



A Medical Look at the Elderly in the Hospices of the City of Kisangani in the Democratic Republic of Congo

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

Article Information

DOI: 10.9734/ISRR/2022/v11i230143

Open Peer Review History:

This journal follows the Advanced Open Peer Review policy. Identity of the Reviewers, Editor(s) and additional Reviewers, peer review comments, different versions of the manuscript, comments of the editors, etc are available here: <https://www.sdiarticle5.com/review-history/90007>

Original Research Article

Received 15 June 2022
Accepted 02 August 2022
Published 10 August 2022

ABSTRACT

Introduction: The aim of the study was to describe the socio-demographic characteristics of the elderly in the old people's home in the city of Kisangani, to assess the health status of these elderly people and to determine the predictors of their medical suffering.

Methodology: This was a cross-sectional study with an analytical focus. The survey method was used through interviews to collect information useful for this study, which benefited from the participation of 56 elderly people living in the hospices of the city of Kisangani.

Results: It was shown that the hospices for the elderly in Kisangani are dominated by women (51.8%), widows and divorcees are in the majority (92.9%), and the primary level predominates (37.5%). Also 41.1% of the subjects suffered since their accommodation, of which acute rheumatism occupies the first position (47.8%) and 52.2% are taken care of by the churches, but 65.2% are not satisfied with the medical treatment, among them, 41.1% do not make medical controls; 85.7% do not walk well and 82.1% do not urinate well. Similarly their suffering in hospices

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was associated with five factors including lack of exercise, not urinating well, insecurity in the hospice, needing a man or woman for sex and not eating well.

Conclusion: Ageing is accompanied by a decrease in the functional capacities of the body. Also, several systems of regulation of physiological parameters are less efficient in the elderly. They need to be cared for so that their end of life is also better in all respects.

Keywords: Medical view; elderly; hospice.

1. INTRODUCTION

The process of ageing, which is a set of physiological and psychological processes, can change the structure and functions of the organism from old age. It is the result of the interrelated effects of genetic and environmental factors to which the body is subjected throughout life.

According to Belmin [1], in his "ageing well" plan, improving the care of the elderly requires, in addition to other aggravating factors, the prevention of undernutrition, as it leads to increased consumption of health care in the over 65s.

The loss of functional autonomy, the risk of which increases considerably with age, leads to specific problems which require specific solutions; these problems, which are still poorly resolved, present society as a whole with a challenge to which public health is in the front line when it comes to the problems of the elderly.

Worldwide, the proportion of people aged 60 and over is increasing faster than any other age group. The elderly constitute 12.5% of the population and by 2051 will account for an estimated 21.4% of the total world population [2].

Between 1970 and 2025, the number of older people is expected to increase by about 694 million and the world will have about 1.2 billion people over the age of 60.

In 2030, there will be 100 elderly women and 86 elderly men. The greatest increase will be in countries with an average income of less than US\$ 2 per day. In detail, almost 9,000 elderly people are victims of homicide in Europe every year. 2.7% suffer physical abuse, 0.7% sexual abuse and 19.4% are victims of financial abuse. In 2050, metropolitan France will have between 58 and 70 million inhabitants of people over 60 years old. [3]. In 2050, there will be more than 2 billion of them, 80% of whom will live in developing countries [4].

In Canada, the elderly (over 65) represent the largest part of the population, increasing from 3.5 million in 1996 to an estimated 6.9 million in 2021 [5].

In developing countries, 42% of adult deaths occur in the elderly (over 60 years of age) compared to 78% in developed countries due to geriatric diseases [6].

In Africa, where population growth is rapid and major economic changes have disrupted lifestyles over the past century, the medical and social roles of older people are also undergoing significant change [7]. Looking at the big picture, people in Africa are now living longer than in the past. Sub-Saharan Africa has an estimated 54 million people aged 60 years and over, or 5% of the world's elderly. The population of older people in sub-Saharan Africa is expected to reach 67 million by 2025 and 163 million by 2050 [8].

According to the Institut National d'Etudes Démographiques in 2009, the number of elderly people in Africa is expected to quadruple between 2010 and 2050, from 56 million to 215 million. The continent will then have 22.5 million people aged 80 or over, five times more than today.

In Senegal, the number of elderly people was 7.4% in 1988 and has now risen to 9%. This rate is expected to reach 11% in 2015 as life expectancy will increase from the current 57 years to 63 years [9].

In Rwanda, according to data provided by the Ministry of Health, the rate of population ageing is 3.2%. However, there is a generalized vulnerability linked to old age following the dramatic situation of the 1994 genocide. As an illustration, the frequency of depression among the elderly was 19% [10].

Uganda and Senegal are among the youngest countries in Africa and the issue of ageing of their populations is not yet topical. According to the last Ugandan census, carried out in 2002, only 5% of its then 26 million inhabitants were

aged 60 or over, while 50% were under 15 years old. At the same time, Senegal had a population of about 10 million, 45% of whom were under 15 years old and just over 5% of whom were 60 years old or over. However, even if the elderly are still few in number, their situation deserves special attention, on the one hand because their proportion of the total population of these countries is set to grow extremely rapidly in the coming decades (Pison, 2009). On the other hand, public policies often neglect them, regardless of the fundamental role they play in society [11].

In the Democratic Republic of Congo, studies in 2003 showed that nearly 80% of the elderly are no longer economically active and that it is especially in urban areas where active life ends earlier (80% inactive). Almost 60% of the elderly do not integrate socially, especially in urban areas (66%). In rural areas 99% of the elderly do not benefit from any intervention of basic or related social services, while in urban areas this proportion is 98% [12].

According to the DPS-Tshopo/DRC Report, published in 2018 in the province of Tshopo precisely in Kisangani, the illiteracy rate of the elderly remains high at 30% and these people represent 6.5% of the general population.

The pre-survey carried out in the 2 communes of the city (Makiso and Mangobo) revealed that several families were hosting elderly people and many of them complained about the difficult behaviour displayed by these people in their families.

The problem of caring for the elderly remains a dilemma. With the help of an NGO (Help Age International) [13], which works in 75 countries with the following targets: social protection, health, life support in old age, HIV/AIDS, emergency-discrimination and abuse (Rights) and networking and association, Africa has reached at least 30% of the care of the elderly.

Growing old has its drawbacks. The behaviour of elderly people living with families and in old people's homes is very difficult and poses a serious problem between them and nurses and family members.

This problem seems to be more pronounced in old people's homes where health care staff are often unable to care for the most vulnerable or to protect them from accusations of witchcraft, stress, chronic illnesses, etc. These considerations condemn the elderly to live alone

in old people's homes, despite the weight of age and the risk of developing geriatric diseases.

This study aims to take a medical look at the elderly in the old people's homes of the city of Kisangani, in order to identify the factors linked to their health problems and to contribute to the reflections on their well-being in the old people's homes of the DRC in general and the city of Kisangani in particular.

In view of the above, we asked ourselves the following fundamental question: What medical view emerges during the stays of the elderly in the old people's homes in the city of Kisangani?.

The following secondary questions follow from this main question: What are the socio-demographic characteristics related to the health problem of the elderly?. What is the health status of the elderly in the old people's homes in Kisangani? Are there any predictors of medical suffering among the elderly?.

In view of the questions raised, we believe that the elderly are subject to some medical suffering in the old people's homes in the city of Kisangani.

These sufferings differ from one elderly person to another and their state of health shows geriatric syndromes, which are linked to certain predictors.

The general objective of this study is to contribute to the improvement of the well-being of elderly people in the hospices of the city of Kisangani, in particular, and of the DRC in general, in terms of their lives.

To achieve this, we set ourselves the following specific objectives: to describe the socio-demographic characteristics of the elderly in the old people's homes in the city of Kisangani, to assess the health status of these elderly people and to determine the predictors of their medical suffering.

2. METHODOLOGY

2.1 Framework and Scope of the Study

This study is part of a gerontological framework because it allows us to take a medical look at the elderly living in the old people's homes in the city of Kisangani.

2.1.1. Type of study

This is a cross-sectional study with an analytical aim. The survey was carried out from 15 June to 28 September 2021 and concerned elderly people living in the two old people's homes in the city of Kisangani.

2.2 Population and Sample

2.2.1. Target population

For the present study, the target population is composed of 56 elderly people living in the two old people's homes in the city of Kisangani.

2.2.2. Sample

To draw the sample for this study, we used the non-probability sampling technique. This technique allowed us to select participants, according to the needs of the study, based on whether they revealed the characteristics and information sought by the study.

This sampling technique is particularly appropriate for practical questions where the experience of the actors (elderly people) is important and the context of this experience is essential to know given its interaction with the worker.

Since our population is finite, we finally worked with the entire target population of this study.

2.2.3. Selection of the sample

1) Inclusion criteria

All elderly people who met the following criteria were included in this study: they were elderly people living in one of the old people's homes in the city of Kisangani selected for this study, they agreed to participate in the study and they were present on the day of the survey.

2) Non-inclusion criteria

The following were excluded from this study: any elderly person outside the old people's homes in the city of Kisangani; any elderly person who refused to participate in this study.

2.3 Method and Technique

The survey method was used to collect data in this study. In addition, the interview was used to

collect information from the elderly living in the hospices.

2.3.1 Data collection instrument

In this study, an interview guide was used to collect the data. Materials such as tape measure, weighing scales, blood glucose meter, test strips, cotton wool, denatured alcohol, self-pricker, and pen were useful for data collection.

2.3.2 Data analysis and processing plan

Data from the collection sites recorded on the data collection tools were compiled and coded. Data entry was done using SPSS- Version 20 software.

Firstly, we proceeded to a description of the data by calculating proportions and percentages for the qualitative variables while on the quantitative variables we calculated the mean and standard deviation;

Secondly, in bivariate analysis, we crossed the independent variables with the dependent variable (suffering of elderly people) to establish the existence or not of links between the different characteristics and the suffering of elderly people in the hospices of the city of Kisangani using Pearson's and Fisher's Chi-2 test. The relationships will be considered significant at a value of $p < 0.05$.

To determine the predictors of suffering among the elderly in the hospices of Kisangani city, we used logistic regression. Any variable with a $p < 0.05$ in the last fitted model will be considered a predictor of suffering of the elderly in the hospices in the city of Kisangani.

Participation in this study was voluntary. Consent was free, informed but only verbal. Respondents were told that if they agreed to participate in the study, a questionnaire would be administered to them. The respondent who freely agreed to be recruited could withdraw from the survey at any time without any prejudice.

3. RESULTS

3.1 Descriptive analysis

The Table 1 shows that the majority of respondents were women (51.8%); 62.5% were aged between 70 and 74 (the average age being 71.1 ± 7.8); 57.2% were widowers; 62.5% were in

a common-law relationship; 53.6% had between 0 and 1 living child (the average number of children was 3.2±2.0 standard deviation); retired civil servants were more represented (37.5%), and 28.5% of the elderly had no education, i.e. they were illiterate.

The Table 2 shows that 23 (41.1%) of the elderly reported suffering from the moment they were admitted; rheumatic fever (47.8%) was the most reported disease; all the elderly suffering (100%) were treated in the old people's home and 52.2% were cared for by the church; while 47.8% had restrictions in taking medicines and the most reported restriction was eating before taking medicines (72.7%).

It is noted in this Table 3 that 65.2% of the elderly sufferers were not satisfied with the treatment they received, the main reason being

the slight improvement (53.3%); 60.7% did not take any physical exercise; but the most common type of physical exercise for those who did was flexible gymnastics (63.6%). With regard to medical check-ups, 58.9% did them, but with irregular frequency (51.5%) and that the lack of medical check-ups was associated with the lack of financial means (69.6%).

The Table 4 shows that the elderly had made suggestions to the hospice authorities and hospice managers, the most common of which was the provision of food to the hospices, at 53.6%.

From this Table 5 it can be seen that 44 (78.6%) of the elderly had a personal history (hypertension, diabetes, ARF, obesity) and 25.0% had at least one hereditary history (hypertension, diabetes, ARF, obesity).

Table 1. Distribution of respondents according to their socio-demographic characteristics

Variables	(n=56)	%
Sex		
Male	27	48.2
Female	29	51.8
Age range (year)		
65 - 69	8	14.3
70 – 74	35	62.5
75 - 79	13	23.2
Marital status		
Widowed	32	57.2
Divorced	20	35.7
Married	4	7.1
Type of marriage		
Civil	11	19.6
Free union	35	62.5
Religious	10	17.9
Number of living children		
0 – 1	30	53.6
2 – 3	21	37.5
4 – 5	5	8.9
Profession		
Retired from the state	21	37.5
State employee	17	30.4
No profession	18	32.1
Level of education		
Primary	21	37.5
Secondary	19	33.9
No level	16	28.5

Table 2. Distribution of respondents according to their medical characteristics

Variables	(n=56)	%
Suffering from hosting		
Yes	23	41.1
No	33	58.9
If yes, which illness	(n=23)	
Diarrhea	6	26.1
Malaria	6	26.1
Rheumatic fever and rheumatic fever	11	47.8
If yes, are you being treated	(n=23)	
Yes	23	100.0
If yes, who pays for the treatment	(n=23)	
Church	12	52.2
Medical centre	6	26.1
Family member	2	8.7
Myself	3	13.0
Having certain restrictions in taking medication	(n=23)	
Yes	11	47.8
No	12	52.2
If yes, which ones	(n=11)	
Eating before taking medication	8	72.7
Body hygiene	3	27.3

Table 3. Distribution of respondents according to their health characteristics

Variables	(n=23)	%
Satisfaction with the medical treatment received		
Yes	8	34.8
No	15	65.2
If no, why not	(n=15)	
No improvement	7	46.7
Slight improvement	8	53.3
Physical exercise	(n=56)	
Yes	22	39.3
No	34	60.7
If yes, what kind of exercise	(n=22)	
Soft exercise	14	63.6
Use of weights or resistance	5	22.7
Climbing up and down stairs	3	13.6
Medical check-ups	(n=56)	
Yes	33	58.9
No	23	41.1
If yes, how often	(n=33)	
Irregular	17	51.5
Regular	9	27.3
I don't know	7	21.2
If no, why not	(n=23)	
Lack of financial means	16	69.6
Lack of support	7	30.4

Table 4. Distribution of respondents according to their suggestions to the authorities and hospice managers

Variables	(n=56)	%
Suggestions to the authorities and hospice managers		
Provide hospices with essential medicines	16	28.6
Provide hospices with food	30	53.6
Provide competent and bona fide staff	4	7.1
Provide hospices with recreational space	6	10.7

Table 5. Distribution of respondents according to their personal, hereditary and collateral history

Variables	(n=56)	%
Having at least one personal history (hypertension, diabetes, AAR, obesity)		
Yes	44	78.6
No	12	21.4
Having at least one hereditary history (hypertension, diabetes, AAR, obesity)		
Yes	14	25.0
No	42	75.0

Table 6. Distribution of respondents according to problems or needs disrupted

Variables	(n=56)	%
Sleeping well		
No	19	33.9
Yes	37	66.1
Urinating well		
No	46	82.1
Yes	10	17.9
Eating well		
No	15	26.8
Yes	41	73.2
Walking well		
No	48	85.7
Yes	8	14.3
Smoking		
Yes	20	35.7
No	36	64.3
Alcoholism		
Yes	36	64.3
No	20	35.7
Hospice insecurity		
Yes	19	33.9
No	37	66.1

The Table 6 shows that 66.1% of the respondents slept well; 82.1% did not urinate well; 73.2% ate well; 85.7% of our subjects did not walk well. 64.3% of the elderly did not smoke, 64.3% drank alcohol and 66.1% did not feel unsafe in the hospice.

Table 7 shows that the majority of the elderly ate once or not at all per day, i.e. 73.2%, of which 42.9% of the food came from begging; 89.3% of the cases did not receive family visits; 71.4% did not need a man or a woman for love; 66.1% were not satisfied with the process of their support, of

which the irregularity of the nursing staff in the hospices was the main reason for dissatisfaction, i.e. 48.7%.

3.2 Bivariate Analysis

In analysing this Table 8, we noted that gender, marital status, low level of education and retirement were factors associated with the

suffering of elderly people in hospice ($p < 0.05$ significant at the conventional 5% level).

From this Table 9, it can be seen that non-exercise, lack of medical checks were factors associated with suffering in the hospice for the elderly ($p < 0.05$ significant at the conventional 5% level).

Table 7. Distribution of respondents according to other problems

Variables	(n=56)	%
Number of meals per day		
0 – 1	41	73.2
2 – 3	15	26.8
Source of food		
State authorities	4	7.1
Begging/ Begging	24	42.9
Churches	12	21.4
Bona fide people	14	25.0
Family member	2	3.6
Frequent visits by family members		
No	50	89.3
Yes	6	10.7
If yes, number of visits per week	(n=6)	
1	4	66.7
2	2	33.3
Need for a male or female love frame	(n=56)	
Yes	16	28.6
No	40	71.4
Satisfaction with support		
No	37	66.1
Yes	19	33.9
If no, why not	(n=37)	
Irregularity of nursing staff in the hospice	18	48.7
Lack of visits from authorities	14	37.8
Social and family rejection	5	13.5

Table 8. Relationship between socio-demographic characteristics and suffering of the elderly in hospice

Variables	Suffering in the hospice				
	Yes	No	Chi-2	p-value	***
Sex					
Male	23	23	8.48	0.004	**
Female	0	10			
Marital status					
Widowed and Divorced	22	20	8.87	0.003	**
Married	1	13			
Educational level					
Analphabetic and primary	15	9	7.96	0.005	**
Secondary and higher	8	24			
Pensions					
Yes	23	23	8.46	0.004	**
No	0	10			

Table 9. Relationship between medical characteristics and hospice suffering of the elderly

Variables	Suffering in the hospice				
	Yes	No	Chi-2	p-value	***
Physical exercise					
No	14	4	14.76	0.000	***
Yes	9	29			
Medical check-up					
No	15	4	17.04	0.000	***
Yes	8	29			
Personal history (hypertension, diabetes, AAR, obesity)					
Yes	6	9	0.10	0.92	NS
No	17	24			
Hereditary and collateral history (hypertension, diabetes, AAR, obesity)					
Yes	5	5	0.40	0.527	NS
No	18	28			

Table 10. Relationship between disrupted problems or needs and suffering of the elderly in hospice

Variables	Suffering in the hospice				
	Yes	No	Chi-2	p-value	***
Sleeping well					
No	0	2	1.44	0.229	NS
Yes	23	31			
Urinating well					
No	15	1	25.6	0.000	***
Yes	8	32			
Eating well					
No	23	20	11.8	0.001	***
Yes	0	13			
Walking well					
No	20	28	0.71	0.70	NS
Yes	3	4			
Smoking					
Yes	4	4	0.30	0.58	NS
No	19	29			
Alcoholism					
Yes	23	30	2.21	0.13	NS
No	0	3			
Insecurity in the hospice					
Yes	8	31	22.43	0.000	***
No	15	2			

From this Table 10, we see that certain needs and disturbed health problems such as not urinating well, not eating well and the problem of insecurity in the hospice were factors associated with the suffering of the elderly in the hospice ($p < 0.05$ significant at the conventional 5% level).

Analysis of this table shows that the need for a man or a woman is a factor associated with the

suffering of elderly people in hospice ($p < 0.05$ significant at the conventional 5% level).

3.3 Multivariate Analysis

The results of the logistic regression retained 5 predictors of the suffering of the elderly at the old people's hospices in Kisangani which are: lack of

Table 11. Relationship between other problems and suffering of the elderly in hospice

Variables	Suffering in the hospice				
	Yes	No	Chi-2	p-value	***
Satisfaction with the support					
No	9	7	2.00	0.123	NS
Yes	14	26			
Needs of a man or woman in the context of love					
Yes	7	3	4.20	0.04	*
No	16	30			

Table 12. Predictors of hospice suffering in the elderly (Logistic regression)

Prédicteurs	Beta	E.S	p-value	Exp(B)	95% confidence interval for Exp(B)	
					Lower	Upper
Lack of exercise	3.571	1.367	.009	35.565	2.439	518.665
Not urinating well	6.833	1.999	.001	928.008	18.440	46701.850
Lack of medical checks	-3.038	1.711	.076	.048	.002	1.371
Insecure in the hospice	3.680	1.078	.001	39.659	4.790	328.366
Need for a man or woman	3.191	1.017	.002	24.309	3.313	178.368
Does not eat well	3.562	.956	.000	35.221	5.408	229.390
Constant	-24.478	2071.820	.991	.000		

physical exercise, not urinating well, feeling insecure at the hospice, needing a man or a woman, not eating well (OR>1 with confidence interval that excludes the value 0, $p<0.05$ significant at the conventional 5% threshold).

- a) Stepwise introduction of variables
- b) The stepwise procedure broke down, as the removal of the results of the least significant variable generated a better fitting model.

4. DISCUSSION

4.1 Socio-demographic Characteristics of Elderly

Our investigations revealed that the majority of respondents in the hospices were women (51.8%); 62.5% were in the 70-74 age group; 57.2% were widowers; 62.5% had entered into a common-law marriage; 53.6% had between 0 and 1 living child; retired civil servants were more represented (37.5%) and 28.5% were illiterate.

We believe that the predominance of the female sex in this study is due to the lack of supervision of this category of elderly by their respective families.

With regard to age, the results of this series corroborate the literature according to which the young elderly (or third age) are dominated by people between 65 and 75 years of age [14], who are at times characterised by morphological changes in their health status.

In this series, the category of elderly at primary level are in the majority, a situation that was linked simply to the degree of consideration given to studies by their parents or sometimes associated with the precariousness of their socio-economic conditions.

But a socio-economic study of senior citizens in Belgium showed that one out of two senior citizens had not gone beyond primary education [15].

This situation is confirmed in the DPS report (2018) in the Province of Tshopo, precisely in Kisangani, where the illiteracy rate of the elderly remains high at 30%.

4.2 Medical Characteristics

This study shows that 41.1% of the elderly reported suffering from the moment they were

admitted to the old people's home, rheumatic fever was the most reported illness (47.8%) and 52.2% were cared for by the church; 47.8% had restrictions in taking medication and the most reported restriction was eating before taking medication (72.7%).

These results confirm those found in a study carried out by a dozen associations, all dedicated to self-help, the fight against precariousness and isolation among about 5,000 elderly people (CCLSPA) in 2018, which indicated that living alone aggravates the suffering of elderly people.

According to De Jaeger [16], ageing is a gradual process characterised by a period of crises and changes. It is obvious that a person does not become old overnight. Old age can be a time of great fragility, linked to the ageing individual's self-awareness, as well as to the way others view him or her. Rheumatism, being a joint disorder characterised by pain, swelling and absence of pus, is linked above all to ageing and osteoarthritis, which is the most common rheumatological disease, is the main reason for consultation in Europe among people over 60. This disease, caused by the destruction of joint cartilage, leads to pain and impotence [17].

The church, being at the service of the people, characterised by acts of charity, only fulfilled its task within the old people's hospices in the city of Kisangani. The restriction of the elderly and the taking of medication before eating are linked to the rheumatological pathology from which they suffer most, in order to protect them from stomach pain.

4.3 Health Characteristics

Gerontology is the field in which the diseases of old age, the inner workings of ageing and the place of the elderly in our society are studied. This literature does not deviate from the results of this series, which report that 65.2% of the elderly sufferers were not satisfied with the treatment they received and that the main reason given was slight improvement (53.3%); 60.7% of the respondents did not exercise, 69.6% did not have medical check-ups due to lack of financial means. These results are also consistent with those of the EDSC-I in 2005, which indicate that care needs in the areas of medical and biological care, food and clothing are often difficult to meet by families who are ill-prepared to respond positively to these different expectations.

To achieve this, a playground in an old people's home is essential. The government should think of the elderly in terms of financial support to take care of their health condition.

4.4 Other Problems of Elderly

In this study, the majority of elderly people ate once or not at all per day (73.2%), of which 42.9% of the food was obtained from begging; 89.3% did not receive family visits; 71.4% did not need a man or a woman for sexual purposes; 66.1% were not satisfied with the process of their care, of which the irregularity of the nursing staff in the old people's homes was the main reason for dissatisfaction (48.7%).

Thus, the elderly, once revered as patriarchs, living libraries and repositories of the wisdom of ancestral culture, educators and knowledge holders, representatives of the ancestors and intermediaries between the dead and the living, are confronted with problems such as access to medical care, undernourishment, socio-emotional deprivation, violence and abuse [18].

Ageing causes a progressive decline in each of our functions (both physical and intellectual). The effects are therefore multiple. In terms of the sexual glands, the production of hormones such as oestrogen and progesterone decreases, leading to a decline in sexual performance. We believe that the dissatisfaction of accompaniment mentioned by the elderly is due to the period of the strike by non-medical health workers throughout the DRC during the period of our study.

4.5 Relationship between Socio-Demographic Characteristics and the Suffering of the Elderly in the Hospice

In this series, we note that gender, marital status, low level of education and retirement are factors associated with the suffering of the elderly in hospice ($p < 0.05$ significant at the conventional 5% level).

These factors contribute to the suffering of the elderly in hospices for the elderly by the fact that, growing old is not asexual, humans are always in search of balance. Also, not having an acceptable intellectual level to have a job, they are unemployed or retired, putting them in a difficult financial management. As a result, life

becomes unbearable and this can be the source of many ills.

4.6 Relationship between Medical Characteristics and the Suffering of the Elderly in Hospice Care

The results of our analyses show that lack of physical exercise, medical controls are factors associated with the suffering of elderly people in hospice ($p < 0.05$ significant at the conventional 5% level).

For a senior citizen, adopting a more physically active lifestyle is a good strategy to combat frailty. Physical activity programmes alone or in combination are effective on mobility impairment or loss in frail older people. Physical activity (walking, climbing stairs, gardening, housework, etc.) is reported to improve short-term memory in elderly people without cognitive impairment and cognitive function in elderly people with subjective cognitive impairment, even if they are chronically ill [19].

The existence of discomfort symptoms is a limitation to keeping elderly people at the end of their lives in their usual place of living.

4.7 Relationship between Disrupted Needs or Problems and the Suffering of the Elderly in the Hospice

From our investigations, it follows that certain needs or disrupted health problems such as: not urinating well, not eating well and the problem of insecurity in the hospice are factors associated with the suffering of the elderly in the hospice ($p < 0.05$ significant at the conventional 5% level).

As for the disrupted problems and needs of elderly people in hospice, in 2013, Rivaud [20] states that bed rest or reduced mobilisation have direct consequences on the functional independence of the elderly person and quickly lead to consequences with multi-systemic repercussions (psychological, cardiopulmonary, neuromuscular, intestinal, bladder, metabolic, etc.).

These consequences can lead to other complications in the elderly person at risk: delirium, deconditioning, falls, incontinence, loss of functional autonomy, constipation, dehydration and immobilisation syndrome

4.8 Relationship between other Problems and the Suffering of the Elderly in the Hospice

This research, after analysis leads us to say that, the need for a man or a woman is a factor associated with the suffering of the elderly in hospice ($p < 0.05$ significant at the conventional 5% level).

Maslow's pyramid of needs is important for every human's life, as the satisfaction of a need for example survival will push the person to the next need [21].

Despite the popular belief that sexuality disappears with age, research shows that it is an important focus for many people over 60. Contemporary realities observed among them point to very real needs for affection and sexual desires translated into various practices (caressing, touching, penetration) [22].

4.9 Predictors of Hospice Suffering in Older People

Analysis from logistic regression retained 5 predictors of elderly people's suffering in hospice which are: lack of physical exercise, not urinating well, feeling unsafe in hospice, needing a man or woman, not eating well ($OR > 1$ with confidence interval that excludes the value 0; $p < 0.05$ significant at the conventional 5% level).

The literature highlights that regular exercise helps prevent or manage many health problems and concerns, including stroke, metabolic syndrome, hypertension, type 2 diabetes, arthritis, and colon and breast cancer. Similarly on the sexual front, in women it improves arousal and in men it is less likely to cause erectile dysfunction. According to Tanoh Ahou [23], in his 2007 series, assisted living facilities for the elderly must guarantee a safe environment, a resident adapted to the arrival of dependency and offering a range of services to be rendered.

5. CONCLUSION

This study took a medical look at the elderly in hospices in the city of Kisangani. We conducted a cross-sectional study with an analytical aim of identifying factors associated with the suffering of the elderly in the hospices of the city of Kisangani. After analysis, we found the following

salient results: Geriatric diseases exist among the elderly living in the old people's homes, such as AR (47.8%), diabetes (7.1%), hypertension (7.1%), and obesity (3.6%) and medical controls of their medical conditions are not done (41.1%). These old people in their hospices are not satisfied with the way they are cared for (65.2%). Furthermore, lack of physical exercise, not urinating properly, feeling insecure in the hospice, needing a man or a woman and not eating well ($OR > 1$ with confidence interval that excludes the value 1, $p < 0.05$ significant at the conventional threshold of 5%) constitute the 5 predictors of the suffering of the elderly in the hospices in the city of Kisangani.

These results allow us to confirm our hypotheses and we say that the suffering of the elderly in the hospices of the city of Kisangani is explained by several factors.

6. STRENGTHS AND LIMITATIONS OF THIS WORK

1) Strengths

Here are some of the points we were able to retain:

- The present study on the health of the elderly is the first in the Tshopo Province;
- Our framework helped us to understand the factors influencing the health of the elderly;
- This research allowed us to understand the predictors of suffering among the elderly in the hospices of the city of Kisangani;
- Chronic diseases exist among the elderly housed in the hospices of the city of Kisangani and this requires effective intervention for their survival.

2) Limitations

The limitations found in this research are as follows:

- A small number of hospices in Tshopo Province to obtain much more comprehensive results;
- A small study sample size;
- The results of this study are only generalizable to two hospices in the city of Kisangani (Old People's Hospice 16th Avenue Tshopo and Saint John of Christ the King of Mangobo Parish).

CONSENT

As per international standard or university standard, respondents' written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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Peer-review history:

*The peer review history for this paper can be accessed here:
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