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An Exploratory Study of Future Plans and Preferences for Long-term Services and Support for Older Kenyan Immigrants

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AN EXPLORATORY STUDY OF FUTURE PLANS AND PREFERENCES FOR LONG-TERM SERVICES AND SUPPORT FOR OLDER KENYAN IMMIGRANTS

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE

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ABSTRACT

Quality of life and client's satisfaction with Long-term Services and Support (LTSS) in later life are influenced by care preference and timely plans. Ethnic, and racial disparities in the use of both informal formal and formal LTSS are reported. Consequently, the diversity in LTSS decision-making has gained attention in research and policy with a predominant focus on migration background, acculturation, and ethnicity. However, LTSS preference data for older Kenyan immigrants are homogenized into the African Americans block without the acknowledgment of their inherent cultural and ethnic diversity. The development of culturally competent, effective, and responsive policies across the LTSS continuum requires factoring in individual variations that influence preferences. The aim of this study was to provide in-depth descriptions of future LTSS planning and preference among older Kenyan immigrants. In this qualitative exploratory study, data from eight older Kenyan immigrants were collected using semi-structured interview questions. A thematic analysis supported the development of five themes financial preparedness, medical insurance coverage, communicating future LTSS plan and preferences with family, home-based LTSS, and long-term care facility based LTSS. In essence, it was identified that older Kenyan immigrants make plans by saving financial resources, getting medical coverage, and engaging in shared decision-making. Older adults prefer receiving LTSS at home over long-term care (LTC) facility, which is influenced by different factors such as the need for privacy, mistrust of LTC facilities, maintaining cultural norm, and avoiding burdening children.

Keywords: Long-term services and support, preferences, older Kenyan immigrants

CHAPTER ONE: INTRODUCTION
Long-term Services and Support: Future Preferences for Older Kenyan Immigrants

Later life is associated with an increased need for care for older adults (OAs) (Hajek et al., 2017) resulting from disability, decline in function and loss of ability to do everyday activities. It is estimated that 70% of the aging population will need long-term support and services (LTSS) in the future based on economic and demographic data (Social Security Administration, 2014). LTSS services are crucial as they help people live independent, safe, and good quality lives when they lose the ability to perform everyday activities autonomously. Although many older adults are aware and terrified of looming health events and loss of autonomy characteristic of later life, relatively few make plans for their imminent LTSS needs (Sörensen & Pinquart, 2001). Considering the projected need, benefits, and inadequate preparation for LTSS, it is important to understand factors that influence its planning and receipt.

Background

LTSS includes a range of health, personal, and supportive care that meets the needs of frail OAs with limited capacity for self-care because of chronic conditions, physical, mental, or cognitive disabilities, injury, or other health-related conditions (Harris-Kojetin et al., 2019; O'Shaughnessy, 2014). LTSS services include assistance with activities of daily living (such as walking, eating, bathing, and dressing), instrumental activities of daily living (such as housework and medication management), and health maintenance tasks (O'Shaughnessy, 2014). LTSS is crucial in improving OAs' optimal levels of physical functioning and quality of life. LTSS is provided in different places by different caregivers, depending on a person's needs. Most LTSS is provided at home by unpaid family members and friends (Abrahamson et al., 2017). It can also be given in a facility such as a nursing home or in the community, for example, in an adult day care centre. Compared to OAs who receive adequate and proper LTSS, those who have unmet

needs develop adverse effects including lowered quality of life, more challenges associated with daily living activities, more physician and emergency-room visits and more hospitalizations, and hospital readmissions, increased psychological stress, and a higher rate of mortality (WHO, 2018).

Culture is significant as individuals' lived experiences are shaped by their cultural values, beliefs, and social contexts (Sun et al., 2021). Cultural identity and orientation remain salient factors which influence the well-being of individuals as it is where people draw on to make healthcare decisions. Cultural differences are witnessed in different aspects of individual lives example living arrangements and health-seeking behaviours. Planning for, preferred options for and use of LTSS are therefore influenced by individual's cultural background which in turn influence how OAs respond to care, and support provided. There are several positive outcomes of recognizing and upholding an individual's culture during the care of older adults. For example, acknowledging and integrating an individual's culture in the care of OAs has been linked to improved quality of life, improved mental and cognitive health, increased social participation, and alleviation of loneliness, and isolation, and encourages engagement in social activities (Thompson et al., 2020; Sun et al., 2021). Therefore, it is important to comprehensively understand, comprehensively, individual cultures of ethnic and racial minorities to facilitate the provision of quality, relevant, and culturally responsive care of their OAs in later life.

Older African Americans are more likely to reside in multigenerational and extended family households that include grandchildren than non-Hispanic white (Chatters et al., 2020). The residential family members living with older African Americans can provide them with companionship and emotional support to perform daily and essential activities (Chatters et al., 2020). According to Qin et al. (2020), older African Americans with health conditions such as

depressive symptoms are more likely to seek support from their extended family members and friends. For most OAs, health is influenced more by their daily lives than by medical interventions (Steinman et al., 2020). For example, the changes in the type of care they receive and the food they eat may influence their health conditions. Withdrawal from formal and informal functional supports increases the vulnerability of OAs to care and health problems. This withdrawal from formal and informal support may influence OAs' point of care, including hospital, residential care, or institutional long-term care facility (Steinman et al., 2020).

Problem Statement

Worldwide, the age group of sixty-five years old and older is growing faster than any other age group (WHO, 2018). Aging is often accompanied by declining health, even if many OAs remain fit and age well. It has been shown that their health is poor as more than 90% of these OAs have at least one chronic condition and 85% experience at least one physical limitation (Travers et al., 2020). Maintaining good physical health and functioning plays an important role that facilitates mobility and enables OAs to perform more integrated functional tasks. These tasks include activities of daily living and realization of social roles and, engage in leisure activities which is provided through LTSS.

Considering the increasing lifespan and poor health span, demand for additional LTSS is expected to increase significantly to fill the gap. Demographic, and social-cultural factors influence planning and preference for and utilization of different LTSS among OAs. These factors include race and ethnicity, family relationships, living arrangements, financial resources, and knowledge about- and accessibility-to LTSS (Pinquart & Sorensen, 2002). Because the OAs population is diverse both socially and culturally, it has multiple, varying, and potentially

conflicting preferences for LTSS. Despite this, existing policies and practices do not reflect the diversity and often fail to meet their desires.

Racial and ethnic disparities exist in the use of either informal or formal LTSS services (Fennel et al., 2010; Mc Garry et al., 2014). In all countries, informal care, often given by family members, supplies a large share of the support and care needed by older people with disability (World Health Organization, 2018). A study by Hajek (2017) showed that the preferred option for LTSS among older immigrants is informal care provided by relatives or friends in recipients', or their relatives' homes. Informal care is dictated by expected filial obligation, a norm in their communities and countries of origin. However, when the supply of caregivers does not match the increasing number of care recipients, a care deficit exists. Consequently, a shift in LTSS preferences from informal to formal and inpatient care emerges to fill the care deficit gap (Min et al., 2005; Pinquart &Sorensen, 2002). The increasing racial and ethnic diversity of the expanding aging population necessitates insight into the role that race/ethnicity plays in determining the choice and subsequent use of LTSS. Only then can culturally competent, effective, and responsive policies be developed.

Despite minorities having higher functional limitations, older white adults constitute most people utilizing formal LTSS (Travers et al., 2020). The factors attributed to the limited utilization of formal LTSS by the ethnic and racial minorities include limited access to funding and discrimination in the institutions providing LTSS (Travers et al., 2020). The underrepresentation of racial and ethnic minorities in formal LTSS institutions limits the understanding of their utilization behaviors related to LTSS. The limited understanding of minorities' utilization of formal LTSS consequently hinders national and state planning for LTSS delivery because of inadequate comprehension of their needs and preference in LTSS (Travers et

al., 2020). The utilization of formal LTSS by racial and ethnic minorities such as older African Americans has nearly tripled in the last decade (Travers et al., 2020). The significant increase in formal LTSS utilization among these minorities is attributed to the decline in informal support due to changes in family structures, a rise in health care needs, and an increase in public funding of care (Travers et al., 2020). Despite the significant increase in the utilization of formal LTSS among elderly ethnic and racial minorities, there is still a need for a comprehensive understanding of their LTSS needs and preferences to facilitate the formulation and enactment of effective and responsive future LTSS policies that are racially and ethnically inclusive. Such a comprehensive understanding can be attained by focusing on LTSS needs and preferences that are specific to each ethnic and racial minority group. Therefore, this exploratory study focused on recent immigrants aged 50years and above who immigrated from Kenya to the United States as adults to explore their plans and preferences regarding LTSS.

Significance

Cultural expectations related to OAs' roles within their communities are significant in encouraging or inhibiting personality changes in later life (Seedsman & Korkmaz Yaylagul, 2018). Recognizing the impact of culture on the care of older adults above 65 years, there is a call for attention and sensitivity in care for older people from different cultures. Culture influences external factors such as education, influences thinking and behavior in relation to health, illness, and disability (Seedsman & Korkmaz Yaylagul, 2018).

The provision of quality and culturally sensitive care requires a comprehensive understanding of the cultural aspects of the recipient of care that influences this care. For example, the reasons for medication nonadherence vary among racial and ethnic groups because culture influences the perception of medication (Shiyanbola et al., 2018). Concerns about

medication are common among African Americans and are attributed to causing medical nonadherence among this group (Shiyanbola et al., 2018). It is, therefore, crucial to understand cultural aspects and concerns relating to care to ensure the provision of quality and culturally sensitive and responsive care to African American OAs receiving LTSS.

It is projected that the population of white and non-white people aged above 65 years will increase by 39% and 89% from 2016 to 2030, respectively (Loukaitou-Sideris et al., 2019). The projected significant increase in the number of older non-whites implies that the needs for this population will correspondingly increase. Non-white older adult immigrants above 65 years face more problems, such as mobility challenges (Loukaitou-Sideris et al., 2019). To address care inequalities, it is crucial to understand how sociocultural factors influence care among OAs. The health disparities among the older adults above 65 years can manifest at both structural and personal levels (Loukaitou-Sideris et al., 2019; Nguyen et al., 2016). The structural level comprises societal and institutional factors that promote bias against older people. The individual-level factors constitute cultural aspects and beliefs that influence a person's care (Shankar et al., 2016).

Studies have suggested that immigrants and refugees often take existing health beliefs and practices to their new countries (Nguyen et al., 2016; Shankar et al., 2017). Migrants are, therefore, more likely to practice both the traditional health behaviors and practices from their countries and communities of origin in combination with the ones practiced in their new destinations as they become acculturated (Nguyen et al., 2016; Shankar et al., 2017). Among the Kenyan communities, people generally rely on traditional family structures for LTSS of the older adults' population (Madichie & Nyakang'o, 2016: Waswa, 2017). However, LTSS preference data for Kenyan immigrants is not available as it is homogenized within the African American

block without acknowledging inherent cultural and ethnic diversity. Many questions remain unanswered in this group: Do older Kenyan immigrants make plans for future LTSS? Are the preferences for LTSS of older Kenyan immigrants organized based on the location of care and care provider, as suggested by previous studies? Do older Kenyan immigrants prefer to receive LTSS from family members in the home setting, as suggested by literature? Answering these questions may uncover important matters that allow us to better understand LTSS needs for recent Kenyan immigrants above 65 years.

Knowledge gained may act as a basis for developing culturally competent LTSS services and delivery strategy that enhances the quality of care, higher satisfaction with the services, and enhancement of quality of life among the aging. Considering the intrinsic and significant influence of culture on the care of OAs there is a need to gain a comprehensive understanding of their individual culture to facilitate the provision of quality and culturally sensitive care. This exploratory qualitative study targeted older Kenyan immigrants aged above 50, born in Kenya, who immigrated to the United States as adults. Two research questions were used to guide this study. The first research question was: What factors do older Kenyan immigrants consider when planning for future LTSS? The second research question was: What factors guide preferences for future LTSS for older Kenyan immigrants? Thematic analysis method was used to analyze collected qualitative data and identify important emerging themes.

Definition of Terms

Long-term Services and Support (LTSS): Is defined as a range of support services that are needed by adults of all ages with care needs as a result of physical and mental limitations that limit their ability to see to all their own needs (O'Shaughnessy, 2014)

CHAPTER TWO: LITERATURE REVIEW

The American population is increasingly aging. The increased lifespan can be attributed to improved medical care and healthcare and hygiene, heathier lifestyles, adequate foods, and a decline in child mortality (WHO, 2018). With this remarkable increase of OAs population, promoting health and well-being becomes a priority for aging well. Well-being in later life might be adversely affected by declining physical health and functioning due to age-related changes and, unmet LTSS needs. The reduced health span and decline in functionality characteristic of later life, increases the need for LTSS to bridge the care gap created. There are different settings in which individuals can receive LTSS, including the community, home, institution, and other residential settings.

Efficient and sustainable LTSS services, which help incapacitated individuals to increase functional independence, consider a multitude of decisions. These decisions include who should provide the care, the location of the care provision, and what types of services are required (Min, 2005). The decisions and choices on LTSS are consequently influenced by the intersection of various factors including the severity of functional disability, family relationships and types of living arrangements, financial resources and knowledge and accessibility to LTSS services (Min, 2005). Additionally, OAs lack financial preparation for healthcare costs and, sufficient knowledge about available LTSS options and they do not get adequate communications about care-related values presents more challenges in meeting LTSS needs.

There exists racial, or ethnic disparities in LTSS delivery, with ethnic minority aged 65 years and above receiving lower quality care, leading to poor health outcomes (Diedrich, 2002; Fabius et al., 2022). The disparity calls for culturally sensitive, competent, sustainable, and effective LTSS services, structures, and programs to manage the imminent eldercare challenge in

later life for older immigrant adults. A comprehensive literature review was conducted to obtain pertinent information on the topic. Four themes guiding the literature review included (a) Unmet LTSS Needs, (b) planning for LTSS, (c) preference for LTSS, (c) LTSS preference for African American immigrants, and (d) LTSS preference for older Kenyan Immigrants.

Unmet LTSS Needs

Unmet or under-met needs occur when LTSS is unavailable or is insufficient to meet the needs of an individual. Compared to OAs who receive adequate and proper LTSS, quality of life for those who have unmet needs has been shown to be lower (Gibson & Verna, 2006), as they experience more vulnerabilities and challenges associated with day-to-day activities (Komisar et al., 2005), more physician and emergency-room visits and more hospitalizations and hospital readmissions (DePalma et al., 2013), increased psychological stress (Quail et al., 2011) and a higher rate of mortality (Zhen at al., 2015). Two in five adults aged 65 years and above (42%) experienced at least one adverse event associated with unmet LTSS needs (Fabius et al., 2021).

Adverse effects of unmet or under met LTSS among OAs are a subject of social, cultural, and demographic factors, social support and health status which work to either mitigate of exacerbate the effects. Findings by Fabius et al. (2021) indicated adverse events were comparatively more prevalent among OAs with worse health. Also, more than half of individuals aged 65 years and above with dementia or those receiving three or more mobility or self-care activities experienced one or more adverse events. Individuals with a low social-economic status also had increased chances of experiencing adverse events due to unmet LTSS needs (Fabius et al., 2022). The highest occurrence of adverse events was found among OAs receiving care from their adult children (DePalma et al., 2013). Additionally, the type and number of caregivers within the helping networks of OAs were also associated with higher chances of experiencing

adverse events associated with unmet LTSS needs (Fabius et al., 2021). Individuals aged 65 years and above with higher chances of experiencing adverse events were more likely to receive care in a large helping network with paid and unpaid services. For instance, the occurrence of adverse events was higher among individuals relying on help from three caregivers or more compared to those receiving or from two or one caregivers (Fabius et al., 2019).

Planning for LTSS

Planning for LTSS entails being prepared for a time of infirmity with reducing or losing the capacity to perform activities of daily living (Friedemann et al., 2004). The necessity of planning for future health care and residential modifications continues to grow as the aging population expands. Inadequate or lack thereof of financial readiness for later life health care costs, insufficient knowledge about available LTSS options, and incomplete clarity about personal care-related values has become an increasing challenge for OAs, their families, and the health sector. LTSS planning is therefore essential to ensure good health and well-being in later life, and avoidance of any adverse effects of unmet or under-met LTSS and undue stress and pressure on the OAs, their families and public health practitioners. There are four steps in the process of planning for future care needs as delineated by Sörensen and Pinquart (2001): "(a) becoming aware, (b) gathering information, (c) deciding on preferences, and (d) making concrete plans." Plans for LTSS may vary based on financial and social resources, sociodemographic factors, or family or personal experiences (Robinson et al., 2014). Despite awareness of potential poor health, and loss of independence in later life, relatively few individuals make plans for receipt of LTSS (Sorensen & Pinquart, 2001).

Individuals may be classified as planners or non-planners for LTSS as a function of their demographic factors, social support, caregiving experience, cultural obligations or familial expectations, and socio-economic status. Increase age, OA women and those with higher

educational levels were more likely to plan for LTSS, while individuals with perceptions of poor health and those with chronic conditions were less likely to plan for LTSS (Black et al., 2008; Robinson et al., 2014). Women had higher chances of planning to use a specific LTSS option than men, such as home care among baby boomers and older adults (Hayek et al. 2017). In addition to planning for later life care, OAs may plan on residential move. However, the decision to move may be influenced by the (a) features of the current housing, (b) functional status, (c) social networks, (d) features of retirement communities, and (e) financial considerations (Robinson et al., 2014). Parents' and caregiving experiences may influence the decisions of adults aged 65 years and above regarding their residential adjustment later in life. In addition, the decision to purchase LTSS insurance is also considered an essential planning behavior among OAs (Sorensen & Pinquart, 2001). Older adults that purchase LTSS insurance are more likely to be married, have prior experience with LTSS, have a high level of education, are financially stable, and non-Hispanic white (Robinson et al., 2014).

According to Robinson et al. (2014), about two-thirds of baby boomers (born between 1946 and 1964) and older adults (born before 1946) expected to utilize LTSS, but only a few individuals indicated saving for the services (Sorensen & Pinquart, 2001). The likelihood of baby boomers planning for LTSS is enhanced by their (a) enhanced income and wealth, (b) reduced rates of marriage and fewer children, (c) more siblings than older adults, (d) individualism leading to an increased demand for better options in care, living arrangements (assisted or community living). Another crucial factor influencing planning for LTSS is societal pressure. This societal pressure can be from national, familial, or cultural norms and it influences whether one should engage in future LTSS planning or not (Black et al., 2005). For instance, implicit or explicit role descriptions for family caregiving and family expectations may impact the degree to

which an individual engages or does not engage in later life care planning. Many of the expectations for eldercare may be elicited by cultural views of the same, such expectations can be specific to a particular culture or familial system (Delgadillo, Sorensen & Costner, 2004; Spitze &Ward, 2000).

States and national governments also play important role in planning for LTSS that ensures older adults receive high-quality services which contribute to improved health outcomes. For older immigrants, planning for LTSS may involve developing a comprehensive LTSS system with services that they can easily access, afford, and choose when they need them according to the Long-Term Services and Supports Subcommittee [LTSSS] (2020). This means that the US leadership will have to develop an easy-to-navigate, understandable, and culturally and linguistically responsive LTSS system involving community-based, home, and residential options. This system will enable older immigrants to quickly connect to the services they need, regardless of where they live or their economic status. Developing an affordable LTSS program is also crucial in meeting the needs of the growing older immigrant population (LTSSS, 2020).

It is critical to acknowledge the personal preferences of older immigrants and labor challenges while planning for LTSS. Family caregivers with additional jobs must be provided with maximum support by creating leave policies such as job protection (LTSSS, 2020). Such policies allow unpaid caregivers to continue earning while providing the needed care and support to the family member. Also, increasing the number of the paid workforce may be essential in meeting the demand of LTSS due to the growing older population (LTSSS, 2020). In addition, public and private partners, or stakeholders such as educational institutions should be involved in attracting, retaining, and training workers to ensure the provision of high-quality LTSS (LTSSS, 2020). Providing benefits, livable salaries, education, training, and advancement opportunities to

health care professionals is crucial in planning for LTSS for immigrants aged 65 years and above. Intentional budget and policy actions will aid in improving job retention and satisfaction among health professionals leading to a more stable workforce to aid in providing LTSS to older immigrants (LTSSS, 2020). Establishing a system to ensure (a) an effective LTSS system meeting the needs of immigrants aged 65 years and above is developed, (b) LTSS delivery is coordinated, (c) seamless access to LTSS is promoted, (d) innovation in LTSS service delivery is enhanced (LTSSS, 2020).

There are barriers to planning for future LTSS including individuals' factors like the lack of skill and abilities to plan (Robinson et al., 2014). Additionally, there are environmental barriers such as inaccessibility and/or unavailability of aging services in their region, lack of or inadequate caregivers, or no acceptable residential care (Sorensen et al., 2011). Effectively translating intention into action therefore requires appropriate internal and external resources. Ultimately, LTSS planning is an evolving process that involves continually evaluating and modifying one's preferences and plans depending on current needs, options, and resources.

Contrary to expectations, African American elders were more likely than Whites to have made long-term care plans and to include institutional as well as family care in their plans. Multivariate findings were that African American elders with more education were more likely than others to have made long-term care plans and educational attainment predicted plans for institutional care. Findings suggest that long-term care decision-making is likely idiosyncratic rather than the result of careful consideration of care options in light of impending long-term care needs. (Mitchell et al., 2000). Immigrants from racial or ethnic minority groups exhibit lower advanced care planning (ACP) (Grace, 2019). For instance, African Americans have reduced chances of engaging in end-of-life care planning compared to their White counterparts.

Factors such as health, informal support, and financial help from family may impact ACP planning and preferences (Grace, 2019).

Preference for LTSS

Care preference is crucial for both client's quality of life and satisfaction with LTSS in later life. To ensure LTSS decisions meet quality of care and life and clients' satisfaction, preparation for LTSS should not only include the OAs and their families, but the values, and preferences of the LTSS recipients (OAs) need to be factored in too. Do care arrangements match individual preferences? According to Kasper et al. (2019), only 1 out of 3 older adults (aged 65 years and above) received care that matched their preferences. LTSS services are provided either in non-institutional settings such as older adult's homes or in institutional contexts, including assisted living (AL) and nursing homes (NHs). Kasper et al. (2019) also found that 3 in 10 people considered assisted living, care in their own home with family help, and care in their own home with paid help as the best LTSS options. There is an increase in acceptance among OAs of residential care contexts offering services and varying levels of independence for residents (Harris-Kojetin et al., 2013). However, 'aging in place' with family or paid help remained the preferred option. Individual preferences might therefore be considered the major aspect changing and shaping the landscape of LTSS service environment options. The changes include increased LTSS facility options and increased emphasis on options that promote aging in place (Harris-Kojetin et al., 2013; Stevenson & Grabowski, 2010) and the growth of nesting home alternatives (Kasper et al., 2019).

Preferences for the receipt of LTSS services and support have been categorized along two related dimensions: care location (home/community vs. institution) and care provider (kin vs. professional/paraprofessional care) (Pinquart & Sorensen, 2002)01; Sorensen & Pinquart 2011). Attitudes toward either of the two care location options, i.e., LTSS institutions and home or

community, are influenced by family structure, previous experiences, and/or relationships (Hajek et al., 2017)). Bias toward home/community-based care has been reported in research (Fabius et al., 2021; Wolff et al., 2008). Based on the findings by Fabius et al. (2021), 7.7 million community-living adults receive help from unpaid caregivers and family members. Expectations of future use of LTSS services have been studied among older adults aged below 65 (Henning-Smith & Shippee, 2015) and those without current care needs (Abrahamson et al., 2017). These studies show that not only do individuals underestimate their projected need for LTSS services, but they also expect that family members will step in when the need arises. A study of individuals aged 65 and above, who developed later care assistance with their activities of daily living, found that 48% and 35% had named their adult children and spouses, respectively, as expected caregivers (Min et al., 2015). While women play the primary caregiving role for men, children are more likely to care for women in their old age (Fabius et al., 2022). The challenge is, increasing rates of childlessness and declining family size reduce the number of likely caregivers for women. Also, women tend to have twice as many years of needing LTSS as men. In addition, women have increased chances of using nursing homes, assisted living, and home health care than men (Abrahamson et al., 2017). Compared to men, women expect to utilize LTSS services, including home-delivered meals, transportation, and home care. Individuals with limited money left at the end of the month do not expect to use LTSS services.

The use of LTSS in institutionalized settings by racial and ethnic adults aged 65 years and above (African Americans and Hispanics) has nearly tripled in the last decade (Travers et al., 2020). Laditka et al. (2006) found that African Americans utilized more LTSS services than other ethnicities. In addition, African American women had increased chances of using personal care aids, adult day centers, transportation, and information and referral than men. Also, African

American women utilized the LTSS services more intensely than men (Laditka et al., 2006). The shift may be associated with (a) increased access to public funding for the care of ethnic or racial minorities in institutionalized LTSS settings, (b) decreased informal support as a result of changes in family structure, and (c) a rise in health care needs among racial or ethnic older adults (Travers et al., 2020). In past years, the underrepresentation of racial or ethnic adults aged 65 years and above in institutionalized LTSS contexts limited the understanding of the group's utilization behaviors and hindered national and state planning for delivering culturally inclusive services. Thus, there is a need to establish and support a range of LTSS options to cater effectively to African American immigrants' needs. The group's needs and preferences should be effectively understood to ensure services and policies are culturally or racially inclusive.

Some of OAs would, however, contemplate either or both living in retirement communities and living with their children, unlike their parents' generation. The challenge with informal family caregiving, however, is the relatively smaller size of the younger population, who could, in theory, assist and support the older population but will be unable to meet the greater demand (Henning-Smith & Shippee, 2015). The care deficit results in a shortage of familial and financial support for these OAs. Contrastingly, other studies have found that some individuals would prefer LTSS assistance from institutions (Anderson & Turner, 2010; Hajek et al., 2017). According to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) (2021), more than half of individuals in the US develop serious disabilities after age 65 and utilize LTSS, such as nursing care or AL. OAs with relatively low incomes over their lifespan have increased chances of needing and using LTSS than those with more earnings. According to ASPE (2021), most adults aged 65 years and above worry about the financial aspects of needing and using LTSS. Therefore, meeting individuals' preferences is a policy

priority that can positively influence quality of care and life. Racial and ethnic disparities exist in using either informal or formal LTSS services (Fennel et al., 2010; Fabius et al., 2019; Diederich et al., 2022).

LTSS preference for African Americans

Although African Americans constitute only 6% of the older adult immigrant population in the US, about a fifth of them is over the age of 55 (Nkimbeng et al., 2021). The increased population of the older African immigrants contributes to the diversity of the OAs population. This in turn presents a need to ensure equity in the delivery of LTSS to achieve the best patient outcomes among all individuals, regardless of race or ethnicity. To achieve person-centered and culturally competent LTSS, understanding the care experiences among individuals from diverse populations and their caregivers is crucial. There are various options to meet the needs and preferences of OAs who are no longer independent in basic self-care, mobility, or daily living activities.

Socio-economic and social-cultural differences are evident with the cultural explanations focusing on consumers' backgrounds, behaviors, beliefs, and attitudes. Racial or ethnic disparities are also common in LTSS delivery (Diedrich, 2022), with OAs racialized groups receiving lower quality care, leading to poorer health outcomes than their white counterparts (Fabius, 2019; Diedrich, 2022). There is also variation across racial and cultural groups in the degree to which family and friends support and assist their elderly (Fabius et al., 2022; McCormick et al. 2002; Min 2005). In past years, the underrepresentation of racial or ethnic adults aged 65 years and above in institutionalized LTSS hindered the understanding of their preferences and needs (Kasper et al., 2019). Consequently, the aging needs of the African American OAs have not fully understood leading to poor health outcomes as their preferences are not factored in provision of LTSS. Therefore, determining the LTSS preferences of older

African American immigrants is crucial in ensuring quality care delivery and achieving the best patient outcomes.

In the African American culture, the practice of aging in place in the context of family and community emerges from the culture and tradition deeply grounded in filial devoutness, the interconnectedness of family members, respect for the elderly, and the spiritual substance of life (Thorne, 2020). The African American family and kinship networks are still the backbones of elder and primary caregiver support. LTSS preference for older African immigrants aged 65 years and above has been explored in several studies. When it comes to caregivers, research suggests that African Americans intend to depend more on informal care than Whites should disabilities arise (Bradley et al.2004). In this case, the family members act as coordinators of care, including but not limited to medication management, monitoring chronic illnesses, diet and nutrition, exercise, and transportation. African American OAs' use of home care correlates with their intention to use services, while white elders' use of home care is associated with need (Bradley et al., 2004).

In another study, disparities in the use of professional services were identified. Older African American individuals are less likely to utilize professional services than their White counterparts (Nguyen et al., 2020). According to Nguyen et al. (2020), approximately 16 % of African Americans did not seek professional services for a personal issue compared to 10% of whites. Also, older African American adults were less likely to seek mental health services than their younger counterparts. Thus, age and race are significant factors in the use of professional services among older adults. Anderson and Turner (2009) found that African American caregivers would prefer out-of-home care if they lost their ability to care for themselves. The three reasons cited for the preference were viewing the next generation of potential caregivers as

ill-equipped for the caregiving task, desire to "spare our children" the burden of caregiving and having no family members or friends left to care for them.

Influence of Culture on Preference for LTSS among Kenyan Immigrants

The older recent African immigrant population, who immigrated to the US as adults, make up a small percentage of the nation's immigrants. However, since the 1970s, their numbers have been steadily expanding – roughly doubling (Anderson, 2020). Significantly different characteristics exist between U.S-born and foreign-born African Americans (Pew Research Center [PRC], 2013). Despite this, most existing literature on African American LTSS engagement combines U.S-born (second- and later-generation) and foreign-born (first-generation) African Americans into the same sample. Mixing several population groups into one analysis sample and regarding them as one population may lead to a limited understanding of foreign-born African immigrants' preference for LTSS. Barriers to LTSS services among immigrants include family obligations, fear of discrimination, language and cultural barriers, and limited information (Scott et al., 2022). Cultural identity and identification remain crucial factors among immigrants in any country (Liu et al., 2020).

Fabius et al. (2022) indicated that race and culture is a significant factor in the preference for LTSS among older adults. According to Diederich et al. (2022), immigrants from cultures with stronger family ties have increased chances of using LTSS options involving the family. However, immigrant patients are less likely to prefer exclusive family care if they have lived in the US for a longer time. Thus, cultural differences in family ties are more likely to guide older immigrant adults' intentions of using certain LTSS options. Hence, LTSS should be patient-centered and honor individuals' beliefs, choices, and preferences. In addition, incorporating culture into LTSS services and considering social determinants of health (SDOH) while also

considering factors of quality of life such as language, communication, and socialization helps improve patient experiences with LTSS (Grace, 2019).

Most Kenyan natives relocating to the US are voluntary immigrants who migrate to pursue professional and educational opportunities (Migration Policy Institute [MPI], 2017). When Kenyans immigrate to the US, they arrive in an ethnically and racially diverse country with a highly individualistic dominant culture where African Americans are a racial minority (US Census Bureau, 2019). The significant shift from the collective way of life and ethnically diverse in their native country and adjusting to the change requires substantial psychological and sociocultural modification. In addition, the literature indicates that immigrants often migrate with health beliefs and practices from their native countries (Nguyen et al., 2016 & Shankar et al., 2017). As a result, immigrants are likely to practice both the traditional health behaviors and practices from their countries and communities of origin in combination with the ones practiced in their new destinations. The extent to which native countries' cultural health practices and beliefs are maintained or changed as people move to new ones is important in addressing the transcultural perspectives of migrants. In turn, this may help understand the needs of racial and ethnic minorities, such as the delivery of culturally appropriate health services, health-seeking behaviors, compliance with treatment, and attendance of health education programs. These includes plans for and the use of available LTSS options.

In the Kenyan culture, the older generation typically receives care from the middle generation, and there is evidence of continued salience of family support for the elderly in Kenya (Cattell, 1990; Atwetwe, 2020). To the middle generation, fulfilling their filial obligation is a noble duty. Nevertheless, changing family values, the rising cost of living and migration into cities or abroad have forced adult children to live away from their elderly parents and thus be

unable to fulfill their filial responsibility (Atwetwe, 2020; Wamwara-Mbugua & Cromwel, 2010), which has led to the growth of old age retirement homes to fill the gap. However, formal eldercare is tantamount to the rejection of the elders by their family and, in some cases, even considered a taboo (Wamwara-Mbugua & Cromwel, 2010). Does the culture of filial obligation as seen in the Kenyan culture influence the preference for LTSS among Kenyan immigrants in the US? In response to this knowledge gap, this exploratory study aimed to explore the plans and preferences for future LTSS among older foreign-born immigrants from Kenya.

Summary

Planning for LTSS is crucial to ensure good health and well-being in later life, and it involves being prepared for a time of infirmity with reducing or losing the capacity to perform activities of daily living (Friedemann et al., 2004). Plans for LTSS may vary based on financial and social resources, sociodemographic factors, or family or personal experiences (Robinson et al., 2014). For instance, Women had higher chances of planning to use a specific LTSS option than men, such as home care among baby boomers and older adults. Individual preferences are considered the major factor influencing the changing landscape of LTSS options (Kasper et al., 2019). There are various options to meet the needs and preferences of older adults who are no longer independent in basic self-care, mobility, or daily living activities. Kasper et al. (2019) found that 3 in 10 people considered AL, care in their own home with family help, and care in their own home with paid help as the best LTSS options.

Thus, evaluating LTSS preferences among older Kenyan immigrant adults is crucial in ensuring quality delivery to achieve the best health outcomes. In the Kenyan culture, the older generation typically receives care from the middle generation, and there is evidence of continued salience of family support for the elderly in Kenya (Cattell, 1990; Atwetwe, 2020). Diederich et al. (2022) indicated that immigrants from cultures with stronger family ties had increased

chances of using LTSS options involving the family. Therefore, determining future LTSS plans and preferences for older Kenyan immigrants may aid in the provision of high-quality care. Hence, there is a need to conduct the proposed qualitative study aimed at exploring the plans and preferences for future LTSS among older foreign-born immigrants aged 50 years and above from Kenya.

CHAPTER THREE: METHODS AND DATA

The development of culturally competent, effective, and responsive policies across the LTSS continuum requires factoring in individual variations that influence LTSS access, choice, and use. This exploratory study aimed to provide in-depth descriptions of plans for future LTSS needs and preference for its receipt among a small sample of older Kenyan immigrants. To achieve the study goals, two research questions were used to guide the study. The first research question was: What factors do older Kenyan immigrants consider when planning for future LTSS? The second research question was: What factors guide preferences for future LTSS for older Kenyan immigrants? Considering the aim of the study and the nature of the research questions, I considered an exploratory, qualitative study as more appropriate as it reveals the meaning of an occurrence or phenomenon as understood by people or groups of people. According to Merriam (2002), the qualitative research design is appropriate when delineating the experiences and views of a particular group of people at a specific point in time and in a specific context. The scientific goal was to stay close to the data and to the informants' own words and reaction to survey items.

Research Strategy

To collect data, I used purposive sampling to gain 8 informants who had responded to the recruitment flier, showing interest in participating in an interview. I communicated with the potential informants to ascertain that they met the inclusion criteria set, and together we scheduled convenient date and time to conduct ZOOM meetings. Before participating in the study, I gave the informants my contact information, as well as the contact information for the Principal Investigator who is also my thesis advisor (Dr. Kathryn Elliott) for the opportunity to reach out with any questions or concerns they may

have regarding the study. The scheduled interviews with the informants were administered and recorded via Zoom with informants' approval. I used an interview guide (Appendix A) with semi-structured questions whose goal was to elicit exhaustive and detailed responses from the informants.

Recruitment and Data Collection

The research was conducted following approval from Minnesota State University Institutional Review Board (IRB). I used non-random, purposive sampling to locate and select study informants for the exploratory study. To be included, informants had to meet the following criteria: (a) be an older Kenyan immigrants aged 50 and above (b) immigrated from Kenya to the US as an adult (c) be willing and capable of participating in a 60- to 90-min interview and follow-up interview if needed. I distributed recruitment fliers on two social groups after permission was sought and given by the groups' administrators. These social media groups are where the target population are members of i.e., WhatsApp and Facebook groups called "Kenyans in the Diaspora". Potential informants reached out to me, and I screened them for eligibility to participate using the inclusion criteria. I managed to meet the target study size of eight older Kenyan immigrants who immigrated from Kenya as older adults.

I conducted the interviews via a secure Zoom meeting. Once the interview date and time was set in consultation with the informant, I created a zoom meeting and sent the invitation to the informant. Before the interview date, I sent the informed consent form to each informant to read to understand what the study entailed. The informed consent forms explained the purpose of the study, assured the informants of the confidentiality and privacy of their data and identity and, included contact information of the principal investigator and IRB incase the informants needed to reach out about any concern. The informed consent forms also gave the informants an

assurance that they could withdraw from the study any time without any explanation or penalty upon them and, that the interview would be recorded for transcription purposes.

I started the meeting with a brief introduction of the study, informed that the sessions were to be recorded for transcription purposes, and asked whether they had any questions or concerns. Informants were also reminded that their participation was voluntary, and they could refuse to answer questions they felt uncomfortable with, and they could end the interview anytime without any penalty. I requested the informants to electronically date, write their name, append their signature, to acknowledge that they understood what the study entailed and send back, if they agreed to participate. All the informants gave me permission to record the meetings for transcription purposes. I started off the interview with an elaborate definition and description of what LTSS is and gave examples. The first interview question was "Do you know someone who is currently receiving long-term care? This was a get-to-know-you question that helped bring the focus of the informants into the general topic of the interview. Other questions included "If at some point in the future you were no longer able to care for yourself, who would take care of you?"

In cases where I did not fully understand an informant's response, when the response was ambiguous or vague or when I sought to obtain in-depth or more specifics from them, I applied the probing techniques, for example, when an informant said, "you know" and assumed I knew what they meant. In other cases, to gain clarity of the responses in some cases, I would repeat the informant's response to them which gave them the opportunity to reflect and either confirm that is what they said/meant or not. Sometimes informants would give answers to questions before I asked them. When I came to those questions later in the interview, I would acknowledge that they already addressed them and I would ask them if they had anything to add to their

response. In cases where the informants did not understand a question, I would rephrase it without changing the context of the question or leading the informant.

The 8 interviews lasted an average of seventy-five minutes each including the introduction which was not recorded. All the 8 informants answered all the interview questions on the interview guide, and none discontinued the interview. At the end of each interview, the signed informed consent forms, the zoom recordings with their corresponding transcripts were downloaded and kept in a password-protected folder under file named using their pseudonyms. Printed copies of the signed informed consent forms will be kept by the principal investigator and will be destroyed after three years.

Interview Sample Demographics

The demographic data collected from the informants included their gender, age, marital status, number of children, highest education qualification, and occupation (see Table 1). Half of the informants were female, while the others were male. Five informants were married, while the other three were single, widowed, or divorced. All informants had at least two children, with one having five children. The informants' educational qualifications ranged from having a high school diploma to a master's degree (see Table 1). The respondents had different professions, such as catering, nursing, management, administration, caregiving, banking, and entrepreneurs (see Table 1).

Table 1: Demographic Attributes of Informants

Informant	Gender	Age	Marital Status	Number of Children	Highest Educational Qualification	Occupation
P1	Female	51	Single	2	High school diploma	Catering
P2	Female	59	Widowed	3	Associate degree	Nurse
P3	Male	55	Married	2	Bachelor's degree	Senior manager
P4	Female	57	Divorced	3	Bachelor's degree	School administrator
P5	Male	50	Married	2	High school diploma	Caregiver
P6	Male	55	Married	2	Master's degree	Business owner
P7	Male	50	Married	5	Bachelor's degree	Business owner
P8	Female	57	Married	3	Bachelor's degree	Teller

Data Analysis

I applied the thematic approach with consisted of six steps to analyze the eight transcripts to answer the research questions. In the first step, I cleaned the zoom transcripts for all the 8 interviews conducted. I downloaded the ZOOM audio recordings with their transcripts then listened to the audios while comparing with the transcripts and making corrections where needed. The first step took an average of six hours per transcript. Pseudonyms (I1 through I8) were used in place of informants' names to ensure privacy and the cleaned transcripts were organized in separate files, named according to each informant's pseudonym, to facilitate the analysis.

In the second step, I read through the transcripts line-by-line to gain a comprehensive idea of the content presented by the respondents (Creswell & Creswell, 2018). Reading the interview transcripts enabled me to understand the depth and relevance of the response in relation to the research questions. As I read, I recorded the theme and overall topic ideas in a reflective journal. Coding of the cleaned transcripts began in the third step and was done manually using the Microsoft word comment option. The coding process involved identifying similar chunks of texts and categorizing them using the actual language used by the informants. The coding process was conducted systematically, where I reviewed each transcript at a time twice

In the fourth step, I combined similar codes which I used to develop the emerging themes relevant to answering the research questions (Creswell & Creswell, 2018). Constant comparison of the codes was done to look for similarities and variations in the categories and codes across the transcripts. Subsequently, I assigned respective content of the transcript to the appropriate theme. The fifth step involved developing visual representations of tables and figures to

represent the themes, facilitating interpretation. In the sixth step, I interpreted the findings by associating the results with published literature (Creswell & Creswell, 2018).

Limitations and Implications

There are several limitations within this thesis. Being that I used purposive sampling, external validity was compromised, and thus findings are not generalizable. Although I did not purpose to get a representative sample, my aim was to gather valuable data. Sampling bias is also reflected as it reasonable to assume that the eight informants volunteered to be interviewed are probably different from those who did not. Being that the informants could assume that I am Kenyan by virtue of my name, some would say "you know" implying that I understood what they meant since we share the same culture. There is also the limitation that this sample of interviewees had similar demographics, experiences, views, and interests due to the convenience sampling from two groups.

Findings from this study should be interpreted with the following caution. First, since the study was exploratory and qualitative in nature, this limits the generalizability of study findings to older Kenyan immigrants in other areas or older adults from different ethnic or racial backgrounds. Second, the examination of plans for LTSS use and preferences only focused on future and not actual plans and use. As such, findings from the current study may not be generalizable to those who are currently using LTSS.

Ethical Considerations

Ethical considerations are crucial in upholding informants' dignity and protecting their rights. Several strategies were used in this study to ensure informants' rights and ethical concerns were upheld. For example, before each interview, informants signed a consent form for

participation. The information included in the consent form included the purpose of the study, researcher contact information, and explanations of the voluntary nature of participation. To ensure the anonymity of the informants, they were all assigned pseudonyms. Additionally, confidentiality was guaranteed by securely conducting interviews using secure Zoom meetings and restricting access to the collected information only to the PI and the student researcher. The transcribed interviews were encrypted and stored in a password-protected computer before, during, and after analysis. Permission to record the interview session was obtained from the informants before the start of the interview after explaining the purpose of the recording. Considering that interviews were used to collect data in this study, there were no significant harm or risks to the informants.

CHAPTER FOUR: ANALYSIS OF STUDY FINDINGS

INTRODUCTION

Population aging is a core phenomenon globally and in the United States. In 2019, 16% (54.1 million) of the entire population in the United States was made up of individuals older than 65 years, which is anticipated to increase to 21.6% by 2040 (Administration for Community Living [ACL], 2021). Nearly one in four older adults in 2019 were from ethnic minority populations. Between 2019 and 2040, racialized and ethnic minority cohorts of individuals aged 65 years and above are expected to increase by 115%. Specifically, Hispanic, Africa American, American Indian/Alaska Native, and Asian Americans 65 years and older are expected to increase by 161%, 80%, 67%, and 102%. Notably, all individuals of African descent are homogenized into the African American cohort, despite varying cultural differences among the groups. However, the categorization of all individual of African descent as African Americans result in disparities in research because population such as Kenyan immigrants in the United States are understudied.

As such, the focus of this study was two-fold. The first was to explore the factors that older Kenyan immigrants consider when making plans for future LTSS. The second was to describe the factors that guide future preferences for LTSS among older Kenyan immigrants. The research questions I sought to answer were (a) What factors do older Kenyan immigrants consider when planning for future LTSS? (b) What factors guide preferences for future LTSS for older Kenyan immigrants? In this chapter, presentation of data, results, and summary are included.

Presentation of Data and Results

The thematic analysis was performed to answer two research were (a) What factors do older Kenyan immigrants consider when planning for future LTSS? (b) What factors guide preferences for future LTSS for older Kenyan immigrants? In this section, I present the results according to the research questions and emerging themes. The thematic analysis helped retrieve five themes (see Table 2). All eight informants had taken the initiative to prepare for later-life care although none had made concrete plans. Among the five informants with LTSS plans, their decisions were promoted by the preference of not burdening their children, work experience-specifically in nursing homes, and witnessing family members and friends being affected by aging-related neurodegenerative diseases such as dementia and Alzheimer's and the consequent challenges on caregiving it presented. The subsequent sections contain a presentation of the results.

Table 2: *Research Questions, Themes, and Definitions*

Research Questions	Themes	Definitions
What factors of planning for future LTSS do older Kenyan immigrants consider?	Financial preparedness	An LTSS planning approach where individuals save money for retirement.
	Medical insurance coverage	An approach for LTSS planning where individuals buy insurance to help them meet their health-related expenditures.
	Communicating LTSS plans and preferences	Talking to family members and friends about their LTSS plan and preferences.
What factors guide preferences for future LTSS for older Kenyan immigrants?	Home Based LTSS	The preference for receiving LTSS at home, which is delivered by family members, nurses, or direct support professionals.

	Long-term care facility Based LTSS	The inclination to receive LTSS from nursing homes or other facilities where specialized professionals deliver care.

Research Question One: Planning for Future LTSS

The first research question sought to be answered was: What factors do older Kenyan immigrants consider when planning for future LTSS? The aim was to identify the strategies older Kenyan immigrants have adopted in preparing for future LTSS. Based on the participants' responses, these older Kenyan immigrants plan for future LTSS by focusing on being financially prepared, acquiring medical insurance coverage, and communicating their LTSS plans and preferences to their families. Table 3 shows the informants who provided responses or did not relate to the themes.

Table 3: *Research Question One Themes and Respondents*

Participants	**I1**	**I2**	**I3**	**I4**	**I5**	**I6**	**I7**	**I8**
Themes								
Financial preparedness	✓	✓	✓	✓	✓	X	✓	✓
Medical insurance coverage	X	X	✓	X	✓	X	✓	✓
Communicating LTSS plans and preferences to family	✓	✓	✓	✓	✓	✓	✓	✓

Theme One: Finances

All informants but I6 indicated that they are making plans for their future LTSS by being financially prepared, proactive, and accumulating resources. The informants used different savings initiatives such as social security, 401K, and personal plans. For instance, I2, indicated, "I have not made any real plans [for LTSS], but all I can say you know is I am saving up some money for retirement. I think that with my social security and 401k benefits, and the additional

money that I will have saved up for my retirement, I will be able to afford a nurse to take care of me at home and get good quality but affordable long-term care and support." For I2, despite not having concrete plans for their future LTSS plans, he is aware that for LTSS he will need to be financially prepared, caregivers, and that his LTSS will be provided at home. I2 acknowledged that the essential thing is having the finances to cover all the costs associated with the preferred retirement option and goes as far as listing the different sources of finances, which provides more financial security, and mentioning that affordability of the LTSS option is an important factor.

In his response, I3 indicated that he has personal savings with a bank "I have some savings with Union bank the first thing is enough resources to cater for all the requirements while in the facility. I have a financial advisor who talks to me and always shares information on what's needed going forward." I3's response introduces the fact that it is not only important to be financially ready by saving up money but that it is equally important to have a professional to guide one with financial planning and make informed decisions. For I1, her justification for being financially prepared is to avoid burdening her daughter to cater for the financial aspect of the LTSS as she has financial responsibilities of her own. I1 had this to say:

> "I think first I will need to have my finances in order because I do not want to financially strain her [daughter] as she also has her children and husband."

By being financially ready for her later life needs and care, I1 avoids undue pressure and stress on her daughter and her own family and possibly avoid the strain that would ensue as a result.

Theme Two: Medical Insurance Coverage

Half of the informants, I3, I5, I7, and I8, indicated that they plan for their future LTSS by enrolling in medical insurance plans. For example, I3 shared that “the major plan is having medical insurance plans as this mostly covers some of the needs required. It will be enough if you are lucky not to have pre-existing conditions or diseases requiring a lot of money." I3 not only talks about the importance of having a health coverage, but he also points out the fact that it has limits dictated by pre-existing conditions. Health insurance can help cover some of the cost of eldercare, it is important to understand what a policyholder is entitled to. I5 also indicated that he will have to purchase some private insurance:

> I will have to get medical insurance, and so I am saving up some money, which I hope will go a long way. I know that Medicaid and, sometimes, Medicare maybe will cover some of the cost…

I5 recognizes that the government-run medical insurance programs maybe be able to cover some costs of health however, he is not sure but by saving some money to get additional insurance, he is not leaving healthcare cost to chance.

Theme Three: Communicating LTSS plans and preferences with family and friends

All the informants indicated that they have or will communicate with their family and friends about their LTSS plans and preferences. I8, said, "I have talked about it [LTSS] to my children. For example, I shared my wishes on Thanksgiving after my mom was diagnosed with dementia and seeing how my sisters’ in-laws and brothers were really struggling with her care.

that was three years ago, so my children know what I would like, I don't want them to worry about taking care of me incase I also get an illness like my mom…I guess for me, I just don't want my children to be stressed out." The decision to share her LTSS plans and preferences with her children was prompted by her mother's diagnosis and her reasons were 3-fold: to avoid burdening her children with her later-life care and the associated decisions, the reality of challenge of caring for an OA with an illness and, taking control and maintaining autonomy over her future LTSS as she knows what she wants. Similarly, I5 added more evidence by indicating that:

> I have shared it with my kids. One must share such things with family so that they know what you have in mind and so that they are not worried about the future. When I discussed the idea of a long-term facility with them, I told them it comes with a cost, so they are aware.

Additionally, I3 said, "I think we [him and his wife] shared with my friends that I have around me….. I will need an attorney. I am not saying my family has wrangles, but I have seen what happens around people who need assistance from their relatives. You would need some legal documentation with the people accessing your resources and giving you care. When someone learns that you cannot do without them, someone takes advantage of your long-term accumulated resources and misuses them for their own selfish needs. But if you have an attorney and a specific accountant designated to manage them, you are in a good position to avoid a mess." Apart from sharing his and his wife's LTSS plans and preferences with their friends, I3

introduces the aspect of legal issues surrounding family caregiving. For him, getting legal presentation will avoid family disputes and financial abuse.

Research Question Two: Long-Term Services and Support Preferences

The second research question was: What factors guide preferences for future LTSS for older Kenyan immigrants? In this question, the focus was on understanding the older Kenyan immigrants' preferences for future LTSS and the reasons behind their choices. As such, it was identified that the informants either preferred receiving LTSS in their homes or in long-term care facilities. The preferences were influenced by different factors discussed in the subsequent sections. Table 4 represents informants who provided or did not have responses related to the respective themes.

Table 4: *Research Question Two Themes and Respondents*

Participants	**I1**	**I2**	**I3**	**I4**	**I5**	**I6**	**I7**	**I8**
Themes								
Home-Based LTSS	✓	✓	✓	✓	X	✓	✓	X
Long Term Care Facility Based LTSS	✓	✓	X	✓	✓	✓	✓	✓

Theme 4: Home-Based LTSS

Sub-theme 1: Privacy and Comfort of Home

Most informants I1, I2, I3, I4, and I6 preferred receiving care at home in the United States or Kenya as their first choice, where the caregivers would be family members or direct support professionals. For instance, I3 indicated that he prefers receiving future LTSS at home, which his children or relatives would provide. He said that:

> …staying at home, where my children or close relatives would take care of me, would be my biggest preference. I prefer my children because they are closer to family members and me. I mean, most private things that I would want people to know will remain confidential….

I3's preference for home-based LTSS care is familiarity and the sense of comfort of having his family members as his caregivers rather than having strangers. By having family members assist him with his later life at home, I3 is assured that his privacy and confidentiality is maintained as it is apparently important to him. Another respondent, I2, said "I am more of a private person, so my home would be a good place for me to get later life care…I would prefer family and friends, because of the privacy. I like someone who has been close to me to help me through that." As such, I2's preference for family or close relatives being the caregivers was supported by her desire for familiarity, closeness, and privacy.

Sub-theme 2: Mistrust of Long-Term Care Facilities

I3 also developed a negative perception of LTC facilities as he witnessed elder abuse and neglect when he worked in the LTC sector. The experience shaped his preference for home care.as he explained: "the nine years of experience working in a nursing home and assisted living made me see them in a negative way… I have seen how the elderly are abused or neglected….so sad…" I2 indicated that: "having worked as a nurse in a long-term care facility and assisted living in the United States, I have seen how the elderly are abused or neglected so for me home would be better..." I2 is speaking from her own work experience in a LTC facility and seeing firsthand the elder abuse and neglect so to ensure her safety, she prefers receiving care from

home. For I2 and I3, the lack of trust in LTC facilities and the need to feel safe are the reasons that sway their preference towards home-based LTSS.

Sub-theme 3: Maintaining Cultural Norm

I6 explained his future preference would be to receive LTSS at home and from his children. I6's preference influenced by his Kenyan cultural background and the concept of filial obligation and responsibility. As a caregiver to his elderly father, the 6th informant said that "in the African culture, children have to take care of their parents as they age. So based on my culture, I feel it's my responsibility to offer care to my aging dad which I am doing at the moment….so based on the way I grew up and cultural setup and my sons witnessing me talking care of their grandpa I hope and wish that I get the same care support from them." Essentially, I6 desires that his 2 sons will be influenced and guided by the same filial responsibility and their first-hand experience watching their father provide LTSS for their grandfather and possibly take up the caregiving role for his later life care. Her Kenyan cultural background significantly supported I2's preference to receive care at home. She indicated, "the background I come from is a country where we did not have nursing facilities and family was everything. I did not see strangers coming into the house to care for the elderly…this is what I see for myself, having my children take care of me" I2 explained that in her Kenyan background, culture dictated how OAs received LTSS which is guided by filial obligation. For both I3 and I2, maintaining the expected social role of adult children with respect to their aging parents is shapes their preference for LTSS at home and from their family and close friends.

In his response, I7 indicated that "I have heard that the government through insurance can pay for old people to be taken care of in their homes so that I would go for those paid caregivers…someone who cares, trained, kind, and one who enjoys taking care of the

elderly because I honestly don't think it is an easy job…..if I can find someone who understands my culture, then that would be a plus, but I am not choosy. If I can receive good care and not be a burden to my children, then I am good with anyone." I7 goes further and points out that having a culturally competent caregiver would be an added advantage but he also states that it would not be at the expense of burdening his children.

Sub-theme 4: Fear of Burdening Children

Congruent with I3 and I2, I4 and I7 indicated that they would prefer receiving future LTSS from home. The difference however is, I4 and I7 would prefer paid caregivers instead of family or friends. I4 indicated that, "I love my home and it is where I am most comfortable. So yeah I would prefer to receive care at home, probably maybe employ a direct support staff or someone who knows how to take care of old people… if I get a condition that requires me to use some equipment, I may consider going to a nursing home to save cost but if it's something that I am still capable of walking and doing some few things, I will stay at home and just employ someone to take care." Although I4 would prefer aging in-place in a non-traditional manner where rather than having family members as caregivers, she would opt for a paid, non-relative. I4's preference, however, is subject to her health status and needs in the sense that is she needed specialize care then she would consider a long-term care facility. The informants rationalized their decisions and acknowledged that receiving care at home might not be possible in some cases.

Theme Five: Long-Term Care Facility Based LTSS

Sub-theme 1: Specialized and On-site Healthcare

Three informants, I5, I7, and I8, preferred receiving future LTSS from long-term care facilities because of the accessibility to required equipment of professionals and equipment, not burdening their children and on-site healthcare professionals. In contrast, the other five considered long-term care facilities a second option when home-based LTSS is not practical. For instance, I5 indicated that:

> "my first choice is going to the facility because everything you need is there in the homes [nursing homes]. Some nurses and therapists take care of the patients so I will not have to worry about finding someone to take care of me… there are all sorts of equipment and machines to use that make life easier… so for me it[long-term care facility] is the best place because it is more convenient than home. You know the reality of the matter is, when we get old and living at home and are no longer able to do things like drive, we will need someone to take us to doctor appointments. However, in the facility, they take care of everything… also, there are other old people and activities so I think I will not be lonely…"

I5 preference is based on the availability of equipment, professionals, and socialization with other OAs within the facility. I5 states that receiving care from long-term care facilities would be the most convenient option because it mitigates the stress of finding a caregiver, support resources like healthcare providers and activities of daily equipment are accessible and available. The informant also considered that being elderly is associated with increased

dependency thus aging in place would not be practical as at some point they would require assistance with some activities.

Sub-theme 2: Not to Burden Children

Similar to I5, I7 advanced the discussion by indicating that " ….I know there are problems in these facilities [long-term care facilities], such as the elderly being beaten, left to lay in their urine, or even how most of the elderly in the nursing homes died because of COVID. But I would still prefer getting my care there because I just do not want to be a bother to my children… you watch a lot of news about older adults in these institutions who are mistreated. For some reason, I think if my kids visit, then I will not be mistreated so much " The participant is not ignorant of the challenges that older adults face while receiving LTSS from long-term care facilities. However, for him, burdening his children with caregiving responsibilities is not an option so he will still opt for LTSS from long-term care facilities. Hence, as a precaution, I7 hopes that his children visiting him in the facility will be a form of policing and monitoring any form of abuse or neglect.

I6 acknowledged his preference was to receive LTSS at home with caregiving support from his family, where his care providers would be his children or direct service professionals. However, he recognizes the fact that that might not be a possibility as his children were born into and grew up with the American culture which might not place filial responsibility over aging parents on their children. He said that:

> it [aging in place] might not happen if my children's American culture overrides the Kenyan culture. They might be unable to do what I am doing for my dad [being the care provider].

Sub-theme3: Advanced Healthcare Needs

> "Another factor that can override that [aging in place] is my health condition. If my health condition deteriorates so much that I would require a lot of healthcare and medical support, my children might not be able to care for me. Then, I might need to be in a facility where I can receive full-time care" reported I6.

I6 recognizes that his health demands might influence his desire for aging in place forcing him to opt for facility-based where his health needs will be adequately met. For I2, a LTC would her second option to home-based LTSS as she indicated " my first choice is just to be taken care at home but if I get sick or become disabled and I need help using special machines then I will have choice but to move to a nursing home…I know I will not be able to afford those things in my house and at that point I will not be able to deal with the hustle so I may consider going to a nursing home to save cost." I2 recognizes that some illness or disabilities require specialized support with equipment so for her convenience, a LTC facility would be her option.

Summary

In Chapter 4, the thematically analyzed data were presented. The data were collected using semi-structured interviews with older Kenyan immigrants. After the analysis, the research

identified that the collected data were sufficient to answer the two research questions; (What factors of planning for future LTSS do older Kenyan immigrants consider? (b) What factors guide preferences for future LTSS for older Kenyan immigrants? Applying a six-step thematic analysis process resulted in retrieving five themes: financial preparedness, acquisition of medical insurance coverage, communicating LTSS preference with family and friends, home-based LTSS, and long-term care facility-based LTSS. Particularly, it was identified that older Kenyan immigrants plan for future LTSS by saving adequate finances, having medical coverage, and sharing their plans and preferences with family and friends. Additionally, it was identified that older Kenyan immigrants prefer home-based LTSS either from family or friends or from a paid caregiver because. Home-based care was preferred because of factors including privacy and confidentiality, mistrust of LTC facilities, maintaining cultural norm and avoiding being a burden to family. In contrast, others have an inclination toward long-term care facilities because of accessibility to specialized and onsite healthcare, not being a burden to children, and advanced healthcare needs.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS FOR FUTURE RESEARCH

In the United States, the older adults' population is on a steady increase. This OAs group is characterized by unique challenges related to their wellness and independence which can be attributed to decline in functions and disability. For instance, the number of Americas 65 years and above is anticipated to increase to 73 million in 2030, making older adults 20% of the entire population (Crowley et al., 2022; Federal Interagency Forum on Aging-Related Statistics, 2020). Additionally, in 2018, 9% of African Americans aged 65 years and above are anticipated to increase to 13% by 2060 (Federal Interagency Forum on Aging-Related Statistics, 2020). Consequently, the expected prevalence of OAs is associated with an increased aging-related neurodegenerative illness and disability, meaning that more individuals will require LTSS.

In the United States, approximately only 15% of older adults 80 years and above received LTSS in their homes (Grabowski, 2021). The American norm is for OAs to seek care in long-term care facilities. However, the above statement cannot be generalized to all racial and ethnic cohorts in the United States. In particular, among Kenyan immigrants categorized as African American, most older adults age in place and are cared for by their family members, per the cultural norm of filial obligation.

Conversely, categorizing all individuals in America with an Africa-decent under the African American cohort results in a disparity in research. Despite sharing an African descent, there are numerous and distinctively different cultural beliefs and practices among immigrants from Africa. The disparity in research is evident thus the need for conducting an exploratory study was to understand the LTSS future preferences among older Kenyan immigrants. The research questions sought to be answered were What factors of planning for future LTSS do older Kenyan immigrants consider? (b) What factors guide preferences for future LTSS for older

Kenyan immigrants? In this chapter, a discussion of the results, recommendations for future practice, and a conclusion are included.

Discussion

In this exploratory qualitative study, the aim was to explore future LTSS plans and preferences among older Kenyan immigrants. A thematic analysis of the collected data resulted in the identification of five themes: financial preparedness, acquisition of medical insurance coverage, communicating plans and preferences with family and friends, home-based LTSS, and long-term care facility based LTSS. In this discussion section, I interpreted the results are based on published literature.

Research Question One: Planning for future LTSS

Many OAs underestimate their future care needs-57% of OAs say they rarely or never think about their future care needs (Walz & Mitchell, 2007), only 15% of OAs report having concrete plan for their care, 55% state they have no plans at all, and 31% report having general preferences with no clear idea of how to implement them (Sorensen & Pinquart, 2001). Contrary to this, it was identified that older Kenyan immigrants are aware of their future need for and make plans for LTSS by ensuring they have adequate finances, buying medical insurance coverage that insure their health, and communicating their future LTSS plans and preferences with their families and friends. Based on the informants' responses, it was evident that all of them acknowledged the essence of planning for LTSS, a decision influenced by either personal experiences such as caring for older adults in a professional capacity or personal family setting, maintaining autonomy over their own LTSS, and saving their family from the burden of caregiving. Although three informants indicated that they had not comprehensively thought

about their LTSS, all individuals had some form of plan albeit not concrete which is consistent with existing literature.

Because planning can enhance access to choices, help individuals gin control over their environment, aid in maintaining health-related quality of life, and prevent disease progression, the aforementioned statistics suggest that one public health strategy in aging services may be to help OAs overcome their reluctance to engage in care planning, a preventive health behavior. The informants acknowledged that a core determinant of the type of LTSS they will receive is the number of resources accessible to them during the time. As such, seven of the informants reported having personal savings accounts, 401K, and social security. In addition, the informants considered having enough financial resources as a core planning initiative. Congruent with the study findings, Robinson et al. (2014) acknowledged finances as a significant determinant of LTSS. When performing the literature search, a gap existed in how older Kenyan immigrants in the United States plan for future LTSS. As such, the findings in this qualitative study advance existing literature by providing evidence that saving in 401k, social security, or personal initiative is a significant future LTSS planning among older Kenyan immigrant students.

In their study, Robinson et al. (2014) posited that purchasing LTSS is an essential planning behavior among individuals aged 65 years and above. However, the findings were not specific to older Kenyan immigrants. Hence, the findings that older Kenyan immigrants prepare for future LTSS by having medical insurance coverage be it Medicare, Medicaid, or from other non-governmental institutions. The interviewed older Kenyan immigrants indicated that they have or will communicate their plans and preferences to their family members, friends, and even seek guidance from professionals including accountants, financial advisors, and attorneys. The findings in this study added to the existing literature by introducing the concept that sharing

future plans and preferences with loved ones is an important component for future LTSS receipt among older Kenyan immigrants. Specifically, talking to family and friends about future LTSS is essential in decreasing worry among the family members. As such, to answer the research question, older Kenyan immigrants make plans for future LTSS by planning their finances, raking medical insurance coverage, and communicating about their plans and preferences with friends and family members.

Research Question Two: Preferences for Future LTSS

In the second research question, the focus was on understanding the preferences of LTSS among older Kenyan immigrants. Based on the informants' responses, the preferences were either (a) aging in place, where their family members and/or direct support professionals would be their care providers, or (b) going to a long-term care facility. Notably, LTSS services and support can be categorized based on the care location and care provider. Conversely, the older Kenyan immigrants acknowledged that their decisions would be influenced by different factors in the future, such as health, finances, family availability and willingness, culture of filial obligation, convenience, and level of burden. The findings that future LTSS plans are dynamic are supported in the published literature. For instance, Sörensen et al. (2011) posited that LTSS is an evolving process requiring individuals to assess their preferences and options based on their needs constantly. The findings in this qualitative study added more evidence on how future LTSS plans change based on time and circumstances.

The preference for older Kenyan immigrant adults for home-based LTSS has been supported in the study findings. In particular, the findings collaborated with Robinson and colleagues' argument that LTSS preference is influenced by sociodemographic attributes, personal experiences, and family characteristics (Robinson et al., 2014). Consistent with Thorne

(2020), filial devoutness was identified in this exploratory study, the older Kenyan immigrants' preference for aging in place with their children or relative being the first choice of caregivers. Two informants expressed their preference for receiving care from direct professional staff of similar ethnicity. Similarly, Travers et al. (2020) supported the essence of professionals who deliver LTSS to be culturally competent.

Although Kasper et al. (2019) did not focus specifically on older Kenyan immigrants in their study, the researchers found that three in 10 older adults prefer receiving care at home, provided either by family members or paid professionals. Congruent with Abrahamson et al. (2017) and Henning-Smith and Shippee's (2015) arguments, it was identified that more than half of the interviewed older Kenyan immigrants expect their families to have a significant role in their LTSS. However, although in this exploratory qualitative study, the older Kenyan immigrants expect to receive support from their families, two core concepts were identified. First, although the Older Kenyan immigrants expect their family members to support them, they do not want to burden them. As such, they plan for their LTSS by saving, obtaining medical coverage, and sharing their future plans and preferences with their loved ones.

In their publication, Diederich et al. (2022) identified that immigrants from cultures that value family ties are more likely to prefer LTSS from family members. The researcher added that, however, the preference for receiving LTSS exclusively from family members decreases with extended residence in the United States because of acculturation. The above statements were supported and contradicted in the qualitative study. To elaborate, the majority of the older Kenyan immigrant preferred aging in place and receiving care from family members, corroborating the findings in the published literature. However, the identified factors that influenced the decision of family members to be the sole care providers were health, finances,

and inclination not to be a burden. The interviewed of interviewed older Kenyan immigrants had lived in the United States for 13 to 30 years and those who had lived longer, such as P2 (27 years of residence in the United States) and P4 (30 years of residence in the United States), preferred receiving care from family members. P6, P7, and P8, who had lived in the United States for 20, 24, and 23 years respectively, preferred receiving care from long-term care facilities, supporting Diederich et al.'s arguments.

Nguyen et al. (2020) posited that African Americans are less likely to seek LTSS from professionals. Similarly, in this qualitative study, it was identified that older Kenyan immigrants would prefer direct professional staff only if their family members lack the capability to meet their needs, especially those related to their health. Second, the older Kenyan immigrants acknowledged that as their heath deteriorates, they would either hire a professional or modify their homes based on their needs if the finances allow. However, it would be expensive and inconvenient; they would not mind receiving care in long-term care facilities. In addition to clarifying older Kenyan immigrants' preferences, the results in this study added to the evidence by providing the attributes that the population needs.

Contrary to the expectation that all older Kenyan immigrants would prefer aging in place, three informants were inclined to receive future LTSS in long-term care facilities. The other five older Kenyan immigrants posited that they would prefer receiving LTSS at a long-term care facility only if their health needs required professional care, did not have the resources, would not like being burdensome, or when they do not have family or relatives to care for them. Anderson and Turner (2009) supported the above-discussed concept by indicating that African Americans prefer receiving care from long-term care facilities only if they do not have family members or friends who can take care of them and do not want to burden their children.

Similarly, the findings collaborated with Grace's argument that health and the availability of support from family and health were significant determinants of LTSS preference. Consistent with Atwetwe's (2020) argument that acculturation, to some extent, influences immigrants' LTSS preference, P6's, P7's, and P8's inclination to receive care from long-term care facilities support the concept's influence. Thus, to answer the research question, it was identified that older Kenyan immigrants prefer either aging in place, where family members or direct support staff would be their caregivers. Alternatively, others prefer long-term care facilities as their first choice, while others as a second option, which their health will influence, family members' availability, and finances.

Recommendations for Future Research

One recommendation for future researchers is to conduct additional qualitative studies involving older Kenyan immigrants to test whether they would identify similar concepts. Another recommendation is for future researchers to conduct studies with older Kenyan immigrants in LTSS, where data would be collected to understand the variance between their planned and current preferences. Understanding the difference would help prove the proposed theory. Also, future researchers can conduct qualitative studies involving the children of older Kenyan immigrants. Collecting data from the population would help understand whether they would be willing to care for their aging parents, per the Kenyan culture, hire a direct service professional, or have them admitted to long-term care facilities where they would receive specialized services from nursing professionals.

Conclusions from the Study

The qualitative methodology-based study focused on older Kenyan immigrants' LTSS future preference. A thematic analysis of the informants' responses helped answer the research questions. Specifically, it was identified that older Kenyan immigrants are aware of their future

LTSS needs and make plans for the same by saving to ensure they have adequate financial resources, get medical coverage, and letting their family and friends about their future plans and preferences. The older Kenyan immigrants preferred receiving home-based LTSS from family members and/or direct service professionals. Although some preferred receiving care at long-term care facilities as a first choice to not burden their children, those inclined to home-based LTSS considered being admitted to institutions based on factors such as finances and family availability.

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APPENDIX A: INTERVIEW QUESTIONS

INTERVIEW QUESTIONS

SECTION 1: LTC Care Needs Awareness & Avoidance

Vignette: We are going to talk about later life care or long-term care which a person needs when they reach an age or point in life where they need support and assistance. This includes support with both activities of daily living like dressing, toileting, feeding, and instrumental activities of daily living like driving and shopping.

1. Do you know of a close person or someone you know that is currently receiving LTC? Why are they receiving that LTC?
2. Have you ever thought about a point in your life where you may need Long-term care (LTC) services and support? **If no, go to 5**
3. If yes to (1), what prompted you to think about it? Apart from what you have mentioned, what else made you think about it? **Probe for more reasons**
4. At what point in the future do you think you might need LTC? **Skip 5**
5. Is there a reason why you think you have not thought about your own LTC? Tell me what would make you think about your own LTC? **Probe for more reasons**
6. Have you made or thought about any plans for how you will receive assistance with LTC? (**If not go to 7)** What kind of plans are those?
7. Did anyone help you explore your options and make those plans? If yes, Who and what suggestions and assistance did they offer you? **Probe**
8. What other ways did you use to explore/make your plans and options? **Probe**

9. Have you shared your future LTC thoughts and plans with anyone? If yes, who have you shared it with? Why this person? If No, why have you not shared your thoughts and plans with anyone?

SECTION 2: LTC Location Preferences

10. Where would you want to receive LTC?
11. Why would you prefer to receive care in (10) above? **Probe**
12. What are the things you would expect to have in the place you prefer to receive LTC from? **Probe for more characteristics**
13. What do you think you will need to have in place to successfully receive LTC support from your preferred location?
14. Can you think of reasons that might prevent you from receiving LTC in your preferred location? Tell me about those reasons?
15. If you were not able to receive the care in your preferred location, what would be your other options? Why this place?
16. Where would you not want/wish/choose to receive help and why not?

SECTION 3: Preferred Provider

1. Who (person) would you choose or want to receive LTC support and services from? Why would you prefer to receive LTC from the provider above?
2. What characteristics do you expect the person you prefer to provide LTC to you to have? **Probe** Why do you want/need them to possess the characteristics? **Probe**
3. Do you have a preferred person in mind? Did you choose them based on the characteristics you just shared with me?

4. Is your preferred LTC care provider aware of your wish? Did they offer or did you ask them?
5. What would you need to have in place to make it possible to receive LTC from your preferred provider?
6. Tell me about reasons that would make it impossible for you to receive LTC from your preferred provider? What would your options be?
7. Tell me about a provider/person/people you would not like to receive LTC from and why not
8. Is there anything that you would like to tell me about what we have talked about?

SECTION 4: Acculturation and Cultural Identity

Variable	***Survey Item***	***Coding Scheme***	***Score***
Language spoken at home	Do you speak mostly native language or English with (person) or do you use both about the same? **1)** Your wife, husband, or person that you live with? **2)** Your children **3)** Your siblings **4)** Your parents	**1)** Mostly native language **2)** Both about the same **3)** Mostly English	0 if the average of valid responses is <2 2 if the average of valid responses is ≥ 2
Proportion of life lived in the United States	In what month, day and year were you born? How many years have you lived in the United States?	The number of years lived in the United States divided by the respondent's age	Value ranging from 0 to 1
Cultural Identity	Between the American and Kenyan culture, which do you mostly identify with?	**1)** Mostly American **2)** Both about the same **3)** Mostly Kenyan	Mostly American=2 Both the same= 1 Mostly Kenyan= 0
Overall score			

Theme 5: Social and Demographic sub-topic

Age: What is your age?

Gender: What is your gender do you identify as?

Marital Status: Are you married?

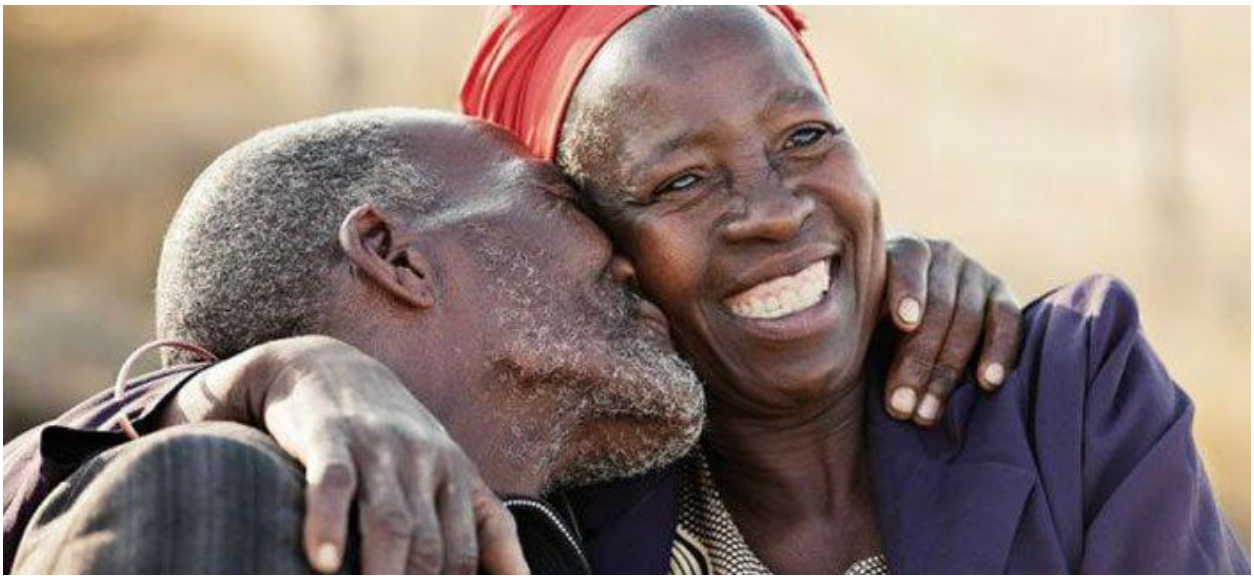
Parental Status: Do you have children?

Education level: What is the highest level of education that you completed?

Occupation: What is your current occupation?

APPENDIX B: RECRUITMENT FLIER
PREFERENCE FOR FUTURE LONG-TERM CARE FOR OLDER KENYAN IMMIGRANTS STUDY

We invite you to participate in this study which is designed to investigate future preference for long-term care for recent among older Kenyan immigrants in the United States.



To participate in the study, you must:

- Be Kenyan, aged 50 years and above
- Immigrated to the US as an adult
- be willing and capable of participating in a 1 hour to 1.5 hours interview and follow-up interview if needed.

This study will be conducted via zoom at a time and date of your convenience.

Participation in the study is VOLUNTARY.

To take part in the study, please contact Lenah Langat at lenah.langat@mnsu.edu or WhatsApp on +5314140167

PI NAME, ADDRESS AND ADDRESS: The principal investigator of the study is Dr Kathryn Elliott professor at Minnesota State University, Mankato at 336 Trafton Science Center N (507)-389-6590. Study IRBNET# 1916355

APPENDIX C: INFORMED CONSENT FORM
INFORMANT INFORMATION SHEET AND INFORMED CONSENT FORM

We are requesting you to participate in a research study titled **Long-term Care: Future Preferences for Older Kenyan Immigrants.** This study is led by Prof. Kathryn Elliott, Department of Anthropology, Minnesota State University, Mankato.

What the study is about

This study is designed to investigate future preference for long-term care support and services among recent, older Kenyan immigrants in the United States.

Who are we recruiting?

We will be interviewing informants who meet the following criteria: (a) be an older Kenyan immigrant aged 50 and above (b) immigrated from Kenya to the US as adults (c) be willing and capable of participating in a 1 hour to 1.5 hours interview and follow-up interview if needed.

What we will ask you to do

Informants who have reached out about their interest in participating in the study will be sent a zoom link after a time and date of the interview has been set. Once you have logged into zoom, we will begin with introductions, ensure that the computers and connections you and interviewer are using are ok, make sure both of you are in locations that ensure privacy and minimal distractions, and that you meet the requirements of the study. Next thing will be to have you read the informant information page and if you agree to participate in the study, you will be asked to sign the informed consent form. However, if you decline to participate, we will end the meeting with an assurance that there will be no penalty on you as participation is voluntary. You are also free to discontinue the interview at any time or skip and questions that may make you uncomfortable. The interviewer will then start recording the interview which is done for transcription purposes. The introduction part will take approximately 10 minutes and the actual interview is expected to last between 1 hour to 1.5 hours. You will be asked questions that will help us collect information on your future preference for long-term care, your cultural identity and level

of acculturation, and demographic data including your age, occupation, marital status, parental status, and education level. The interviews will be conducted and recorded, with your consent, via zoom.

Informant Name Initials

Risks and discomforts

We do not anticipate any risks from participating in this research.

Benefits

Through the study, you may indirectly benefit by thinking about or making concrete plans for your own long-term care when the time comes. Through the information gathered from this study, we hope to learn more about what older Kenyan immigrants wish for in terms of long-term care services and support. This information may be useful in the development of long-term care services and support policies and programs which cater to the specific needs of older Kenyan immigrants.

Audio/Video Recording

With your permission, we would like to record our interview so that we can focus on our conversation and for transcription purposes. Video recordings will be stored locally only to ensure your confidentiality, they will not be accessible to Zoom and they will be destroyed once transcribed.

Privacy/Confidentiality/Data Security

Your privacy will be maintained by keeping identifying information separate from research information. For example, your signed informed consent forms will be kept separate from the survey data and the two will not be connected. To further ensure your anonymity, you will be assigned pseudonyms meaning that your real names will not be used. Please note that email communication is neither private nor secure. Though we are taking precautions to protect your privacy, you should be aware that information sent through e-mail could be read by a third party. Please note that only the PI and the student investigator will have access to your identifying information.

Sharing De-identified Data Collected in this Research

De-identified data from this study may be shared with the research community at large to advance science and health. We will remove or code any personal information that could identify you before files are shared with other researchers to ensure that, by current scientific standards and known methods, no one will be able to identify you from the information we share. Despite these measures, we cannot guarantee anonymity of your personal data.

Informant Name Initials _____

Taking part is voluntary

Your decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato, and refusal to participate will involve no penalty or loss of benefits.

Follow up studies

May we contact you again to request your participation in a follow up study? Yes/No

If you have questions

The main researcher conducting this study is Dr Kathryn Elliott a professor of Anthropology at Minnesota State University, Mankato. Please ask any questions you have now. If you have questions later, you may contact Dr Kathryn Elliott at kathryn.elliott@mnsu.edu or at +1 5073896590. If you have any questions about informants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board, at (507) 389-1242.

You will be given a copy of this informant information sheet and signed informed consent form.

Statement of Consent (Please initial box)

1. I confirm that I am 18 years and above ☐

2. I confirm that I have read and understand the subject information sheet dated.....for the above study. I may keep this information sheet for my records, and I have had the opportunity to ask questions which have been answered fully. ☐

3. I understand that my participation is voluntary, and I am free to withdraw, without giving any reason and without being penalized or disadvantaged in any way. ☐

4. I understand that sections of my recorded comments and transcript text may be looked at by responsible individuals in the study. I give permission for these individuals to access this data as relevant to this and future research. ☐

5. I am willing to have this interview audio/video recorded. ☐

6. I understand that this consent form will be kept separate from the data and that the researchers will maintain my anonymity throughout the project, including in publication. ☐

7. I agree to take part in the above study. ☐

_____	_____	_____
Name of Informant	**Date**	**Signature**

_____	_____	_____
Name of Researcher	**Date**	**Signature**

IRBNet# 1916355

This consent form will be kept by the researcher for three years after the completion of the study of the study.