INSTITUTIONALIZATION AS A FORM OF OLD AGE CARE IN KENYA

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BY

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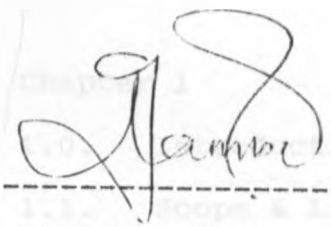
ODHIAMBO CALVIN. E.

DEDICATION

This work is dedicated to my dear grandmother, whom I do not wish to see institutionalized.

DECLARATION

I declare that this is my own original work which has not been submitted anywhere by anyone for any degree



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This work has been submitted for examination by my approval as a University Supervisor

Dr. Mauri Yambo

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ABSTRACT

This study investigated the causes and effects of institutionalization as a form of old age care in Kenya. Specifically, the study sought to identify the main factors that led to the establishment of old people's homes and the adoption of institutional life. Particular attention was also paid to the pattern of life in different homes and the effects of institutional life on the aged.

Eight residential homes were purposively selected from Mombasa, Kisumu, Trans-Nzoia, Murang'a, Kirinyaga and Nairobi districts. The target population was represented by a sample of 148 respondents, which included an experimental group of 112 randomly selected old people from the homes for the aged, and a 'comparison' group of 30 purposively selected old people living in their own homes. The key instrument of data collection was the interview schedule, although unstructured interviews were also carried out with certain key informants. Information adduced from the respondents was analysed by aid of a computer using inferential and descriptive statistics.

The study found that homes for the aged were mainly established due to the disintegration of the family, which traditionally provided old age care, and the destitution of the aged resulting from the loss of

informal care by the family. This was attributed to the rapid social change that has characterised the Kenyan society lately.

The major factors that led the aged to residential care were found to be economic, social and medical. The most significant was found to be the economic, contrary to previous findings of scholars such as Lawton (1980) and Oomen (1991,b). Further, the effects of lack of social support and poor health were found to be vitiated by relative or absolute economic well-being. It is both the economic factor and social support that also happened to provide the major difference between the experimental and'comparison' group, with the latter emerging more advantaged. There was no significant difference between the experimental and'comparison' groups with regard to health status as both were found to be rather low.

Regarding impacts of institutional care, it was found that, to the majority, institutional life provided the very basic neccesities that the aged lacked previously. In the homes there was at least some food, shelter, clothing and medical care. This, however was at the cost of alienation from family and community members, lack of meaningful relation within the homes, loss of autonomy, and fatalism. The impact of institutional care on the aged was also found to be dependent upon their socio-economic backgrounds. Those

who had reasonable socio-economic status found institutional life a misery, while to the majority who previously experienced hardships, the impersonality of institutional life still seemed more desirable.

Life in the homes was characterized by inactivity where the majority of the residents simply awaited food, sleep and, ultimately death. This was attributed to the fact that, save for one or two homes, the majority of the homes lacked adequate facilities and staff and exhibited a quality of life which was rather rudimentary.

In view of the foregoing, it was concluded that, as it is practised presently, institutionalization is not an appropriate way of caring for the aged in Kenya. Although institutional care is motivated by real concerns, it is recommended that other ways and means of caring for the aged without necessarily withdrawing them from their communities should be explored. Specifically, domiciliary care for the aged was recommended. Alternatively, if institutional care has to be continued then a supervisory unit should be established by an able body to vet each new home and to ensure that the existing ones are maintained and managed to a particular acceptable standard. Preferably, residential care for the aged should be left to religious organizations which from the

findings seemed to be doing far much better than the local municipalities. To scholars, it was recommended that further research on the impact of institutionalization of the aged be done with a view to ascertaining which one, between institutionalization and domiciliary care, would be the most appropriate and effective way of caring for the aged in Kenya.

CHAPTER ONE: INTRODUCTION

1.0 INTRODUCTION AND PROBLEM STATEMENT.

Aging, which has for a long time been considered as an issue of concern only for developed countries is slowly but steadily emerging as a concern for many developing countries as well. The same is true of problems concomitant with old age. That there is a problem of ageing is manifested by the emergence of homes for old people in many developing countries, and Kenya is no exception.

Old age has been defined as a period characterized by decline and deterioration in health, vitality, social usefulness and independence (see Victor, 1987:3). Many of the problems that beset the aged are seen as related to their physiology, for instance, frailty, poor vision or blindness, inability to resist diseases, among others. The physical deterioration that beset old people make them susceptible to diseases and take away their physical usefulness, or independence. In some cases old age can be seen as a recycle of human life; a second phase of infancy where an old person re-experiences infancy with its various needs for care in bathing, preparation (and at times actual receiving) of food,

running errands, and even going to the toilet. Others, because of loss of teeth, need special foods, while others who become immobilized due to frailty have to be moved from one place to another and so need continuous care.

Besides physiological problems, other problems that the aged have to contend with include those of housing-ranging from total homelessness to inadequate or inappropriate accommodation, food, clothing and loneliness. The implication of this is that an increase in the number of old people means an increased need for provision of care to a group of people many of who can no longer care for themselves.

By 1976, Kenya had about 587,983 people aged 60 and above. This number had increased to about 703,626 by 1979 (Republic of Kenya, 1976 and 1979). At the time of the last population census in 1989, the number of the aged in Kenya was estimated at 1.14 million (HAK situational Report, 1983:). Going by this rate of increase, and considering that the latest estimates reflect the position as it was nearly two years ago, it can be expected that the current number exceeds the 1989 figures by far. This increase could not have been of much concern if there was provision of care for the aged within their own environments. However, as Tout (1989:23) points out, the aged in developing

countries are caught in a limbo - a predicament to which there is no visible solution.

Though they are demographically categorized as 'dependent' they can depend neither on the informal, traditional network (such as extended family) which is rapidly breaking down, nor on the formal provision of essential personal social service (such as pension schemes or other social security) which is yet to be established in many countries. Even in those countries in which there is provision of social security, these are very inadequate and cannot serve the needs of the people. It is note worthy that in Kenya, less than 9% of the citizens avail for pension scheme. But even still, this is seen as quite insignificant and inadequate considering that inflation erodes the real value of the amount received (see Oomen, 1991:4).

Although the majority of the aged in Kenya continue to live in rural areas where a few fend for themselves while others depend on care and support from their families, an increasing number can no longer rely on, or get, such support and care and so have to look for alternative ways and means of survival (see HAK Situational Report, 1988:3) It is this group of people, who have been described as destitute old people, which were identified by the government of Kenya in the Sessional Paper No. 7 of

1971 as a group requiring attention. One of the ways that was identified for provision of care for this group was through establishment of old peoples homes where the aged would receive institutional care.

The idea of institutionalization of the aged, or homes for old people, is an alien one in Africa (see Kanyongo-male and Onyango, 1984:89,90). The practice is considered as inconsistent with traditional beliefs and practices that formed part of African culture.

In traditional African societies the aged were cared for by their children or members of the extended family (HAK situational Report, 1988:14; Kayongo-male and Onyango, 1984:89). They lived together with other members of the community and formed part of what has been called the extended family. In all African communities, the aged were held in high esteem and were usually the judges, rulers and religious leaders. They were considered as the wise old leaders who provided guidance, counselling and teaching to younger members of society (see Carva and Liddiard, 1982:20). They acted as the embodiments of wisdom and experience; the repository of societal norms and values which were imperative for survival and continuity of society.

Living together within the community facilitated smooth continuity of community life, with older members providing directions of how to maintain the

very important cultural heritage and younger members providing the aged with the necessary means of subsistence. The mutual co-existence of the different generations within a community welded them into a coherent whole - a socially integrated group which provided the impetus and basis for community life.

In view of the foregoing, institutionalization of the aged emerges as a culture inconsistent with African practices. Homes for old people are seen as emerging as places to accommodate and take care of the aged who, for one reason or another, cannot continue with normal community life (HAK Situational Report,1990:6). The fact of the occurrence of these homes is indicative of some abnormalities within the African society or family which has always provided care for the aged (HAK Situational Report, 1990:5).

Although institutionalization of the aged has neither been very prevalent nor appreciated in many developing countries, it seems to be a common feature in developed countries. Many of these developed countries are considered as capitalistic in nature and characterized by individualism, lack of mutual concern for one another, and survival for the fittest. These societies are seen as loosely integrated and kinship ties no longer binding. If this is true then the distinction between Western and African societies may be seen as a reflection of such typologies as

society/community of Redfield, Gemeinshaft/Geselshaft of Tonnies, and Organic/mechanical solidarity of Durkheim. The obverse of developed societies are developing societies which are seen as characterized by close kinship ties and mutual obligation of one to another. Under such circumstances the aged would be expected to continue living in their natural environs, enjoying traditional roles and rights and depending upon the care and support of their families and/or relatives.

The paradox, which is the major concern of the study, is that a number of old people in Kenya can no longer get care from, or within, their families, relatives, or immediate natural environs. These leave their natural habitats and move to old people's homes for institutional care. Although the proportion is not yet very large, there is every indication that more and more homes are either being built or being planned, besides the ones already in existence. This means that more and more old people will turn (or be driven) to institutional life within the next few years or so. Given that institutionalization is considered as 'un-African', meaning that it is not expected to occur in Africa, and yet it persists in Kenya, there is need to investigate the reasons why certain old people have to turn to institutional care or why a particular community can no longer provide

traditional care for its aged members. There seem to be certain push factors, within the community, or pull factors, within the institutions, which need to be elucidated.

Our concern with institutionalization of the aged emanates from three factors. First, although some studies have been done to isolate factors that lead to institutional care and evaluations made of institutionalization as a form of old age care, most of these studies have been done by western scholars and have tended to suggest that background factors such as destitution, absence of family or relatives to provide care, poverty, physical frailties, among others, are primary proximate determinants of institutionalization. Some of these claims, however, have remained unsupported by empirical evidence. In any case, even if there was all the evidence in support of these contentions, factors stated as leading to institutional care would only be true regarding western societies on which the findings are based. As a matter of fact, western and African societies are seen as quite different and as having social, political, economic and environmental patterns that are so diverse that whatever happens in the west, for instance, cannot be directly applicable in Africa. What this means, simply, is that findings based on studies done in the west cannot be generalized and

used in application to Kenya. There is need therefore to carry out such a study to determine whether the same factors obtaining in western societies are present in Kenya, and if so, to show the pattern through which these factors manifest themselves in Kenya.

It is important to note here that western writers generally seem to confine the phenomenon of institutional care of the aged to western, or 'developed' societies. The impression they give is that Africa presents a 'Golden Age' where old people still enjoy very high esteem and perform very important roles in society, that the African communal way of life, together with the extended family system, which is seen as still in existence, has helped the aged in Africa to escape from the feeling of segregation, disenchantment, isolation, helplessness, and redundancy which characterizes the aged in developed countries. However, the emergence of homes for the aged in Kenya, alongside other developing societies in Africa, casts doubts to such contentions. This presents a disjunction between what is not expected to take place and what is actually taking place, which needs to be explained by use of empirical data.

Secondly, there are a number of studies which have been done in Kenya on issues related to old age.

These studies cover themes such as pension and retirement (Clarke 1961; Ocholla-Ayayo, 1985; Turner 1963; Angima 1985, and Kithinji 1989). Other areas covered include problems on health and health care (Ogada Were, 1984; Menya 1985, and Oomen 1991). However, these have not had the same focus as the current study and only a few have some distant bearing on the problem we are trying to address, as will be shown later. Other studies (Khasiani, 1987 and Oucho 1988) have tried to focus on some of the problems that beset old people within their communities and are generally agreed that social change has adversely affected the aged in Africa. These scholars, however, make no mention of, or reference to, institutionalization of the aged as part of the effects of social change in African societies.

The only studies available to this researcher that touch on institutional care of the aged, though not focusing directly on institutionalization, are those by Oomen (1991), Cox (1976) and Kithinji (1991). Apart from Kithinji, the other two (Oomen and Cox) at least tried to visit one or so homes of the aged and interviewed a few residents (albeit randomly, as in the case of Cox) or made some generalized observation besides talking with a few members of staff (as in the case of Oomen). These studies, including reports by HelpAge Kenya, the latter which are not based on any

empirical study, seem to agree with western scholars that destitution is the primary factor leading to institutional care. Besides merely mentioning destitution, the scholars mentioned above have also gone ahead to attribute it to a much emphasized social change and disintegration of the African (extended) family though without elaborating on the patterns or dynamics of the destitution that leads to institutionalization of the aged. Besides, no clear relationship has been established between disintegration of the family, destitution, and institutionalization. As such, it is our feeling and contention that the issue of institutionalization of the aged in Kenya has not been adequately addressed.

Thirdly, there is an unresolved debate or controversy about the effects of institutionalization on the aged. Whereas some scholars have contended that institutional care adversely affects the aged, others argue that institutional care actually provides solutions to some of the problems that beset the aged within their natural environment; that institutional care provides the aged with the happiness and meaning in life that they were deprived of wherever they came from. In view of this, it is important to investigate and find out how institutional life affects the aged or how the homes perform as alternatives to the isolation, lack of care or destitution that is

supposed to have driven the aged to institutional life. This is critical granting that whereas homes for old people are on the increase in Kenya, these are now being discouraged in many developed countries (see Cox, 1976:26 and Oomen, 1991:1).

By way of summary it can be stated that the main aim of the current study is to find out the causes and effects of institutionalization as a form of old age care in selected homes in Kenya. And, in order to do this, the study specifically attempts to;

(i) Investigate factors that led to the establishment of the homes,

(ii) Establish factors that led the aged to institutional life.

(iii) Find out the impact that institutional care has on the aged

(iv) Assess the type of life in which old people live in the homes, and

(v) Compare and contrast life within different homes.

1.1 SCOPE AND LIMITATION OF THE STUDY.

This is an exploratory and explanatory cross-sectional study. By the time of interviewing documentary evidence showed that there were about sixteen homes for the aged scattered within ten

districts in Kenya. However the study does not include all existing homes, but rather confines itself to a smaller sample as will be later shown under methodology.

There are different types of homes, some located in urban areas while others in rural areas, some exclusively for whites while others for Africans, some exclusively for females while others unisex, some sponsored and managed by church organizations while others sponsored or managed by municipal councils. Representations of each of these types are be covered in this study.

There are two major anticipated limitations of this study. First, in seeking to understand the actual factors leading to institutional care, the current study used the institutionalized aged as the unit of analysis. The objective of this was to try and adduce background information about the residents from themselves. This could have been more adequately achieved if the same information could have been sought from any surviving relative(s) of the institutionalized aged. This would act as a check against any possible mis-information. However, this will not be feasible due to certain anticipated practical and logistical problems.

Even if it were possible to surmount some of these problems within the given constraints of time,

finances, personnel and communication, there would be problems of appropriate sampling method and size. In any case, the few relatives that could have been located and interviewed could have provided cases too few to act as a basis for any empirical conclusion. In other words, there are foreseeable costs of feasibility, validity and reliability accruing from any attempt to trace relatives of the residents that will not be easily borne or justified in view of the little worth that such additional information will be to the current study, given the present constraints.

Second, in trying to assess the effects of institutionalization on the aged, there would have been need for a longitudinal study where, possibly, the pre-institutional life of each inmate would have been studied. This would have been followed by other studies immediately after commencement of institutional care and after some years of institutionalization. This would have been able to give clearer evidence and evaluation of the effects of institutional care on the aged. However, as was stated earlier, the current study was a cross-sectional study carried out during one visit. This was once again due to some of the constraints mentioned above.

It would be presumptions for any study to claim for itself ability to fill all information gaps on any problem of study. If it will succeed in filling

certain academic lacunae within its limitations and identify others to be filled by other studies, or if it will be able to generate some academic debate, such a study will have fulfilled part of an academic objective and asserted its reason for existence. Therefore, the stated limitations not withstanding, the current study is seen as significant in-so-far-as it seeks to;

(i) fill in certain information gaps that have either been identified both in the introductory sections of this study and in the subsequent chapter of literature review.

(ii) act as a pioneering study on the issue of institutional care for the aged *per se* given that this is an area which has either been ignored or merely alluded to in previous studies,

(iii) deal with a portion of our population which, for long, has been ignored due to western oriented over-romanticized assumptions that all is well with our old people and they are receiving all the necessary care and support from their families or relatives, and,

(iv) give certain information and make certain recommendations for the sake of those who

are currently involved with old age care. This is with the aim of improving already existing programs, or identifying better ways of providing this care.

CHAPTER TWO: LITERATURE REVIEW

If, in much of the literature discussed here, there is a preponderance of research done in Western societies by Western scholars, this is simply reflective of how little African scholars, and more so, Kenyans, have addressed themselves to the issue of the institutionalization of the aged. Moreover, the few studies done in Kenya, as will later on be shown, reflect, to a greater or lesser degree, the general trend that is expected elsewhere in Africa; that is a simple patterning after, or echoing of, studies done in Western societies. This is because aging has not been considered as a crucial problem for most African countries and has therefore not been a focus of most researchers. Literature from Western societies is reviewed here so as to identify their analytical framework and possible methodological contribution to our study. The very few available studies done in Kenya are also reviewed in order to provide a justification for the focus of this study within the selected locations.

2.1 OLD AGE CARE

That the aged need to be cared for and supported is indisputable. Old age care has been seen as operating at three levels. There is family care where old people live within their natural environments and are provided for by, and within, their families. The second level is community care, which differs from family care in that people, other than immediate family members, pool resources to provide care for the aged among them. Such care includes the provision of housing, common day-care centres, hospitalization, and old people's homes, among others. The third level is state care which comes in form of pensions, social security and the like (see Oomen, 1991 (a):4).

Of the three types of old age care, the first and the third seem to be generally in decline, or very inadequate where they still exist (see Tout, 1989:45). A number of scholars, among them Cox (1976:15), Oomen (1992:4), Tout (1989: 12-16), Onyango and Kayongo-male (1984:90), Davis and Van den (1981:140), and Khasiani (1987:20), generally seem to agree that the family, both extended and nuclear, has failed to provide the care and support for the aged which was traditionally seen as its obligation. The arguments for this will be advanced later.

Whereas family care for the aged was geared towards a number of people, state care, in the form of

pension schemes, is very selective in its beneficiaries. Those who benefit from the scheme are only those who were once in regular employment either in the public or private sector. Even then, as Kithinji (1989:92) shows, the appropriate management of this scheme is itself a problem. In a study she did on retirement among civil servants within the TSC (Teachers' Service Commission), Kithinji found that many retired teachers soon realized that their retirement benefits could not sustain them for long. Much of the money they received was eaten up by inflation. Some of the retired teachers became victims of mismanagement and ended up leading rather miserable and poverty-stricken lives.

Since both family and state-care seem to be in decline and are either considered as inadequate or benefiting very few of the aged, the majority seem to have no alternative other than to look to community for care. Community care, however, cannot be received by everyone who seeks it, but is rather dependent upon the availability of the type of assistance that is sought and the genuineness of the case. This means that not all who are liable to, or seek, community care, receive it. Those who benefit from community care may receive either domiciliary care, (that is care within one's customary environment) or

institutional care (where the aged are removed from their customary environments).

2.2 INSTITUTIONALIZATION .

The act of providing institutional care has been referred to as institutionalization. According to Webster's Third New International Dictionary (1976), institutionalization is a noun that shows the quality or state of being or becoming institutionalized. It is considered as the action of institutionalizing. This definition assumes that one knows the meaning of 'to institutionalize'. Webster (1976) defines this as a verb that refers to the act of placing in, or committing to, the care of a specialized institution. It refers to the act of accustoming (a person) so firmly to the care and supervised routine of an institution as to make incapable of managing life independently. What this means is that the institutionalized person has very little, or no, discretion on his pattern of life.

Although in institutional care for the aged, the degree of independence may vary from one home to another, generally speaking, it appears that in institutionalization the aged are removed from their customary environment to a new one and are subjected to a relatively flexible or inflexible supervision.

The aged are thus made to live under environments, or conditions, which are unfamiliar, if not strange. This may be seen as an act of alienation.

According to Webster (1976) alienation is the act of withdrawal or separation of a person... from a position of former attachment. In this regard, the removal of the aged from their natural environments into old people's homes may be seen as alienating them from the rest of community members. If this is so, then alienation may be seen from two perspectives; either as a cause of removal from the natural environment (referring to institutional placement) or as an effect of institutionalization. As a cause, the aged may be alienated when their customary environment becomes unfriendly, hostile or indifferent to them; when they see in society a change from affection, sympathy and interest to coldness, aloofness or antipathy; when they have no means of livelihood yet no one within their immediate environment seems willing to provide for them. Such persons may be seen as driven into institutional care by alienation. In effect, alienation may be seen to have occurred if through institutionalization the aged feel estranged from their customary environment or associations.

Faced with these two divergent views, it can be said then that whether alienation is to be considered as a cause or effect would largely depend on who is

looking at it and from what perspective. For instance, if to an institutionalized aged the act of removal from the former environment was occasioned by feelings of isolation and loneliness that he was experiencing, then, to this person, such a separation amounts not to an act of alienation but rather, an integration into a new and more meaningful community. The above argument notwithstanding, the question of whether institutionalization is caused by, or leads to, alienation of the aged within their environment is an issue which can only be resolved empirically, not polemically. We now turn briefly to previous studies to see what has been said regarding this issue.

2.3.0 FACTORS LEADING TO INSTITUTIONALIZATION OF THE AGED

It has been suggested that certain personal characteristics of the aged influence or determine their institutional placement. In a study done by Hickey (1980) it was concluded that personal frailty and ill-health are among some personal factors that lead to institutionalization of the aged. But these have been seen by others as conditions that are generally associated with old age (see Victor, 1987:3, Tout, 1989:125-29; McGraugh, 1979:123 and Oomen, 1991: 1-4). In fact, studies done by geriatricians and

gerontologists have also demonstrated that old age is a period beset with physiological deterioration which makes the aged unable to live independently. Their physical condition makes them dependent upon other members of society.

To say that physical frailty and ill-health cause institutional placement of the aged does not mean that the frail or the unhealthy will necessarily resort to institutional care. It is likely that not all old people experience the same effects of physical deterioration and that not all who suffer such decline in physical vitality go in for institutional care. On the other hand, it is probable that there are others who turn to institutional care without any manifested trait of physical frailty or ill-health. If such a possibility exists then it can be said that physical frailty and ill-health do not necessarily lead to institutionalization. There must be some intervening factors that need to be brought to light.

It is true that as individuals grow older they become more and more prone to diseases. This has been seen as normal senescence and is attributed to the weakening of the body metabolic system. Cassel (1976) adds an interesting aspect to this. In a study on the contribution of the social environment to host resistance, Cassel found that susceptibility to

disease at old age is dependent upon one's social status and lifestyle (see McGaugh, 1979:312).

According to this, those with high status, for instance, should be able to have better health than those with lower status. Expressed in other words, although all old people may experience health problems, given that ill-health will vary with one's social status one who, for instance, has a high socio-economic status, for instance, will be less likely to suffer from much health incapacity because he can manage to lead a good lifestyle which, according to Cassel, helps to ameliorate one's ill-health, or health status. Such a person should be less likely to turn to institutional care.

It is important to note that even in case of low social status, one does not automatically become liable to institutional care. Scholars like Gelfand and Olsen (1980:110) and Lowenthal and Haven (1968:56) see an interaction between personal vulnerability and loss, or inadequacy, of social support as ultimately the most likely to bring about institutional placements. Besides, Shanas (1962:60) in a national survey on the health of old persons, found that greater numbers of functionally impaired older persons continued to live independently in their communities than were placed in institutions. Those remaining in the community in spite of severe incapacity were able

to do so because of the availability of formal and/or informal social support.

So far we have been presented with personal frailty (or ill-health) and lack of social support as factors that determine whether or not an old person is to be placed under institutional care. But the two factors need not be considered exclusively.

Physical frailty is a condition bad enough. But when, in addition to lack of the vitality needed for self-sustenance, an old person lacks such social contacts as friends, relatives, spouse or children from whom the support and/or care which is very crucial at this stage can be procured, the old person gets into a predicament which makes him amenable to institutional care. Physical frailty, which is indeed an indication of low health status, becomes asserted through lack of social support. Put in other words, physiological deterioration has to synchronize with lack of social support in order to become a determinant of institutional placement.

Whereas it is easy to understand the incidence of physical deterioration at old age (this being a natural concomitant of ageing), it is not so easy to appreciate the idea of lack of social support, especially from the African perspective. Social support stems from social contacts or relationships such as with friends, relatives, spouse, and children

(see McGraugh, 1979:321-322). To say that one has no social support implies that either one has absolutely no social relations or these relations exist but for one reason or another, cannot, or do not, function to provide the support or care which is needed by the aged. The difficulty that arises in understanding any of the two suppositions stems from the fact that in traditional African communities the aged lived with or near younger members of their community. In accordance with principles of reciprocity between generations, the elderly were assured of care and support so that their standards of living matched those of the rest of their community (see HAK situational Report, 1988:5).

That there may be lack of social support to certain old people in Kenya is a paradox that needs to be explained. Whereas it is not difficult to understand the occurrence of lack of social support in Western societies, that is, if we accept the contentions that such societies have developed rather impersonal relationships and are characterized by individualistic tendencies that vitiate kinship ties, it is not easy to understand why the same should apply in a society like ours where kinship ties are still seen as binding.

The foregoing argument should not be construed to mean lack of appreciation of the importance of social

support. On the contrary social support is very important, not only for the aged but even for other members of society. As the old adage goes, 'no man is an island to himself'. Man needs others in order to live as a social being, which he is. This dependency can be for both emotional and material comfort or well being. From the material point of view, dependency decreases if the one being assisted is self-sufficient. Then, the others are needed only to provide emotional support or companionship. The aged who lack material support may suffer destitution if, in addition, they are unable to provide for themselves. By implication, one who can maintain or sustain himself will not suffer much even in case of absence of social relations to provide material support.

But material support is not all that any member of society will need. Besides material support, the emotional support that comes from frequent interaction with one's social contacts is also very vital for man's existence; and this the age need as well. This view is supported by a number of scholars. For instance, in considering factors that made the institutional setting potentially desirable to the elderly seeking entry to institutions, Pincus (1968;58) identified the following as the most important;

(i) The desire for care and security,

(ii) The desire for people or companionship, and

(iii) The desire for activities.

Another study on social isolation in old age by Lowenthal (1964:42) found that social isolation and absence of supportive interpersonal relationships differentiated the aged who entered institutional facilities from those who were able to remain in the community in spite of personal frailty.

Seeing how vital social support is, we wish to propose that the aged who lack social support are most likely to be placed under institutional care if they come from poor backgrounds. But this is only half of the statement. This is because, as has been shown previously, physical frailty and lack of social support harmonize to determine institutional placement. As such we wish to contend further that the aged who lack social support will most likely end up in institutional care if, in addition, they have low health status.

The mention of social support draws our attention to the issue of the family. The question as to why there is institutional care for the aged also questions, though only implicitly, why there is no family care for the aged. Old age care was

traditionally vested upon the family. An understanding of why the family can no longer carry out this function effectively will also illuminate the reasons why the aged have to be committed to institutional care instead.

There is a feeling among scholars on studies related to the family that although the (extended) family traditionally played the role of caring for the aged, there has been a decline in the performance of this role (see Tout, 1989:45; Oomen, 1991a:4; Khasiani; 1987:26, among others). This change has been attributed to the disintegration of the family which has in turn been seen as caused by social change.

There is ample evidence to show that in Western or 'modern' societies, increased population, urbanization, and technological improvement, among other things, have adversely affected the family. For instance, urbanization has given rise to rural-urban migration of many youths and adults. These are people who, given the unfavourable conditions in rural areas and their inability to get meaningful livelihood in such areas, are forced to look for employment in urban areas. In reference to this, Davis and Van den (1981:5) note that with increased modernization filial relationships have tended to weaken. This is so

because family members have had to separate in pursuit of education, training, and employment.

When we turn to developing societies, and especially to Kenya (which is more relevant in the present study), it becomes a little difficult to asses the extent to which social change has disrupted the family. It seems that, in spite of urbanization and/or migration, the aged who remain in rural areas continue to receive occasional visits from their families or relatives; an indication that the sanctity of the family has not been discarded. Besides, even though the family has tended to separate and nucleate there is no evidence that with this separation and nucleation there has been a corresponding severance of relations with the extended family. As such one may contend that, although physically separated from their families, the aged in Kenya do not experience the same isolation as is experienced by those in certain developed countries. However, such a statement would only complicate even further, any attempts to explain why, if the assumption is true, a number of old people in Kenya are committed to institutional, rather than family care. It is expedient to leave such a paradox to be resolved empirically.

When Davis and Van den (1981) wrote about the disintegration of the family in Western societies, they did not attribute it solely to urbanization or

migration. Rather, they saw the disintegration of the family as contemporaneous with the disintegration of systems of mutual obligations among family members. These are the systems that previously ensured that the majority of elderly people remained in their family circles. Davis and Van den attributed this decline to the "individualized" tendencies of the modern society.

The modern society is seen as characterized by emphasis on individual achievement and aspirations. Here, desire and quest for social mobility militate against large or extended families. The nuclear family becomes the 'norm' and concern for family members is reduced to the level of spouse and children. It is these who get priority over the extended family. Under such circumstances the aged tend to become marginalized and are made to develop feelings of being a burden. This position finds support in a research conducted by Lowenthal and Haven (1968) on interaction and adaptation of the aged into society. In this study the most dominant factors that were seen as influencing decisions to enter into institutional care were found to be socially related. The factors that were mentioned included rejection by children, death of spouse, fear of being a burden, and concern over being alone. A number of the aged interviewed wanted to be out of the way of their sons, daughters, daughters-in-law, and other relatives.

Although not seen as crucial yet, it has been suggested that with increased modernization the Kenyan society is moving rather fast towards certain Western values, especially those regarding interpersonal or family relations. If this is true then it could be possible that some of the aged who become institutionalized are driven there due to neglect or rejection by their families or children.

But why would the family be of such paramount importance to the aged such that its disintegration or failure to give any support to the aged, would seem to lead, invariably, to the institutionalization of the aged? In our view, the disintegration of the family can only be a concern if the aged have nothing to fall back to in case of withdrawal of family members; something like savings, investments or any economic activity that can serve as a means of livelihood. But it seems that many old people, just like many other Kenyans, come from rather poor socio-economic backgrounds and might have had no savings or investments from which to get old age security. With regards to economic activities, it would appear that the physical deterioration, which is characteristic of ageing, seems to hamper against any attempts to actively participate in economic production (even if at subsistence level). This is not so much as a result of the inadequacy of their skills as it is of

the fact that their very labour is considered redundant. According to Myles (see Guillemard, 1983:23) the major problem is that there has been a change in the societal mode of production which has dislodged the aged.

Traditionally many African communities depended upon a peasant mode of production based on subsistence farming through the family as the basic unit of production. With modernization there has been a shift from agriculture and a tendency towards industrialization based on the capitalist mode of production which subsists through exploitation of wage labour. In this mode of production, labour becomes commodified and the population becomes dependent upon the wage relation and labour market for survival. The type of labour required here is an educated and mobile labour; conditions which many old people cannot meet. Inability to meet these requirements leads to the relegation of the aged to the fringes of the labour market. Since they have no access to the labour market they are turned into social dependents. What becomes a dilemma is that, whereas the aged are forced to become dependent upon their communities for care, the very community base to provide this care, the extended family, is not there, or is unable to provide the care. This precipitates destitution and a search for care outside the boundaries of normal community

life; which inexorably makes the aged liable to institutional placement.

One may feel that the argument advanced here is a little eurocentric and thus not directly applicable to the Kenyan situation. Although it may be true that the majority of the aged in Kenya may not be well integrated into the economy, one may however argue that they do not necessarily have to sell their labour in the market in order to survive; that such a situation may apply more to developed countries where labour has been fully commodified. If we go by such sentiments then we can aver that if the aged in Kenya seem to have no means of subsistence then it could be that the main reasons for this lie somewhere in their background, which background is a major determinant of their present condition and their ability to relate to the vagaries of the contemporary Kenyan society.

In concluding the discussion regarding the family, we wish to contend that disintegration of the family alone is not a reason adequate enough to explain or justify institutional placement of the aged. Lack of family support only becomes crucial if, in addition, the aged are not able to get their own means of subsistence. Our assumption, in other words, is that the aged who lack family care but have some alternative economic means for survival, or have the physical vitality to fend for themselves, will not, of

necessity, be liable for institutional care. Having said this we wish to hypothesize that the disintegration of the family will lead to the institutionalization of the aged who come from low income households.

In the foregoing part, attempts have been made to isolate the factors that have been given by Western scholars as leading to institutionalization of the aged. The major factors that emerge from the discussion can be summarized as, personal factors such as low social status, physiological deterioration, and lack of social support, which is manifested in loneliness, lack of dependents, weakening in filial relationships, disintegration of the family, lack or death of spouse, relatives, friends and children. It is the combination of low social status, physiological deterioration (or low health status) and lack of social support that can be said to lead to destitution, a factor to which many scholars have attributed the institutionalization of the aged. Some of these factors have been considered in a few studies done in Kenya. The succeeding section is a review of some of these studies.

2.3.1 STUDIES DONE IN KENYA.

In considering studies done in Kenya we wish to select two of these for further discussion (see pages for the entire list of studies). The two studies are by Cox(1976) and Oomen (1991).

The study done by Cox (1976) focused on the socio-economic environment of the contemporary Kikuyu aged, as compared with the environment of their ancestors, in relation to certain constraints impinging upon the Kikuyu society then. This study was concluded by a visit to a home for the aged in Thogoto, Kiambu district.

What emerges from Cox's study is that the aged in the contemporary Kenyan society seem to undergo more strains than previously. For instance, most of them no longer enjoy the privileges of esteem or care which were traditionally enjoyed by the aged. Moreover, although a few old people still receive care from their families, not all have family circles in which they can get this care. These tend to become dependent upon neighbours who are themselves overburdened by economic strains. Within their communities, the aged are beset with problems of lack of food and shelter, loneliness, loss of spouse, parents, friends and relatives. Cox summarizes these problems as 'destitution'. However, Cox does not

attempt to explain how or why these factors necessarily lead to institutionalization of the aged.

There is no attempt to trace these factors to the socio-economic backgrounds of the aged to see how they synchronize and necessitate institutional care. From discussion of literature from Western societies, it is felt that the issue of institutional care for the aged cannot be adequately addressed without consideration of certain background factors. In the absence of an exposition and establishment of an interrelation between the background factors, and a demonstration of how they link up with, and determine, institutional placement of the aged, we find such a work to be of limited value as an explanation of institutionalization of the aged. Moreover, the time when the study was conducted, 1976, and the location, Kiambu district, are factors that militate against any attempt to generalize the findings of Cox or to use them to explain institutionalization in Kenya today.

The second study, which was done by Oomen in early 1991, seems to share Cox's view that destitution is the major factor that drives the aged into institutional care. Oomen, who is a geriatrician, conducted a study whose main focus was the imminent danger of the growing burden of disease and disability among the increasing population of elderly people in Kenya. His main aim was to provide information about;

(i) the geographical distribution of health and nutrition,

(ii) social circumstances of the elderly in Kenya,

(iii) the various ways of support given to the elderly, and,

(iv) key problems requiring further study or solution.

Oomen's study, like Cox's, concluded with a visit to some old people's homes. Oomen visited a total of four homes in Busia, Ahero and Nairobi.

What emerges from Oomen's study is that the aged are beset with a host of medical problems which make them liable for care. Part of this care is given in form of community health care. According to Oomen, although much of the problems are socially related, the extended family which traditionally provided this kind of care can no longer do so effectively. The aged have thus to turn to community care which is provided through day-care centres, reconstruction of shelters, feeding centres, old people's homes and eye clinics, among others (see Oomen 1991:5).

According to Oomen, the current homes for the aged were erected out of sheer distress and compassion, and were intended only for those who were absolutely destitute and could not expect to get care

from their families. Like Cox, Oomen does not make any attempt to explain how this destitution occurs or why it necessarily makes one deserving of institutional care.

The visits made by Oomen to the four homes for the aged are used to provide descriptive information of the numbers of residents in the homes and on the organizational structure, in terms of existing staff and the physical environment of the homes. No attempt, however, is made to evaluate the social environment of the homes (for instance, the pattern of interaction of the residents or their degree of integration within the homes), and to show the significance of both the physical and social environment to the residents. It is our contention that any study on institutional care for the aged will be of limited value if it does not address itself to the impacts of institutionalization on the aged. From our review of literature by Western scholars (as will be shown subsequently) the two factors; the social and physical environments of the homes, appear to be very important indicators and/or determinants of how institutionalization affects the aged.

In concluding the discussion on studies done in Kenya, two important issues that emerge from the review need to be restated. First, it appears that very little has been done in Kenya regarding the issue

of institutional care for the aged. What exists as studies in this respect presents, in our estimation, a dearth of information regarding this phenomenon. Besides, what the studies cover, in terms of focus, does not provide adequate coverage for the objectives which have been set out for the current study. Second, regarding the factors leading to institutionalization of the aged, the most important (if not the only) factor which has been given is destitution. However, no explanation is given to explain exactly how or why destitution leads to institutional care.

There are very salient dynamics of destitution which we are unable to get from the literature reviewed. For instance, we still do not know exactly what this destitution is, how it manifests itself within our society, why it occurs, and why it necessarily leads to institutionalization of the aged. In any case, if we proceed from the 'destitution point of view' it would be on the assumption that all who go for institutional care do so out of compulsion; that they are pushed out of their natural settings due to some factors that adversely affect them. It is expected, however, that in Kenya there are some old people who, as in certain developed countries, turn to institutional care out of their own volition or as a result of an understanding between themselves and

their families or relatives, without necessarily being compelled.

The foregoing statement should not be understood as a rejection of the proposition that destitution leads to institutional care of the aged. On the contrary, we feel strongly that destitution may actually lead to institutionalization of the aged. The issue we are raising is that there is need to demonstrate how this occurs - this is lacking in the literature already reviewed. Besides, we feel that the mere mention of destitution as a determinant of institutional care for the aged does not settle the question of the factors that lead to institutionalization. There may be other factors besides destitution. This study will attempt to find out if there are other factors that determine the institutional placement of the aged in Kenya.

2.4 IMPACTS OF INSTITUTIONALIZATION ON THE AGED

In considering previous studies dealing with effects of institutionalization on the aged, a dual pattern seems to emerge. There are those scholars (among them Peterson Quadagno, 1985; Seelbash and Hansen, 1980; Smith and Bengstson, 1979; Binstock et al, 1985) who view institutional care rather positively and as a remedy to problems that beset the

aged in society. On the other hand, there are scholars like Townsend 1962; Goffman, 1961; Ward, 1984; Tibbitts 1962; Kahana and Harel, 1972; among others, who view institutional care rather negatively and see it as adversely affecting the aged residents.

The proponents of institutionalization see it as providing the aged with what their immediate community could not give them. Those who were previously isolated due to limitations of mobility are brought close to one another and in a social context where there is a potential for developing new relationships (Peterson and Quadagno, 1985: 390). These are old people who had suffered loss of social support and were made to feel rejected. In the institutions it would seem that their well-being is enhanced when they are placed within an interpersonal environment of a congregate setting (see carp, 1968 in Peterson and Quadagno, 1985:390). Although there may be a natural drop in some interaction due to a change in accessibility to old friends and relatives, a potential rise in other interactions due to the nearness of others in the institutions is seen to feel this gap.

When we recall some of the factors given as leading to institutional placement of the aged, one can appreciate the implied positive effects of institutional care. If the aged can get from the

institutions certain basic requirements which they lacked in their places of origin, then institutional care would seem to provide a better alternative to them. If this is so, then it can be rightly asserted, as does Carp, 1968 (see Peterson and Quadagno, 1985:390), that institutional care enhances the well-being of the aged. However; in as much as this may be true, there is need for a proviso. This is because there are other scholars who see institutional care as only having negative impacts on the aged. Such scholars see institutionalization as a process of de-personalization, especially given that the aged in such homes are subject to patterned ways of living where everyone does the same thing to the extent that there is no room for one to asset one's individuality or discretion (Tibbitts, 1962:171). Besides, the fact that the aged live and do things collectively, is seen as depriving them of their privacy. The institutionalized aged are further portrayed as isolated from the rest of society members, suffering loss of prestige and damaged dignity (Tout, 1989:149); as having low morale, negative self-image, preoccupation with the past, feelings of personal insignificance, withdrawal, anxiety, and excessive fear of death (Goffman, 1961:163).

It would be important to discuss, albeit very briefly, a few of the issues raised here. Starting

with the issue of lack of privacy, patterning of one's behaviour, lack of independence and freedom of choice, as is contended by Townsend (in Tibbitts 1962:171). It is important to note that the question of presence or absence of these factors is one that cannot be answered in a general manner. This is a question that needs to be seen as dependent upon each individual home for the aged, and the practices therein. As was shown in the initial chapters, old people's homes in Kenya are managed by different organizations. It is expected that the different managements will reflect differences in degrees of privacy and independence in each home. Impacts relating to degrees of privacy, independence, and freedom of choice can therefore be seen as contingent upon each home and each management. To effectively assess the impacts of institutionalization on the aged we suggest that different homes should be compared and contrasted.

Another impact of institutionalization that has been suggested is lack of intimate family relationship. In a study regarding family relations among the aged, Brody (1977:92) concluded that the institutionalized aged seem to be abandoned by members of their families. But such a view is contradicted by Seelbach and Hansen (1980:320) and Smith and Bengston (1979:125) who see family relations among the aged as normal and, if anything, having a tendency to

strengthen. It may be true that family relations among the aged either improve or decline with institutionalization. However, no study has been done to verify this in Kenya.

In considering interaction between the resident aged and their relatives or families, it is important to note that the aged living in the homes are physically separated from the rest of their family members who probably have to cover long distances to reach the institutions. Definitely, then, it can be expected that interaction between the aged and their families will not be as frequent as they would have been prior to institutional placement of the aged. Kahana and Havel (1972:24) who did a study on family relations of the institutionalized aged found that it was more difficult for residents in old people's homes to continue maintaining contacts with previous relations. The major barrier was lack of accessibility of the institutions to the relatives. The same idea is reflected by Townsend (1957:74) who, in a study relating to the family life of old people, found distance to be an impediment to continued interaction with family members. Townsend (1957) went further to note that when visitation actually occurred it was usually for a very short time, considering that such visitations form only a small portion of the institution's day to day activities. Given these

facts, it is important for one to be circumspect in considering the view that family ties are strengthened with institutionalization.

From the brief discussion on literature relating to the impacts of institutionalization on the aged it is evident that there is no agreement as to whether institutional care affects the aged positively or negatively. The two divergent views can be summarized as follows; whereas one group sees institutionalization as enhancing the well-being of the aged, another group sees institutionalization as counter-productive: Instead of rehabilitating the aged, institutional placement is seen in the latter case as not only alienating the aged from the rest of the community but even from their own selves.

Given these divergent views, one may not be able to assert categorically that institutionalization invariably has either negative or positive impacts on the aged. Of the two opposing views, it would be a little presumptuous for somebody to point to one view as definitely true, to the exclusion of the other. In order to strike a balance between these two views, we wish to propose that a truly objective assessment of the impacts of institutionalization on the aged must take into consideration certain two factors, these are:-

i) the environment where the aged was prior to institutional placement, and

ii) the new environment in which the aged is trying to adjust (within the institution).

The essence of this is to see how one environment differs from another. It can be expected that if, for instance, in their previous environments, the aged suffered certain deprivations which they are able to get within the institutions, then to such people, institutional care will definitely be a relief and a solution to some of their previous problems. Given such a case it can be said that institutionalization enhances the well-being of the aged who come from poor backgrounds. But such a statement is only based on the assumption that the new environment is actually an improvement over the previous one. It can be expect that the aged who previously enjoyed a good standard of living may find problems in adjusting to an old people's home which has lower standards. To such people, institutional care will have negative impacts because it will be depriving them of certain things they previously enjoyed.

In considering the impact of institutionalization on the aged, the establishment of a direct cause - effect relationship between the factor of institutionalization and any observable characteristic

traits of the aged residents is rather difficult. This is because there may be certain intervening factors which, unless identified, may lead to wrong conclusions. Three of these factors are discussed below.

The first factor relates to behaviour which may be attributed to the previous history and environment of the institutionalized persons. Data based on diverse studies confirm the view that close social relations are relatively uncommon among older persons in the institutions. In some of these studies, Peterson and Quadagno (1983) noted that the absence of close interpersonal ties may not be a function of institutionalization per se. Instead, it is likely to reflect diminished opportunities with some significant others (or certain social contacts) as persons age; which may have actually led to institutionalization in the first place. In agreement with this, Granick and Nehamow (1961), in a study based on Pre admission Isolation as a Factor in Adjustment to an Old Age Home, noted that those elderly persons who had been socially isolated prior to institutional placement appeared to have greater difficulties in learning social norms of the particular institutions. This group was also found to be the most likely to encounter problems and conflicts in interacting with others.

What the findings above imply is that by simply looking at the institutionalized aged one may notice low interrelations among them and quickly attribute this to the process of institutionalization. It is important, before making such a conclusion, to consider the behaviour or background of the aged prior to institutionalization.

The second factor relates to behaviour which may be attributed to the physical or mental state of the particular aged person prior to institutional placement. An example of this is where someone may be seen with certain psychopathic tendencies. Yet this may actually be the same mental state in which the person was before being committed to institutional care. As such it can be expected that the effect of institutionalization on the aged will depend on the old person's pre-institutional health background.

The third factor that may affect conclusions relate to behaviour which may be attributed to exposure to the conditions prevailing in the particular home for the aged. What this means is that different persons may manifest different trends or impacts which may vary according to the environment in which they find themselves. It is noteworthy that considerable differences exist in different homes for the aged in terms of physical and social environment as well as characteristics of residents. What this

implies is that institutional differences need to be addressed when considering the effects of institutionalization (see Peterson and Quadagno, 1985:417).

The importance of the physical and social environments as factors influencing behaviour of the institutionalized have been stressed by a number of scholars among whom are Lawton (1970), Goldfarb (1977), Nelson and Paluk (1980) and Friedman (1966). All these see the environment within the institution as affecting the aged either positively or negatively. Included within such an environment are the workers or personnel charged with the care of the aged. The influence of these workers on the aged cannot be ignored. This is because, through the constant interaction (or lack of interaction) between the aged and the staff members, institutionalization can either prove dramatic or traumatic, rehabilitative or disruptive, attractive or repulsive. Without belabouring the point, the argument here is that any assessment of the impact of institutional life on the aged must, of necessity, take into consideration conditions that obtain in the institutions.

In conclusion, regarding the impacts of institutionalization on the aged, there are certain positive and negative factors that have emerged from the literature reviewed. Positive factors noted

include provision of care and company to the previously neglected and isolated aged. But the negative (or adverse) effects seem to preponderate. These include decline in interaction between the inmates and both family members and friends, loss of old friends, decline in social status and prestige, depersonalization, and social withdrawal. The validity of these assertions can only be ascertained by looking for these factors in the homes for the aged in Kenya. It is important, in pursuance of such a goal, to note that:

(i) the impact of institutionalization on the aged will depend on their pre-institutional background. This background may be social, economic and/or physical,

(ii) the impact of institutionalization on the aged will depend on the environment within the institution. This environment may be both social and physical.

2.5 FRAMEWORK OF THE STUDY.

From the literature reviewed, it is apparent that the phenomenon under study cannot be fitted within just one framework. There are different aspects of the study which relate to different perspectives. Two

perspectives that emerge more prominently are Social Change and Life Changes approach.

There are two dimensions to this study. The first dimension relates to the causes of institutionalization while the second relates to the impacts of institutionalization on the aged. Social change applies to the first dimension whereas Life Changes apply both to certain aspects of the first dimension and the second dimension.

The first aspect of the study that is explained is the shift from family to institutional care for the aged. This is explained by social change.

Social Change.

According to Rogers (1971:7), social change is a process by which alteration occurs in the structure and function of a social system. If we confine ourselves to the family as the 'social system' the literature reviewed shows that the family has undergone certain changes. These changes can be classified as 'structural' and 'functional'.

Structurally, there has been a disintegration of the family. The extended form of family which was characteristic of the traditional African society has tended to break down and to be replaced by the conjugal or nuclear family (see Etzioni, 1964:182). Functionally, there has been a decline in roles that

were traditionally performed by the family. According to Ogburn (1954:5), these roles included procreation, education, socialization, production, worship, and recreation, among others. In the contemporary society most of these roles have been assumed by certain specialized institutions. Thus, education and part of socialization have been taken over by the education system in form of schools; production, by the economic system in form of factories and industries; worship by the religious system in form of churches; recreation, by the commercial entertainment industry in the form of theatres, sports grounds, and the like. These, and other changes, have greatly weakened the influence of the family over its members.

Change in any system can also be understood by considering its source. According to this framework, change can be either internally or externally induced. Change that originates from within (the system) is called 'immanent change', and that which emanates from without is called 'contact change'. Regarding the family, it appears that much of the change that has occurred therein can be attributed more to the impingement of certain external, rather than to internal, factors. Both Ogburn (1968:354) and Lloyd (1968:19) aptly see changes within the structure and function of the family as consequent to changes in

economics and technology, and in response to the modernizing process and economic development that obtains in the environment within which the family finds itself. Implicitly then, the family changes in order to adapt itself to its external environment. This view finds support in the adaptation theory of change according to which social systems adapt to (their) external environments (see Cohen, 1968:191).. The external environment in this case is composed of those specialized systems that have usurped certain functions that were traditionally performed by the family. But the changes in the family can also be attributed to modernization.

Modernization, according to Rogers (1971:10) is the process by which individuals change from a traditional way of life to a more complex, technologically advanced and rapidly changing style of living. The impacts of this process on the family, according to the literature reviewed, includes the displacement of the aged. With its structure and functions already disrupted, the family has been rendered ill-equipped to provide adequate care for the aged. This has in turn made the aged very susceptible to institutionalization.

So as not to take for granted the implied invariability of institutionalization of the aged, it

is important to briefly delineate the theoretical process by which institutionalization occurs.

Institutionalization of the aged has been appropriately regarded as an alien idea or practice in Kenya (see Onyango and Kayongo-Male,1984:89,90). The implication of this contention, especially when considered from the perspective of social change, is that institutional care for the aged in Kenya is exogenous, or externally induced. This view relates to the contention of contact change according to which change occurs within a social system when sources external to the system introduce a new idea (see Rogers 1971:8,9). The new idea in this case can be considered as the institutionalization of old age care, and the social system as the family. Since according to this view institutional care for the aged is a new idea, there would need to be an agent, or an external source of the idea. In order to identify the external source in this respect, one needs to note that the very first homes for the aged in Kenya were established by white missionaries. What this implies is that institutionalization as a form of old age care in Kenya can be traced from factors or forces external to the Kenyan society.

The contention that institutionalization of the aged in Kenya is externally induced should not be understood to imply an involuntary acceptance of an

alien culture. Whereas the exogeneity of the idea may not be in dispute, it would, however, be presumptuous to consider institutional care for the aged as an imposition of an alien way of life by certain external forces. It is more plausible to regard institutional placement of the aged as resulting from an interplay of, on one hand, certain factors inherent in society or impinging upon the aged, and, on the other hand, the very idea of institutional care. In this case institutional placement of the aged occurs when such an action (of institutionalization) is seen (by the aged) as an immediate and/or appropriate solution to certain needs which cannot be adequately met otherwise. Thus the 'alien' idea of institutional care for the aged becomes desirable and is adopted out of necessity.

The contention advanced above is that although the idea of institutionalization of the aged is externally induced, its acceptance is not determined by the external source (or force) but rather by the aged themselves. In other words, it results from selective contact change.

Contact change has two dimensions; it can either be 'directed' or 'selective'.

Directed contact change occurs when forces external to a social system deliberately and intentionally introduce new ideas in order to achieve

certain externally defined goals. On the other hand selective contact change occurs when members of a social system are exposed to external influences and adopt (or reject) a new idea from that source according to their need (see Rogers 19/1:9).

By application, institutionalization of the aged may be accepted and adopted when it is seen as functional or as a response to certain needs of the aged. What is important in this view then, is not the source of the idea but rather the very needs that necessitate the adoption of the new idea. It therefore follows that the adoption of institutional care must be viewed in terms of the needs that it satisfies. These needs can be best appreciated by focusing on the aged themselves. In order to do this we turn to Life Changes approach.

LIFE CHANGES

Life changes refer to the alterations in the state of an individual in terms of circumstances, appearance, mind, health,status, roles, etc.

Senescence, which is a process of aging, is regarded as a life change (McGaugh, 1979: 312). For the aged life changes are evidenced in retirement, socio-economic decline (or increase), marriage, (or

divorce), bereavement (of spouse, offspring, relative etc), loss of close friends, etc.

According to this perspective, whether or not an old person becomes a dependant is determined by the degree and nature of the life changes and how the aged manage to cope with them. From our literature review, it was observed that the general areas of an old person's life that are affected by life changes could be summarised as the socio-economic status, health status and social support. According to Cassel (1976) these three aspects tend to be inter-related (not necessarily causally) and an effect in one aspect will lead to an effect in another. For instance, if a life change disrupts the socio-economic status of the aged, this will most likely affect the health status as well. An old person who has no meaningful means of livelihood may not have sufficient food to eat or have the ability to avoid certain health risks. Such a person would have to depend on social support to cope with the life change.

A life change will alternatively affect one's health status. Such a person would not be expected to maintain a good socio-economic status independently. This again may lead to dependency upon social support for survival.

Cassel (1976) shows the relationship between health status and social support by noting that when

a life change disrupts a person's "meaningful" or "supportive" social contacts, it also affects the health. According to Cassel, social contacts are supportive when they encourage and enforce proper diet, medical check ups or treatment, and when they provide resources needed for coping with particular problems. It then follows that if social support is disrupted, the old person's health will also be affected. Such a person then becomes amenable to institutional placement, especially if the socio-economic status has also been disrupted.

It can be said from the foregoing that social support acts as an intervening factor between socio-economic status, health status and institutionalization.

By way of summary, because of the life changes the aged undergo, they cannot adequately care for themselves. Where their economic status, health status and social support have been disrupted, the aged invariably become susceptible to institutionalization.

Institutionalization, like senescence, marks a major life change for the aged. The aged who had lived within their natural environments as free members of society undergo change from their old status and roles to a new status as institutionalized aged and roles concomitant with this new status. This

change requires certain adjustment which in turn may have certain impacts on the aged.

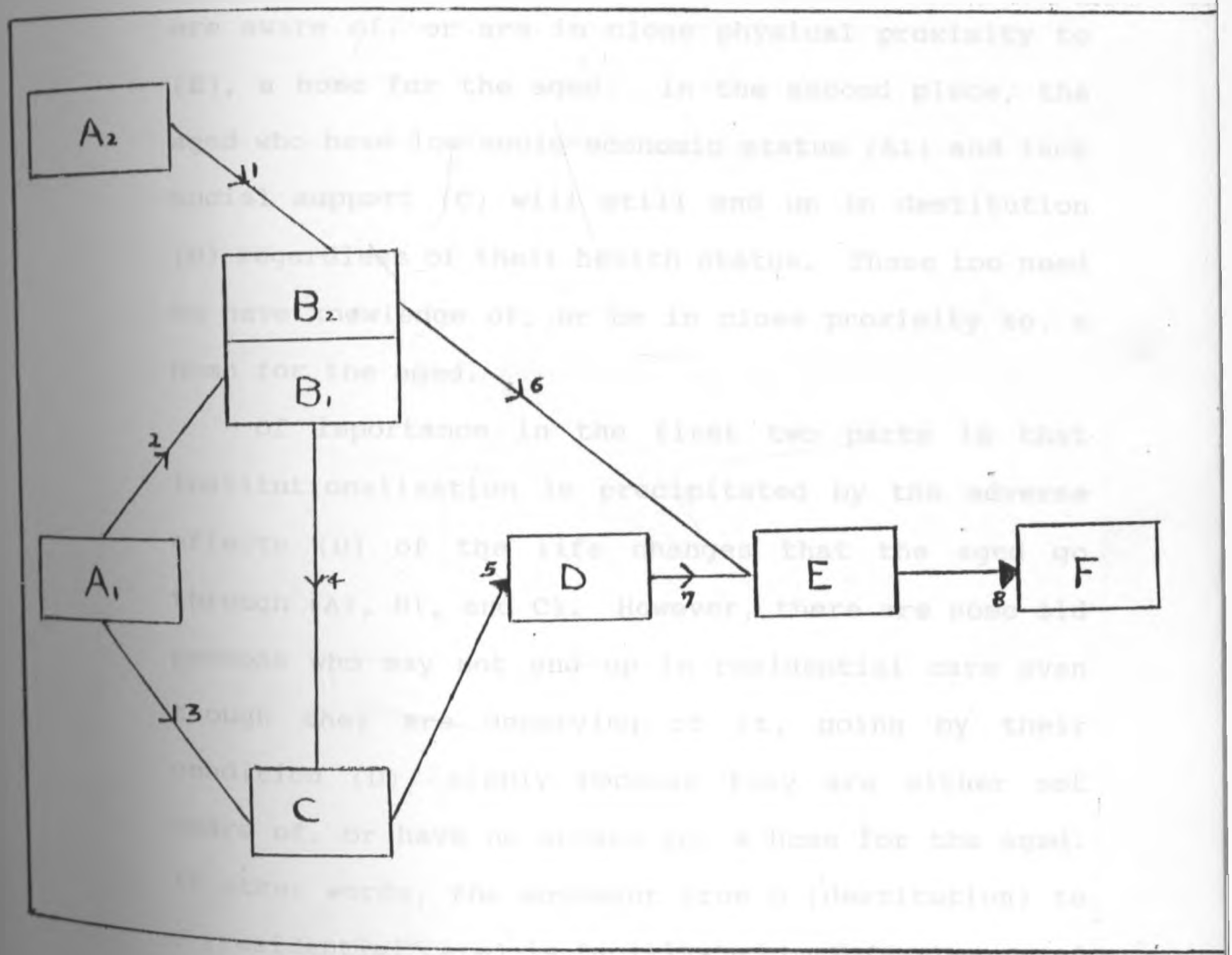
The change from normal community life to institutional life renders the aged unable to carry out his ordinary roles and so requires certain adjustments. These are done in conformity to the newly acquired status and in adaptation to the environment and its demands on the aged (Clausen, 1968:185).

Adjustment for the aged is necessitated by the fact that, for one, he finds himself in an environment which is unfamiliar. Secondly, he enters into a place where there is an expected decorum which may differ from his own orientation to life or disposition. Thirdly, the aged gets into a new social set-up that may mean new inter-personal relations. Lastly, the change of environment may envisage an encounter with a new culture, especially if the home is composed of people with heterogenous cultural backgrounds. The degree and success of adjustment to this new environment will determine the impact of this new way of life on the aged.

2.6 CONCEPTUAL MODEL

The issues discussed in the foregoing literature review and framework can be summarised in the following model which is in two phases. The first phase relates to the causes of institutionalization while the second relates to its impact on the aged.

CAUSES OF INSTITUTIONALIZATION



2.6.1. EXPLANATION OF THE MODEL

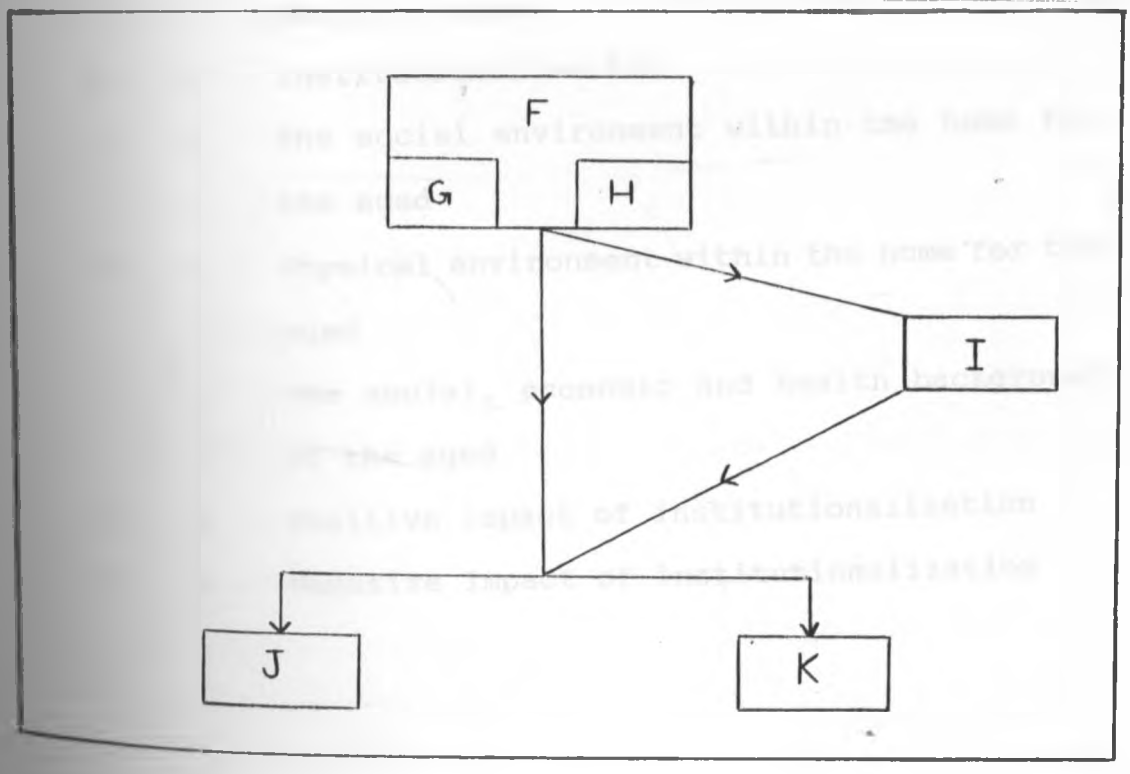
Briefly, in the first phase of the model, institutionalization of the aged emanates from three general directions. In the first place, the aged with low socio-economic status (A1) who also have low health status (B1) will end up in destitution (D) if, in addition, they lack social support (C). These then will end up in residential care (F) provided that they are aware of, or are in close physical proximity to (E), a home for the aged. In the second place, the aged who have low socio-economic status (A1) and lack social support (C) will still end up in destitution (D) regardless of their health status. These too need to have knowledge of, or be in close proximity to, a home for the aged.

Of importance in the first two parts is that institutionalization is precipitated by the adverse effects (D) of the life changes that the aged go through (A1, B1, and C). However, there are some old persons who may not end up in residential care even though they are deserving of it, going by their condition (D), simply because they are either not aware of, or have no access to, a home for the aged. In other words, the movement from D (destitution) to F (residential care) is facilitated by E (awareness of or access to a home for the aged).

In the third place, there are other old people who will end up in residential care (F) even though they have a favourable socio-economic status (A2) and health status (B2). Although these may not experience any destitution (D), they are likely to end up in residential care provided that they have knowledge of or access to (E) a home for the aged.

In the second phase of the model institutionalization may have either a positive (J) or negative (K) impact on the aged depending on the social and physical environment within the home for the aged (G and H) and/or the socio-economic and health background of the aged (I).

IMPACT OF INSTITUTIONALIZATION ON THE AGED



KEY

A^1 = The aged with low socio-economic status (LSES)

A^2 = The aged with high socio-economic status (HSES)

B1 = The aged with low health status

B2 = The aged with HSES

C = Lack of social support (i.e. lack or death of friends/relative/ family/spouse)

D = Destitution (i.e abandonment, lack of provision, deprivation, lack of basic necessities of life)

E = Knowledge/awareness and/or nearness of old people's homes

F = Institutionalization

G = The social environment within the home for the aged

H = Physical environment within the home for the aged

I = The social, economic and health background of the aged

J = Positive impact of institutionalization

K = Negative impact of institutionalization

CHAPTER THREE: METHODOLOGY

3.1 SITE DESCRIPTION

This study covered six districts, viz, Mombasa, Kisumu, Trans-Nzoia, Murang'a, Kirinyaga, and Nairobi (see Map 3.1). Below is a brief description of each site. (Information used here was compiled from the district development plans for each of the districts).

(i) MOMBASA

Mombasa is one of the six districts that form the Coast province. The district has an area of 275 Km². which includes the island surrounded by crescent shaped portion of the mainland consisting of Kisauni, Changamwe and Likoni.

Land Distribution

Out of the 275 km² of the total land area, state land occupies 207 km² (or 75.3%). Of the remaining 24.7%, 23.6% is underwater and only 1.1% (or 3 km²) is trust land. This is the only land that is available for small holders. The implication of this is that the majority of people in Mombasa are landless. A small portion of the district's households occupy the trust lands. Another large proportion of the population are

squatters on land already marked for government projects. These people are very insecure and often find themselves without residence in the event of eviction.

Much of the land in Mombasa is used for residential premises, manufacturing, industrial and commercial unit, local shopping centres, harbour and various other infrastructure and social amenities. Agriculture is practised at a very minimal level as compared to other districts.

Demographic Profile

According to the population census of 1979, Mombasa district had a population of 341,148 people. The estimates for 1988 were 492,024 people. This represents an increase of about 44.2%. The census report, the estimates (for 1988), and projections for 1990 and 1993 show a male preponderance in the population aged 60 and above. The average proportion of males for the four years was 52.2% meaning that women aged 60 and above composed only 47.8% of the entire population aged 60 and above (Republic of Kenya, 1989 (i):16).

There are four divisions in Mombasa. These are Likoni, Kisauni, Changamwe and Mvita (island). The most densely populated area, according to the 1979 census, was the island which accounted for 40.5% of the entire

population then. Incidentally, the island accounts for only 4.7% of the entire area of Mombasa district.

Mombasa, like Nairobi, is a primate urban centre, meaning that there is generally a great influx of people. According to the 1979 census, there were 206,878 in-migrants and 38,999 out-migrants, indicating a net in-migration of 167,879. This means that close to 49.2% of the total population of Mombasa were in-migrants.

Ethnic Distribution

By 1979, indigenous Kenyans accounted for 80.5% of the district's total population. Non-Kenyans formed the remaining 19.5% (Republic of Kenya, 1989:18). Among the Kenyan Africans, the Miji Kenda were the most populous, accounting for 25.8% of the total district population. This was followed surprisingly by the Luo who accounted for 13.5% and the Kamba who accounted for 11.8% of the total district population. The rest were the Luhya, the Taita and the Kikuyu respectively.

(ii) KISUMU

Kisumu district covers a total area of 2660 km² of which 567 km² is under water. Kisumu is the second largest of the four districts that compose Nyanza Province.

The district lies in a depression that is part of a large lowland. It surrounds the Nyanza Gulf, a protruding part of Lake Victoria at the head of which is Kisumu Town. East of Kisumu Town are the Kano plains, occasionally broken by low ridges and rivers.

The district can be divided into three topographical zones; the Kano plains, the upland area of Nyabondo, and the midland areas of Maseno. The upland areas comprise

of ridges which rise gently to altitude 1835 m. above sea level, while Kano plans lie on the floor of the Rift valley which is a flat stretch bordered to the north and east by escarpments.

The above formation renders itself vulnerable to flooding especially the lower Kano plains and particularly in the Nyando Valley. Notably the 1988 long rains caused a lot of flooding which virtually brought all activities to a standstill. Residents had to be evacuated to high ground for safety. A lot of crops and livestock were destroyed.

Land Use

Much of the arable land in the district is used for cash crops. The most important cash crop is sugar cane followed by cotton and rice. Less than 10% of the total land is devoted to subsistence farming. The most widely grown subsistence crops are maize, sorghum and sweet potatoes.

Demographic Profile

According to the 1979 population census, Kisumu district had a population of 536,754 people. The estimates for 1988 were 715,346, meaning an increase of about 33.3%. From the population census, the 1988 estimates, and the

projections for 1993 (Republic of Kenya, 1989:(ii):18), it appears that there is a preponderance of males in the population aged 60 and above. Average, males accounted for 56.3% of the 60 and above, meaning that females of the same category accounted for only 43.7%.

Ethnic Distribution

According to the 1979 census, the most dominant ethnic group was the Luo. These accounted for 91.1% of the total district population. These were followed by the Luhya and the Kikuyu who accounted for 4.7% and 0.7% respectively. The remaining 3.5% comprised of other smaller ethnic groups and races (Republic of Kenya, 1979).

Socio-Economic Profile

Kisumu district derives most of its livelihood from small scale agricultural farming, fishing, and industrial activities. These are the major sources that provide income for the basic needs like adequate nutrition, shelter and clothing, good health and education.

Income for the district is derived from three main sources; farm enterprise, non-farm enterprises, and salaries and wages. According to the economic survey for

1988, Kisumu is one of the 10 districts grouped as having an average monthly income which is less than KShs. 830.

(iii) TRANS NZOIA

Trans Nzoia district is the smallest of the 13 districts that compose Rift Valley Province. It covers an area of 2468 km² which represents 0.4% of the whole republic and 1.4% of Rift Valley Province.

Demographic Profile

According to the 1979 census, Trans Nzoia district had a population of 259,503. Estimates for 1988 were put at 439,811, representing an increase of about 69.5%. According to the 1979 census, the 1988 estimates, the 1990 and 1993 projections (Republic of Kenya, 1989 (iii)) there was a preponderance of males in the category aged 60 and above. On a average, males constituted around 53.1% of the class of 60 and above. This means that women represented just 46.9%.

Besides the natural increase, much of the population in the district are in-migrants.

Ethnic Distribution

The table below shows the distribution on the population in the district by ethnicity for the year 1979.

Table 3.2 Ethnic Distribution, 1979

Group	Numbers	Proportion
Luhya	128,025	49.3
Kalenjin	58,644	22.6
Kikuyu	26,630	10.3
Others	46,204	17.8
Total	259,503	100.0

Source: Republic of Kenya, 1989:20

The most populous ethnic group according to the table above were the Luhya who accounted for 49.3% of the total population. These were followed by the Kalenjin and the Kikuyu who accounted for 22.6% and 10.3% respectively.

The "other" category included the Turkana and the Pokot who continually found themselves driven away from

their natural environs either because of raids by certain hostile tribes or by harsh climatic conditions such as drought which appears to be a very frequent natural disaster especially around West Pokot and Turkana areas.

Socio-Economic Profile

Agriculture is the mainstay of the economy. Employment and income opportunities as well as poverty distribution problems all hinge on the agricultural and land holding system. There are large scale farmers everywhere in the district, and the squatters and landless live among the better farmers to supply the available cheap labour. Employment is therefore easily available to willing manual workers. At peaks demand for labour is higher than the supply. This could partly explain the great influx of people into Trans Nzoia District.

Pockets of under-consumption are found among the landless and squatters though the district is one of the granaries in Kenya, the production of maize which is the staple food is commercialized in the lands of a few farmers with hundreds of hectares of land. The squatter section of the economy is on the increase.

(iv) MURANGA

Muranga is one of the five districts in Central Province and covers an area of 2476 km². The land rises gradually from the East to West ending in the slopes of the Aberdare Mountains. The highest areas in the west have a deeply dissected topography and are drained by several rivers. The altitude of the district varies from about 914 m to 3353 m above sea level. The topography of the lower eastern portion ranges gently rolling to level land around the Kakuzi Hills.

Because of the deeply dissected topography evident in most parts of the district, soil erosion is a serious problem particularly in the high western zone. Landslides and other earth movements are also common in this zone. The terrain has an important effect on agriculture; only particular crops like tea can do well on these steep slopes.

Land Use Patters

There are generally three categories of land tenure in the district; Freehold, Government, and Trust. Of the entire land area in the district, 1482 km² (or 59.8%) is available for small holders, 888 km² (or 35.9%) is government land, 41 km² (or 1.7%) is Trust land, and 65 km² (or 2.6%) is Freehold.

Freehold land is the land formerly owned by European settlers. This has now been adjudicated to private ownership often through small holder schemes. Government land consists of forest, the Aberdares and other reserves, including alienated land that formerly belonged to European farmers. This is now leased to individual small scale and large scale holders. Trust land was formerly called the native reserve. This land is now owned by small holders, often with very fragmented plots. Over 60% of the district land area is trust land.

Socio-economic Profile

Muranga district relies heavily on agriculture to provide employment and incomes. The principal cash crops are coffee, tea, sisal and pineapple. Those who live in the high and medium potential areas and who are majorly tea and coffee growers have better socio-economic status than those in the marginal and rangelands. Whereas only 35% of the households in the high potential areas of Kandara, Kigumo, Kiharu and Kangema divisions are below poverty line, the figure is 65% in Makuyu division (Republic of Kenya, 1989 (iv):36). In terms of actual incomes the "very rich", mostly in the high potential areas were earning KShs. 2500 per annum, whereas the "very poor" (below poverty line) who were mostly found in

Makuyu division were earning less than KShs. 249 per annum. The poor are mostly the squatters.

Demographic Profile

By the 1979 census the population of Muranga district stood at 648,333. Estimates for 1987 put the population at 912,744, implying a 40.8% increase. From the census report of 1979 (Republic of Kenya, 1979), the estimates of 1988 and projections for 1990, it appears that there was a preponderance of females in the population aged 60 and above (Republic of Kenya, 1979 (iv):19). On the average females accounted for 57.8% of that particular age group. This is quite unique as it deviates from the trend shown in the other districts where males tend to preponderate.

Sex ratio can be used to distinguish regions of out-migration which will usually have female majority, from regions of in-migration, which will usually have male majority. The sex ratio and female preponderance evidenced in Muranga indicates that it experiences out-migration especially of males. These tend to migrate to Nairobi, due to its proximity and in search of wage employment.

Ethnic Distribution

The Kikuyu are the predominant ethnic group in Muranga, comprising over 95% of the population. The Kamba are second accounting for 2.9% of the population.

(v) KIRINYAGA

Kirinyaga is one of the five districts that compose the Central Province. The district covers 1437 km² and is approximately 0.3% of Kenya's total land area. The northern part of the district is covered by Mt. Kenya forest, occupying 300 km² which is about 21% of the district. The local zones border Eastern Province and are dry areas with low rainfall and poor soils. The north-west and eastern parts of the district are conducive to cash crops because of high rainfall and altitude which is over 1800 meters above sea level.

Demographic Profile

According to the 1979 census there were 291,431 people in the district. Estimates for 1988 placed the number at 402,892 implying an increase of 38.3% over a period of 10 years. Those aged 60 and above were 16,696 out of which 53.2% were females. This trend is similar to the one seen in Muranga district where there is a

preponderance of females (Republic of Kenya, 1989 (iv):11).

Socio-economic Profile

About 85% of the population in Kirinyaga is in the rural areas. This population earns it's livelihood through cash crops, food crops and livestock farming. There are no large farms or estates in the district.

In terms of income distribution, the population in Ndia and Gichugu divisions enjoy higher income levels due to the presence of more stable cash crops such as coffee and tea in addition to dairy farming.

(vi) NAIROBI

Nairobi is the capital city of Kenya and covers 684 km^2. Nairobi can be divided into three major areas viz. The industrial area - towards the south and east of Nairobi, the Central Business District (CBD) and the residential area scattered around the CBD. The Central Business District comprises the major government offices, hotels and institutions of learning, among others.

Demographic Profile

According to the 1979 census the population of Nairobi was 827,775. According to provisional census of 1989 the population had increased to over 1,346,000 showing an increase of over 62%.

According to the 1979 population census, there were 14,512 people aged 60 and above. Out of this 59.7% were men. The implication of this is that Nairobi is an area of in-migration. Given that it is the capital city it can be understood why it acts as a magnet for so many in-migrants.

Ethnic Distribution

The 1979 population census shows that the most populous ethnic group was the Kikuyu. These accounted for 33.4% of the total population in Nairobi. The second largest were the Luo accounting for 18.2%. These were followed by the Luhya, with 16.2%, then the Kamba, with 12.5% of the areas population.

3.2 POPULATION AND SAMPLING

The target population in this study will be the institutionalized aged. These are old people of diverse ages who have been committed to the care of old people's

home due to certain reasons which the study will attempt to elucidate.

Prior to the field work, a total of 15 homes for the aged were counted across the country. These were distributed among 10 districts as shown in Table 3.3.

These districts were located in areas which had different agro-ecological and socio-economic environments, different ethnic groups which represented different cultures. Different homes were managed by different organizations or bodies (Table 3.4). All these factors were taken into consideration in selecting the appropriate sample.

Table 3.3. Districts where homes for the aged are located

DISTRICT	HOME
1.Mombasa	(i) Little Sisters of the poor
	(ii) Alms House of the Aged
2.Nairobi	(i) Little Sisters of the Poor
	(ii) Kariobangi Chesire Home
	(iii) Matumaini Home - Pumwani

		(iv)	Mji wa Huruma - Karura
		(v)	Sir Charles Disney Memorial Home -Muthaiga.
3.	Kisumu	(i)	Ahero 'Jo-ot' social service - Ahero
4.	Busia	(i)	Mabale Home - Busia
5.	Kiambu	(i)	Thogoto Home for the Aged -Thogoto
6.	Siaya	(i)	Kambare Home - Gem
7.	Murang'a	(i)	Gaturi Home for the Aged
8.	Kirinyaga	(i)	Sagana Home - Sagana
9.	Nakuru	(i)	Alms House for the Aged - Nakuru
10.	Trans Nzoia	(i)	Bahati Home for the Aged- Kitale

SOURCE: Sample Survey

Table 3.4. Home for the Aged by Sponsors/Managers and Base

HOME	SPONSOR/MANAGER	BASE
Little sisters of the poor	Catholic Church	Urban
Alms House for the Age	Local Municipality	Urban
Little sister of the poor	Catholic Church	Urban
Kariobangi Cheshire Home	Church Organization	Urban
Nji Wa Mumruma	Mother Teresa	Urban
Matumaini Home	C.P.K Church	Urban
Nji Wa waree	City Council	Urban
Sir Charles Dianey	Private	Urban
Mabale Home -Busia	Catholic Church	Urban
Alms House for the Aged	Local Municipality	Urban
Bahati Home for the Aged	Local Municipality	Urban
Ahero 'Jo-ot' Social Service	Catholic Church	Rural
Thogoto Home for the Aged	PCEA Church	Rural
Kambare Home	Catholic Church	Rural
Gaturi Home for the Aged	Catholic Church	Rural
Saqana Home for the Aged	Catholic Church	Rural

SOURCE: Sample Survey

In selecting the sample, a multi-stage sampling method was used. This was done at three levels and was both purposive and random. This type of sampling was used mainly due to;

(i) the wide dispersion of the sampling units. This gave rise to the need to lower field costs in terms of time and money, and to minimize concomitant inconveniences which included the inaccessibility of certain areas, and

(ii) lack of a sampling frame for the entire population of the aged. This necessitated a special kind of

listing. Due to the reason given in (i) above, it proved advantageous and convenient to confine the special listing to a few manageable areas, and hence the reason for clustering.

Multi-stage sampling was done on three aggregates of units. The first aggregate was the districts which were also considered as the primary unit of sampling. The districts were appropriately called a cluster because they contained a number of homes which also constituted a sampling unit. The second aggregate, which was also regarded as the secondary unit of sampling, was of the homes for the aged. These were considered as a cluster because in them were individual old people who were the basic unit of enquiry to whom the results were to relate. The third aggregate, which was considered as the tertiary unit of sampling, consisted of the institutionalized aged.

Sampling was done within each of the three aggregates. At the primary level 6 districts were purposively selected out of the original 10 districts which constituted the area of dispersion of homes for the aged (Table 3.5). The reason for purposive sampling is that it allows for the researcher's own judgement

regarding the items to be chosen, and discretion to pick only those which best meet the purpose of this study.

TABLE 3.5: **HOMES TO BE INCLUDED IN THE SAMPLE (BY DISTRICT, SPONSOR, AND ANY SIGNIFICANT CHARACTERISTIC).**

DISTRICT	HOME	SPONSOR	SIGNIFICANT CHARACTERISTIC
MOMBASA	(i) Little sister of the poor	Church	-
	(ii) Alms House of the Aged	Public	-
NAIROBI	(i) Kariobangi Cheshire Home	Church	-
	(ii) Mji wa Huruma	Public	-
	(iii) Sir Charles Disney	Private	Whites Only
KISUMU	(i) Ahero 'Jo-ot' Social Services	Church	Community based
MURANG'A	(i) Gaturi Home	Church	-
KIAMBU	(i) Thogoto Home	Church	Exclusively for
TRANS-NZOIA	(i) Babati Home	Public	women

SOURCE: Sample Survey

The 6 districts were purposively selected for the following reasons;

(i) (a) Mombasa is the only urban centre which is predominantly muslim. Muslims espouse a culture which differs markedly from that of non-muslims. These different cultural factors

will be compared to see whether there is any cultural influence in institutionalization.

(b) There were only two homes for the aged in Mombasa. One sponsored and managed by a church organization while the other managed by the local municipality. This would facilitate a comparison of the two homes while holding the factor of cultural diversity constant and would help to show the impact of management on the provision of institutional care.

(ii) (a) Nairobi is a cosmopolitan, and Kenya's primate, city. Unlike in any other district, therefore, Nairobi is expected to have a number of people with very diverse cultural backgrounds. This diversity, was considered important in the understanding of the factors that lead to institutionalization, was not easily obtainable elsewhere.

(b) Nairobi had the largest number of homes in any given district. These homes can be generally classified as (i) sponsored by church organizations. (ii) sponsored by city council, and (iii) privately sponsored. A representative each of the three categories

was included in the sample. Since there was only one privately sponsored home (exclusively for whites) and one sponsored by the city council, both of these were automatically included in the sample. With regard to the church-sponsored homes, Matumaini home was selected out of the four church-sponsored homes. Besides Matumaini, the other three homes are sponsored either by the catholic church or an organization affiliated to the catholic church. Having already selected the little sisters of the poor in Mombasa, this was seen as a sufficient representation of catholic church-sponsored homes. Matumaini is sponsored by the C.P.K. (Church of the Province of Kenya).

(iii) Ahero'jo-ot' social service which is located in Kisumu district is a unique home and differs from any others. The uniqueness stems from the fact that the residents in 'jo-ot' are allowed a free and frequent interaction with the other members of the community. It is community based in that it is the

immediate community that supplies the residents with their daily food (HAK Situational Report, 1988;15). What is happening at Ahero may not be happening in any other home. As such, it would be important to see how the impact of institutionalization, under circumstances as found in Ahero, will differ from that of any other home.

(iv) Kirinyaga district had only one home and this was the only home in Kenya which was exclusively for females. This house was selected for purposes of comparison with the others which were for both sexes.

(v) Trans-Nzoia district was selected because of the need to include within the sample a number of local municipality-sponsored homes for comparison with the church - sponsored homes. Out of four homes, three were considered as a better representation of local municipality/city council-sponsored homes. Having already selected a home in Mombasa and Nairobi, Bahati home in Kitale was selected as

the third local municipality-sponsored home. The basis for the selection of this home was that it is located in an area which is expected to have a culture which is different from those of the two homes already selected. Mombasa is located in a dominantly muslim culture and Nairobi and Nakuru (the latter which was therefore, omitted) are located in areas which are dominantly Kikuyu. Kitale is therefore, unique in that it is located in an area which is dominantly Luhya. These cultural diversities are considered as appropriate bases for comparison of the homes.

(vi) Murang'a district was selected basically because of it proximity and accessibility. The only one home which is located in Murang'a district will therefore be included in the sample.

Within the 6 districts there were 11 homes. At the secondary level 8 homes were purposively selected as explained above. Within these homes there was a total of 294 old people. Out of these, a proportion of two fifths

(2/5) was randomly selected by use of simple lottery. The final stage, which was also the tertiary unit, therefore, had a sample of 118 individual old people drawn from the selected homes (Table 3.6). The sampling design described above is shown in Table 3.7 below.

Table 3.6 **Distribution and Sample of Old People Drawn From 8 Homes**

Homes	Total Population			Sample Size		
	Males	Females	Total	Males	Females	Total
Little Sister	37	29	66	15	12	27
Alms House	20	10	30	8	4	12
Ahero 'Jo ot'	6	49	55	2	20	22
Bahati	3	14	17	1	6	7
Gaturi	38	0	38	15	0	15
Mji wa Huruma	27	8	35	11	3	14
Matumaini	0	5	5	0	2	2
Sagana	0	48	48	0	19	19
Total	131	163	294	52	66	118

SOURCE: Sample Survey

Multi-stage sampling was used mainly due to the following two reasons:-

(i) it facilitated a concentration of the field work in specific areas thereby leading to a saving of time, labour and finances.

(ii) it obviated the necessity of having a sampling frame covering the entire population. Whereas it was very difficult to obtain a sampling frame at the primary and secondary stages of sampling (mainly because of the unavailability of such a frame and due to the vastness of the areas involved) it was much more practical, and convenient, to get a sampling frame at the tertiary stage.

The Sample size of 118 drawn from the homes was considered appropriate because of constraints in time, personnel and finances. Secondly, in addition to this sample it was found imperative to select a control group of the same size. This comprised of old people who were not institutionalized inspite of sharing certain characteristics with the institutionalized aged.

Table 3.7 **Sampling Design**

AGGREGATE	POPULATION	SAMPLE	METHOD OF SELECTION
Primary (Districts)	10	6	Purposive
Secondary (Homes)	11	8	Purposive
Tertiary (The Aged)	294	118	Proportionate random sampling

The rationale for having a control group was that (i) if institutionalization was to be considered as a variable in the study, then certain un-institutionalized aged had to be included. Otherwise, as long as the sample contained only institutionalized persons, institutionalization would remain a constant and not a variable; (ii) the use of the control group would further strengthen the findings and validity of the study. Using the control group, it would be possible to do comparisons and to see the actual differences between those aged who ended up in the homes for institutional care and those who remained within their natural environments despite old age.

In selecting the control group, a purposive sampling method was used. This method was considered appropriate because:

(i) there was no sampling fame available from which to draw the desired sample.

(ii) there was need to include into the control group only those old people who had certain characteristics. This could not be left to chance.

Initially a sample of 118 old people was selected from the control group. The main criteria used in selecting this number were:

(i) Proximity:- the control group was selected from among old people living in their old houses but within the community immediately neighbouring a particular home which had been selected in the first sample. This was done in order to control for cultural diversity between the experimental (or the main), and the control group. (It is important to note that in each home, over 90% of the residents were drawn from the neighbouring community).

(ii) Sample Size:- those included in the sample from each community had to be of the same number as those drawn from the homes in the experimental group.

(iii) personal characteristics:- these had to be, as much as possible, similar to those of the institutionalized aged. Since it was not possible to control all characteristics, attempts were made to

control for only sex, age, residence, and place of origin, though not with 100% precision. Other characteristics such as family size, occupation, income etc., which could not be controlled at all still provided vital information and bases for comparing and contrasting the two groups.

3.3. PROBLEMS ENCOUNTERED IN THE FIELD

A number of problems were encountered in the field. A few of these that had certain significant implications on the study are mentioned below.

The first problem was a tragic loss of field questionnaires through theft of the researcher's luggage during one of the trips. These were 118 questionnaires which bore information obtained from the control group. In a bid to recapture at least some of the lost information, a repeat field work was undertaken. Due to the time and financial implications of the task, it was not possible to repeat the interviews in all the 6 districts initially covered. Only three districts, viz, Nairobi, Murang'a and Kirinyaga were selected for the repeat field work. These districts were generally selected because of their proximity.

Specifically, Nairobi was selected because there it was possible to capture a wide cultural diversity.

Murang'a was selected because it had the only exclusively male home. Sagana was selected because it had the only exclusively female rural-based home. The three districts provided a fair representation of certain important characteristics regarding the lost sample, under the given constraints. Out of the three districts, a total sample of 30 respondents was selected. This represented 25% of the respondents interviewed from the homes earlier selected within the three regions.

The implication of the problem mentioned above is that certain information that had earlier been obtained in the lost sample may not be reflected in the repeat sample. Besides, the 'control group' can now not be used in the originally intended way. Rather, it will be considered simply as a 'comparison' group.

The second problem related to inaccessibility of one of the homes. Initially the Charles Disney memorial home in Nairobi was selected in the sample. When approached, the administrator of the home declined to divulge any information about the residents (for purposes of sampling) insisting that doing so would amount to interfering with their privacy. Although permission was finally granted for conducting of interviews, the administration unequivocally stated that it would not involve itself in the interviews or give any information

about the residents without their permission. The researcher was urged to try and secure interviews with any willing resident; a task which proved very formidable. No sooner had the researcher started conducting interviews than there was a large hue and cry from the residents who registered their resentment at what they considered as an interference with their private lives. Consequently the entire home was dropped from the sample. The implication of this is twofold:-

(i) whereas the original intention was to visit 9 homes, only 8 were eventually covered, and

(ii) the home which was dropped was the only one known to be exclusively for whites. This home had been purposively selected to provide a basis for comparison between the whites only home and others which were dominated by indigenous Kenyans. This will now not be possible.

The third problem related to under-age residents within the homes for the aged. The random sampling used to select respondents within each home netted some six persons aged as low as twenty four. Although these were also institutionalized, they however could not fit within the category considered as 'aged' (those aged 50 and above). Consequently these persons were dropped out of

the sample thus effectively reducing the sample size from 118 as earlier desired to 112. This distorts our intended proportions and denies us the opportunity of considering critically the characteristics of the under-age within the homes for the aged.

The fourth and fifth problems related to lack of adequate documentation of homes for the aged in Kenya and lack of a centralized system from where adequate information pertaining to each home could be obtained. These had certain implications on the study.

First, initial information obtained by word of mouth and from available literature indicated that there were only 15 homes for the aged in Kenya and that these were dispersed within 10 districts. However field experience indicated that there were actually more than 15 homes in Kenya. Since this information was not available prior to the field work, sampling was done without consideration of the additional homes. Incidentally, some of these homes might have represented characteristics which were not covered in the homes initially selected.

Secondly, initial information showed that the only home exclusively for women was Thogoto in Kiambu district. This was untrue as Thogoto home turned out to be for both sexes. The actual home exclusively for women

turned out to be Sagana in Kirinyaga district. Thogoto home was subsequently dropped in preference for Sagana.

The fifth problem related to communication barrier especially with the rural based Kikuyu-speaking respondents. For those who could not adequately express themselves in a language known to the researcher, an interpreter was used. This inhibited free communication with the respondents. There is a likelihood that certain responses were modified or altered by the interpreters, undetected by the researcher.

Finally, there was a problem of memory lapse especially among the very aged. A number of them could not recall certain needed information,a major problem being their ages. Memory lapse accounted for the many 'can't recall' responses that appear in the data presentation.

3.4 METHODS OF DATA COLLECTION

Four methods were used for data collection. These included interview of sampled respondents, observation, key informant interviews, and review of documentary materials.

(i) Structured Interview.

The interview schedule was the major tool for data collection. This method was selected because most of the respondents were not competent enough to respond to written questions. Besides, this method was found to be more advantageous in that it gave room for checking any possible misunderstanding of a question, probing, follow-up, first-hand opportunity for making assessment of the situation at hand and making observations. The interview schedule had both open-and closed-ended questions. The questions mainly revolved on personal characteristics of the residents, background information on social and economic factors, place of origin, reasons for seeking institutional care, patterns of life within the homes, problems experienced in the homes, among others. These questions provided the basis for testing of the research hypotheses.

(ii) Observation.

Observation was used to supplement the other methods. The choice of this method was based on the fact that, given the exploratory nature of this study, the method would facilitate observation of significant features of institutional care which are little known. It would allow for first-hand perception of what actually took place in the homes, rather than to rely entirely on

verbal responses. It would also assist in answering certain questions to which respondents may be evasive. The main areas of concern for observation include the daily routines in the homes, their physical structures as well as the living conditions there.

Key Informant Interviews.

Interviews were conducted with certain key informants. These included officials from the department of social services within the Ministry of Culture and Social Services, officials from Help Age Kenya, and certain members of Staff within homes for the aged. These interviews were both structured and unstructured.

The aim of key informant interviews was to obtain information about Management of the homes, get background information concerning the homes, check information given by the aged, and any other relevant information which might have not been obtained from the institutionalized aged. Documentary materials was used basically to provided secondary data. Material used here included reports from Help Age Kenya, records from homes for the aged, and other relevant documents from existing libraries.

(iv) Field Note-Books.

In cases where interview schedules could not be used to record information, field note-books were used. Besides, field notebooks were used to record any observation and/or information for which no space was provided, or which could not be recorded in, the interview schedules. The notebooks were thus used to supplement interview schedules.

3.5 VARIABLE SPECIFICATION AND OPERATIONALIZATION

There are three main hypotheses in this study; the first one relates to the causes of institutionalization while the last two relate to the effects (or impacts) of institutionalization on the aged. The hypotheses state that:

H_1: the aged who have low socio-economic status and low health status are more likely to be institutionalized if, in addition, they lack social support (pages 17-27).

H_2 the impact of institutionalization will depend upon the physical and social environment within the home for the aged (pages 32-40).

H_3 the impact of institutionalization will depend on the socio-economic and health background of the institutionalized aged (pages 32-40).

MAIN VARIABLES

DEPENDENT		INDEPENDENT
H_1	Institutionalization	(a) low socio-economic status (b) low health status (c) lack of social support
H_2	Impact of institutionalization	Physical and social environment
H_3	Impact of institutionalization	Socio-economic and health background

3.6. DEFINITIONS, INDICATORS AND MEASUREMENTS OF VARIABLES

1. Institutionalization

This was used to refer to the act of committing an old person to the care and supervised routine of a home for the aged. An old person who lived in such a home depending on it for food, shelter and clothing was to be considered as institutionalized (institutional care, residential care and institutionalization are here used as synonyms).

2. Impact of Institutionalization

This referred to the negative or positive effects of institutional care on the aged. It referred to the benefits or deprivations that the aged experience within the homes.

The indicators used here included, the degree of integration of the aged within the homes and, the attitudes of the aged towards the homes.

To measure impact of institutionalization on the aged, observations were made on the involvement of the aged in activities in the homes; their patterns of interaction among themselves and the staff within the

homes, and between themselves and outsiders. Questions were asked concerning their feelings towards the homes and any problems that they encountered within the homes.

3. Low Socio-Economic Status

Socio-economic status was used to assess the social and economic position that the aged held prior to institutionalization. Indicators for socio-economic status included previous occupation, income, residence and level of formal education.

To measure socio-economic status, background information was sought regarding previous occupation of the aged, amount of income received per month, place of residence (in terms of location and adequacy of residence) and level education. Anyone who had no adequate source of income was considered as having had a low socio-economic status.

A source of income was considered adequate if it provided the daily basic necessities of life-like food, clothing and shelter.

4. Lack of Social Support.

The word social support was used to refer to any social relations and forms that the aged had before institutionalization.

Social relations considered here included friends, relatives and offspring, and spouse of the aged.

To measure social support, questions were asked concerning;

(i) any social relationship that the aged had by the time of institutionalization;

(ii) frequency of contacts that he/she had with the social relations;

iii) frequency, amount and type of care of support that the aged received from the social relations.

5. Low-Health-Status

The word health status was used to refer to the physiological conditions or state of the body at a particular time. This may be classified as either low or high. In this study, low health status was used to refer to the high degree or incidence of illness that the aged suffered prior to institutionalization. In order to

determine ones status of health, it was important to consider;

(i) the type of disease from which the aged suffered;

(ii) the frequency of the disease, and

iii) the intensity of the disease.

To measure the type of disease, questions were asked as to whether the aged suffered from any particular morbid disease. The frequency of the disease was determined by the number of times in a month the aged suffered from a type of disease. The intensity or severity of the disease was determined by inquiring about any incapacity resulting from a disease, incidence of hospitalization, or ceasation from any type of work previously engaged in.

6. Socio-Physical Environment

This was used to refer to social and physical conditions under which the aged live within the homes. To assess the socio-physical environment of the homes, factors to be considered included the rules and regulations within the homes, degree of freedom, activities carried out, patterns of interaction, structure of buildings, physical facilities available,

management of the homes, residential arrangements (such as sleeping, feeding and living), composition of the homes (in terms of personnel, number of residents, ages, sexes, ethnic groups, etc).

Data adduced from this variable was not strictly used for measurement but rather to form a bulk of descriptive data to show and compare conditions within different homes.

7. Socio-Economic Background

This was used in the same sense as socio-economic status (in Number 3 above). This was because in this study, social and economic status was seen as being determined by socio-economic background. Therefore, over and above, those indicated in socio-economic status, other factors considered here included marital status, social contacts and health status.

CHAPTER FOUR: HOMES FOR THE AGED IN KENYA: - A PROFILE

This section provides a description, albeit briefly, of each on the eight homes for the aged covered in this study. Attempts are also made to compare and contrast life in the various homes. First, a brief word about the major reasons given for establishing the homes.

Generally, homes for the aged in Kenya were established out of concern for the disabled and neglected aged who were sickly and suffering from various deprivations yet without anyone to provide any (adequate) care. This was attributed to the disintegration of the extended family which traditionally provided such care. The ideal that was being pursued here was the restoration of the dignity of the neglected aged by making them feel, and see themselves as, part of the human community. Although probably just varying slightly in expression, this emerged as the main reason for, and goal pursued by, the eight homes described below.

4.1 LITTLE SISTERS OF THE POOR

The home is located in Tudor within Mombasa town. The management of the home is under the "Little Sisters

of the Poor" - a catholic order started in France. For the running of the home, the Little Sisters rely on charity in the form of donations from well-wishers and the local community.

The home houses 66 aged persons (37 males and 29 females). Although most of them are indigenous coast people, a few come from other regions within and outside the country. However, this does not seem to have affected relations among the residents. There is a warm and friendly relationship among the residents and between them and the care staff. Residents know one another by name and interact quite freely with the care staff.

The staff comprises of seven catholic sisters and 17 others including a priest. The sisters are directly involved with the day to day care of the aged. The sisters have undergone general training in nursing which facilitates their care for the aged. The sisters are not wage - employed but, rather, consider themselves as voluntary workers - which to them is not an occupation but a vocation.

The main residential place consists of a storeyed building with two wings, one for males the other for females. Residents live two or three in well-furnished and well-kept rooms. The rooms are cleaned daily, bedding and clothing are also changed daily.

The residents engage in various activities in the home. These include helping in kitchen work, laundry, sweeping the compound, watering flowers, handcrafts such as basketry, knitting and crocheting, among others. Done quite voluntarily, these activities are aimed at making the aged feel an integral part of the family of the little sisters. Besides, there are other recreational activities which include get-togethers once every month during which time there are dances and invited groups to entertain the residents. In addition, the institutionalized are occasionally taken out for tours. There are also television sets which the residents watch in the evenings. For those who need exercises, there is a well equipped gymnasium for physical exercise.

Medical care is quite up-to-date. Almost every week some medical personnel visit the home to give the residents medical check-up. Those who have eye problems are issued with spectacles (according to prescriptions) and those with problems in walking are provided with crutches or wheel-chairs. Those in need of urgent or major medical treatment are transported to the nearest hospital in a vehicle donated for use in the home.

Meals in the home are quite prompt and varied. The residents wake up at 6.00 am. to bathe and go for prayers before breakfast at 8.00 a.m. There is another session

of prayer before a 10.00 O'clock tea. Lunch follows from 11.30 a.m. then another tea at 4.00 p.m. The last meal comes at 6.00 p.m. During meals the residents are allowed to eat whatever they wish within the day's menu. Foods provided comprise of tea, porridge and bread for breakfast. The main dishes are mainly fish, meat, eggs, chicken, vegetables, ugali, rice, chapati and milk, among others. There is no rationing on food. None of the residents expressed any complaint about the care staff or services rendered.

4.2 MOMBASA ALMS HOUSE

Managed by the local municipal council, the home is situated near Changamwe along Mombasa-Nairobi road. All the 30 respondents (20 males and 10 females) had previously been resident in Mombasa for a considerable length of time. (This is one of the conditions for admission). Although drawn from diverse ethnic backgrounds, the residents have almost totally assimilated the Swahili culture. As a result, the residents no longer see one another as 'strangers', which is a vital integrative factor.

Residents have various characteristics, some are mentally retarded, others senile, while some are just

aged. All these are however, lumped together in the home. Since some need more specialized care, their being grouped together raises questions as to how adequate or appropriate the care they receive in the home can be.

The care staff comprises of one social worker, a few cooks, attendants, grounds-men, and a nurse. Apart from the nurse and the social worker, the rest of the staff is not trained on any issues relating to old age care. This raises a question about the adequacy of the care staff. The care staff is not only inadequate in terms of lack of relevant training but even numerically. For instance, one attendant has to look after 13 residents. How this is feasible is a wonder. Besides, the social worker who incidentally, should be the superintendent of the home, does not reside within. Both the aged residents and the attendants therefore lack supervision much of the time.

Although there is a dispensary within the home, this only handles minor ailments. Most of the cases have to be transferred to the main hospital. Getting there is not easy since there is no vehicle specifically assigned to the home. Besides, the one nurse who is in charge of the residents' health does not stay around during the night. What this implies is that any resident who falls

ill during the night would not get any immediate medical attention - a rather unfortunate situation.

Much of the facilities in the home are generally in a poor condition. Although there are single rooms where the residents sleep, these are rather poorly maintained. The rooms are not cleaned frequently, the clothing and bedding at times have to wait for a few weeks before being changed or washed. This portends unknown health hazards.

Other services offered reflect the same state of maintenance. There is a general complaint about the quality and quantity of food offered. There seems to be no set times for meals. For instance, breakfast at times comes after 9.00 am. and supper as early as 4.00 p.m. (no lunch is provided). Those who cannot take supper that early have to keep it and eat it later on, cold. This is because the cooks who do not stay within the home have to leave early and are also often unable to get to the home in time. Further, a number of the aged residents who are considered 'able' have to clean their own rooms and do their own laundry. The concern with this is that whether or not one is 'able' is usually decided by the attendants and therefore at times inspite of the feelings of the individual resident.

The general state of services rendered in the home is also reflected in the relationship between the staff and the institutionalized. This relationship is characterised by impersonality and suspicion. Although the residents are free to go out at will, beg for alms on the streets or take alcohol if they wish (so long as it is done 'moderately'), many of them feel that they are in the home, not by choice, but rather due to lack of an alternative place. There is a general feeling of discontentment with the care received in the home.

4.3 AHERO 'JO-OT' SOCIAL SERVICES

Ahero 'Jo-ot' comprises of 9 centers or villages for the aged scattered within the Kano plains. This is therefore not a 'home' in the strict sense. Rather, the 55 residents (6 males and 49 females) are scattered within each of the centres but coordinated by the local Catholic Parish. Although the coordination of the services is done by the local parish, the actual running is done by the local community. Sub-parish members in each center have organized themselves into committee which oversee the collection of food-stuffs, clothing, beddings, money and any other facilities needed by the aged residents. There is no care-staff as found in

the other homes. Residents here are generally left to manage their own lives almost independently. Each lives in a mud-walled and grass-thatched or iron-roofed hut built by members of the local community. Each occupant is responsible for his or her own hut and survival basically in terms of hygiene and preparation of meals. Besides the fact that they are brought together in a center, the aged residents lead an almost normal community life.

There is not much in terms of physical facilities. Each hut is equipped with just the very basic facilities needed to make a relative degree of normal life possible. Such facilities include utensils, bedding, clothing and a few pieces of furniture. In addition, each center has a bore-hole or well from which the residents draw their water.

Since the residents are drawn from the same community and speak a similar language, there is no problem of communication. Instead, there seems to exist very cordial and intimate relations among them.

Given their rural setting, many of the centers are withdrawn from any main roads. This creates a problem of transport. This problem is especially worse during rainy seasons when the area gets flooded or when one falls ill. During sickness, the residents have to walk long

distances to get to the nearest health center or means of transport.

The centers are situated in a region that has two extreme climatic conditions - floods and drought. This has an implication on availability of food. Since the residents depend on the local community for food supplies, shortages at the community levels, especially during adverse climates, is reflected at the centers. Much of the complaints in the centers therefore relate to shortage of food. Besides, since both the climate and soil type is not very conducive for agriculture, any hopes of growing foods within the centers to supplement supplies are greatly diminished.

Because it takes long to collect food-stuffs from the community members, foods are distributed only once a week. The implication of this is that anyone whose supplies run dry before the next allocation has to find other sources. But since resources are scarce, survival becomes rather difficult. The residents have to go borrowing and resort to taking only one meal in a day.

4.4 BAHATI HOME

Built in the early 1960s, the home is located within Kitale town and managed by the local municipal council.

There are three rows of permanent blocks each having seven rooms. Each aged resident is allocated a room. At the center of the compound is an ablution block and a tap for drawing water.

Most of the 17 aged residents (3 males and 14 females) come from neighbouring districts. The residents are allowed to live with members of their immediate families. Each of the male residents live together with their wives while a number of the female residents live together with their children. Since the existing staff of three is only concerned with ensuring the cleanliness of the compound and that of the ablution block, the aged residents have to clean their own rooms, prepare their own meals, do their own laundry. Those with members of their families get assistance from them. The freedom to live with their family members within the home has greatly diminished any feelings of loneliness, isolation or alienation for the aged residents.

Monthly provisions of food-stuffs are received from the home. The home, on its part, gets money for the same from the local municipal council. When there is any delay in this, the residents have to look for their own food. Even when food is supplied, the ratio given rarely lasts for a month. Residents then have to look for alternative means of survival. Some resort to begging or

gathering food from the local market. Because of this, there is a general complaint about shortage of food in the home.

Within the home there is no institutionally organized activity. Residents are free and under no strict supervision. They are generally responsible for their own day to day activities. The freedom to go out at will has helped to minimize any feelings of depression. As such, there is no complaint against the care - takers. Instead, there seems to be very free interaction between them.

4.5 GATURI HOME

Started in 1966, the home was established and is managed by the catholic church. The running of the home is mainly facilitated by finances from the local catholic diocese and the local community which donates food-stuffs.

All the 38 residents are male and mostly from Murang'a district. Although there are a few others from different districts, many of these, including the Father-in-charge, have learned the local language. Problems of communication especially relating to language barriers therefore do not exist.

The care-staff consists of the catholic Father, a couple of catholic sisters and the subordinate staff comprising mainly of cooks, cleaners, and grounds-men. None of these has any training on issues relating to old age care. Generally, residents are not required to do any duties within the home. However, a few assist (at will) in such chores as peeling of potatoes. The cleaning of rooms, laundry, and preparation of meals are done by the care staff. Residents are also allowed to move freely within or without the home, so long as permission is sought.

There are no recreational facilities within the home. However, there is a chapel where residents are expected to attend prayers about three times a day. Besides, there is a dispensary within the home and a resident nurse to attend to the old people's health problems. A doctor also visits the home at least once a week to give the residents medical check-ups.

Three meals are served in a day. These mainly comprise of porridge (breakfast), vegetables, ugali, mixture of maize and beans, and mashed bananas and potatoes. Meals and the care staff are the two main areas of concern to majority of the residents. The complaint against food is its monotony. Some residents even complained that they never subsisted on such foods

even in their own homes. This raises the issue of cultural differences between residents and its effect on their ability to adapt to the institutional environment.

Regarding the care staff, although the over-all head of the home is the Father-in-charge, the day to day care of the residents is the onus of the 'lower' staff. The aged residents have reservations about the way they are treated and their relations with their attendants.

4.6 MATUMAINI HOME

The name literally means a 'home of hope'. Located within the city of Nairobi around Majengo/Pangani area, the home is managed by the Church of Province of Kenya (CPK). All the five residents are females who previously lived within the city. They are attended to by a staff of about five which includes two cooks, two attendants and the local parish priest.

There is no institutionally organized activity within the home. Most of the time, the residents tend to sit in their rooms or in groups of twos or three, to chat. Otherwise, there is really no close interaction between the residents. Those who are able are free to visit the neighbouring community.

There is not much in terms of physical facilities, neither are there any recreational facilities. There is no health services within the home or a medical personnel. In case of illness the residents are taken to any near health center. The cleaning of rooms, laundry, and preparation of meals are done by the care staff whose relationship with the residents seemed rather secondary. For instance, it was a little surprising that the attendants did not know much about the background of the aged, neither could the local priest give any history about the home.

4.7 MJI WA HURUMA

The name literally means a 'village of compassion'. Established in 1965 the home is located outside the city center, off the Nairobi-Kiambu road at the end of the Karura forest. Although this is a city council premise, its management was given to the Salvation Army.

The 35 aged residents (27 males and 8 females) are taken care of by a staff of twelve comprising of 2 cooks, 2 watchmen, 2 shamba boys cum groundsmen, 4 attendants and 2 Salvation Army officers. None of these has any training on old age care.

In terms of composition, although the home is situated in Kikuyu land and dominated by Kikuyu - speaking old persons, there are minority groups from other communities. This causes problems in communication, not only among the institutionalized but also with the care staff. Other concerns include general feelings of isolation and loneliness expressed by residents, especially of minority tribes; most of who cannot communicate in any languages other than their own.

The home does not only admit the aged per se. Although among the 35 there are those who are there simply due to old age, some are residents because of sickness (such as polio, leprosy, among others). Others have certain physical disabilities while others are mentally retarded. Some are not really 'aged'. This mixture poses certain problems regarding the type of care the aged can adequately get from the home. Some of these aged persons need more specialized care.

Even though a number of the residents have health problems, there is no readily available medical care within the home. The sick have to be transported to a nearby dispensary whenever need arises. Since the home is situated far from the main road, the sick have to rely on transportation by an old vehicle which is also used as

a means of conveyance of food, fuel, and running of other errands.

Structurally, much of the buildings in the home are quite old and generally in disrepair. There are no private rooms and so the residents have to share. But this applies only to females. The males have to contend with congestion in an open room which is also used as a dinning hall and worship room. Besides, there are no adequate recreational facilities save for a television set in the men's room. Much of the time the residents spend time basking in the sun or conversing. The conversations however exclude those whose languages are spoken only by themselves and who do not know any other languages.

Hygiene in the home leaves a lot to be desired. For instance, although residential rooms are cleaned almost daily, the residents however, bathe only twice a week and their clothing and beddings changed only once a week.

From the care staff it was established that the main problem faced in the home relates to finances. The city council does not honour its financial obligations to the home as initially agreed. Further, besides the money the Salvation Army gives, the home has to rely on donations from well wishers, which comes rather infrequently. This is considered as the cause of shortage and lack of many

varieties in food, lack of adequate clothing and beddings, and the dilapidated buildings in the home.

4.8 SAGANA HOME

Sagana Home for the aged is situated about two kilometres from Sagana township. The home is run and managed by the Consolata Fathers - a Catholic order. Although part of the finances are provided by the church, the home relies mainly on donations from the local community and other well-wishers as well.

All the 48 residents are females drawn from the adjoining community. Most of these residents suffer from various diseases including mental disorders. Those in need of medical care find it readily available within the home. The fact that all the residents are drawn from the local community helps to alleviate problems that might have arisen regarding 'strange' diets, communication, and feelings of isolation or discrimination which might be occasioned by cultural heterogeneity. There is a notable atmosphere of tranquillity generally attributed to the religious orientation of the home.

Although there are paid subordinate staff members (mainly involved in cooking and other odd jobs), the

actual care staff is composed of catholic sisters. These, like the little sisters of the poor, see their work among the aged as a vocation - a calling - rather than an occupation. The impact of this is felt in the very cordial relationships and spirit of friendliness that obtains in the home.

4.9 DISCUSSIONS

The eight homes for the aged described in the foregoing sections can be generally classified into two categories, namely, those run by church organizations and those run by local municipal councils. Homes run by church organizations include the Little Sisters of the Poor, Ahero 'jo-ot' social services, Gaturi Home, Mji wa Huruma, Matumaini Home, and Sagana Home. Those run by local municipal councils are Mombasa Alms house and Bahati Home.

As generally observed, institutional life in public (or local municipal council) homes tend to differ from that in the church maintained homes. Concerns such as of hygiene, foods, poor resident - staff relationships, inactivity, financial problems, among others, abound more in the public than in the church - maintained homes.

Whereas many of the aged in the public homes seem resigned to life and rather fatalistic, those in church - maintained homes seem to have a relative degree of contentment with their lot. This is attributed to the religious teachings the aged get in the homes. These teachings attempt to console them and to give them some hope beyond any present suffering. Although death is inevitable, to them, death is looked at with anticipation and as an opportunity for life in another sphere. Even though the reality of this view cannot be debated here, it should suffice to state that whatever the case may be, the way the aged in church-run homes relate to their present conditions is much more favourable than that of the aged in public institutions.

Life for the aged in most of the homes is quite sedentary and characterized by inactivity. Although this may be attributed to the old people's physical inabilities, the lack of facilities observed in most of the homes cannot be ignored. Only the Little Sisters for the Poor and Sagana Home for the Aged seemed exceptional in this regard.

It was observed that in some of the homes, the very aged are mixed with those in their middle ages (or younger). In other homes certain mentally disturbed old persons were mixed together with mentally sound aged

residents. Yet is some homes there was heterogeneity in cultural backgrounds. In all these cases of 'mixtures' problems of integration emerged. There was however no such problem in homes where residents were relatively homogeneous in terms of age, sex, and cultural background, among other characteristics. It can be concluded from this that a greater degree of integration in the homes can be achieved when residents who are admitted in a particular home generally have similar characteristics and cultural backgrounds.

In nearly all the homes, the care staff did not have even a general training on old age care. To expect that such a staff will adequately care for the aged people who have rather peculiar problems and needs is rather presumptuous It is probably not surprising then that most of the aged residents expressed reservations regarding the type of care given in such homes.

In homes where the institutionalized have some relative freedom over their own affairs and lead a life almost similar to that within any normal community, problems of interpersonal relationships seem greatly diminished. Examples of such homes are Bahati (Kitale) where residents are allowed to live with members of their families, and Ahero, where institutional life retains certain characteristics of normal community life.

Besides, adaptation to the institutional environment in such homes tended to be much easier. It seems then that the closer the institutional life is to the normal community life, the less the problems of integration within the homes tend to be.

Although it is difficult to assess from data available, the impact of institutional exclusiveness or co-existence in terms of sex, it is apparent that if institution is meant to re-integrate the aged into normal community life, such separation does not help to achieve this. By such segregation on sex, the institutionalized aged are denied an aspect of normal community life. Even though such exclusiveness might have been occasioned by moral concerns, as was the case in Matumaini, Gaturi, and Sagana, there is no evidence from the other homes to justify such a concern.

Of all the homes, Ahero 'jo-ot' social services seemed the most unique especially in terms of its structure. Certainly, allowing the aged to lead an almost independent life has its advantages, as already noted. However, considering some of the difficulties the residents in Ahero experienced, (such as in food, communication and personal care), it seems that such arrangements expose the aged to certain dangers that can be avoided. For instance, the very senile probably

require some persons to be constantly available to provide any needed care.

This chapter has attempted to give a general description and discussion of what goes on in the selected homes for the aged. What has emerged is the unique problems and deprivations that the aged have to contend with in the homes. Even though certain homes fare much better than others, such 'successful' homes are the minority. Most of the homes face certain problems and lack certain basic facilities to the extent that institutionalization in such homes cannot be considered as an adequate form of old age care.

CHAPTER FIVE: BACKGROUND INFORMATION ON THE AGED

The following section presents and discusses major findings relating to background factors of the aged. Four main aspects are considered here, namely; the demographic, economic, social, and medical aspects of aging. The aged, especially those who end up in residential care, are portrayed as economically dependent, socially isolated, and physically debilitated. Data in the latter portions of this section are viewed under these three broad areas.

5:1 DEMOGRAPHIC DATA

Demographic data considered here relate to personal characteristics of the aged and include age, sex and marital status.

(i) Age

The present study focused mainly on the institutionalized aged. The majority of the respondents were therefore expected to be very advanced in age. Table 5.1 below shows that the majority (55.4%) of the institutionalized aged could not recall their ages. However, such a finding was anticipated. Many of the old people were expected to be unable to recall their chronological ages mainly due to memory lapse and/or illiteracy. What is intriguing, though, is that none of the aged in the

non-institutionalized category interviewed reported inability to recall their ages even though they were generally of the same ages as their institutionalized counterparts.

Table 5.1 Age Distribution of the institutionalized and non-institutionalized aged.

Age Group	Residents	%	Non-residents	%
50-59	6	5.4	4	13.3
60-69	14	12.5	13	43.3
70-79	11	9.8	4	13.3
80-89	11	9.8	6	20.0
90-99	5	4.5	1	3.3
100-109	2	1.8	1	3.3
110+	1	0.9	1	3.3
Can't recall	62	55.4	-	-
Total	112	100.0	30	100.0

SOURCE: Sample Survey

The difference between the institutional residents and non-residents is indicative of some differences in certain other characteristics of the two groups, which will be illuminated subsequently.

The majority of those who could recall their ages fell between the ages of 60 and 89, as is shown in Table 5.1. above. The mean ages for the two groups were 75.9 and 72.9 for the institutionalized and non-institutionalized aged respectively. A difference of means test estabished no significant difference in the ages of the two groups.

(ii) Sex

It is a general perception that females tend to live longer than males in most instances. A population census report of Kenya (1979:27) shows a general preponderance of females in the Kenyan population. What this implies is that, under normal circumstances, there will be more females than males in any social set-up. Consistent with this contention, research done elsewhere generally indicates a preponderance of females over males in residential homes for the aged (see Victor, 1987: 297).

The preponderance of females in old peoples' homes, according to Oomen (1991 (b):4), was due to the tendency of females to have a much higher dependency rate on account of their economic subordination to males. As will be shown later, this contention is supported by the present findings which show that twice as many females as males had no independent means of livelihood. What is implied here is that, because of their high rates of mortality (see Monsted and Walji, 1978:52), most males tend to precede their wives in death. Since most of these females would have had no independent means of livelihood, loss of the male head would signify a loss of economic support and a resultant inability to continue surviving independently within the community.

However, the proposition made above fails to confirm general stereotypes that portray the male as naturally disinclined towards domestic work. Men, especially the aged, are viewed as having a general tendency to depend upon females for domestic care. The implication of this is that the absence of a female around an aged male would render him unable to survive independently within the community.

It seems, then, that none of the sexes has any inherent propensity towards institutionalization. The table below shows the proportion of the aged residents by sex.

Table 5.2 **Distribution of the Institutionalized Aged by Sex**

Sex	Frequency	Percentage
Male	53	44.6
Female	62	55.4
Total	112	100.0

SOURCE: Sample Survey

In Table 5.2 it is noted that, as Victor (1987) observed, females tend to be the majority in residential homes for the aged. As already discussed in the preceeding two pages, the distribution in the table above can be attributed to; (i) the general preponderance of females in the Kenyan poopulation and, (ii) females' tendency to depend upon males, as concluded by Oomen (1991:4).

(iii) **Marital Status**

Certain studies on the effect of marital status on life experiences of the aged suggest that the married are more likely to be integrated into social life than the unmarried (or the single). For instance, in a study of the significance of marital status on aging and suicide Block (1972), found that the widowed were less able to be integrated in society (see Peterson and Quadagno, 1989:53). This was attributed to the fact that negative or adverse marital experiences tend to disrupt established patterns of behaviour, produce differential treatment from others, and modify one's self-identify (Peterson and Quadagno, 1989:72). On this premise, it can be expected that the majority of the aged under residential care would be those with adverse marital experiences such as the 'widowed', the 'separated' and the 'never married'. The table below shows the findings of the current study.

Table 5.3 **Distribution of the aged by Marital Status**

Marital Status	Residents		Non-residents	
Married	9	(8.0)	10.0	(33.3)
Never Married	33.0	(29.5)	1.0	(3.3)
Separated	16.0	(14.3)	2.0	(6.7)
Widowed	52.0	(46.4)	17.0	(56.6)
Cohabiting	2.0	(1.8)	-	
Total	112	(100.0)	30	(100.0)

SOURCE: Sample Survey

From the information obtained from the Table above it seems that the majority of the institutionalized aged were the widowed. This finding is consistent with the contentions made in the foregoing section. What is quite surprising, however, is that more than half (56.6%) of the non-institutionalized aged interviewed were also widowed, yet these managed to remain within their own communities. What the finding suggests is that adverse marital circumstances is a general characteristic of the aged and does not therefore constitute a significant basis for explaining why one group ends up in residential care while another does not.

The resolution of the apparent paradox lies in the realization that, as Block (1972) suggests, marriage (or lack of marriage) is only protective (or disruptive) in combination with (or absence of) other social resources. What this means is that those who are able to avoid institutionalization despite the loss, or absence, of a marriage partner, do so because they are able to rely on other resources. As will be shown later, the non-institutionalized aged seemed to have had certain social and economic advantages over the aged who ended up in residential care. These advantages may explain why the former group was able to continue with a certain level of normal community

life inspite of apparent adverse marital circumstances.

It is noteworthy that whereas there was a larger proportion of the aged falling under the 'married' category among non-residents than residents, at the same time there were more cases of the 'never married' and the separated among residents than non-residents. If we consider the 'never married', the separated' and the 'widowed' as an aggregate, it appears that, in general, more of the institutionalized aged had experienced disruptive marital circumstances than in the non-insitutionalized group.

Different studies suggest that the effects of life changes on marital circumstances tend to affect females more than males. For instance, studies done in Fiji, South Korea, Malaysia, Philippines (Andrews et al, (1986), and in Bangladesh by Ibrahim (1985), show that there are more married men than women and more widows than widowers among the aged (see Tout, 1989:89,99). A similar conclusion was made by Victor (1987:117).

One possible reason why adverse marital experiences would affect females more than males is that most women tend to marry men older than themselves. What this implies is that, since the expectation of life is inversely proportional to aging, and given that mortality differentials by sex

tends to be to the advantage of the females, a man who manages to live up to old age will more likely be found with his spouse. On the other hand, a woman who manages to live up to a similar age will more likely have been bereaved of her spouse since he would have been much older and therefore having a shorter life expectancy. In order to verify this, it was imperative that marital status be disaggregated by sex. Table 5.4. below presents the findings.

Table 5.4 **Disaggregation of the Marital Status of the Aged By Sex**

Marital Status	Residents		Non-Residents	
	Male	Female	Male	Female
Married	9 (18.0)	-	7 (53.9)	3 (17.7)
Never Married	21 (42.0)	12 (19.4)	-	1 (5.9)
Separated	9 (18.0)	6 (9.8)	1 (7.7)	1 (5.9)
Widowed	10 (20.0)	43 (69.4)	5 (38.5)	12 (70.6)
Cohabiting	1 (2.0)	1 (1.6)	-	-
Total	50 (100.0)	62 (100.0)	13(100.0)	17(100.0)

SOURCE: Sample Survey

Table 5.4 shows that in general, albeit with a few exceptions, there were more females than males falling in the categories of the 'never married', 'separated' and 'widowed'. Further, in both groups (of residents and non-residents) the majority of those who were 'married' were the males. The contentions of Andrew et al (1986), Ibrahims (1985) and Victor (1987) that females are more affected than males regarding

marital circumstances seem sustainable on the basis of the present findings.

In considering the bearing that marital status has on institutionalization of the aged, it is important to note that marital status alone does not explain the decision to accept or avoid institutional care. Larson (1978) suggested that socio-economic, health and other factors do intervene between adverse marital circumstances and other life experiences such as institutionalization. The next section deals with the socio-economic and health characteristics of the aged.

5.2 ECONOMIC FACTORS

In relation to economic factors, four main indicators are considered here; namely; education, occupation, income, and savings.

(i) Education

Education is one of the important indicators of economic status and means of livelihood. The cohort of the aged constituting the sample for the study was not expected to exhibit significant levels of education, mainly because of the under-developed system of education in the country during the old people's prime years. Table 5.5. below shows the distribution of the aged by the levels of education.

Table 5.5 Distribution of the Aged by Level of Education Attained

Level of Education (in years)	Residents	Non-residents
0	90 (80.4)	15 (50.0)
1-2	10 (8.9)	2 (6.7)
3-4	5 (4.5)	4 (13.3)
5-6	5 (4.5)	4 (13.3)
7-8	2 (1.8)	4 (13.3)
9 and above	0 -	1 (3.3)
Total	112 (100.0)	30 (100.0)

$\bar{X}_1 = 0.76$ $\bar{X}_2 = 2.67$
$SD_1 = 1.9$ $SD = 3.2$

SOURCE: Sample Survey

From Table 5.5 it appears that the majority of the institutionalized aged (80.4%) had received no education. Only 19.6% of these respondents seemed to have had some education. Although this was expected, given the reasons already mentioned above, it is remarkable that 50% of the aged who tended to be of a similar cohort in the non-institutionalized group reported having had some education. The difference in educational attainment for the two groups also emerges clearly when it is considered that the average level of education was 0.76 and 2.67 for institutionalized (residents) and the non-institutionalized (non-residents) respectively.

By looking at the educational differences between the institutionalized and non-institutionalized aged,

and considering that the group that had a higher average level of education was also the one that managed to continue with life outside the homes for the aged, it is probable that low level of education played some role in determining insitutionalization of the aged. However, such a proposition does not explain why the non-residents who had lower levels of education were not placed under residential care or why the institutionalized aged who had attained comparatively higher levels of education still ended up in residential care. This paradox probably implies that education alone may not determine or prevent residential placement - which then prompts a consideration of another factor.

(ii) **Occupation**

In the absence of any external support, one's occupation constitutes the major means of livelihood. In such a case one's occupation would determine whether or not one can survive within any given community. The general image portrayed of the aged, especially those who get into residential care, is of a group of impoverished and economically dependent people who have no one to care for them (Tout, 1989:23). The same view is shared by Victor (1987) who sees the aged as characterized by loss of vitality and decline in social and economic usefulness. On the basis of perception, it was expected that the majority

of the institutionalized aged would be those who had had no occupation or independent means of livelihood immediately prior to residential admission. Such a contention appeared sustainable on the basis of the findings shown below.

Table 5.6 **Distribution of the Institutionalized and Non-institutionalized Aged by Occupational Status**

Occupational Status	Residents	Non-residents
Employed Unemployed	52 (46.4) 60 (53.6)	20 (69.0) 9 (31.0)
Total	112 (100.0)	29 (100.0)

SOURCE: Sample Survey

From Table 5.6 it is apparent that slightly more than half (53.6%) of the institutionalized aged had no independent means of earning a living prior to admission to residential care. This corresponds with only 31% of the non-residents. Considering the two groups, it appears that once again, in regard to occupation, as was the case in education, the institutionalized aged appear to be disadvantaged. If one's independent survival within a given community depends on one's occupational status, then it can be expected that those without any income-generating

activity, or occupation, would tend to be more susceptible to institutional placement than the rest.

In this regard, the fact that more of the non-residents than residents reported having had some occupation may be sugestive of why the latter group ended up in residential care in larger numbers. This, however, does not explain why the 46.4% of the institutionalized aged who previously had employment still ended up in old people's homes, or why the 31% of the non-institutionalized aged still managed to survive within their natural communities in spite of having had no employment.

Regarding the 31% of the aged who reported having had no employment and yet still managed to eschew institutionalization, it is possible that these had some means of livelihood other than their occupation. This will be made more evident in the subsequent section considering the incomes of the aged.

Regarding those who had been employed but still ended up in residential care, a reason for institutionalization may be that they had had low paying jobs. Occupational status is hierarchical, meaning that certain occupations tend to be more rewarding or gainful economically than others. In considering occupational status, it is important to reflect upon the types of occupations the aged had, especially during the period immediately prior to

admission (for residents) and the time of interviewing (for non-residents). Table 5.7 below attempts to show this.

Table 5.7 **Types of Occupations Held By the Aged by Both the Institutionalized and the Non-Institutionalized Aged**

Type of Occupation	Residents	Non-residents
Small trader	11 (21.2)	2 (10.0)
Large Scale farmer	2 (3.9)	4 (20.0)
Subsistent farmer	13 (25.0)	1 (5.0)
Business entrepreneur	-	5 (25.0)
Skilled labourer	6 (11.5)	3 (15.0)
Unskilled labourer	20 (38.5)	5 (25.0)
Total	52 (100.0)	20 (100.0)

SOURCE: Sample Survey

Table 5.7 above shows that the majority of the institutionalized aged who reported having been employed just prior to institutionalization were unskilled labourers and subsistent farmers. As for the non-institutionalized aged, the majority were unskilled labourers and business men/women. Arguably, unskilled labour, subsistence farming and small trading could be considered as relatively low-paying occupations. If this is true, it is notable then that more than three quarters (84.7%) of the aged placed under residental care were those who previously had

low economically rewarding occupations. This corresponds with only two fifths (40%) from the group which was not placed in residential care. This gives an impression that the majority of the aged who were institutionalized were those who previously had no gainful occupation. In order to verify this, there is need to consider the income the aged received (immediately prior to admission, for those in residential care, and by the time of interviewing for non-residents).

(iii) **Income**

Following from the information on occupation above, it was anticipated that the majority of the institutionalized aged would be those who previously had very low levels of income, if any. From Table 5.8 below, it appears that more than half of the respondents from the residents and non-resident categories had never had any income. Even though, there were more of such among the institutionalized than the non-institutionalized.

Table 5.8 **Distribution of the Institutionalized and Non- Institutionalized Aged by Income**

Income Levels	Residents	Non-Residents
None	103 (92.0)	16 (53.3)
1 - 499	7 (6.3)	2 (6.7)
500 - 999	1 (0.9)	3 (10.0)
1000-1499	1 (0.9)	3 (10.0)
1500-1999	0 -	0 -
2000-2499	0 -	4 (13.3)
2500-2999	0 -	1 (3.3)
3000+	0 -	1 (3.3)
Total	112 (100.0)	30 (100.0)

SOURCE: Sample Survey

The income distribution shown above indicates that whereas only 8% of the institutional residents previously received any income, they received less than KSh. 1,500/= a month with an average of KShs. 20/= only. This contrasts greatly with the non-residents among whom 46.7% reported receiving some income. Income levels for this group were upto over KSh. 3,000/= a month with an average incoem of KSh. 832.80 per person. When considered, the difference of the main incomes for the two groups turned out to be highly significant.

In understanding the reasons for the income differentials between the institutionalized and non-institutionalized aged, it is important to remember that, as already seen in Table 5.7, the non-institutionalized aged appeared to have more

economically gainful occupations. Secondly, besides their main occupations, quite unlike the aged who ended up in residential care, the non-institutionlized aged reported having other supplementary sources of income. Such other sources included trading, rents, farming and assistance from relatives and offspring. Once again, present findings tend to suggest that the aged who remained within their own communities had some advantages over those who ended up in residential care.

(iv) **Savings**

Information on savings made by the aged was considered important as an indicator of any old age security that the respondents might have had. It was expected that those who had previously made some savings would have had some economic base to fall back on thereby being able to avoid institutional care even in the absence of any income generating activities or external help.

Data collected on savings by the aged did not yield any useful information. In the first place, only 5.4% and 23.3% of the institutionalized and non-institutionalized aged, respectively, reported having made any savings. However, an even much lower percentage of respondents from the two groups were able to give the actual amount of savings made. In

the absence of this, the data adduced on any savings made by the aged proved to be too inadequate for any useful discussion.

In concluding the section on economic factors of the aged, information adduced suggests that whereas most of the aged are economically deprived, those who manage to remain within their own communities leading normal lives seem to be better off economically than those who become institutionalized. Those who manage to avoid institutionalization seem to have relatively better education, occupation, and incomes than those who end up in residential homes. However, there are a number of those who were not in old people's homes but who exhibited similar deprivations as their counterparts in the homes. This implies that not all who avoid institutionalization do so because of economic advantage. There may be other factors, one being social, which explain their avoidance of institutionalization.

5.3 SOCIAL FACTORS

The social factors considered here relate basically to the social relations that the aged had prior to institutionalization, and the type of interaction that existed among them. The aim of this is to find out whether or not the aged were socially

isolated from other community members, especially members of their immediate families.

(i) **Household Structure**

Lowenthal and Haven (1968:56) found that most of the elderly who entered residential care had previously been isolated. Such a view was, however, not supported by Kahana and Kahana (1984) (in Peterson and Quadagno, 1989:407) who, on the basis of studies done elsewhere, concluded that the majority of the aged who turned to residential care were not isolated but actually had friends, other family members and relatives around them prior to admission. It is important to note that the two studies referred to above were both conducted in a developed society. The point is that experiences in developed societies are expected to differ markedly from those obtaining in a developing society like ours (refer to the chapter of literature review). A comparison of one of the findings (Kahana and Kahana, 1984) and the present finding, shows certain interesting facts as can be seen in the table below.

Table 5.9 (a) **Distribution of Respondents by Persons lived with Just Prior to Institutionalization**

Persons(s) Respondents lived with	Kahana and Kahana (1984) %	Odhiambo (1992) %
Alone	48	57.1
With offspring	26	7.1
With relative(s)	5	5.4
With spouse	13	16.1
With friends(s)	8	14.3
Total	100.0	100.0

SOURCES: (i) Peterson and Quadagno, 1989:407
(ii) Sample Survey

Although according to Kahana and Kahana (1984) the 48% who lived alone formed a minority (given that 52% lived with others), both studies reported in Table 5.9(a) show that quite a significant portion of the aged lived alone prior to institutionalization. Apparently there is no major difference between the two findings. The difference seems to be merely statistical and in interpretation. Another way of interpreting the Kahanas' (1984) finding could be that nearly half (48%) of the aged lived alone. Furthermore, it is interesting to note that the two findings shown in the table above seem to fit very well into the general trend of changes in household

residential patterns according to certain studies done in the United Kingdom (Victor, 1987:219).

Four of these studies show a steady increase in the proportion of the aged who lived alone and, on the contrary, a decline in the proportion of those who lived with others (including spouses, children, and relatives). Table 5.9(b) below compares these four findings with the present ones and those of Kahana and Kahana (1984).

Table 5.9(b) **Comparison of Household Structure of the Aged Prior to Institutionalization.**

Person(s) Respondent lived with	1945	1962	1976	1980	1984	1992
Alone	10	22	30	34	48	15.1
With Spouse	30	33	44	45	13	16.1
With others	60	44	27	22	39	26.8

Sources:(i) Victor C.R, 1987:219
Table 10.3 for Sheldon (1948), Shanas et al (1968), Hunt (1978), and Evandrow et al (1985)

(ii) Peterson and Quadagno (1989: 407) for Kahana and Kahana (1984)

(iii) Sample Survey

The changes in household structure (especially for those living alone) that is evidenced in Table 5.9(b) above can be attributed to certain developmental changes in both Western (or developed) and African (or developing) societies from the pre-

industrial (or traditional) to the contemporary Western and African societies. Part of these developments relate to migration of younger members of a community from their parental or ancestral homes to other locations. This would partly explain the steady increase in the proportions of the aged living alone.

Regarding those who stayed with their spouses and 'others', the trend seems to be interrupted from 1984. The other four previous studies, from 1945, seem to indicate a steady increase in survival rates for spouses, and a resultant decline in 'others'. Considering that the first four studies were done in the United Kingdom, the findings seem quite consistent, and in keeping, with conditions obtaining in developed societies. This is because certain studies in the U.K. show that changes that occurred in death rates right from the pre-industrial period helped to raise the levels of life expectancy on the average from 49.8 years in 1901 to 73.0 years by 1983 (see Victor, 1987:109). What this means is that more older people were able to live longer than previously. This experience does not seem to obtain in most developing countries, Kenya inclusive, where general mortality rates still tend to be fairly high. This low life expectancy for those aged 60 and above could explain the findings presented in Table 5.3 and why

very few of the aged in the present study had their spouses living with them.

Given the steady increase in survival rates of spouses of the institutionalized aged, as shown by Sheldon (1948), Shanas et al (1968), Hunt (1978), and Evandrow (1984), who, like the anteceding scholars, had done their studies in a developed country, found that very few of the institutionalized aged previously lived with their spouses. Since life expectancy in North America is almost similar to those in the U.K. (Victor, 1987:112), which implies that there should be very little difference in survival rates for spouses in the two places, it is the onus of the Kahanas (1984), who carried out their study in North America, to explain the decline in proportions of the old people shown as still living with their spouses prior to their institutionalization.

A notable difference in household structure among the aged appears when the non-institutionalized group is considered. It is notable that only 16.7% of the control group reported living alone. The rest lived in the company of their spouses, offsprings, and other relatives. This finding confirms our earlier suspicion that the aged who managed to remain within their own communities previously had closer filial associations than those who ended up in residential care. This seemed to contribute to their ability to

avoid institutional care. These findings confirm earlier expectations that an old person who had someone to provide company and/or care would not necessarily feel the need for institutional care as much as those who did not have such social support.

(ii) **Offspring**

The general image presented of the institutiounalized aged is of a group of people neglected and abandoned by their children. Traditionally, as already seen in previous chapters, children played a major role in the care of their (aged) parents. This is why the plight of the aged has partly been attributed to migration of their offspring. In order to find out whether or not the respondents suffered neglect from their offsprings it was considered important first to find out whether the respondents had had any children. Responses given show that whereas only 58% (or (65)) of the institutionalizated aged reported having had children, all 100% of the aged in the non-institutionalized category reported having had some children. As will be shown subsequently, childlessness seemed to have been a key factor in the survival of the aged. As such, the difference between the two groups with regard to child -birth cannot be ignored in explaining institutional care forthe aged.

Although it is not easy, from information gathered, to explain the difference seen between the institutionalized and the non-institutionalized aged regarding child-birth, certain factors seem to emerge when the incidence of child-birth is cross-tabulated with marital status of the respondents. The findings are shown in the Table 5.10 below.

Table 5.10 **Distribution of the aged by child-birth and marital status.**

	Residents			Non-residents		
Marital Status	with children	with no children	Total	With children	No Child	Total
Married	9 (100.0)	0 (0)	9(100.0)	10(100.0)	-	10(100.0)
Never Married	2 (6.1)	31(93.9)	33(100.0)	1(100.0)	-	1(100.0)
Separated	10(62.5)	6(37.5)	16(100.0)	2(100.0)	-	2(100.0)
Widowed	42(80.8)	10(19.2)	42(100.0)	17(100.0)	-	17(100.0)
Cohabiting	2(100.0)	0(0)	2(100.0)	0(0)	-	0(0)
Total	65(58.0)	47(42.0)	112(100.0)	30(100.0)	-	30(100.0)

SOURCE: Sample Survey

Table 5.10 shows that the majority of the institutionalized aged who reported having had any children were the 'married' and 'cohabiting'. All respondents within these two categories had given birth. Regarding those who had never had any children, findings shown in the same table indicate that all the 'victims' were also those who had experienced adverse marital circumstances such as never marrying, separation, and widowhood. What can

be inferred from this finding is that adverse marital circumstances seem to affect instance of childbirth. That there were more respondents with adverse marital circumstances among the aged who ended up in residential care than among those who didn't is an important factor in explaining the differences between the two groups with regard to childbirth.

Besides simply finding out whether or not the aged had had any children, the state of the children (whether dead or alive) by the time of interviewing was also considered important. Table 5.11 below provides information on the number of surviving children for both the institutionalized (residents) and non-institutionalized (non-residents) aged.

Information from Table 5.11 shows that 34.4% and 10% of the institutionalized and non-institutionalized aged, respectively, had been bereaved of all their offspring. In total, 69 of the institutionalized aged did not have any children upon whom they could depend. There were only 3 (or 10%) of such cases among the non-institutionalized aged.

Functionally, and from the perspectives of certain aged people, the usefulness of children in any family is not based on their sheer numbers but, rather, on the supportive roles they play within their particular families. In other words, according to this view, children only become useful to their

parents (especially the aged ones) if and when they provide some assistance or support. The mere fact of childbirth was therefore considered to be of little help to the aged save for if some social support accrued from such births.

Table 5.11 **Distribution of children surviving to both the institutionalized and Non-institutionalized aged**

Number of children alive	Residents	Non-Residents
0	21 (34.4)	3 (10.0)
1	13 (21.3)	5 (16.7)
2	13 (21.3)	4 (13.3)
3	5 (8.2)	4 (13.3)
4	6 (9.8)	9 (30.0)
5	1 (1.6)	3 (10.0)
6	0 (0)	1 (3.3)
7	1 (1.6)	0 (0)
8	0 (0)	1 (3.3)
9	1 (1.6)	0 (0)
TOTAL	*61 (100.0)	30 (100.0)
	$\Sigma fx_1 = 112$	$\Sigma fx_2 = 90$
	$\bar{x}_1 = 1.6$	$\bar{x}_2 = 3.0$

(* 48 respondents had not had any child. There was 1 non-response)

SOURCE: Sample Survey

Earlier on it had been expected that the aged with supportive children would have greater disinclination to institutional care than those who did not. This was based on the view that the majority of the aged are dependant upon social support for

survival, as previously shown by Lowenthal and Haven, 1968:56; Gelfand and Olsen, 1980:110; Pincus, 1968:58. Besides, other scholars such as Shanas (1962:60) and Lowenthal (1964:42) has also found social support as the major factor differentiating the institutionalized aged from those who managed to remain within their own communities.

In order to confirm this, information on the distribution of the aged respondents by assistance received from their offspring was considered. Table 5.12 below shows the findings.

It is apparent from Table 5.12 that only 29.3% of the institutionalized aged received any assistance from their offspring prior to residential placement. This contrasts markedly with the non-institutionalized group where 66.7% reported receiving assistance from their offspring by the time of interviewing. That the majority of the respndents who reported receiving assistance from their offspring were the non-institutionalized aged seems to confirm earlier contentions that those with supportive children tend to have greater aversion to residential care.

Table 5.12 **Distribution of the aged by assistance given by offspring**

Response Category	Residents	Non-residents
Received some assistance	12 (29.3)	18 (66.7)
Received no assistance	29 (70.7)	9 (33.3)
Total	41 (100.0)	27 (100.0)

SOURCE: Sample Survey

Considering further the finding in Table 5.12, it appears that the majority of the institutionalized aged (70.7%) who had any surviving offspring prior to the time of institutionalization received no assistance from them. This relates to only 33.3% for the non-institutionalized aged. The important question that this distribution raises is why certain offspring would fail to give any assistance to their aged parents.

The general assumption that has been held is that the majority of the aged who end up in residential care are those who had been neglected by their offspring. What is implied here is apathy on the part of the offspring. Whereas there may not be sufficient data to confirm or dissprove this contention, it can nevertheless be expected that although certain offsprings may fail to assist their parents due to

apathy, others are probably constrained by lack of any meaningful employment. Therefore, before accusing the majority of offsprings of negligence, it would be important to find out whether the children were actually in a position to assist. One way of doing this is by considering the status of the offspring occupations prior to their parents' institutionalization.

The occupational status of offspring is considered important because it helps in assessing the economic status of the offsprings and in understanding whether failure to provide any assistance was by choice or dictated by adverse economic factors. It makes a difference if the offspring have no gainful occupation and so give no assistance and if they give no assistance and yet they have some gainful occupation. Data on occupational status of the offspring are shown in Table 5.13 below.

It is evident from Table 5.13 that a sizeable portion (43.9%) of the institutionalized aged had none of their offsprings employed. This contrasts with non-institutionalized group where 81.5% of the respondents were survived with offspring who had some form of employment. There was a further 29.6% of respondents in the institutionalized category who had apparently lost touch with their offspring and so did not know what the offspring did.

Even though Table 5.13 shows that the majority of the institutionalized aged had offspring who had no employment, this does not necessarily explain why the majority of these respondents received no assistance from their offsprings, as Table 5.12 indicates. However, the issue can be clarified by relating the findings regarding reception of assistance from offspring (Table 5.12) with the offspring employment status (Table 5.13). The results are shown in Tables 5.14 and 5.15 below.

Table 5.13: **Occupational status of offspring as given by both the institutionalized and non-institutionalized aged**

Occupational status of offspring	Residents	Non-residents
Employed	10 (24.4)	22 (81.5)
Unemployed	18 (43.9)	5 (18.5)
No idea	13 (31.7)	0 (-)
Total	41 (100.0)	27 (100.0)

SOURCE: Sample Survey

Considering both Tables 5.14 and 5.15 together, a few issues become apparent. In the first case, both tables show that the majority of the aged who received no assistance from their offspring were parents of children who had no employment. But the similarity between the two tables seem to end there.

Table 5.14: **Distribution of the institutionalized aged by assistance received from offsprings' employment status**

Employment status of offspring

Assistance	Employed	unemployed	No idea	RT
Received some assistance	7 (6.3)	22 (34.4)	9 (29.0)	38 (33.9)
Received no assistance	10 (58.8)	42 (65.6)	22 (71.0)	74 (66.1)
Total	17 (100.0)	64 (100.0)	31 (100.0)	*112(100.0)

(* Total number of children surviving among the institutionalized aged)

SOURCE: Sample Survey

Table 5.15: **Distribution of the non-institutionalized aged by assistance received from offspring and the offsprings' employment status**

Employment status of offspring

Response Category	Employed	unemployed	No idea	Row Total
Received some assistance	40 (81.6)	22 (62.9)	4 (66.7)	66 (73.3)
Received no assistance	9 (18.4)	13 (37.1)	2 (33.3)	24 (26.3)
Total	49 (100.0)	35 (100.0)	6 (100.0)	*90 (100.0)

(* Total number of children surviving among the non-institutionalized aged)

SOURCE: Sample Survey

Table 5.14 and 5.15 differ in the sense that whereas among the non-institutionalized aged (Table 5.15), the majority of the offspring gave some assistance whether or not they were employed, among the institutionalized aged (Table 15.4), the majority of the offspring, both in the employed and the unemployed categories, still gave no assistance to their aged parents.

What can be inferred from the findings of Tables 5.14 and 5.15 is that the giving of assistance to the aged depended on factors other than their offsprings' status of employment. Lack of employment on the part of offspring can therefore not suffice to explain why the majority of the institutionalized aged previously received no assistance from their children. It is easier to believe that the majority of offsprings who failed to give any assistance to their institutionalized parents did so by default.

The conclusion made above does not disclaim the fact that those who have employment have better chances of assisting their parents. Table 5.15 shows this very clearly but goes further to suggest that unemployment is not necessarily a hindrance to the giving of assistance. There are different forms of assistance that can be given. Some of which do not require one to have any employment.

Two points need to be clarified in relation to Tables 5.14 and 5.15. The first issue relates to the

category of offspring who had no employment but still gave assistance to their aged parents. The second issue is in regards to the group of offsprings who gave no assistance to their parents in spite of being employed. The first issue has already been addressed in the conclusion given above where assistance to the aged was seen as independent of the occupation of the offspring. It is appropriate, at this juncture, to add that besides finances, the respondents who reported receiving assistance from their offspring also cited such items as clothing, food, and domestic chores. That the giving of some of this assistance does not require any gainful employment need not be overemphasised. Regarding the second issue, it was felt that the respondents be asked to give their views on why some of their children did not assist them. Two reasons that were given related to sex of the offspring and changes occurring in society.

Regarding the sex of offspring, the impression given was that married female offspring tended to give less assistance to their parents than their male counterparts to their parents. This was attributed to the fact that after leaving their ancestral homes and establishing their own homes and families, many females tended to be more preoccupied with their conjugal responsibilities. Their allegiance was foremost to their husbands and children. In this

respect, male offspring were considered to be more supportive; for in spite of their conjugal responsibilities they still maintained their assistance to their parents.

Regarding changes in society, certain respondents decried the fact that children of the present generation were so engrossed in their own affairs that they could not give any assistance to their parents. Some of the parents attributed this to changing economic conditions which made survival difficult even for the children themselves.

Children's support to their parents is not confined to material assistance. It was expected that actual physical contacts between the aged and their offspring would also be important. Physical contact between the aged and their offspring was considered in terms of visitations received by the former. Based on stereotypes, the current study set off on the premise that the majority of the aged are isolated and as such have very minimal contacts with their offspring. In order to confirm this, respondents were asked whether they received any visitation from their offspring during the period immediately prior to admission, for the institutionalized, and by the time of interviewing, for the non-institutionalized aged. Responses given are shown on the table below.

Table 5.16: **Distribution of respondents according to visitation received from offsprings**

Residential Category

Response Category	Residents	Non-residents
Received visitation from offspring	14 (34.1)	18 (66.7)
Received no visitation from offspring	15 (34.1) 18 (40.9) 11 (25.0)	18 (66.7) 7 (25.9) 2 (7.4)
Lived together with offspring	9 (22.0)	2 (7.4)
Total	41 (100.0)	27 (100.0)

SOURCE: Sample Survey

From Table 5.16 it seems that whereas the majority (66.7%) of non-institutionalized aged received visitation from their offspring the corresponding proportion for the institutionalized group was only 34.1%. In addition there were other 22% from the institutionalized group and 7.4% from the non-institutionalized group who were staying with their offspring. In total then, it appears that 74.1% of the aged who did not end up in residenaitl care previously had some physical contact with their offspring as opposed to 56.1% of those who ended up in residential care. The slight difference notwithstanding, the two percentages taken together

suggest that the majority of the aged were in physical contact with their offsprings.

To conclude that the majority of the aged were not isolated from their offspring, on the basis of the foregoing findings, would be a little presumptuous. The significance of visitations to the aged does not lie simply on the occurence of such visitations but rather on their extent or frequency. When the issue of frequency of such visitations was considered, it turned out that most of the respondents did not have any regular contact with their offspring. Table 5.17 presents this finding.

Table 5.17 Distribution of Respondents by the Frequency of Visitation From Offsprings

Frequency of Visitation	Residents	Non-residents
Often (more than once a month	3 (21.4)	4 (22.2)
Monthly	0 (0)	2 (11.1)
Occasionally	8 (57.1)	9 (50.0)
Rarely	3 (21.4)	3 (16.7)
Total	*14 (100.0)	*18 (100.0)

(* The issue of frequency of visitation was not applicable to 27 and 9 respondents from the institutionalized and non-institutionalized categories, respectively).

SOURCE: Sample Survey

Table 5.17 shows that out of the institutionalized aged who reported having received any visitation from their offspring, only 21.4% did so on a regular basis. If these are combined with those who lived together with their offspring, it appears

that only a total of 29.3% of the institutionalized aged with any surviving offspring actually came into any regular physical contact with them. The picture is not any better for the non-institutionalized aged where only 33.3% received any regular visitation from their offspring. In actual numbers this relates to only six of the non-institutionalized aged.

If this number is combined with those who live with their offspring (Table 5.16), then only 19.5% of the non-institutionalized aged seem to have had any frequent physical contacts with their offspring. Looking at the findings in both Tables 5.16 and 5.17 the deduction that can be made is that the majority of the aged had no meaningful contacts with their offspring. In other words, contentions that the majority of the aged appear to be isolated from their offspring seem tenable on the basis of present findings.

The fact that a majority of the aged in both the institutionalized and non-institutionalized groups received no visitations from their offspring was found to be rather intriguing. This is because such a finding fails to conform to the general picture, especially by Western writers, in which filial relations in African societies are gloried. The important question to ask then should be why those who

are expected to exhibit very close kinship ties should appear this alienated.

Lack of family support for the aged has been attributed to urbanization and migration of family members from rural to urban areas (van den, 1981:5 and Help Age Kenya, 1988:10). A 1988 Help Age Kenya report further suggested that the geographical distance between the aged and their offspring hinders the latter, from protecting and providing for the aged (Help Age Kenya, 1988). This view seemed to corroborate Oomen's finding (1991 b:5) that geographic distance is one of the main factors disrupting family support.

However, these findings failed to confirm those of Litwak and Szelenyi (1969), which suggest that geographic proximity cannot be considered as a hindrance to support from primary relations (such as one's offspring). In other words, close family members were found able to defy any geographic distance to visit or assist an aged consanguine. In order to verify this the issue of visits by offspring was considered in terms of the location of each offspring (whether similar to, or different from, those of their aged parents). The Tables below show the results obtained.

Tables 5.18 and 5.19 show some major differences between the aged who finally ended up in institutional

care and those who did not. From Tabloe 5.18, it can be deduced that the majority of the offspring paid no visitation to their aged parents the similarity or difference of their locations notwithstanding. On the contrary, Table 5.19 shows that the majority of the offspring of the non-institutionalized aged paid visits to their aged parents whether they lived in similar locations or not. Considering this finding, the geographic distance between the aged and their offspring does not seem to have had any influence on visitations.

Table 5.18: **Distribution of the Institutionalized Aged by Visitation by Offspring and Offspring's Location vis a vis the Aged**

Response Category	Location of the Offspring vis a vis the Respondent's: Similar	Different	RT
Received some visitation	6 (33.3)	19 (43.2)	25 (40.3)
Received no visitation	12 (66.7)	25 (56.8)	37 (59.7)
Total	18 (100.0)	44 (100.0)	*62 (100.0)

(* Number of offspring surviving among the institutionalized Aged. The question was not applicable to 50 of the offspring)

SOURCE: Sample Survey

Table 5.19: **Distribution of the Non-institutionalized Aged by Visitation by Offsprings and the Offspring's Location vis a vis the Aged**

Response Category	Location of the Offspring vis a vis the Respondent's Similar	Different	RT
Received some visitors	22 (91.7)	36 (72.0)	58 (78.4)
Received no visitation	2 (8.3)	14 (28.0)	16 (21.6)
Total	24 (100.0)	50 (100.0)	*74 (100.0)

(* Number of offspring surviving among the non-institutionalized Aged. The question was not applicable to 16 of the offspring)

SOURCE: Sample Survey

Expressed in other words, there is no evidence to support contentions that the majority of the aged did not receive any visitations from their offspring because of geographic distance between them. Accordingly, the contentions of Van den (1981), HAK (1988) and Oomen (1991) are disapproved.

In concluding the section on offspring of the aged, it is noteworthy that the institutionalized group exhibited more previous disadvantages than the non-institutionalized group. First, there were few

cases of births of children among those who got institutionalized than those who did not. Second, mortality rates of offspring seemed higher among the institutionalized than among the non-institutionalized aged. Third, more children of the institutionalized aged were uneducated (or less educated) than those of the non-institutionalized aged. Lastly, offspring of the non-institutionalized group were more supportive of their aged parents than these of the aged who were later on admitted into residential care. All in all, the contention that a majority of the aged are neglected or abandoned by their offspring seems more tenable in relation to the aged who ended up in institutional care than those who didn't.

(iii) **Relatives**

The importance of data on relatives of the aged in the present study is that, in the absence of spouses, and besides the offspring, relatives were the second closest family members of the respondents. Moreover, it was expected that relatives could act as alternative sources of family support.

Findings regarding the availability of relatives suggest that the majority of the aged from both experimental and control groups had some relatives somewhere (Table 5.20 below). However, more of the non-institutionalized aged reported having relatives

than the institutionalized aged. There was a small portion of the institutionalized aged who had no idea of the existence of any relatives. In total, about 41.1% of the aged who ended up in residential care seemed not to have had any relatives, as opposed to only 13.3% from the group that precluded institutionalization.

Table 5.20: **Distribution of the Respondents by Whether or not they had any Relatives**

Response Category	Residents	Non-Residents
Had some relatives	58 (51.8)	26 (86.7)
Had no relatives	46 (41.1)	4 (13.3)
Not sure	8 (7.1)	- (-)
Total	112 (100.0)	30 (100.0)

SOURCE: Sample Survey

The concept of 'having no relatives' seems rather puzzling. When asked to explain how this was possible, respondents gave responses that could be classified under three categories. First, there were those whose deceased parents had had no sibling. Such ended up as the only surviving members of their families. Secondly, there were those who possibly had some relatives but who remained unknown to the aged.

Thirdly, there were those who had known relatives but who did not identify with them; such respondents did not consider relatives on the basis of consanguinity, but rather, on the basis of the performance of roles concomitant with such a status. One such respondent is quoted below as saying;

> ***.... one's relative is only he who can give some help. If someone does not give any assistance there is no reason why such a one should be called a relative...***

It seemed then that the significance of relatives lay mainly on the supportive roles they were able to play. Given that what the majority of the aged needed, or lacked, was support or care, one can appreciate why, to such old people, the issue of relatives was viewed more functionally than relationally (or status-wise).

As is shown in Table 5.21 below, it appeared that the majority of respondents who reported having some relatives from both groups, received no assistance from them.

Although the non-institutionalized aged seemed to fare a little better than those who ended up in residential care, what is evident from the table above is that the majority of the aged did not have any support from their relatives.

Table 5.21: **Distribution of the Respondents on the Basis of Reception of Assistance from any Relatives**

Response Category	Residents	Non-Residents
Received some assistance	7 (12.1)	10 (38.5)
Received no assistance	51 (87.9)	16 (61.5)
Total	*63 (100.0)	*26 (100.0)

(Fifty four (54) and four (4) respondents from the institutionalized and non-institutionalized categories, respectively, were not positive about having had any relatives)

SOURCE: Sample Survey

In attempting to explain why the majority of respondents seemed to have received no assistance from their relatives, three factors were considered. These factors were sex of relatives, occupation of relatives, and economic status of the respondents.

The significance of sex of relatives is that, as was seen in relation to offspring, males appeared to be more supportive than females. In this regard, it is likely that if the majority of the relatives were married females then very little assistance, if any, could be expected from them. This view is based on the assumption that most females tend to be

economically dependent upon their husbands, and further that once married, most females tend to focus whatever resources they have upon their conjugal responsibilities. Available data is however insufficient to confirm or dispprove these contentions.

In relation to the economic status of the respondents, it is our contention that those who are relatively better off economically will not be in dire need of assistance from relatives, especially if the assistance is material. Since the majority in the non-institutionalized group appeared to exhibit relative economic well-being, it is not strange that many of them received no assistance from their relatives. What is not clear, however, is why the majority of the institutionalized aged also received no assistance from their relatives whereas the same respondents appeared to suffer economic deprivations. In attempting to provide an explanation for this, the occupations of the relatives are considered.

Data on occupation of relatives of the respondents was considered important in order to confirm whether the majority of the relatives who gave no assistance to the aged were unemployed. On the other hand it was also necessary to see whether the majority of those who gave assistance were employed. Arguably, it is difficult to condemn as negligent any

unemployed relative who fails to give assistance to an old person, especially where material assistance is needed. But in order to excuse the relatives of the respondents in the current study it must be shown that the majority of them had no gainful employment. Table 5.22 presents data on occupational status of these relatives.

It is evident from Table 22 that the majority (80.8%) of respondents from the non-institutionalized aged had at least one relative in gainful employment. Only 37.8% of the aged who ended up in residential care had such a relative. Those who reported that none of their relatives had any employment accounted for 22.4% and 19.2% of the respondents in the institutionalized and non-institutionalized categories respectively.

Table 5.22: **Distribution of the Institutionalized and Non-institutionalized aged by Occupational Status Of Their Relatives**

Response Category	Residents	Non-residents
Had a relative employed	19 (37.8)	21 (80.8)
Had no relative employed	13 (22.4)	5 (19.2)
Not Sure	26 (44.8)	- (-)
Total	63 (100.0)	26 (100.0)

SOURCE: Sample Survey

What can be deduced from this is that, besides having had no employment themselves, the majority of the aged who were ultimately placed under residential care also had relatives who were equally deprived. On the other hand, the majority of the aged who precluded residential care, who incidentally reported being in gainful employment, also had relatives who were gainfully employed. In essence, it seems that the 'culture of poverty' which was evinced by the institutionalized aged also characterized the lives of their relatives. Similarly, the relative prosperity which seemed to characterize the non-institutionalized group also seemed to apply to their relatives.

Going by the findings presented in Table 5.22 there is no clear indication that, in general, the majority of the respondents did not have relatives who were gainfully employed. It is therefore quite paradoxical that so many of the relatives of the institutionalized aged were employed yet only a few gave any assistance to their aged. It appears that decisions to give out any assistance were not based on the relatives' occupational status. However, in order to confirm this, it is important to relate assistance from relatives to the relatives occupational status. The results are shown in the tables below.

Table 5.23(a): **Distribution of the institutionalized aged by assistance received from relatives and the relatives' employment status**

Employment Status of Relatives

Response Category	Employed	Unemployed	No Idea	Row Total
Received some assistance	3 (15.8) (42.9)	2 (15.4) (28.6)	2 (7.7) (28.6)	7(12.1) (100.0)
Received no assistance	16 (84.2) (31.4)	11 (84.6) (21.6)	24(92.3) (47.0)	51(87.9) (100.0)
Total	19 (100.0)	13 (100.0)	26(100.0)	58(100.0)

SOURCE: Sample Survey

Both Table 5.23 (a) and 5.23 (b) consistently show that the majority of the aged who had relatives with some form of employment still received no assistance. The same appplies to those relatives who had no employment. Judging by these findings, the assertion that decisions to give out any assistance might have not been based on the relatives employment status seems sustainable. Indeed, there is no evidence to suggest that the majority of the aged did not receive any assistance from their relatives because the majority of the same relatives had no gainful employment.

Table 5.23(b): **Distribution of the non-institutionalized aged by assistance received from relatives and the relatives' employment status**

Employment status of relatives

Response Category	Employed	Unemployed	Row Total
Received some assistance	8 (38.1) (80.0)	2 (40.0) (20.0)	10 (38.5) (100.0)
Received no assistance	13 (61.9) (81.3)	3 (60.0) (18.7)	16 (61.5) (100.0)
Total	21(100.0)	5 (100.0)	26(100.0)

SOURCE: Sample Survey

When considering Tables 5.13 and 5.21 together, it can be inferred that offsprinl tend to be more supportive than relatives. That the majority of the relatives had gainful employment but still failed to give any assistance to the aged is probably an indication of lack of empathy that relatives have towards their aged.

Besides the giving of assistance, another way of determining the supportiveness of relatives was to consider the incidence and frequency of their visitation to the aged. From the foregoing tables, one can easily conclude that most of the relatives appear indifferent to the plight of their aged consanguines. However, for this to be confirmed it

needs to be demonstrated that these relatives never even came into physical contacts with the aged. Table 5.24 presents the findings on this.

Table 5.24: **Distribution of respondents by whether or not they received visitation from relatives**

Residential Category

Responses	Residents	Non-Residents
Received visitation from relatives	11 (16.7)	13 (50.0)
Received no visitation from relatives	48 (72.7)	11 (42.3)
Lived together with relatives	7 (10.6)	2 (7.7)
Total	*66(100.0)	*26 (100.0)

(* 46 and 4 respondents from the institutionalized and non-institutionalized groups respectively, reported having had no relatives. Table 5.20).

SOURCE: Sample Survey

Table 5.24 shows that whereas half (50%) of respondents from the non-institutionalized group had received visitations from their relatives, only 16.9% from the institutionalized group had done the same. The majority (71.8%) of respondents from the

institutionalized group had not received any visitation from their relatives prior to residential admission. Besides the 16.9% who consented to having been visited by relatives, there was an additional 11.3% from the institutionalized group who were living with their relatives. When the two groups are combined, the portion of those who had any physical contacts with their relatives becomes 28.2%. As for the non-institutionalized group, there were 7.7% of the aged who lived with their relatives. This adds up to a total of 57.7% of respondents who had any physical contact with their relatives within the same group.

On the basis of present findings, it is apparent that kinship ties were stronger among the control than the experimental group. What can be deduced from this is that the aged who ended up in residential care had been totally alienated from their relatives. For those who managed to remain within their communities, even though many of their relatives did not give them any assistance, they were not isolated as they still kept physical contacts.

In concluding the section on social factors of the aged, data presented here have consistently shown that the aged who ended up in residential care were more socially disadvantaged than their counterparts who managed to remain within their own communities.

The institutionalized group exhibited much social isolation prior to residential admission. Compared to the non-institutionalized group, the aged who ended in residential care had fewer births, higher child mortality rates, and minimal social support from both their offspring and relatives. Given their economic deprivation, which was exacerbated by social isolation, it is little wonder that a greater number of such aged persons ended up in residential care. The next section presents data relating to the health aspect of the aged.

5.4 HEALTH FACTORS

Data on the health characteristics of the aged that are considered here generally relate to health problems, types, and intensity of disease.

(i) Incidence of Health Problem

Various studies have consistently shown the majority of the aged as suffering from health problems. Victor (1987:3), Tout (1989: 125-29), and Oomen (1991:1-4), show illness as one of the major problems that the aged have to contend with. On the basis of previous findings and general expectations, it was anticipated that the majority of the respondents in the present study would exhibit a greater incidence of illness. Besides, following the

trend in the previous sections where the non-institutionalized aged appeared to be more advantaged, it was expected that the aged who ended up in institutional care would differ markedly from those who did not, with respect to health. This was verified by asking the aged respondents whether they had any health problems. For the institutionalized group, the focus was on the period immediately prior to institutionalization, while for the non-institutionalized group, the focus was on the period of interview. Table 5.25 below presents the findings.

Table 5.25: **Distribution of the respondents by incidence of any health problem**

Response Category	Residents	Non-residents
Had some health problems	88 (78.6)	21 (70.8)
Had no health problems	24 (21.4)	9 (30.0)
Total	112 (100.0)	30 (100.0)

SOURCE: Sample Survey

From Table 5.25, it is observed that in both groups, the majority (70% and above) of the respondents experienced some health problems. This finding seems consistent with conclusions of Victor

(1987), Tout (1989), and Oomen (1991) that the majority of the aged suffer from health problems. The reason for such an incidence of health problems among the aged has been given as the physiological changes that characterize their life (Victor 1987:8,9).

It is noteworthy that, according to Table 5.25, there seems to be no major difference between the institutionalized and non-institutionalized aged in relation to health problems. Since certain findings such as by Hickey (1980), had shown that health problems were some of the major determinants of institutionalization, it was expected that those who managed to avoid institutional care would also exhibit better health conditions. What the findings suggest is that health problems are not unique to the institutionalized since even the majority of those who avoided residential care still had certain health problem.

(ii) Types of disease

The various health problems that respondents stated were categorized under acute or chronic. According to Victor (1987:247), acute health problems refer to the self limiting conditions of short duration, usually three months or less. Included here would be influenza, coughs, stomach-aches, among others. On the other hand, chronic health problems

tend to be long-term and are not usually easily curable. Examples of such problems would be paralysis, physical disablement, and arthritis.

Using the categories mentioned above, the Table below shows the proportions of respondents in each of the institutionalized and non-institutionalized groups. Since certain respondents reported suffering from both categories of diseases (acute and chronic) the distribution in Table 5.26 relate to all responses given by the aged. The percentages do not therefore add up to one hundred.

Table 5.26: **Prevalence of Acute and Chronic Diseases among the institutionalized and non-institutionalized aged (%)**

Type of Disease	Residents	Non-residents
Acute	30.5	36.6
Chronic	77.4	66.6

SOURCE: Sample Survey

Table 5.26 shows that whereas the minority of the aged suffered from acute health problems, in both groups, over 60% had chronic health problems. The most common acute health problems cited included stomach-aches, chest pains, coughs, and general body aches. On the other hand, the most common chronic health problems mentioned included physical

disablement, paralysis, eye problems low back pain, and arthritis. Going by the data in Table 5.26 bove it seems that once again, there is no major difference between the experimental and the control group with regards to health problems.

(iii) **Intensity of disease**

Data on intensity of disease was collected around three areas, namely, frequency of health problems, long-standing disability or impaired activity resulting from the problem, and medical care contact. Table 5.27 below presents findings on frequency of health problems.

Table 5.27: **Distribution of the Institutionalized and Non-Institutionalized Aged by Frequency of health problems suffered**

Frequency of health problems	Residents	Non-residents
Persistent	63 (74.1)	15 (71.4)
Occasional	11 (12.9)	3 (14.3)
Rare	11 (12.9)	3 (13.3)
Total	*85 (100.0)	*21 (100.0)

(* Twenty four (24) and nine (9) respondents from the two groups, respectively, reported having no health problems.There were three missing cases among the institutionalized)

SOURCE: Sample Survey

Table 5.27 shows that in both groups, over 70% of the respondents had persistent health problems. These had problems that were either permanent or that recurred more than twice in six months. These findings are in conformity with those presented in the two antecedent tables, all of which consistently show that both the institutionalized and the non-institutionalized groups suffered similar problems.

According to the World Health Organization, health in aged persons is best measured in terms of functions. The degree of fitness, rather than extent of pathology, provides the most meaningful measure of the amount of services the aged will require (see Shanas and Maddex, 1976:576). By application, it is apt to consider health problems besetting the aged to be more significant when it can be shown that they limit or disrupt normal activities of the aged. At the same time , it is reasonable to expect that health problems can only result into need for institutional placement where there was a resultant impairment of normal activities or ability to survive independently. In order to verify this, respondents were asked whether they had had to disrupt their normal activities due to their health problems. The table below presents the findings. From Table 5.28 it is evident that the majority of respondents from both groups had had illness that disrupted their normal

activities. It is significant to note that in spite of suffering a similar fate, the non-institutionalized group continued surviving within their natural environments.

The impression from this is that there were certain factors that must have intervened in favour of the control group and that enabled them to avoid institutional placement in spite of their physical debility. Two possible reasons are apparent. First, it is possible that the majority in this particular group had supportive network facilities that helped to ameliorate possible effects of health problems.

Table 5.28: **Distribution of Respondents by Incidence of an Illness Impairing Normal Activity**

Response Category	Residents	Non Residents
Had an impairing illness	64 (72.7)	17 (80.9)
Had no impairing illness	24 (27.3)	4 (19.1)
Total	88 (100.0)	21 (100.0)

SOURCE: Sample Survey

It has been shown in previous sections that the majority of the non-institutionalized aged had better social support than the institutionalized group. This fact seems to satisfy the first contention made above. It now remains to be seen whether the control group

benefited from medical attention more than the experimental group. In order to find out this the respondents were asked whether they had sought any medical attention subsequent to their health problems. Table 5.29 presents the findings.

It is evident from Table 5.29 that only 42% of the institutionalized aged previously sought any medical attention. This contrasts markedly with the non-institutionalized group where the majority (90.5%) reported seeking medical care due to their health problems. Going by Table 5.28 which showed that the majority of the aged in both categories suffered from health problems as intense as to disrupt their normal activities, it is perplexing that the majority (58%) in the institutionalized category had sought no medical care.

Table 5.29: **Distribution of Respondents by Medical Care Contacts Made**

Response Category	Residents	Non-Residents
Sought some medical care	37 (42.0)	19 (90.5)
Sought no medical care	51 (58.0)	2 (9.5)
Total	88 (100.0)	21 (100.0)

SOURCE: Sample Survey

Decision to seek medical care may be dependent upon one's subjective observation of frequency of symptoms and assessment of health status, availability of supportive networks (especially in cases of chronic debility or invalidity), and access to medical facilities. Several studies have consistently shown that subjectively assessed health problems usually rate much lower than in reality. According to a General Household Survey in Great Britain (1982), Graney and Zimmerman (1980), and Ford (1985), most old people tend to underestimate or ignore their health problems, thereby failing to seek any medical care (Victor, 1987:267-70).

Besides, in considering health self-report variations among older people, Graney (1981) concluded that older men had greater tendencies to fail to contact physicians even when appropriate symptoms were noticed. The reason given for this was that most men were unwilling to interrupt their rigid work routines to seek medical care. In order to verify this, the respondents were asked to give reasons for failure to seek medical attention. Since from Table 5.29, only 2 out of 21 non-institutionalized aged indicated that they had not sought any medical care, failure to seek medical attention was not considered as a major problem for this particular group. The group was therefore excluded from Table 5.30 below.

Table 5.30: **Distribution of the institutionalized Aged who Failed to Seek Medical Attention by the reasons for the Failure**

Reasons for failure to seek medical care	Respondents
Disease was incurable	3 (6.1)
Had no access to medical facilities	13 (26.5)
Did not consider disease as really serious	33 (67.4)
Total	*49 (100.0)

(* Two missing cases)

SOURCE: Sample Survey

Present findings lend credence to the contention that medical care contact depends on subjective evaluation of health problems. The most common reason given for failure to seek medical care was that the aged did not consider their illness as serious enough to warrant medical care. This accounted for 67.4% of the responses. It will be recalled that other findings presented in this section showed that the majority of the respondents had chronic health problems. It is interesting then that the majority who reported to having such health problems did not consider them as deserving medical attention. This paradox may be explained by considering the different bases upon which health problems are gauged or assessed.

Health has been considerd from two perspectives; the first is the functional model and the second the medical model. The functional model focuses on the maintenance of function which is in turn considered as an indication of wellness. On the other hand, the medical model focuses on presence of disease which is in turn considered as an indication of illness.

Wellness, based on the functional model which is usually a more subjective assessment, refers to an individual's capacity to continue with normal functions in spite of any disease. Here the individual who is able to maintain high levels of vigour considers himself as 'well'. Many old people are known to function with a few chronic problems which they consider as 'normal'. Since in their own assessment they consider themselves as 'well' - simply because they continue to perform certain activites - these old persons are unlikely to perceive the need for medical services simply because of the absence of a noticeable functional decline.

On the other hand, illness, which is a more objective assessment, reflects the presence of one or more pathological condition(s) (Peterson and Quadagno, 1989: 290). In this regard, even in the absence of functional decline, an individual will be adjudged ill if disease is present. This was the basis generally employed in the present study.

In view of the foregoing, it is possible to understand why certain respondents considered themselves as lacking any 'serious illness' in spite of their pathological conditions.

The second most important reason that was given for failure to seek medical care related to lack of access to medical facilities. This reason was attributed to three factors. First, there were old people who lived in locations that were geographically withdrawn from the nearest health centres. Problems of accessibility here related mainly to communication problems. Second, there were cases where procurement of any medical care required payments. Those who could not afford to pay for medical services found themselves unable to receive medical care. Third, there were cases where the aged suffered chronic debilities which hindered them from reaching available medical facilities. Such respondents also lacked people to help them in getting medical care.

Lastly the 6.1% of the respondents who considered their health problems as incurable were mainly the physically disabled and the paralytics. Conceivably, even if there might have been a desire to get medical care, since there was very little that could be done medically to alter their conditions, seeking of medical attention by this class of the aged could have only been futile.

From the data presented in this section, it is evident that health was a major problem to the majority of the aged. However, the popular stereotype of old age as a period of universal ill health and a progressive and inescapable decline and deterioration in health, vitality, social usefulness, and independence, remains largely untenable. Empirical evidence presented here shows that there was a portion of old people (the non-institutionalized group) who managed to remain within their own communities, functioning and leading normal lives in spite of prevalence of health problems.

The difference in fates between the aged who ultimately ended up in institutional care and those who managed to avoid institutionalization lies in the fact that the latter group had certain factors that worked to their advantage and which ameliorated the effects of their ill health. It is not by sheer coincidence that those who exhibited adverse economic deprivations, coupled with lack of supportive networks are also the ones who ended up in residential care, while those who evinced relative economic well-being and social support managed to avoid institutional care.

CHAPTER SIX: INSTITUTIONAL LIFE

Having seen, in the previous chapter, the background factors that affected the aged, focus is now turned to information relating to insitutional life. Data in this section relate mainly to the institutionalized aged.

Before delving into the main contents of this chapter, it is important to make a note on the relationship between this and the previous chapter. The focus of Chapter Five was mainly the demographic, social, economic, and health backgrounds of the aged. As probably will be remembered, one of the main aims of the current study was to investigate the conditions or factors that neccessitate institutionalization of the aged in Kenya.

As such, information on the old peoples' background was considered as significant to this aim in-so-far as it would provide a basis, or otherwise, for the reasons given by the aged for seeking institutional care. In other words, the information obtaining in the present chapter, part of which relates to the old peoples' reasons for institutionalization, must be considered in view of the old peoples' backgrounds, as shown in chapter five. If part of the present chapter may therefore appear to bear information similar to the one shown in

the previous chapter this will only act as a confirmation of our assumption that, to a greater or lesser extent, institutionalization of the aged is determined by the old peoples' backgrounds.

6.1 ADMISSION TO RESIDENTIAL CARE

In a study carried out in America, Kahana and Kahana (1979) found that the majority of decisions to enter residential homes often involved significant others. Most significantly, the majority of the aged were admitted either in the presence, or with the consent, of family members. This finding is quite puzzling especially considering that in the present study the majority of family members expressed greater unwillingness to the sending of their aged kin to residential homes. The concern was not so much what the aged would think, but rather, how the community would perceive the action. One such family members is quoted as saying:

> *.... If I am still alive, and if I can still manage, I will continue to struggle and maintain my mother. I can't allow her to be taken to old peoples' homes. People will feel that I have abandoned my mother....*

Besides, there were old people within their communities who could not entertain any thought of going into residential care simply because their family members would not agree.

What can be deduced from this is that those who had close family members found it rather difficult to

accept institutional care. On the basis of findings in the foregoing chapter, and contrary to Kahana and Kahana's (1979) findings, most of the aged who became institutionalized were expected to have done so in the absence of any close family members. In view of the general stereotypes regarding close African kinship ties, it would appear strange if family members consigned their aged to institutionalization instead of caring for them.

From Table 6.1 it is noted that family members were involved in only 11.6% of the cases. The majority of the admissions (54.5%) involved 'others' who were neither friends nor kin. What can be deduced from this is that very few primary relations or significant others were involved in decisions for institutional admissions.

Table 6.1: **Distribution of the institutionalized aged by persons involved in their residential admission**

Response Category	Number of Respondents
*Family members	13 (11.6)
Friends	10 (8.9)
Self	10 (8.9)
*Others	61 (54.5)
Can't recall	18 (16.1)
Total	112 (100.0)

(* 'Family members' included sibling and offspring whereas'others' included residential staff, local administration, religious leaders, and social workers)

SOURCE: Sample Survey

Reasons for the greater involvement of others in residential admissions can be better appreciated when reference is made to Table 5.9 (a). From information presented in Table 5.9 (a) it was evident that more than half (57.1%) of the institutionalized aged lived alone prior to institutionalization. Only 28.6% resided with close family members. What this implies is that the majority of those who were taken to residential homes by people other than family members probably had no relatives around them. Although on the basis of present information it is difficult to prove or rule out the question of abandonement of the aged by their family members (or relatives), what seems clear and consistent with conclusions of Oomen (1991 (a):4), is that the majority of the aged who are taken into residential care in Kenya are admitted in the absence of any family members.

6.2 FACTORS INFLUENCING INSTITUTIONAL PLACEMENT

Various scholars, including Cox (1976) and Oomen (1991), have attributed institutionalization of the aged to destitution. According to Webster's Third New International dictionary (1986:615), destitution refers to a state of deprivation of necessities of life. It is a condition that characterizes the life of someone who has been forsaken or abandoned, or who lacks any provisions or possessions and resources by which life can be sustained. Thus defined,

destitution would encapsulate the social, economic, and medical concerns of any individual. In explaining residential admissions, certain scholars have highlighted on one or two of these concerns as the major determinants of institutionalization.

In a study relating to elderly adaptation to institutionalization, Kahana and Kahana (1979) found that the primary determinants of institutional entry were social factors. According to their study, among four reasons given, the socially related factors accounted for nearly half (48%) of the respondents. This finding is consistent with that of Oomen (1991(b):7) according to which social problems of the aged were seen as the most crucial and hence the major determinants of institutionalization. Both the findings of Kahana and Kahana (1979) and Oomen (1991) conform with the general portraits of the aged as people who are socially isolated or alienated (HAK, 1990:2, Riley and Foner, 1968, Lowenthal and Haven, 1968:56). However, the findings do not agree with those of Braithwaite (1986). In a study conducted in Barbados, Braithwaite (1986) found that the worst problem besetting the aged, and which consequently influenced residential placement, was economically related. Economically related problems accounted for 47.8% of the responses while health and social problems accounted for only 16.5% and 9.6%

respectively. Various other problems accounted for the remaining 26.1%.

In attempting to understand the apparent inconsistency in the reports mentioned above, it is important to note that whereas Kahana and Kahana (1979) conducted their study in a developed Western society, both Braithwaite (1986) and Oomen (1991) based their studies in developing third world societies. The differences in the findings may thus be reflective of the different and peculiar problems that beset the developed and developing societies. In explaining why social concerns were not an issue in his findings, Braithwaite (1986) is quoted as saying that,

> *... whereas the findings... here .... bear out the findings... about Third World societies that kinship network support is widespread, they do not bear out the conventional view that the elderly are recipients of widespread financial support.... (Tout, 1989:111).*

What is implied in the quotation above is that, in developing societies the major problems that the aged are perceived to be experiencing are more economic than social, while in developed societies, old age problems are seen to be more socially, than economically related. This is majorly due to the perceived economic well-being in developed societies and the converse in developing societies. By application, the major problem besetting the aged and therefore, determining institutionalization of the

aged in the present study was expected to be more of economic than social. In order to find out this, respondents were asked to give the reasons why they adopted residential care. Respondents mentioned more than one reason. The table below presents these responses, expressed in terms of percentages of respondents who cited each reason.

Table 6.2 **Reasons for Institutionalization**

Health problems	78	66.1
Lack of care	81	70.3
Lack of adequate shelter	15	12.7
Lack of place of residence	54	45.8
Lack of means of subsistence	84	71.2
Feelings of being a burden to host	8	6.8
Domestic conflicts	11	9.3
Old age	11	9.3
Loneliness	2	1.7
Other reasons	3	2.5

SOURCE: Sample Survey

The reasons given in Table 6.2 above can be grouped in five classes in order of significance, as is shown below;

(i)	Social factors	77.1%
(ii)	Health factors	75.4%
(iii	Economic factors	71.2%
(iv)	Residential-environmental factors	58.5%
(v)	Other reasons	2.5%

Reasons relating to social factors from table 6.2 include'lack of care', 'feelings of being an economic

burden to host', 'domestic conflicts' and 'feeling of loneliness'. Health-related reasons include. 'health problems' and 'old age'. Economic reasons include 'lack of means of subsistence'. Residential factors include, 'lack of place of residence', and 'lack of adequate shelter'.

That social, and not economic, factors should be the most commonly mentioned concerns is somehow intriguing. This is because, as was shown in the previous chapter, the aged who managed to remain within their own communities had greater economic than social advantages over those who ultimately ended up in residential care. Besides, present findings seem to contradict widespread conventional views as shown by Braithwaite (1986), that socially related problems do not constitute the primary concern of the aged in third world societies. In order to understand the seeming paradox, it is instructive to consider how the non-institutionalized aged managed to avoid residential care in spite of suffering problems similar to those of the institutionalised aged. The different responses that were given were classified as shown in Table 6.3 below.

Table 6.3: **Reasons Given by Non-Institutionalized Aged for Avoiding residential Care (%).**

Health	13.3
Social	50.0
Economic	56.7
Others	6.7

SOURCE: Sample Survey

Findings presented in Table 6.3 show that the majority of the aged who managed to avoid institutional placement attributed this to perceived economic well-being or advantages over the institutionalised aged. Besides, what can be inferred from present information is that, where there was economic well-being, social and health factors became secondary. It seems then that the major shortcoming of the aged who failed to continue with normal community life, thereby ending in residential homes, was economic deprivation. Expressed in other words, social and health problems only become pronounced because of lack of economic well-being. Further, as was shown in the previous chapter, the non-institutionalized group managed to remain within their own communities in spite of lack of social support and ill-health because they were more economically endowed than the aged who ended up in residential care.

Present findings also differ from general assumptions that a majority of the aged go into residential care primarily because of their physical or medical problems. Although the centrality of

physical problems in the lives of the aged cannot be contested, it is interesting to note that in the present findings the health factor does not emerge as the primary determinant of institutional admission. As is shown in Table 6.3, only a minority (13%) considered themselves to have physical or medical advantages over those who are institutionalised. What can be deduced from this (and which is proved in the previous chapter) is that health problems are common to both the aged who enter residential homes and those who do not. These findings are therefore consistent with conclusions made by Oomen (1991 (b):7) that social problems of the institutionalised aged are greater than medical ones.

The foregoing discussion should not be construed to imply a single-factor determinant of institutionalization. Whereas it is true that one factor preponderates in influencing decisions for residential placement, there is no basis to dispute that all the reasons given in Table 6.2 form some of the factors that determine institutional placement of the aged. Incidentally, all respondents gave more than one reason for entering residential care. What can be deduced from this is that institutionalization is precipitated by an interplay between more than one factor. Lawton (1980) sees this interplay as a balance and sees the deteriorating balance between ability to undertake care and social support as the

most important factor responsible for institutional placement of the age, (see Peterson and Quadagno, 1989: 395).

Ability to undertake self care, in this respect, relates to the physical and economic well-being of the aged. The multiple factors that determine institutionalization of the aged is thus seen in the interaction between the physical debility, economic deprivation, and lack of social support that leads to a state of destitution which is given by Cox (1976) and Oomen (1991) as the primary determinant of institutionalization.

6.3 INSTITUTIONAL PARTICIPATION

Disengagement theory, as formulated by Cumming and Henry (1961), suggests that old people generally tend to experience decline or loss of activity. According to the theory, such loss of activity is independent of factors such as poor health and poverty. In other words, proponents of disengagement theory consider the loss of activity in old age as a natural and inevitable concomitant of aging. Although perceived as a natural characteristic of senescence, loss of activity has also appeared to be exacerbated by loss of roles (see Peterson and Quadagno, 1989:72). The bearing of these contentions on the present study is that, consistent with previous conclusions that institutional life epitomises a major loss of roles,

it was expected that the majority of the respondents would exhibit low participation in any activities in the residential homes.

Previous studies by Kahana and Kahana (1979) and surveys by Help Age Kenya (HAK 1988) concluded that the majority of institutionalised persons participate in institutional activities. These findings appeared consistent with general expectations and with findings anticipated in the present study. In order to find out the situations obtaining among the institutionalised, respondents were asked whether they participated in any voluntary activities in the homes. Table 6.4 presents the responses.

It is observed that the majority of the respondents (56.2%) did not participate in any voluntary activities in the homes.The impression obtainable from this finding conforms to the contentions of the proponents of disengagement theory and to the expectations of the present study. This finding is also consistent with information provided earlier that portrays the institutionalised aged as majorly physically debilitated. As health problems provide one of the main reasons for institutional placement, it is reasonable to expect the respondents to be physically unable to actively participate in activities in the homes. Such a conclusion, however, is contradicted by findings of Kahana and Kahana (1979) and the Help Age Kenya Survey (1988).

Table 6.4: **Distribution of the Institutionalized Aged in terms of whether or not they participated in voluntary activities in the homes.**

Response Category	Number of Respondents
Participated in some activities	49 (43.8)
Did not participate in any activities	63 (56.2)
Total	112 (100.0)

SOURCE: Sample Survey

In considering institutional participation it is important to identify the different types of activities. Activities in the homes can either be voluntary or compulsory, requiring mobility or sedentary. In evaluating levels of institutional participation, Kahana and Kahana (1979) focused mainly on social activities such as church attendance and visitations, among others. These were institutionally organised group activities in which all residents were expected to benefit. Even though a number of residential homes in the present study had organised worship, there was very little other institutionally organised activity. Consequently the present study focused only on voluntary or self-initiated activities. It is evident then that the present focus differs from that of Kahana and Kahana (1979). The

apparent inconsistency between the two findings can thus be attributed to the difference in the focus.

Regarding the Help Age Kenya Survey (1988) which posits images of actively participating institutionalized aged, it suffices to note that the conclusion was mainly based on sedentary and institutionally organized activities. The HAK (1988) survey thus differs slightly with the present study which found that those who participated in activities in the homes were mainly engaged in general cleaning, Kitchen work, basketry, laundry, gardening, and general domestic work. It is probably important at this juncture to add that if the HAK survey (1988) alluded to such activities then the conclusions were largely exaggerated because those who actually participated as such were a minority, as is shown in Table 6.4. On the basis of present findings, there is scepticism in accepting conclusions that majority of the institutionalized aged actively participate in the homes.

Besides physical debility, lack of participation in residential homes has also been attributed to negative marital experiences. In attempting to explain why certain old persons appeared non participatory in residential homes, Kahana and Kahana (1979) noted that there were higher levels of participation among the married than any of the single categories which included the never married, the

widowed, the divorced or separated. The argument advanced in explaining this observation was that the married tended to be more settled psychologically and socially integrated than the single. In considering the validity of such a contention, it was found necessary to view the issue of institutional participation in relation to the marital status of the respondents. The findings are shown in table below.

Table 6.5: **Distribution of the Institutionalized Aged by Marital Status and Any Participation in Activities within the Residential Homes**

Marital Status	Participation in Activities: Participated in some activities	Did not participate	Total
Married	1 (11.1)	8 (88.9)	9 (100.0)
Never married	13 (39.4)	20 (60.6)	33 (100.0)
Widowed	28 (53.8)	24 (46.2)	52 (100.0)
Separated	5 (31.3)	11 (68.7)	16 (100.0)
Cohabiting	2 (100.0)	0 (0)	2 (100.0)
Total	49 (43.8)	63 (56.2)	112 (100.0)

SOURCE: Sample Survey

With the exception of the widowed and those co-habiting, it is evident from Table 6.5 that the majority of the respondents who had undergone negative marital experiences also tended to exhibit lack of participation in institutional activities. Quite unexpectedly though, the majority of those who were married also turned out to be non-participants. Following the contentions of Kahana and Kahana (1979),

it was expected that the majority of the married respondents would show greater tendencies towards activity while the majority of the widowed would show greater aversion towards participating in activities in the homes. However, present findings do not seem to support the contention that marital status has a bearing on institutional participation. Arguably, there are factors that affect activity levels of institutional residents, but there is no indication that marital status is one of them.

6.4 INSTITUTIONAL SOCIAL BEHAVIOUR

The social behaviour considered here is that which relates to interpersonal behaviour or interaction within the homes for the aged. The types of interaction considered here are those between the residents themselves, the residents and staff, and residents and non-residents (outsiders).

(i) Resident-Resident Interaction.

Existing literature is replete with studies that show diminished social interactions among the aged in residential homes. This has been attributed to relocation stress (Tobin and Lieberman, 1976), inactivity (Goffesman and Bourstorm, 1974), and dehumanizing treatment by staff members (Gubrium, 1975).

Tobin and Lieberman (1976) suggest that the shifting of the aged from their normal residence to old people's homes is usually accompanied by some psycho-social effects that are exhibited in feelings of stress. According to this, when the aged get into residential homes they find themselves in a different social set-up which involves interpersonal relations with others with whom they are unfamiliar. It is the feeling of isolation and displacement, resulting from this, that heightens the lack of interaction among the aged residents. In order to verify this contention it is necessary to consider the levels at which the institutionalized aged interacted with each other. The responses are presented in Table 6.6 below.

Table 6.6: **Distribution of the Institutionalized Aged by Level of Interaction Among Themselves**

Response	No. of Respondents
Very friendly	5 (4.5)
Friendly	90 (81.8)
Not so friendly	11 (10.0)
Unfriendly	4 (3.6)
Total	*110 (100.0)

(* There were two non-responses)

SOURCE: Sample Survey

Information in Table 6.6 above shows that the majority of the respondents (86.3%) considered their interactions as either 'friendly' or 'very friendly'.

It is temptig to conclude from this finding that the institutionalized aged had very intimate relationships among themselves. However, when the respondents were asked whether they had any close friends among their colleagues, only 39.8% answered affrimatively. The remaining 60.2% did not have any such close friends. The importance of data on the availability of close friends is that, if considered superficially, instances of interaction among the aged may simply reflect the fact that relationships are formed in the homes, without necessarily showing the nature of such relationships. That the majority of the respondents considered their interactions as friendly while only a minority had close friends suggest that much of the interaction in the homes was probably just superficial or impersonal. In explaining why he had no close friend in the home, one of the respondents was quoted as saying;

> *... all of us come from different places, we are here because of different problems. We have nothing in common. Each has his own problem to contend with...."*

What can be inferred from this statement is that the lack of very close relationships between a majority of the institutionalized aged could be an attribute of the cultural heterogeneity that obtains in most residential homes. Quite conceivably, it is difficult for any two people to interact closely unless they share something in common. Consequently,

a commonality of ethnic or cultural background would be expected to enhance feelings of togetherness or belonging. In other words, the aged who shared common origins were expected to exhibit closer ties than those from different origins. In order to verify this, it was considered important to view the level of resident - resident interaction in relation to their places of origin. The table below presents the findings.

Table 6.7: **Distribution of the Institutionalized Aged by Level of Interaction Among Themselves By Place of Origin**

Place of Origin (either common or different)

Interaction	Common Origin	Different Origin	Total
Very friendly	3 (4.2)	2 (5.3)	5 (4.5)
Friendly	61 (84.7)	29 (76.3)	90 (81.8)
Not so friendly	6 (8.3)	5 (13.2)	11 (10.0)
Unfriendly	2 (2.8)	2 (5.3)	4 (3.6)
Total	72 (100.0)	38 (100.0)	110 (100.0)

SOURCE: Sample Survey

Information from Table 6.7 shows clearly that the majority of those whose interaction was either friendly or very friendly had common origin. Besides, although not very pronounced, there are indications that the majority of those who had problems in interactions were those who had different origins. It seems then that cultural backgrounds had certain

bearing on institutional interaction. On the basis of this, it seems logical to conclude that the majority of the respondents who did not develop any primary relationships in the homes were those who did not share a common cultural background with the majority of the residents. Minority groups seem to have had greater difficulties in institutional social interaction.

(ii) **Resident-Staff Interaction**

Besides fellow residents, the social environment in residential homes for the aged was also composed of care staff. Data on the relationship that existed between the aged residents and the staff is important because it is the latter who interacted with the aged on a daily basis in the process of rendering institutional care. It is the staff who interpreted and put into effected the policies of the various homes. It is logical to expect that the welfare of the institutionalized aged would depend on the attitude of the staff towards them and vice versa.

Several previous studies suggest that in general, there exist poor relations between residents and residential staff. Gubrium (1975) and Kahana (1975) considered the treatment of the aged by residential staff as dehumanizing. On their part, Gottensman and Bourstrom (1974) found that out of the 1144 residents in old people' homes in Michigan, 73% had no

meaningful interaction with the staff. Only 17% reported having any such interaction with the staff. A similar finding was made by Watson and Maxwell (1977). The latter two researchers attributed the low resident-staff interaction to differences in racial composition of residents and staff.

Whatever reasons may exist, the findings shown above portray a rather grim picture of resident-staff relationship. It is important to note that all the studies presented above relate to developed societies. In order to confirm whether a similar trend could apply in the present situation, aged residents were asked to describe the relationship that existed between them and institutional staff. The responses are presented in Table 6.8

Table 6.8: **Distribution of the Institutionalized Aged by the type of relationship that existed between them and the Residential Staff**

Type of Relationship	No. of Respondents
Very friendly	22 (24.2)
Friendly	57 (62.6)
Not so friendly	5 (5.5)
Unfriendly	7 (7.7)
Total	91 (100.0)

(There were 4 non-responses and 17 N/A)

SOURCE: Sample Survey

Information from Table 6.8 shows that the majority of the residents (86.8%) had very good relations with the staff members. Only 13.2% seemed to have some problems. There were 17 respondents who lived in homes without care staff. To such respondents the question of resident-staff relationship did not apply. (The N/A cases are discussed elsewhere in the report).

The impression formed on the basis of Table 6.8 is that, contrary to previous studies showing poor resident-staff relationships, present findings suggest that most of the respondents had good relationships with their care staff.

Although a relatively small portion of the respondents seemed to experience some problems in their interaction with the staff, this category was considered as very critical. The findings that the majority of residents had favourable relationships with residential staff should be accepted rather cautiously. This is because it was suspected that certain respondents did not express their real feelings out of fear of reprisals from the staff. This was exemplified in an encounter with one of the respondents who initially had denied experiencing any problems.

However, after getting an assurance that whatever information given would be held in strict confidence, the respondent recounted all sorts of humiliation that

those of them who came from different ethnic groups had to suffer at the hands of the residential staff. What this suggests is that most of institutionalized aged are so desperately in need of care that they would rather silently suffer mistreatment by the staff than to jeopardize their residence in the homes. It is in view of this that the 13.2% of the aged who indicated having some problems in their relations with the staff are consider as more honest in reflecting their feelings. These found the staff to be discriminatory, mistreating, untrustworthy and inefficient, among others.

(iii) **Resident - Non-resident Interaction**

In a study on the effects of long-term care of older people, Brody (1977) found that institutional life strains ties between residents and non-residents. Part of the factors seen as contributing to this were barriers that exist in terms of accessibility of residential homes. Such a finding was however, inconsistent with those of Seelbach and Hansen (1980), Smith and Bengston (1979), and York and Calyson (1977). According to these scholars, stable, and at times increasing, interaction was observed between institutional residents and non-residents. In order to verify the different findings mentioned above, it was considered necessary to find out whether the institutionalized aged received any visitation from

outside the homes. The responses are presented in Table 6.9 below.

It is apparent from Table 6.9 that only 45.8% of the respondents received any visitation from non-residents. The majority (54.2%) received no such visitation. Present findings give the impression that resident-nonresident interaction was less than satisfactory.

Table 6.9: **Distribution of the Institutionalized Aged by whether or not they received any visitors from outside the homes**

Response Category	No. of respondents
Received some visitors Received no visitors	49 (45.8) 58 (54.2)
Total	* 107 (100.0)

(* There were 5 non-responses)

SOURCE: Sample Survey

Besides merely getting information on instance of nonresident visitations, it was considered important to know the type of people who actually visited the residents. Data on this, presented in Table 6.10 below, shows three types of visitors; relatives, family members, and friends. There is no clear preponderance of any group over the other.

Table 6.10: **Distribution of the Institutionalized Aged by Type of Visitors they Received from Outside the Homes**

Types of Visitors Received	No. Of Respondents
Immediate Family Members Relatives Friends Others	15 (30.6) 15 (30.6) 12 (24.5) 7 (14.3)
Total	*49 (100.8)

(* Only 49 out of the 112 respondents reported receiving any visitors. See Table 6.8)

SOURCE: Sample Survey

If the immediate family members (mainly referring to sibling and offspring) are placed in the same category as 'relatives', it turns out that some 61.2% of the institutionalized aged received visitations from their kin. However, it needs to be borne in mind that this percentage relates just to the 49 respondents who received some visitors. If considered on the basis of the total number of the institutionalized respondents (112) it turns out that only 26.8% of the aged actually received visitors from without the houses.

Considering that more than half of the institutionalized aged reported having some relatives (Table 5.20) yet a much smaller portion received visits from their relatives (Table 6.10), it seems more logical to conclude that there was no improved

interaction between the residents and non-residents. The view that resident - non-resident interaction remain normal or improve in homes for the aged seems untenable on the basis of present findings.

6.5 INSTITUTIONAL EFFECTS

Whether institutionalization affects the aged positively or negatively is a question that has been the subject of a lot of arguments and counter arguments. In spite of much polemic, the question still remains unresolved. In considering views that institutional care acts as a solution to much of the problems besetting the aged, a consideration of the benefits the aged found in residential care was deemed crucial. Table 6.11 presents the findings.

Table 6.11: **Benefits From reidential Care (%)**

None	5.1
Medical care	58.5
Provision of food	51.7
Provision of clothing	30.5
Provision of shelter	49.2
Someone to care	22.0
Companionship	33.1

Source: Sample Survey

Since residents gave more than one reason, the responses presented above are expressed in terms of percentages of total respondents for each reason. According to Table 6.11 the majority of respondents considered the main benefits of institutionalization

to be, medical care, food, and shelter. Only 5.1% of the respondents felt that they had not benefited in any way.

Considering the reasons given for institutional placement (refer to Table 6.2) it is appreciable why the majority of the respondents found institutional care beneficial. To them, institutional living provided solutions to some of their besetting problems. The fact that the majority found institutional care beneficial suggests that, contrary to previous findings referring to negative aspects of institutionalization, institutional care seems to alleviate some of the problems that lead most old people to residential homes.

To say that institutionalization is generally beneficial to the aged does not imply an absence of negative aspects of residential living. As Table 6.11 shows, there were some 5.1% of the respondents who saw nothing positive in the homes. It was suspected that the expression of disenchantment suggested the existence of certain problems in the residential homes. In order to verify this, the respondents were asked to mention any problems that they experienced within the homes.

The majority of the respondents (85.6%) mentioned that they had nothing to complain about. Only 14.4% expressed disgruntlement. The fact that relatively fewer respondents expressed certain discontentment

with institutional care lends credence to views that institutionalization generally affects the aged positively.

Although the 14.5% who had some institutional problems constituted the minority, it was considered important to find out the various problems that these respondents experienced in residential homes. Since almost all respondents mentioned more than one problem, the frequencies in Table 6.12 below refer to the number of *responses* rather than the number of *respondents*. Likewise the percentages in the same table is that of responses given for each problem. In other words, the Table deals with the number of times a problem was mentioned or the most commonly mentioned problem rather than the number of people who mentioned the problem.

Table 6.12 **Problems experienced by the aged in residential care (%)**

Types of Problems	Frequencies
Deterioration of health	9 (12.0)
Conflicts with colleagues	9 (12.0)
Conflicts with care staff	9 (12.0)
Feelings of isolation	9 (12.0)
Lack of adequate food	13 (17.3)
Provision of poor services	11 (14.7)
Total lack of care	7 (9.3)
Lack of finances	6 (8.0)
Others	2 (2.7)
Total	75 (100.0)

Source: Sample Survey

In comparing Tables 6.11 and 6.12 it is apparent that most of the problems mentioned above are the obverse of the institutional benefits mentioned by other respondents. It is fascinating to note that whereas certain respondents benefited from medical care and improved health, to others, institutional care only led to a deterioration of health. Besides, whereas to certain respondents institutional life saved them from previous feelings of isolation by providing companionship, to others, institutional care was bedevilled with conflicts with fellow residents and care staff, and heightened feelings of isolation. Further, whereas to certain respondents institutionalization provided the food, clothing, shelter, and care that was previously unavailable, others found in residential homes a total lack of care, or at best, inadequate food, poor services, and lack of any finances for personal use.

The apparent lack of unity noted in the responses given above should not be constructed to imply a contradiction. Rather, this is indicative of the different effects that institutionalization has on the aged. Some of these differences further reflect the diversities in backgrounds and perceptions of the respondents which largely influenced their reactions. It is note-worthy that whereas certain respondents who had previously lived relatively comfortably and others who were admitted to the homes under compulsion

generally felt disgruntled, those who had come from more adverse backgrounds felt very contented with residential care.

Some of the problems mentioned in Table 6.12 may be attributed to institutional care. For instance, findings of this study showed that in certain homes, the aged residents were left to manage their own lives, and as such had no care staff. Such respondents found "a total lack of care" in the homes (refer to Chapter 4). In addition, present findings showed that most of the homes did not allocate any pocket money to the residents. The assumption was that the homes catered for all the basic needs of the resident. However, this study found that, in addition to "basic" needs, some of the respondents used tobacco either for smoking, chewing or stuffing, while others used alcoholic beverages. However, no provisions were made for these in almost all the homes. Those respondents who were affected therefore felt the need for some money for their own use; such money was not readily available.

Although certain respondents complained of deterioration of health in the homes, in reality there may be no casual relationship between institutionalization and deterioration in health. Decline in health may either be a consequence of a prolonged pre-institutional pathology, or a natural concomitant of aging. As such, such decline in health

may not necessarily be consequent to institutional placement.

When asked whether they would be willing to leave the homes for their previous places of residence, it is interesting to note that only 14.4% were willing to quit while the majority (83%) would not entertain the thought of leaving the residential homes. Those who expressed willingness to leave the homes wanted to go back and care for their offspring and property while others did not feel comfortable in the homes. The majority who expressed unwillingness to quit residential care gave responses such as, "has nowhere to return to"; "has no one to provide care", can't go back to previous problems". What can be deduced from these responses is that the majority of the institutionalized aged came from such hardship conditions that any problems experienced in the residential homes seemed more bearable.

In considering the effects of institutionalization on the aged, Fox (1976:6) concluded that majority of the aged are withdrawn and resigned to fate; that they only have a present to live in and no future. What is implied here is that, most of institutionalized aged see their lives as terminal. In order to verify this, respondents were asked about their plans for the future. Table 6.13 presents the responses.

Table 6.13: Distribution of the Institutionalized Aged by any plans they had for their future

Response Category	No. of Respondents
Has no plans	46 (41.4)
Plans to stay till death	49 (44.1)
Plans to look for employment	6 (5.4)
Plans to return to place of origin	4 (3.6)
Plans to stay on till recovery	6 (5.4)
Total	111 (100.0)

(One Non-response)

SOURCE: Sample survey

Table 6.13 shows that 41.4% of the respondents had no plans beyond institutional life. In addition to these, 44.1% saw no hopes of living beyond the residential homes, these were simply waiting for death. The first two categories in the table above represents a total of 85.5% of the aged who saw institutional life as terminal, beyond which there was no hope of life. On the basis of present data, the conclusions of Fox (1976:6) seem quite sustainable; the majority of institutionalized aged are resigned to fate.

In the foregoing section, attempts have been made to establish the effects of institutionalization of the aged. Whatever factors considered here indicate either a positive or negative effect of institutional life. Positive effects relate to cases where the aged find institutionalized as favourable, beneficial, and an improvement of their previous life.

Institutionalization is however considered to have affected the aged negatively if it leaves them with feelings of disgruntlement, degradation and humiliation. From the data presented in this section, institutionalization seems to have had a positive effect on the majority of the aged, as is summarized in Table 6.14 below.

Tabke 6.14: **Distribution of the aged according to the effects of institutionalization on them**

Institutional Effects	No. of Respondents
Positive	88 (80.0)
Negative	22 (20.0)
Total	110 (100.0)

(Two missing cases)

SOURCE: Sample Survey

Two factors have emerged from discussions in this section which can provide possible explanations for the distribution in Table 6.14. One, it has been seen that most of the aged had previously suffered adverse deprivations prior to their institutionalization. It seems that institutional care provided a relief to the majority of those aged persons; hence, the positive effects. Two, much of the complaints expressed by the institutionalized aged relate to conditions that obtain in the residential homes. It is probable that where life in the homes was not an improvement of one's previous life, institutionalization was viewed

rather negatively. In other words, present findings seem to support the view that the impact of institutionalization on the aged persons depends on their background and also on the environment within the residential home.

CHAPTER SEVEN: ANALYSIS AND INTERPRETATION OF FACTORS WHICH INFLUENCE INSTITUTIONALIZATION OF THE AGED

The following chapter attempts to examine and interpret the relationship between the major variables in the study. In order to do this, three main statistical tests have been employed.

The difference of means, difference of proportions and Kolmogorov-smirnov tests have been used to test the difference between institutionalized and non-institutionalized aged with respect to certain independent variables and, by extension, the statistical significance of the various independent variable(s). The chi-square test has also been used as a test of significance especially for hypotheses two and three. Besides, the gamma has been used, where appropriate, to measure the strength of association between the said variables.

In addition to the tests mentioned above, multiple and stepwise regressions have been used to establish both the individual and the joint effects of the factors considered as determinants of institutionalization of the aged.

7.1.0 **H1: The aged who have low socio-economic status and low health status will most likely be institutionalized if, in addition, they lack social support.**

In order to adequately test the foregoing hypothesis, the effects of each of the three main independent variables - socio-economic status, health status and social support have been isolated and considered separately. First, the socio-economic status. In considering socio-economic status of the aged, four indicators have been used. These indicators include occupational status, type of employment, income, and level of education.

Table 7:1 **Residential placement by occupation of aged.**

	Residential Category	
Occupation	Residents	Non-residents
Employed	52 (46.4)	20 (69.0)
Unemployed	60 (53.6)	9 (31.0)
TOTAL	112 (100.0)	29 (100.0)

Z(cal) = 2.66. Significant at 95% confidence level.
γ = 0.44

Evidence from Table 7.1 shows that there is a significant difference in the proportion of the aged who previously had no employment and are in

residential care and those who lived independently in spite of having had no employment. (The period of focus is immediately before institutionalization, for residents, and by the time of interviewing, for non-residents). Accordingly, we reject the null hypothesis predicting lack of difference between residents and non-residents, in favour of the alternative hypothesis that the proportion of residents who were previously employed will tend to be greater than that of the aged who remained outside residential homes in spite of having had no employment. It seems logical, on the basis of present findings, to conclude that the previous state of occupation of the aged had some bearing on their residential placement. It would appear quite inconceivable that it was by mere chance that the majority of the aged who ended up in residential care were those who previously had no employment.

The relationship between previous occupational status and residence is further supported by the gamma value of -0.44 which suggests that there was a moderately strong but negative association between the two variables. By implication, lack of any occupation tended to push the aged into residential care.

The present findings are consistent with the tentative conclusion made earlier (Table 5.6) that the aged who had no independent means of earning a living

would be more susceptible to residential care. The significance of the old people's previous occupation on their residential placement need not be over-emphasized. Suffice here to state that without a previous independent means of livelihood, it would be difficult for the majority of the aged to survive without seeking for external care, especially if needed domestic care was not quite available within one's own natural community, as will be shown subsequently.

Considering further the Table 7.1, it appears that although the non-residents who had not had any employment were slightly less than half of those who were employed, the difference between the same categories for the institutionalized aged seemed to have been a mere 7.2%. What this implies is that there was no significant difference between the once employed and the never employed among the institutionalized age[1]. Accordingly, data on occupational status were not considered as very convincing and an elaboration was sought. In seeking a more elaborative data, the type of employment the aged had was considered. The findings are shown in Table 7.2 below.

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[1] When subjected to a test of difference of proportions, the two proportions (of residents) yielded a Z value of 0.76 which was much lower than the critical limit of 1.65 at 95% confidence level

Table 7.2 Residential Placement By Type of Employment.

Type of employment	Residential Category	
	Residents	Non-residents
unskilled labourer	20 (38.5)	5 (25.0)
small trader	11 (21.2)	2 (10.0)
subsistence farmer	13 (25.0)	1 (5.0)
large scale farmer	2 (3.9)	4 (20.0)
skilled labourer	6 (11.5)	3 (15.0)
Business	0 (0)	5 (25.0)
TOTAL	52 (100.0)	20 (100.0)

χ^2 = 39.29 with 2 df. Highly significant at 95% confidence level.
γ = 0.47.

The assumption underlying the test above was that there was no significant difference on the basis of type of occupation between institutionalized and non-institutionalized aged. The Smirnov test set to confirm this proposition yielded a of 39.39 which was found to be highly significant even above the study's acceptance level of 95%. Accordingly, the null hypothesis was rejected and it was concluded that the two categories of respondents (both the residents and non-residents) were significantly different in regards to types of employment they had.

What can be deduced from present findings is that even though close to 46% of the aged in residential care reported having had some employment prior to their institutionalization (Table 7.1), the nature of their occupations did not seem adequate enough to

enable them to survive independently. It is not by mere coincidence, then, that the majority of the aged who appeared to have had low placed jobs were also the majority who ended up in residential care. The type of employment the aged had seems to have had some influence on their residential placement. The foregoing conclusion is supported by the test of association based on the gamma of 0.47 which suggest that the relationship between type of employment and residential placement was fairly strong.

Earlier (Table 5.8) we got an impression that the level of income the aged received (prior to institutionalization and by the time of interviewing for both the residents and non-residents, respectively) had some influence on the old people's residential placement. This impression was based on the data on income the aged received which seemed to indicate an income differential between the aged in residential care and those who were not. This differential seemed to have been in favour of the non-institutionalized aged. As such, it was tentatively concluded that the aged who previously had low levels of income (or none) would have greater inclination towards institutionalization.

Although it was observed that more of the residents had previously had lower or no incomes, compared to non-residents, it is important to show

whether this difference had any statistical significance. Table 7.3 below attempts to do this.

Table 7.3 Income differentials between residents and non-residents of old people's homes.

Income levels (KShs)	Residents	Non-residents
0 - 499	110 (98.2)	18 (60.0)
500 - 999	1 (0.9)	3 (10.0)
1000 - 1499	1 (0.9)	3 (10.0)
1500 - 1999	0 (0)	0 (0)
2000 - 2499	0 (0)	4 (13.3)
2500 - 2999	0 (0)	1 (3.3)
3000 and over	0 (0)	1 (3.3)
TOTAL	12 (100.0)	30 (100.0)

Z (cal) = 4.87 Significant at 95% confidence level.
γ= -0.9

The test of difference of means set on the basis of data in Table 7.3 yielded a Z of 4.87 which was much higher than the critical limit of 1.65 at 95% level of confidence. Accordingly, it was concluded that there is a significant difference between the institutionalized and the non-institutionalized age in regards to levels of income received.

In testing the income differentials between the aged residents and non-residents, the study was also trying to find out whether there was any relationship between level of income and residential placement. To state that the institutionalized aged had much lower

incomes than the non-institutionalized age, and that the majority of the aged who previously had low levels of incomes are the ones who tended to enter residential care, is, in essence, a statement that the old people's previous levels of income had an influence on their residential placement. This assertion seems to get support from the test of association where the gamma of - 0.9 seems to indicate a rather strong but negative association between residence and level of income. There seems to be ground to conclude that the lower the levels of income the aged received the greater was their tendency to be institutionalized.

When considering the level of education of the aged (Table 5.5), the impression formed was that the majority of the aged who ended up in residential care also seemed to have had rather low levels of education in comparison to the aged who were not in residential care. On the basis of this, it was tentatively concluded that the level of education the aged received had some influence on their residential placement.

The validity of the tentative conclusion made above, however, lies in the assumption that the average years of education attained by the aged in residential care was actually lower than that of their counterparts who managed to continue with normal

community life. To verify this, the difference in the average education between the two categories of the aged was tested. Results are shown in Table 7.4 below.

Table 7:4 **Difference in levels of education between residents and non-residents**

Level of education (Years)	Residential Category			
	Residents		Non-Residents	
0	90	(80.4)	15	(50.0)
1 - 2	10	(8.9)	2	(6.7)
3 - 4	5	(4.5)	4	(13.3)
5 - 6	5	(4.5)	4	(13.3)
7 - 8	2	(1.8)	4	(13.3)
9 and above	0	(0)	1	(3.3)
TOTAL	112	(100.0)	30	(100.0)

Z (cal) = 2.58. significant at 99% confidence level
γ = -0.86.

Present findings show that there was a significant difference between residents and non-residents with regards to the levels of education attained. This finding confirms our earlier conclusion (Table 5.5) that the aged who ended up in residential care had a much lower educational attainment than those who stayed away.

The findings on the difference of levels of education attained by both categories of respondents shades some light on the relationship between education and residential placement. To say that the majority of the aged who ended up in residential care

are the ones who previously had low education is another way of stating that education had a negative influence on institutionalization. In other words, the aged who previously had higher levels of education tended to have a disinclination towards residential care while those who had low levels of education tended to be more susceptible to residential care. The gamma of -0.86 confirms this negative relationship.

Findings in Table 7.4 confirm those from the three previous tables which show that, in general, the institutionalized aged were rather disadvantaged economically. These findings provide reasonable ground to conclude that, in this study, in respect to the aged who ended up in residential care, their low economic status had a significant bearing on their institutionalization.

In considering social support, four factors that were used included marital status, household structure, assistance given, and visitation paid to the aged by others. Earlier (Table 5.3) it was tentatively concluded that marital status tended to have no influence on institutionalization of aged. This was based on the observation that the majority of the respondents had undergone adverse marital experiences (such as divorce, widowhood, and separation). The tentative conclusion which differed from the impressions given by Block (1972) that the

aged with adverse marital experiences would be more disinclined towards the maintenance of normal community life, was based on the assumption that both the institutionalized and the non-institutionalized aged had had similar marital experiences. In order to verify this, there is need to see whether there was any significant difference between residents and non-residents with regards to marital experiences.

In comparing the marital experiences of the two categories of the aged, a difference of proportions test was conducted. To facilitate this test, the marital statuses of the aged were categorized into two. The first category, called the 'single', included the 'never married', the 'separated' and the'widowed'. The second category called'the married' , comprised of the married *perse* and those cohabiting. The findings are shown on Table 7.5 below.

Table 7.5 **Difference in marital experiences of the residents and non-resident aged**

Marital status	Residential category	
	Residents	Non-residents
Single	101 (90.2)	20 (66.7)
Married	11 (9.8)	10 (33.3)
Total	112(100.0)	30 (100.0)

Z(cal) = 3.22. Highly significant at 95% level of confidence

γ = -0.64

The difference of proportions test yielded a Z of 3.22. Since this was much higher than the study's set critical limit of 1.65, it was concluded that there is a significant difference in the marital experiences of the aged in the two categories. Accordingly, earlier contentions about similarity in marital experiences between institutionalized and non-institutionalized aged are discounted. If, as present evidence seem to suggest, the majority of the institutionalized aged were those who generally experienced rather adverse marital experiences, it seems reasonable to conclude that these adverse marital experiences had an influence on their residential placement. The association between marital experiences and residence appears to have been fairly strong from the gamma of 0.64 obtained.

As was noted earlier, Lowenthal and Haven (1968) found that most of the elderly who entered residential care had previously lived in isolation. this position was however contradicted by Kahana and Kahana (1984) who, in a different study, found that the majority of the aged who turned to residential care previously lived around friends, family members or other relatives. The issue here is whether or not the aged who ended up in residential care previously lived with people who could have acted as a source of care.

Although our study found that the majority of the institutionalized aged previously had no one upon whom they could rely for care, when considered in the light of the findings of Kahana and Kahana (1984), the latter appears rather confounding. What the findings of the Kahanas imply is that there was no difference between residents and non-residence with regards to the presence of a significant other. In other words, the Kahanas seem to suggest that institutionalization occurred regardless of whether the aged previously lived in isolation or not.

If the impression the Kahanas give is true, then it seems unreasonable to conclude, as we tentatively did, that the aged who end up in residential care are those who previously lived in isolation. There is need, then, to confirm whether or not there was any significant difference between the institutionalized and non-institutionalized aged with regards to their household structures (i.e. Persons they lived with). Table 7.6 below attempts to do this.

Present findings confirm our earlier conclusions and those of Lowenthal and Haven (1968) that most of the aged who ended up in residential care were those who previously lived in isolation. There is no evidence to support the view that both residents and non-residents previously had similar household structures.

Table 7.6 **Difference in household structures between residents and non-residents.**

Response category	Residential category	
	Residents	Non-residents
Live alone	64 (57.1)	5 (17.2)
Lives with someone	48 (42.9)	24 (82.8)
Total	112(100.0)	29 (100.0)

Z(cal) = 3.89. Highly significant at 95% level of confidence

γ = 0.73

The conclusions made above appear to be contradict those of Kahana and Kahana (1984) according to whom the majority of the aged who turned to residential care previously lived in isolation. In trying to understand the reason for the'inconsistency' inherent in the two findings, an interesting dimension of the Kahanas' (1984) finding emerges.

It is possible that an old person can live with others who do not necessarily offer any support or adequate care. In fact, it is probably true that some of the old people in this study ended in residential care as a result of frustration from those with whom they lived. In this respect, then, the mere presence of others around certain old people does not necessarily imply support or care. If the Kahanas referred to mere physical presence then we can say that the aged need not be alienated physically and

materially in order to appear isolated. In our estimation, physical detachment and/or withholding of material support constitute isolation, whether they appear simultaneously or not.

According to Lowenthal and Haven (1968), Gelfand and Olsen (1980), and Pincus (1962), the majority of the aged cannot survive independent of social support. From the foregoing paragraphs, the issue of social support has been seen to transcend mere physical presence and to include all kinds of assistance offered to the aged. Going by previous findings (see tables 5.13 and 5.21), it was tentatively concluded that the majority of the aged who ended up in residential care were those who previously received no external assistance of any form. Accordingly, lack of assistance to the aged was seen to be an influential factor in their institutionalization.

The conclusions referred to above seem to have been in conformity with the findings of Shanas (1962) and Lowenthal (1964) that social support was the major factor differentiating the institutionalized aged from those who managed to remain within their own communities.

The issue of the difference between the institutionalized and the non-institutionalized aged is very central to the present test. If it can be demonstrated that there was a significant difference

between residents and non-residents with regards to previous assistance received, and that the residents were more disadvantaged, then the assertion that assistance received by the aged (both prior to institutionalization and by the time of interviewing for residents and non-residents respectively) had a significant bearing on their residential placement can be sustained. Table 7.7 below attempts to do this.

Table 7.7 **Residential placement by reception of any assistance**

Response category	Residential category	
	Residents	Non-residents
Received some assistance	21 (26.2)	22 (75.9)
Received no assistance	59 (73.8)	7 (24.1)
Total	80 (100.0)	29 (100.0)

Z(cal) = 4.69. Highly significant at 95% level of confidence

γ = -0.8

Findings in Table 7.7 show that there was a significant difference between the proportions of the institutionalized and the non-institutionalized aged who previously received some assistance from consanguines or friends. The findings of Shanas (1962) and Lowenthal (1964) that the aged who ended up in residential care differed from those who managed to

remain within their own communities with regards to social support is confirmed. There seems to be a reasonable ground to conclude that lack of any assistance to the aged tended to influence decisions for institutionalization.

The association between residential placement and assistance was found to be quite strong but negative. Based on present findings, it appears true to conclude that the aged who ended up in residential care did so because of lack of adequate care or support. (This conclusion, by no means ignores any other determinant factors).

As was earlier noted, social support refers both to the giving of material help and physical closeness. Findings in Table 7.6 showed that the aged who ended up in residential care were mainly those who had previously lived in isolation. The question of isolation calls for a little elaboration because there exists a possibility that even though the majority of the aged lived alone, they were nevertheless in close contacts with other relatives, friends or family members.

Based on findings in Table 5.17 and 5.24, it was tentatively concluded that the majority of the aged who were admitted into residential care had previously had no contacts with significant others. These others included the old person's kin or offspring. The

validity of this tentative conclusion lies in the assumption that the proportion of the aged who previously had any close physical contacts with others (i.e. in terms of visitations) was less than that of the aged who managed to avoid residential care. Table 7.8 below verifies this.

Table 7.8 **Residential placement on the basis of instance of visitation received by the aged.**

Response category	Residential category	
	Residents	Non-residents
Received some visitation	34 (42.5)	20 (71.4)
Received no visitation	46 (57.5)	8 (28.6)
Total	80 (100.0)	28 (100.0)

Z(cal) = 2.63. Highly significant at 95% level of confidence.
γ = -0.54

On the basis of Table 7.8, residents and non-residents differed significantly with regards to physical contacts with others. It is true that those who ended up in residential care were mainly those who previously had no contacts with significant others. Besides, it also appears true that visitation received from others had some significance on residential placement. The issue should not be simplified to mere instance of visitation. The essence of such

visitation is that the aged lived in reasonable contact with others. There is evidence to suggest that visitation had a negative relationship with institutionalization. The implication here, which really is our conclusion, is that social alienation of the aged tended to precipitate institutionalization. These findings reinforce those in Table 7.6.

Findings obtained from Tables 7.5 to 7.8 seem to be consistent in suggesting that, in general, the institutionalized aged had a much weaker or less adequate social support than their non-institutionalized counterparts. Besides, there seem to be ample evidence to support the conclusion that lack of adequate social support had an influence on the residential placement of the aged.

Finally, in considering health status, three factors were used. The factors included the state of health, frequency, and intensity of illness of the aged. Once again, the period of focus was immediately prior to institutionalization, for residents, and by the time of interviewing, for non-residents.

The general state of health of the aged was found to be rather poor (Table 5.28). In giving reasons for institutionalization of the aged, certain scholars such as Hickey (1980) had shown health problems as some of the major determinants. What is implied by this is that the aged who ended up in residential care

were conceived to have previously had a lower state of health than those who maintained normal lives within their own communities. On the contrary, findings of our study seemed to have indicated lack of difference in the state of health of residents and non-residents. Based on these findings, it was tentatively concluded that institutionalization of the aged was not influenced by their state of health.

Table 7.9 **Residential placement by respondents previous state of health.**

State of Health	Residential category	
	Residents	Non-residents
Well	24(21.4)	9 (30.0)
Unwell	88(78.6)	21 (70.0)
Total	112(100.0)	30 (100.0)

Z(cal) = 0.42. Not significant at 95% level of confidence.

γ = -0.22

The validity of the statement made above lies in the assumption that there is no statistically significant difference in the proportions of both the residents and non-residents who indicated having had some health problems. Table 7.9 attempts to verify the assumption.

The difference between the institutionalized and the non-institutionalized aged was found to be

significant only at a level of confidence much lower than 40%. This was far much below our acceptance level of 95% degree of confidence. Accordingly, it was concluded that there was no significant difference between the residents and non-residents on the basis of state of health. Even though present findings support contentions of such scholars as Victor (1987), Tout (1989), Oomen (1991) and Hickey (1980), among others, that ill health is one of the major problems of the aged, there is no evidence adequate enough to show that health problems were a major determinant of institutionalization of the aged in our study. Table 7.9 was elaborated with a view to establishing any relationship between frequency of illness and residential placement.

Table 7.10 **Residential placement of the aged by the frequency of their illness.**

Frequency of illness	Residential category	
	Residents	Non-residents
Persistent	63(74.1)	15 (71.4)
Occasional/rare	22(25.9)	6 (28.6)
Total	85(100.0)	21 (100.0)

Z(cal) = 0.25. Not significant at 95% level of confidence

γ = -0.07

Table 7.10 shows that even among the aged who reported having some health problems there was no significant difference between residents and non-residents with regards to the frequency of these problems.

This finding confirms those in Table 7.9 and further supports our conclusion that there is no significant relationship between health and institutionalization. This conclusion was further strengthened in Table 7.11 when the issue of intensity of illness was considered.

Table 7.11 **Residential placement of the aged by intensity of their illness.**

Extent of illness	Residential category	
	Residents	Non-residents
Disruptive of normal activities	64(72.7)	17 (81.0)
Not Disruptive of normal activities	24(27.3)	4 (19.0)
Total	85(100.0)	21 (100.0)

Z(cal) = -0.78. Significant at 70% level of confidence

γ = -0.23

In Table 7.11, the difference between residents and non-residents was found to be significant at 70% level of confidence. Quite interestingly, at this level the proportion of residents whose health

problems disrupted their normal activities was slightly lower than that of the non-residents in the same category. Although the finding is rather intriguing, it gives room to speculate that intensity of illness was not a determinant of institutionalization of the aged. Arguably, if this was so then a larger proportion of residents should have been those whose illness was so intense as to make them disrupt their normal activities.

Although Table 7.11 shows some difference between the institutionalized and non-institutionalized aged on the basis of intensity of illness, this difference was not found to be statistically significant at the study's level of acceptance. This finding therefore strengthens the conclusions based on Tables 7.9 and 7.10 that institutionalization was not influenced by the old people's health. In other words, based on the three anteceding tables, this study fails to find adequate evidence to suggest that the aged who ended up in residential care were influenced by health problems.

7:1:1 The Economic, Social, and Health Factors Influencing Institutionalization of the Aged

This section attempts to give a summary of all the factors considered in H1 as determinants of

institutionalization of the aged. In doing so regression analysis is adopted to assess both the individual and joint effects of the independent variables on institutionalization. The first Table, 7.12, considers the economic factors.

Table 7.12 shows that the total variance in the dependent variable explained by the four economically related factors is 52.25%. This is quite significant and suggests that the majority of decisions for institutionalization of the aged were based on economic factors.

Table 7.12 **Socio-economic predictors of institutionalization of the aged in Kenya.**

Predictors (independent variables)	Simple r	r^2	% of individual variance explained	% ofcumulative variance explained
Income	-0.54501	0.3	29.70	29.70
Education	-0.31684	0.1	10.04	39.74
Type of employment	0.30285	0.09	9.17	48.91
Occupation	-0.18396	0.03	3.34	52.25
Total variance explained			52.25	52.25

SOURCE: Sample Survey

The simple r in column two indicates the strength and direction of the correlation between each predictor and institutionalization. The strongest relationship is between income and institutionalization where r is equal to -0.55. The relationship between the two variables is negative, which implies that the higher the level of income of a respondent was, the lower his or her chances of institutionalization tended to be. In other words, this confirms our earlier conclusion (Table 7.3) that, besides other factors, the aged who ended up in residential care where influenced by the low levels of income they previously received.

The correlation between the remaining predictors are all rather weak. This implies that there are probably other factors that are more significant as determinants of institutionalization of the aged in Kenya.

Even though two of the predictors (education and occupation) have negative correlations with institutionalization, an indication that lack of adequate education and employment tend to influence institutionalization, the relationship between the dependent variable and type of employment was found to be positive though weak. This looks rather intriguing.

A normal relationship between type of employment and institutionalization would have been expected to be negative so that one could predict that the less gainful one's employment was, the greater would be the chances of institutionalization. What this finding shows is probably the inappropriateness of this study's usage of type of employment as an indicator of economic status. A more useful basis for ranking or ordering the types of employment would have been the economic (or quantitative) significance of each type. We were unable to get this information from the respondents.

Table 7.13 shows that the total variance explained by the four indicators of social support is 45.9%. Although this is just slightly lower than the total variance explained by the socio-economic factors, it is nonetheless quite significant.

According to Table 7.13, two of the predictors related negatively with institutionalization whereas two factors have positive correlations. The negative correlates are assistance and visitation from kin, with assistance being the strongest. What this implies is that the aged who had been isolated by their kin, thereby receiving neither any assistance nor any visitation from them were more inclined towards institutional care. This conforms to

conclusions made elsewhere in this study (Tables 7.7 and 7.8).

Table 7.13 **The impact of social support on institutionalization of the aged.**

Predictors (independent variables)	Simple r	r^2	% of individual variance explained	% of cumulative variance explained
Assistance from kin	-0.49845	0.25	24.85	24.85
Household structure	0.28295	0.08	8.01	32.86
Marital status	0.26662	0.07	7.11	39.97
Visitation from kin	-0.24345	0.06	5.93	45.9
Total variance explained			45.95	45.9

SOURCE: Sample Survey

Regarding the two indicators (household structure and marital status) that are positively correlated with institutionalization, the finding is rather surprising bewildering. It is inconceivable to imagine that the aged who had close contacts (i.e persons with whom they were staying) would be more inclined to residential care than those without. Findings of this study already shown in previous sections suggest otherwise. The direction of the correlation between the dependent variables and these

two predictors is rather confounding. We can rest our case regarding this relationship by suggesting further investigation on these relationships.

Table 7.14 **Health-related factors considered as predictors of institutionalization of the aged**

Predictors (independent variables)	Simple r	r^2	% of individual variance explained	% of cumulative variance explained
State of health	-0.09290	0.008	0.86	0.86
Intensify of health	-0.06087	0.004	0.37	1.23
Frequency of health	-0.01680	0.0003	0.03	1.26
Total variance explained			1.26	1.26

SOURCE: Sample Survey

Table 7.14 shows that the total variance in the dependent variable explained by health status was only 1.26%. This is quite low and suggests that health factors do not have a significant impact on institutionalization. Even when considered jointly with any of the antecedent independent variables, the influence of health status on institutionalization is negligible. Even though the correlation between institutionalization and the three health factors is

very weak, the negative value of the simple rs imply that had the correlation been stronger it could have been concluded that the lower the health status of the aged the greater the chances of institutionalization would be.However, on the basis of these findings, there is no validity for such a conclusion.

The foregoing conclusion fails to confirm general stereotypes which regard health problems as some of the major factors that influence institutionalization of the aged. Like Shanas (1962:60), the present study shows that since there were greater numbers of functionally impaired old people who still continued to live independently within their own communities, health problems, cannot be considered as significant determinant of institutionalization in Kenya.

This section of the study has attempted to asses the total variance in the dependent variable that is explained by the three major factors - socio-economic status, social support, and health status. It has been observed that the most significant predictor of institutionalization relate to socio-economic factors which account for 52.3% of the variance, followed by social support and health factors which account for 45.9% and 1.3% respectively. In view of this, it is concluded that the most significant determinants of institutionalization of the aged in Kenya relate to

socio-economic and social support factors. Health factors are insignificant.

7.2 H_2 The impact of institutionalization on the aged depends upon the physical and social environment of the residential home.

As already shown elsewhere in this study, certain scholars such as Lawton (1970), Goldfarb (1977), Nelson and Paluk (1980), among others, considered the environment of the institution in which the aged lived as responsible for the impact that institutionalization had on the aged. The concern of these scholars was that institutionalization does not invariably have a negative or positive impact on the aged. On the contrary, such impacts are seen as dependant upon certain physical and social conditions obtaining in each home (refer to sub-chapter 2.4 of the current study).

In relating the institutional environment to the impact that institutionalization had on the aged, it was observed that institutionalization had a positive impact on majority of the aged who resided in homes where the social and physical environment was considered as favourable (Table 6.14). On the other hand, the majority of the aged upon whom institutionalization had a negative impact also turned

up to be those who considered their institutional environments as either 'satisfactory' or 'unfavourable'. On the basis of these observations, it was tentatively concluded that the social and physical environment within the residential homes had some bearing on the way the aged related to institutionalization. Table 7.15 below attempts to verify this conclusion.

Table 7.15 **The Impact of Instotutionalization on the Aged and the Social and Physical Environment of the Residential Homes.**

Institutional environment	Positive	Negative	Total
Favourable	57 (65.5)	6 (27.3)	63 (57.8)
Satisfactory/ Unfavourable	30 (34.5)	16 (72.7)	46 (42.2)
TOTAL	87 (100.0)	22 (100.0)	109 (100.0)

χ^2 = 15.6 with 1 df. Highly significant at 95% confidence level.
γ = 0.8

Findings in Table 7.15 show that there exists a highly significant relationship between the impact of institutionalization and the institutional environment. The gamma of 0.8 further shows that the relationship between the two variables is rather strong and positive. It seems reasonable, from this finding, to conclude that the institutional

environment within which the aged lived had a significant influence on the perceived impact of institutionalization on the aged. In other words, present evidence seems to suggest that institutional care had a positive impact on the aged who lived in residential homes with favourable environments whereas it had a negative impact on the aged who lived in homes with a less favourable social and physical environment.

Going by the conclusion made above, there seems to be no justification for the generalized belief that institutionalization almost invariably has a negative or positive impact on the (institutionalized) aged. Far from this, our findings confirm, as Peterson and Quadagno (1985) have asserted, that factors obtaining within particular homes need to be addressed when considering the issue of the impact of institutionalization on the aged.

7.3 H_3 The impact of institutionalization depends on the background of the aged.

In analyzing the background of the aged, three factors have been considered, namely, their economic and health statuses and state of social support immediately prior to institutionalization, for residents, and by the time of interviewing, for non-

residents. The first table below attempts to relate the impact of institutionalization to the economic background of the aged.

Table 7.16 **The Impact of Institutionalization and the economic background of the aged.**

Impact of Institutionalization

Economic Background	Positive	Negative	Total
Unfavourable	53 (60.2)	16 (72.7)	69 (62.7)
Satisfactory/ Favourable	35 (39.8)	6 (27.3)	41 (37.3)
TOTAL	88 (100.0)	22 (100.0)	110 100.0)

χ^2 = 0.837 with 1 df. NOT significant at 95% confidence level.
γ = -0.28

Earlier it was observed that the majority of the aged upon whom institutionalization had a positive impact were those who previously came from fairly poor or economically deprived backgrounds. At the same time, though, it was also observed that institutional care had a negative impact on those whose economic background was rather unfavourable. Although it was expected that institutionalization would enhance the well-being of the aged who came from poor backgrounds (implying that the majority of the aged would respond more favourably or positively to institutionalization)

the observed findings suggested the contrary. These observations gave the impression that the old people's economic backgrounds had no bearing on the impact of institutionalization on them.

Findings in Table 7.16 seem to support this earlier conclusion. The test of significance between economic background and impact of institutionalization yielded a chi-square of 0.8 which was only significant at a confidence level much lower than 30% which was far below the study's acceptance level of 95 per cent. This suggests that there is no significant relationship between the old people's economic background and the perceived impact of institutionalization on the aged. Moreover, the association between the two variables is also rather weak and negative, as is indicated by the gamma of -0.28. Accordingly, this study fails to find substantial ground to support the view that the aged who previously suffered certain economic deprivations would have a more favourable view of institutionalization. Neither does the old people's health background provide any help, as findings in Table 7.17 show.

In considering the impact of institutionalization and the health background of the aged, it was previously observed that institutionalization had a positive impact on both the aged who had satisfactory

health backgrounds and also those who had unfavourable(or poor) health backgrounds. In other words, institutionalization seemed to have had a generally positive impact on the aged irrespective of their health backgrounds. What this implied was that the health background of the aged had no significant influence on the impact of institutionalization on the aged. Table 7.17 attempts to verify this.

Table 7.17 **The Impact of Institutionalization and the health background of the aged.**

	Impact of Institutionalization		
Health Background	Positive	Negative	Total
Unfavourable	25 (29.1)	8 (40.0)	33 (31.1)
Satisfactory/ Favourable	61 (70.9)	12 (60.0)	73 (68.9)
TOTAL	86 (100.0)	20 (100.0)	106 100.0)

$X^2 = 1.13$ with 1 df. Significant at 70% confidence level.

$P < 0.05$

$\gamma = -0.24$

According to findings in Table 7.17 the relationship between the impact of institutionalization on the aged and their health

background was significant only at 70% level of confidence. However, this was much lower than the study's critical limit set at 0.05. Besides, the association between the two variables appeared to be rather weak and negative as shown by the gamma of -0.24. Accordingly, it was concluded that there is no adequate evidence to support the view that the health background of the aged influence the perceived impact of institutionalization on the aged.

Earlier on it was observed that institutionalization had a positive impact on the majority of the aged who previously lacked social support and also those who previously had satisfactory or adequate social support. Even though it was previously expected that the aged who came from backgrounds with adequate social support would perceive of the impacts of institutionalization as negative, the observations from the findings suggested otherwise - leading to a tentative conclusion that the impact of institutionalization on the aged is not influenced by the old people's social support. Findings in Table 7.18 attempt to confirm this.

Findings in Table 7.18 show that there is no significant relationship between the impact of institutionalization on the aged and their previous social support. Moreover, the gamma shows that there was a very weak and negative association between the

two variables. This study, therefore, fails to find any conclusive evidence to annul our tentative conclusion.

Table 7.18 **The Impact of Institutionalization and the Old People's Social Support.**

Impact of Institutionalization

Previous Social Support	Positive	Negative	Total
Unfavourable	47 (53.4)	13 (59.1)	60 (54.5)
Satisfactory/ Favourable	41 (46.6)	9 (40.9)	50 (45.5)
TOTAL	88 (100.0)	22 (100.0)	110 100.0)

χ^2 = 0.27 with 1 df. NOT significant at 95% confidence level.

γ = -0.12

In understanding the present findings, it is instructive to note that, quite conceivably, those who were previously denied any social support probably also suffered other deprivations which institutional care possibly met. On the other hand, it would appear presumptuous to imagine that those who previously had adequate social support had no other problems which institutionalization could alleviate. On the contrary, findings already discussed elsewhere in this study show that a good number of those who had no previous problems with social support however had

certain economic and/or health concerns (refer to sub-chapter 6.2). It is possible that the aged in this category, whose economic and health needs were met through institutional care, would relate favourably to institutional care irrespective of the type of social support they previously received.

In concluding the foregoing section, attempts have been made here to test the hypothesis that the impact of institutionalization on the aged depends on some of their background factors. Three different tests of significance have been used to try to relate the impact of institutionalization on the aged to aspects of their social, economic, and health backgrounds. However, all these tests have consistently showed that none of the three background factors has any significant relationship with the perceived impact of institutionalization on the aged. It is therefore concluded that, as far as this study is concerned, there is no adequate ground to support the contention that the impact of institutionalization is determined by the social, economic, and health backgrounds of the aged. This conclusion is expounded in the discussion subsequent to Table 7.19 which attempts to summarize the tests of the study's second and third hypotheses by showing the degree of variance in the impact of institutionalization on the aged which is explained by their background factors and the

social and physical environments within the residential homes.

Table 7.19 **Predictors of the Impact of Institutionalization on the aged.**

Predictors (Independent Variables)	Simple r	r^2	% of individual variance	% of cumulative
Institutional environment	0.31974	0.1	10.22	10.22
Economic Background	-0.09267	0.009	0.86	11.08
Health Background	-0.08493	0.007	0.72	11.08
Social Support	-0.01856	0.003	0.02	11.82
Total variance explained			11.82	11.82

SOURCE: Sample Survey

In general, Table 7.19 shows that the four predictors of the impact of institutionalization on the aged explain only about 11.82% of the total variance. Of this total, a larger portion of 10.22% is explained by environmental factors within the homes for the aged. The background factors of the aged explain only 1.6% of the variance, which is rather low. This finding suggests two things: First, the environment within the residential homes for the aged is a much better determinant of the impact of institutionalization than the old people's backgrounds. Secondly, the total variance in the

dependent variable which is unexplained by the four predictors considered here is 88.18 per cent. Compared to the portion that is explained, all the four factors appear to be rather poor, if not inadequate predictors of the impact that institutionalization has on the aged. There are probably more appropriate predictors than the ones considered here.

More specifically, Table 7.19 contains, among other things, the simple r which indicates both the strength and direction of the correlation between each predictor and the impact of institutionalization on the aged. The strongest correlation is between institutional environment and the impact of institutionalization when r is 0.32. The relationship between the two variables is also positive implying that the aged who lived in residential homes with a favourable environment also perceived the impact of institutionalization as positive.

Even though the correlation between institutional environment and impact of institutionalization is fairly weak, it nevertheless confirms, to some degree, the views of scholars such as Lawton (1970), Goldfarb (1977), Nelson and Paluk (1980), among others, that the environment within the old people's homes has some influence on the impact that institutionalization has on the aged. What is suggested here is that, based on

present findings, the institutional environment does not appear to be a major determinant of the impact of institutionalization on the aged.

The correlation between 'economic background' and 'impact of institutionalization' is rather weak and negative. Whereas the weakness of the correlation indicates a possible interplay of more than one factor (in this case the economic background) in determining the perceived impact of institutionalization on the aged, the negative direction of the correlation suggests that to a relative degree, the more favourable the economic background of the aged was the more negative or unfavourable the impact of institutionalization on the aged tended to be. The same applies to the relationships between both the 'health background ' and 'social support' and 'social support' and the 'impact of institutionalization'. In the latter correlations, there is some indication, albeit slight, that the more favourable the health background and previous social support of the aged was, the more negatively the impact of institutionalization was perceived to be.

As can be noted, the correlations between each of the three background factors and the impacts of institutionalization on the aged are rather weak. Such a finding was unanticipated. The important question to ask here would be why there appears to be

no significant relationship between these background factors and the impact of institutionalization, contrary to previous expectations. Three suggestions are made.

First, as already indicated, the absence of a strong correlation between the old people's background factors and the perceived impact of institutionalization on the aged is probably indicative of the fact that besides the three factors, there are other more significant factors which however did not emerge in the current study.

Secondly, the present correlations are just between each (single) predictor and the impact of the institutionalization on the aged. This does not take into consideration some of our findings that portray the aged as having had multiple, rather than single, concerns (prior to institutionalization). As already indicated elsewhere in this study, when asked about the problems that led them to institutional care, each of the aged mentioned more than one concern. This being so, it is conceivable to expect that an old person who, for instance, ended up in residential care while having economic and/or health problems might also have lacked social support. Depending on which problem the old person considered as pertinent, such an old person may view institutionalization unfavourably even though one or two of the problems

(not subjectively considered as crucial) were addressed, or favourably even though one or two of the problems remain unresolved. The true (or actual) correlation between each background factor and the impact of institutionalization becomes rather evasive because the impact of institutionalization is viewed rather subjectively.

Lastly, it is probable that the correlation between the background factors of the aged and the impact of institutionalization was affected by an intervening factor-namely, the institutional environment. What this implies is that an old person who for instance views institutionalization as negative in spite of coming from a poor background may do so in consideration of the institutional environment. In other words, the impact of institutionalization, rather than depending solely on the background of the aged, is also determined by the institutional environment. As such, it is expected that a more comprehensive evaluation of the impact of institutionalization on the aged must take into consideration the environment within the homes for the aged in addition to the old people's backgrounds. This, however, is not achieved when a correlation is sought only between the background factors and the impact of institutionalization.

Columns four and five of

Table 7.19 provide support for the forgoing proposition by showing that when the three background factors were considered alone, they accounted for only 1.6% of the total variance. However, when considered together with the 'institutional environment' factors, they explained an additional 10.22% of the total variance.

CHAPTER EIGHT: SUMMARY, CONCLUSIONSIONS AND RECOMMENDATIONS

The main purpose of this study was to find out the causes and effects of institutionalization as a form of old age care in selected homes for the aged in Kenya.

Concern about old age care in Kenya was provoked by the fact that, although the traditional domestic care for the aged through the extended family was in decline - undermined by the breakdown of the extended family, available literature dominated mainly by Western scholars, still glorified old age care in developing countries. The aged, particularly in Africa, were portrayed as closely integrated and enjoying family care due to existing strong kinship ties. This view was, however, in contradiction of the prevailing phenomenon of homes for the aged in Kenya which suggested the existence of some problem in old age care. The current study was conceived out of a desire to attempt to resolve the apparent contradiction.

In order to meet such an objective, the study specifically sought to investigate factors that led to the establishment of old people's homes, factors that led the aged to institutional life, the impact of

institutionalization on the aged, and to assess, compare, and contrast the type of life old people live in the various homes.

No comprehensive literature was found in relation to institutional care for the aged in Kenya. Much of the literature available dealt with the problem of old age care as it obtained mainly in developed societies. However, from the review of this literature, it was concluded that the aged who tended to be institutionalized were those who previously had low socio-economic status, low health status, and lacked social support. Even though it was difficult to categorically state whether institutionalization of the aged affected them positively or negatively, the literature suggested two main factors that would determine the impact of institutionalization on the aged. These were, on one hand, the physical and social environment within the home for the aged, and on the other hand, the socio-economic and health backgrounds of the individual aged persons.

The verification of the study's main assumptions, as deduced from the literature review, was facilitated by interviews of 112 respondents aged 50 and above. These were selected through purposive and proportionate random sampling from eleven homes for the aged scattered within some ten districts. In addition, some 30 respondents, also aged 50 and above

but living independently, were also selected purposively for purposes of comparison with the institutionalized aged. In considering the old people's economic status, their level of formal education, occupational status, type of employment, and levels of income were assessed. Besides, the old people's previous health status was established by considering their previous state of health, frequency, and intensity of illness. Finally, information relating to the respondents previous marital experiences, household structures, assistance, and visitation received from any relatives was used to find out the old peoples previous social support.

Economically, the aged who ended up in residential care turned out to have had a very weak economic base, if any. For instance, a majority of them had had no meaningful education. The very low education these aged persons received was inadequate to guarantee any gainful employment. Although educational attainment was also relatively low for the non-institutionalized aged, more of them turned out to have had some gainful employment.

The economic essence of any form of employment is the income that accrues from it. It was found that the non-institutionalized aged had higher levels of income than those who ended up in residential care. In effect, those who ended up in the homes for the

aged had no economic security to fall back on. Views that the institutionalized aged are those who previously lacked economic independence or usefulness turned out to be true. The implication of this finding is that, as long as the aged will continue to depend entirely on other members of society for their survival, their future economic well-being can only be bleak. There will still be an influx into homes for the aged.

Economic security can be in the form of savings and or investments. Where no adequate savings or investments were made in one's prime time, dependence upon others for survival is inevitable. But chances of such survival look grim especially if social support cannot be assured.

Even where there may not be any independent economic security for the aged, continuation of a certain degree of normal life within one's own community is still possible. This is so especially if social support is available in the form of care, visitation, and assistance from family members, relatives or friends. However, in the study, it was observed that for the majority of the institutionalized aged, such social support was previously lacking. For instance, the majority of these aged persons had previously undergone adverse marital experiences, alienation from their kin who

neither gave any assistance nor visited, and general isolation as they turned out to have lived on their own without any one to provide any care. That the majority of the aged who ended up in institutional care did so because of destitution seems sustainable from findings of this study - that is if destitution is taken to mean general social and economic deprivation.

It had previously been assumed that poor health is one of the main determinants of institutionalization of the aged. Although the study found that the majority of the aged who finally ended up in residential care previously suffered many health problems, the centrality of the health factor in determining institutionalization remained in doubt.

The primacy of the health factor in determining institutionalization of the aged was probably undermined even further by findings that both the non-institutionalized and institutionalized aged alike previously suffered from health problems. Besides, among the non-institutionalized, the main reason for avoiding residential care was not any advantages in health, but rather, in economic well-being and social support.

The implication of this finding is that before any emphasis can be laid on a single factor as determining institutionalization, other factors need

to be considered. Findings of this study showed that institutional care for the aged was precipitated by an interplay of economic, social, and health factors. Rather than showing that health factors have no effect whatsoever on institutionalization of the aged, the finding that a greater number of functionally impaired old people still managed to live independently within their own communities should be considered as an indication that poor health will not necessarily lead to institutional care if there is relative economic well-being and social support. However, ill health will exacerbate the destitution of an old person who has neither a secure economic base nor any supportive social networks.

In considering interpersonal relationships involving the institutionalized aged, the study did not find any meaningful social interaction. Such interactions were considered at three levels; that is, among the institutionalized themselves, between the institutionalized and the residential (or care) staff, and between the institutionalized and outsiders such as close family members, relatives or friends.

At all the three levels, interactions tended to be rather superficial and impersonal. This finding was rather surprising because previous studies had portrayed institutionalization as a means through which the aged who had previously lived in isolation

are brought into a new social environment. This new environment, it was assumed, would facilitate new and more meaningful social interactions. But this did not seem to have occurred. Three factors emerged from the study to explain this finding.

Concerning interaction among the institutionalized aged, it was observed that persons who shared a common cultural origin tended to relate much closer than those from different origins. Cultural heterogeneity in the homes was thus found to be a hindrance to meaningful or intimate social relations. The implication of this is that, as much as possible, the aged should be confined to homes within their own cultural settings. This will not only have a bearing on their social interaction but also on their integration within the homes, especially regarding their adaptability to the institutional environment, which in this case will not be very strange.

Regarding interaction between the institutionalized and the care staff, it was observed that even though the institutionalized aged may want to portray images of very good relations, this is just out of fear of certain adverse repercussions. In reality, much of the interaction with the residential staff is rather impersonal. Most of the institutionalized aged feel discriminated against and

mistreated. Unfortunately the risks involved in voicing any discontent are too high.

Although relations between the institutionalized cannot be termed as cordial, images of the institutionalized in certain developed countries who are dehumanized and whose lives are totally regulated to the extent that they cannot exercise or assert their individuality have not fully developed in this country. This notwithstanding, from findings of this study, it seems that special considerations need to be made on the care staff in evaluating the favourability of institutionalization as a form of old age care. An untrained and generally indifferent staff who are not motivated by any higher moral obligation to the aged, and who consider their work among the aged as a mere means to pecuniary gain, will most likely make institutionalization a misery.

Relations between the institutionalized and their families, relatives or friends were found to be generally in decline. Although the majority of the institutionalized aged previously had no close relations with such social networks, institutionalization seemed to place further barriers on any previously existing relations. It seems, from these findings, that once they have entered institutional care, many of the aged are abandoned by any existing relatives or friends. It would seem

that, in this respect, homes for the aged are considered more or less like asylums where the aged who can nolonger be accommodated within their own communities are 'exiled'. Concern for their welfare is then transferred entirely to the homes and the residential staff therein. This apparent alienation of the aged from the rest of their community members makes community (or domiciliary) care for the aged appear more preferable than institutionalization.

On the impacts of institutionalization on the aged, it was observed that, generally, for the majority of the aged persons who previously suffered deprivations in food, clothing, shelter, health, and companionship, among others, institutional care provided a relief. However, and quite surprisingly, certain aged persons expressed disgruntlement with institutional life, seeing it as a further 'destruction' of their already 'broken lives'.

The implication of this finding is that, one cannot categorically declare that institutionalization invariably has negative or positive effects on the aged. Two considerations must be made before such a conclusion; namely, the background of the aged and the institutional environment. For those who came from less favourable backgrounds, institutional care had notable benefits. However, those who had previously had a relatively good economic, social, and health

background, institutionalization was seen as a degradation and a humiliation. But this also depended on whether or not life in the homes was an improvement over the aged persons previous life.

In considering institutional life, it was observed that different homes varied with regards to the quality of care and standard of living. Life in church-maintained homes was found to be much better than in public homes. Although a few of the homes provided what could be termed as 'satisfactory' care, the majority of the homes had certain unique problems and lacked certain facilities that were so crucial for meaningful institutional life. Consequently it was concluded that, as practised in a majority of the homes, institutionalization does not appear to be an adequate form of old age care.

RECOMMENDATIONS

As an alternative to institutional care for the aged, it is recommended that community based (or domiciliary) care should be emphasized. Here, the aged will still be given any needed care but without removing or withdrawing them from the rest of community members.

However, and secondly, if institutionalization of the aged must be continued, then residents must be drawn from the immediate community. In other words, the aged who go into residential care must be restricted to homes within their own communities. This will take care of any problems that may arise from cultural heterogeneity.

Thirdly, handling the aged does not only require patience but also training and tact. Much of the care staff are ill-equipped to care for the aged mainly because of lack of relevant training. It is recommended that those who are involved in old age care must undergo some related training. Since most of the needs of the aged include those of health, it is preferable that the care staff be knowledgeable in issues related to geriatrics so as to be better equipped to provide adequate old age care.

Fourthly, church-maintained homes seem to provide better care than public homes. It is recommended that

old age care be managed by church organizations. Besides providing care for the aged, religious organizations tend also to give emotional comfort to enable the aged face their last moments with confidence rather than resignation and fatalism.

Fifth, presently, it seems that each home operates rather independently. The maintenance of some minimum standard is imperative. There is need therefore for a body to co-ordinate or supervise old age care. This body will have the onus of approving any organization that desires to start old age care. This will help minimize the disparities that presently exists in different homes. Such a role could probably be played by Help-Age Kenya.

Implications for Future Studies

1 From the findings, it has been concluded that institutionalization does not emerge as an appropriate way of caring for the aged. A more community based care has been recommended instead. There is need to find out the viability of this proposal and probably compare it with institutionalization.

2 The study has tried to find the causes and effects of institutionalization as a form of old

age care. Whereas establishing the causes has not been a major problem, it is felt that a more adequate analysis of the effects would require a longitudinal or tracer study covering a wider period of time.

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