

UNIVERSITY OF NAIROBI

FACULTY OF ARTS

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

**AN INVESTIGATION INTO THE PATHWAYS OF OLDER
PEOPLE INTO GERONTOLOGICAL INSTITUTION: THE
CASE OF KARIOBANGI CHESIRE HOME, KASARANI -
NAIROBI**

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**A Project Paper Submitted in the Partial Fulfillment of the
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Masters of Arts in Sociology (Counselling) of the
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DECLARATION

I declare this project is my original work and that it has not been presented to any other university or institution for academic purposes.

Name: Mutea Rukwaru


Signed

~~Ababa~~ Date 9/11/2011

This project has been submitted for the examination with the approval of my university Supervisor

Supervisor:

Signed



Professor Charles Nzioka

Date 09.11.2011

DEDICATION

This project is dedicated to the memory of my late mother Salome Kairu who was a great advocate of higher learning and my surviving father Rukwaru Thingi aged 88 years whom I continue learning more on the arena of life.

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ABSTRACT

The study was on investigation into the pathways of older people into gerontological institution, a case of Kariobangi Chesire Home for the Aged, Kasarani, Nairobi. The objective of the study was to find out factors contributing to institutionalization of older persons and to establish the quality of care older persons get in such institutions.

The study was conducted using a mixed methods approach. Methods of data collection included questionnaire, key informant interviews and case studies in order to get rich information. Secondary data was also obtained through the internet, government publications, international journals and publications and also existing records in Kariobangi Chesire Home for the Aged. Descriptive statistics were used to analyze the data and to generate percentages and frequencies.

The key findings were that poverty, poor access to health care, weakened social networks and abandonment contributed to the institutionalization of older persons. The study also found that with an increase population of older people, high quality institutional care was necessary. The study concluded that the government should while also addressing critique issues with poverty should also establish more gerontological institutions in both urban and rural areas.

CHAPTER ONE: INTRODUCTION TO THE STUDY

1.0 Introduction

The mental image the society has of an older person within somewhat elastic boundaries is one who has retired from his work, who no longer expects to produce children and who shows some bodily signs of the wear and tear of life. In other words a vulnerable person.

The older persons are not useless in the community or society. They are the transmitters of knowledge from previous generations, and so they become vessels of the people's traditions. They were not only the passers-on of their people's skills, folklore, myth, history and tradition but also that segment of the society responsible for seeing that these were upheld and continued. Older men were also seen as repository of the sacred traditions and secrets of the society that are communicated only to certain persons when they have arrived at a definite age. This can be very clear when we consider the "Kaya" among Mijikenda of coast province and "Njurincheke" a council of elders among the Meru community of Eastern Province. One had to undergo certain rituals in order to be allowed to become members of "Kaya" or "Njurincheke".

In traditional societies, older persons were also the spiritual leaders. They also guided the youth and also imparted their knowledge of medicinal herbs and remedies. They also passed on their skills as "nurses" and as healers, and also gave advice on rearing children. It is to be noted that today the grandmother's role has been made almost obsolete by gadgets. Children no longer hear her tales of the past and traditional stories. The television set and the radio has become an oracle. Labour saving devices have rendered her aid in the kitchen superfluous (unnecessary). Traditional recipes and remedies are transmitted via cook books, doctors and pharmacies.

Those older persons (60 years and over) who retire before they build houses for themselves and are less affluent may spend the last part of their lives in the homes of one of their children and they may perform some minor services in return for their upkeep. Others can end up being confined more and more to less attractive homes for the aged, to hospitals or to other institutions. It is only the extremely independent older persons who are able to avoid the pitfalls of the institution to carve out for themselves a good life. Some older persons may be having a lot of money to have pleasure but it is important to note that pleasure is not a sustaining diet for all day and everyday. Stimulation may be lacking and boredom sets in. Retirement should not make one vulnerable and an object of pity and ridicule and that is why the former president of USA, President Nixon on 25 June 1971 said the following:

What we must build in this country among all our people is a new attitude toward old age, an attitude which insists that there can be no retirement from responsibility, and no retirement from citizenship.

Ageing is such a challenge and for this matter, human beings for many years have been struggling with how to slow down the ageing process. Dreams of eternal youth would be embraced by everyone if it was possible. Cosmetologists have made fortunes out of men and women trying to attain eternal youth. Plastic surgeons are not complaining as the rich part with millions of shillings to have facial muscles tweaked to eliminate those wrinkles, bags under the eye or slightly double chin.

Those who live, for many years will have experienced many challenges including many undesirable events and dramas. One might have lost many friends, might have stood at open

graves until one is tired of listening to obituaries, and perhaps might have endured terminal illness.

To many people ageing is a period to be dreaded because many are not prepared for it. With declining health and fortunes, the question is, are they going to spend their last days on earth in a hospital, a gerontological home or where?

1.1 Background of the study

The dream of every human being is to live for many years and to be booming with zest of youth. During Biblical times people used to live for many years, for instance Methuselah lived 969 years, Noah lived 950 years and Adam lived 930 years. Adam got his first born son Seth when he was 130 years (Genesis chapter 5). Sadly those Biblical times are no longer with us.

The international community has not been silent on the plight of older persons and Kenya being a signatory to these international protocols and covenants has been in the forefront and have even enshrined the issues of older persons in her Constitution. The Madrid International plan of Action on Ageing (2002) adopted the first World Assembly on Ageing in Vienna (1982) which came up with Vienna International Plan of – Action on Ageing (VIPAA) and it is this first World Assembly which has guided the course of thinking and action. Issues of human rights for older persons were taken up in 1991 in the formulation of the United Nations principles for older persons which provided guidance in the areas of independence, participation, care, self-fulfillment and dignity.

The international plan of action on ageing (2002) recognized that there were three priority directions which are older persons and development, advancing health and well-being into old age and ensuring enabling and supportive environment.

There are a number of central themes running through the international plan of action on Ageing (2002) and these are fundamental freedoms of older persons, eradicating poverty, fully and effective participation of older persons, provision of opportunities for older persons, ensuring full enjoyment, commitment to gender equality, recognition of the crucial importance of families, intergenerational interdependence, solidarity and reciprocity for social development and finally provision of health care, support and social protection.

The African Union Policy Framework and Plan of action on Ageing has pointed out that today's society has been built by the efforts deployed by previous generation of people who should be guaranteed better living conditions for meaningful transition to old age. These guarantees include access to efficient health care services and specialized living environment, the right to retirement, pension, active participation in leisure, sporting and cultural programmes and lastly the right to custody and company of their children and grandchildren.

The rights of older persons to be respected and protected have been enshrined in a number of international instruments and protocols and these are United Nations plan of Action on Ageing (1982), United Nations principles for older persons (1991), United Nations proclamation on Ageing (1992), United Nations Universal Declaration of Human Rights (1948) Africa Chapter of Human and People's rights, international covenant in civil and political rights (ICCPR), international covenant, economic, social and cultural rights, United Nations Declaration on the Rights to development (1986), Convention on the Elimination of Discrimination against women (CEDAW) (1979), convention against Torture and other cruel, inhuman or degrading treatment or punishment (CAT)(1989) and United Nations standards rules on equalization of opportunities for persons with disabilities (1996).

The Kenya Government has a social protection policy (Government of Kenya 2006) whose main purpose is to address poverty and reduce vulnerability in the country through a creation of a framework, which provides and promotes immediate support to the poor and vulnerable and also build their productive capacity. Areas which have been identified as part of the social protection are the Older persons, Disabled persons and Orphans and Vulnerable children.

Kenya has shown her commitment to the issues of older persons as evidenced by being a signatory to protocols and instruments touching on older persons, for instance World Assembly on Ageing (2002) World Assembly on Ageing (1982), United Nations Principles for older persons (1991), United Nations Proclamation on Ageing (1992), 25th ordinary session of the OAU labour and social affairs commission in Ouagadougou Burkina Faso (2002) and lastly the 38th ordinary session of the Heads of State and Government in Durban in South Africa (2002) on ageing.

Kenya has gone further to domesticate the Madrid International Plan Action on Ageing and she has produced the National Policy on Ageing and older Persons (2005). She has also identified the gaps in her policy documents in regard to issues of older persons and the 9th National Development Plan (2002 – 2008) the National Population Policy (Sessional Paper No. 1 of 2000) and the Constitution of Kenya (2010) are some of the examples.

At the regional level, Kenya is a signatory to the Livingstone Declaration (2006) which committed African Governments, under the auspices of the African Union (AU) to improve the implementation of National Social Protection Programmes. The commission for African

Union also identified social transfers as a key tool in tackling extreme poverty in Sub-Saharan Africa.

Most communities in Kenya have a positive tradition of taking care of older persons. Kenyan people, including older persons, live in the human society with the extended family pattern. Within the extended family network, elderly persons had the rights to receive care and respects from their family members and relatives. In most communities in Kenya the elderly persons were held in esteem and taken care of. With modernization which has introduced cash economy and subsequent rural-urban migration, the extended family network has been weakened and so the caring for the older persons has become a serious concern.

With improved longevity the number of older persons is burgeoning and so is that of older persons who have no children or relatives to rely on. It is of essence that arrangements be sought in the middle of weakening extended family structures. In the midst of a weakened family structure, what alternative care can be offered to take care of those older persons, especially in the midst of escalating levels of poverty?

1.2 Statement of the problem

The study's focus is on the plight of older persons in a political economy which is capitalistic. The Kenyan society is changing very fast and the demands of the capitalistic system are overwhelming. The capitalistic system has brought the cash economy, modern education and industrialization. This has led to rural-urban migration as people migrate to urban areas to look for employment. With this transition in the society, sudden changes in all spheres of social life and the weakening of family and communal structures, it is very clear that life for older persons is a challenge. Industrialization, urbanization and westernization

have caused a gradual disintegration of the extended family system rendering it ineffective as a social security institution. Older persons find themselves vulnerable and without any source of social protection. When older persons are left in rural areas after their strong young people have migrated to urban areas, they get affected and so are those in urban areas especially those whose fortunes have deteriorated. These demands of the capitalistic system which has fragmented the extended family will be a permanent feature of our society. With the fragmentation of extended family system, is institutional care a panacea to the problems of the older persons?

The demands for industrial labour which is propelling people to urban areas will be a continuous phenomenon. The older persons are getting affected yet there is no visible initiative to replace the traditional care.

The economy in Kenya is changing very fast and this is affecting especially the older persons. Poverty is a stark reality. Even those who were rich in yester years may find their fortunes in doldrums and sometimes may find themselves without a shelter.

Kenya's National Policy on Ageing and older Persons is "shy" on the issue of institutionalization of older persons. The government does not encourage establishment of gerontological homes. The policy states that there should be control of these gerontological homes if they have to be established. This is evident that the government does not have any pragmatic attempt to provide care of the older persons. The government has focused on providing 1500 shillings to very poor households which have older persons but it is silent on the care of older persons. The local authorities and religious groups have attempted to come

up with gerontological homes but these homes are few, far between, poorly financed and dilapidated.

Kenya, like many other countries, has a growing population of older persons. According to Kenya National Bureau of Statistics (KNBS) the population of those aged 60 years and over in 1999 was 1,488,322 and in 2009 the population of older persons was 1,630,000. This shows there was an increase of 9.5 percent in the number of older persons. It is estimated that the population of older persons in Kenya in the year 2050 will be 7,937,000 which will represent 9 percent of the total population. This means that the percentage increase of older persons will have increased by 5 percent that is 4 percent in 2009 to 9 percent in 2050. This rising population of older persons has implications on all spheres. There will be the issue of medical costs, feeding and general care. With the rising population the issue of institutional care for the older persons is likely to come up especially for the vulnerable older persons.

1.3 Purpose of the Study

The objective of the study was two fold:

1. To find out factors that lead to the institutionalization of older persons.
2. To establish the quality of care in these gerontological homes.

1.4 Research Questions

Objective one was to find out if poverty, access to health care, gender, family size and social networks contributed to institutionalization of older persons and objective two was to find out if older persons were getting quality care in the home for the aged.

Answers to the following questions helped in addressing objective one and two:

1. Does poverty contribute to the institutionalization of older persons?
2. Does access to health care play a role in the institutionalization of older persons?
3. Does social networks contribute to the institutionalization of older persons?
4. Is institutionalization of older persons related to family size?
5. Does gender play a role in the institutionalization of older persons?
6. Do older persons get quality care in the home for the aged?

1.5 Justification of the study

In Kenya according to Sessional Paper No 6 of 2005 the number of older persons has risen dramatically since the first National Census report in 1948, from a modest 270,000 to 1,488,322 older persons in 1999. This rapid increase of older persons is a matter of concern for this population has special needs which need to be addressed especially with regard to shelter and general care.

The study realizes that traditionally the family played a very important role as a welfare system. It catered for all members of society. The role of older persons traditionally included leadership, guidance and advice. In return the older persons were assured of total support for their needs. Today the scenario is changing. Today's life is characterized by individualism, urbanization and industrial advancement.

With this transition and sudden changes in all spheres of social life, and the weakening of the family and communal structures, it is very clear that life for older people is a challenge which the society can ignore at its own peril. In essence, it is worthy noting that industrialization, urbanization and westernization have caused a gradual disintegration of the extended family

system rendering it ineffective as a social security institution. With these changes, older persons find themselves vulnerable and without any source of social protection.

When strong young people migrate to urban areas, they are usually at the apex of their productive life. With old age and deteriorating fortunes they are likely to suffer and may end up in homes for the aged especially if they had cut links with their rural families. Older persons who were left in the rural areas might end up being affected by the rural urban migration through neglect. Kenya's 9th National Development Plan (2002-2008) and Sessional Paper No 1 of 2000 on the National Population Policy noted that disintegration of the extended family system due to urbanization and poverty have rendered older persons helpless.

Kenya National Policy on Ageing and Older Persons does not commit itself on the issue of gerontological homes. The policy urges that older persons should be taken care of by their kins, children, friends or work-mates. The policy also points out that where these gerontological homes exist, they should be regulated, so that we do not experience a mushrooming of gerontological homes. Yet the policy ironically does not specify who is going to build these homes. The policy document realizes there is a problem of shelter for older persons yet it is not outright on what has to be done. It views the issue of gerontological homes with a tongue in the cheek and is even 'shy' to mention it. With the weakening of extended family networks due to urbanization, industrialization and the increasing number of older persons together with the cash economy which has contributed to people migrating to urban areas in search of labour in industries, an alternative care and also quality care for these older persons who are left vulnerable due to these sudden changes need to be found.

The findings from the research are a food for thought on the alternative care of older persons. Knowing what drives people to these gerontological homes has assisted in coming up with intervention strategies, has added to the world of knowledge and assisted in understanding the state of homes for the aged, that is their conditions, and this assisted in understanding the quality of care these older persons get.

1.6 The scope of the study

The focus of the study was persons who were institutionalized and aged 60 years and over. So it excluded those persons who were outside the home for the aged even if they were 60 years and over. The parameters the study considered were poverty, access to health care, Social networks, family size, gender, and quality of care in gerontological homes.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

Literature review was discussed under the following sub-themes: definition of older persons, magnitude of aging, international conferences and aging, older persons and their needs, care of older persons in historical perspective, traditional care of older persons, aging in a capitalist world (fast changing world), care of the older persons in western societies, aging and human rights, constitution and aging and aging and national policy.

2.1 Definition of "Older" Persons

World Health Organization (WHO) ([www.WHOin/health info/survey/ageingdefinorder/en/index.html](http://www.WHOin/health_info/survey/ageingdefinorder/en/index.html)) defines an older person by adopting the United Nations Standard definition whose cut off is 60 years to refer to older population. The African union has adopted the United Nations' definition of an older person and Kenya has also adopted the same definition in her policy Kenya-National Policy on Older Persons and Ageing (2005).

This is a definition which many times is associated with the age at which one can begin to receive pension benefits. This definition can be a challenge in many parts of the developing world where majority do not have birth certificates or they may not even remember when they were born. It is also to be noted that there are many people living in rural areas who are not in formal employment yet for lack of an acceptable definition we have to accept this default definition for standardization purposes. Socially constructed meanings in the developing countries are significant such as the roles assigned to older people, or the loss of roles, when they become grandparents, cessation of menopause in case of women or when they begin to do less or different work. Different communities and societies have different definitions of older persons.

2.1.2 Magnitude of Aging (Trends)

Globally there is population ageing. Population ageing is a shift in the distribution of a country's population towards older ages. This is reflected in the decline in the proportion composed of children and a rise in the population of elderly persons. This phenomenon may arise from two demographic effects, that is longevity and declining fertility. Virtually all regions of the world are now experiencing growth in the numbers of elderly residents. According to Leonid and Heuveline (2003) for the world as a whole, the elderly will grow from 6.9% of the population in 2000 to a projected 19.3% in 2050. In Latin America and the Caribbean the increase will be from 5.4 % in 2000 to 16.9% in 2050. In China the increase will be more spectacular from 6.9% in 2000 to 22.7% in 2050.

The world population aged 60 years and above is increasing rapidly. Whereas in 1950 it was 200 million, by 2000 it had increased three fold to nearly 606 million. It is projected that by the year 2025, the world population of the aged will double to reach 1.2 billion and 2.0 billion by 2050 (Kenya's National Policy on older persons and Ageing 2005). According to World population ageing (2009) a United Nations document the number of older persons had increased to 737 million and by 2050, it is projected to reach 2 billion.

In Africa the projected increase is from 3.3% in 2000 to 6.9% in 2050. According to the United States of America Census Bureau (1999) the older population will continue to grow over the next 30 years (2000-2030). In South Africa the increase will be from 7 to 11.5%, Ghana 5.1 to 9.5%, Sudan 3.9 to 6.4% and Mozambique 3.9 to 5.7 percent. During this period the population of older persons will more than double despite the AIDS epidemic. In absolute figures notable increase will be realized in Democratic Republic of Congo whereby the older persons will increase from 2.1 to 4.9 million, Mozambique from 0.8 million to 2.1 million,

Cairo Programme of Action Paras 6.17, 6.19, and 6.20 stated:-

“We heads of states and Government .. will create.... Action..... improve the possibility of older persons achieving a better life..... Develop and implement policies to ensure that all people have adequate economic and social protection during... widowhood, disability and old age” (www.iisd.ca/cairo.html)

Copenhagen Programme of Action paras 24, 25 and 40

“With the increase in life expectancy and the growing number of older women, their health concerns require particular attention. Diseases of ageing and the interrelationships of ageing and disability among women..... Need particular attention..... Actions to be taken... Develop information, programmes and services to assist women to understand and adapt to changes associated with ageing and to address and treat the health needs of older women..... discrimination in..... hiring and remuneration, promotion..... continue to restrict employment, economic, professional and other opportunities,..... for women... actions to be taken..... Adopt and implement laws against discrimination based on sex in the labour market, especially considering older women workers, hiring and promotion, the extension of employment benefits and social security and working conditions...”

(www.un.org/documents/ga/conf/166-9.htm)

Beijing Platform for Action paras 101, 106 and 165

Older persons are entitled to lead fulfilling and productive lives and should have opportunities for full participation in their communities and society, and in all decision making regarding their well-being especially their shelter needs. Their many contributions to the political, social and economic processes of human settlements should be recognized and valued. Special attention should be given to meeting their evolving housing and mobility

Ghana from 1 million to 2.8 million, Cameroon from 0.8 million to 1.6 million and Uganda from 0.8 million to 1.9 million.

The trend of Kenya's ageing population follows the global trend. According to Kenya National Bureau of statistics the number of older persons has been increasing since the first census report of 1948. In 1948 the population of older persons was 270,000, 1959 was 440,000, 1969 was 550,000, 1979 was 765,000, 1989 was 1,070,000, 1999 was 1,400,000 and 2009 the population of older persons was 1,630,000. From 1948 to 2009 the population of older persons has increased by 503.70 percent. This population ageing will pose a great challenge for the healthcare systems and general care for the older persons.

2.1.3. International conferences and ageing

There have been a number of world conferences which recognized the special needs of older persons. The UN General Assembly Proclamation on Ageing (www.un.org/documents/gal/res/47/a47r005.htm), International Conference on Population and Development in Cairo (1994), (www.iisd.ca/cairo.html), World Summit for Social Development in Copenhagen in 1995, (www.un.org/esa/socdev/wssso/text-version/index.html). World Conference on Women in Beijing (1995) (www.un.org/womenwatch/daw/beijing) and Habitat II conference in Istanbul (1996) (www.iisd.ca/habitat) urged the support of national initiatives on ageing so that appropriate national policies and programmes for the elderly are considered as part of the overall development strategies. The Assembly urged the Government and non-government organizations to give full support to the elderly persons. The above conferences had come up with specific declaration and programme of action.

needs in order to enable them to continue to lead rewarding lives in their communities (www.un.org/womenwatch/daw/beijing/platform/declar.htm) ... we.... Commit ourselves to promoting shelter and supporting basic services and facilities for education and health for older persons.....". United Nations conference on Human Settlement (www.unhabitat.org/downloads/docs/2072_61331_1st-dec.pdf) – Habitat II Istanbul-declaration of Human Settlements came up with Habitat Agenda paras 17 and 40 which recognized the importance of shelter. (www.iisd.ca/habitat)

The World Assembly on Ageing was held in Vienna in 1982 where the first International Plan of Action, (www.un.org/documents/ga/res/36/a36r030.htm) (Vienna International Plan of Action on Ageing (VIPAA), was adopted by the United Nations member states. The Action Plan contained 62 recommendations for action in Key areas, among them being human rights, poverty, the family, social welfare, income security, housing and living environments, health, training and education. Kenya was among the 126 countries that adopted the plan thus making a commitment for its implementation. The plan of action urged Governments to devote more attention to the question of ageing and to utilize fully the support, provided by development partners and non-governmental organizations including the elderly persons themselves. (www.un.org/es/globalissues/ageing/docs/vipaa.pdf)

In 2002 there was the Second World Assembly on Ageing (www.un.org/swaa2002/) held in Madrid Spain. It came up with Madrid Plan of Action on Ageing (MIPAA) The plan of action identified three main priority directions namely participation of older persons in their societies as citizens with full rights, the assurance that persons everywhere are able to age with security and dignity and linking ageing to other frameworks for social and economic development and human rights. (www.ngls.org/orf/pdf/MIPAA.pdf).

There was the 38th Ordinary Session of the Assembly of Heads of State and Government in Durban, South Africa in July 2002. The policy framework provides guidelines and binds all African Union member countries to formulate national policies on ageing in order to improve the lives of the continent's older persons. (www.umn.edu/humanrts/africa/ahg171-184.html)

In March 2006 there was an intergovernmental regional conference organized by African Union and was held in Lusaka, Zambia and its theme was a transformative agenda for the 21st century: Examining the case for basic social protection in Africa. The conference discussed measures for protecting the poorest in Africa. It emphasized the importance of social protection in form of social transfers. It is through the Livingstone Declaration (www2.ohchr.org/English/law/ccpr.htm) that led to cash transfer for older persons that the Kenyan Government is currently implementing in selected districts and this is expected to be scaled to all constituencies during this financial year 2011/2012 whereby households with older persons who are 65 years and over have a member of the household disabled or with terminal illness or they have an orphan in the household are given a stipend of 1500 shillings.

2.1.4. Older persons and their needs

According to National Policy on older persons and Aging (2005) quality of life of older persons include access to efficient health care services, specialized living environment, participation in leisure and cultural programmes and being in the company of their children and grandchildren. Maslow (1943) viewed clothing, food, shelter and health as crucial needs for survival. He also commented that feeling a sense of belonging and acceptance from family members, intimate partners or close colleagues is very important. In the absence of these elements any human being and in this case of the study older persons will be susceptible to loneliness, social anxiety and clinical depression.

(En.wikipedia.org/wiki/maslow's-hierarchy - of - needs) Manfred Max Neef a Chilean economist and an environmentalist classified fundamental needs as protection, affection, leisure and freedoms. (En.wikipedia.org/wiki/Manfred-max Neef)

According to Holstege and Riekse (2002) older persons needs includes being assisted with activities of daily living, spiritual support and healthcare which might have taken an abrupt downturn in health after an illness or accident that requires medical attention and hospitalization. They also commented that older persons need to be shown tender feelings and also to take more time with them. They need to be assisted on when to see a medical specialist. In a nutshell Holstege and Riekse have pointed out that the major services which the caregivers give to older persons are activities of daily living such as bathing, dressing, getting in and out of chairs and helping them with medications.

2.1.5. Care of older persons in historical perspective

John and John (1956:157) noted that previously support of needy people had been the concern of the family, the locality and private philanthropy and the state maintained a lukewarm approach to institutionalization of older persons and so this lukewarmness of the state towards institutionalizations of older persons have a historical background. John and John (1956:137) commented that the American communities taking over English traditions of Elizabethan times, once herded the sick and destitute persons, young and old into poor houses or doled out more or less sporadic outdoor relief to the poor in the homes briefly in the form of fuel and groceries. In the early decade of the twentieth century, other and better means were being developed to care for dependent children, the physically and mentally-handicapped. Public revulsion increased against the use of the poor almshouse as a trash heap for the unfortunate and against the uncertainty and stigma associated with outdoor relief. It is

also interesting to note that the relief workers used to herd the sick, the destitute, young and old men and women in one house!

Haber (1983:83) has given the historical development of institutional homes for the aged. In 1903 Homer Folks, commissioner of New York City's Charities announced a new policy for the city almshouse. The institution would now be called the Home for the aged. In contrast to the poor houses of the past, New York's asylums were not filled with lazy, corrupt or able-bodied. Most of the residents were simply old and ailing and they had entered the poor houses in order to receive badly needed food, shelter and medical attention. Folks declared that these older persons should be regarded with more consideration. He contended that the adoption of a new name for the institution was intended to bring dignity to such aged sufferers. The institutionalized elderly would no longer be treated as disgraced paupers. Throughout the nineteenth century private asylums were established to attract the once middle class who had become incapable of providing for themselves.

Haber (1983:83) has pointed out that throughout the America's history, the almshouse had always served as a shelter for those who were destitute in old age. These almshouses played so many functions from what one would have expected. They served as an asylum for the punishment of the vagrant and able bodied and as a residence for the poverty-stricken and ailing. But in the late nineteenth century, upon the removal of the "lazy and corrupt" the hospital like atmosphere of the institution became dominant.

The chaplain of the New York almshouse (renamed City Home of the Aged and infirm in 1903) defended his asylum as a proper haven for the old. He commented "what can a man or woman aged and infirm look for in life, more than a warm room and clean comfortable beds

to sleep in – good wholesome and varied food to eat, a church to go to, plenty of papers, magazines and books to read?”

With time there was a new development to take care of the class. It is of interest to note that in the second half of the nineteenth century the Charity worker and the Social scientist became convinced of the growing number of destitute elderly persons. This necessitated the emergence of homes for the aged to take care of different classes and needs. There emerged privately institutionalized homes organized by religious groups, Haber (1983:99). Homes were founded by Lutherans in 1859, Methodists and Jews in 1865, Presbyterians in 1872 and 1885 and the Evangelical Association in 1888 and Little Sisters of the Poor in 1869. Religious commitment was crucial for you to be admitted. Secondly there were homes maintained by labour organization - John and John (1956:28) Thirdly there were privately owned nursing homes, then communal nursing and boarding homes managed by local groups of charitable minded citizens John and John (1956:28) There were also the Federal government Homes for the aged in respective counties and lastly own homes or relative homes.

2.1.6 Traditional care of older persons

Traditionally the role of older persons in African household or families for that matter was to advise, direct and to lead their families and societies in those practices, rituals and ceremonies that ensured their survival, existence and continuity. They were involved in the socialization of society and ensured the attainment and passing on society's knowledge, values and norms. Historically the elders provided care to the children who in turn provided care to them in their old age. The Shona saying, “Kerere Kagokurerawo” as pointed out by Nhongo (2004) (look after it and will look after you) exemplifies this. The more children one had, the more

chances there were of receiving better care when one was no longer able to provide for himself or herself. There was a system that ensured that the needs of individuals were catered for within the family. Nobody would starve when other members of the family had plenty.

In the traditional setting, roles and relationships were very clear and it was the role of older people as the custodians of tradition and cultural practices to pass on this knowledge. Traditionally elder care was the responsibility of family members. Inheritance of human beings (men and women) and wealth had a big role in the African family. It ensured that the widow remained in the family so that she could be cared with her children. So care of older persons was provided within the extended family home.

2.1.7 Aging in a capitalist world

A capitalist society is characterized by modernization which Preston (1996:170) views as a process whereby the less developed countries would shift from traditional patterns of life to become industrialized. Industrial society was driven by the demanding logic of industrialism. Emile Durkheim a French sociologist saw modernization in terms of division of labour while Max Weber saw it in terms of evolvement of modern bureaucracy. In pre-modern societies the elders were the one who passed the knowledge and they played a very important part in socialization but this role has been taken over by churches and the formal education. In modern societies people rely on expert systems and not on older persons. Giddens talked of technologies as indicators of modernization. Giddens also looked on the aspect of communication as an aspect of modernization. In traditional societies, messages used to be passed by word of mouth so the older persons played a very important role. But now there is the computer, fax, and telephone. Messages can be passed in a second through electronic mail (e-mail).

Richard (1979:81) discussed modernization by viewing Everett Rogers and Alex Inkeles who constructed a dichotomy of traditional societies and modern societies. According to them traditional societies are rural, illiterate, designated political structures, agricultural, extended family system, low economic participation, low per capita income, little commerce, poor transport system, oral media system, poor nutrition, high birthrates and short life expectancy while modern society was characterized by urban, literacy, electoral political structure, industrial, nuclear family, high economic participation, high per capita income, improved transport system, much commerce, mass media system, good nutrition, low birth rates and extended life expectancy. New technologies which come with modernization has led to advancements in medical care and this has led to increase of population and especially the older persons.

Modernization has come up with urbanization monetary economy and industrialization. With cash economy comes individualism as noted by Georg Simmel (1908/1971c:154). Money became the yardstick of measuring poverty. It has been the concern of international community on the escalating poverty, (Millennium Development Goals 2000) (www.un.org/millenniumgoals/) and the Kenya Government has been concerned as evidenced by her various development documents – African Socialism and its Application to Planning, (Session Paper No. 10 of 1965), Poverty Reduction Strategy Paper (2001), Economic Recovery Strategy for Wealth and Employment Creation (2003 – 2007) (2004 revised), Kenyan Vision 2030 (2008), Kenya Integration Household and Budget survey (2005/06), Social Protection Policy (2006) and National Social Protection Policy (2010) draft.

In almost all these documents the older persons have been indentified as vulnerable. A large population of the Kenyan population is trapped in chronic poverty according to Kenya

Integration Household and Budget Survey of 2005/06). Economic Recovery Strategy (2004) pointed out that the determinants of poverty in Kenya are location urban /rural, household size, level of education of household head, gender (male versus female headed households) agricultural output and access to land. National social protection policy (2010) draft has commented that poverty tended to impact more on those who cannot generate income or access livelihoods independently such as orphans and vulnerable children, children headed households, unemployed youth, older persons, are vulnerable groups which include the disabled.

HelpAge International in its documentary on Ageing entitled “Ageing issues in Africa a summary (2000)” has commented on poverty in regard to older persons:

In the majority of the countries worldwide but particularly in the developing countries, older people are typically the poorest members of society and live far below the poverty line. Whilst the cycle of poverty is hard to break for anyone, the challenges are even greater for older people as society ignores their needs and fails to recognize their potential so making it hard for them to change their situation.

In the year 2000, leaders from around the world gathered at the United Nations, Millenium Summit and they were drawn together by a vision of the world in 2015 in which extreme hunger and poverty will be eradicated (Goal number one) achieve universal primary education (Goal number two) and Goal number three- to promote gender equality to empower women. Education is very important as a human resource to both young and old. It is important to equip human beings with knowledge, skills attitudes and values that will enable the labour force to use the nations natural and manmade resources productively. It is no wonder that the government has consistently directed large proportions of its exchequer to education and training.

Education contributes to reduction in poverty and birth rates, and improves health, strengthens institutions of civil society and national capacity as well as improving governance as noted by Ndwiga (2004). According to Kenya National adult literacy survey Report (2007; xiv) has commented that literacy is a pillar for national development. It equips citizens with the knowledge and competencies to be able to seek gainful employment or engage in income activities. Furthermore, it empowers citizens (especially women) to participate in social and political decision making processes, enjoy their fundamental rights and enable them to lead a dignified life. For many older persons spending their last days on earth in a gerontological home is not living a dignified life.

Kenya has realized the importance of education and that is why she has been a signatory to international conventions on education including that of the World Declaration on Education for All (EFA) Jomtein, (www.unesco.org/education/efa/-/jomtein-declaration.s.htm) Thailand (1990) and the EFA (www.unesco.org/new/en/education/--/efarepart-and-) framework for action adopted at the World Education Forum www.unesco.org/education/efa/wef-2000/ (Dakar Senegal 2000). In its Poverty Reduction Strategy Paper (PRSP)(2004) the government has acknowledged the importance of empowering people through education to improve their well-being and contribute towards the realization of a new-industrialized country status as per vision 2030.

According to World Population Ageing (2009:36) illiteracy remains high among older people, especially among older women in developing countries. The population of illiterate persons among those aged 65 or over in developing countries is estimated at 46 per cent. On average, in developing countries, 58 per cent of women and 34 percent of men aged 65 years or over are illiterate, a gap of 24 percent points.

According to the 1999 Population and Housing Census in Kenya, an estimated 4.2 million adults were illiterate, 60 percent of them being women. Kenya is committed to achieving all six EFA goals including that of reducing adult illiteracy by 50 percent by the year 2015 – Kenya National Adult Literacy Survey Report (2007; ix)

HelpAge International in their document entitled “Ageing issues in Africa” A summary reiterated that older people should have access to appropriate educational and training programmes. Investing in human capital by providing people with income earning opportunities through education is a fundamental universal human right for all including older persons. Income earning opportunities is the surest way of empowering them to be responsible of their destiny and an undisputed path for poverty reduction. Holstege and Riekse (2002:9) observed that older persons have less formal education than younger groups and they argue that research has shown that with education come better health and higher income.

To achieve vision 2030 requires a functionally literate adult population which can effectively contribute to economic production and participate in the democratic processes of the country. According to Kenya National Adult Literacy Survey Report (2007) only 26.9 percent of adults had achieved the desired level requisite for making any meaningful contribution to vision 2030. It is of interest to note that literacy levels correlated with poverty levels when mapping was done, and this is significant to show the importance of education. The study recognizes that an educated person is likely to have a reasonable income which will shield him or her during old age.

Modernization has also led to rural-urban migration. People migrate to urban areas to seek industrial employment. In rural areas, surviving often on small family farms is difficult and so it becomes challenging to improve one's standards of living beyond basic sustenance. Farming is dependent on unpredictable environmental conditions, and in times of drought, flood and pestilence, survival becomes extremely problematic and so cities and towns become easy exit route.

Macharia (2003) has noted that people migrate to cities due to marital unhappiness, lack of social services in the rural areas, daughters who refuse to accept marriage arranged by their parents were more likely to migrate to avoid misery of an arranged marriage usually to an older spouses, incestuous relations which are embarrassing, being accused of theft or witchcraft and unhappy wives or young girls move to urban centers either to trade or to purchase prostitution. Political instability and incitement like the post-election violence of 2008 in Kenya, cultural factor that men are bread winners and so they are expected to move and go anywhere to get that bread, drought, initial fare to the city, perception of cities, that is cities are known to be places where money, services and wealth are concentrated. Cities are also seen as places of fortunes, education opportunities, existence of social networks, health and entertainment, all contribute to rural-urban migration. Proximity to urban center and the anonymity of urban areas also contribute to rural-urban migration.

Rural migrants are attracted by the possibilities that cities offer but often end up settling in shanties or slums and experience extreme poverty. Michael Lipton ([En.wikipedia.org/wiki/Paleolithic_continuity_theory](http://en.wikipedia.org/wiki/Paleolithic_continuity_theory)) quoting Varshy (1993:5) in his book called *Beyond urban bias* (en.wikipedia.org/wiki/urban-bias) said this..... the most important conflict in the poor countries of the world today is not between labour and capital but between rural class and

urban classes. What Michael is bringing out is the dichotomy of rural-urban which fuels rural-urban migration and this represents the class bias and the uneven development and resource allocation. Urban areas in essence have experienced dualistic development, where a modern formal settlement exists alongside a large informal urban settlement as observed by Rukwaru (2008:63-69). Rural-urban migration has contributed to the fragmentation of families and this has greatly affected the older persons.

In summary modern life has greatly affected the older persons. Size of the families have decreased and this has greatly affected the traditional care which the older persons used to enjoy. The geographical dispersion of families, the greater life expectancy of older persons and the tendency of women to be educated and working outside their homes have all affected the care of older persons. The traditional extended family system has been greatly affected and many older persons are feeling the effect of the social changes, especially the aspect of women working when traditionally they used to be home keepers.

2.1.8 Care of the Older Persons in Western Societies

The ageing of the population in the western countries presents major challenges for public policy. In France in 2010 the total institutionalization of older persons was 825,000 Australia was 179,000, Canada was 262,000, Sweden was 143,000 and USA was 1,727,000. Many countries have committed themselves to finance the care for older persons from the public kit. For instance in 2010 Germany used 0.72% of its GDP to finance home care and institutions, Sweden used 2.59% of her GDP, and USA used 0.59% of her GDP.
(en.wikipedia.org/wiki/elderly-care)

The provision of care for older people in western countries are well coordinated and their governments are very keen on their needs unlike developing societies. The provision of care for older people relies on both the unpaid care of families and other carers alongside publicly and privately funded social care services. In many instances social care services are mainly arranged by local authorities, through funding from central government supplement by revenue from council tax, other local sources and by charges that older people are asked to pay for services.

The majority of services are delivered by private and voluntary sector organizations. Care users have also the option of arranging their own provision including directly employing their care workers. Local authorities have their own criteria regarding needs and increasingly eligibility is restricted to older people with higher levels of assessed needs. Growing demand for care and cost implications are matters of great concerns. Employing social workers to take care of these older persons is not easy. In many cases the social care providers are poorly paid and so they go to seek greener pastures and this makes the turnover to be high.

Care for the older persons in western societies is well organized. In many cases the countries are welfare states. The social protection schemes are well managed to cushion the older persons. The government and the private sector are very much involved in providing the care. Homes for the aged are usually managed by respective local authorities, individuals and charitable organizations. The developing countries have a long way to go in their care for their older persons.

2.1.9 Aging and human rights

The following have been referred in reference to aging and human rights;-

The United Nations Commitment and Guiding Principles towards the realization of human rights is enshrined in the International Bills of Rights which consists of Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (1966), the international Covenant on Economic, Social and Cultural Rights (1966) and this International Bills of Right is reinforced by other International Human Rights Treaties, Covenants and instruments such as the International Convention on the Elimination of All forms of Discrimination against Women (CEDAW) (1979). There is also the United Nations Principles for Older Persons 1991.

Global Action on Aging advocates for the protection of older persons as a key element of the human rights movement. Older people often face serious discrimination. The Madrid International Plan of Action on Aging (MIPAA) adopted by United Nation member states in 2002, recommends many specific rights for older persons in a wide number of areas. In its priority direction 1: older persons and development, MIPAA specify “ active participation in society and development, work and the ageing labour force, access to knowledge, education and training and intergenerational solidarity and eradication of poverty”. In addition priority direction 111: Ensuring enabling and supportive environment focuses on “ housing and the living environment, neglect, abuse and violence and images of ageing”.

([www.achpr.org/english/---/rights of order persons.pdf](http://www.achpr.org/english/---/rights_of_order_persons.pdf), www.hrweb.org/legal/cat-html, www2.ohchr.org/English/law/ccpr.htm, www.un.org/events/humanrights/2007/photos/declaration%20-eng.pdf, www.umn.edu/humanrts/resolutions/47/5ga/1992.html).

Chapter four of the Constitution of Kenya (2010) discusses the Bill of Rights.

Article 19(2) states:

That the purpose of recognizing and protecting human rights and fundamental freedoms is to preserve the dignity of individuals and communities and to promote social justice and the realization of the potential of all human beings.

Article 27 (1) through four also emphasizes on the rights of all human beings

Article 27 subsection one states:

Every person is equal before the law and has the right to equal potential and equal benefit of the law.

Article 27 (2) states:

Equality includes the full and equal enjoyment of all rights and fundamental freedoms.

Article 27 (3) states:

Women and men have the right to equal treatment, including the right to equal opportunities in political, economic cultural and social spheres.

Chapter 5 of the Constitution of Kenya establishes the Kenya National Human Rights and Equality Commission whose functions among others are;-

Article 59 (2)

- (a) to promote respect for human rights and develop a culture of human rights in the Republic.
- (b) To promote gender equality and equity generally and to coordinate and facilitate gender mainstreaming in national development.

2.1.10 Constitution and Aging

Constitution of Kenya 2010 have also given preeminence to the issues of older persons. The following articles are important to note:-

Article 27 (4) states:

The state shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.

Article 21 (3) states:

All state organs and public officers have the duty to address the needs of the vulnerable groups within society, including women, older members of society, person with disabilities, children, youth, members of minority or marginalized communities and members of particular ethnic, religious or cultural communities.

Article 56 States:

The state shall put in place affirmative action programmes designed to ensure that minorities and marginalized groups:-

- (a) Participate and are represented in governance and other spheres of life.
- (b) Are provided special opportunities in education and economic fields
- (c) Are provided special opportunities for access to employment.

- (d) Develop their cultural values, languages and practices and
- (e) Have reasonable access to water health services and infrastructure

Article 57 states:

The state shall take measures to ensure the rights of older persons

- (a) To fully participate in the affairs of society
- (b) To pursue their personal development
- (c) To live in dignity and respect and be free from abuse and
- (d) To receive reasonable care and assistance from their family and state.

2.1.11 Aging and national policy

Kenya has the National policy on Older Persons and aging which is Sessional Paper No. 6 of 2005. In 1982, the United Nations through its resolution 37/51 convened the first ever World Assembly on Ageing in Vienna Austria to address issues pertaining to the older persons and their implications on national development. This was later critically reviewed and reformulated through the international plan of action on ageing agreed upon during the Second World Assembly on Ageing in April 2002 in Madrid, Spain. The African Union also formulated and adopted its policy framework and plan of action on ageing in July 2002 focusing on older persons on the continent. Kenya being a member of United Nations and African Union is a signatory to these declarations- (National policy on older persons and aging 2005 (vii). The Kenya National Policy on Older persons and Aging is an evidence on Kenya's seriousness in domesticating key international instruments and conventions on protection of older persons.

The main issues the policy addresses are law and human rights, poverty and sustained livelihood. Poor health and lack of access to health care including HIV/ADS, harmful traditional cultural practices in the family and community, gender issues, food security and nutrition, housing and physical amenities, access to information, education, training and the

media employment and income security, persons with disability, social security, social welfare, retirement, conflicts and disaster situations and institutional arrangements in support of older persons affairs.

The policy addresses the issue of poverty and sustainable livelihood. The government under social protection programme based on social protection policy of 2006 came up with cash transfer whereby the household which are caring for older persons that is those who are 65 years and over, have orphans or vulnerable children, have a disabled person or have a member of the household terminally ill are considered to be extremely poor and they are to be given 1500 Kenya shillings per month. The Kenya National Policy on Older Persons and Aging recommends that these poor older persons should be given waiver to health services and access to subsidized food items and be given concessions for transport.

The National Policy on Older persons and Aging (2005:33) comments on the housing and physical amenities and emphasizes that decent housing is a basic need and human right. The policy de-emphasizes institutional care for the older persons. It is very clear from the available data that the population of older persons in Kenya is increasing. Much as the policy de-emphasizes institutional care for older persons it does not give alternative care for those who have no where to go.

The policy comments that institutions which take care of the older persons in towns should be regulated. It is as if institutions for the care of older persons have flooded urban areas yet it is clear at practical level the government has been lukewarm on issues of institutional care.

According to the policy the government does not have firm commitment on the homecare or institutional care of older persons. The government does not supplement the few gerontological (homes for the aged) homes which are sponsored by faith based organizations. The little commitment the government has shown is in supporting few households which are extremely poor and they are housing older persons who are 65 years and over under the cash transfer programme. The programme is funded from the exchequer but it is a drop in the ocean for example 0.001 percent of the total budget this financial year (2011-2012).

2.2 Theoretical Framework

2.2.0 Introduction

According to Bengtson et al (2009) a theory is used to describe interpretations of ideas and observations. Theorizing is a process of developing ideas that allow us to understand and explain empirical observations. The justification for using a theory is that it provides anchors for thinking and guidelines for examining data. This study utilized activity theory and disengagement theory.

According to Bengtson et al., (2009) a theory is used to describe interpretations of ideas and observations. Theorizing is a process of developing ideas that allow us to understand and explain empirical observations. The justification for using a theory is that it provides anchors for thinking and guidelines for examining data. This study utilized activity theory and disengagement theory of aging which the study considered to be offshoots of social exchange theory. Before delving into these two theories the study discussed the social exchange theory to give the rationale of using the theories and to show how they fit in the mainstream theory and aging.

2.2.1 Social Exchange Theory.

According to internet (<http://changingminds.org/org/explantaions/theories/social-exchange.htm>) social exchange grew out of the interaction of economics, psychology and sociology. According to Homans (1958), the initiator of the theory, it was developed to understand the social behaviour of humans in economic undertaking. The fundamental difference between economic exchange and social exchange theory is in the way actors are viewed. Exchange theory “views actors (person or firm) as dealing not with another actor but with a market” (Emerson 1987) responding to various market characteristics, while social exchange theory views the exchange relationships between specific actors of “actions contingent on rewarding reactions from others” (Blau, 1964).

According to George Homans people will continue to engage in behaviours they find rewarding and cease behaviours that have too high of costs. Social exchange theory posits that human behaviour is reciprocal. Much of the human behaviour is guided by consideration of exchange. (see www.soc./astate.edu/sapp/homans.ppt) Social exchange according to Blau (1964) can be observed everywhere once we are sensitized about it. It is not only present in market (economic) relations, but in friendship and love. Ndonga commented that when social exchange takes place between individuals in their daily interaction, it enhances social integration. (see www.fluc.org/laup/esap/publications/chea/eajourn/Blau.php)

Wikipedia gives an elaborate definition of social exchange theory. According to Wikipedia, social exchange theory posits that all human relationships are formed by the use of a subjective-cost-benefit analysis and the comparison of alternatives. Costs are the elements of relational life that have negative value to a person such as the effort put into a relationship and the negatives of a partner. Costs can be time, money, or effort. Rewards are the elements

of a relationship that have positive value. Rewards can be sense of acceptance, support and companionship. The social exchange perspective argues that people calculate the overall worth of a particular relationship by subtracting its cost from the rewards it provides. (en.wikipedia.org/wiki/social-exchange-theory)

According to social exchange theory, $\text{worth} = \text{Rewards} - \text{costs}$. Benefits includes things such as material financial gains, social status and emotional comforts. Costs generally consists of sacrifices of time, money or lost opportunities. So in social exchange outcome is very critical and outcome is defined to be the difference between the benefits and the cost.

In social exchange if benefits are less or the cost is too high one is likely to withdraw from the relationship. How is this relationship demonstrated in activity theory and disengagement theory?

2.2.1.1 Activity theory of aging

The reference for the above theory is:

The activity theory of aging, originally constructed on the basis of American research and predominantly tested in the United States of America asserts that an individual's life satisfaction is directly related to his degree of social interaction or level of activity.

The activity theory emphasizes the importance of ongoing social activity. This theory suggests that a persons' self concept is related to the roles held by that person. If a person for instance retires he does not carry his office title with him or her. To many people office titles confers to them a sense of high self esteem. So when one leaves an organization minus their title they get affected and they feel as if they are worthless and many of them fail to adapt to the other life because of being in a denial state. According to this theory retiring may not be

so traumatic if the person actively maintains other roles, such as familial roles, recreational activities, volunteer and community roles. According to this theory, in order for elderly persons to age successfully and gracefully they need to maintain a positive sense of self and they have to substitute new roles for those that are lost because of age.

The activity theory assumes that older age is abrupt and that the process of ageing leaves people alone and miserable and cut off from social networks. The theory posits that old people should be encouraged to remain active and develop old-age friends, and standards and expectations of middle age should be projected to older age, and that older persons should be encouraged to broaden their social networks and be involved. The activity theory asserts in a nutshell that all living beings are actively aging whether they are 20 years or 100 years, but their levels of activity might determine how long they keep having birthdays. The activity theory suggests that as people age they start to lose the identity they had in work or in family life. And those who continue to participate in activities and interact socially have high quality of life and tend to be healthier and live longer. In part it enhances a sense of self esteem. So it is important to get older persons involved rather than keeping them passive or sedentary. (see [Health.howstuffworks.com/aging/--/activity theory-of aging.htm](http://Health.howstuffworks.com/aging/--/activity-theory-of-aging.htm))

According to this theory a person's self concept is related to the roles held by that person. If a person retires he/she may lose the status and trappings of the office. On the process the person will not be able to maintain the old friends. He may be having a lot of time at his disposal which may be different with his former friends. Money may also be a problem. So keeping companionship may be a challenge because of change of status, time and financial challenge. So when the friends consider the benefits they have to get from the social relationship, they may consider it a worthless venture or unworthy relationship, and so they

delink and on the process they cut communication. Who wants to associate with an idler, a person with financial burden and one who cannot add value to the relationship no matter what parameters you consider?

2.2.1.2. Disengagement theory of aging

The reference of the above theory is:

The social scientists Eliane Cumming and William Henry outlined the disengagement theory of aging in their 1961 book, "Growing old". They based their theory on data from the Kansas City study of adult life in which the researchers from the University of Chicago followed several hundred adults from middle to old age. The biological process of aging has an intriguing symmetrical quality. As babies, people depend on care givers to feed them, transport them and to soothe their discomforts. While growing up, people break away from their guardians and they form an external support network. When people cross the threshold of old age, their bodies begin to breakdown and they gradually fall back into the care of others. According to disengagement theory, old age comes with dependency. Along with freedom to bathe and eat at their own time, their freedom and ability to socialize diminish as well. Certain social networks will naturally disintegrate after retirement or moving into a long term care facility like gerontological home. From there, the amount of interaction with other people depends largely on health and mobility. The proponents of disengagement theory view older persons as useless and people who have nothing to offer to the society. Disengagement theory suggested that older people should withdraw and settle into inactivity until death. (see [Health.howstuffworks.com/---/aging/elder--/disengagement theory.htm](http://Health.howstuffworks.com/---/aging/elder--/disengagement%20theory.htm).)

According to this theory when older people age they become weak and they depend on caregivers to feed them and transport them. Because of mobility problem their ability to socialize diminishes. With declined health and limited social networks their value declines and they end up losing many friends because they are now more of a liability than asset. They may be forsaken, deserted and abandoned. This is because people will not invest in a relationship where the returns is zero or negative. Negative in the sense where for example a caregiver will end up experiencing emotional burnout hence affecting ones health and with it comes financial cost depleting ones resources or spending a lot resources to take care of the older person who is sick.

It can be seen how the activity theory and disengagement theory are linking with social exchange theory which emphasizes that for a relationship to continue there should be a social equilibrium that is $\text{Costs} = \text{Benefits}$. If costs are higher than the benefits one is likely to withdraw or the relationship remains lukewarm.

2.3 Definition of key terms

2.3.1 Vulnerability –is defined as openness to adverse external events or shocks and cannot make the necessary adjustments to protect him or herself. (see also Odufuwa, 2008)

2.3.2 Elderly care – is defined as the fulfillment of the special needs and requirements that are unique to senior citizens. This broad term encompasses assisted living, adult day care, long term care, nursing homes, hospice care and home-care (see <http://en.wikipedia.org/wiki/elderly-care>).

2.3.3 Quality indicators – are defined as the responsibilities of staff members and organizations, adequate staff competence, as well as reports of adverse events and complaints. (see <http://herkules oulu.fi>).

2.3.4 Quality of life in a nursing home – Is defined as a degree to which personal identity, independence, free – choice and interaction with others are stimulated. <http://herkules oulu.fi>

2.3.5 Poverty- is defined as a condition characterized by deprivation of basic human needs that is food, homelessness, water, inadequate housing, land, access to toilets, living in slums and lack of a job. (See UN 1995)

2.3.6 Social protection programme – Is a public intervention to assist individuals, households and communities to manage risk better and that provide support to the critically poor (see www.il0.org/public/english/protection/download/lifecycle.pdf).

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter discusses site, types of sampling, sampling frame (universe), sample size, rationale/criteria of sample size, methods of data collection, types and justification of usage of each method, method of data analysis and limitation of the study

3.1 Methodology

The study used mixed methods that is both qualitative and quantitative methods. For quantitative data the study utilized questionnaire and secondary data. To get qualitative data the study utilized indepth interview, case study and observation method. The qualitative method was geared to getting experiences of older persons especially when they are in the home for the aged. Indepth interviews assisted in getting information about feelings, opinions and experiences of older persons. This method was very useful because it was possible to get the interpretative perspective, that is the connection and relationships a person sees between particular events, phenomenon and beliefs. This deep search for participants feeling and perspectives was time consuming and very costly. The rationale for using qualitative method was to do intensive study on a small sample without the aim of making generalization to the larger population. Quantitative data was useful because standardization and pre-coding was easier and it also helped to get basic demographic characteristics of the sample.

In summary the questionnaire assisted in getting primary data, the key informants and observation assisted in collaborating the information given by older persons. The case study brought out lessons learnt.

3.1.1. Site Description

Kariobangi Chesire Home for the aged – Nyumba ya Wazee and day care centre is situated in Kariobangi, Kasarani district in Nairobi County. It is situated next to Korogocho slum areas and it is not very far from the populous Mathare Valley slum which is in Starehe District (The location of the home is shown in the map which is in the appendix 5).

In Nairobi there are six homes for the aged and out of the six homes, Kasarani has a high proportion (50 percent). Kasarani has the Kariobangi Chesire Home for the Aged which is sponsored by the Missionary of the Franciscan Sisters, then there is the Little Sisters of the Poor sponsored by the Catholic Church, and then the Queen of apostles. In Langata there is the Missionaries of Charity which is sponsored by Mother Teresa. This home caters for the older persons, disabled and orphan. In Starehe district there is also the Missionaries of Charity which also caters for older persons, disabled and orphans. In Westlands district there is Mji wa Huruma whose sponsor is the Nairobi City Council and by Extension Local Government.

Kariobangi Chesire Home for the aged is sponsored by the Franciscan Sisters of the Order of Saint Francis of Assis. This home was started to meet the needs of the **elderly poor** of the area. By the late 70's they had begun to live in temporary shelters and unsanitary conditions in Korogocho, Huruma, Grogan, Ngei and its environs. The first six rooms were erected in 1980 with the assistance of HelpAge, United Kingdom. In 1986, another sixteen rooms were added with the assistance of Caritas, Austria. A staff house was also added. Research carried out on the elderly slum dwellers in September 1986 revealed the need for a day care centre.

The Irish Government sponsored the building of the centre which was furnished with the help of the HelpAge Kenya and the American Women's Association. A number of other donors have since then assisted with the building of additional rooms and a sick-bay dispensary. In 1994 a new dining room cum T.V. room was added. Among those donors was the Charity Sweepstake which assisted in the construction of a chapel. Others who assisted are the Uchumi Chain of Supermarkets, Homegrown and Lions Rotary Club of Nairobi.

3.1.2 Services offered by the home

The home houses 34 very poor elderly men and women. These elderly persons receives dedicated care, diet and medical help within an atmosphere of love and spiritual wellbeing. The main purpose is to help those elderly persons spend their days or years with true human dignity using their minds and strength for each other and to live in loving harmony exercising their freedom and their faith.

The home also provide outreach programmes for the neighbouring slum areas of Korogocho and its environs. The home provided hot meals, handouts of food, medical needs and body care. The home has definite programmes to take care of the marginalized people and it has allocated three days in a week for service, that is Tuesdays, Wednesday and Friday. In a week the home takes care of about 120 people. The blind the disabled persons and the lepers are among the beneficiaries of the services offered by the home.

Not included in the 120 are their own children and the orphans. The issue of leprosy cases is astounding because to many, leprosy is associated with Biblical times. The interesting part of these leprosy cases is that all of them are from Korogocho slums and majority of them are from Tanzania and they came independently but they are now a close knit community with

very close ties. When these lepers come to the home for the aged they receive medical care, food, clothing, walking sticks, crutches among other considerations including moral support. When these lepers from Tanzania are not in the home, they are out in the city begging and whatever they get they repatriate back home to support both immediate and extended families with needs like education and food.

The home does not discriminate when offering services. The care providers were not interested with one's religion or tribe. Once you are admitted to the home you are expected to observe the following; not to smoke, drink or fight.

3.1.2 Rationalization for choice of study institution

Paying close scrutiny on the typology of the Homes for the Aged in Nairobi county, it is evident that the role of the government and even the private sector in regard to gerontological homes is minimal. It is of interest to note that a high proportion of these homes of the aged in Nairobi county are located in Kasarani and sponsored by Catholic Church. Now a question lingers, why is Kariobangi Chesire Home for the Aged ideal for the study?

The following factors were critical in the choice of Kariobangi Chesire Home for the Aged as a case study:

1. It was the only home taking care of only the elderly persons at residential level. The other homes were having a "mixed" – older persons, disabled, mentally challenged and orphans. So this aspect of residential care of **only the elderly**, were critical for the study.

2. The home had a broad, elaborate and comprehensive outreach programme which catered for a number of marginalized groups within its environments. The other homes in the whole of Nairobi County did not have such arrangements.
3. The home housed both men and women and so the aspect of gender which was critical for the study was taken care of.
4. Since the home was handling the institutionalization of older persons, it was ideal for the study, as the focus of the study was to find out factors contributing to institutionalization, and quality of care the older persons get in the home for the aged. So Kariobangi Chesire for the Aged scored highly on a number of factors favouring the study against the other homes for the aged in Nairobi county, hence its choice.

3.2 Purposive sampling

The study utilized purposive sampling. Purposive sampling is a non probability method because the degree to which the sample differs from the population universe remains unknown. Purposive sampling groups participants according to certain pre-selected criteria. In purposive sampling people are selected because of who they are and what they know rather than by chance ([changingminds.org>.....>research>sampling](http://changingminds.org/research/sampling))

3.2.1 Rationale/Criteria for choosing participants in the sample

The sampling frame of the population was the total number of older persons residing in Kariobangi Chesire Home for the Aged in 2010. The population size was 34 older persons. The sample size was 14 older persons. The study intended to have 20 but it was not possible, because those older persons who were in the home for the aged who were not senile, who were mentally alert and were willing to participate in the research and were not sick were 14.

Qualitative data was also obtained from key informants. These were an administrator, parish priest, a nurse/attendant and four older persons. The study intended to have 10 key informants but it was not possible due to unavailability and pressure on the time on the side of the key informants so the study ended in having three key informants, a mortality rate of 70%. The term key informants referred to anyone who could provide a detailed information and opinion based on his or her knowledge of a particular issue. Key informant interviews helped to get qualitative information that could be crosschecked.

The key informant was required to have the following characteristics:

- Should have a good understanding about issues and problems of the older persons.
- Should understand the language of the participants (older persons in the home). Older persons may be having their unique language. If the researcher did not understand the language of the participants, interpretation of the participants meanings, motives and behaviours would be difficult.
- Should not be senile
- Should have oratorical powers
- Should be willing to participate in the research process

3.3 Methods of data collection

3.3.1 Secondary data/content analysis

In this method of data collection, the study utilized data which had already been collected, in other words secondary data. It is a non-reactive method for it removes the researcher from dealing directly with interactions, events or subjects. The study used internet, government publications, books and international literature. The study also used institutional records from Kariobangi Chesire Home for the aged.

3.3.2 Questionnaire

A written questionnaire is a data collection tool in which written questions that are to be answered by respondents are presented in a written form. The questions can be either open ended or closed with pre-categorized answers.

The study utilized questionnaire because of the following advantages:

- Standardization makes analysis easier
- Pre-coding makes analysis of data easier
- Helps to get basic demographic characteristics of the sample.

Despite the above strengths a questionnaire cannot elicit deep feelings. With a questionnaire one cannot understand people's interpretations, people's perceptions of reality and one may not be able to understand the complex issues surrounding older persons, that is their feelings, and the problems they face while in the Home for the aged. One needs a "feel" and a story to understand the participants. You needed to hear their story so that you are able to visualize and to have a "real" picture. Other supplementary methods like observation, indepth interviews and case study were of great use.

3.3.3. Observation method

Observation methods are techniques in which the researcher relies on his or her powers of observation rather than communicating with a person in order to obtain information.

Observation techniques can be direct or indirect, disguised or undisguised, structured or unstructured and can also be either human or mechanical.

The study used disguised observation, that is the participants (older persons in the home for the aged and are in the sample) were not aware that they were being observed. The study also used unstructured observation, that is there was no restriction placed on what the observer noted. All in the focus of the study was observed. Observation method helped in

understanding the state of housing, accommodation, feeding, dressing and leisure activities existing in the Home for the aged. The advantages of this method was that the researcher was able to get actual insight and not reported condition or situation and time and cost was minimal.

The limitation of this method was the inability to pry beneath the behavior observed. It was also difficult to observe attitudes, motivations and other internal conditions. It was not possible to answer the question why? This meant another method had to be used to enable a deep understanding of the phenomenon and to be able to answer the question why and that was why the study was supplemented by key informant interviewing and case study.

3.3.4 Indepth Interview

Indepth interview is a technique designed to elicit a vivid picture of the participants' perspective on the research topic. During indepth interviews the person being interviewed is considered the expert and the interviewer is considered the student. The researcher's interviewing technique is motivated by the desire to learn everything the participant can share about the research topic. The researcher engaged the participants by posing questions in a neutral manner, listening attentively to participant response and asking questions and probes based on the responses. Participants were not led according to any preconceived notions, nor were they encouraged to provide particular answers by expressing approval or disapproval of what they said. Indepth interview was very useful because it was possible to elicit rich data and new insights into the older persons past life, their feelings and opinions and the quality of care in the home for the aged. The interview focused on administrators, a parish priest, and a nurses/attendants and four representatives of older persons who had a knowledge and experience of dealing with old persons and also had a story to tell as an older person.

The study used semi-structured interview guide that listed a pre-determined set of questions or issues that were explored during the interview. This guide served as a checklist during the interview and it ensured that basically the same information was obtained from a number of people. The interviewer was free to pursue certain questions in great depth. The advantage of the interview guide approach was that it made interviewing of a number of different persons more systematic and comprehensive.

3.3.5. Case study

Case study referred to the collection and presentation of detailed information about a particular participant or small group, frequently including the account of subjects themselves (Writing.colostate.ed/guides/research/casestudy). Case study is a form of qualitative descriptive research and the case study looks intensively at an individual or a small group and drawing conclusions about that participant or group and only on that specific context. Researchers do not focus on the discovery of a universal, generalizable truth nor do they typically look for cause – effect relationship. Instead, emphasis is placed on exploration and description.

Case study method has advantages. Unlike quantitative methods of research like the survey which focuses on the questions of who, what, where, how much and how many, case studies are the preferred strategy when how and when questions are asked. It is also preferred when there is a contemporary focus within a real life context.

The study had four cases of older persons. The past life of the participant was probed and they told their story of their life. These people had a wealthy of experiences. They had experiences both outside the home and within the home especially the aspect of quality of

care. These cases were exciting. Apart from answering how and when questions, they were able to give an insight of older persons experiences.

3.4 Methods of data analysis

3.4.1 Methods of data analysis

The study used simple descriptive statistics. These simple statistics were frequencies and percentages. Descriptive statistics were used to analyse the data and frequencies and percentages were used.

3.4.2 How analysis was done

The researcher summarized the data and went through the interview responses and looked for themes. After identifying the themes coding was done according to frequency number or times a variable was mentioned.

The researcher did the analysis through focus by question – in this the research focused the analysis to look at how individuals responded to the question. The researcher organized the data by question to look across all respondents and their answers in order to identify consistencies and differences. All the data from each question were put together. Secondly the researcher read through the text and found themes and issues that recur in the data. The researcher looked for themes in the life stories of older persons.

Thirdly the researcher looked on the relative importance of themes. The number of times a particular theme appeared indicated the importance. These counts provide a rough estimates of relative importance and they were not suited for statistical analysis, but they revealed general patterns in the data.

CHAPTER FOUR: PRESENTATION OF DATA, ANALYSIS AND DISCUSSION

4.1 Introduction

This chapter covers presentation of data, analysis, discussion and study limitations. The study set out to address two objectives. These two objectives were to find out factors that contributed to institutionalization of older persons and to establish the quality of care of older persons in the home for the aged. To assess the two objectives research questions were used, observation guide, interview guide and case histories. The questions were to find out if poverty, access to health, family size, weakening social networks, and gender contributed to the institutionalization of older persons and also to establish if older persons got quality care in the gerontological home.

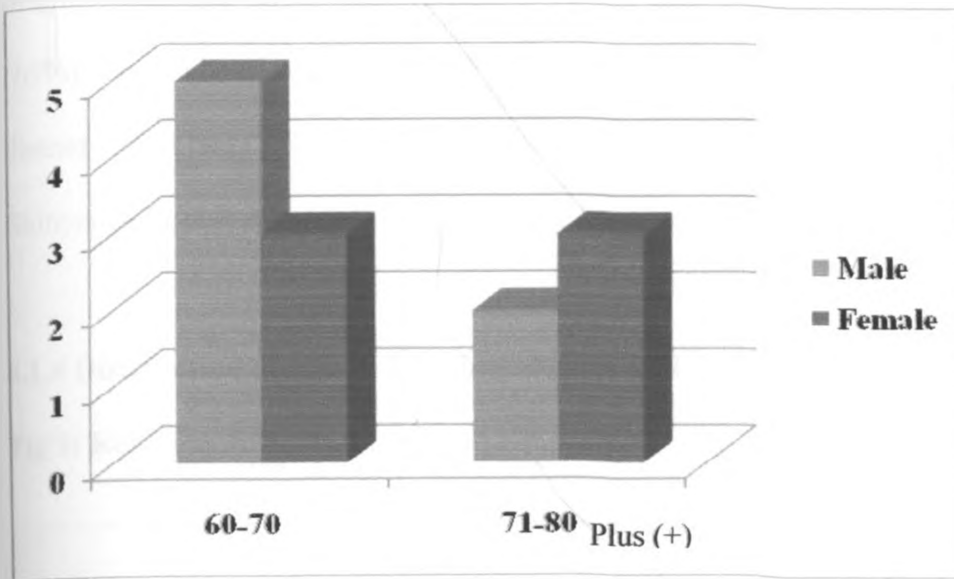
4.1.1 Characteristics of the respondents

Under this section, we examine the characteristics of the respondents namely gender, age, home district of the respondents before they came to the home for the aged and their religious affiliation.

4.1.2 Distribution of respondents by gender and age

According to the data collected in Kariobangi Chesire Home for the Aged, dispersion of the respondents was from 60 years to 80 years plus as can be seen from figure 1 below.

Fig 1: Age Distribution by Gender and Age



Source: (Study, 2011)

As can be seen from Figure 1 above more males are represented than females in the age category of 60-70 years while in the category of 71-80 plus there were more female than males.

4.1.3 Distribution of respondents by home district/county

Table 1: Home district/county

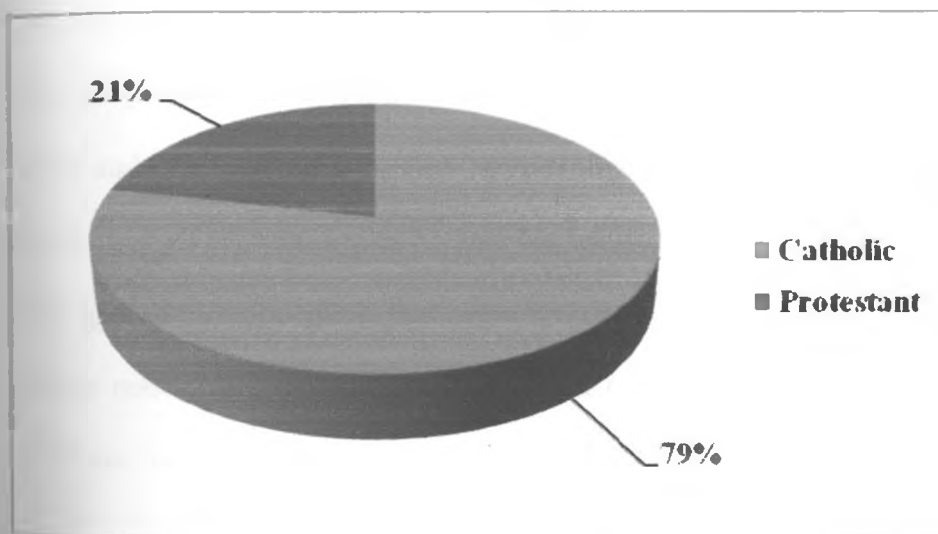
	Frequency	Percent
Embu	1	7
Kiambu	5	36
Makueni	1	7
Murang'a	4	29
Nyeri	1	7
Shinyanga - Tanzania	1	7
Siaya	1	7
Total	14	100

Source: (Study, 2011)

The above Table showed the distribution of the respondents according to their districts of origin. According to the Table, majority of the older persons were from Central Province (65%). The highest population came from Kiambu district (36%) and followed by Murang'a district which had (29%), all from Central Province. There was a case of one foreigner from Shinyanga in Tanzania.

4.1.4 Distribution of respondents by religious affiliation

Fig 2: Religious Affiliation



Source: (Study, 2011)

As can be seen in Fig. 2 majority of the respondents were of Catholic Faith (79%) while those of Protestant Faith composed of 21%. It is of interest to note that Kariobangi Chesire Home for the Aged is sponsored and managed by the Franciscan Sisters of the order of St. Francis of Assis which is a Catholic Order. This might explain why there were more Catholics than Protestants.

4.1.5 Distribution of respondents by marital status

Table 2: Marital Status

	Frequency	Percent
Married	3	22
Separated	2	14
Widowed	2	14
Single	7	50
Total	14	100

Source: (Study, 2011)

Data in Table 2 above shows that a higher proportion of the respondents were single (50%). This category had never married. But looking at the percentages of those who had separated (14%) and who could be termed as “special singles” since they were not having their spouses, the category of broader singles became big totaling to 78%. What might have happened to the marriages of older people is that some spouses might have died or they might have left for various reasons like mistreatment, barrenness or desertion. “Singlehood” is a great challenge in old age because of the aspect of care.

4.2.0 Objective of the study

The objective of the study was to find out factors that led to the institutionalization of older persons and also to establish the quality of care the older persons got in these gerontological homes.

In order to assess if the objective of the study was achieved the following research questions were answered:

- Does poverty contribute to the institutionalization of older persons?
- Does access to health care play a role in the institutionalization of older persons?
- Does social networks contribute to the institutionalization of older persons?

- Is institutionalization of older persons related to family size?
- Does gender play a role in the institutionalization of older persons?
- Do older persons get quality care in the home for the aged?

The study endeavored to answer the above questions and below are the analysis:

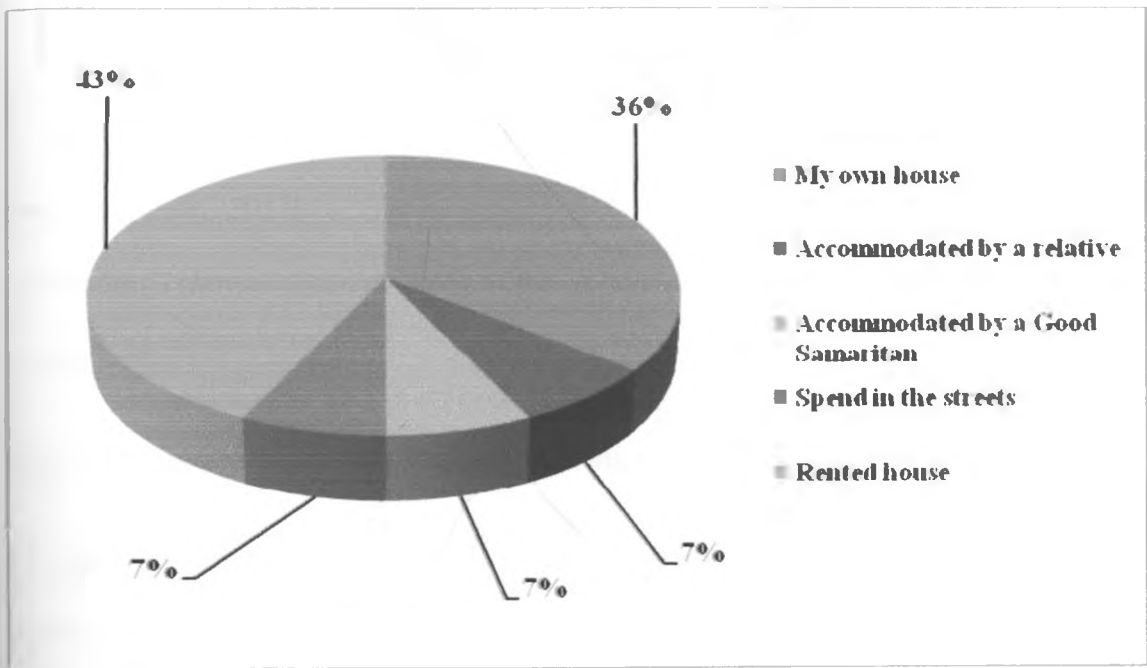
4.2.1 Poverty

The study hypothesized that poverty is a critical factor that can lead to institutionalization of older persons. The study in its attempt to assess the socio-economic status of the respondents, used proximate indicators of poverty. These proximate factors were owning a house, owning land, employment, education the estate they were living in, in Nairobi before being admitted in the home, the number of rooms in the house before coming to the home and the source of water before coming to the home.

4.2.1.1 Ownership of house

In regard to ownership of a house, respondents were asked if they had ever owned a house before coming to the home for the aged. The results are showed in Figure 3 below:

Figure 3: Ownership of house where they lived



Source: (Study, 2011)

According to the findings 43% were living in rental houses, 36% were living in their own houses before coming to the home, 7% were accommodated by a good Samaritan, 7% were accommodated by a relative and 7% spent in the streets. According to the findings a high proportion of the respondents were living in rental houses.

4.2.1.2 Owning land

Land is a resource and so it is a critical factor as an indirect measure of either poverty or richness. The respondents were asked if they owned land before coming to the home. The results were as in table 3 below.

Table 3 Those who owned land

	Frequency	Percentage
Yes	3	21
No	11	79
Total	14	100%

Source: (Study, 2011)

Our findings showed that a majority of the respondents (79%) did not own land and only 21% owned land.

4.2.1.3 The estate the respondents were living before coming to the home for the aged

The estate one lived in Nairobi was posited to be an indirect measurement of one's socio-economic status. Living in a middle class estate like Buruburu, Umoja, Kariobangi south and many others can to some extent estimate the income levels of an individual. Living in slum areas in most cases can reflect the poverty level of an individual. Slum areas are associated with high levels of poverty, deteriorated environmental conditions, no privacy, poor housing conditions, overcrowding, poor roads, poor toilets, water problems and serious hygiene problems and food problems. The Table 4 below shows which estate the respondents were living before coming to the home.

Table 4: Estate they were living in Nairobi before coming to the home for the aged

	Frequency	Percent
Kariobangi	3	21
Kia-Michael	2	14
Korogocho	7	50
Mathare north	1	7
No response	1	7
Total	14	100

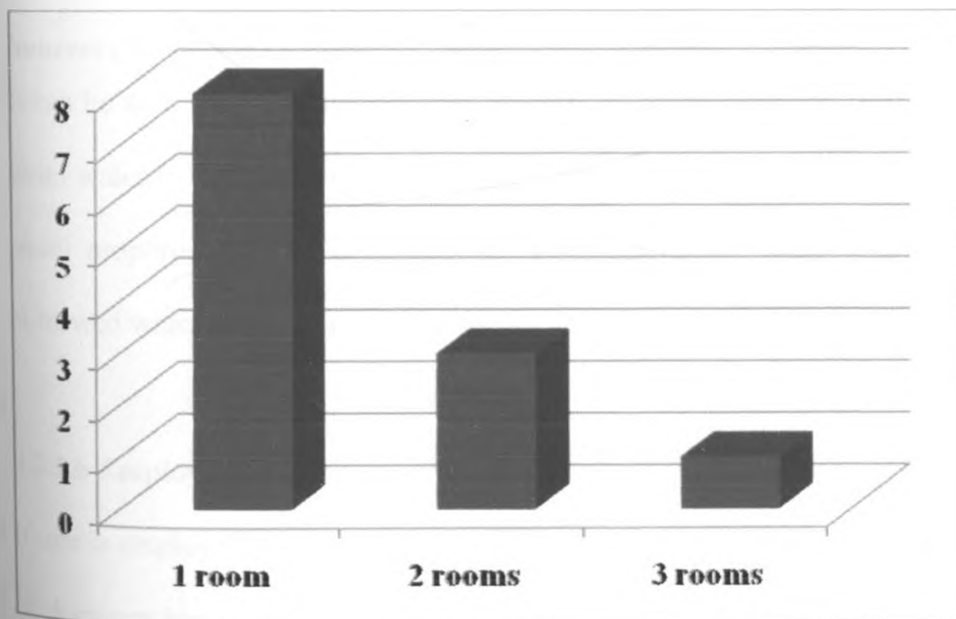
Source: (Study, 2011)

A majority of the respondents were from slum areas (93%). They had come from Kia-Michael, Kariobangi, Mathare North and Korogocho. A high proportion (50%) of these respondents came from Korogocho.

4.2.1.4 Number of rooms in the house

It was our contention that the number of rooms in a house indicates the size of the house and it can also be a proximate indicator of one's social-economic status. The more the rooms in a house the better off one is economically, Fig. 4 below shows the results of the findings. A majority of the respondents (57%) were staying in a single room. 29% were staying in a house with 2 rooms and 7 % were staying in a house with more than 3 rooms.

Fig 4: Number of rooms in the house



Source: (Study, 2011)

4.2.1.5 Source of clean water

Water is very basic to life and problem of accessing clean water can bring multiple problems and especially the issue of diseases. Accessibility to water can also be an indirect measurement of socio-economic status of a respondent. Table 5 below showed the source of clean water by the respondents.

Table 5 Source of clean water

Source	Frequency	Percentage
Communal piped water	2	14%
Borrow from neighbours	2	14%
Buy from vendor	8	57%
River	1	7%
No response	1	7%
Total	14	100%

Source: (Study, 2011)

It can be seen from the findings that majority of the respondents depended on vendors to get clean water (57%). This means they did not have piped water of their own in their houses. A small proportion (14%) depended on communal piped water while the same percentage borrowed water from their neighbours.

4.2.1.6 Employment

If one is employed one can be certain of a continuous source of income but if one is jobless or does not have a business then one is in a vulnerable state. The study investigated this aspect by asking the respondents what they were doing for a living before they came to the home for the aged. The results were as shown by Table 6 below.

Table 6. Employment of respondents before coming to the home

	Frequency	Percentage
Self employed	1	7
Jobless	13	93
Total	14	100

Source: (Study, 2011)

From Table 6 above it is clear that majority of the respondents (93%) were jobless and a negligible proportion (7%) were self-employed. This would suggest that a majority of older persons were poor.

4.2.1.7 Education

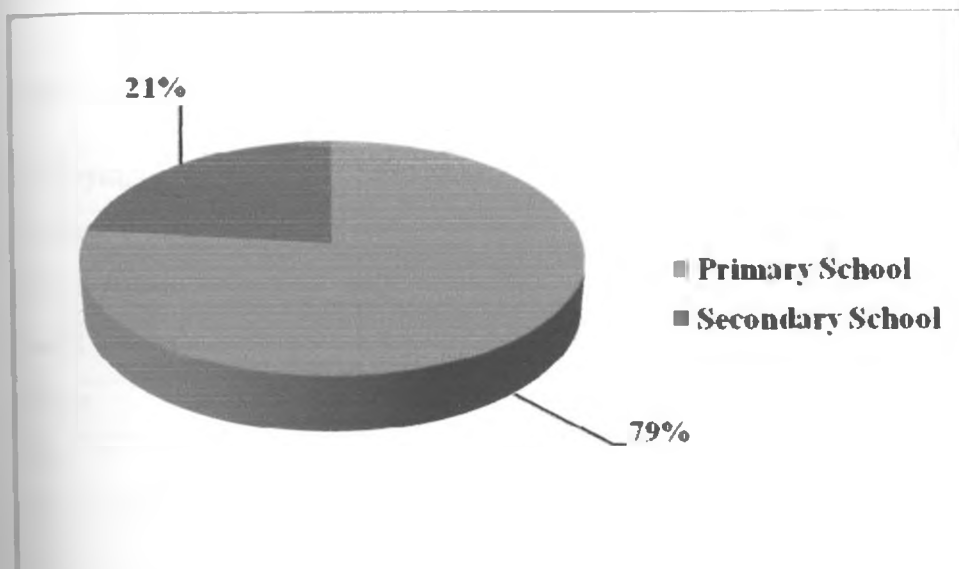
Education contributes greatly to the society as noted by Ndwiga (2004). So it is important to equip human beings with knowledge, skills, attitudes and values and this will enable proper utilization of both manmade resources and natural resources. Kenya National Adult Literacy Survey Report of 2007 commented that education is the pillar to national development. Education equips citizens with the knowledge and competencies to be able to seek gainful employment or engage in income. Investing in education is investing in the future especially during old age. Ndwiga (2004) noted that education contributes to reduction in poverty and birth rates, and it improves health status and strengthens institutions of societies especially those on governance.

The Kenya National Adult Literacy Survey Report (2007) observed that only 26.9 percent of adults had achieved the desired level requisite for making any meaningful contribution to vision 2030. It is of interest to note that literacy levels correlated with poverty levels when mapping was done according to Kenya National Literacy Survey (2007). This is very important to show the relationship between poverty and education. Holstege and Riekse

(2002) observed that older persons have less formal education than younger groups and they argued that research has shown that with education come better health and higher income.

The study posits that there is a relationship between education and poverty. Poor people are likely to be less educated. Figure 5 below agrees with this contention. According to Figure 5 a majority of the respondents were of primary school education (79%) and few were of secondary education (21%).

Fig. 5: Highest level of education achieved



Source: (Study, 2011)

The study also wanted to establish if the respondents had children. Table 7 below showed the results

Table 7; Respondents who had children

Responses	Frequency	Percentage
Yes	12	86
No	2	14
Total	14	100

Source: (Study, 2011)

Table 7 above shows that a majority of the respondents (86%) had children. The study also wanted to establish what these children do. Below were the results as showed in Table 8.

Table 8: Children's Employment

Employment	Frequency	Percentages
Employed	1	10
Self-employed	2	20
Casual labour	3	30
Jobless	4	40
Total	10	100

Source: (Study, 2011)

However, as can be seen from Table 8 above, most of these children did not have stable source of income. A high proportion (40%) were jobless and only 10% were employed. A majority of them were either doing casual labour or they were jobless which totalled to 70%.

The study went a head to establish if the children had land. Fig 6 below showed the results.

Fig 6: Children who had land



Source (Study, 2011)

According to the findings 92% of the children did not have land and only 8% had land.

From the above findings it is clear that the majority of older persons were poor as indicated by lack of land, not owning a house, living in one roomed house, living in slum areas, having a problem to have their own water source, low education, and being jobless. It is important to note that even their children were poor as shown by the study. So according to the study poverty is very critical in the institutionalization of older persons.

This study agrees with Haber (1983) who pointed out that through out the America's history, the almshouse had always served as a shelter for those who were destitute in old age. He pointed out that the almshouses served as a residence for the poverty – stricken. The study also agrees with John and John (1956) who commented that the American communities herded the sick and destitute persons into poor houses or doled out more or less sporadic outdoor relief to the poor in the homes briefly in the form of fuel and groceries. The study is

also in agreement with comments from HelpAge International in its documentary on Ageing entitled “ **Ageing issues in Africa**” a summary (2000) had this to say on poverty in regard to older persons:

In the majority of the countries worldwide but particularly in the developing countries, older people are typically the poorest members of society and live far below the poverty line. Whilst the cycle of poverty is hard to break for anyone, the challenges are even greater for older people as society ignores their needs and fails to recognize their potential so making it hard for them to change their situation.

The findings of the study also agrees with the comments of Odufuwa (2008) who commented that older persons are vulnerable from economic stress and poverty standpoint.

These findings on poverty also agrees with Father Juma who was the parish priest and who was one of the key informants and who is a doctoral holder and an advisor to the cardinal in Kenya. According to him poverty was the main cause of institutionalization of older persons He had this to say:

“Most of the people come to this home because of poverty, abandonment and having sold their land, and those who did not marry or got married.

Halima who was also the administrator of the Kariobangi Chesire Home for the aged also said

“Poverty is critical to all those who were institutionalized in the home ”

4.2.2 Family size

Large family size can be a strain to family resources and though the relationship between family size and poverty may not be a direct one always, large family size can strain a family

and especially if it is not endowed with resources. The study set out to find the family size of the respondents. Below were the results as indicated by Table 9 below;

Table 9. Family size of the respondents

Family Size	Frequency	Percentage
0-3	6	43
4-5	4	29
6-7	4	29
Total	14	100

Source: (Study, 2011)

According to our findings, higher proportion that is 43% had a family size of 0-3, while the family size of 4-5 and 6-7 had a 29% respectively. This is contrary to the expectations of the study. This is because in many cases poverty is correlated with large family size for instance, the Economic Recovery Strategy pointed out that the determinants of poverty in Kenya are house hold size, level of education of household held and access to land. Some possible reasons why high proportion of the respondent had a small family size of 0-3 (43%) while majority of the respondents had 4-7 members (57%) may be because a high proportion of them were singles (50%) and a big number were divorced or separated. So there is a possibility that before death or separation/divorce they were a young family.

4.2.3 Social Networks

With modernization and social change people have been forced by circumstances to go to cities to seek for greener pastures for instance industrial employment as observed by Macharia (2003). Life becomes very hard in rural areas and surviving on small farms can be difficult and especially on farming which is dependent on unpredictable environmental

conditions, and so cities and towns become easy exit route. Cities are seen as places of fortunes, education opportunities and existence of social networks.

The study wanted to find out if extended family networks weakened with rural –urban migration. It also wanted to find out if family members visited the respondents in the home for the aged or if the respondents were sick and the hospital bills were high necessitating assistance could the family members come to assist, or when the respondents were staying in their own house, were they staying with members of their families?

Table 10 below shows the distribution of reasons why the respondents came to Nairobi or the reasons for migration

Table 10: Reasons for coming to Nairobi

	Frequency	Percentage
To look for job	8	57
To come to this home	1	7
Business	1	7
Came to live with friends	1	7
Casual labour	1	7
Relocated	1	7
Seeking assistance	1	7
Total	14	100

Source: (Study, 2011)

According to Table 10 majority of the respondents migrated to Nairobi to look for a job (57%). Others had come to Nairobi to do business, to live with a friend, to do casual labour, and to seek assistance.

The study wanted also to find out if the respondents had cut links with their rural kins after coming to Nairobi and whether they were staying with any relative in Nairobi. Table 11 below showed the results.

Table 11. Whom they stayed with in their own house

	Frequency	Percentage
My wife	1	7
My child	2	14
Alone	9	64
Friends	1	7
Grandchildren	1	7
Total	14	100

Source: (Study, 2011)

It can be seen from the table above that majority of the respondents were staying alone (64%) and a few were staying with their children and grandchildren (21%).

The study also wanted to establish if the social networks were still existing. If the networks were still existing the relatives would come to assist during the time of crisis like sickness and especially when the financial assistance is needed to offset the hospital bills. It was necessary to establish who used to assist the respondents during such times. Table 12 below showed the results of who assisted the respondents in paying the hospital bills.

Table 12; Who use to pay for respondent's hospital bills when lastly hospitalized?

	Frequency	Percentage
Well wishers	4	44
Well wishers/respondent	1	11
Church	3	33
Friends	1	11
Total	9	100

Source: (Study, 2011)

From table 12 above, it can be seen the total is 9 instead of 14, this is because the other five respondents did not express that they had a situation which needed intervention financially since they did not require to pay the hospital bills. The great proportion of assistance

appeared to come from well wishers and the church (78%) with well wishers contributing the highest proportion (44%). It is of interest to note that family members and relatives were not involved. This may suggest weakened social networks.

The study also wanted to establish who used to take care of the respondents when they were sick and were not hospitalized. Table 13 below showed the results:

Table 13: When you were sick and not hospitalized, who used to take care of you?

	Frequency	Percentage
Neighbours	5	36
Church	1	7
Self	8	57
Total	14	100

Source: (Study, 2011)

Table 13 shows that a majority of the respondents (57%) took care of themselves when sick and not hospitalized and secondly the neighbours appeared to offer the vast form of assistance of care providers (36%). Family members and relatives were not available to give assistance to their relative in the hour of need.

The study wanted to find out if an individual's social networks with the rural areas weakened after migrating to urban areas. The findings have established that the networks weakened after an individual migrated to urban areas. How is this shown by the study?

Majority of the respondents were staying alone in the urban areas (64%) and when some of them were hospitalized it was the church and well-wishers who helped them to pay hospital bills. Family members and other extended relatives were not involved. When

respondents were sick and they were not hospitalized, they used to take care of themselves (57%) and also the neighbours came to assist (36%). Note that relatives were not involved.

According to the findings rural-urban migration weakened the kingship bonds and this greatly weakened and compromised the quality of care older persons got especially when they became sick and helpless in a “foreign” environment. Rural migrants were attracted by the possibilities that cities will offer but they ended up settling in shanties and slums and end up experiencing extreme poverty. All the respondents in the study were living in slum areas before they got admitted in the home for the aged. This is what Michael (1993) noted.

These findings agrees with Michael (1993) who further observed that modern life has affected the traditional care which the older persons used to enjoy. The geographical dispersion of families and the traditional extended family system have been affected and this has greatly affected the older persons when it came to quality care.

The findings agree with disengagement theory of aging. According to this theory freedom and ability to socialize diminish as well. Certain social networks will naturally disintegrate with age or after moving into a long term care facility like a gerontological home. This is because the amount of interaction with other people depends largely on health and mobility.

Sessional paper No 1 of 2000 on National population policy also noted that disintegration of the family system due to urbanization and poverty have rendered older persons helpless.

In a nutshell what the findings postulates is that with rural-urban migration the nuclear family is weakened and so are its social networks.

4.2.4 Access to Health Care

Health is very critical to every human being and not only to the older persons. A high proportion of those older persons admitted in the home for the aged were sick before admission. The respondents were asked what their health status was before being institutionalized. The results of the study are showed below in Table 14.

Table 14: Health status of individuals before admission to the home for the aged

Status	Frequency	Percentage
Healthy	5	36
Uncertain	3	21
Unhealthy	6	43
Total	14	100.0

Sources: (Study, 2011)

The findings showed that a high proportion of the respondents were unhealthy as indicated by 43% in Table 14 above.

This finding is in agreement with Haber (1983) who commented that most of the residents in New York's asylum were old and ailing and they had entered the poor houses in order to receive badly needed food, shelter and medical attention. Haber also pointed out that in the late nineteenth century, upon the removal of the "lazy and corrupt" the hospital-like atmosphere of the institution became dominant.

This finding is also in agreement with disengagement theory of aging. This theory contends that when people cross the threshold of old age, their bodies begin to breakdown and they gradually fall back into the care of others. According to disengagement theory of aging, old age comes with dependency. With declining health older persons behave as babies, they have to depend on caregivers to feed them, transport them and soothe their discomforts.

Accessibility to health care is very critical for lack of it can contribute to institutionalization of older persons.

4.2.5 Quality of care of older persons in the gerontological home

Quality of care of older persons is the fulfillment of the special needs and requirements that are unique to older persons. This will encompass assisted living, long term care and home care. Quality care should be maintained when it come to handling older persons in the home. The institutional home should make the residents live as good as possible in spite of their health problems, reduced level of functioning and extensive dependency. Quality of life in gerontological home should stimulate personal identity, independence, free choice and interaction with others. A high proportion of respondents had many problems before they came to the home. A high proportion of them reported having been unhealthy (43%) (refer to Table 14).

4.2.5.1 Respondents assessment of the situation in the home

The respondents assessment of the situation in the home for the aged were discussed under the following sub-headings: Leisure and social interaction, hospitality, food and activities of daily living.

4.2.5.1.1. Leisure and social interaction

The home encouraged and stimulated health social interaction. Most respondents were very happy and they enjoyed interacting with peers. Table 15 below shows the list of leisure activities older persons engaged in.

Table 15: Leisure activities older persons engaged in

Leisure activities	Frequency	Percentage
Watching T.V	4	13
Talking to Friends	11	34
Taking a walk outside the home	7	22
Giving voluntary services	4	13
Listening to the Radio	5	16
Sleeping	1	3
Total		100.0

Source: (Study, 2011)

According to table 15 above a high proportion of the respondents enjoyed talking to friends (34%), others enjoyed taking a walk outside the home, others enjoyed watching television, listening to the radio and others giving voluntary services.

Halima who was the administrator of the home corroborated what the respondents had said concerning leisure activities in the home for the aged. She said:

“The activities in the home were prayers, sitting together outside, older people seeing how food was served, talked with each other, sat together, sat in a wheelchair, watched TVs and listened to the radio”.

This finding is in line with the activity theory of aging. This theory asserts that an individual's life satisfaction is directly related to his degree of social interaction or level of activity. The activity theory emphasizes the importance of social activity. According to this theory, in order for elderly persons to age successfully and gracefully they need to actively maintain other roles such as familial roles, recreational activities, volunteer and community roles.

This finding is in agreement with disengagement theory that states that as a person ages and health declines one has to depend on caregivers for activities of daily living. The social interaction also is minimized and the older persons lose their former friends and that is why it is healthy when the home for the aged stimulates social interaction.

4.2.5.1.2 Hospitality

The home for the aged was very conducive and hospitable and the following observations and comments confirm this:

Dafina a nurse/attendant commented that she enjoyed working in the home because the older persons were very cooperative. She had this to say:

“These older persons are very obedient like small children so it is a joy to serve them”.

The researcher had an opportunity to make observation and to interact with the staff and the older persons and also to take a walk in home and this was his impression:

“The home was shockingly clean. The condition of toilets and bathroom were excellent. The condition of the kitchen and dining hall were excellent. The compound and all facilities were in good condition and the older persons interacted freely and the atmosphere was serene and friendly”.

Mrs Mars (case three) had this to say about the home:

“Thank God that I am in this home where I am appreciated. These are my real relatives, real brothers and sisters. This home is like a heaven to me. I dread the day I could be told to leave this home, where would I go, God forbid it happening”.

Mr. Venus (Case one) had this comment:

“I am happy for this home, my colleagues are friendly. The rooms are

very comfortable and the staff are friendly and I feel at home. I would have died along time ago if I was not brought to this home!.

This finding is in agreement with Haber (1983) who quoted the chaplain of the New York almshouse (renamed City Home of the Aged and infirm in 1903) who said:

“What can a man or woman aged and infirm look for in life, more than a warm room and clean comfortable beds to sleep in a good wholesome and varied food to eat, a church to go to, plenty of papers, magazines and books to read”

4.2.5.1.3 Food

Food is very essential to health and more so to the older persons and so the study wanted to establish how the respondents felt about food in the home. Table 16 below shows the findings:

Table 16: Quality and Quantity of food

Quality and Quantity of food	Frequency	Percentage
Good and Adequate	13	93
Good but not adequate	1	7
Bad and inadequate	0	0
Total	14	100

Source: (Study, 2011)

According to table 16 above a majority of respondents were getting good and adequate food (93%), 7% said they got good but inadequate food and none said was getting bad and inadequate food.

Halima the administrator of the home had this to say on the issue of food:

“For the 12 years I have been incharge of this home no one has been sick due to malnutrition

apart from older person's diseases like arthritis and bone problem"

Mr. Venus (Case one) on the issue of food commented this way:

"I am happy for this home, my colleagues are friendly. I get good food and tea and I am assisted to move around....."

This finding is in agreement with Haber (1983) who quoted the chaplain of the New York almshouse (renamed City Home of the Aged and infirm in 1903) who said

"What can a man or woman aged and infirm look for in life, more than a warm room and clean comfortable beds to sleep in a good wholesome and varied food to eat,"

4.2.5.1.4 Activities of daily living

The respondents in the home were happy that they were being assisted in the activities of daily living. Those who were not able to dress themselves because of their condition were assisted, those who could not be able to bathe were assisted and those who were not able to feed were assisted. They were also assisted with taking medication.

The study wanted to find out the aspect of clothing/dressing and Table 17 below shows the results.

Table 17: Dressing/clothing

Response	Frequency	Percentage
Yes	9	64
No	5	36
Total	14	100.0

Source: (Study, 2011)

According to table 17 above, 64% of the respondents had a problem to dress themselves because of their condition and this is a majority of the respondents. But they were assisted by the workers in the home. This is just one of the many activities of daily living.

Mr. Venus (Case one) commented on the activities of daily living:

"I am happy for this home, my colleagues are friendly. I get good food and tea and I am assisted to move around. The rooms are very comfortable and the staff are friendly and I feel at home. I would have died along time ago if I was not brought to this home!."

This finding is in agreement with Haber (1983) who quoted the chaplain of the New York alms house (renamed City Home of the Aged and infirm in 1903) who said:

"What can a man or woman aged and infirm look for in life, more than a warm room and clean comfortable beds to sleep in a good wholesome and varied food to eat, a church to go to, plenty of papers, magazines and books to read"

This finding is also in agreement with Holstege and Riekse (2002) who commented that older persons needs includes being assisted with activities of daily living, spiritual support and healthcare which might have taken an abrupt downturn after an illness or accident and requires medical attention and hospitalization. They also commented that older persons need to be shown tender feelings and also to take more time with them. They need to be assisted on when to see a medical specialist. In a nutshell Holstege and Riekse have pointed out that the major services which the caregivers give to older persons are activities of daily living such as bathing, dressing, getting in and out of chairs and helping them with medications.

The finding is also in agreement with disengagement theory that states that as a person ages the health declines and has to depend on caregivers for activities of daily living. The theory states that when people ages they are likely to be dependent like babies and they have to be assisted and the older persons loose their friends and that is why a home for the aged will provide the much needed care in the activities of daily living.

4.2.6 Case Studies

4.2.6.1 Introduction

Case study referred to the collection and presentation of detailed information about a particular participant or small group. It is a form of qualitative descriptive research and the case study looks intensively at an individual or a small group and drawing conclusions only about that participant or group and only on that specific context. Case studies are the preferred strategy when how and when questions are asked. It is also preferred when there is a contemporary focus within a real life context.

The study focused on four cases of older persons. The chronological age of the respondent and the duration of the stay in the home were critical factors on top of considerations like not being senile, willing to participate in the research, not being sick and able to communicate. Each of those respondents had a story to tell about their life, what happened that they ended in the home and their experiences in the home. These four cases were utilized to enrich the findings. The four case histories had one man and three women. These cases covered abandonment, social networks, access to health care and poverty.

4.2.6.1.1. Case one: Social network

The respondent was abandoned by the family members after migrating to Nairobi. When he became sick he had no one to take care of him and he ended up in the home for the aged.

This is a case of weakened social networks. Below is the story of Mr. Venus:

Mr. Venus is an old man aged 82 years and he is the oldest member of Kariobangi Chesire Home for the aged. He comes from Central Province and he did not have an opportunity of attending school. He is a victim of Mau Mau freedom war. A few years after the war started

he suffered a misfortune which still traumatizes him to date. He lost his two sons and his wife but he managed to escape. He sold his piece of land and came to Nairobi. Though the incident happened many years ago it is very vivid in his memory and he is very much traumatized. He laments:

*“ I do not want to remember that incident.
Imagine being in the world without children,
wife or land, but thank God I am alive ”
He breaks down into tears.*

Despite this misfortune he managed to pick up the pieces. He came to Nairobi and started a shoemaking business and he also got married and got one son and two daughters. With time he started having chest problems and his health deteriorated and so was his business. The wife ran away with their two children. He was impoverished, forsaken and neglected.

While the social workers were in their routine work in the slum where Mr. Venus lived, the neighbours referred him to them for they were worried he was living on borrowed time after he had exhausted their generosity. The social workers brought him to Kariobangi Chesire Home for the aged. He does not know where his wife and children went. However he feels relaxed and happy though he feels that life has been unfair to him.

He comments:

*“I am happy for this home, my colleagues are friendly.
I get good food and tea and I am assisted to move
around. The rooms are very comfortable and the
staff are friendly and I feel at home. I would have
died along time ago if I was not brought to this home!.*

Case analysis

According to this case Mr. Venus ended in Kariobangi Chesire Home for the Aged because of poverty especially after his business collapsed and sickness set in. He was not educated and did not have land. His migration to Nairobi delinked him from his extended family

members. He ended up in the home for the aged but he is happy with the quality of care he is getting.

The finding is in agreement with disengagement theory of aging which states that as a person ages and his health declines he becomes dependent on caregivers. With old age and declining health, you are likely to lose your close friends and family members. The social networks become weak with the weakening nuclear family which has been worsened by rural-urban migration.

4.2.6.1.2 Case two: Access to health care/poverty

The respondent was abandoned in the home because the family members could not afford to access health care because of their poverty. Below is the story of Mrs. Pluto.

Mrs. Pluto was born and brought up in Western Kenya and she is in her mid seventies. She is a widow and she has never attended school. She has three sons and two daughters. One of her daughters is married to a man who lives in a middle class estate in Nairobi with his family. Mrs. Pluto was left alone in her rural area tending to her small shamba to get daily bread. But as fate would have it she suffered stroke and was put on a wheelchair. Her daughter and her son-in-law decided that she should relocate to Nairobi for quality care but this ended up to be the stepping stone to Kariobangi Chesire Home for the Aged.

Her daughters who knew the existence of Kariobangi Chesire Home for the Aged decided to take their mother there, but they impressed upon her that she should not disclose she was their mother, but she should say that she was their aunt. They expressed to the administrator of the home how they have been overwhelmed by taking care of their "aunt" and how they

had reached their maximum and also considering her medical condition. "Aunt" was admitted to the home.

After sometime a young man came to see how "aunt" was fairing. Upon some questioning by the administrator of the home, the young man revealed that he was coming to see his mother in-law and those who brought her, one was his wife and the other a sister in-law. The young man told the administrator that it had become very challenging to take care of his mother in-law because of her deteriorating health condition and the state of poverty at home. He told the administrator of the home that he is overwhelmed because he is educating his three brothers in-law in the university and he is very sure after they complete their education and they get a job they will come for their mother. He laments:

"We feel very guilty for keeping our mother here and that is why my wife did not come with me, but what can we do?"

Analysis of the case

Mrs. Pluto ended up in Kariobangi Chesire Home for the Aged because of her deteriorating health condition. She needed special care and treatment of which her immediate family could not afford. On top of poverty it emotionally stressed them. Her three sons had come to Nairobi for their university education and so taking care of her was a challenge. From this case it may seem as if the daughters were very inhuman but listening to the reasons why they did what they did may make you change your view and judgment.

This finding is in agreement with John and John (1956) who commented that the American communities herded the sick and destitute persons into poor houses or doled out more or less sporadic outdoor relief to the poor in the homes in the form of groceries and fuel.

This study is also in line with disengagement theory that states that as a person ages the body system weakens and has to depend on caregivers for activities of daily living. The level of dependency is high with old age and especially when one is sick.

4.2.6.1.3 Case three : Abandonment

The respondent was abandoned by the sister because of sickness and also because her sister was poor. This is a case of abandonment necessitated by poverty and sickness. Below is the story of Mrs. Mars:

Mrs. Mars is an elderly lady aged about 75 years and she comes from Central Province she did not have any formal education. She was married but was divorced because she could not bear a child. She relocated to Nairobi to stay with her sister. She stayed there for sometime assisting her with her household chores. She has three brothers who are in abject poverty and they are jobless. When Mrs. Mars became sick with diabetes, her sister could no longer contain her. When she became sick she lost her value. After all her sister could not afford medication and special diet. She was also poor and lived in the slums. Her sister told her to leave her house and try her luck somewhere else. Where was she to go? She had to spend in the streets. The chief of the area found her in the street and took her to Kaiobangi Chesire Home for the Aged where she was admitted.

Mrs. Mars laments:

"My sister threw me out, my brothers did not care and my husband chased me away because I could not give birth as if it was my fault. Thank God that I am in this home where I am appreciated. These are my real relatives, real brothers and sisters. This home is like heaven to me. I dread the day I could be told to leave this home where could I go,

one of her relatives come to visit her.

Analysis of the case

This finding is in line with disengagement theory of aging. Mrs Mars became sick and helpless. According to this theory, when people cross the threshold of old age, their bodies begin to break down and gradually fall back into the care of others. According to disengagement theory, old age comes with dependency. With decline in health and mobility the circle of social networks declines and it becomes worse with poverty.

2.6.1.4 Case four: Poverty /Social Networks

The respondent was abandoned because of his declining health and poverty. Below is the life story of Mr. Jupiter.

Mr. Jupiter is an old man aged 70 years and comes from Eastern Province. He does not have any formal education. He was married and had two sons. He had a piece of land in his rural area but he sold it and once he did that, his two sons were very bitter and he was beaten and he relocated to Nairobi. When he came to Nairobi he had a lot of money, after all he had sold the land. So he engaged in a life of leisure engaging in wine and women, and with time he had exhausted his money.

He used to live in a middle class in Nairobi but with his fortune having taken a downward trend he had to relocate to a slum area. The women whom he had during his good days disappeared. After all how could they stay with somebody who was broke? While in the slum he contracted tuberculosis (TB) and his health declined. There was nobody to take care of

him for he was staying alone. The community started taking care of him but with time they could not care for him any longer, so they brought him to the home because he was sick and nobody to take care of him any longer. Nobody from his family comes to visit him.

Analysis of the case

Mr. Jupiter ended up in Kariobangi Chesire Home for the Aged because of his poverty which was as a result of declining fortune and having sold his land. His deteriorating health and yet nobody to take care of him finally made him to be admitted to the home through community intervention.

The findings of the case are in line with disengagement theory of aging. The theory states that with old age comes declining of the body due to poor health and low immunal system. So there is a tendency to become dependent on caregivers for your survival. You may not have energy to manage your businesses if you had some. You are likely to loose even your close friends and so your network of friends narrows as they tend to disappear because of your too much dependency. It even become worse if your mobility is a challenge or if you have to be assisted with activities of everyday living like being fed, dressing, bathing or being taken to the toilet. This is why a gerontological home come would be great assistance in such cases.

4.2.7 Discussions on the findings

4.2.7.1 Care of older persons in a society in transition

Kenya is a society on transition. It is changing very fast and the demands of a capitalistic economy is overburdening the population. The capitalistic system has brought the cash economy, modern education and industrialization. These changes have led to rural-urban migration as people migrate to urban areas either to look for employment as the study

revealed that most of the older persons who came to Nairobi came to Nairobi to look for jobs, others migrated to trade or to do business. Others migrate to cities because of the misguided notion that cities are places where money, goods, services and wealth are concentrated, and ironically they end up in slum areas as many of the respondents in the study did. Cities are also seen as places of fortunes, education opportunities, entertainment, health facilities and places to run to after having done embarrassing things in your rural areas. This is because anonymity and indifference of urban areas will be ideal for this sort of unbecoming behaviour. With urbanization and industrialization, sudden changes are felt in all spheres of life and especially the family. The community structures and extended family system is weakened rendering it ineffective as a social security system. Older persons have found themselves in a predicament. They find themselves in a society which is not fully rural or fully westernized. They find themselves in a state of dilemma.

The findings of the study has proved that social change and transition of the society have left older persons in a precarious state. During the time of need especially when the respondents were sick, majority were being taken care of by the neighbours and not relatives or immediate family. When they were hospitalized it was the church and well-wishers who helped them to settle bills. This is a clear indication that since they came to Nairobi they had had cut ties with their rural folks.

All in all when those persons migrated to Nairobi and later their fortunes declined or became sick the quality of care was greatly compromised. This is because in the traditional society, care of the older persons or members of the family was shouldered by the family but now it has been weakened. Now it is the church and good neighbours who step in to assist during

hard times when one is in urban areas and the social networks have been delinked or weakened.

4.2.7.2 Care of older persons and poverty

According to the findings of the study poverty is a critical feature of the older persons. Majority of the respondents came from their rural areas to look for jobs and majority ended up in slum areas where life was miserable. Life in the slums was a challenge. Majority were living in single rooms. They had problem to get water for bathing and domestic needs. Accessing toilets and bathrooms was not easy. Getting good and adequate food was a problem. Majority were living alone and they had delinked themselves from their rural kin.

Majority of the older persons were very poor, had no land, no job or stable businesses. Their children were also poor and did not have stable source of income. Majority of the respondents had low education that is primary education or no education at all. Education is very important in life. Many studies have linked education to income, birth rate, improved health and improved governance. Education equips citizens with the knowledge to be able to seek gainful employment or to engage in income generating activities. Education empowers citizens to participate in social and political decision-making processes, enjoying their fundamental rights and enabling them to lead a dignified life. One of the respondents was divorced because she could not give birth. If she had reasonable education, her life could probably have taken another dimension. In a nutshell majority of the respondents were very poor and their children who could have taken care of them were equally poor. To make matters worse, to many of the respondents their spouses were nowhere to be seen.

In the four cases analyzed there were emerging themes or issues which seemed to be recurring and these were poverty, poor access to health care and weakened social networks. These recurrences suggest there is a relationship. They suggest that there may be cause – effect relationship between poverty, poor access to health care and weakened social networks though it may be difficult to establish the direction. Is it weakened social networks that led to poverty, then poor access to health care and finally being admitted to the home for the aged or is it poverty that led to weakened social networks, which finally led to being admitted to the home for the aged?. Whatever the direction of change, poverty and breakdown of family is a reality at nuclear level. This makes care of older persons a big challenge especially when their health declines. The study has established that care of older persons is a big challenge facing our society. Poverty, and access to health care is a reality of life in our society.

4.2.7.3 Quality of care in the home for the aged

Older persons have special needs. They need specialized care and in many cases special diet. They need quality care which they cannot get either from house girls or houseboys.

When these older persons were taken to the homes for the aged they got quality care. They were assisted in bathing, washing clothes, mobility, feeding and even those with toilet problems were assisted. They felt appreciated, loved and well-cared. They were sure at last somebody cared. There were mutual concerns for each other. They were sure of medical care and so they did not have to worry and no wonder the chaplain of the New York city Home of the Aged and infirm commented:

"What can a man or woman aged and infirm look for in life, more than a warm room and clean comfortable bed to sleep – good wholesome and varied food to eat, a church to go to, plenty of papers, magazines and books to read?"
(Haber 1983).

The challenges of the modern society especially the aspect of health care is a fact the society cannot afford to turn a blind eye. Health, quality care, especially activities of daily living and also someone to keep them company are critical needs of older persons. The issue of company is very important to older persons. No wonder one of the respondents had this to say:

*“When I used to be left at home alone,
I used to feel like a spare tyre”.*

In our traditional society there are taboos and mores governing our behaviour. Many of the older persons had suffered stroke and so their motor skills were impaired. If one was unable to dress or wash it became a challenge for the immediate family to wash their father, grandmother, grandfather, or mother but in the home for the aged this aspect is well handled. There are men workers to assist older men and women workers to assist older women in matters of dressing, bathing or if other intimate needs arises. The study has established that the older persons in the gerontological home gets quality care and they are happy, no wonder one respondent commented:

*“To me the home is like a heaven, I don't know
what would happen if I am told to leave”.*

4.2.7.4 Abandonment

According to the findings most of the older persons were abandoned by their family members when they became sick. It might have seemed a if that was a very in human act but one has to appreciate that taking care of the old and sick persons is not a role for faint hearted.

Care giving and quality one for that, matter is not easy. Caregivers can end up getting depression, frustration, insomnia, demoralization, guilt, feelings of helplessness, irritability, lower morale and emotional exhaustion. Women for example have multiple roles: These multiple roles leads to stress. Many of them sacrifice their own leisure, interests and social

lives along with time spent with their immediate families. Many end up neglecting their own health which results in inability to continue as caregivers. In spite of personal resolve and support it is important for caregivers to know when they have reached the limit of their care giving abilities. They should not sacrifice their own families or their own health to all-consuming care giving.

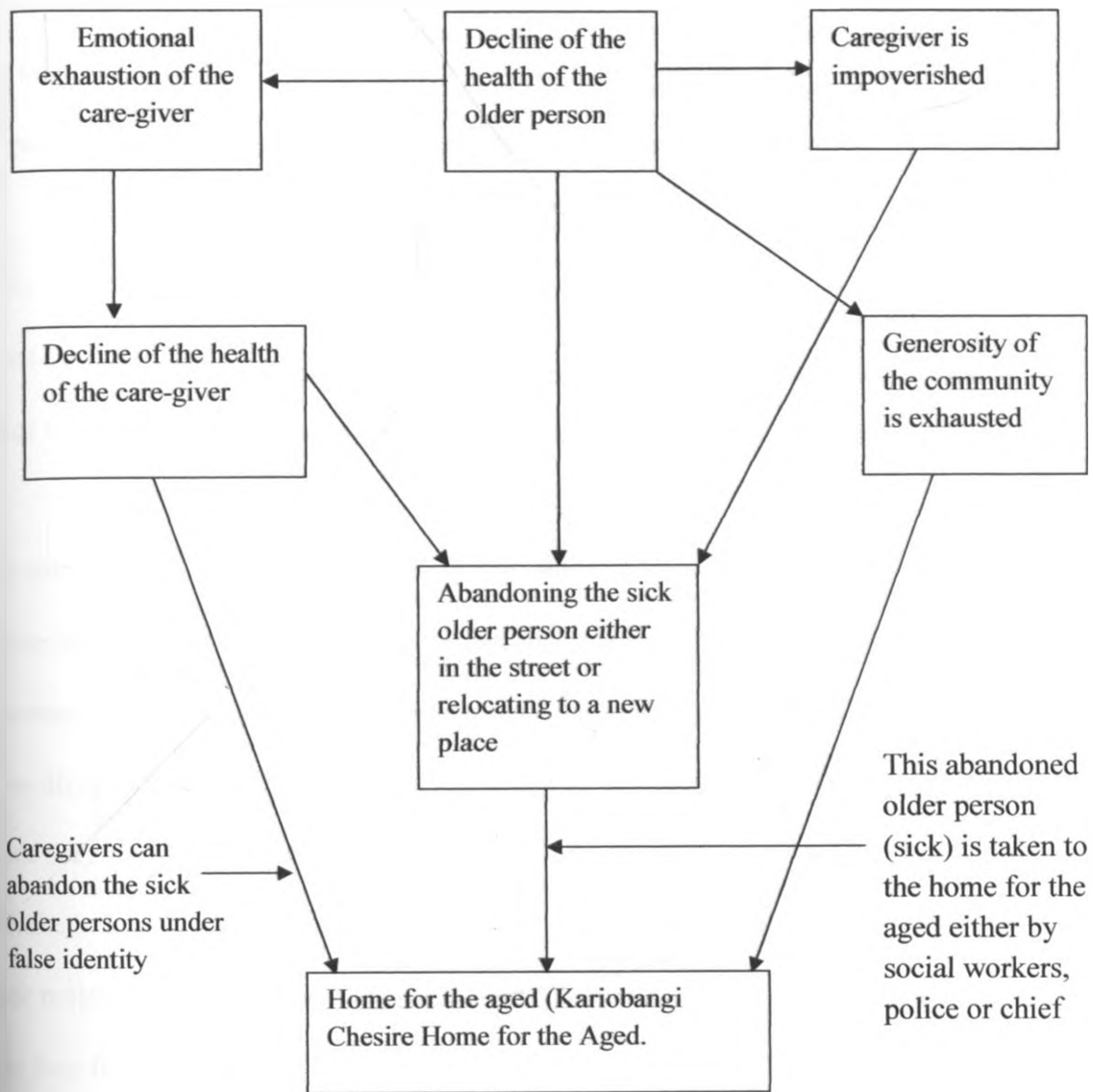
Care givers can reach a stage where they can no longer cope due to elders multiple and/or progressively serious health conditions. When they experience burnout it is high time to seek additional support. A woman may be expected to be a mother, a wife, grandmother, home maker, and paid employee. She may occupy all these roles or most of them. She is expected to clean the house, fix meals, wash clothes, provide disciplines and structure for youngsters, encourage and support her husband, offer moral and spiritual training to children, put out "emotional brush fires", and to look after an old man or woman and sometime to make sure they have taken drugs, eaten and also to see the doctor. They seem to be everywhere and everything. Weight of load may affect marriage, personal health, and emotional equilibrium of the carer. Dependency may affect the resources of the care-givers. This could threaten the family's lifestyle. The personal dreams may be delayed because the medical costs for the aging loved ones end up eating away the savings and peace of mind.

The care-giver can end up feeling frustrated or even resentful. There could be new restrictions on personal freedom and time, and new demands competing with personal goals. Tensions may mount not only with immediate family but also between the caregiver and the siblings. The caregiver may debate or quarrel with siblings about decisions concerning the elders healthcare, living situation or possessions.

Perhaps becoming a caregiver has coincided with retirement. Just when one expected to be free of work obligations, instead of enjoying grandchildren, travelling and hobbies you are facing more work, this time the practical tasks of care-giving, or perhaps one is in the middle of working years and the children have only recently become independent. One has been looking forward to having time for other things, a delayed vacation, catching up on time with your spouse, re-romancing your marriage, starting your own business, catching up on your sleep, or just having time to sit in a chair and do nothing for once in your life.

This wearing down and burnout of caregivers in term of emotion and resources may be the reason family members abandon their older persons who are sick, or they use deceptive means to make them admitted in the home by hiding their real identity or their real relationship they have with the older person. Figure 7 below can help to explain possible reasons on how most of the older persons ended up in the home.

Fig 7. Pathways to Kariobangi Chesire Home for the Aged



Source: (Study, 2011)

According to the above diagram, it can be explained how the older persons ended in Kariobangi Chesire Home for the Aged. When the health of the older persons decline, there is emotional exhaustion of the care giver. This emotional exhaustion leads to the decline of health of the care giver. The care giver has two options;-

- i. To abandon the sick older person either in the street or re-locating to a new place.
- ii. To take the sick older person to the home under false identity

It can also be seen with the decline of health of the older person, it leads to the care giver being impoverished in terms of resources and so he abandons the sick older person either in the street or relocating to a new place. Now with the abandoned sick older persons, they can be picked by either the police, chief or social workers and taken to the home for the aged.

With the decline of the health of older persons who has been abandoned, the community takes care of the person. But with time the generosity of the community is exhausted and they takes the older person to the home for the aged.

Chronic poverty pervaded the lives of the older persons who were in Kariobangi Chesire Home for the Aged. The older persons had lost touch with their families and so there was no emotional attachment. When the older persons became sick, and their fortunes had taken a nose dive, medication became a challenge and so external support was the answer. After all, since they migrated to Nairobi they delinked from their rural homes. It is not that the family members do not want to assist but they do not have the capacity or they may have depleted their resources together with their emotional strength, like the case where the son in-law said that they felt guilty for keeping their mother in the home but what could they do in the midst of chronic poverty and emotional demands tied with special care.

In a nutshell the study shows that our society is changing very fast. Western societies changed and stabilized and that is why they have elaborate welfare systems to take care of their older persons. The challenges in Kenyan society is enormous. Taking care of the older persons at home level and giving them quality care is a daunting task.

Ideally home based care is good because it has certain advantages:

- For instance you do not need to relocate the older person to unfamiliar environment.
- They can be able to interact freely and with ease with family members as the language is not a problem
- The older persons can be able to enjoy their traditional foods unlike the institution.
- It is easier for members of extended family to visit them without feeling guilty unlike the institution.
- There are no administrative costs involved in home care.

Home based care for older persons is the best but it is no longer tenable because of the prevailing circumstances. Families have fragmented and poverty is a reality in Kenyan. When older persons become sick they need special care and also good medication, the immediate and extended family members may be unable and so they require support from somewhere. It is not that they hate their older members but resources and emotional strain and burnout cannot allow. So a way out has to be found which is pragmatic and accepting the reality of our times. The study has shown that poverty and poor access to health care and weakened social networks were critical factors when it came to admission of older persons to the homes for the aged.

4.2.8 Study Limitations

The study limitations are digression, home schedule, sickness, confidentiality and scarcity of secondary data.

4.2.8.1 Digression

Most of the respondents had a lot of stories to tell about their lives and they ended up digressing from the question and this affected time one had to take interviewing one respondent. This much talking was an indicator of how involved the respondents were and also shows that rapport was created.

4.2.8.2 Home schedule

The schedule of the activities in the home especially the aspect of prayers which was three times a day, affected the period of data collection.

4.2.8.3 Sickness/illness

Sickness of the potential respondents affected the sample size. Initially the study intended to have 20 respondents but it ended up having 14 respondents for the other 6 potential respondents were sick. On the part of the key informants the study intended to have 10 but it ended up having 3 key informants because of unavailability on their part due to scarcity of time.

4.2.8.4 Confidentiality

Confidentiality of data was another barrier that was faced during the conducting of the study. Every organization has their own secrecy that is not revealed to others. Kariobangi Chesire Home for the aged was not exceptional.

4.2.8.5 Scarcity of data

Scarcity of secondary data and publications on the area of institutionalization and care of older persons made triangulation using available data a challenge.

CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summaries of the findings, conclusions, recommendations, and areas for further research.

5.1 Summary of the Findings

The objective of the study was to find out factors that contributed to institutionalization of older persons and also to establish the quality of care those older persons got in the gerontological home. The study established that poverty, weak social networks, and poor access to health care contributed greatly to the institutionalization of older persons. The findings of the study also established that institutional care enhanced the quality of life for older persons.

According to the study gender did not contribute to the institutionalization of older persons. Apart from the case (case No. 3) who was divorced because she could not give birth, out of the four cases presented there were no other gender issues related to the institutionalization. Not forgetting out of the four cases presented three were women. The study also established that the family size did not influence the institutionalization of older persons. A high proportion of the respondents had a small family size of 0-3 (43%) while those with 4-7 members totalled to 57%.

5.2 Conclusion

Based on the study it can be concluded that the major findings of the study were that older persons found themselves in institutional care as a result of poverty, loosened social networks, poor access to health care, deprivation, discrimination and abandonment.

5.3 Recommendations

The recommendations on major findings are poverty, access to health care, social networks and abandonment.

5.3.1 Abandonment

According to free online dictionary, Thesaurus and Encyclopedia, abandonment is defined as withdrawing one's support or help from especially in spite of duty, allegiance or responsibility, that is to desert (www.international-divorce.com). The study has established that almost all the older persons in the home for the aged were abandoned by family members. They were abandoned either in the streets or in the home for the aged. This abandonment came up as a result of the caregiver experiencing emotional burnout or depletion of resources. The four cases who gave their stories confirmed this. Abandonment is a phenomenon which will be with us for a very long time. Based on this, the study recommends the following;

5.3.1.1. Public Homes

Public homes for the aged to be established in every county. These institutional homes will take care of the older persons whose relatives are chronically poor and they require quality care and specialized medical attention. The government can fund the construction and management of those gerontological homes.

5.3.1.2. Private Homes

Private sector can be encouraged to have high class homes to take care of older persons from well to do families or those older persons who can be able to sponsor their stay. If older persons are taken to these homes for the aged they will save their caregivers emotional burnout, resource depletion and cultural barriers associated with activities of daily living to older persons like dressing and bathing them.

5.3.1.3 Funding

The government should commit itself to financing from the exchequer the Faith Based homes for the aged. This will improve the capacity of those faith based homes enabling them to take more cases of abandoned older persons.

5.3.2 Poverty

Without income it is difficult to attend to a number of things including the basics of life. If one is poor even health can be compromised. If one is sick it may be difficult to afford even medication or to afford the services of a good doctor. Getting basics of life like food become a daunting task. The study found majority of the respondents were poor and based on these finding the following are recommended;

5.3.2.1 Pro-Poor Programmes

The government should come up with pro-poor programmes. These programmes should be geared towards empowering the poor people and this aspect should be considered from the planning stage.

5.3.2.2. Affirmative Action

Affirmative action is a deliberate move undertaken to correct a certain omission or commission which might have been occasioned either, by historical circumstances, cultural or geographical, but it has a time aspect. If the situation is corrected, then the affirmative action stops. On this line it is recommended that if there are new opportunities in terms of employments a certain percentage for example one percent can be preserved either for the poor persons or their children. This will apply if there are any resources to be distributed to the general populace.

5.3.2.3. Building Capacity of Men and Women

They should be trained in the skills, methods, knowledge and leadership needed to take self-reliant actions so they can meet their own basic needs, improve their communities and build better futures for themselves and their children.

5.3.2.4. Implementing Income-Generating Activities

Groups to be encouraged to join together in self-help groups which are focusing on income-generating projects. They should attend workshops to learn new and innovative methods of increasing household income through value-adding strategy.

5.3.2.5 Manage Food Banks

People are empowered to create, stock and manage their own food banks at the community level. This helps to stabilize day-to-day food prices in local markets during times of crisis.

5.3.2.6. Agricultural Improvement

Farmers should be given appropriate farming technology and farm inputs, such as improved high-yield variety seeds and fertilizer. This enables small-scale farmers to not only improve crop yield but also to diversify crops, which is critical to ensuring food security in their communities. These inputs should be subsidized.

5.3.2.7 Access to Credit

Credit should be readily accessible to farmers. The focus should be on women. Women should have easy access to credit, increase their food production, engage in income-generating activities, and increase their savings. They should have easy access to microfinance institutions and other organizations. Women can deposit a certain percentage of their loan principal into a savings account, thereby creating a strong culture of savings within communities. Women will finally use their new wealth to improve the health, education and nutrition of their families.

5.3.2.8 Infrastructure

The government should provide rural electricity which is subsidized to assist people of low income to start cottage industries. Provision of water in rural areas will help in rural agriculture. Government tractors should also be stationed in every ward so that farmers can hire them at reduced rates.

5.3.2.9 National Social Security Fund

The government should encourage those people in the informal sectors to join National Social Security Fund. Serious sensitization can be done by the government encouraging the members by topping up the same amount members have contributed.

5.3.2.10 Preparing for Retirement

People should be advised to prepare for retirement early through the following:

- Developing a culture of savings and to be prudent in financial management.
- Planning your family well (you should not have a small child when you are about 60 years)
- Investing in real estates (rental houses and houses to sell)
- Building a residential house or buying one.
- Investing in premium bonds
- Investing in shares.

5.3.2.11 Confidence Building Programmes

Programmes should be planned which are geared towards building confidence and shifting people's mind-set from one of dependency on outside help to one of self-reliance. The individuals or community should feel empowered to solve their own problems and make a difference in their villages. This change in mindset should manifest itself in an increased capacity to deal effectively with crises when they occur.

5.3.3 Social Networks

According to Wikipedia a social network is a social structure made up of individuals or organizations who are connected or tied by one or more specific types of independence such as friendship, kinship, common interest, financial exchange, dislike, sexual relationships or relationships of beliefs, knowledge or prestige. The rural-urban migration has weakened nuclear families, and as a result have weakened the social networks. This weakening of social networks have hence affected the quality of care of older persons especially when they became sick. The following recommendations will strengthen the social networks:

5.3.3.1. Infrastructure

Infrastructure in the rural areas should be improved, that is road networks, electricity and water systems. The government should address the issue of rural-urban dichotomy which fuels rural-urban migration. This means it should address the issue of uneven development and resource allocation. The government should allocate more resources to rural areas and also equalization fund to be given to all those areas which have lagged behind. This means the government should attempt to make rural areas attractive and places of opportunities. Improvement of infrastructure will make rural areas attractive and so those migrants in urban areas will be able to visit rural areas frequently as it will be affordable and convenient once roads are improved. This will improve the social networks.

5.3.3.2 Investment in Rural Areas

Private developers who are willing to invest in rural areas by constructing universities and hospitals should be given waivers in terms of tax concessions. Those people who have migrated to urban areas should be encouraged to invest in rural areas. They should be admonished not to forget or neglect the rural areas they came from. When investment opportunities are opened in the rural areas, those who had migrated to urban areas will be encouraged to invest and this will mean they will be more frequent in their rural homes and this will strengthen the social networks.

5.3.3.3 Social Capital

The social capital can be used to measure social network. Social capital according to Wikipedia (en.wikipedia.org/wiki/social-capital) is the value that an individual gets from the social network. If the social capital is strong it means that the social network is strong. If social networks are weak so is the social capital.

For those who have migrated to urban areas to get maximum social capital, they should invest in social networks through the following:

- Frequent visits to rural areas
- Attending family meetings especially family get together and especially during public holidays.
- Make sure if there is fundraising in your village for education or medical, building schools or churches send your contributions if you are not able to attend.
- Attend weddings and funerals in your village
- When your kins come to the city assist them with bus fare back if they are in need and also accommodate them for the short time they are in the city.
- Be a member of welfare groups in the city especially those of members from your village or area.

5.3.4 Access to Healthcare

Access to health care impacts on the overall physical, social and mental health status, prevention of diseases and disability, detection and treatment of health conditions, quality of life, preventable death and life expectancy.

Disparities in access to health services affect individuals and society. Limited access to health care impacts people's ability to reach their full potential and negatively affecting their quality of life. Barriers to services include: lack of availability, high cost and lack of insurance coverage. These barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services and hospitalizations that could have been prevented.

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The study makes the following recommendation on coverage, waivers and subsidy:

5.3.4.1 Coverage

Health insurance coverage helps patients get into the health care systems. Uninsured people are less likely to receive medical care, more likely to die early and are more likely to have poor health status. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Based on this argument the government can pay insurance premiums to some insurance firms so that they can cater for the very poor who can be identified and they are given identity cards (Smart cards).

5.3.4.2 Waivers

The ministry of health should give special waivers to the older persons who are sick and they cannot be able to pay for their treatment. They should be given exemptions.

5.3.4.3 Subsidy

In many cases older persons condition can lead to mobility problems. Arthritis and stroke are common among older persons. Older persons need wheelchairs, walking sticks and other special devices to assist them. The government should organize so that these devices are available and affordable to older persons. These devices including wheelchairs should be subsidized so that the older persons don't suffer.

5.4 Areas for Further Research

The following areas are recommended for further research.

5.4.1 Place of Origin

Further research should be carried out to find why majority of older persons in Kariobangi Chesire Home for the Aged were from Central Province of Kenya.

5.4.2 Marital Status

Research should be carried to find out why most of the older persons in Kariobangi Chesire Home for the Aged were 'single'. Majority were either widowed, separated, divorced or single. Very few were married.

5.4.3 Comparative Study

A comparative study need to be conducted in an institution in a rural setting and compare it with one in an urban setting to find the aspect of quality of care of the older persons. A similar study should also be done to compare the quality of care older persons get in faith based homes and one sponsored by the state.

5.4.4. Caregiver and the Older Person

A study should be carried out to find how the family of the caregiver was affected by taking care of an older person.

5.4.5 Abandonment

A research should be carried to find out in depth why those older persons were abandoned. Was it because of failing health, dwindling fortunes, or the excessive demand on the care giver in regard to activities of daily living?

5.4.6 Home based Care Versus Institutional Care

A study should be done to find out what the general population feels about institutional care vis a vis home based care, that is solicit their views.

5.4.7 Gender

A study should be conducted to find out why there were more women than men in the home for the aged.

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Standard Newspapers of 31 August 2011.

APPENDIX 1

UNIVERSITY OF NAIROBI
FACULTY OF ARTS
DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK
RESEARCH QUESTIONNAIRE

DATE.....

Kariobangi Chesire
Home for the Aged

1. Questionnaire number (Name optional).....
2. Sex : Male Female
3. Year of birth.....
4. Which is your home district/county?
5. Religious affiliation Catholic Protestant Muslim
Others (specify).....
6. Marital status : Married Separated widowed Single
No response
7. What is the highest level of education achieved? No formal education
Primary school Secondary School College University
8. Where were you before coming to the home?
Nairobi Mombasa Kisumu Nakuru Eldoret
Other towns (Specify).....
9. What is your family size?
10. How long have you been in Nairobi?
- (0-5yrs) (5-10yrs) (10-15yrs) (15-20yrs) (over 20 yrs)
11. Why did you come to Nairobi?
To look for a job
Had got a friend
To stay with a kin
To come to this home
Others (specify).....
12. What did you used to do for a living?
Employed (Government, others)
Self employed
Jobless

13. If you were self employed how was your business doing?

Was not doing well so was closed

Had a loan and was auctioned

Others (specify).....

14. If you were not employed or did not have a business, how were you getting necessities for your daily living?

Supported by kin

Supported by charitable organizations

Begging

Others (Specify).....

15. Did you have land? Yes No

16. If the answer to No. 15 is yes, where is the land located?

17. Who used to own the home in which you used to reside in?

My own house

Accommodated by a relative

Accommodated by a Good Samaritan

Spend in the streets.

18. If you were staying in your own house, who did you use to stay with?

My wife and children

My wife

My children

My brothers

My sisters

My cousins

My friends

Others (Specify).....

19. If you were living in Nairobi, in which particular estate did you live in?

20. If your answer to question 17 above is 'own house' did the house you were staying in have a floor? Yes No

21. How were the roofing materials of your house?

Iron sheets

Sacks

Polythene papers

Others (specify).....

22. How many rooms did your house have?

1 room

2 rooms

3 rooms

More than 3

23. How many people shared the rooms?

More than 4 (overcrowded)

Less than 4 (not crowded)

24. Before coming to the home, did you have access to clean water?

Yes

No.

25. If yes did you used to have

Own piped water

Communal piped water

Others (specify)

26. What do you feel about water for bathing in the home?

Adequate

Inadequate

27. What do you feel about water for washing in the home?

Adequate

Inadequate

28. Before coming to the home, did you have access to the bathroom?

Yes

No

29. Do you have access to a bathroom now? Yes No.

30. Are the bathrooms older persons friendly? Yes No

31. Are you able to bathe on your own? Yes No

32. If no, do the care givers assist you? Yes No

33. Before coming to the home, did you have access to the toilet? Yes No

34. Do you have access to the toilet now? Yes No

35. Are the toilets older persons friendly? Yes No

36. Are you able to go to the toilet on your own? Yes No

37. If no do the care givers assist you? Yes No

38. Before coming to the home, what did you feel about food?

Good and adequate

Good but inadequate

Bad and inadequate

39. How do you feel about food at the home?

Good and adequate

Good but inadequate

Bad and inadequate

40. Are you able to feed yourself?

Yes

No

41. If no, do the care givers assist you?

Yes

No

42. What would you say about your health previously?

Very healthy

Healthy

Uncertain

Unhealthy

Very unhealthy

43. Did you use to get sickly and had to be hospitalized?

Yes

No

44. If you got hospitalized who used to pay for your hospital bills?

NHIF

Well wishers

Myself

Others (specify).....

45. When you were sick and not hospitalized, who used to take care of you?

My wife and children

My wife

My children

My brothers

My sisters

My neighbours

My cousins

Others (specify).....

46. What is your feeling about the quality of the health care you are getting currently?

Good and adequate

Inadequate

47. When you are sick, are the health workers available to attend to you? Yes No

48. Before coming to the home, did you experience difficulty in clothing yourself?

Yes

No.

49. Are you able to dress yourself now?

Yes

No.

50. If no, do the care givers assist you? Yes No

51. Are you able to walk about from room to room? Yes No

52. If no, do the care givers assist you? Yes No

53. Do you have free time? Yes No

54. If yes what do you do?

Reading

Watch T.V.

Listening to a radio

Talking to friends

Taking a walk outside the home

Sleeping

Giving voluntary services

Others (specify).....

55. Do you share good times, laughing and playing with your peers?

Yes No

56. Are you involved in religious activities now?

Yes

No

57. Do you have children? Yes No

58. If yes, how many?

59. If yes what do they do?

Employed

Self employed

Others specify.....

60. Do your children come to visit you? Yes No

61. If yes how frequently? Weekly Monthly

Others specify).....

62. Do you have brothers? Yes No.

63. If yes, how many?

64. If yes what do they do?

Employed

Self employed

Others specify.....

65. Do your brothers come to visit you? Yes No

66. If yes how frequently?

Weekly

Monthly

Others (specify).....

67. Do you have sisters? Yes No

68. If yes, how many?

69. If yes what do they do?

Employed

Self employed

Others specify.....

70. Do your sisters come to visit you? Yes No

71. If yes how frequently? Weekly Monthly

Others (specify).....

72. Do your children have land? Yes No

73. Do your brothers have land? Yes No

74. Do your sisters have land? Yes No

APPENDIX 2
UNIVERSITY OF NAIROBI
FACULTY OF ARTS
DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK
INDEPTH INTERVIEW GUIDE

Date.....

Kariobangi Chesire
Home for the Aged

1. What are major concerns for older people in the home?
2. Where do most of the older people in the home come from? Region?
3. What brings them here?
4. Do they have relatives?
5. Do they have homes?
6. Why do they prefer institutional care to home based care?
7. Who brings these people here?
8. Do they find easy to cope with institutional care? If so why? If not why?
9. What challenges does the home face in providing care to older people?
10. How does the home mitigate these challenges?
11. How do you see institutional care in the future?
12. Do you think institutional care offer the solution to the needs of our older people?

APPENDIX 3
UNIVERSITY OF NAIROBI
FACULTY OF ARTS
DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK
OBSERVATION GUIDE

Date.....

Kariobangi Chesire
Home for the Aged

- | | | | | | | | | |
|-------------------------------------|-----------|--------------------------|------|--------------------------|---------|--------------------------|------|--------------------------|
| 1. Ajuja | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 2. Darts and dartboard | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 3. Cards (playing) | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 4. Radio/cassette | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 5. T.V | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 6. Newspaper | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 7. Library | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 8. Church/ Chapel | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 9. Mosque | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 10. Built in wardrobe | Yes | <input type="checkbox"/> | No. | <input type="checkbox"/> | | | | |
| 11. Condition of the toilet : | Excellent | <input type="checkbox"/> | Good | <input type="checkbox"/> | Average | <input type="checkbox"/> | poor | <input type="checkbox"/> |
| 12. Condition of beds and beddings: | Excellent | <input type="checkbox"/> | Good | <input type="checkbox"/> | Average | <input type="checkbox"/> | poor | <input type="checkbox"/> |
| 13. Condition to the kitchen: | Excellent | <input type="checkbox"/> | Good | <input type="checkbox"/> | Average | <input type="checkbox"/> | poor | <input type="checkbox"/> |
| 14. Condition of the dining hall: | Excellent | <input type="checkbox"/> | Good | <input type="checkbox"/> | Average | <input type="checkbox"/> | poor | <input type="checkbox"/> |
| 15. Condition of the bathroom : | Excellent | <input type="checkbox"/> | Good | <input type="checkbox"/> | Average | <input type="checkbox"/> | poor | <input type="checkbox"/> |
| 16. Dressing of older persons: | Excellent | <input type="checkbox"/> | Good | <input type="checkbox"/> | Average | <input type="checkbox"/> | poor | <input type="checkbox"/> |

APPENDIX 4
CONSENT DOCUMENT AND INTRODUCTION

My name is Mutea Rukwaru and I am a student in the Department of Sociology and Social Work of the University of Nairobi. I am pursuing M.A. (Counselling) degree and I am carrying out a research to find out what leads to institutionalization of older persons, their experiences in these homes for the aged, and the quality of care they get. I would appreciate if you could spare some of your valuable time to give me your views and opinions. Our discussion with you is likely to take approximately a quarter to one hour. I am aware that you may find some questions rather sensitive, but should you not feel comfortable answering them, please say so and I will stop the interview altogether or move on to the next question, whichever you prefer.

Participants Agreement (Signed/oral)

I have been fully made aware of the purposes of this research and I am aware that my participation in this interview is voluntary. I am also aware that if, for any reason and at any time, I would wish to stop the interview, I will be at liberty to do so without having to offer any explanation.

I understand that all information I provide during this interview will be kept in strict confidence and that my name will not appear in any reports. I have also been made aware that any subsequent uses of data obtained through this interview will be subject to standard data use policies which protect the anonymity of individuals and institutions. I further understand that upon completion of this project, all data will be destroyed or stored in a secure location.

If I should have any questions relating to his study I am free to contact the interviewer - Mutea Rukwaru, Telephone +254 (0) 20344206 Nairobi.

I have read and understood the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

I have been given a copy of this consent form.

Participant's Signature

Date.

Interviewer's Signature

Date.

Oral Consent

Date.

APPENDIX 5: Map of the Kariobangi Chesire Home for the Aged Sketch

