narok District Hospital	8	
Loitoktok District	8	
Sub-Total	**112**	
Nairobi		
Nyumba ya Wazee-Nairobi	5	
KNH	14	
Mbagathi District	10	
Nairobi Hospital	7	
Aga Khan Hospital	6	
Avenue Hospital	7	
Guru Nanak	7	
Mater	6	

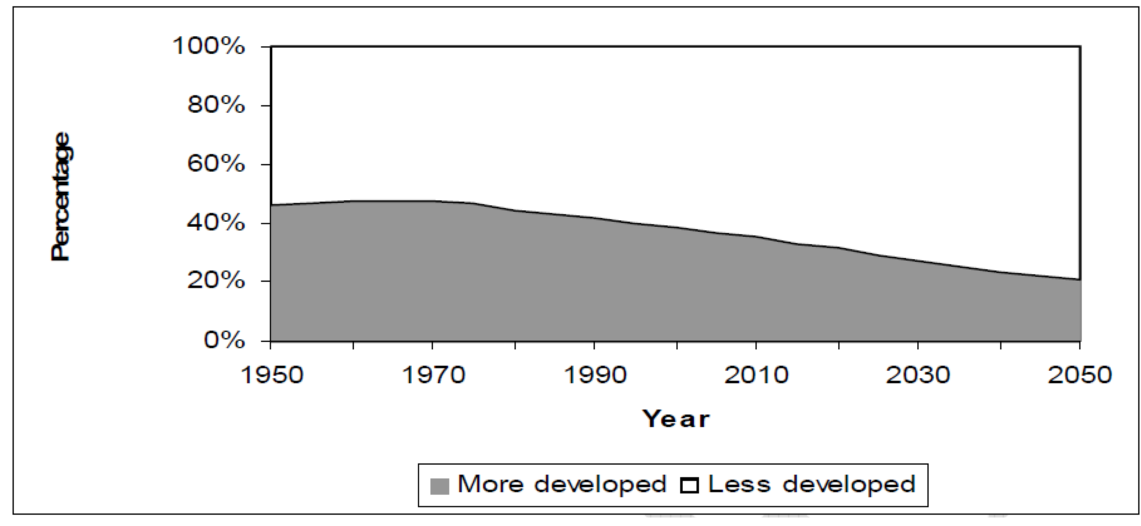
Nairobi West	6	
Metropolitan Hospital	6	
Nazareth	7	
Mathare Hospital	7	
Nairobi Women	7	
Sub-Total	**102**	
Western		
Kakamega PGH	11	
Busia District Hospital	8	
Bungoma District Hospital	12	
St. Mary-Mumias	9	
Vihiga District Hospital	8	
Kaimosi Hospital	7	
Mbale District Hospital	9	
Mukumu Mission	8	
Webuye District Hospital	9	
Sub-Total	**81**	
	Total	**295**

APPENDIX I: POPULATION AGED 65 AND OVER: 1980, 2010, 2050



Source: United Nations (2009), *World Population Prospects, 2008 Revision*

APPENDIX J: DISTRIBUTION OF WORLD POPULATION AGED 65 AND OVER BY DEVELOPMENT REGION, 1950-2050



Source: United Nations (2009). *World Population Ageing*, *2009*