

# **CHAPTER 1**

## **INTRODUCTION**

### **1.0 Overview**

This chapter gives a background on caring for the aged in old people's homes in Zambia and implications for adult education programmes. The chapter discusses population ageing in Zambia, the environment in which population ageing occurs in Zambia, implications of population ageing and old people's homes in Zambia. It then presents the statement of the problem, purpose of the study, objectives of the study and research questions, significance of the study, as well as operational definition of terms.

### **1.1 Background to the Study**

Old people's homes are institutions in which needy aged persons are cared for. In Zambia old people's homes are a post-Second World War phenomenon. The first home was established after the end of the Second World War. In 1948, the British colonial government in the then Northern Rhodesia established the first home for the aged in the country, which was Mitanda home for the aged in Ndola. The Salvation Army was given the responsibility of running it while the government provided an annual grant of 3,000 pounds to meet the running costs. However, the home admitted only non-Africans. The colonial government felt that Africans should be looked after by their families. Elderly Africans who could not work on account of age or disability were repatriated to their villages or homes of origin in the rural areas. However, in 1962 a decision was made to extend the homes to Africans who were destitute. Other homes were set up at Maramba in Livingstone in March 1963 and Chibolya in Mufulira in September 1963. After independence in 1964 privately run homes for the aged were set up in Lusaka, Sesheke and Mongu (Kamwengo, 2001). At the time of this study, there were nine old people's homes in Zambia.

Kamwengo (2001) explains that although institutional care of the aged was discouraged in Zambia, the government decided to retain the existing old people's homes. This was because it realised that there would always be some people in institutions of care because of factors such as childlessness and cultural taboos associated with ageing; there would be some people who are not able to trace their families or remember their villages mainly because of urbanisation or illness; and there would always be some people without families to look after them.

The aged must be acknowledged as integral members of society and must have the right to enjoy a good quality of life and full equity in access to the services necessary for optimal health. The positive contribution of older persons to development, and as a resource for their families, communities and society, must be recognised (WHO, 2004). This entails that the aged, regardless of their circumstances in life, are entitled to care and support by society in order that they can live positively and feel appreciated. Caring for the aged in old people's homes should include adequate provision of services such as food, shelter, health care, entertainment, clothes, religious and spiritual support, counselling and education.

Education is a human right and a basic need for the fulfilment of an individual's aspiration. It is an essential tool for the goals of equality, development and peace (Gender Statistics Report, 2010). The significance of education in the life of an individual, regardless of his/her age, gender, race, colour and creed cannot be overemphasised. Education leads to individual creativity, improved participation in the social economic, cultural and political life of society, and hence, to a more effective contribution to human development. In fact, education is prerequisite not only for the full exercise of the individual's rights but also for understanding and respecting the rights of others (Kelly, 1999). In order to put institutional care of the aged in context, it would be helpful to firstly look at population ageing in Zambia.

#### **1.1.1 Population Ageing in Zambia**

Zambia has one of the fastest growing populations in Sub-Saharan Africa. The population grew at a rate of 2.8 percent per annum during the intercensal period of 2000 – 2010, which was an increase over the annual rate of population growth of 2.4 percent per annum recorded during the period 1990 – 2000. Zambia's population age structure shows that 45 percent of the population is below the age of 15 years. This age group constitutes 48.6 percent of the total population in rural areas and 40.5 percent of the total population in urban areas. This means that Zambia has a very young population, with the potential for continuous growth (Zambia 2010 Census of Population and Housing Population Summary Report, 2012).

The population of Zambia, like global and regional populations, is undergoing unprecedented experiences of ageing. While Zambia may not be classified as an ageing country due to its youthful population, the process has already been initiated, and the absolute number of people aged 60 and above is growing tremendously (Mapoma, 2013). Projections in Mapoma's PhD study (2013) have shown that the growth rate of people aged 60+ is ranging

between 2.5 and 3.3 per cent per annum for the period 2000 to 2015. From 2020 to 2050, the population of older people will grow between 2.5 and 5 percent per annum respectively. By 2050, there will be approximately 38 million people in Zambia and about 8 percent or 3,040,000 of these will be aged 60 and above. In general terms, although Zambia's population will remain predominantly young, the number of older people will continue growing. Mapoma (2013) explains that despite uncertainties that necessarily underlie population estimates and particularly projections for the future, there is no doubt that population ageing in Zambia is becoming a demographic reality. He asserts that this pace of population ageing is many times faster than experienced historically by the more developed countries and, therefore, requires serious attention. Kamwengo (1997) describes population ageing in Zambia as absolutely dramatic and attributes it to factors such as the moderate decline in mortality rates and more and more people surviving to enter old age than was the case in the past.

It can be noted from the foregoing that Zambia's population currently comprises a relatively small proportion of the aged compared to that of the young. However, like any other country in the world, this structure and composition will change over the years. As the population continues ageing, it will bring with it its own challenges and opportunities for families, the government and other stakeholders. The next section looks at the environment in which population ageing occurs in Zambia.

### **1.1.2 The Environment in which Population Ageing occurs in Zambia**

Population ageing in Zambia occurs in an environment where poverty levels have been high and the Human Immune Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) pandemic has negatively affected a large segment of the population including the aged. Additionally, economic policies such as the Structural Adjustment Programmes (SAPs) have also had their own effect on the socio-economic status of the population. It would be helpful to briefly describe each of the three factors.

#### **(a) High Poverty Levels**

Poverty levels are very high in Zambia. Poverty increased immensely from 70 % in 1996 to 73 % in 1998. It is higher in the rural areas (83 %) than in the urban areas (56 %) even though the highest increase between 1996 and 1998 was recorded in the urban areas (Kamwengo, 2004). Poverty is multidimensional and complex in nature and manifests itself in various

forms, which makes its definition not always straight forward. No single definition can exhaustively capture all aspects of poverty. However, an individual is said to be poor if he/she suffers some levels of economic and social deprivation. The most commonly used indicator of poverty is income deprivation. Many poverty assessments across the world use the income shortfall approach when measuring poverty as this concept directly relates to income deprivation (UN Statistics Division, 2005). The Central Statistical Office has adopted the material wellbeing perception of poverty in which the poor are defined as those members of society who are unable to afford minimum basic human needs, comprising food and non-food items, given all their total income (Living Conditions Monitoring Survey Report, 2012).

Poverty entails more than lack of adequate income to meet basic needs. It also entails lack of access to social services, assets, markets and institutions. It is closely associated with powerlessness, marginality, isolation, vulnerability and social exclusion (Bull, 2001). Therefore, one of the challenges facing Zambia today is to reduce poverty and economic inequality among the population. Despite the recent turnaround in the economy as shown by real GDP growth of more than 5 percent, the majority of Zambians continue to live in poverty (Living Conditions Monitoring Survey Report, 2012).

Majority of Zambians have continued to live in poverty. Results from the 2006 and 2010 Living Condition Monitory Surveys (LCMS), show that poverty levels have remained high despite recording a decline between 2006 and 2010. The proportion of the population falling below the poverty line reduced from 62.8 percent in 2006 to 60.5 percent in 2010. The percentage of the extremely poor marginally declined from 42.7 percent to 42.3 percent (Zambia 2010 Census of Population and Housing National Analytical Report, 2012).

**(b) The HIV/AIDS Pandemic**

The HIV/AIDS pandemic has become a serious health and development crisis throughout much of Sub-Saharan Africa, including Zambia. UNAIDS estimated the number of infections worldwide at about 37.8 million by the end of 2003, of which about 25 million were found in Sub-Saharan Africa. About 4.8 million persons became newly infected in 2002, 3 million of whom were Sub-Saharan Africans. Worldwide, about 2.9 persons died from AIDS in 2002 and Sub-Saharan Africa accounted for 2.24 million in total (The HIV/AIDS Pandemic in Zambia, 2004).

The HIV/AIDS pandemic has affected every aspect of life in Africa, from people's livelihoods to the capacities of national states. The deepening impact has been a key concern of many national and international borders. At family level the majority of those who are affected by HIV/AIDS are in their reproductive and productive years, and are very often the sole breadwinners. HIV/AIDS has, therefore, had a devastating effect on income levels. This has led to high poverty levels, changes in patterns of household consumption, withdrawal of children from school, limited access to health and other services due to inability to pay and the weakening of the family as a basic social unit, particularly the extended family, which is an important social safety net in Zambia (National HIV/AIDS/STI/TB Policy, 2005). This has implications on the capacity of families to look after their elderly members and does, to a certain extent, determine the kind of support and care that can be provided to them.

According to Kamwengo (2004:8), the HIV/AIDS pandemic affects older people in the following ways:

- i. They lose their children, spouses, relatives and other loved ones.
- ii. They lose the bread earners, which means loss of care and support.
- iii. They have to take up the caring role to nurse their sick children, spouses and other loved ones. While looking after the sick, they have no time to attend to any economic activities. At the same time they spend all their meager resources on the treatment of the sick.
- iv. They risk exposure to infections and fluids from infected persons.
- v. They look after orphaned children even though most of them are in need of assistance themselves.
- vi. They risk contracting HIV because of the fact that some of them are still sexually active persons.

**(c) The Structural Adjustment Programme**

In 1991 the government of Zambia introduced the Structural Adjustment Programme (SAP) as the main development programme to reform the country and improve economic performance. The programme has had its own successes and shortcomings. Some components of the programme, such as privatisation, were implemented at record pace. Others, such as liberalisation of agricultural marketing, did not completely take root. A substantial segment of the population is still adversely affected by the cost of reforming the Zambian economy (Living Conditions Monitoring Survey Report, 2012). One of the

consequences of the SAP was loss of employment through retrenchments among some citizens due to the employment policy which advocated internal restructuring of firms and downsizing of the work force. Retrenchments occurred mainly in the civil service and parastatal organisations. The SAP has had implications for elderly care as some families have experienced reduced or total lack of income resulting in less capacity to adequately support their immediate and extended families and provide care to the aged.

The combination of high poverty levels, the HIV/AIDS pandemic and SAP, among other factors, has created an environment in which the aged have been negatively affected in Zambia. Some of them may have become vulnerable and ended up with no resources and no one to look after them when they eventually become frail and in need of help. They may consequently slide into destitution, homelessness and helplessness. Some may end up in old people's homes, although these institutions are currently quite few in Zambia.

### **1.1.3 Implications of Population Ageing in Zambia**

Population ageing has significant social and economic implications at individual, family and societal levels. It also has important consequences and opportunities for a country's development. Although the percentage of older persons is currently much higher in developed countries, the pace of population ageing is much more rapid in developing countries and their transition from a young to an old structure will occur over a short period. Furthermore, not only do developing countries have less time to adjust to a growing population of older persons, they are also at much lower levels of economic development and will, therefore, experience greater challenges in meeting the needs of the increasing number of older people (HelpAge International, 2012).

Population ageing in less developed environments like Zambia may entail an increase in poverty levels among the vulnerable, including the aged. Oluwabamide and Eghafona (2012) assert that the implications of poverty for the aged are quite obvious. Poverty means that the aged in Africa are coping with poor health, lack of basic education, the impact of HIV/AIDS and much more. They also assert that lack of income security makes the aged vulnerable and open to abuse and that poverty remains one of the key impediments to the support of older people. HelpAge International (2012) further points out that poverty in intergenerational households, more often than not, results in families de-prioritising older people in favour of other age groups and that the ever increasing urbanisation is exacerbating this trend.

Kamwengo (2001:33) points out that the rapid increase in the elderly population has the following implications:

- i. It has led to an increase in the number of old-olds, the majority of whom are frail, housebound, in need of basic care and more likely to experience one or more chronic health problems.
- ii. It has contributed to an increase in multigenerational families, implying that it is not uncommon to find three or four generational families.
- iii. It has resulted in a large number of widows, which means loss of a spouse, income and support.
- iv. It has contributed to the increased burden on family bread earners who have to support elderly parents, their own families and in some cases other elderly relatives.
- v. With urbanisation and the tendency of adult children to live away from parents, especially because of employment, it has created hardships in terms of support for the elderly parents. The inter-household sharing of resources is severely limited by distance.
- vi. It has increased the pressure on public resources and services for the aged. Every year the government spends a lot of money on homes for the aged, public welfare assistance and free health care for the elderly. The increase in the aged means there will be more pressure to allocate more resources to these services of the aged.
- vii. It has created, and in some cases, increased the need for training on issues relating to the aged among health and welfare staff in homes for the aged and staff in organisations that look after the aged.

The growth in the population of the aged will further put pressure on the health, public welfare assistance scheme and other social support services that the government and Non-Governmental Organisations (NGOs) make available to the aged. The pressure will be severe because of the declining economy, reduction in funding to social services, increasing demand made on the nation's budget from a variety competing needy areas and segments of the population and business and public sector downsizing that often results in retrenchments. The increase in the aged will further result in the increase in the dependence ratio. The increase in dependence ratio means there will be more aged people for every 100 working Zambians.

This also means there will be a heavier burden on the working group. Additionally, the growth in the population of the aged will put pressure on financial and psychological resources of the families and the community. The pressure will be made worse by the weakening ties and support in the extended family, the tendency of some children to avoid the burden of supporting the aged and deterioration of the economy (Kamwengo, 1997).

Ribeiro et al. (2010) also observe that an ageing population has significant implications for the number of healthcare professionals required since the proportion of individuals aged above 65 years is estimated to increase massively. They state that the education of tomorrow's health care professionals is fundamental. They further point out that psychologists and psychiatrists must become highly qualified health care providers, skilled in the assessment and treatment of problems of older adults, their families and caregivers. In order to achieve this, well designed educational programmes in geriatrics and gerontology and a well planned infrastructure to support older people's care must be developed.

Population ageing is, therefore, a critical area of concern requiring immediate action due to rapid demographic changes involving a revolution in age longevity. Globally, the number of the ageing population 60 years and above has increased drastically, with no exception to the Zambian population (Ndonyo, 2011). Therefore, the government and other stakeholders have to ultimately respond to the phenomenon of population ageing by putting in place programmes and strategies which will ensure that the welfare of the aged in Zambia is uplifted and their dignity upheld. Namakando (2004) asserts that the implication of the projected population growth among the aged is that Zambia will have to contend with the burden of chronic diseases and disabilities, which predispose the older people to depend on others for activities of daily living.

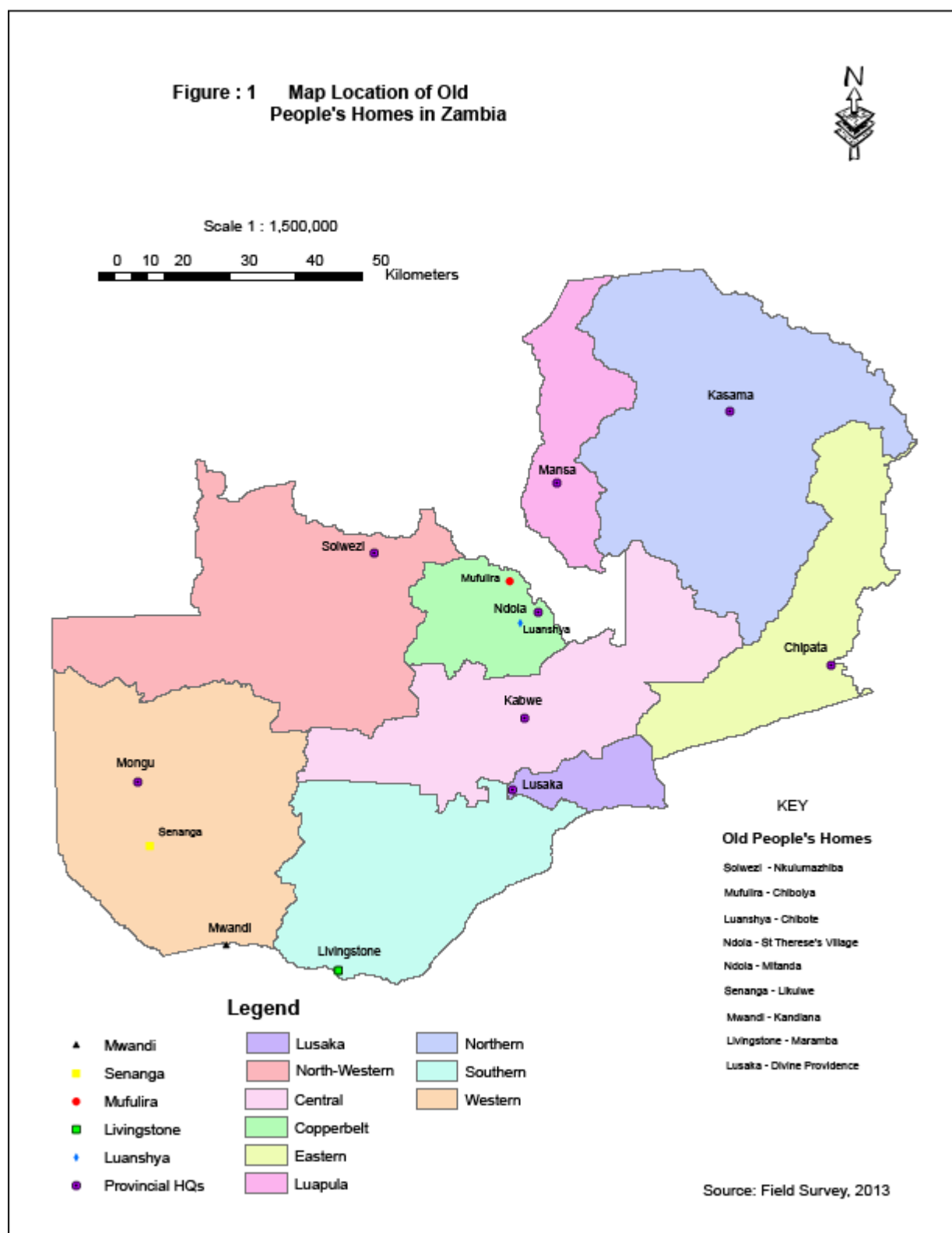
#### **1.1.4 Old People's Homes in Zambia**

The Brief on the Department of Social Welfare (n.d.) states that old people's homes are one of the programmes for the aged in Zambia. They are a form of institutional care support offered to the aged, that is, men and women above 60 and 65 years respectively, the lower limit being 60 years. The homes were set up for the purpose of taking care of vulnerable and homeless elderly people who had no support from relatives and who could not take care of themselves.



There are two main categories of old people's homes in Zambia. The first category comprises government homes which are owned by the state through the Ministry of Community Development, Mother and Child Health (MCDMCH) and are budgeted for directly by the Ministry of Finance. The second category comprises private homes which are owned and run by Faith-Based Organisations (FBOs) but which receive financial support from the government through grants. This is confirmed by the Draft National Policy on Ageing (2011) which states that government runs two older persons' homes and provides financial and technical support to the remaining six homes under FBOs providing care and support to older persons. However, this study established that there were seven old people's homes that were being run by FBOs.

As earlier stated, there were nine old people's homes in Zambia at the time of the study namely, Maramba in Livingstone, Chibote in Luanshya, Chibolya in Mufulira, Divine Providence Home in Lusaka, Mitanda and St. Therese's Village in Ndola, Likulwe in Senanga, Kandiana in Sesheke, and Nkulumazhiba in Solwezi. Only two homes, Maramba and Chibolya are run by the government through the department of Social Welfare under the Ministry of Community Development, Mother and Child Health. The rest are run by FBOs, that is, churches. Below is the map showing the location of old people's homes by provinces and districts:



In addition to old people's homes, the government also runs transit homes or shelters called 'Places of Safety'. These are institutions providing temporary shelter, food and care to stranded and destitute persons of different ages, including children, who are relocated once a

permanent solution, such as locating their next-of-kin, is found. They include Bwacha in Kabwe and Matero in Lusaka (Kamwengo, 2004). The government is moving towards putting up homes of safety in every province. One such a home, which was meant for temporarily accommodating victims of gender-based violence, was opened in Mansa at the time of this study.

## **1.2 Statement of the Problem**

Caring for the aged in old people's homes in Zambia is a form of institutional care for the aged and it is a practice that dates back to the post-Second World War period. For the aged to receive the best care in old people's homes, they require provision of adequate care. Furthermore, coping with being cared for in an institutional setting and adapting to the new situation by the aged could be enhanced through the provision of relevant programmes including adult education programmes. However, little is known about the adequacy of the care provided in old people's homes in Zambia, implying that there is an information and knowledge gap. Furthermore, no study has been undertaken to determine the extent to which adult education programmes are provided to the aged in old people's homes, hence the relevance of this study. This study, therefore, sought to examine the care provided to the aged in old people's homes in Zambia and implications for adult education programmes.

## **1.3 Purpose of the Study**

The purpose of the study was to examine the care provided to the aged in old people's homes in Zambia and implications for adult education programmes.

## **1.4 Objectives of the Study**

The objectives of the study were to:

- i. Establish factors that led to the aged moving to old people's homes in Zambia.
- ii. Assess services provided to the aged in old people's homes in Zambia.
- iii. Identify challenges faced by the aged in old people's homes in Zambia.
- iv. Ascertain challenges faced by caregivers in old people's homes in Zambia.
- v. Establish the extent to which adult education programmes were provided in old people's homes in Zambia.

## 1.5 Research Questions

The study was guided by the following questions:

- i. What factors led to the aged moving to old people's homes in Zambia?
- ii. How adequate were services provided to the aged in old people's homes in Zambia?
- iii. What challenges did the aged in old people's homes in Zambia face?
- iv. What challenges did caregivers in old people's homes in Zambia face?
- v. To what extent were adult education programmes provided in old people's homes in Zambia?

## 1.6 Significance of the Study

This study sought to provide empirical research findings on care for the aged in old people's homes in Zambia and implications for adult education programmes. The study is policy-relevant as it may be used to guide and enhance decision making *vis-à-vis* the improvement of welfare of the aged in old people's homes in Zambia. It was hoped that the study would provide some valuable insights into institutional care of the aged in Zambia and the challenges faced by the aged and caregivers. Furthermore, caregivers, social welfare officers and adult educators could use the findings of this study to come up with strategies and interventions that could enhance the care for the aged in old people's homes and improve their general welfare. The findings of the study may also add to the already existing body of knowledge on institutionalisation and programmes for the aged, with emphasis on educational provision. Lastly, it is hoped that the findings of the study may generate information for future research on institutionalisation and education for the aged in Zambia as well as stimulate public debate on the phenomenon of old people's homes and assist in directing government policy on these institutions.

## 1.7 Operational Definition of Terms

For purposes of this study key words were operationally defined as follows:

**Abuse** – Any action that is likely to cause older persons physical injury, psychological and emotional distress or loss of material and financial resources (Draft National Policy on Ageing, 2011).

**Activities of Daily Living (ADL)** – Basic activities that are necessary to independent living, including eating, bathing and toileting (WHO, 2004).

**Adequacy** – Refers to sufficiency for a specific requirement. It refers to whether a given level of effectiveness results in the satisfaction of needs and values (Sapru, 2004).

**Adult Education** – Activities designed for the purpose of bringing about learning among those whose age, social roles and self-perception define them as adults (Nafunko, Amutabi and Otunga, 2005).

**Aged Person** – A male or female who is 60 years and older (Draft National Policy on Ageing, 2011).

**Care** – The provision of food, accommodation, health services and other domestic and personal services to elderly persons (Kamwengo, 2002).

**Caregiver** - A person who provides support and assistance, formal or informal, with various activities to persons with disabilities or long-term conditions, or persons who are elderly. This person may provide emotional or financial support, as well as hands-on help with different tasks (WHO, 2004).

**Chronic Illness** – Refers either to physical or mental illness or to a disability caused by disease that persists over a period of time (Koffi, 1982).

**Dependency Ratio** - The total dependency ratio is the number of persons under age 15 plus persons aged 65 or over per one hundred persons 15 to 64. It is the sum of the youth dependency ratio and the old-age dependency ratio (World Population Ageing, 2007).

**Educational Gerontology:** The study and practice of instructional endeavours for and about ageing and the aged (Kamwengo, 2001).

**Formal Adult Education** – Education in formal learning institutions such as schools and colleges for adult learners. This includes those adults who already have some academic certification, but who may wish to acquire further education (Nafuko, Amutabi and Otunga, 2005)

**Geriatrics** – The branch of medicine dealing with care of older persons (Draft National Policy on Ageing, 2011). It is a branch of medicine specialising in the health and illnesses of old age and the appropriate care and services (WHO, 2004).

**Gerontology** - The multidisciplinary study of all aspects of ageing, including health, biological, sociological, psychological, economic, behavioural and environmental factors (WHO, 2004).

**Home for the Aged** – An institution providing food, accommodation, nursing care, physical, social and emotional care to elderly and other debilitated persons (Kamwengo, 2002).

**Hospice** – A home or institution that specialises in the care of the terminally ill and provides support for their families. The goal of hospice is to provide care for the patient and manage pain and other symptoms, not cure the illness (State and Federal Programmes for Older Adult, 2012).

**Life Expectancy** – The predicted length of one's life (Hoyer and Roodin, 2003).

**Life-Long Learning** – The idea that individuals can engage in learning throughout their life span in order to cope with life issues (Nafukho, Amutabi and Otunga, 2005).

**Literacy** – The ability to both read and write in any language. Members of the population who are able to read and write are literate, while those who cannot read and write in any language are considered illiterate (Central Statistical Office, 2012).

**Longevity** – The number of years an individual actually lives (Hoyer and Roodin, 2003).

**Long-Term Care** – Consists of those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive and maintenance services for individuals of all age groups who have chronic physical and/or mental impairments, in a variety of institutional and noninstitutional health care settings, including the home, with the goal of promoting the optimum level of physical, social and psychological functioning (Koffi, 1982).

**Non-Communicable Diseases** – Diseases which cannot be transmitted from one person to another (National Health Policy, 2012).

**Non-Formal Adult Education** – Learning that takes place outside formal learning institutions and that is specifically meant for adult learners. It involves the education provided to adults by non-governmental and private organisations, for those adults interested in acquiring specific knowledge and skills for life improvement (Nafuko, Amutabi and Otunga, 2005).

**Palliative care** – Care of people who have been diagnosed with a life threatening or chronic illness (National Health Policy, 2012).

**Social Protection** – Policies and practices that protect and promote the livelihoods and welfare of people suffering from critical levels of poverty and deprivation and/or are vulnerable to risks and shocks (Draft National Policy on Ageing, 2011). They can best be understood as policies and programmes which aim to help poor and vulnerable people manage risk and overcome deprivation, through direct cash or in-kind transfers (Ayana, 2012).

**Social Security** – All social transfers in kind or in cash that are organised by the state or parastatal organisations or agreed upon through the collective bargaining process. Benefits include cash transfers such as pensions, unemployment and injury benefits, short term benefits such as sickness and maternity benefits, as well as in-kind benefits such as health benefits (Draft National Policy on Ageing, 2011).

**Vulnerable** – Somebody or something that can be hurt, harmed or attacked easily especially because of being small or weak (Draft National Policy on Ageing, 2011).

## **1.8 Organisation of the Study**

This study comprises seven chapters. The first chapter introduces the study by presenting the background to the study, statement of the problem, purpose of the study, objectives and research questions of the study. It further presents the significance of the study, operational definition of terms and organisation of the study. It ends with a summary.

The second chapter provides the theoretical framework of the study. Two theories namely, activity theory and continuity theory are described. The chapter then explains the relevance of the theories to this study.

The third chapter presents the literature review of the study, which describes the concept of ageing and who an aged person is, global population ageing, global action on ageing, living arrangements for the aged in the world, care for the aged in the world and institutional care of the aged. It also analyses information and studies on factors contributing to institutionalisation of the aged, services provided to the aged in old people's homes, challenges faced by both the aged and care givers and the extent to which adult education programmes are provided in old people's homes.

The fourth chapter presents the methodology used in the study. It consists of the research design, population and study areas, sample, sampling procedure and instruments of data collection. It also explains how data was collected and analysed. It further presents the ethical considerations of the study and the challenges encountered during data collection. The fifth chapter presents the findings of the study, which are in line with the objectives of the study.

The sixth chapter discusses the findings of the study in the context of the available literature on caring for the aged in old people's homes and implications for Adult Education programmes. Chapter seven presents the conclusion of the study with a discussion on the implications of the results for policy and practice. It also presents recommendations of the study and suggests areas for further research.

## **1.9 Summary**

This chapter has provided background on caring for the aged in old people's homes in Zambia and implications for adult education programmes. It has discussed population ageing in Zambia, the environment in which ageing occurs in Zambia, implications of population ageing and old people's homes in Zambia. It has also presented the statement of the problem, purpose of the study, objectives and research questions of the study, significance of the study, as well as operational definition of terms. The next chapter presents the theoretical framework which guided the study.



## **CHAPTER 2**

### **THEORETICAL FRAMEWORK**

#### **2.0 Overview**

This chapter presents the theoretical framework that guided the study. A theoretical framework is a collection of interrelated ideas based on theories. It is a reasoned set of prepositions, which are derived from and are supported by data or evidence. A theoretical framework accounts for or explains phenomena. It attempts to clarify why things are the way they are, based on theories. A theoretical framework is a general set of assumptions about the nature of phenomena. To understand theoretical frameworks, an analysis of theories has to be made (Kombo and Tromp, 2006). Furthermore, Howe (1987) states that theories as frameworks for research provide maps for understanding the social and personal landscape of the human experience.

This study was guided by two psychosocial theories of ageing, namely activity and continuity theories. Psychosocial theories of ageing attempt to explain human development and ageing in terms of individual changes in cognitive functions, behaviour, roles, relationships, coping ability and social changes (Wadensten, 2006). Kamwengo (2001:16-17) adds: “The psychosocial theories state that since the significance of ageing is social, it is vitally important for us to examine the ageing changes that affect socialisation and life satisfaction.” The two theories that constituted the theoretical framework of this study are discussed below.

#### **2.1 Activity Theory**

Activity theory challenges the disengagement theory which holds that ageing is an inevitable mutual withdrawal or disengagement that leads to reduced interaction between older persons and other people in the social system and that older persons may withdraw from activities and roles that they have been engaged in partly because they recognise their limitation in terms of energy and knowledge (Kamwengo, 2001). Disengagement theory posits that this withdrawal by older persons is innate, universal and unidirectional (Edwards, 2011). To the contrary, activity theory emphasises the importance of ongoing social activity and states that a person's self-concept is related to the roles held by that person hence, retiring for example, may not be so harmful if the person actively maintains other roles, such as familial roles, recreational roles, volunteer and community roles (Drăghia, 2009). Additionally, Drăghia (2009) explains

that in order to maintain a positive self-esteem, the person must substitute new roles for those that are lost because of age. He points out that studies have shown that the type of activity that the aged engage in does matter, just as it does with younger people. This implies that the aged should continue to engage in a variety of activities which suit their age, ability and interest for as long as they can. It also implies that the aged are able to adopt new roles, friendships and activities to replace the lost ones.

Activity theory proposes that successful ageing occurs when older adults stay active and maintain social interactions. The theory assumes that there is a positive relationship between activity and life satisfaction (Edwards, 2011). Therefore, successful ageing is highly dependent upon maintaining a high level of activity. The theory further states that the more activity the aged are engaged in, the more satisfied they are likely to be with life and that what is natural and normal for most ageing individuals is to remain active at levels of activity similar to those they experienced in middle-age for as long as possible (Blackburn and Dulmus, 2007). Successful ageing, according to Bowling and Dieppe (2005), can be defined from three main perspectives or theories, namely: biomedical theories, psychosocial approaches and lay views. Biomedical theories define successful ageing largely in terms of the optimisation of life expectancy while minimising physical and mental deterioration and disability. While the biomedical model emphasises absence of disease and maintenance of physical and mental functioning as keys to ageing successfully, psychosocial models emphasise life satisfaction, social participation and functioning and psychological resources, including personal growth. Bowling and Dieppe (2005) explain that investigations into older people's views of what successful ageing is have shown that their definition includes mental, psychological, physical and social health, functioning and resources, life satisfaction, having a sense of purpose, financial security, learning new things, accomplishments, physical appearance, productivity, contribution to life, sense of humour and spirituality. Bowling and Dieppe call these lay views of successful ageing.

Activity theory further suggests that there are no differences between middle-aged and old people, with the exception of biological and health-related factors. Therefore, in activity theory, it is assumed that maintaining the activity patterns and values typical of middle age is necessary in having a rich and satisfying life (Wadensten, 2006). According to Katz (2000), old age can be a lively and creative experience and that idleness, not ageing, hastens illness

and decline. Activity theory predicts that as individuals age, they will use strategies that involve forging new social roles and relationships or identifying existing ones to fill the gap rather than disengaging, as proposed by disengagement theory (Blackburn and Dulmus, 2007). Therefore, according to activity theory:

Except for the inevitable changes in biology and health, older people are the same as middle-aged people, with essentially the same psychological and social needs. In this view, the decreased social involvement that characterises old age results from the withdrawal by society from the aging person; and the decrease in interaction proceeds against the desires of most aging men and women. The older person who ages optimally is the person who stays active and who manages to resist the shrinking of his or her social world. He or she maintains the activities of middle age as long as possible, and then finds substitutes for those activities he or she is forced to relinquish—substitutes for work when he or she is forced to retire; substitutes for friends or loved ones whom he or she loses by death (Blackburn and Dulmus, 2007:28).

The implication of the above statement is that unless they are constrained by poor health or disability, the aged are able to participate in creative and productive activities, including educational programmes, which may make their lives more worthwhile, productive and more meaningful. It entails that the aged in various environments and settings, should be provided with programmes and activities which would keep them busy and engaged as opposed to doing nothing and idling most of the time. Richardson, Janet and Ong (2013:1-2) add: “Through being actively engaged in and with the world, it is believed that older people will be healthier, have better quality of life and be productive for longer.”

Ageways: Practical Issues in Ageing and Development (2004) asserts that the ageing process is influenced by lifestyle, environmental factors, health care, disease and genetics. It states that postponement of illness and disability can be achieved by undertaking physical and intellectual activities, keeping socially active, having a healthy lifestyle and having access to health interventions and care. Nyanguru (1991) also asserts that persons in their late 60s and 70s are not considered as old and that many people of 90 and 100 are still active and lucid. He gives an example of White elderly Zimbabweans in his study titled: ‘Health Problems of the Elderly Living in Institutions and Homes,’ whom he describes as still fit and active even when over 80 years of age.

### 2.1.1 Major Concepts of Activity Theory

According to Blackburn and Dulmus (2007), activity theory is built around four major concepts namely; activity, equilibrium, adaptation to role loss, and life satisfaction. These concepts are described below:

(a) Activity - At its simplest, activity is any form of doing. However, in Havighurst's original formulation of activity theory, activity was not just a level of doing but also a pattern of activity that formed the person's lifestyle. Activity theory predicted that maintaining both level and pattern of activities from middle age into old age would lead to the highest level of life satisfaction in older age (Blackburn and Dulmus, 2007). However, according to Katz (2000), despite the pervasiveness of the term in gerontological research, there is no universal definition or standard science of activity. There are different forms of activity referred to by gerontologists, in particular, activity as physical movement, activity as pursuit of everyday interests and activity as social participation.

Additionally, Mapoma (2013) points out that according to The World Health Organisation's Active Ageing Policy Framework (2002) the word 'active' refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. He explains that older people who retire from work, and those who are ill or live with disabilities, for example, could remain active contributors to their families, peers, communities and nations. This implies that, like their counterparts living in communities, the aged living in institutional care should also be accorded an opportunity to engage in activities according to their abilities and capabilities so that their health and general welfare could be enhanced. Therefore, programmes to keep them engaged and productive should be designed and made available to them.

(b) Equilibrium - Activity theory makes the functionalist assumption that activity patterns arise to meet human needs and that the needs of older people are not different from the needs of middle-aged people. Therefore, whatever equilibrium the person has achieved in middle age should be maintained into one's senior years. Significant assaults to this midlife equilibrium are best resisted and lost activities or roles should be replaced. Simply dropping out on the part of older people would not meet functional needs and would, therefore, be expected to lead to lowered life satisfaction (Blackburn and Dulmus, 2007).

(c) **Adaptation to Role Loss** - Role loss was assumed to be a common experience for ageing individuals because of the withdrawal of society from the ageing person. Activity theory predicted that the most successful way to adapt to role loss was to find a substitute role to satisfy needs. This implies that the aged, including those residing in institutional homes are able to adapt to a new environment when need arises and to take up new roles and responsibilities as long as they are given the opportunity and a conducive environment is created for them.

(d) **Life Satisfaction** – On how it would be known when a person has aged successfully, both activity theorists and disengagement theorists agreed on one thing; that life satisfaction was the best criterion for measuring social and psychological adjustment. Havighurst and his colleagues' concept of life satisfaction was made up of five components, namely: zest and enthusiasm, resolution and fortitude, a feeling of accomplishment, self-esteem, and optimism (Blackburn and Dulmus, 2007).

### **2.1.2 Association of Activity with Well-being in Old Age**

Edwards (2011) points out that increases in life expectancy of the aged must be associated with corresponding gains in their physical, social and emotional wellbeing, which entails quality of life, productive ageing and successful ageing. Quality of life is associated with positive physical health, psychological well-being, social relationships and networks. Productive ageing is associated with any activity by an older adult that contributes to producing goods or services including volunteerism and civic engagement, while successful ageing entails low probability of disease and disability, high cognitive and physical function capacity, active engagement with life and positive spirituality. In a bid to further explain the association of activity with well-being in old age, Edwards (2011) describes some important concepts and these are presented below:

#### **(a) Physical Activity**

Edwards (2011) defines physical activity as any bodily movement produced by skeletal muscles that requires energy expenditure. He explains that physical activity includes, but is not limited to exercise. It includes activities involving bodily movement that are done as part of playing, working, active transportation, house chores and recreational activities. Edwards further explains that older adults, both male and female, can benefit from regular physical

activity, which needs not to be strenuous to achieve health benefits. He states that older adults can obtain significant health benefits with a moderate amount of physical activity, preferably daily. He further states that a moderate amount of activity can be obtained in longer sessions of moderately intense activities, such as walking, or in shorter sessions of more vigorous activities, such as fast walking or stair walking. Sanderson and Scherbov (2008:14) observe: “Older people today are more active than previous generations and athletes are now playing at close to the top of their game at late ages, and 70-year-olds are climbing Mt. Everest.”

**(b) Cognitive Stimulation**

Edwards (2011) points out that an environment that is cognitively and socially challenging facilitates enhanced cognitive performance and that an environment that provides little stimulation results in boredom and cognitive decline. He adds that social interactions and social networks challenge the individuals to communicate and utilise their cognitive abilities to apprehend both verbal and nonverbal communication, and help to maintain cognitive abilities in old age. This has implications for the kind of services provided and programmes that are designed for the aged in an institutional setting. The aged ought not to be seen as passive individuals who should do little or nothing most of the time. They should, instead be seen as active members who need creative activities including education to intellectually stimulate them and keep them engaged.

**(c) Leisure Activities**

According to Edwards (2011), active engagement in cognitively stimulating leisure activities is associated with enhanced memory function, decreased depression and increased life satisfaction. He explains that participation in leisure activities is associated with a reduced risk of dementia. The word ‘dementia’ describes a number of progressive brain diseases that affect a person’s memory, thinking, behaviour and emotions. All types of dementia result in a decline in mental function, especially memory which interferes with daily activities and social relationships. Dementia usually progresses steadily over a number of years. The speed at which it progresses varies from person to person. There is currently no known cure for most forms of dementia although research in this area is continuing (HelpAge International, 2012). Edwards (2011) concludes that activity supports successful ageing in that it reduces the risk of chronic and disabling disease, sustains cognitive, physical and social function, and enhances feelings of mastery, self confidence and independence.

In their study titled 'Finding the Key to Happy Aging: A Day Reconstruction Study of Happiness,' Oerlemans, Bakker and Veenhoven (2011) describe the kind of daily life-style which contributed to the happiness of retired seniors. They conclude that seniors or elderly persons could enhance the happiness they experience beyond their baseline level by engaging in social, physical and cognitive activities. Oyedeki (1992) adds that a high rate of contentment coincided with longevity among the elders interviewed in his study. He explains that it is widely accepted in developed countries that remaining active in some interesting, meaningful social role has a positive physical, psychological and social impact on longevity.

Despite its positive contribution, activity theory has faced some criticism. Katz (2000:139) states: "During the 1980s, political economists such as Carroll L. Estes (1983) and Meredith Minkler (1984) castigated activity theorists for their narrow focus on individual adaptation and satisfaction to the neglect of larger structural issues and differences in old age, based on class, race and gender." Kamwengo (2001) also points out that the major criticism to activity theory is that not all older persons want to maintain high activity. He explains that some older persons voluntarily reduce activity and seek no substitutes. He further explains that the notion that individuals have to reconstruct their lives by substituting new roles and activities for lost ones as they age implies that they have a lot of control over their social situations and have the means and ability to do so, which may not be so in some cases.

However, Katz (2000) contends that in spite of the criticism levelled against activity theory, its enduring legacy is that it provided a conceptual space for the ideal activity to emerge and circulate expansively within ageing studies and among those professions where new roles in recreational counselling, health promotion, and rehabilitation therapy were being created. This implies that activity is of crucial significance to the lives of the aged, both those living in the community and those who are institutionalised. Ndonyo (2011:2) asserts: "In all countries, and in developing countries in particular, measures to help older people remain healthy and active are a necessity, not a luxury." Furthermore, Wadensten (2006) reveals that in Sweden, care of older people, staff, care activities and organisation of care are all influenced by activity theory.

The above discussion of activity theory has highlighted the importance of physical activity, cognitive stimulation and leisure activities in the lives of the elderly in whatever setting. The

theory emphasises that the more activity the aged are engaged in, the more satisfied they are likely to be with life and that when those desiring to remain active incur loss of the activities, they tend to find substitutes for the lost activities and roles. This study, therefore, took the view that activity, including that of an educational nature, should be at the centre of the welfare of the aged in institutional homes and programmes should be designed in such a way that they take care of this aspect.

## **2.2 Continuity Theory**

The second theory that constituted the theoretical framework of this study was continuity theory. This is a theory of adult development which proposes that in making adaptive choices middle-aged and older adults attempt to preserve and maintain existing psychological and social patterns by applying familiar knowledge, skills and strategies (Kelly, 1993). The theory suggests that maturing persons will develop certain habits, preferences and commitments that become part of their personalities. Therefore, when an individual grows older, there will be continuity of that personality. This means that the individual self or personality remains consistent despite the life changes. Continuity theory emphasises that the foundation of earlier life experiences such as skills, personality traits and dispositions, creates a repertoire of coping strategies that older individuals can call on to adapt to age-related changing circumstances (Blackburn and Dulmus, 2007). The basic premise of continuity theory is that each individual develops a personality over the course of a lifetime that is a stable feature of their individuality, which affects how they react to events. This implies that individuals attempt to maintain personality continuity as they age (John, 1984).

Continuity theory explains how people adapt to their own ageing. It posits that the elderly try to preserve and maintain internal and external structures by using strategies that maintain in this way the continuity. In later life, adults tend to use continuity as an adaptive strategy to deal with changes that occur during normal ageing (Drăghia, 2009).

### **2.2.1 Perspectives used in Continuity Theory**

Continuity theory can be looked at from a number of perspectives. Firstly, it is seen as being evolutionary in which case it assumes that the patterns of ideas and skills, which people use to adapt and act, develop and persist overtime. It also assumes that a course of developmental direction can usually be identified and that the individual's orientation is not to remain personally unchanged but rather consistent with the individual's past, to influence the



direction and degree of change in accordance with the individual's goals. Thus, individuals are presumed to play an active part in their own development (Kelly, 1993). This implies that an individual develops habits and preferences and other dispositions during the process of becoming an adult and these become connected with the personality. Therefore, as adults strive to achieve their goals, their past experiences, decisions and behaviour will form the foundation for the present and future decisions and behaviours (Wadensten, 2006).

The second perspective of continuity theory is that it is seen as being constructionist. The theory assumes that people, in relation to their life experience, actively develop individualised personal constructs, ideas of what is going on in the world and why. It states that some of the people's most important personal constructs concern their concepts of self and their personal life-styles. Continuity theory also acknowledges that people's personal constructs are greatly influenced by the social constructions of reality that they learn from those around them and from the mass media. The third perspective of continuity theory is that it is about adaptation. The theory assumes that individual choices are made not only to achieve goals but to adapt to constantly changing circumstances. Accordingly, continuity theory deals with the development of and maintenance of adaptive capacity, particularly in the latter part of adulthood. One of the main ideas in continuity theory is that, in adapting to ageing, people attempt to preserve and maintain long-standing patterns of thought and behaviour that they believe constitute important and potent adaptive skills and arrangements. In other words, when faced with adaptive challenges, people tend to rely on what they see as their established adaptive strengths (Kelly, 1993).

The fourth perspective is that continuity theory is about selective investment. The theory presumes that people make decisions, based on feedback from experience, about where it is best to focus their efforts to develop skills and knowledge. People select and develop ideas, relationships, environments and activities based on their personal concepts of desired developmental direction and of available opportunity (Kelly, 1993). However, Kelly clarifies that there is no magical transformation that persons undergo at some standard age, not even at 65. He says that there are transitions later in life that have powerful impacts on resources, opportunities, expectations and relationships. He explains, for example, that retirement does remove determinative obligations and schedules for those who have been employed and being widowed does alter the most immediate context of life. Kelly further explains that life

does change for older adults in both sudden and incremental ways and that activities they engage in may also change.

Maintaining patterns of thought, activities and habits is the most common strategy for adaptation as people age. Continuity theory holds that, in making adaptive choices, middle-aged and older adults try to preserve and maintain existing internal and external structures, and they prefer to accomplish this objective by using strategies tied to their past experiences of themselves and their social world (Minhat, Rahmah and Khadijah, 2013). Furthermore, Johansson and Athlin (2009) point out that older people could also change their habits when it was truly necessary and adapt to new circumstances.

### **2.2.2 Relationship between Continuity and Change**

In discussing continuity, it is important to understand the relationship between continuity and change. Continuity is not an absence of change. Continuity refers to a coherence or consistency of patterns over time. Specific changes tend to be given significance in relation to a general notion of a relatively continuous whole. Individual change and evolution are usually perceived as occurring against a backdrop of considerable continuity. Continuity in adult development is paradoxical. There is both similarity over time and obvious change. One can be identifiably similar in comparison with a past self and still have changed considerably. People are apparently motivated not only to perceive themselves as characters exhibiting continuity over time but also act to extend that continuity into the future as well. Continuity theory thus contends that middle-aged and older adults are both predisposed and motivated toward inner psychological continuity as well as outward continuity of social behaviour and circumstances (Kelly, 1993).

In the continuity theory perspective, successful ageing depends on the individual's ability to maintain and continue previous patterns or find new roles (Wadensten, 2006). Therefore, continuity does not mean that nothing changes in people's lives as they age. It means that new life experiences occur and the aged must adapt to them with familiar and persistence processes and attributes. This may be the case with the aged residing in institutions such as old people's homes because they usually have to relocate to a new environment with new and sometimes unfamiliar living arrangements. They have to adapt to the new environment, but at the same time maintain their basic personality traits, values and interests. This implies that caregivers and other stakeholders should be able to create an environment within these

institutions which will enable the aged to express their abilities, interests and talents for their own benefit and that of others.

### **2.2.3 Association between Previous and Current Participation in Leisure Activities by the Elderly**

According to continuity theory, leisure participation in old age is often a continuation of their participation at younger age. In their study on leisure participation among the elderly attending selected health clinics in Malaysia, Minhat, Rahmah, Khadijah (2013) established that there was a continuity pattern of the activities currently performed by the elderly with what they had done when they were younger. They explain that leisure participation while younger was found to influence the elderly interest and desire to be involved in certain types of activities. Minhat, Rahmah and Khadijah (2013) explain that very often, the elderly are more likely to be involved and continue doing the same activities that were carried out in their younger days albeit a gradual decline in total time spent as age increases. They, however, point out that due to certain constraints, commitments and life events such as retirement, declining health status and physical function, some elderly have to choose an alternative leisure activity to suit the changing condition. The study concluded that there was a significant continuation between current and former leisure involvement of the elderly in cognitive, social and productive activities. It further concluded that the elderly who were involved in leisure activities when they were younger were more likely to engage in cognitive, social and productive leisure activities later in life. The implication is that caregivers and other providers should seek to identify interests, skills and talents in the aged residing in institutional homes and provide opportunities for them to express themselves and engage in the activities they are familiar with. Where this is not possible, they could be provided with alternative activities, but which will keep them engaged and busy.

Silvesterstein and Praker (2002) in their study on 'Leisure Activities and Quality of Life among the Oldest Old in Sweden', examined the importance of leisure activities for maintaining quality of life in late old age and the contextual factors that shape the consequences of activity gain or loss. Using a nationally representative longitudinal sample of the oldest old in Sweden, they found that passing from middle to advanced old age did not necessarily entail the loss of activity. Though a large portion of older Swedes did in fact withdraw from leisure activities as they aged, a fair percentage still remained active into their high 80s. Particularly, noteworthy was the large percentage of older adults who took up

walking as an activity in which they frequently engaged. According to Silvesterstein and Praker (2002), one likely reason for this increase was greater knowledge, emphasised by media and health professionals, of the benefits of aerobic exercise in later life. They observe that increase in walking may be an adaptation to the reduction in gardening, or to the cessation of more vigorous types of exercises such as running, and swimming.

The major criticism of continuity theory is that it fails to take into account the societal changes that influence individual expectations and behaviours (Kamwengo, 2001). The other criticism is that it fails to demonstrate how social institutions impact the individuals and the way they age.

#### **2.2.4 Relevance of Activity and Continuity Theories to this Study**

Activity and continuity theories were chosen for this study because they were considered relevant to the welfare and care for the aged in old people's homes in Zambia. The two theories may work better with the aged who are not yet institutionalised. However, the understanding is that even those who are in institutional homes can engage in meaningful activities and remain productive as long as an enabling environment is created for them. Activity theory was chosen to help the researcher explain how the aged, both in the community and in an institutional set-up interact with each other and how they can be kept active and occupied. Continuity theory, on the other hand, was chosen to help the researcher explain how the aged cope with life and adapt to the numerous changes that follow their moving to old people's homes from previous living arrangements and environments while maintaining their basic personality make-up, interests, skills, values and attitudes.

Activity theory is particularly central to this study because it emphasises the importance of activity in the lives of the aged, implying that it promotes healthy and active ageing. The theory maintains that people should maintain their middle age activities. Evidence shows that those who maintain their middle life age activities live a more satisfying life (Namakando, 2004). Therefore, the aged in old people's homes should not only be provided with basic necessities of life such as food, shelter and clothing, but should also, be provided with other services and activities such as games, physical exercises, visitations, adequate recreation and education. This is because in activity theory perspective, there is an assumption that activity is vital to well-being. Stress is placed on the importance of older people being dynamic and active participants in the world around them (Wadensten, 2006). Nevertheless, it is important

to customise and relate the application of the theory to local conditions and the environment. This means that caregivers, adult educators and other service providers should never relegate the significance of activity even as they plan and design programmes for the aged in old people's homes in Zambia.

Continuity theory is also relevant to this study in the sense that it is reminding us that although the aged residing in old people's homes moved from their previous dwellings, which were significantly different from their new situations, their basic personalities, values, interests and related aspects remained fairly consistent. For example, from the religious perspective, the aged may maintain their church affiliation and denominations they belonged to before moving to old people's homes and may still want to identify with these denominations. Similarly, those with specific skills and are still energetic, may wish to continue practicing them and even pass on to others, given the opportunity and means to do so. The implication is that caregivers and other stakeholders should be able to identify skills and interests that the aged may possess and create an environment in which they would put them to use in order to lead more productive lives.

It should be pointed out that in adopting activity and continuity theories as theoretical framework of the study, the researcher observed that the theories may be deemed more relevant to Western societies, which have developed economies, systems and facilities. However, this does not mean that theories and studies developed and done elsewhere cannot be used and that their ideas are inappropriate to a study in a non-western society like Zambia (Chakulimba, 1986). The two theories have certain aspects which are relevant and applicable to the Zambian context, such as activities and provision of services which could improve the welfare and wellbeing of the aged residing in old people's homes, hence the researcher adopted them for this study. This is reiterated by Wadensten (2006:347) who states: "...psychosocial theories contain underlying values that influence society and staff as regards their views of the ageing process and how care of older people should be carried out." Activity and continuity theories, therefore, provide a justification for activities for the aged in old people's homes in Zambia.

However, the literature reviewed on activity and continuity theories shows that the importance of educational activities for the aged has not been highlighted. This study has, therefore, endeavoured to fill this gap. Furthermore, one of the perspectives of activity theory

is that the aged should, as much as possible, participate in activities which are intellectually stimulating, hence the relevance of learning activities.

### **2.3 Summary**

It can be noted from the foregoing that activity and continuity theories are relevant to this study as they highlight the significance of activity and social participation in the lives of the aged in various settings. The theories also explain the coping and adapting strategies that the aged employ in their lives in different settings. The two theories, therefore, complement each other. Activity theory highlights the benefits that the aged can derive from participating in stimulating and productive activities, while continuity theory entails consistency in the basic personality, interests and preferences by individuals even as they adapt to changing circumstances in their lives. The theoretical framework ultimately guided the researcher in addressing the study objectives by conceptualising caring for the aged in old people's homes and highlighting the importance of providing creative and learning activities.

## **CHAPTER 3**

### **LITERATURE REVIEW**

#### **3.0 Overview**

A literature review is an account of what has been published on a topic by accredited scholars and researchers. It is a critical look at the existing research that is significant to the work that the researcher will be carrying out. It involves examining documents such as books, magazines, journals and dissertations that have a bearing on the study being conducted (Kombo and Tromp, 2006). This chapter, therefore, presents a review of literature on caring for the aged in old people's homes and implications for adult education programmes and focuses on the following themes: the concept of ageing and who an aged person is, global population ageing, global action on ageing, living arrangements for the aged in the world, care for the aged in the world and in Zambia and institutional care of the aged. The chapter further presents the review of literature on factors that led to the aged moving to old people's homes, services provided to the aged in old people's homes, challenges faced by the aged in old people's homes and their caregivers, as well as the provision of adult education programmes for the aged. It also brings out the findings of other studies, how they relate to the current study and identifies gaps.

The study of Gerontology at the University of Zambia started with the late Professor Martin M. Kamwengo and his major work covered the following areas: *Growing Old in Zambia*, in which he discussed old and new perspectives of ageing in the African and Zambia contexts; *Ageing and the Elderly in Zambia*, in which he highlighted the nature and scope as well as the history of Gerontology, among other issues. His other work was on *Elderly Women in South Africa*, in which he discussed issues, challenges and future prospects for elderly women in that country. The latter work enabled Zambia to have a comparative perspective of ageing and related aspects in the two countries. This study was, therefore, inspired by the works of the late Kamwengo, but included an educational perspective *vis-à-vis* care for the aged in old people's homes, which was not necessarily his focus.

### 3.1 The Concept of Ageing

According to Kamwengo (2001) ageing is a term that is used to refer to the process of growing old, which begins at conception and continues until death. He explains that the process involves a series of normal, universal and progressive changes, which occur throughout the life span of a person. Kamwengo further explains that these changes are universal because they occur to all people and are a normal part of human development. They include changes in physiological, psychological and sociological functions in a person's life.

Ageing is a natural and inevitable process which cannot be stopped and everyone will, ultimately, become old if they live long enough. The United Nations High Commissioner for Human Rights, Ms. Navanethem Pillay states: "We must all accept the inevitability of ageing; what we do not have to, and must not accept is that old age brings with it lesser access to, and enjoyment of, the full-range of human rights" (HelpAge International, 2012: 32). Furthermore, WHO (1991:3) states: "Every one of us started to age before we were born and we continue to do so throughout our entire life course. Ageing is a natural process and should be welcomed, because the alternative would be premature death." Ferrano (1990) explains that ageing involves biological, psychological, social and spiritual changes in individuals in varying rates. He points out that the transitions associated with the life course are not linearly related to chronological age and that the process of ageing itself is also multidimensional in nature and, as such, the approach to the study of ageing must recognise the dynamics of ageing and the multidimensionality of this dynamism.

Ndonyo (2011) posits that in the scientific context, ageing is the progressive and generalised impairment of functions resulting in the loss of adaptive response to stress and increasing risk of age-related diseases. She explains that the overall effects of these alterations is an increase in the probability of dying, which is evident from the rise in age-specific death rates in a population. Hoyer and Roodin (2003) assert that a conceptual distinction is made between the concepts of primary ageing and secondary ageing. They explain that primary ageing, which is the same as senescence, refers to changes that are gradual, inevitable, universal and insidious. These changes occur in representative individuals living under representative conditions. Changes associated with primary ageing are not a consequence of disease. Secondary ageing, on the other hand, refers to the processes that affect the rate at which primary ageing occurs. Intense work-related stress, prolonged exposure to environmental toxins and the



consequences of disease are examples of secondary factors that accelerate the rate of primary ageing processes.

It is recognised that ageing affects people differently. Thus, it is impossible to classify anyone as a “typically” old person or any trait as “typical” of old age. People age differently because they have different hereditary endowments, different socioeconomic and educational backgrounds and different patterns of living. These differences are apparent among members of the same sex, but they are even more apparent when men and women are compared because ageing takes place at different rates for the two sexes (Hurlock, 1980).

Dubey, Bhasin, Gupta and Sharma (2011) point out that many people think that ageing is a completely negative final segment of the human life span, which they say is not the case. They further state that awareness and acceptance of the fact that ageing has physiological, psychological and social determinants would make the ageing process acceptable, cheerful perhaps even desirable by making living meaningful.

In a study titled ‘Citizens, Good Practice and Quality of Life in Residential Care Homes’, Bland (2005) established that there were three recurring themes in the literature on ageing. The first theme was that ageing was a homogenous experience; secondly that it was a predominantly negative experience involving disease and dependency and thirdly, that it involved poverty. She, however, points out that this was ageing viewed from the perspective of people who were not yet ‘old’ in the chronological sense of the word and who did not yet regard themselves as ‘old’. This implies that there are people who view ageing as an inherently negative development associated with decline in individuals’ capacities and abilities. To the contrary, people have unique experiences and age differently and not all aged persons are dependent until they advance so much in age. Therefore, ageing should not be viewed as a frightening experience, but a phase in human development which everyone will pass through. It should, instead, be viewed positively, even as it may bring with it some challenges.

In summary, Kamwengo (2004) suggests that the concept of ageing can be understood better if its key characteristics are looked at; namely that ageing is:

- i. A natural process that takes place in all human beings.
- ii. An inevitable and inescapable process.

- iii. An unstoppable process which can only be slowed down and its intensity reduced through a number of interventions such as plastic surgery and use of lotions and creams but cannot be stopped.
- iv. A process that takes place gradually and progressively.
- v. A process that involves a number of changes, which are physical, psychological and social.
- vi. A process in which changes take place in cells, tissues, organs and individuals at different rates.
- vii. A process that involves behaviour, cognition and personality adjustment changes.
- viii. A process that involves modifications to social roles, personal interactions and status.

### 3.2 **Who is an Aged Person?**

Literature reviewed indicates that defining an aged person is not easy because society defines the concept differently, depending on the context. For example, Kamwengo (2001) defines an aged person as one who is 65 years and older. The Draft National Policy on Ageing (2011), on the other hand, defines an older person as a male or female who is 60 years and older. Hurlock (1980) explains that age 60 is usually considered the dividing line between middle and old age but that there is a recognition that chronological age is a poor criterion to use in marking off the beginning of old age. This is because there are such marked differences among individuals in the age at which ageing begins. Hurlock (1980) further explains that because of better living conditions and better health care, most men and women do not show the mental and physical signs of ageing until the mid-sixties or even early-seventies. He concludes that for that reason, there is a gradual trend towards using 65, the age of retirement in many businesses, to mark the beginning of old age.

HelpAge International (2012) states that the United Nations uses 60 years to refer to older people and that this line, which divides younger and older cohorts of a population, is also used by demographers. HelpAge International (2012), however, explains that in many developed countries, the age of 65 is used as a reference point for older persons as this is often the age at which persons become eligible for old-age social security benefits. It concludes that there is no exact definition of “old” as this concept has different meanings in different societies.

The Draft National Policy on Ageing (2011) points out that in Zambia there has usually been lack of a clear definition of “older person” in most government policies. It states that whereas the Health Exemption policy defines older persons as those above 65 years, other policies such as the Social Welfare Policy, define older persons as those aged 60 and above. Madzingira (1997:1) observes: “Most developed countries define the elderly as those people who have retired and the retirement or pensionable age that is clearly stipulated is 65 years. This is acceptable especially in countries where life expectancy has reached 75 years and above”.

Ndonyo (2011) explains that whatever age is used within different contexts, it is important to acknowledge that in whatever order old age occurs is not a precise marker for the changes that accompany ageing and that there are dramatic variations in health status, participation and the level of independence among older people of the same age. She advises policy and decision makers to take these variations into account when designing policies and programmes for their older populations, stating that enacting broad social policies based on chronological age alone can be discriminatory and counterproductive to the wellbeing of aged persons.

The foregoing shows that there is no universally accepted definition of an aged person. This is because different perspectives and contexts come into play in an attempt to do so and this may bring about some inconsistency. For example, in the Zambian context, the Draft National Policy on Ageing (2011:8) states: “The absence of an agreed definition of older persons in the country means that where data exists, it is often not comparable, inadequate and unharmonised.” However, this study adopted the United Nations definition of an aged person, which stipulates that persons aged 60 years or over are considered elderly. This is also in line with the Draft National Policy on Ageing (2011) which defines an older person as a male or female who is 60 years and older. Furthermore, the terms aged, older persons, the elderly, elderly persons and senior citizens were taken to mean the same thing and, therefore, used interchangeably in this study.

### **3.3 Global Population Ageing**

To start with, it would be important to understand what population ageing is. According to World Population Ageing (2007), population ageing is the process whereby older people, as

individuals, account for a proportionally larger share of the total population. WHO (2004) further defines population ageing as the increase over time in the proportion of the population of a specified older age.

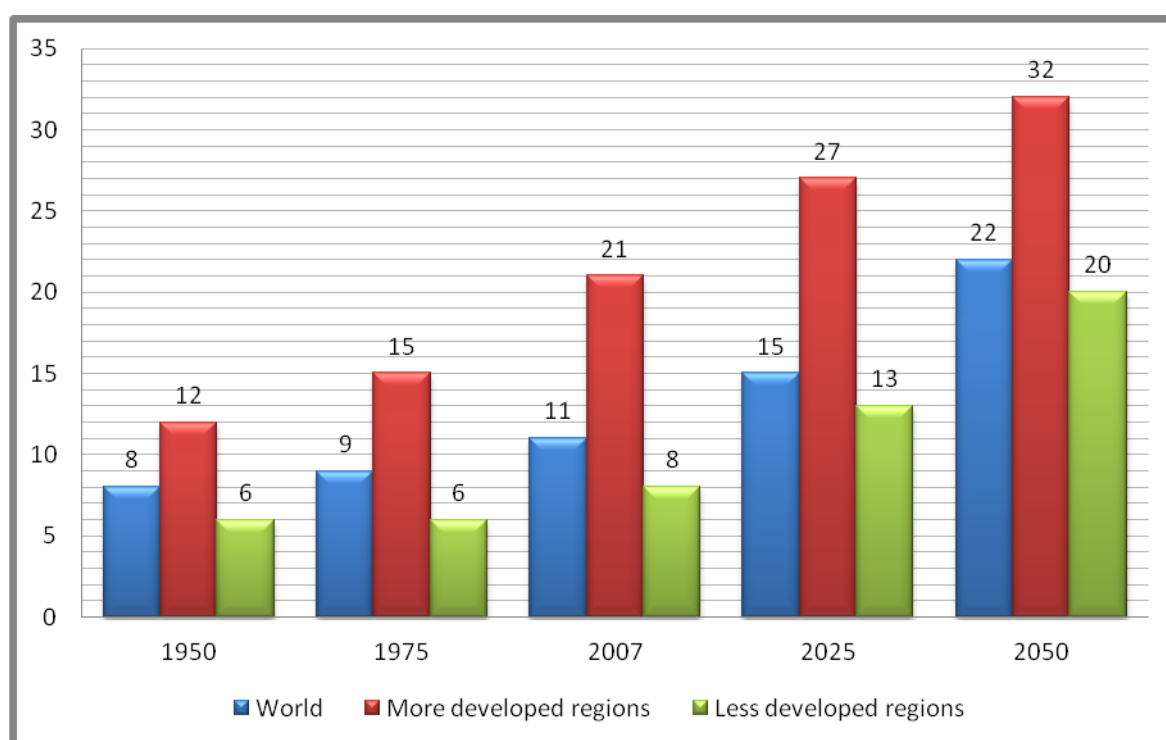
Globally the population is ageing and the number and proportion of older people is increasing. The world is experiencing rapid demographic transition, as people have fewer children and live longer. Populations are ageing in all countries, including in the developing world. It has been projected that by 2050, less developed regions will have a population age structure similar to today's developed world, with almost equal proportions over 60 and under 15. Already two-thirds of the world's older people live in developing countries. By 2050, this will increase by 80 percent. The number of people aged over 60 in the developing world was predicted to rise from 375 million in 2000 to 1,500 million in 2050. Even in developing countries with relatively young populations, the proportion of older people will rise significantly as a result of declining fertility rates and rising life expectancy. In Sub-Saharan Africa the number of people aged 60 and over will more than double in the next 30 years despite the impact of HIV/AIDS on life expectancy at birth. By 2050, nearly one in four people in Asia and Latin America and one in ten in Sub-Saharan Africa will be over 60 (Age and Security, 2008).

Older people constitute a significant proportion of the global population. Estimates for 2013 showed that those over 50 accounted for 21.7 percent of the population and those over 60, 11.8 percent. By 2050, the over-60 population will account for 22 percent, exceeding the numbers of children under 15 for the first time in history (HelpAge International, 2013). World Population Ageing (2007) states that the proportion of older persons in the world will more than double by 2050. It explains that since the older population has grown faster than the total population, the proportion of older persons relative to the rest of the population has increased tremendously. It further states that at the global level, 8 percent of the population was at least 60 years of age in 1950 and just over 5 percent was at least 65 years of age. By 2007, those proportions had increased to 11 percent and just under 8 percent, respectively. By 2050, 22 percent of the world population is projected to be 60 years or over and just under 17 percent will likely be 65 or over.

By 1950, developed countries as a whole had a higher proportion of their population aged 60 years or over than developing countries (12 percent vs. 6 percent). Developed countries

continue being at a more advanced stage of the demographic transition and have populations that are already showing signs of ageing. Furthermore, their populations are projected to remain considerably older than those of developing countries as a whole. Currently, 21 percent of the population in the more developed regions is aged 60 years or over, whereas just about 8 percent of that in the less developed regions is in that age group. By 2050, 32 percent of the population of the more developed regions is projected to be 60 years or over, whereas the equivalent proportion will likely be 20 percent in the less developed region (World Population Ageing, 2007). Figure 1 below shows the projection of the proportion of population aged 60 or over worldwide:

**Figure 2: Proportion of Population aged 60 years or over: World and Development Regions, 1950-2050**



Source: World Population Ageing, 2007.

### 3.3.1 Population Ageing in Africa

Concern about population ageing in Africa traditionally has focused on relatively high rates of fertility and mortality, expansion of basic health programmes, and more recently, on the devastation resulting from the HIV/AIDS pandemic. Overlooked in the face of these pressing issues is the fact that most African populations are ageing, albeit at a slower rate than in much

of the developing world (Kinsella and Ferreira, 1997). However, despite remaining younger than all other continents, Africa's population is growing older. The current 44 million 60+ population is expected to increase 4-fold to 160 million in 2050. As elsewhere, 'becoming an old person' in Africa is a social process faced with various acute challenges evolving from global and local transformations. Social scientists, policy makers, both local and global, and entrepreneurs are gradually discovering this social category as a group with its own unique needs. The HIV/AIDS pandemic, politics of heritage, changes in public health, and the increasing dominance of youths in Africa's public spheres have transformed both the status of older people and their roles in society. These changes also impact on the ways in which older people are being taken care of (Ageing in Sub-Saharan Africa: Spaces and Practices of Care, 2013).

### **3.3.2 Why the World's Population is Ageing**

The study reviewed literature on why the world's population is ageing in order to understand the factors that make population ageing such a significant phenomenon. Abidemi (2005) states that the elderly population is increasing in all countries of the world and that this is due to several factors which include decline in fertility, improvement in public health and increase in life expectancy. He adds that decline in fertility has been brought about by more wide spread acceptability of family planning, while increase in life expectancy is attributed to improved medical care brought about by technological advancement.

Population ageing is occurring because of declining fertility rates, lower infant mortality and increasing survival at older ages. Total fertility dropped by half from five children per woman in 1955 to 2.5 children in 2010 – 2015 and it is expected to continue to decline. Life expectancy at birth has risen substantially across the world; it is not just a developed world phenomenon. In 2010 – 2015 life expectancy is 78 years in developed countries and 68 years in developing regions. By 2045 – 2050, newborns can expect to live to 83 years in developed regions and 74 years in developing regions. Older persons are, therefore, the world's fastest growing population group amidst rapidly changing family structures and the possibility of declining family support (HelpAge International, 2012). Declining family support may impact negatively on the aged as they may lack the care they need as they advance in age, especially in the Third World context.

### 3.3.3 The Phenomenon of the “Old - Old”

The older population itself is ageing. The number of persons aged 80 or over, often referred to as the “oldest old”, has been increasing more rapidly than the older population as a whole. The number and proportion of centenarians is growing even faster. Globally, 1.6 percent of the population is now aged 80 or over and the proportion is projected to rise to 4.3 percent by 2050, reaching 402 million. The number of centenarians in the world is projected to increase from fewer than 316,600 in 2011 to 3.2 million in 2050. For example, in the United Kingdom, there are projected to be half a million centenarians by 2066 and one third of babies born in 2012 can expect to celebrate their 100<sup>th</sup> birthday. In China, there are currently 14,300 centenarians. This number is expected to increase to 362,500 persons aged 100 or over by 2050. In Japan, there are already 49,500 centenarians and by 2050, this number is expected to increase to 617,000, of whom 500,000 will be women. This means that nearly 1 percent of Japan’s population will be aged 100 years or over by mid-century (HelpAge, International, 2012).

In Britain, much of the rest of Europe and North America, the number and proportion of very old people, who are most at risk of institutional residence, is growing rapidly. However, institutional care is costly, and the question of how to fund it has become a major issue of public debate and concern for providers and older people and their relatives. While only a minority of older people live in institutions, in ‘old-old’ age groups this minority is a large one. In England and Wales in 1991, over a quarter of women aged 85 years and over lived in non-private households, the official term used to denote communal establishments of whatever type (Grund and Glasser, 1997).

The implications of increasing life expectancy in the age distribution of the population are being felt in developing regions too. Until now, there have been more people aged 80 years or over in developed countries. By 2025, the balance will have shifted. By 2050, it is projected that there will be more than twice as many people aged 80 years or over in developing regions, at 280 million, compared with 122 million in the developed regions (HelpAge International, 2012).

### 3.4 Global Action on Ageing

Having realised that population ageing was such a significant and growing phenomenon with far-reaching consequences, the world had to come up with actions to try to mitigate some of the challenges that come with population ageing. One of the first major global actions on ageing was the Madrid International Plan of Action on Ageing (MIPAA), which was held in Madrid in April 2002. The Assembly brought together delegates of more than 160 governments, intergovernmental institutions and NGOs to respond to the opportunities and challenges of population ageing. Zambia was also represented at this assembly. The MIPAA marked the turning point in how the world would address the key challenges of building a society for all ages. The plan focused on three major priority areas: older persons and development, advancing health and well-being into old age; and ensuring enabling and supportive environments. It represented the first time governments adopted a comprehensive approach linking ageing to other frameworks for social and economic development and human rights, most notably those agreed to at the United Nations Conferences and Summits in the 1990s (World Population Ageing, 2007). The Assembly pledged to extend the right to development to older persons and to halve their poverty by 2015 in line with the First Millennium Development Goal. The Assembly identified poverty as the greatest threat to older people worldwide and called on governments, public and private institutions to incorporate older people into development processes and allocate resources accordingly (HelpAge International, 2002).

Governments, including Zambia, adopted the MIPAA in order to respond to the challenges of older persons from the ageing population by bringing them onto national development agenda (Draft National Policy on Ageing, 2011). By adopting the MIPAA, governments agreed for the first time on the need to link ageing with human rights. This happened at a time when the human rights approach to development was gaining increasing importance on the international stage, as for example, during the International Conference on Population and Development held in Cairo in 1994 and the Fourth World Conference on Women held in Beijing in 1995. The population declaration affirmed the commitment to the protection of all human rights and fundamental freedoms, including the right to development. There was a shift away from viewing older persons as welfare beneficiaries to active participants in the development process, whose rights must be respected, protected and guaranteed. The Madrid



Plan includes a specific recommendation to include older persons to be full participants in the development process and share in its benefits (HelpAge International, 2012).

However, HelpAge International (2012) observes that globally, the Political Declaration and the MIPAA continue to be the sole international instruments on ageing and that there is no binding international human rights instrument specifically devoted to the older persons. It states that even though there are various obligations *vis-à-vis* older men and women implicit in most core human rights treaties, to date, the body of work done by the international human rights mechanisms on ageing and their monitoring of the situation of older people is relatively limited and scattered.

The Population Division of the United Nations has a long tradition of studying population ageing, including by estimating and projecting the size and characteristics of ageing populations and by examining the determinants and consequences of population ageing. From the groundbreaking report on population ageing published in 1956 which focused mainly on population ageing in the more developed countries to the United Nations World Chart on Population Ageing published in 2006, the Population Division has consistently sought to bring population ageing to the attention of governments and the international community (World Population Ageing, 2007).

Consequently, the United Nations Commission on Social Development decided to conduct every five years, a review and appraisal of progress made in implementing the MIPAA. Furthermore, the General Assembly stressed the need for population data to be disaggregated by age and sex. The report provided the demographic foundation for the follow-up of activities of the Second World Assembly on Ageing. It considered the process of population ageing for the world as a whole, for more areas and regions as well as individual countries. Demographic profiles covering the period 1950 to 2050 were provided for each country, highlighting the relevant indicators of population ageing. The contents of the report underscored four major findings:

- i. Population ageing is unprecedented, a process without parallel in the history of humanity - The report stated that at the world level, the number of older people was expected to exceed the number of children for the first time in 2047. In the more

developed regions, where population ageing was far advanced, the number of children dropped below that of adult persons in 1998.

- ii. Population ageing is pervasive since it is affecting nearly all the countries of the world - The report explained that the resulting slowdown in the growth of the number of children coupled with the steady increase in the number of older persons has a direct bearing on both the intergenerational and intragenerational equity and solidarity that are the foundation of society.
- iii. Population ageing is profound, having major consequences and implications for all facets of human life - The report indicated that in the economic area, population ageing would have an impact on economic growth, savings, investment, consumption, labour markets, pensions, taxation and intergenerational transfers. It further indicated that in the social sphere, population ageing influences family composition and living arrangements, housing demand, migration trends, epidemiology and the need for healthcare services. It stated that in the political arena, population ageing may shape voting patterns and political representation.
- iv. Population ageing is enduring - The report concluded that since 1950 the population of older persons had been rising steadily, passing from 8 percent in 1950 to 11 percent in 2007 and expected to reach 22 percent in 2050 and that as long as old age mortality continued to decline and fertility remain low, the proportion of older persons would continue to increase (World Population Ageing, 2007).

### **3.5 Progress on Global Action on Ageing**

Some progress has been made in adopting new policies and plans on ageing. HelpAge International and the United Nations Population Fund (UNFPA) with funding from the John D. and Catherine T. McArthur Foundation, reviewed government action on ageing in policy and legislation and research and data, since the adoption of the MIPAA and its political Declaration in 2002. Summary information supplied by 133 countries on progress in the three priority directions of MIPAA, namely, older persons and development, advancing health and well-being into old age and ensuring enabling and supportive environments, was reviewed, along with detailed information from 32 countries. The review showed that 47 countries had approved and published national policies on ageing since 2002. Ten had passed overarching legislation on ageing. Others had passed specific laws dealing with issues affecting older people. Developing countries, in particular, had made progress in mainstreaming ageing into

sectoral policy. Some had set up official bodies to ensure that governments respond appropriately to challenges of ageing. Overall, however, mechanisms and budgets for implementing policies on ageing were lacking, as was government attention to the “bottom-up approach” to the review and appraisal of MIPAA (Ageing and Development, 2011). However, Zambia has not fared very well on this score because it has even failed to enact the national policy on ageing which has been in draft form since work on it started in 2008. Although the policy has since been approved by Cabinet it is still awaiting ratification by parliament so that it could be given a legal framework.

The above literature is pertinent and relevant to this study as it has described the concept of ageing and steps and actions taken by nations of the world to identify the unique challenges faced by the aged. It has highlighted the magnitude of global ageing and its possible effect on various facets of life and sectors of the global economy. It has also pointed out the need for every country to consider the aged as a significant segment of the global population and put mechanisms and strategies in place towards improvement of their welfare. It has further assessed the progress made by countries in adopting new policies and plans on ageing.

### **3.6 Living Arrangements for the Aged in the World**

Among several indicators of the status of the elderly in society, their living arrangements occupy an important place. The concept of living arrangements refers to the familial system of support and care of the elderly. In the absence of a well-developed system for providing social services to the elderly, they have to rely on persons living in their close proximity. The elderly expect economic, social and emotional support from family members as their economic productivity and physical strength decline with advancing age. Thus living arrangements becomes an important constituent of the overall wellbeing of the elderly and provides some indication of the level of actual support available to them (Rajan and Kumar, 2003). The researcher reviewed literature on the living arrangements for the aged from a global perspective in order to gain insights into how they live and are provided for. The literature revealed that there were several living arrangements for the aged in the world and that these varied from one country and context to another.

Since it attached great importance to the global living arrangements for the aged, the Madrid International Plan of Action on Ageing (MIPAA) called for research on the advantages and disadvantages of different living arrangements for older persons, including familial co-

residence and independent living, in different cultures and settings. The findings of the research established that even the most basic demographic descriptions of the living arrangements of older people had not been available in many countries (Report of the Second World Assembly on Ageing, 2002). The publication provided the first global survey and analysis of the patterns and trends in the living arrangements of older persons. Comparable data were presented for more than 130 countries. The publication analysed the demographic, social and economic correlates of living arrangement of people aged 60 years or over as well, focusing on co-residence with family members, solitary living and the institutionalisation of older persons. The following were the major findings of the research:

- i. About one out of every seven older persons, approximately 90 million people, lived alone - The large majority of these people, about 60 million, were women. Worldwide, 19 percent of older women lived alone, compared with 8 percent of older men.
- ii. There was a widespread trend towards independent forms of living arrangements among older persons - The trend towards living alone or with a spouse only was in accordance with the general preference for independence in economically developed countries, and there was a growing preference for separate residence in some developing countries as well.
- iii. The reason that more older women than older men lived alone was that older women were less likely to be married - Worldwide, about 45 percent of women aged 60 years or over were married, while among men the comparable proportion was approximately 80 percent. Among the unmarried, however, more men than women lived alone in most countries.
- iv. While the most common arrangement in the developed countries was for older persons to live apart from their children, a large majority of older persons in less developed countries lived with their children - Around three quarters of older persons in the less developed regions were living with a child or grandchild. In European countries, by contrast, the average was about 25 percent.
- v. In many developed countries, institutional living had become an option for older persons who had difficulty managing on their own or who needed specialised medical services - The question how to provide long-term care for older persons who needed assistance, and the escalating costs of providing

such care, had become pressing policy concerns in developed countries. In some countries, policies promoting “ageing in place” in the community appeared to have halted or reversed earlier trends towards higher rates of institutionalisation.

- vi. In many of the countries with high rates of HIV infection, the proportion of older persons living with grandchildren, but not with children (skipped-generation households), had increased - In the countries where at least 10 percent of adults had been infected with HIV, the proportion of older persons in skipped-generation households grew by 2.7 percentage points, in a period averaging only seven years (Report of the Second World Assembly on Ageing, 2002).

The world’s population is ageing, with changes in the living arrangements of the elderly occurring in most countries, as a result of lower fertility, higher mobility, changing attitudes about family structure and function, and increasing life expectancy, especially mortality declines in late life. There are important interactions between population ageing, changes in the living arrangements of the elderly and the need for long-term care service. Such interactions are directly related to community and family support systems and public policies (Suzman and Manton, 1992). Living arrangements are, therefore, a consequence of population growth and population ageing.

### **3.7 Care for the Aged in the World**

When human beings grow old and advance in years, they may require to be cared for by their family members, friends, communities and society in general. Like any other category of the population, the aged have various needs which have to be met in order for them to lead fulfilling and worthy lives and society has the obligation to meet these needs. Old Age and Ethics of Care (2008:20) states:

Everyone has the right to safety in their old age, which includes the right to receive necessary treatment and good care. As society, we have an obligation to ensure that the elderly receive the care they need and that their human dignity, right to self-determination and right to live according to their personal values are respected. We can assess the current state and development needs of eldercare by thinking how we would like to be treated when we are old and in need of help and care.

Traditionally, care of the aged in all societies around the world has been the responsibility of family members and within the extended family home. Increasingly, however, in modern society, care of the elderly is now being provided by the state and/or charitable institutions as care by the extended family system has generally declined. The reasons for this change includes decreasing family size, the greater life expectancy of the elderly people, the geographical dispersion of the family and the tendency of women to be educated and work outside the home. Although this affected European and North American countries first, it is now increasingly affecting Asian and African countries also (Hendricks and Hendricks, 1981).

In India, the family has been the traditional social institution for the support and care of the elderly. Caring for the elderly by family members, especially children and grand-children, has been a practice down the ages. Aged persons had a vital role to play in the family and in society. They also enjoyed social security against infirmities, losses and had the privilege of being cared for by the younger generation. They were accorded a high status as decision makers in the joint family system. However, over the years, changes have been taking place in the socio-economic and demographic dimensions. Changes such as reduction in the number of children a couple has, higher life expectancy, greater involvement of younger women, who have been the chief caretakers of the elderly in economic activities outside the home, physical separation of parents and adult children due to urbanisation and age, selective rural to urban area migration, spread of western culture and life style, and the growing individualism among other factors, have had their impact on the traditional family system. Gradually, Indian society is moving away from the joint family to nuclear family system. These changes have profound implications for the support and care of the elderly (Rajan and Kumar, 2003).

Wu, White, Cash and Foster (2009) point out that Taiwanese culture shows great respect for older people who are traditionally cared for at home by their families. They however, assert that the older population in Taiwan is rapidly increasing and this demographic shift, together with various socio-economic changes, has resulted in institutional homes such as nursing homes becoming a new and significant care option for older persons.

In much of Africa, older persons traditionally rely on their extended family, especially their own children, for their welfare. This is largely because the collective nature of the African culture plays an important role when it comes to taking care of the aged. This could even be interpreted from rich African proverbs such as “*Mayo mpapa naine nkakupapa*”. This is a Zambian Bemba proverb directly translated as “*Mother, take care of me now and I will reciprocate in future.*” It should be noted that the concept ‘mother’ in the above proverb is a collective one, which includes fathers, uncles, aunts, grandparents or other carers. However, as a result of the HIV/AIDS pandemic, conflicts, shocks such as recurrent droughts and rapid urbanization, many older persons in Sub-Saharan Africa have become primary sources of support for their families and/or caregivers for grandchildren because prime-age adults have fallen ill, died or migrated (World Population Ageing, 2013). Oyedele (1992) adds that in many African countries the elderly are supported by the family and extended family systems, but that this practice is difficult to sustain, especially in these hard times. He contends that governments have, thus far, not placed the care and education of elders on their priority lists but have instead placed older workers on top of their retirement list whenever it becomes necessary to reduce the labour force, which he says has happened in Nigeria since 1975.

In an article titled ‘Nutritional Status, Functional Ability and Food Habits of Institutionalised and Non-Institutionalised Elderly People in Morogoro Region, Tanzania’, Nyaruhucha, Msuya and Matrida (2004) state that in a number of cases, families in Tanzania, which historically have taken care of their elderly, have now changed to institutionalisation through the state or religious organisations. They conclude that some elderly people have ended up receiving care in public institutions other than from their families. This implies that some families in Tanzania have failed to take care of their elderly parents and relations due to a number of socio-economic factors such as poverty and who, consequently, may end up in institutional homes for the aged.

### **3.8 Care for the Aged in Zambia**

Kamwengo (1997) states that providers of care and support for the aged in Zambia are many but that they can be grouped into five major categories, namely the extended family, the aged themselves, government, charity and institutional homes. He explains that most of the care and support available to the aged in the community is provided by the extended family which comprises adult children, siblings, other relatives and friends. The aged, who are their own

providers have resources or incomes from other sources, while the government provides care and support through the Ministry of Health by way of free health care, Public Welfare Assistance Scheme (PWAS) and Social Cash Transfer Scheme (SCTS). Kamwengo (1997) further explains that support from specific providers under charity includes churches, business houses, service organisations, like Lions and Rotary clubs and NGOs such as Programme Against Malnutrition (PAM) and Hope Foundation. The other providers of care are institutional homes, which are referred to as old people's homes or homes for the aged, which he says can be classified on the basis of whether they are government run or privately run.

Kamwengo (2002) explains that financial, material and emotional support from the extended family is often referred to as the traditional social support system and it is voluntary and free from government involvement. He, however, points out that a growing concern about this support system is that it is weakening as a result of the influence of industrialisation, urbanisation, mass education and the prevailing social and economic conditions. He adds that these factors have affected the capacity of the extended family to care for the elderly in Zambia. The Draft National Policy on Ageing (2011) further states that although the family forms the best form of support for its members, the structures are dynamic and the traditional patterns of care and support are no longer guaranteed in Zambia. It further states that the high poverty levels coupled with the HIV/AIDS pandemic has made the extended family system which used to be a social safety net, become overstretched and ineffective. The next section describes institutional care and terminologies used to refer to institutions that care for the aged in different contexts.

### **3.9 Institutional Care and Terminologies used to refer to Institutional Homes for the Aged**

One may ask what is meant by institutional care. According to Oldman and Quilgars (1999), institutional care is where individuals spend a bulk of their sleeping and walking times in a setting which is not their home. Denham (1983) explains that in many institutions, activities of daily life such as sleep, work and play are carried out under one roof. He further explains that these institutions are governed by one authority and each phase of a person's daily routine is rigidly fixed and is carried out in company of others, who are treated alike. Denham



(1983) also states that there are enforced activities which are part of the overall plan designed to fulfil the official aims of the institution.

The literature reviewed showed that there are various terminologies that are used to refer to institutions that care for the aged in different countries and contexts. In their study titled 'Nursing Homes in 10 Nations: A Comparison between Countries and Settings,' Ribbe et al. (1997) indicate that when making comparisons in terms of institutional care for the aged, it is essential to note that there are no universally accepted definitions for different long-term care services. Below are some of the terminologies that are used to refer to various forms of institutional care for the aged, according to the literature reviewed.

#### **(a) Nursing Homes**

According to Ribbe et al. (1997), a nursing home is an institution providing nursing care 24 hours a day, assistance with activities of daily living and mobility, psychosocial and personal care, paramedical care, such as physiotherapy and occupational therapy, as well as room and board to elderly people. Ribbe et al. (1997) explain that availability of these different types of care, especially paramedical care, varies from facility to facility and from country to country. They further explain that nursing homes mainly serve frail elders with chronic diseases, disabilities, either physical or mental, mainly dementia, or both. Countries that use the term nursing homes include Israel (Silberstein, Zeltzer, Kossovsky and Pinkerfeld, 1970), Japan (Campbel, 1984) and the United States of America (Kane and Kane, 1978), just to mention a few.

#### **(b) Care Homes**

A care home is a residential facility that provides accommodation and offers a range of care and support services. Care homes may provide a limited number of services to support low dependency or may provide a wide range of services to cater for the continuum from low to high dependency care (WHO, 2004). In England care homes provide a range of services. Some homes provide residential care which includes a place to stay, meals and laundry services, along with a whole range of personal care such as helping people with bathing and eating. Others provide nursing care in addition to the personal care, helping residents with medical care (Care Homes for Older People in the UK, 2005).

Goodman and Woolley (2004) point out that in England, care homes provide for older people who have been assessed as needing ongoing help with personal and/or nursing care. They explain that some care homes can provide both types of care, but that the majority differentiate between residential, which involves personal and social care, and nursing care. Goodman and Woolley (2004) add that most (72%) care homes in England offer residential and personal care only and that the independent sector is the main provider of 90% of these homes.

### **(c) Aged Care Homes**

In Australia, institutional care for the aged is provided by aged care homes. Five Steps to Entry into Residential Aged Care (2011) states that institutional aged care in Australia is for older people who for a variety of reasons can no longer live at home. It also states that aged care homes are owned and operated by people or organisations that have the approval of government. The homes ensure that residents have the care that they need, whether they just need help with day-to-day tasks, assistance with personal care or 24-hour nursing care. Residential aged care can be offered as either permanent or short-term care. Short-term care in an aged care home is called residential respite care.

There are two main types of residential aged care in Australia, namely, low level care and high level care. While some aged care homes specialise in low or high level care, many homes offer the full continuum of care, which allows residents to stay in the same home as their care needs increase. Mostly, people in low level care can walk or move about on their own. Low level care focuses on personal care services (help with dressing, eating, bathing, etc), accommodation, support services (cleaning, laundry and meals) and some allied health services such as physiotherapy. Nursing care can be given when required. Most low level aged care homes have nurses on staff, or at least have ready access to them. High level care provides functionally very dependent people with 24 hour care either by registered nurses or under the supervision of registered nurses. Nursing care is combined with accommodation, support services (cleaning, laundry and meals), personal care services (help with dressing, eating, toileting, bathing and moving around) and allied health services (such as physiotherapy, occupational therapy, recreational therapy and podiatry) (Ageing and Aged Care in Australia, 2008).

#### **(d) Old People's Homes**

Kamwengo (2002) posits that a home for the aged or old people's home is an institution providing food, accommodation, nursing care, physical, social and emotional care to elderly and other debilitated persons. The Draft National Policy on Ageing (2011) also states that homes for the aged are homes which keep older people in need of care and are supported wholly or partly by voluntary organisations. Kamwengo (2001) further explains that institutional care for the aged in Zambia is limited to the services provided by homes for the aged and that in the past it included services provided by a nursing home and a geriatric centre. However, since the only nursing home in Lusaka and the geriatric centre in Ndola stopped functioning, the only serving institutions for the elderly have been the homes for the aged. In the Zambian context, the terms old people's homes and homes for the aged are used interchangeably. Other countries that use the terminology of homes for the aged are Zimbabwe (Nyanguru, 1990; 1991), Egypt (Rugh, 1981) and India (Tripathi 2014), among others. Tripathi states that in India, homes for the aged are also referred to as old-age homes.

#### **Combination of Terminologies**

The literature reviewed showed that some countries use a combination and variety of terminologies to refer to institutional homes for the aged, depending on the services and level of care provided. For example, Ribbe (1993) states that in the Netherlands the most important institutions for the elderly are the homes for the aged and Dutch nursing homes. He explains that a home for the aged is an institution in which at least five elderly persons are permanently lodged and where complete or partial servicing is provided, while a Dutch nursing home can be described as an institution which provides temporary or permanent multidisciplinary treatment, guidance and support, and nursing care for elderly patients with long-term complex health problems, expressed primarily in functional disorders and handicaps. Steverink (2001) adds that elderly people who live in nursing homes in the Netherlands are physically and/or mentally ill and need special medical and nursing care, while those living in homes for the aged do not need this special type of care, but only help with activities of daily living.

Jeths and Thorslund (1994) point out that as in other Scandinavian countries, the public system in Sweden, for providing social services and medical care is extensive and that the elderly receive care in a variety of institutions such as nursing homes, geriatric wards and old

age-homes. Mollica (2002) also points out that in the United States of America, the term residential care is often adopted as a label for various types of elderly facilities both within American and across each state, which include residential care, assisted living, board and care, personal care homes, sheltered care and foster care.

Furthermore, Simone (2008) explains that residential care services for the elderly in Hong Kong are delivered through several providers, namely: the Hospital Authority, Department of health, Social Welfare Department, non-governmental organisations, volunteers, and private 'for profit' businesses. These care services are mainly provided by the private sector, followed by subvented homes, run by both government and NGOs, and a few self-financing homes. Both private and self-financing homes adopt a continual care, which allows for the admittance of customers at various levels of frailty. Subvented residential care services aim to provide residential care and facilities for elders aged 65 or above, who for personal, social, health or other reasons, cannot adequately be taken care of at home. Subvented homes are classified into different types based on different levels of frailty and care, including hostels for the elderly, homes for the aged, care and attention homes for the elderly and nursing homes. Hostels for the elderly provide communal living accommodation, programme activities and round-the-clock staff support for elders who are capable of self-care. Homes for the aged provide residential care and a limited degree of assistance in activities of daily living for elders who are unable to live independently in the community and yet are not dependent on assistance with personal or nursing care. Care and attention homes for the elderly provide residential care, personal care and limited nursing care for elders who suffer from poor health or physical/mild mental disabilities with deficiencies in activities of daily living but are mentally suitable for communal living. Nursing homes provide residential care, personal care, regular basic medical and nursing care and support for elders who suffer from poor health or physical/mental disabilities and deficiency in activities of daily living but are mentally suitable for communal living.

As can be noted from the foregoing, different terminologies are used to refer to institutions that care for the aged in different countries and settings. In some cases, the terminologies are used interchangeably; for example, residential homes and nursing homes (Erichsen and Büssing, 2013). The bottom-line is that they all provide institutional care for the needy

elderly persons. In the Zambian context the terminology used to refer to institutions that care for the aged is old people's homes or homes for the aged, which this study adopted.

### **3.10 Critique of Institutionalisation of the Aged**

The literature reviewed revealed a number of strengths and weaknesses of institutionalisation of the aged. Hurlock (1980) points out that while many elderly people may rebel against giving up their own homes and going into an institution, there are certain advantages to this type of living. The strengths of institutionalisation of the aged, according to Hurlock, are that:

- i. Maintenance and repairs are provided by the institution.
- ii. All meals are available at reasonable costs.
- iii. Provision is made for suitable recreations and amusements.
- iv. Opportunities are available for contacts with contemporaries with similar interests and abilities.
- v. There is greater chance for acceptance by contemporaries than when with young people.
- vi. It eliminates loneliness because people are always available for companionship.
- vii. It provides opportunities for contacts with contemporaries, which they usually do not have if they live in their own homes or in the homes of grown children.
- viii. Holiday celebrations for those with no families are provided.
- ix. Opportunity for prestige based on past accomplishments that would not occur in groups of younger people.

Hurlock (1980) adds that elderly persons who live in a home for the aged have recreations provided for them that are suited to their physical and mental abilities. He contends that elderly persons who live in their own homes or with a married child have fewer opportunities for recreation, especially if their economic status is poor or if failing health or transportation problems prevent them from participating in community-sponsored recreational activities. Mangallathil (2011) further states that the advantages of old people's homes are that they provide a safe haven for older persons who have nowhere to go or no one to support them and that the homes create a family-like atmosphere where older persons share their joys and sorrows with each other. He explains that these homes have special medical facilities for senior citizens such as mobile health care systems, ambulances, nurses and provision of well balanced meals to enable them live a healthy life. Mangallathil (2011) also states that the

aged in old people's homes have a lot of free time and can, consequently, utilise it creatively and can pursue any hobbies in a very peaceful atmosphere. He says that since the aged do not have big expectations, they do not have to spend money a lot and that have freedom to pursue and participate in religious activities.

However, the problem with the foregoing strengths of institutionalisation of the aged is that they may mostly be applicable to Western societies with developed economies and infrastructure and hence, can provide fairly adequate care and services to their elderly citizens. For example, one of the advantages presented by Mangallathil is that old people's homes have special medical facilities for senior citizens such as mobile health care systems, ambulances, nurses and provision of well balanced meals to enable them live a healthy life, which may not be the case with developing countries like Zambia which generally face economic and financial challenges.

Goodman and Woolley (2004) report that in the United Kingdom, older people who are resident in care homes because of their needs for social and personal care receive their health care from primary health care. They point out that there is evidence that the impact of providing general practitioner (GP) services to older people in institutional settings is greater than providing for older people in their own homes.

Beside the strengths of institutional care for the aged, the literature reviewed also showed that there are weaknesses inherent in this living arrangement. Hurlock (1980) states that among the weaknesses of institutionalisation of the aged are that:

- i. Living in an institution is more expensive than living in one's own home.
- ii. Like all institutional food, it is less appealing than home-cooked food.
- iii. There is close and constant contact with some people who may be uncongenial.
- iv. The location of institutional homes is often some distance away from shops, amusements and community organisations.
- v. The location of institutional homes is usually at some distance from family and friends.

Kaplan (1953) adds that when the older person moves into a home for the aged, he/she gives up his/her home and independence. He explains that this constitutes an extreme break with

his/her community and yet, the characteristic pattern is for older people to remain in the same community and among the people they grew up with. He, therefore, suggests that focus should be on utilising the residents' contacts, social relations, and personal ties so that there is no irremedial break with the past. He, however, states that this is not always done. Kaplan (1953) points out that there is already evidence that institutions for the aged have actually facilitated the process of individual deterioration.

Nyanguru (1991) contends that many writers have discussed the negative aspect of institutional care and that the literature is replete with descriptions of the institutionalised elderly as disoriented, disorganised, withdrawn, apathetic, depressed and hopeless. He explains that some writers have suggested that the elderly in institutions are deprived of intimate family relationships which leads to depersonalisation and that the talents they possess atrophy through disuse. He adds that the elderly in institutions may become resigned and depressed. Bland (2005) also argues that despite policy initiatives and changes in the nature of provision for elderly persons, underlying ageist policies towards senior citizens have consistently been to encourage independence from the state, to emphasise family responsibility and to offer statutory residential care as the last resort in the United Kingdom. She says that the result of such policies is that residential care is seen as stigmatising and entry as a sign of moral failure. Additionally, Luppá et al. (2010) state that institutionalisation is associated with several negative outcomes such as increased mortality, restricted quality of life as well as questionable quality of care.

Hurlock (1980), however, explains that how well elderly people adjust to institutional living depends on many conditions, four of which he says are both common and essential. Firstly, when men and women enter an institution voluntarily, instead of being forced to do so by circumstances, they will be happier and have a stronger motivation to adjust to radical changes that institutional living brings. Secondly, the more accustomed men and women become to being with other people and to taking part in shared activities, the more they will enjoy the social contacts and recreational opportunities provided by the institutions. Thirdly, elderly people will adjust better to living in an institution if it is close enough to where they lived before so that they can maintain contact with family members and friends. Hurlock (1980) states that going to an institution that is far away from the former home is usually a traumatic experience and militates against good adjustment to institutional living and to happiness. Fourthly, and perhaps most importantly, according to Hurlock, regardless of

where elderly people live, it is important that they feel they are still part of the family and not cut off from contacts with their children and relatives. As their friends die, or otherwise become unable to provide companionship, elderly people depend increasingly on their families. However, what Hurlock overlooked in his analysis is the fact that some aged persons have no family members to turn to for companionship and only have fellow residents to depend on for this aspect of their wellbeing. The literature reviewed has indicated that some elderly persons residing in institutional homes have no family members, let alone their own children.

The researcher's view is that, like any other parts of the world, old people's homes, as a form of institutional care for the aged, are a reality in Zambia, although the official government policy is that they should be a measure of last resort. Old people's homes have always had a key role in the provision of care for older people and have been in existence since the post-Second World War era. These institutions play quite an important role of providing care to needy elderly persons in our society, some of whom may have been living in dire circumstances and conditions prior to their admission.

### **3.11 Factors that Led to Institutionalisation of the Aged**

The researcher reviewed literature on factors that led to the institutionalisation of the aged in order to gain some insights into why the aged found themselves in these institutions. The literature indicates that there were several factors that led to the institutionalisation of the aged and these varied from one situation and context to another. Böckerman, Johansson and Saarni (2010) assert that as populations across the Western world age, research on the determinants of why people become institutionalised is expanding rapidly.

Five Steps to Entry into Residential Aged Care (2011) states that while older people living in care homes in the United Kingdom have different reasons for entering care, they do have one particular characteristic in common and that is the inability to perform certain activities of daily living. It states that people entering care homes generally do so because they are no longer able to live independently. Bland (2005:89) also asserts:

Institutional care in the UK became what it was always intended to be, the last resort of the desperate. Entry to the workhouse/poorhouse was due to 'dependency', whether on grounds of destitution, sickness or disability, rather than age. The policy response to increased demand was to reduce costs by restricting eligibility and exerting pressure on families.



In their study on 'Residential Care Homes for Older Persons in England', Bebbington, Darton and Netten (2001) contend that people who were admitted to residential care homes in England tended to be particularly old, either living alone or in a situation where other household members could no longer cope, were less wealthy and in poor health. The study also revealed that when Social Workers were asked to give reasons for admitting new residents to residential care homes, they gave a number of reasons but that physical and mental problems predominated. Other reasons given by Social Workers, according to the study were, in order of significance, functional disablement, stress on carers, lack of motivation, the present home being physically unsuitable, family breakdown, including loss of carer, need for rehabilitation, fear of being the victim of crime, abuse and loneliness or isolation.

Similarly, a study on why the aged moved to institutional homes in Britain by Oldman and Quilgars (1999) established that several residents of the homes talked about their decision to move in terms of being free of the burden of being cared for by relatives, a reversal of the conventional view of informal care. They explain that such a notion is in conflict with the popular view that admission to a care home signals loss of independence. They also explain that elderly residents felt that once freed from being a burden on their relatives, they could have a better relationship with them. Oldman and Quilgars (1999:381) conclude:

In certain circumstances, older people value collective living arrangements. So although we accept that the processes of institutionalisation go on in residential care, they do not do so in an undifferentiated way. For instance some older residents will have made a positive choice to move in to a home....The social isolation that some experience in their own homes depersonalises and dehumanises. Life at home can be bleak.

Tischler (2002) points out that in the United States of America the biggest concern of the elderly is where they will live and who will take care of them when they get sick. He explains that the American nuclear family ordinarily is not prepared to accommodate an ageing parent who is sick or whose spouse has recently died. In addition, with the increasing life span many elderly who may be in their late 70s or 80s have sons and daughters who themselves may be in their 50s or even 60s. As a result, those older people who have trouble moving around or caring for themselves often find themselves with no choice but to live in protected environments such as nursing homes or care homes.

Nihtilä and Martikaenen (2007) undertook a study to assess how household income and other socio-economic factors were associated with the probability of entering an institution for long-term care in Finland. The study indicates that prospective studies have consistently shown that as well as advanced aged, the probability of entering institutional care is associated with functional disability, cognitive impairment and dementia. Nihtilä and Martikaenen (2007) add that research has shown that increase in probability of admission to institutional care is also associated with certain living arrangements such as living alone, or not having a spouse.

In Australia the main reasons for the aged moving to residential aged care homes include illness, disability, bereavement, an emergency, the need of their carer, family or friends, or because it is no longer possible to manage at home without help. (Five Steps to Entry into Residential Aged Care, 2011). Additionally, Ageing and Aged Care in Australia (2008:22) states: "One of the major reasons older people seek assistance from community care programmes to enter residential aged care is dementia. An estimated 209,000 Australians have some form of dementia." However, the above factors are based on Western countries with developed economies. It would, therefore, be helpful to also examine factors that lead to the institutionalisation of the aged from the perspective on non-Western and developing countries. These are discussed below.

In their study titled "Placing Elderly Parents in Institutions in Urban China", Zhan, Feng and Luo (2008) sought to determine reasons why the elderly in China were placed in institutions. Findings from interviews with both family members and the elderly revealed that the major reasons for institutional placement of the aged were most often related to adult children's unavailability because of busy schedules or geographic distance. The study showed that every family member interviewed stated lack of adequate time as the major reason for institutional placement of his or her elderly parents. The second major reason for placement of elderly parents in an institution was the level of the elder's disability. The study explains that some elders needed around-the-clock care after a major stroke or illness, while others needed regular or constant medical attention that the family was unable to provide. The study also established that having to climb stairs because of lack of elevators in apartment buildings was one of the other reasons for institutional placement. The latter reason implies that the elderly were typically capable of performing daily activities, but climbing several flights of stairs

made life unmanageable for them and they, therefore, had to move to an institution for the aged.

Zhan, Feng and Luo (2008) further point out that adult children of institutionalised elderly persons in China justified the practice of keeping their aged parents in old people's homes because they believed that having parents in these institutions to be cared for by professionals was actually a better expression of filial piety or *xiao* than providing poor and intermittent care at home, especially as the elderly parents were becoming more and more dependent. The children felt that providing proper financial support for their elders in institutional settings and continuing their emotional support were even better ways of showing love and care for them, particularly when the children were not readily available for them.

Lalan (2014) established that the reasons for shifting to an institution for elderly persons or an old-age home in India were varied. His study revealed that the most common (40%) reason given by elderly respondents for shifting into an institution was conflict with their sons, whom they said would insult them. Thirty percent of the elderly stated that they had nobody to take care of them, while 25 % indicated that they had no sons and since they did not want to live with their married daughters, they opted to move to an old-age home. A further 5% percent stated that they moved to the home in order to lead an independent and peaceful life. The latter reason implies that the aged believed that they would be better off living in an institution than in the community where they would be dependent on family members for care but who could be too busy for them. They believed that an institutional setting would assure them of security, independence and social contact with their peers and relative peace of mind.

Tripathi (2014) asserts that in India old people feel totally neglected and sometimes have to take refuge in old-age homes. He explains that old-age homes are a Western concept, totally alien to the Indian people, but that westernisation of Indian society has given rise to this problem of caring for the old. Tripathi (2014) further explains that the rising need for institutional support system for the elderly in India is now felt due to loneliness arising from loss of joint family brought about by social change, lack of family or friends, inability to care for themselves and inability to adjust after the death of a spouse. Dubey, Bhasin, Gupat and Sharma (2011) also assert that in India nowadays, the role of families in taking care of older persons has declined due to structural changes which have taken place in the Indian society

and the concomitant disintegration of the joint family system which results in the rejection or neglect of the aged. They explain that elderly people go to institutions mainly because they have no relatives to care for them. Additionally, Kavita, Bipin and Geeta (2012) report that the main reason given by half of the respondents residing in old people's homes in India, whom they studied, was family conflict.

Oluwabamide and Eghafona (2012) report that in some rural communities in Africa older people were often accused of practicing witchcraft. They explain that younger members of these communities often called the older people witches and wizards and that this was one of the factors that made older people withdraw from other members of the community as they were afraid of being harmed. Oluwabamide and Eghafona (2012) went on to recommend that African governments should, in partnership with the private sector, establish homes for the aged in all rural communities in their respective countries in order to save the elderly from harassment and abuse.

Rugh (1981) asserts that in Egypt institutions for the aged meet the needs of a small minority of elderly people whose families have abrogated their responsibilities for important reasons. He, however, clarifies that the growth of institutions for the aged does not necessarily reflect a widespread rejection of familial responsibilities and that in almost every case cited where the voluntary initiative of the individual was not the reasons for admission to an institution, an element of coercion existed in the circumstances of the individual. Rugh (1981) explains that families of institutionalised individuals do not appear to willingly abrogate their responsibilities but are usually forced by poverty, limited space, distance, social sanctions, conflict of allegiance to a spouse, inability to provide appropriate care, among other reasons, to abandon their obligation.

In a study titled 'The Quality of Life of the Elderly Living in Institutions and Homes in Zimbabwe', Nyanguru (1990) states that as a result of a declining rural economy and the lack of an adequate social security system in urban Zimbabwe, many of the nation's elders faced severe economic hardships. He explains that the elderly were without resources to pay rent or buy food, clothing and other necessities of life. He states that many elderly residents reported that they had no one to look after them and that they slept in the open, which led to their being placed in institutions for the aged. Nyanguru's (1990) study reveals that the reasons for

admission into homes for the elderly in Zimbabwe were varied but that the major issue for European respondents (49 %) was security. He explains that most of the European elderly had found it unsafe to live alone as they had been targets of break-ins and robberies in their houses and some had even been murdered. He states that some elderly people reported that they had built security fences around their homes but this did not give them the security they needed. However, Nyanguru's study also revealed that the majority of African (92 %) and Coloured (75 %) elderly had entered homes for the aged because of destitution. None of the Europeans gave destitution as the reason for entering a home. Other reasons given by the aged for entering old people's homes, according to the study, included physical disability, strained relationships with relatives such as daughters-in-law and children, the houses they were living in being too big, in the case of Europeans, loneliness, ill-treatment by husbands and to be near relatives.

In South Africa old-age homes came into existence within the social work domain because of various social problems including loneliness, economic and housing problems, deteriorating mobility of the older persons and lack of family and other support systems for them in the community. Welfare and church organisations, mainly from the White population groups, developed institutional care within their own cultural background to take care of older people. The population of older people in old-age homes changed over the years as the residents became older, more frail and in need of nursing care (Perold and Muller, 2000). Kamwengo (2002) posits that the number of elderly women receiving institutional care in South Africa is rapidly increasing due to the growing numbers of women entering old age. He explains that admission to the homes for the aged is based on age, inability to look after oneself, being disabled or lacking accommodation.

The Draft National Policy on Ageing (2011) points out that although the family forms the best form of support for its members, the structures are dynamic and the traditional patterns of care and support are no longer guaranteed in Zambia. It explains that the high poverty levels, coupled with the HIV/AIDS pandemic, has made the extended family system which used to be a social safety net, become overstretched and ineffective. HelpAge International (2003) asserts that the aged in Zambia are facing a very big problem. It is either they are abandoned by the community and their relatives on allegations of practicing witchcraft or they are forced to look after their grandchildren, whose parents die of AIDS without leaving

anything for these old people, who become surrogate parents. Some of the abandoned elderly persons find themselves in old people's homes.

It is clear from the foregoing review of literature that there are several factors that contribute to institutionalisation of the aged globally. Depending on the context and socio-economic situation of a country, factors include loneliness, disability, inability to perform activities of daily living, destitution, safety and security, lack of family support, the desire to be independent of carers at home in order to seek professional care, as well as avoidance of being a burden on children and other family members. The literature revealed that the main factors that lead to the institutionalisation of the aged in Zambia was articulated by Kamwengo (1997) who states that old people's homes try to meet the needs of aged residents who are there because there is no one to care for them in the community. However, the literature review also showed that there was dearth of information on the major factors that lead to institutionalisation of the aged in Zambia, from the perspective of the aged themselves, their caregivers and other stakeholders, hence the relevance of this study.

### **3.12 Services provided to the Aged in Old People's Homes**

This section presents literature reviewed pertaining to the services and care provided to the aged in old people's homes in various contexts. The main services considered in the literature review included food, shelter, health care, clothes, entertainment, religious and spiritual support and counselling, among others. The literature review also examined studies that have been undertaken by other researchers on these services.

All human beings, regardless of their circumstances, are entitled to the basic necessities of life, such as food and nutrition, health care, clothing, entertainment, religious and spiritual support, counselling and education and it is the duty of every government and stakeholders to ensure that all citizens have access to these services. The reality, however, is that some members of society may not adequately access, or not access at all, some of these services due to various socio-economic factors and life circumstances. The various services provided to the aged in institutional care are described below.

#### **3.12.1 Food and Nutrition**

Food is one of the basic human needs and must be met if survival is to be guaranteed. Adequate nutrition is described by the World Health Organisation (2002) as a cornerstone of

the health of all people and a fundamental human right. Food and nutrients that are obtained from food are essential to keeping the body alive and healthy (Ayana, 2012). As with the general population, older people need energy and a balanced diet. Older people also have particular needs for vitamins and minerals, and, in many cases, food that is easy to chew and digest (Ageways: Practical Issues in Ageing and Development, 2014). However, “People in care homes are among the most vulnerable in our community. They depend on the care home and its staff to provide balanced meals and ready access to as much water and other liquids as they need”(Eating Well in Care Homes for Older People, 2009:1).

Residents in institutional care regard the food they are given as one of the most important factors in determining their quality of life. It is important in maintaining their health and wellbeing. Failure to eat, through physical inability, depression, or because the food is inadequate or unappetising can lead to malnutrition with serious consequences for health. Care staff should monitor the individual resident’s food intake in as discreet and unregimented a way as possible. Care and tact should always be used. The availability, quality and style of presentation of food, along with the way in which staff assist residents at mealtimes, are crucial in ensuring residents receive a wholesome, appealing and nutritious diet (Care Homes for Older People: National Minimum Standards, 2003).

It is generally expected that the aged in institutional homes would be provided with adequate and nutritious food, not only to save them from starvation but also to prevent malnutrition, given the support the homes receive from governments, the private sector and well-wishers. However, Cowan, Roberts, Fitzpatrick (2004:225) report: “Despite being preventable and treatable, malnutrition remains a problem in the developed world and the nutritional needs of many older people in long-term care settings are not met.” Furthermore, findings of a PhD study by Suominen (2007) titled ‘Nutrition and Nutritional Care of Elderly People in Finish Nursing Homes and Hospitals,’ established that malnutrition was common among elderly residents and patients living in nursing homes and hospitals in Finland. The study showed that 11% to 57% of the studied elderly suffered from malnutrition and 40 to 89% were at risk of malnutrition whereas only 0 to 16% had a good nutrition status. The malnutrition was mainly attributed to resident-and patient-related factors such as dementia, impaired activities of daily living, swallowing difficulties and constipation as well as some nutritional care

related factors, such as eating less than half of the offered food portion and not receiving snacks.

Suominen (2007) explains that malnutrition has a negative influence on elderly residents' and patients' health and quality of life. Suominen further explains that nutritional care seems to have a positive effect on elderly individuals' nutritional status and wellbeing, but points out that studies of Finnish elderly people's nutrition and nutritional care in institutions are scarce. Similarly, Marleen (2006) postulates that malnutrition is frequently observed in elderly people living in nursing homes and homes for the elderly in the Netherlands and that anorexia resulting in inadequate dietary intake is often a cause of malnutrition. Marleen explains that malnutrition in old age affects several aspects of functioning and that earlier research has shown that a complete dietary supplement improves the nutritional status of the aged.

Di-Maria-Ghalili and Amella (2012) state that while poor nutrition is not a natural concomitant of ageing, older adults are at risk for malnutrition due to physiological, social, dietary and environmental risk factors. They explain that weight loss in adults is often associated with a loss of muscle mass and can ultimately impact functional status. They further explain that malnutrition in older adults is associated with complications and premature death and that the progression to malnutrition is often insidious and often undetected. The implications of the above findings are that although there may be a steady supply of food items in institutional homes, some elderly residents are still bound to suffer from malnutrition due to ill-health, frailty and impairment. Cowan, Roberts and Fitzpatrick (2004) assert that despite the progress of biomedical sciences in the 21<sup>st</sup> Century, malnutrition remains a significant problem not only in developing countries but also in the developed world. It is, therefore, important that the dietary needs of the aged, especially the weak and frail are well taken care of.

In a study whose objective was to determine the nutritional status, food habits and functional abilities of institutionalised and non-Institutionalised elderly people in Morogoro, Tanzania, Nyaruhucha, Msuya and Matrida (2004) established that there was great variation between the elderly who were cared for in institutional homes and those cared for by their relatives in terms of nutritional status as reflected by their Body Mass Index (BMI) levels. The study concluded that the institutionalised elderly appeared to be better off than their counterparts



who were cared for by their relatives in the community. They stated that this could be attributed to the fact that institutions for the aged, which are either funded by government or the private sector are in a position to provide basic necessities of life to residents. The residents are, therefore, assured of food supplies, besides other services, unlike their counterparts in the community whose carers could be struggling financially. This is also highlighted by Oluwabamie and Eghafona (2012:63) who state: “Most old people in contemporary African societies suffer from malnutrition and a major challenge for them is how to get adequate food.”

The Draft National Policy on Ageing (2011) also states that due to high levels of poverty in Zambia, the majority of older persons can barely afford a meal a day. As a result, they lack good nutrition and are malnourished. It explains that this situation has been compounded by the lack of appropriate interventions targeting them. Bamford, Heaven, May and Moynihan (2012) add that optimising the dietary intake of older people can prevent nutritional deficiencies and diet-related diseases, thereby improving their quality of life.

In a comparative analysis of the care and support available to the needy in institutional homes and the community, Kamwengo (1997) established that food was supplied to old people's homes in Zambia on a regular basis. He explains that although organisations running the homes for the aged experienced inadequate funding from time to time, efforts were made to ensure that food was available to the residents all the time. He adds that the food was supplied not only on a regular basis, but also in adequate amounts. The implication of his finding was that the aged in institutional homes were generally better off than their counterparts in the community when it came to access and provision of food in Zambia. McGivern (2007) points out that barriers to good nutrition in care homes include the following:

- Poor awareness and understanding of dietary issues amongst staff.
- Failure to identify residents at risk of malnutrition.
- Inadequate menus.
- Poor provision for modified-texture diets.
- Poor communication structures.
- Poor standard of feeding practices.
- Little attention to dining environment and presentation of meals.

### 3.12.2 Shelter

HelpAge International (2011) posits that shelter is a basic human right for people of all ages but that for older people the sense of security and comfort that a home provides is particularly important. However, the Draft National Policy on Ageing (2011) contends that Zambia has had inadequate housing plans, designs and programmes that empower its citizens with decent housing before reaching old age and this negatively affects vulnerable groups. Information on how citizens can access decent shelter is not easily accessible and worse still in local languages and Braille for those who have poor or no eyesight. On the other hand, property disputes, especially where older women are involved have not been adequately dealt with considering their feeble conditions. Therefore, some elderly people find themselves homeless and if they cannot be admitted to any of the homes for the aged, they remain in a vulnerable and desperate situation.

The links between the style of a care home, its philosophy of care and its size, design and layout are interwoven. A home which sets out to offer family-like care is unlikely to be successful if it operates in a large building with high numbers of resident places. It would need special design features, being divided into smaller units each with its own communal focus, for example, to measure up to its claim to offer a domestic, family-scale environment (Care Homes for Older People: National Minimum Standards, 2003).

Where special needs are catered for, the design and layout of the physical environment of the home are crucial. People with a high level of visual impairment will require particular design features to help them negotiate the environment, many of which may not only be advantageous to all older people, but will be essential to them. Older people with learning disabilities may have been used to living in small group homes and other small scale settings when they were younger (at least since the development of community care policies) and are likely to prefer a continuation of that style of living as they get older. People with dementia have particular needs for the layout of communal space and associated signage which aid their remaining capacity (Care Homes for Older People: National Minimum Standards, 2003).

## **Housing options for Older People**

The literature reviewed indicated that there are various housing options available to the aged in various countries and contexts. However, according to Ferreira (n.d.), housing in which older people reside as well as the types of housing available to them may be divided into two broad categories. The first category is general housing which comprises dwellings, houses or apartments, either owned or rented by older individuals or a member of their household, in which the older household members reside either independently or with family and/or others. The second category is specialist housing which consists of several types of shelter that are purposely built and managed for older people, such as retirement villages, group housing schemes, assisted living facilities, residential care facilities and nursing homes, in which some level of care and support services is offered to the residents. The main focus of this study was on the second shelter category. Shelter is a very important aspect of service provision to the aged, both in the community and in institutional care. According to Robinson (n.d.), there are several housing options that are available to older people in the United States of America. These are described below:

### **(a) Owning a house**

In this option, the types of housing available for older people include single family homes, condominiums, cooperatives and manufactured or mobile homes. When in their own homes, many older adults live independently. Depending on the locality, homeowners may be able to obtain in-home support services and community services to support their continued independence. Many older adults want to stay in the homes where they have lived for many years. For others, downsizing to a smaller home is an alternative. Active adult communities and retirement communities are increasingly an option. While remaining in one's own home may be highly desirable for older adults, the wisdom of choosing that option depends on making certain that their health, social and financial needs are met.

### **(b) Renting a home**

Renting a home may be an attractive choice. Many housing options are available as rentals, and some offer special services and amenities. Rental options include single-family houses, apartments, mobile homes in parks, retirement communities, and apartment complexes specifically designed for adults over 55 years of age. Most rental units are private, although it

is possible to pay rent to share a home or to rent a single room in a home. Rental housing may be publicly or privately owned, operated or managed.

**(c) Group Living**

Group living arrangements are a housing option that is very important to many older adults. Group settings provide housing, a range of in-home support services and some social activities. Both the housing and in-home support services are designed to meet the individual needs of those who require help with activities of daily living or instrumental activities of daily living. However, group housing does not offer the level of medical care provided in nursing homes.

**(d) Board and Care Homes**

Board and care homes are private and in-residential settings. A board and care home is often a converted or adapted single-family home. This type of home provides the following services: a basic room which may be shared with another person, meals, help with instrumental activities of daily living, the arrangements for or provision of transportation to medical and other appointments, reminders to take medications and daily contact with staff. Services such as meals, supervision and transportation are usually handled by the home's owner or manager.

**(e) Adult Foster Care Homes**

An adult foster care home provides room, board and in-home support services in a family setting. Generally, an adult foster care home provides more in-home support services than a board and care home. These homes may meet the needs of adults who require periodic or regular assistance with activities of daily living. Some adult foster care homes may offer more complex care if the staff has experience and is trained to provide it. In some cases, visiting nurses provide the necessary assistance.

**(f) Adult Care Facilities**

Adult care facilities provide room, board and in-home support services to six or more adults who are not related to the operator. Services for residents may be similar to a board and care home or an adult foster care home. Adult care facilities generally have more residents. They are, therefore, less likely to resemble family life. Adult care facilities may also be called

congregate housing. These facilities are available for older adults who are no longer able or willing to live completely independently. Generally, residents live in a private apartment and are capable of getting to the communal dining area independently. They usually receive help with grocery shopping, meal preparation and housework.

**(g) Residential Care Facilities**

A residential care facility is a group residence that provides each resident with, at a minimum, assistance with bathing, dressing, and help with medications on a 24-hour-a-day basis. The facility may also provide medical services to elderly residents under certain circumstances.

**(h) Assisted Living Facilities**

Assisted living facilities are a housing option for those who need a wide range of in-home support services to help them with activities of daily living. However, residents in these facilities do not require the level of continuous nursing care that a nursing home offers. People who live in newer assisted living facilities usually have their own private apartments. Private apartments generally are self-contained, with their own bedroom, bathroom, small kitchen and living area. Alternatively, individual living spaces, consisting of a private or semiprivate sleeping area and a shared bathroom, may resemble a dormitory or hotel. There are usually common areas for socialising with other residents.

**(i) Continuing Care Retirement Communities**

A continuing care retirement community (CCRC) provides a comprehensive, lifetime range of services, to include housing, residential services and nursing care. A person moving into a CCRC is required to sign a contract with the provider which contains information on the services that are available and the costs of those services. All housing is usually part of one campus setting. In these housing communities, residents live in the type of housing appropriate for their needs and desires. They can move from one level of care to another, while remaining in the CCRC. For example, a resident could start out living independently in a private individual home or apartment. If daily care becomes necessary, the resident could then move into an assisted living facility. The CCRC's nursing home cares for those who require higher levels of care. CCRC contracts usually require that residents use the CCRC nursing home if the resident needs nursing care.

In a study to assess the availability of basic facilities for the aged in old people's homes in Ahmedabad, Gujarat, India, Kaviata, Bipin and Geeta (2012) report that the shelter provided to the residents was inadequate. The study established that 38.5% of all old people's homes were overcrowded as they accommodated more people than their established capacity. In Zambia, Sichingabula (2000) made an environmental assessment of Divine Providence Home for older people in Lusaka in order to ascertain its suitability in catering for their unique needs. She concluded that the home was meeting its objective of housing destitute older persons, even though the design of its buildings did not take into consideration the physical and psychological needs of older persons. She observed that the economic conditions of the country could not allow modifications to the buildings and its facilities in the foreseeable future. The literature review has indicated that there is little information on the adequacy of shelter for the aged in old people's homes in Zambia, hence the significance of this study.

### **3.12.3 Health Care**

WHO (2004) defines health as the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It also states that health has many dimensions, namely anatomical, physiological and mental dimensions and is largely culturally defined. HelpAge International (2012) asserts that in order to realise their right to enjoy the highest attainable standard of physical and mental health, older persons must have access to age-friendly and affordable health care information and services that meet their needs. This includes preventive, curative and long-term care. A life-course perspective should include health promotion and disease prevention activities that focus on maintaining independence, preventing and delaying disease and disability and providing treatment.

According to Raju (2011), it is obvious that people become more and more susceptible to chronic diseases, physical disabilities and mental incapacities in their old age. As age advances due to deteriorating physical conditions, the body becomes more prone to illness. The illnesses of the elderly are multiple and chronic in nature. Arthritis, rheumatism, heart problems and high blood pressure are the most prevalent chronic diseases affecting them. Raju contends that some of the health problems of the elderly can also be attributed to social values. He gives an example of India where he says the idea that old age is an age of ailments and physical infirmities is deeply rooted in the minds of people and many of the sufferings

and physical troubles which are curable are accepted as natural and inevitable by the elderly themselves.

Health status is an important indicator of the quality of life of the elderly. Ageing increases the proportion of elderly with increased morbidities and functional disability. Addressing this issue has major implications for the government as well for the elderly in areas of socio-economic and health conditions in all the societies of the world (Ramachandran and Radhika, 2013). The demographic transition to an ageing population, accompanied by an epidemiological transition from the predominance of infectious diseases to non-communicable diseases, is associated with an increasing demand for health care and long-term care. Although not an inevitable outcome of growing old, the numbers of older people affected by mental health problems are increasing due to population ageing. Their management has become an increasing concern for both developing and developed countries (HelpAge International, 2012).

Ribeiro, Feranades, Firmino, Simões and Paúl (2010) point out that the increasing demand for services by older adults and the inability of care systems to embrace the needs of an ageing population have highlighted concerns with the quality and adequacy of services provided. They further point out that specialised attendance, professional assessment and treatment and adequate consultation services for older adults and their families have emerged as prime issues in geriatric care management. They add that within this context, clinical training in mental health has been progressively highlighted due to the imperative need to promote age-related competencies and attitudes among professionals who work directly with older adults, particularly with those who are frail, psychologically vulnerable, physically ill, and cognitively impaired. This implies that provision of adequate care to the aged through timely delivery of appropriated health services cannot be overemphasised.

Goodman and Woodlley (2004) posit that research has suggested that older people in residential care homes in the United Kingdom are a vulnerable population who have a spectrum of health needs amenable to nursing support and interventions from primary care. O'reilly, Courtney, and Edwards (2007) point out that residential aged care is unique in the context of health care in that as well as providing clinical services, residential aged care facilities also provide a place to live and hence it is not surprising that perceptions of what

constitutes quality of care would encompass a broader range of issues than in a more traditional health care organisation such as acute hospitals.

Nyanguru (1991) contends that although health is identified as a basic need, other basic needs being 'inputs' in the process which 'produce' good health, African countries have few resources to devote to health care and hence, progress in primary health care has concentrated on maternal and child health and contagious diseases. He explains that the problems of an ageing population have not been seen as important because the aged are such a small part of the population. Nyanguru (1991), however, points out that life expectancy has increased and the proportion and the number of elderly people in Africa is growing. This implies that the health needs of the aged in whatever circumstances, including those residing in institutions for the aged, should not be relegated or neglected as they are also an important segment of the population.

In a study titled 'Health-related quality of life of elderly living in nursing home and homes in a district of Iran: Implications for policy makers', Heydari, Khani and Shahhosseini (2012) sought to assess the health-related quality of life of elderly people residing in institutions and those living in their own homes. The study showed that the elderly living in their own homes generally scored better in terms of health-related quality of life than those living in a nursing home, implying that the health services in institutional homes were inadequate. The study observed that researchers and practitioners working with elderly people should be sensitive to the particularities of the specific context and population they work within. It emphasised the importance of planning programmes to increase elderly people's social assistance and improve medical, health and counselling services for them. The study recommended that all relevant stakeholders consider this fact in their interactions with the elderly, with prioritisation of health promotion programmes and resource allocation. It further recommended that there was need to improve and strengthen formal care in the nursing home and reorienting health services both in the community and in homes for the elderly.

Furthermore, Jaiganesh, Prasad and Janaki (2013) sought to establish the health problems among the elderly in old people's homes in urban areas of Chennai, India. They studied 19 old people's homes, 7 of which were managed by government, 9 by private agencies and 3 by Trusts. The study established that the major health problems faced by the aged were visual,



followed by hypertension, depression, arthritis, diabetes and hearing problems. The study concluded that the prevalence of health problems among the aged in old people's homes was high and, therefore, periodic health check-ups to identify morbidity conditions at the early stage and provision of adequate treatment which should lead to their having better quality of life was necessary. This implies that the health needs of the aged residing in institutional homes in Chennai were not adequate and hence there was need to invest more in the health services of the aged so that they could access appropriate health care.

The Draft National Policy on Ageing (2011) states that good health is a very important factor in ageing, which contributes positively to people's participation in community life. It, nonetheless, points out that the health system in Zambia has abolished payment of user fees for accessing primary health care only and not other health services. It adds that most health centres lack essential medicines, appropriate clinical structures and personnel in the field of geriatrics. It further states that due to most health centres being poorly equipped, older persons are forced to purchase or seek medical services from other sources which require payment. This makes access to health facilities by the aged rather difficult. Therefore, access to the much needed medical services by both the aged living in the community and those residing in old people's homes may not be easy.

Kamwengo (1997) points out that some providers of health services in Zambia acknowledged that while efforts were being made to provide health services to all the people, the high cost of providing the care was hampering efforts to adequately meet the health needs of the aged. This implies that while, acknowledging the importance of health care for all categories of the population, more so the aged, including those in an institutional care, service providers faced some challenges in meeting this need.

#### **3.12.4 Entertainment**

The aged, just like other age groups, need and are entitled to entertainment. This includes those residing in institutional homes. Five Steps to Entry into Residential Aged Care (2011) states that in Australia, residents of aged care homes are encouraged and supported to participate in as many interests and activities as possible. It states that the homes run programmes of activities which are both internal and community-based, catering for many interests of the residents and that these programmes are planned and carried out with input

from the residents, their families and communities. Additionally, many aged care homes in Australia have activity officers or therapists who discuss residents' hobbies and interests with them. The officers then work out how hobbies and interests can be continued in the residents' new environment and if possible they may offer the residents other activities. This is in line with activity and continuity theories.

In his study titled 'Watching television in later life: a deeper understanding of television viewing in the homes of old people and in geriatric care contexts', Östlund (2010) sought to establish the importance of television among the elderly residing in their homes and those residing in geriatric homes in Sweden. The study indicated that watching television was the most frequent type of interest among 86-year olds living at home and that they actually watched more television than any other age group, an activity that seemed to increase over the life-span and remained constant throughout the years. The study revealed that in geriatric care homes, residents also spent a large part of their time watching television, which sometimes was the only socialising activity they could participate in.

The study, however, also revealed that personnel of the geriatric homes care were not aware of the importance of television viewing for residents as they did not offer them more opportunities to watch television and discuss what they had seen. The study observed that there was much more to be done to utilise television viewing to increase the quality of life of older people. The study further observed that television viewing constitutes a link between the home and the outside world when it comes to receiving information, orienting oneself in society, interpreting and understanding context. This makes television viewing a coping strategy for dealing with the gap that exists between the nursing home and the outside world.

The study concluded that television is also a technology and as such represents something more than just a device for receiving information. It represents ongoing technological developments and in turn, the development of society. The study further concluded that the long-held assumption that television is a passive occupation was not confirmed in its results. Instead, the results showed that television viewing offered older people an active way to remain socially integrated, to structure daily life and to satisfy needs for reflection and contemplation.

In Zambia, Kamwengo (1997) compared two old people's homes, namely Maramba and Divine Providence Home in order to establish the kind of entertainment and pass-time activities the aged were provided with and engaged in respectively. He established that in terms of entertainment, Maramba only provided radio and television, while Divine Providence Home provided television, radio, parties with soft drinks and site-seeing. In terms of pass-time activities, Kamwengo established that the aged at Maramba old people's home engaged in resting, sleeping and chatting with friends, while at Divine Providence Home, they engaged in gardening, cleaning rooms, resting and talking to friends and nuns. However, the weakness with Kamwengo's study was that it only compared two homes in his assessment of the entertainment provided to the aged, which was not representative of most of the homes in the country. This study, therefore, undertook a comprehensive assessment of this service by studying all the nine old people's homes in Zambia. Furthermore, there was no mention of the need for educational activities in Kamwengo's work as these seem not to have been part of the focus of the study, possibly because they were not considered necessary. This study, therefore, sought to fill this gap by bringing in educational programmes and activities for the aged in old people's homes.

#### **3.12.5 Religious and Spiritual Support**

According to the literature reviewed, the other important service that old people's homes provide to residents is religious and spiritual support. Idinopulous (1999) defines religion as a set of beliefs concerning the cause, nature and purpose of the universe, especially when considered as the creation of a superhuman agency or agencies usually involving devotional and ritual observation and often containing a moral code governing the conduct of human affairs. It is a collection of cultural systems, beliefs and world views that establishes symbols that relate humanity to spiritual and sometimes to moral values. Furthermore, according to Indabawa and Mpofu (2006), religion can be described as a vehicle used to denote the various ways through which human beings relate to what they believe to be the creator. The creator is believed by many to be a Higher or Supreme Being with omnipotent power and authority to create and sustain the earth and all its living and non-living things.

Spirituality has been defined as: "The quest for understanding life's ultimate questions and the meaning and purpose of living, which often leads to the development of rituals and a shared religious community" (Marche, 2006:50). According to Hoyer and Roodin (2003),

spiritual feelings and beliefs appear to be related to health and adults report that spirituality contributes to enhanced feelings of well-being, inner emotional peace and satisfaction with life. He points out that spirituality and participation in formal religious services are regularly identified elements in the lives of many centenarians. He also states that older adults who attend religious services regularly and participate in the formal structures of organised religion show improved health status, reduced incidence of chronic disease and more effective coping with stress.

According to Duprey, Bhasin, Gupta and Sharma (2011), there is a common belief in India that in old age people tend to become more and more inclined towards religion and that to an extent, religion provides a sort of social support in the form of personal gatherings with whom they could share their thoughts. Marche (2006:52) adds: "Religious affiliations may also help relieve symptoms of anxiety and depression by offering a social network." Jain, Sharma and Joshi (2013) assert that religious coping is one of the most preferred coping strategies by older people and observe that health professionals are beginning to appreciate seriously the role that religious faith plays in the lives of older people, particularly those with chronic illness and disability. They also state that medical research is showing that many older people are religious and depend on religion as a major way of coping with physical, health and emotional problems. Marche (2006) points out that religious coping strategies might include reading scripture, prayer, meditation, religious beliefs, and community support. He explains that these methods of coping have been employed by seniors to deal with stress, illness, disability, dying, bereavement and social isolation.

Therefore, participation in spiritual and religious activities is one of the significant activities for the aged in institutional care homes. Marche (2006:50) states: "Researchers have sought to measure religiosity based on variables such as church-attendance and involvement in institutionally organised activities." Marche adds that statistics show that seniors in Canada tend to be very involved in religious activity and are most likely to attend religious functions on a regular basis. Marche further states that given the increase in the senior population in Canada, and the importance of religious involvement for seniors, it is important that further consideration is given to the spiritual care needs of this growing population. This should include the aged residing in institutional homes.

In a research article titled ‘Spiritual Needs of Elderly Living in Residential/Nursing Homes,’ Erichsen and Büssing (2013) contend that the elderly living in residential and nursing homes have specific psychosocial and spiritual needs which are in most cases not recognised and can thus not be addressed. They recommend that adequate health care for the elderly should not only consider decreasing functional capacities of elderly, but also the individual’s perception of health and self-esteem. The implication of this observation is that caregivers in institutional homes have the tendency to underestimate the significance of psychological and spiritual needs of their clients and the impact these needs have on the lives of elderly persons.

### **3.12.6 Counselling**

The other service provided to the aged that was considered in the review of literature was counselling. Perez (1965) defines counselling as an interactive process co-joining the client, who is vulnerable and who needs assistance, and the counsellor who is trained and educated to give this assistance, the goal of which is to help the client learn to deal more effectively with himself/herself and the reality of his/her environment. Counselling is an information-exchange process, with the additional component of sharing feelings and emotions that the client finds difficult or disturbing.

Manthei and Nourse (2012) state that although all people face challenges as they age, they are never too old to learn new skills, change their behaviour, grow in insight and understanding, or maintain good emotional health. They argue that although older people are used to getting on with life themselves, it is recognised that a skilled professional can be useful at times by helping them to:

- Understand and move through depression.
- Reduce personal anxiety and/or stress.
- Make their own decisions about issues they find challenging.
- Improve their relationships with others.
- Develop their sense of well-being.
- Come to terms with events and decisions in their lives.

Counselling is vital to the welfare and well being of the aged in old people’s homes because residing in an institutional set-up can be a challenge in itself. Once admitted to old people’s homes, the aged have to adapt to a new environment and fit into the routines that go with

institutionalisation. They, in many cases, have to live with strangers in this set-up. Through counselling, therefore, the aged may be assisted to cope with their new life and environment and live more positively, especially that some of them may live in old people's homes for a long time, with some living there for the rest of their lives. Kaplan (1953) points out that an old people's home should fill a social usefulness for its residents. It must contribute to the emotional and physical well-being of the people residing in it. It should also create a warm, friendly atmosphere, not only to preserve the assets of the senior citizens but also to increase their capacity for adjustment.

Manthei and Nourse (2012) assert that those living with or caring for the elderly might also need emotional support and professional counselling since the role of caregivers can be challenging and can exact an emotional toll. They explain that caregivers and/or family members may need help in planning for their own future as carers, or in dealing with stress and fatigue. They further point out that caregivers might also need help in dealing with anger or guilt they may feel toward the elderly in their care. Bernstein (1990) posits that there are a number of specialised areas of knowledge that are essential for effective counselling. He adds that counsellors need to understand how the elderly age and how they react to that ageing and to loss. This includes understanding both the normal ageing process and the common problems of ageing, such as biological loss; emotional reactions to changes in health, family, work, and social networks; and fear of change and diminished potency in key areas of life.

### **3.12.7 Efficacy of Services provided by Institutional Homes**

Drennan et al. (2012) assert that the vast majority of older people in receipt of care in the residential sector in Ireland are cared for in high quality, safe and supportive settings. He, however, explains that there is also international evidence to suggest that a significant minority of older people in residential homes are nursed in inadequate physical environments and experience a loss of personal freedom.

Overall, institutional homes provide important services to the needy aged in different situations and context. The homes strive to provide basic necessities of life and other services that are relevant to the welfare and wellbeing of elderly residents. In his study titled 'A Sociological Study of Old Persons Residing in an Old Age Home of Delhi, India', Lalan (2014:22) describes the services provided by one old people's homes in India as follows:

The old age home provides all the necessary facilities to the old persons such as lodging/boarding, clothing and bedding, case work and counselling services, medical care, television, radio and religious discourse, newspaper and other programmes, helpers to assist the bedridden or incapacitated. Occasionally, old persons are taken out by special transport to other religious places. Staff include: one superintendent, one welfare officer, one staff nurse, one part-time doctor, one upper division clerk, one care taker, one house attendant, one lady maid, two cooks, two washer men, four sweepers and one-time barber. Every old person gets his/her bed tea at 6 a.m. and they are served with breakfast from 9.00 a.m. to 10.00 a.m., which includes bread, milk and fruits. They visit the library between 1.00 a.m. and 12.00 noon. Lunch is served from 13.00 to 14.00 p.m. and food items include unlimited *roti*, rice, pulse, vegetables, cheese or one egg. Every old person gets some items for daily use, such as tooth paste, bath soap, washing powder. They take rest till 5 p.m. and then they have dinner.

The above statement highlights efforts by an old people's home aimed at taking care of elderly residents through provision of a variety of services, which they may otherwise not have received in their communities due to their disadvantaged socio-economic status. The statement has shown an example of comprehensive provision of services to the aged in a typical old people's home in India. Old people's homes in other contexts such as Zambia, could pick a leaf from the above examples and offer relevant and appropriate facilities to their elderly residents.

In a study titled 'Institutionalisation and Quality of Life for Elderly People in Finland', whose aim was to examine whether there were systematic differences between the quality of life of an individual who is institutionalised and one who is not, Böckerman, Johansson and Saarni (2011) established that when controlling for health and functional status, demographic and income level, individuals who lived in old people's homes actually reported significantly higher levels of subjective wellbeing than those who lived at home. They argue that this finding could be explained by the waiting lists of older persons for care homes. They state that this implied that there were individuals living at home who were so frail that they should really be living in an institution for elderly people, but because of the waiting lists for these institutions, they were living at home with a decreased quality of life as a consequence.

In his PhD Thesis titled 'Quality of institutional elderly care in Slovenia', Habjanic (2009) conducted interviews with staff members, residents and relatives on various aspects of institutional care in Slovenia. He established that all the three parties agreed that quality of institutional elderly care should comprise good physical care, sound communication, friendly

relationships, more time for treatment and adequate staff regulations. He also explains, however, that the three categories of respondents also differed in their emphasis on some aspects of service provision. For example, residents emphasised sound communication in form of conversations but did not emphasise personal hygiene. Staff members, on the other hand, emphasised the importance of having appropriate numbers of staff and regulatory standards for nursing interventions. Staff members also pointed out that opportunities for further education and training for staff should be available, if possible, financed by nursing homes or the government, while relatives were mainly concerned about the safety of the elderly residents, food quality and liquids which should be made available (Habjanic, 2009:125).

Simone (2008) observes that other than a pleasant living environment and advanced facilities, a lively atmosphere with homely touches and personal privacy should be provided in homes for the elderly. He states that home-style touches can be projected by carefully selected furniture and decorations, while a lively atmosphere can be created by a friendly neighbourhood and staff, as well as interesting activities organised for the residents. Simone (2008) further states that different classes covering a range of interests and entertainment as well as various pass-times should be arranged periodically to make living in the elderly home more interesting and less boring. He explains that friendly and caring staff in the institutions can also help satisfy the needs of the elderly. He further explains that if staff chatted with the elderly residents daily and showed care and compassion to them, it would help stimulate a more home-style atmosphere and reduce loneliness. This implies that there should be training and orientation programmes for caregivers in order to equip them with the above aspects of elderly care. The importance of education and training for caregivers working with the aged, can, therefore, not be overemphasised.

Furthermore, a research on 'Improving quality of life for older people in long-stay care settings in Ireland', Murphy, O'shea, Cooney, Shiel and Hodgins (2006) highlighted the need for residents' engagement in meaningful activities as a way of enhancing quality of life in an institutional setting. The research noted that the quality of life experienced by residents in long-stay care facilities is enhanced by:

- The inclusion of the widest possible range of purposeful activities.



- The inclusion of activities with which residents have been familiar and interested in the past.
- Consultation with residents to identify their preferences for activities.
- Provision of opportunities to ‘get out’ of the facility in order to take part in activities.

The findings by Murphy, O’shea, Cooney, Shiel and Hodgins (2006) are in line with activity theory which proposes that successful ageing occurs when older adults stay active for as long as possible and maintain social interaction. The theory adds that successful ageing is highly dependent upon older persons maintaining a high level of activity. The findings are also consistent with continuity theory which states that patterns of ideas, skills and interests which people use to adapt and act develop and persist over time.

According to the literature reviewed, other services provided to the aged in institutional homes include personal care services which are available to older persons who are physically disabled, frail or generally ill. These services include bathing, using the toilet, putting to and taking out of bed, washing clothes, laundry, taking medication and preparing food (Kamwengo, 1997). Additionally, Simone (2008:324) states: “Other than basic personal care, more advanced personal services could be introduced. For example, regular body or foot massages for the elderly, daily walks and stretching activities for the disabled.” However, the literature review established that there was a dearth of literature on the adequacy of services provided to the aged in institutional homes in Zambia, hence the relevance of this study.

### **3.12.8 Monitoring the Quality of Services in Old People’s Homes**

In this study, the researcher was also interested in finding out whether there existed any mechanisms for measuring and monitoring the quality of services provided in old people’s homes. The literature reviewed indicated that countries had different ways of monitoring standards of care and ensuring quality in the delivery of care to the aged in old people’s homes. For example, in England, since 2003, all home care provider organisations have been required to register with the Care Quality Commission (CQC), formerly the Commission for Social Care Inspection, the independent regulatory body overseeing the quality of all English health and social care services. Providers must comply with core national quality and safe standards which include respect for users’ dignity and rights; evidence of the organisation’s financial viability; and good quality management. In addition, CQC promotes improvement

in the service quality by assessing and publishing information on the quality of care over and above minimum standard benchmarks. Regular inspections, announced and unannounced, of providers are undertaken and these may also be prompted by complaints made directly to the CQC (Glendinning, 2012).

Actions to enforce the minimum quality and safety standards in care homes in England include increased monitoring, site visits and improvement and compliance actions in which providers are legally obliged to report how they will achieve and maintain quality standards. Glendinning (2012:297), however, states: “Despite these quality control measures, the underfunding of home care services in general continues to be reflected in poor quality.”

In Australia the government has implemented a number of measures to monitor the quality of care and services provided in Australian government funded aged care homes. All funded homes must meet required accreditation standards and demonstrate continuous improvement regarding the quality of care and services provided to residents. The Aged Care Standards Accreditation Agency assesses aged care homes for accreditation and monitors homes to ensure their ongoing compliance with the accreditation standards. The Department of Health and Ageing may impose sanctions on aged care homes that have not met the requirements of the Aged Act 1997 (Five Steps to Entry into Residential Aged Care, 2011).

All aged care homes in Australia must provide a specified range of care and services to residents. These requirements vary according to each resident’s care needs. Nonetheless, for all residents, services should include things such as:

- i. Staff to provide help at all times, including in emergency situations.
- ii. Assistance with daily living activities such as bathing, showering, dressing and mobility.
- iii. Assistance with medications.
- iv. Meals and refreshments, taking into account special dietary needs.
- v. Basic furnishings including carpets, curtains, chairs, beds and bed linen, bath towels, face washers and toilet paper.
- vi. A laundry service, cleaning services and maintenance of buildings and grounds.
- vii. Social activities.

For residents with high level care needs, the services should also include such things as continence aids, basic medical and pharmaceutical supplies, nursing services and therapy services. Furthermore, all residential aged care homes are required to employ suitably skilled and qualified staff to provide assistance to residents. For example, all residents with high level care needs must have any nursing services carried out by a registered nurse (Five Steps to Entry into Residential Aged Care, 2011:2).

### **3.12.9 How the Quality of Elderly Care in Old People's Homes can be Enhanced**

The researcher reviewed literature on how the quality of elderly care in old people's homes could be enhanced. A review to examine the research evidence available to support improved care for older people in residential homes in England by Szczepura, Clay, Nelson and Wild (2008) points out that quality improvement interventions in care homes should include monitoring quality of care, strengthening the care-giving workforce and building organisational capacity. It, however, cautions that simply providing care homes with comparative quality performance feedback, access to training and performance incentives does not appear to lead to significant improvements, but that adding real-time feedback of adherence may produce improvements although these are not sustainable. The review concludes that quality improvement is more likely to be successful in institutional homes with a culture that promotes innovation and staff empowerment.

In his PhD Thesis titled 'A Study of the Intention of Elderly Institutionalisation: The Impact of Chinese Values – Hsiao and Bao', Simone (2008) suggests that the following ideas could help to improve the standards of care for the aged in old people's homes:

- Regulations and guidelines on the operation of old people's homes should be enacted in order to guide caregivers and stakeholders on service provision to the aged.
- The government should take the initiative of educating people on elderly knowledge and caring skills.
- There should be a stable supply of human resources to old people's homes in order to enhance provision of care for residents.
- Training in elderly care should be organised by the government. For example, it should be added to the curriculum of employee retraining programmes organised by the government in order to maintain a consistent supply of skilled labour.

- The government should develop care giving skills as professional knowledge through a licensing system or educational system, just as nursing is recognised as a specialist profession.
- The government should set up professional geriatric nursing for elderly residential care services, which would not only enhance the status of the job but also help boost the morale of workers.
- The government should support other associations to operate elderly residential care services and encourage voluntary associations to operate care services through provision of land, facilities or subsidies (Simone, 2008:331).

In order to ensure that minimum standards of care are observed by institutional homes for the aged, it is necessary that guidelines and regulations are put in place for caregivers and other stakeholders to follow. However, the literature review revealed that there were no written guidelines on how the standards of care for the aged in old people's homes could be improved and how the quality of elderly care could be enhanced in Africa, and Zambia, in particular, hence the significance of this study.

### **3.13 Challenges Faced by the Aged**

The researcher further reviewed literature to help him understand challenges the aged in the community and those residing in institutional homes faced. To start with, Oluwabamide and Eghafona (2012) assert that until recently, older people in African societies faced little or no challenges. They point out that this was because what today constitute challenges did not exist in the past and that prior to contact with or evolution of factors that brought about social and cultural change, African cultures did create conditions of comfort, adequate care and respect for the elderly. They, however, contend that older people in African societies have in recent times been facing a great deal of challenges which have affected their perception of ageing. These challenges have emanated from modernisation and other agents of change. Oluwabamide and Eghafona (2012) explain that the interdependence that used to be the hallmark of the extended family in African societies is gradually being replaced by emphasis on the autonomy and independence of the nuclear family consisting of a man, his wife or wives and their children. They point out that usually within the extended family structure, the aged were given a pride of a place and adequately catered for by other members of the family, but with the recent emphasis on the nuclear family, the aged are being gradually

ignored. They further explain that the mutual obligations of the extended family are being systematically eroded by increased emphasis on material success and individualism. This implies that due to the fast changing socio-economic environment in which the nuclear family has generally taken centre-stage, some elderly persons may no longer be assured of adequate care and support from their children or other family members. Consequently, some may endure hardship and destitution and even end up in old people's homes. Abanyam (2013:41-42) states:

This change has resulted to the evolution of many problems, which the elderly did not experience before the coming of the Europeans. In African societies today, elderly people are abandoned by their families and some are kept in nursing homes where they experience the worst dehumanising and agonising conditions.

The literature reviewed has indicated that the aged, both in the community and in institutional care face a number of challenges in their day-to-day lives. These challenges are at individual and societal levels. They are discussed below.

### **3.13.1 Low Self-esteem and Loneliness**

One of the main challenges faced by the aged, according to the literature reviewed, is low self-esteem and loneliness. Self-esteem, also known as self-regard, is defined as people's evaluation about their own worth, competence and desirability (Konrath, 2012). Loneliness, on the other hand, is a situation experienced by an individual as one where there is an unpleasant or inadmissible lack of certain relationships. This includes situations where the number of existing relationships is smaller than considered desirable or admissible as well as situations where the intimacy one wishes for has not been realised (Gierveld, 1998).

In his PhD study titled 'Population Ageing in Zambia: Magnitude, Challenges and Determinants,' Mapoma (2013) indentified challenges faced by the aged, both those living in the community and those living in old people's homes in Zambia at two levels, namely, individual and socio-economic or environmental levels. He points out that the main individual level challenge amongst older people was low self-esteem and loneliness. He explains that throughout his discourse, it was clear that almost all other challenges, both at micro and macro levels, fed into the exacerbation of low self esteem and loneliness and that other individual or micro level challenges that were reported included health problems and functional limitations among the elderly. Mapoma (2013) states that his study established

that the aged residing in old people's homes reported experiencing more loneliness (55.6%) compared to those in communities (51.7%). He explains that this situation was not out of the ordinary because majority of the people in homes for the aged were restricted or less free compared to their counterparts in communities.

Furthermore, in a study titled 'Changes in the factors related to loneliness in older men: The Zutphen Elderly Study', Tijhuis, De Jong-Gierveld, Feskens and Kromhout (1999) point out that older people experience an increase in loneliness as they age. The study indicates that very old people appear most prone to loneliness, possibly because of loss of close ties and increasing dependency. The study also shows that in the process of loneliness, it is not the status of health and social relationships that is important, but a change in these characteristics. The study explains that losing a partner, deterioration of health and institutionalisation influence loneliness among elderly people. The study concludes that age is only related to loneliness in the very old. However, the weakness of Tijhuis, De Jong-Gierveld, Feskens and Kromhout's study was that it only investigated loneliness in older men to the exclusion of older women.

### **3.13.2 Lack of Appropriate Health Structures for the Aged**

The other challenge faced by the aged, according to the literature reviewed was lack of appropriate health structures for the aged. Mapoma (2013) observes that health in old age has not only to do with the presence or absence of disease and adds that availability and quality of care is very important. He, however, points out that care for older people especially in developing countries, is in a general sense dwindling and without properly developed institutional care systems supported by the state, health conditions for older people will become even more challenging, and may lead to other problems. Kamwengo (2004:64) adds: "Many elderly people have more than one chronic health problems and these problems result in a sick role that makes the elderly assume a dependent role." Simone (2008), therefore, recommends that regulations which would compel all old people's homes to have geriatric nurses, therapists and social workers should be enacted.

Five Steps to Entry into Residential Aged Care (2005) reveals that in all aged care homes in Australia, individual residents are entitled to choose their own doctors and if the doctors do not visit their care home, they will be assisted in choosing an alternative. The aged care

homes help residents to access any health care services they need, whether this is a doctor or another health care professional. However, in the Zambian context, this arrangement may not be feasible owing to the shortage of medical personnel and specialised medical facilities. Kaplan (1953) explains that the Walker Methodist Home for the Aged in Minneapolis was the first home in the United States of America to set up an occupational therapy department for its residents. In 1946 it hired an occupational therapist, whose primary job was to open up recreational opportunities for the residents.

Ndonyo (2011) conducted a study on Healthy Ageing in Zambia, whose purpose was to respond to the global concern and the United Nations Plan of Action on Healthy Ageing. The objective of this baseline data was to provide a documentary analysis of information on policies and guidelines on healthy ageing programmes in Zambia, determine an insight perspective of health needs of older persons in order to make recommendations that would strengthen healthy ageing programmes and policies in the country. The findings showed that there was lack of appropriate structures in the health care systems to address the needs of elderly people in Zambia and that only one sector, the Ministry of Community Development and Social Services (MCDSS), now the Ministry of Community Development, Mother and Child Health (MCDMCH), had attempted to provide limited structures and enacting a national policy framework on ageing in Zambia.

The findings of Ndonyo (2011)'s study further showed that health policies and programmes had not set priorities to address issues on geriatric medical care in the health system. The study also indicated that there was lack of effective coordination between the health delivery system and social services in the provision of health needs for elderly people and this was found to be a major challenge in the provision of care among older persons with chronic disabilities. The study recommended that policy framework guidelines be redesigned in order to facilitate development of the Healthy Ageing programme in Zambia within the framework of public health care. It further recommended that health promotion should aim at promoting activities, initiatives and structures which would enhance the wellbeing, health, choice, independence and quality of life for all ages.

### **3.13.3 Age-Related Ailments**

The other challenge that the aged face, according to the literature reviewed, is age-related ailments. Winston (1947) states that many of the most compelling problems of the aged

centre around their physical condition. Those who have no marked infirmities and require only periodic general medical supervision create relatively little problem. The second group, however, are infirm as well as aged with permanent physical disabilities, so they require regular medical care and often regular physical care. These are persons who are partially able to meet their own needs but for whom special provisions must be made. The third group consists of the chronically ill, a considerable proportion of whom are bedridden. These are the most difficult to deal with as facilities for the chronically ill are inadequate at best with facilities at a moderate rate totally non-existent in most communities.

With ageing comes increased prevalence of age-related diseases such as cardiovascular diseases, diabetes, arthritis, Alzheimer's and other dementias (Brijnath, 2012). According to Mapoma (2013), apart from low self-esteem and loneliness, the aged living in the community and those in old people's homes also face the challenge of ailments. He states that the main ailments reported by the aged in his study included general body pains and headache, backache, respiratory infections, sight problems, malaria, high blood pressure and stomach problems. Others included non-communicable diseases such as diabetes and stroke. The global prevalence of diabetes is around 10 percent and more than 80 percent of diabetes deaths occur in low and middle income countries. Global ageing is recognised to be a major factor in the increasing predominance of non-communicable diseases in developing countries. The prevalence of chronic illness increases significantly in old age. Older people in low and middle income countries are at especially high risk of cardiovascular diseases, stroke, diabetes and dementia (HelpAge International, 2013).

#### **3.13.4 Functional Limitations**

Mapoma (2013) asserts that another notable challenge older people face is their inability to perform certain functions considered important to day-to-day living. He explains that functional limitations are mostly a consequence of declining health and that increases in functional limitations also require increase in care giving. Mapoma further explains that old age and ill-health limit the elderly persons' capacity to perform certain roles and functions. Functional limitations among the aged have obvious implications for staffing levels among caregivers and medical staff and other personnel whose services may be needed more than for other age groups in the population.



### **3.13.5 Poor Sanitary Facilities**

According to the literature reviewed, the aged also face the challenge of poor sanitary facilities. Mapoma (2013) points out that good sanitary facilities as well as good and reliable sources of drinking water are good markers of health, not only to the community generally, but to elderly persons as well and can be a source of health challenges if not available. He states that in his study, over half of the elderly respondents reported that they used pit latrines as toilet facilities. Mapoma explains that while it is recognised that this finding was consistent with findings from the 2007 Zambia Demographic and Health Survey (ZDHS), where the commonest sanitary facility available to most households was the pit latrine, it also demonstrated that senior citizens were more likely to use pit latrines compared to the general population in Zambia.

In his study titled ‘Quality Institutional Elderly Care in Slovenia’, Habjanic (2009) points out that there was generally poor hygiene in homes for the aged and lack of physical activities in Slovenia. He also points out that the levels of cleanliness in the apartments were unsatisfactory. His study concludes that relatives of the institutionalised elderly expressed dissatisfaction with the care offered in care homes and described it as deficient. The literature reviewed showed that there was a dearth of information on this aspect of service provision in old people’s homes in Zambia.

### **3.13.6 Lack of Privacy**

The other challenge faced by the aged in institutional homes, according to the literature reviewed, is lack of privacy. Ngwane (2011) posits that as people age, they experience privacy loss due to health care needs particularly in nursing homes. Consequently, balancing care giving of elders with respect for private boundaries represents a challenge to health care providers. Ngwane also points out that most often people think of privacy only in terms of their bodies being exposed, but that lack of privacy is also related to handling of patient information and residents not being able to be alone when they feel the need to do so.

The study titled ‘Improving quality of life for older people in long-stay care settings in Ireland’ by Murphy, O’shea, Cooney, Shiel and Hodgins (2006) established that the elderly in care homes in Ireland considered the physical and social environment of the facility to be key determinants of residents’ quality of life. The study revealed that the identified major

negative impacts on quality of life of the aged were lack of privacy and an institutionalised approach to care. The study concluded that a shift to individualised and person-centred care was viewed as central to improving quality of life and well-being of the elderly in long-stay care. Bland (2005) explains that privacy in residential care can be violated in very many ways. Bodily privacy involves issues of nudity and few residents wish staff to be involved in intimate personal care activities such as using the toilet or taking a bath or shower. It also extends to the right to privacy of information held on the residents by the home. Bland, (2005) asserts that for most people the privacy of their own room is crucially important to their quality of life in residential care.

Cooney (2012) states that issues that support residents' ability to maintain their identity include opportunities for them to be on their own, privacy, having their personal belongings around them and feeling known and valued as individuals. The most visual way in which residents express their identity is through personalisation of their space. Residents who have a room of their own have greatest opportunity to create personal space. Old Age and Ethics of Care (2008) posits that respecting privacy often requires giving consideration to the small things that nevertheless may be very important to the elderly, but that those in need of extensive help are at risk of losing their privacy and human dignity. It states that personal hygiene, sensitive personal data and personal relationships are examples of private matters and everyone working with the elderly has an ethical obligation to keep those issues confidential. It states that the right to privacy is also the constitutional right of institutionalised patients.

Petterson and Sidenvall (2007) point out that in the old types of Swedish nursing homes, several persons lived in the same room. Over the past few decades, however, buildings have been modernised, providing one-room flats that allow residents to have their own private sphere. On the other hand, in a study on 'Transition to residential care: expectations of the elderly Chinese in Hong Kong,' Diana (1999) established that the Chinese values of balance, harmony and collectivism made it easier for elders in residential care homes to remain open and accept the communal way of living and consequently not bother so much about issues of privacy.

The implication of the foregoing is that the aged are entitled to privacy, dignity and protection from any harm. Additionally, caregivers should be properly trained and well

remunerated for them to better offer service to the aged and guarantee some level of privacy. The aged also deserve respect from caregivers and members of the public so that they feel a sense of self-worth and esteem.

#### **3.13.7 Lack of Social Contact**

The other challenge faced by the aged, according to the literature reviewed, is lack of social contact. Groenewald and Van Vuuren (1998) posit that social contact with the outside world, particularly via their children, relatives and spiritual workers, is very important for the elderly. They point out that there is always the possibility, however, that this contact may decrease when an elderly person moves into an old people's home and that he/she may become increasingly socially isolated. They explain that the elderly in old people's homes have had to detach themselves from their familiar surroundings, and sometimes also from their friends but that this process of detachment is not an absolute breaking of ties with significant others and hence, contact with these significant others remains important for the elderly.

Nyanguru (1990) adds that social contacts and relationships are very important for people in homes for the aged. He explains that his study showed that in Zimbabwe a high percentage of European respondents had relatives and friends who visited them, while very few Africans had had visitors since they entered the homes. He explains that most African respondents did not have any relatives visiting them probably because, as immigrants, they had no relatives in Zimbabwe. Nyanguru (1990) goes on to point out that in the absence of relatives, friends are an important source of social contact for the aged, with another source being fellow residents in the homes. He concludes that friends are very important in reducing loneliness and enhancing the quality of life of the elderly in homes for the aged.

#### **3.13.8 Lack of Palliative Services**

The literature reviewed further showed that lack of palliative services was one of the challenges faced by the aged, especially in the Third World context. By palliative care is meant the active total care offered to a person and his/her family when it is recognised that the illness is no longer curable, in order to concentrate on the person's quality of life and the alleviation of distressing symptoms. The focus of palliative care is neither to hasten nor postpone death. It provides relief from pain and other distressing symptoms and integrates the psychological and spiritual aspects of care. It offers a support system to help relatives and

friends cope during an individual's illness and with their bereavement (WHO, 2004). Zambia has a large unmet need for palliative care services for patients suffering from various terminal and chronic illnesses. It is reported that 14.3 % of Zambians are living with HIV and a proportion of these require palliative care services, and there are many more Zambians with other life-limiting illnesses that also require this care. Patients with life-limiting illnesses and their families mostly receive physical care without support for their psychological, social and spiritual care needs. There is, therefore, need to scale up palliative care interventions in Zambia which are already being provided by public and private practitioners as well as community/home-based care programmes (National Health Policy, 2012).

### **3.13.9 Ageism**

The other challenge the aged face, according to the reviewed literature, is ageism. Hendricks and Hendricks (1981) state that gerontologists have coined the term ageism to refer to the pejorative image of someone who is old simply because of his or her age. They explain that like racism or sexism, ageism is the wholesome discrimination against all members of the category, though usually it appears in more covert form. Hendricks and Hendricks (1981) explain that threatened cutbacks in social security, failure to provide meaningful outlets or activities, or the belief that those in their sixties and beyond do not benefit from psychotherapy are all examples of subtle, or in some cases, not so subtle, appraisals of the old. They further explain that part of the myth, which is a fundamental if implicit element of ageism, is the view that the elderly are somehow different from others' present or future selves and, therefore, not subject to the same desires, concerns or fears. Hendricks and Hendricks (1981) conclude that ageism can be detrimental to the wellbeing of the aged as it can lead to their discrimination and exclusion from certain activities and services just on account of their age. Ageism affects both the aged living in the community and those in institutional homes. However, Kamwengo (1997:69) asserts: "The aged in the community are more likely to be subjected to emotional and physical abuse than those in institutional homes."

Lalan (2014), therefore, suggests that the nations of the world must create an environment in which ageing is accepted as a natural part of the life cycle, where anti-ageing attitudes are discouraged, where older people are given the right to live in dignity, free of abuse and exploitation and are given opportunities to participate fully in educational, cultural and

economic activities. This entails that the aged, including those residing in old people's homes, should be considered worthwhile members of the community, whose needs should adequately be met and whose interests should be protected.

### **3.13.10 Loss of Respect**

The literature reviewed indicated that loss of respect is another challenge faced by the aged, especially in Africa. Abanyam (2013) asserts that prior to the contact with the West, older people were highly valued in African society because of their accumulated knowledge and wisdom, which they used to settle disputes, integrate the society and educate the young. In return, they enjoyed many privileges in the society. However, changes in the structure of African society occasioned by the introduction of formal education by the West neutralized this traditional system of caring for older people as they are now facing many challenges.

Oluwabamide and Eghafona (2012) explain that in this era of modernity, the elderly in Africa are no longer respected, which is a clear departure from what it used to be in the past. They state that in the past children and younger adults usually had reverence for older people and this was a norm. Oluwabamide and Eghafona (2012) further state that in urban centres, there is no longer regard for the aged, especially among young people. This lack of respect for the aged has some implications for their welfare. They may be discriminated against and abused by the young who may not have much regard for their wellbeing and interest. Oluwabamide and Eghafona (2012) give an example of public places where feeble adults may be left standing while energetic young one sit down which they say is a departure from African culture which prescribes that younger persons should stand up and invite the elderly to sit.

In summary, Nyaruhucha, Msuya and Matrida (2004:252) highlight the challenges faced by the institutionalised and non-institutionalised elderly persons in Tanzania in their study when they state:

...Other problems noticed among elderly people in institutional homes in Tanzania were availability of only a single meal per day and absence of recreational facilities. The study further reveals that only 33% (sample = 100, i.e. 50 institutionalised and 50 non-institutionalised) of both institutionalised and non-institutionalised attained primary level of education while the rest had no formal education. Other common problems noted for both institutionalised and non-institutionalised respondents were lack of immediate assistance as required, and little or absence of health services.

It is evident from the foregoing that the aged, both in the community and institutional homes face challenges in their day-to-day lives. Useful insights could be got from these challenges

and learnt from, especially that most of them may not be peculiar to a particular country or context. There is need to address some of the challenges so that the aged could be viewed more positively and provided with the services they need. The next section discusses the challenges faced by caregivers in old people's homes.

### **3.14 Challenges Faced by Caregivers in Old People's Homes**

This section presents literature on challenges faced by caregivers in institutional homes for the aged. A caregiver, in this context, is a person who provides support and assistance, formal or informal, with various activities to persons with disabilities or long-term conditions, or persons who are elderly. This person may provide emotional or financial support, as well as hands-on help with different tasks (WHO, 2004). The literature review revealed that caregivers face a number of challenges in their provision of services and care to the aged in institutional homes and the major ones are presented below.

#### **3.14.1 Financial Constraints**

One of the major challenges faced by caregivers in old people's homes is financial constraints. Care Homes for Older People in the UK (2005) states that the residents of care homes for older people in the United Kingdom can broadly be funded in the following ways:

1. Self-funders, which entails private residents paying fees in full themselves.
2. Private residents, where a representative of residents is paying some or all of the fees on their behalf.
3. Residents funded by their own pension and other benefits and partly by their Local Authority or Trust.
4. Residents funded by their own pension and other benefits and partly by their Local Authority or Health Trust, but who also have a 'top up' fee paid by a third party.
5. Entirely National Health Services (NHS) funded.

However, Glendinning (2012) reports that long-term care in England is widely acknowledged to be seriously under-funded relative to levels of need. He explains that despite sharing demographic pressures common to all European countries, there has been a continuing political failure to achieve a comprehensive, sustainable and equitable basis for funding social care in England and that since 1998, several official and independent committees of

enquiry have proposed funding reforms, but failed to secure the necessary political commitment.

Glendinning (2012) adds that local authorities in England are responsible for funding and ensuring the provision of home care services which are financed from central and local taxation. Although accountable to central government through a range of financial controls and performance management mechanisms, local authorities are able to decide the proportions of their overall budgets to be allocated to different services. Persistent Challenges to Providing Quality Care (2012) states that in England people are being admitted with more severe and complex care needs, but with inadequate funding allocated to meet their needs as both social care and Continuing Health Care (CHC) eligibility criteria are being tightened.

### **3.14.2 Inadequate staff**

The literature reviewed indicated that the other major challenge faced by caregivers in institutional homes for the aged is inadequate staff. Persistent Challenges to Providing Quality Care (2012) asserts that in England the shortage of care assistants and registered nurses was reported to be among the top issues that most frustrated caregivers about their jobs. It, however, explains that while many members felt that staffing levels was a key issue and concern for them, the lack of guidance on staffing levels in care homes made it hard to quantify the extent of the problem. It states that what was clear was that staffing levels was an issue that put considerable pressure on staff. Low staffing levels impacted on the quality of care that they could deliver and many caregivers felt that the care they were delivering fell short of their own expectations. Low staffing levels also compounded the pressure care homes had with meeting the needs of residents with higher dependency and more complex needs.

Furthermore, in their study titled 'Care home residents' experiences and social relationships with staff,' Cook and Brown-Wilson (2010) posit that getting to know staff in terms of their names, personal details and interests is complex for older residents. They explain that care homes are busy social environments where the routines of the home tend to influence the extent to which residents and staff interact with each other. Knowing staff is important to older residents as they are able to identify who they could trust, who would treat them with dignity and would be willing to meet their preferences. Discontinuity in staffing contributes

to uncertainty and heightens awareness of the need to continuously negotiate care. Exchanges between residents and staff provide opportunities to share personal information, which lead to familiarity with the other person's background and mutual understanding of their life circumstances. The implication is that there should be adequate provision of staff in old people's homes to take care of the unique needs of the elderly residents. There should also be continuity and security of tenure among staff so that they work long enough in the homes, understand the needs and aspirations of the residents and, ultimately, provide them with appropriate care.

In a study titled 'The Composition of Old Age Homes in South Africa in Relation to Residents and Nursing Personnel', Perod and Muller (2000) established that overall, there was a serious shortage of the much needed registered nurses at some old age homes in South Africa. The study shows that 5 (0.03%) old age homes indicated that they had no professional registered nurse on the staff establishment although they took care of a 24-hour based frail care service. Sixteen old age homes (11.03%) had only one registered nurse while 30 (20.69%) had two registered nurses on the personnel establishment to take care of a 24-hour based frail care service. The study concluded that a serious shortage of professional nurses prevailed in old age homes resulting in unacceptable low ratio of registered nurse in relation to the residents and registered nurse in relation to the other nursing personnel (enrolled category/lay health workers). The study further concluded that lay workers comprising unregulated geriatric caregivers, with no formal nursing training, constituted 42.22% of the total nursing workforce in old age homes in South Africa which was unacceptably high for frail care.

Where residents of old people's homes have a high level of physical dependency in relation to capacity to perform the activities of daily living, staffing levels will need to reflect the needs of those residents. Where they require significant nursing attention, the skill mix of the staffing establishment must be adjusted accordingly. Residents with dementia also require care from appropriately skilled staff. In determining appropriate staffing establishments in all care homes and in nursing care homes in particular, the regulatory requirement that staffing levels and skills mix are adequate to meet the assessed and recorded needs of the residents at all times in the particular home in question must be met (Care Homes for Older People: Minimum Standards, 2003).



### 3.14.3 Lack of Training Opportunities

The other challenge faced by caregivers in old people's homes, according to the literature reviewed, was lack of training opportunities. Training is a planned activity, or sequenced set of activities aimed at developing appropriate skills, knowledge and attitudes of participants for improved performance at individual, organisational and national levels (Public Service Training Policy, 1996). Training means a structured learning experience directed towards acquiring specific knowledge, skills and attitudes required for effective performance in the current job and future roles (Procedures and Guidelines for Human Resource Development in the Public Service, n.d.).

In order for caregivers to provide appropriate services and care to the aged in old people's homes, it is important that they possess knowledge and skills on how to deliver these services and care. It is, therefore, important to provide education and training opportunities to caregivers to enable them perform their duties professionally and more diligently. Blackburn and Dulmus (2007) postulate that education interventions are designed to provide caregivers with critical information that will enhance their abilities to provide care and cope with associated stress of looking after the aged. They explain that most of these programmes are intended to either increase the knowledge or skills of caregivers to provide care or address their psycho-emotional needs by teaching self-care or coping skills. They also explain that skill-focused educational programmes include those that teach about specific disease processes, direct care skills and behaviour management.

According to Beringer, and Crawford (2003), there is a relationship between nursing home outcome and staffing levels. They also state that lack of staffing, skill-mix, training and services leaves the elderly people at risk of harm. They suggest that care facilities should make a greater investment in staff training and professional development to reduce the high turnover of staff. Glendinning (2012) reports that in England home care workers' skill levels are relatively low but that employing agencies are required to have specified levels of qualified staff and that skills and qualification levels of workers in care homes are slowly rising through workplace-based training and assessment. He explains that new unqualified staff must register for training within 6 months of starting employment, but that up to the end of March 2007, between a fifth and a quarter of registered home care agencies had not yet met this requirement. Glendinning (2012) further reports that home care provider

organisations in England reported significant problems in recruiting and retaining staff and turnover was high due to low pay levels. Persistent Challenges in Providing Quality Care (2012) also states that a lack of training for care assistants' courses which were considered essential in the provision of even basic care, such as manual handling, was identified as one of the challenges in care homes in England.

In their study on 'Improving quality of life for older people in long-stay care settings in Ireland,' Murphy, O'shea, Cooney, Shiel and Hodgins (2006:21) indicate that a programme of education and training is required to facilitate the development of an ethos of care that focuses on quality of life and addresses the attitudinal and organisational changes. The study also revealed that training opportunities were limited for those working in the elderly care sector in Ireland and that the traditional focus of training for long-stay care staff had been on the process of nursing care delivery only, ignoring other aspects of care.

Furthermore, in his study on the 'Quality of institutional elderly care offered in the nursing homes on Slovenia,' Habjanic (2009) states that from the point of view of the relatives of the aged, the main challenges faced by institutions in Slovenia were inadequacy of nursing staff and care and an uncomfortable environment. He points out that care giving staff comprised poorly educated and unmotivated staff who suffered from physical and mental fatigue because of too much routine work. He explains that they were also unmotivated because of low salaries.

Moriarty, Kam, Coomber, Rutter and Turner (2010) prescribe on-site training for caregivers which they say tends to be favoured over off-site delivery because it is easier to organise in terms of fitting in with staff's regular working hours. They state that outcomes of training of care workers have been measured through self-report and/or by observation and that the most frequent benefits of training reported by workers are great confidence in providing care and greater understanding of the issues faced by older persons. It is, therefore, of crucial significance that caregivers working with the aged in old people's homes are equipped with the necessary knowledge, skills, competencies and attitudes in issue of ageing and how to better care for the aged without abusing or neglecting them.

Habjanic (2009) posits that moving to a nursing home is like moving to a new home, for residents usually a final destination in their life and that an important role of staff members is to provide residence to the elderly like it was back home. He explains that homeliness provides residents with welcome feelings, conjunction with new environment and other people living in the nursing homes and that in order for staff members to provide such an environment, they need some skills, insights, competencies and attitudes which can largely come as a result of professional training, seeing that elderly care is a specialised area. The implication, therefore, is that old people's homes should employ staff that are appropriately trained and/or train those that are already working in these institutions by exposing them to relevant courses and programmes to do with elderly care and welfare.

Drennan et al. (2012) report that professionals working with older people in institutional care settings in Ireland received training in the area of elder abuse. They point out that education of all staff who work in the care home sector is central to the recognition and prevention of neglect and abuse of older people. Drennan et al. further point out that education and training that incorporates strategies on recognising and reporting potential neglect and abuse is also an important component as is training in how to deal effectively with conflicts that may arise between staff and residents. They explain that there are a number of training programmes that could be incorporated into undergraduate and continuing education for health and social care professionals that cover both an awareness and understanding of abuse and psychological aspects such as dealing with abuse and stress reduction.

Furthermore, Campbell (1982) reports that staff training for personnel caring for the aged in Japan is conducted throughout the year, both in nursing homes and outside. Funds are specifically designated by the government to each home for training purposes. Training sessions are an attempt to provide systematic training and certification to improve the skills and knowledge of care workers. The Zambian government and other agencies could pick a leaf from the Japanese and other situations and promote training of caregivers and other personnel who play a role in caring for the aged in old people's homes. For example, in Kenya, a five-day course for mid-level or senior programme manager, social workers, health care professionals, senior government officers or planners and others interested in ageing issues was mounted. The course covered the demographic situation and socio-economic

implications for Africa, HIV/AIDS and its impact on older people, gender dimensions of ageing; poverty and research and policies on ageing (HelpAge International, 2004).

The literature review revealed that there was a dearth of information on challenges faced by caregivers in institutional homes, especially from the African perspective, including Zambia, possibly because institutionalisation of the aged is not so widespread on the continent and hence, not much research has been conducted on this aspect of elderly care. This study, therefore, provides an opportunity to generate information that will highlight these challenges for other developing countries to gain some insights from.

### **3.15 Adult Education Programmes for the Aged**

The literature review also focused on the provision of adult education programmes to the aged in the community and in institutional settings such as old people's homes. The literature review starts by highlighting the significance of education in general. It then describes the main forms of education and discusses education as life-long learning, the concept of adult education and principles governing adult education, among other aspects.

#### **3.15.1 The Significance of Education**

Education is taken to comprise organised and sustained communication designed to bring about learning (Kelly, 1999). It is a process of acquiring knowledge, skills, competencies, attitudes, values, beliefs and behaviour, which are transmitted from one generation to the next. The Zambia Poverty Reduction Strategy paper 2002 – 2004 (2002) states that all citizens of a country have a right to education. Munoz (2010) also states that education is an individual right but it is also a social right whose maximum expression is in full exercise of this right by a person. He explains that education is not limited to a period of time in men and women's lives, but encompasses the full course of their existence.

The significance of education in the life of an individual, regardless of his/her age, gender, race, colour and creed cannot be overemphasised. Education leads to individual creativity, improved participation in the social, economic, cultural and political life of society, and hence, to more effective contribution to human development. In fact, education is prerequisite not only for the full exercise of the individual's rights but also for understanding and respecting the rights of others (Kelly, 1999).

Since its beginning, the United Nations have expressed their conviction that education is one of the basic pillars on which modern societies should lean (Adult Education and Development, 2013). In Zambia, the mission of the Ministry of Education is to guide the provision of education for all Zambians so that they are able to pursue knowledge and skills, manifest excellence in performance and moral uprightness, defend democratic ideals and accept and value other persons on the basis of their personal worth and dignity, irrespective of gender, religion, ethnic origin or any other discriminatory characteristic (Educating Our Future, 1996).

At the Fourth International Conference on Adult Education in Paris in 1985, the right to learn was defined as the right to read and write; to question and analyse; to imagine and create; to learn about the world as it is and as it was; to have access to educational resources; and to develop individual and collaborative skills (Kelly, 1999). Therefore, no one should be excluded from the process of learning and acquiring knowledge, skills and competencies regardless of his/her unique circumstances or conditions. It would be helpful to briefly describe the main forms of education in order to have some insight into what would be relevant to the aged residing in old people's homes as well as their caregivers.

### **3.15.2 Forms of Education**

According to Ngaka, Openjuru, and Mazur (2012), there are different forms of education, ranging from formal to non-formal and informal education depending on the context, methods, curriculum and teaching and learning materials used. Sichula (2012) also states that education occurs through informal, non-formal and formal systems of learning. Kelly (1999) adds that education, by its very nature, is a continuous process, starting from earliest infancy through adulthood that necessarily entails a variety of methods and sources of learning. He also groups these learning methods into three categories namely, informal education, formal education and non-formal education, while recognising that there is an overlap and a high degree of interaction between them. The three forms of education are briefly described below.

#### **(a) Informal Education**

By informal education is meant the truly lifelong process whereby every individual acquires attitudes, values, skills and knowledge from daily experience and the educative influences and resources in his or her environment, that is, from family and neighbours, from work and

play, from the marketplace, the library and the mass media (Kelly, 1999). Ngaka, Openjuru, and Mazur (2012:110) further state: “Informal learning refers to a largely unconscious process through which people acquire and accumulate experience, knowledge, skills, attitudes and insights from daily life experiences and exposure to the environment.”

**(b) Formal Education**

Formal education refers to the hierarchically structured, chronologically graded education system, running from primary school through the university and including, in addition to general academic studies, a variety of specialised programmes and institutions for full-time technical and professional training (Kelly, 1999). Ngaka, Openjuru, and Mazur (2012) further define formal education as that type of education which is structured, in some cases state supported, certified and follows a predetermined/written curriculum. The training of caregivers operating in institutional homes would mainly fall under formal education.

**(c) Non-formal Education**

Non-formal education is any organised activity outside the established formal system, whether operating separately or as an important feature of some broader activity that is intended to serve identifiable learning clienteles and learning objectives (Kelly, 1999). Ngaka, Openjuru, and Mazur (2012) also define non-formal education as that type of education which takes place outside of the formally organised schools such as adult literacy and continuing education programmes for adults and out-of-school youths which do not necessarily emphasise certification. They explain that non-formal education may refer to any educational activity organised by different agencies for a particular target group in a given population, especially adults outside the framework of formal education to provide selected types of skills.

Rabušíkova and Rabušić (2006) undertook a study in which they sought to compare the participation of adults in formal education and non-formal education in the Czech Republic. The study established that the Czech adult population generally showed little interest in formal education as they did not find it necessary or relevant to their immediate needs. The study concluded that owing to this finding, theoretically room should be left for non-formal education which in a way seems easier as it is faster, very current, often down-to-earth and easy to make use of in practice. The implication is that this form of education would be more

relevant and appealing to the aged including those residing in old people's homes for the same reasons advanced by Rabušikova and Rabušic. In agreeing with the above view on non-formal education, Alfageme (2007) points out that educational programmes aimed specifically at older people could be in the non-formal learning environment. He explains that these programmes could not necessarily be provided by education or training centres, although they could make use of them and that the programmes would have a marked local character.

In the context of this study, non-formal education is considered relevant and ideal for the aged in old people's homes. This is supported by Alan-Mutka and Punie (2007) who state that for all age groups, and especially for older people, non-formal learning is an important part of life that needs to be considered when aiming for supporting learning, even though it may be difficult to arrange and even though its results cannot always be measured. Dib (1988) gives the following as the main types of non-formal education:

- (i) Vocational non-formal education, which encompasses skills such as carpentry, tailoring, metal work, farming, fish breeding and fishing, among others.
- (ii) Knowledge non-formal education, which includes areas such as advocacy, human rights, civic and political education as well as health education.

### **3.15.3 Education Viewed as Life-Long Learning**

The idea and necessity of seeing education as a lifelong process has been emphasised by the International Commission on the Development of Education. In contrast to the view that equates education with schooling and measures it by years of exposure, the Commission adopted from the outset a concept of education that equates it broadly with learning regardless of where, when or how the learning occurs (Kelly, 1999). The role of life-long learning is critical in addressing global educational issues and challenges. Life-long learning ('from cradle to the grave'), is a philosophy, a conceptual framework and an organisation principle of all forms of education, based on inclusive, emancipator, humanistic and democratic values. It is all encompassing and integral to the vision of a knowledge based on society (Adult and Development, 2013).

According to Rabušicová and Rabušic (2006) lifelong learning has some basic features. The first is that education is no longer limited to a certain stage of life, that is, the school-age

period but instead spans an entire lifetime. The second feature of lifelong learning is that it involves not only formal education provided by educational institutions, but all forms and types of learning regardless of the institution or the environment, be it at the place of work, in the home, or in a municipality context. The third feature is that of equal opportunity guaranteed to everyone regardless of age, motivation, talent or social status.

Grandal (2008) points out that many elderly individuals demonstrate great interest and ability to learn new information and that ageing should not be seen as purely a time for decreased abilities but rather as an opportunity for growth, increased wisdom and the attainment of new skills. This means that the aged are capable of learning in different contexts and situations so long as they are provided with the opportunity to do so. Merriam and Cunningham (1989:533) add:

Older adults represent a significant clientele for adult educators over the next several decades. Current participation data, though limited to institutionalised learning, reflect the variety of interests among individual older learners and serve to rebut the myth that older adults cannot learn or are not interested in learning.

The implication of the above statement is that older persons are able to learn and acquire knowledge, skills, and attitudes in various disciplines and aspects of life and share with others. For example, some elderly people in old people's homes may be frail. However, they possess a huge reservoir of knowledge, skills and wisdom which they could pass on to others, meaning that they could be used as resource persons in these homes. The concept of life-long learning also entails learning for adjustment and for coping with life in different contexts.

#### **3.15.4 The Concept of Adult Education**

Attempts to define adult education have been plagued by controversies over goals, methods, content and objectives. These controversies have been compounded by the nebulous definition of who an adult is. What is indisputable, however, is the fact that all societies accept that they are human beings that are considered adults and any form of organised, scheduled, systematic and purposeful learning for such people can thus be classified as adult education (Mbozi, 2006). Nafunko, Amutabi and Otunga (2005) define adult education as activities designed for the purpose of bringing about learning among those whose age, social roles and self-perception define them as adults.



The literature reviewed points to the fact that adult education is not easy to define as there are some misunderstandings and misconceptions. Knowles (1980) explains that people have little difficulty getting a clear picture of what elementary education is or what secondary education is or what higher education is, rather than what adult education is. He points out:

...Adult education is much harder to picture because it takes place in all sorts of buildings and even no buildings at all, involves all sorts of people, has no set curriculum, and often isn't even labeled 'adult education,' but such things as "staff development", "manpower development", "developmental education", "in-service education", "continuing education", life-long education and many others (Knowles 1980:25).

Knowles (1980) contends that one problem contributing to the confusion surrounding the term adult education is that it is used with at least three different meanings. Firstly, in its broadest sense, the term describes the process of adults learning. In this sense it encompasses practically all experiences of mature men and women by which they acquire new knowledge, understanding, skills, attitudes, interests or values. It is a process that is used by adults for their self-development, both alone and with others and is used by institutions of all kinds for the growth and development of their employees, members and clients. It is an educational process that is often used in combination with production processes, political processes or service processes. Secondly, in its more technical meaning, adult education describes a set of organised activities carried out by a wide variety of institutions for the accomplishment of specific educational objectives. In this sense it encompasses all the organised classes, study groups, lecture series, planned reading programmes, guided discussions, conferences, institutes, workshops and correspondence courses in which adults engage. The third meaning combines all the above process and activities into the idea of a movement or field of social practice. In this sense, adult education brings together into a discrete social system all individuals, institutions and associations concerned with the education of adults and perceives them as working toward the common goals of improving the methods and materials of adult learning, extending the opportunities for adults to learn and advancing the general level of culture.

Knowles (1980) explains that another problem contributing to the confusion is that adult education is such a relatively new field of social practice that is still in the process of forming an identity that is separate from youth education, social work, counselling and related fields of social practice. Rogers (1992) adds that adult education has for a long time been narrowly

conceived as the mere provision of literacy education. Youngman (1998) goes on to give a summary of terms that have been used to refer to adult education in Africa and they include: agricultural extension, in-service training, literacy, out-of-school education, community development and vocational training.

However, this study adopted what it considered an elaborate and comprehensive definition by UNESCO (1976), which takes adult education to mean:

The entire body of organised educational processes, whatever the content, level and method, whether formal or otherwise, whether they prolong or replace initial education in the schools, colleges as well as apprenticeship, whereby persons regarded as adults by the society to which they belong, develop their abilities, enrich their knowledge, improve their technical or professional qualifications and bring about changes in their attitudes or behaviour in the twofold perspective of full personal development and participation in balanced independent social, economic and cultural development.

#### **3.15.5 Principles Governing Adult Education**

The literature reviewed further indicated that adult education is guided by some principles. Firstly, adult Education believes in the principle of human desire for self-improvement. It believes that adults, by nature, have a desire to improve themselves in their social, intellectual, economic and political status and, therefore, voluntarily opt to undergo programmes of their choice. The primary mission of adult education, therefore, is to stimulate this dormant and latent desire for self-improvement. It is this principle which helps many people as reinforcement for participating in various adult education courses leading to effective learning outcomes (Shikur, 1997).

Shikur (1997) states that the other important principle of adult education relates to the strong belief in the educability of humankind. Adult education basically negates the belief that learning is possible only in childhood and not later in adult life. He explains that every experience one undergoes, particularly in the process of attaining maturity in physical, emotional and intellectual sense, enlarges this repertoire of knowledge which affects or modifies his/her future behaviour and that it is evident that, regardless of their age adults have an inert ability to learn. Shikur (1997) further explains that human life is not static but changeable, creating demands for new knowledge and skills and that in the context of adult education, education and learning experiences are considered synonymous. He points out that

adults always seek to find happiness and fulfillment in life and, therefore, are likely to readily respond to the modifications of their human and material environments, provided they are assisted in discovering the ways and means of doing so and that education is one such means of achieving this. Shikur concludes that the principle of adult education is founded on the belief that education is the sole means by which people can attain happiness and fulfillment in life in whatsoever manner the human happiness is interpreted, that is, attainment of philosophical, intellectual, economic or social happiness.

#### **3.15.6 Purpose of Adult Education**

Gboku and Lekoto (2007) state that the overall purpose of adult education is to help individuals become knowledgeable, skilled and dedicated citizens who are willing to work individually and collectively towards achieving and maintaining an improved quality of life. They state that this encompassing purpose of adult education can also be expressed by stating the range of activities it covers. They point out that adult education:

- i. Provides relevant education of persons regarded as adults.
- ii. May be organised in or out of school settings and other formal education institutions.
- iii. May represent a basic education or may expand or replace the package of knowledge, skills, attitudes, values and interests a person has acquired previously.
- iv. Encourages the continuous growth and development of individuals.
- v. Helps people to respond to practical problems and issues of adult life.
- vi. Prepares people for current and future work opportunities.
- vii. Assists organisations in achieving desired results and adapting to change.
- viii. Provides opportunities to examine community and societal issues, foster change for the common good and promotes a civil society.
- ix. Helps adults to develop new abilities or competencies or enrich their knowledge or improve their technical or professional qualifications.
- x. Helps to give adults new directions in life by engaging them in formation, reformation and transformation.
- xi. Helps adults to change their behaviours, skills, interests, attitudes and values.
- xii. Aims in the end to lead on to full personal development, socially, culturally, economically and politically.

The implication of the above is that since adult education is broad and all encompassing, it should be adapted to the needs of individuals at different levels of their lives and in different situations and circumstances. Adult education programmes should be responsive to the needs and aspirations of the target groups or participants, who should appreciate its value, if it is to be effective and relevant. In fact, it is generally believed that many people participate in adult education programmes, not just for the sake of career advancement, but also to develop leisure interest, to enhance their sense of wellbeing and to increase satisfaction with life in general. The study of the relationship between adult education and the quality of life is very important because the purpose of adult education is not confined to conferring knowledge and skills for career mobility. For example, adult education seeks to promote social, cultural and political participation as an end in itself and as a means for improving the welfare of the people. It aims to increase the general ability and willingness of people in their roles as citizens, to become involved in and to influence the further development of society. Participation in adult education is also regarded as constituting a means for personal enrichment, self-fulfilment and the development of leisure activities (Tuijnman, 1990).

### **3.15.7 Range of Adult Education Programmes**

The literature reviewed indicated that the range of adult education programmes is large but that two broad categorisations can be used to differentiate them. There are programmes that seek to offer equivalents of the types of programmes offered in formal education, namely basic (primary, lower and upper, secondary and tertiary). The mode of delivery here tends to be classroom, regular face-to-face or distance and open learning. These programmes are often called adult primary (or adult basic education), adult secondary (or adult tertiary). They normally share the same content with the equivalent formal education programmes and also face similar problems as those experienced in formal education. The second category is that of adult non-formal education programmes. These are generally open in content, methods and techniques, with wide opportunities for learner participation at every stage. They seek to meet the immediate needs of adult learners (Indabawa and Mpofu, 2006).

The latter category, which is non-formal education, is relevant and more useful to older learners such as those found in old people's homes. This is because non-formal education programmes are flexible and respond to the unique needs of individual learners. Indawa and

Mpofu (2006) assert that there are as many types of adult education programmes and activities as there are varieties of clientele needing them for various purposes and that the type of adult education programme that any one person or group will need is best determined by them. They, however, point out that people may be assisted to ensure that they make the right choice and that usually experts and providers of adult education programmes are best suited to assist those who need adult education programmes.

Gboku and Lekoko (2007) state that effective adult education programmes enable people to develop new knowledge, attitudes and behaviours that will help to sustain improved quality of life for individual adults, groups and communities and society at large. Ehiamentolor and Oduaran (1991:7) In Gboku and Lekoko (2007) indentified the following as important adult education programmes:

- i. Adult Basic Education, including basic literacy, functional literacy and numeracy.
- ii. Out of School Youth Programmes.
- iii. Income Generating Programmes.
- iv. Extension Programmes including agricultural extension, community health extension, extra-mural studies and continuing education.
- v. Distance Learning Programmes, including correspondence schools and open universities.
- vi. Workplace Literacy Programmes.
- vii. Training and re-training programmes including vocational/technical training, workers' education and labour relations.
- viii. Civic education, including community development and political socializations.
- ix. Liberal education, including conscientisation and rural animation.

Gboku and Lekoko (2007) explain that the above list is not exhaustive as there are also intergenerational programmes, citizenship education and others. It should, however, be noted that not all the above adult education programmes may be relevant to the needs of aged residing in old people's homes.

### 3.15.8 Educational Needs of Older People

Most countries in the world currently experience an important demographic change due to an increasing older population; a trend which will be even more dramatic in the next decades. This will also have an impact on the learning activities in these countries, influencing, for instance, what needs to be learned, how this will be learned and who will be learning or teaching it. Learning plays a key role in ageing societies as it can help to address many challenges such as increasing social and health expenditures; older people's participation in employment; re-skilling and up-skilling in the knowledge-based society; and intergenerational sharing of experiences and knowledge. However, it is important to recognise older people as a heterogeneous group, in terms of self-confidence for learning, learning skills and interests, health and social connections, among others (Ala-Mutka and Punie, 2007).

Ala-Mutka and Punie (2007:2) state: "In general, older people's learning motivation is related to improving their everyday lives, to keeping themselves active and to sharing their knowledge with others and to connecting with other learners." Additionally, taking part in learning can help increase an older person's quality of life, as well as reduce health and social care costs. It can also bring a range of benefits for family and friends, as well as for the carer (Enhancing Informal Learning for Older People in Care Homes, 2010).

Boulton, Gillian and Purdie (2003) point out that the capacity of older adults to remain physically, mentally and socially active is dependent on continued participation in learning and education but that older adults are often not considered as likely candidates for learning. They conducted two studies to gain a better understanding of learning among adults over 70 years of age. In the first study, they interviewed 17 adults about their learning needs, the barriers they perceived to meeting these needs and their efficacy for overcoming these barriers. Boulton, Gillian and Purdie (2003) then used the results of that study to construct a learning needs barrier and efficacy questionnaire which was completed by 160 older adults. The findings of the two studies were that the least important needs indicated by the respondents were those associated with technology. The most important needs were associated with transportation, health and safety. The studies concluded that in general, participants were confident they could successfully address needs related to health, safety, leisure and transportation but not those associated with technology.

It should be pointed out that although Boulton, Gillian and Purdie's (2003) studies did not deal with the aged residing in institutional homes, the findings are relevant to this study as they give some insight into some of the learning priorities and preferences among the aged. Furthermore, although the study was undertaken in a Western context with quite different socio-economic conditions from Africa and Zambia, the study is reminding us that it is important to find out from the recipients of the learning, what kind of educational programmes or learning activities they would like to participate in so that their needs are appropriately responded to.

However, there is a generally held notion or stereotype worldwide that the aged are not interested in learning and that they have passed their learning age as is reflected in the investment in the education of children and adolescents as Courtenay (1994:12) observes:

Even a cursory reflection of the public funding for education will reveal that priority is given to kindergarten through high skill (K-12) education specifically directed at children and adolescents. This reality in public policy is supported by such prevailing stereotypes as the belief that older individuals cannot or do not wish to learn.

In his study on 'Elderly Women in South Africa: Issues, Challenges and Future Prospects', Kamwengo (2002) points out that until recently, it had been rare for people to talk about elderly women participating in educational programmes in South Africa because education had been conceptualised as something associated with children. He explains that the prevailing view was that educational institutions were designed and geared towards the needs of children and that the institutions were expected to provide children with education which prepared them for living as adults. Kamwengo (2002), however, explains that the growing emphasis on lifelong education, which is education that occurs throughout life, training and retraining had proved this traditional view of education to be untrue. He further explains that there had been a historical myth that elderly people were rigid, inflexible and difficult to change but that there was a substantial body of knowledge which described how elderly people successfully acquired coping skills needed to deal with role changes and physiological changes they usually experienced rendering the myth absolutely untrue.

Kamwengo (2002) goes on to point out that there was a negative view in South Africa that elderly people could not learn and that they experienced decrease in their learning ability. He states that a number of elderly women had accepted this myth and came to believe that they were not capable of learning. He, however, explains that elderly women in educational

programmes in recent years have proved the myth to be wrong as many of them are learning well into their seventies when illness and physiological impairment begin to set in. Kamwengo (2002) states that the work of Howard McClusky (1971) contributed to the understanding of the needs of elderly women, including elderly men in this case. McClusky identified five categories of needs and they included:

- i. Coping or survival needs - which must be satisfied even at minimum levels so that the elderly can function adequately in society. They can be addressed by such programmes as adult basic education, education for health, economic adjustment, family as well as legal adjustments. When coping needs are satisfied, the elderly are more likely to maintain psychological health and physical wellbeing.
- ii. Expressive needs - which refer to needs that allow the elderly women (and men) to engage in educational programmes for its own sake. Educational programmes which are often used to address expressive needs include physical recreation, art, music and crafts.
- iii. Contributive needs - which are addressed by educational programmes that allow elderly women (and men) to be of service to others. Examples of such educational programmes include volunteer programmes, community participation and second careers.
- iv. Influence needs - which refer to needs of elderly women (and men) to exert influence or control over the direction and quality of life. Examples of programmes which address influence needs include civic and political education and community action.
- v. Transcendence needs - which are needs whose satisfaction leads to the achievement of a sense of fulfilment and being able to overcome the limitations of physical declines.

Habjanic (2009) established that older people entering institutional custody in Slovenia today are, in general, better educated and also better versed, with some of them for example, able to use the computer. He explains that residents and their relatives have higher expectations and demands of events and activities including educational programmes. Habjanic further points out that relatives of the residents expect staff working in care homes to organise activities that improve the quality of life of the elderly, such as morning exercises, cooking gatherings and other activities which would cater for all categories of residents including the poorly mobile or immobile residents.



Kamal and Patil (nd) undertook a study titled 'Computer and Internet Uses among Elderly Population: Adding Activity and Quality to Life'. The main objective of the study was to investigate if computer technology exerts significant influence on the lives of the aged and if computer adds value to older people's day-to-day life in the United States of America. The respondents comprised 100 elderly persons aged 60 years and above and living in their own homes. The study established that a large percentage of older citizens were computer literate, used internet on a regular basis and believed that lack of basic computer skills was a disadvantage. Various activities ranging from e-mail and chat on the internet to surfing the net for useful information were common activities undertaken by older citizens. Kamal and Patil (n.d.) further asked the aged to give reasons why they had purchased computers. The study established that at the top (77%) of the reasons given by the aged for purchasing and using computers, educational enrichment was singled out as one of the main motivations. The study concluded that computer use among the older population added value to their lives and that the results of the study supported the notion that older people adapted successfully to the electronic age. It concluded that various activities the aged engaged in using the computer relieved them from social and emotional isolation and added quality and value to their day-to-day life. The study further concluded that an older person who ages optimally is the person who stays active and manages to resist the shrinkage of his/her social world and that staying active adds quality to the life of an elderly person and helps him/her age successfully. This is consistent with activity and continuity theories.

The problem with the study by Kamal and Patil (nd) was that it was carried out on elite older citizens who had the means to purchase computers and accessories for their use. It, therefore, may not be so applicable to the Zambian situation where owning a computer may still be a luxury to most of the citizenry. However, with the passage of time and as the socio-economic situation changes, a situation where computers are accessed by the aged for their use may come. Additionally, the study was carried out among the non-institutionalised elderly citizens. However, despite this weakness, insights may be gained from the study to the effect that the aged, just like young people, are able to use modern technology to learn, communicate, keep active and enrich their lives given the opportunity and the right environment. This could be a reality in Zambia in future.

### **3.15.9 Benefits of Education to Older Persons**

The literature reviewed indicated that there are various benefits that education provides to all citizens such as promoting economic growth, national productivity, innovations and social cohesion (Central Statistical Office, 2012). There are many benefits that older people can derive from participating in learning programmes. Some of the benefits are personal development, gaining new skills and a sense of achievement within the activity undertaken. Personal development includes better physical and mental health through increased self-confidence, self-esteem, increased mobility, reduced dependence on others, better ability to manage pain and illness, lowered levels of depression and faster recovery rates. Additionally older people are left with a greater sense of wellness and general well being (NIANCE Briefing Sheet – 67, 2005).

The NIACE Briefing Sheet 67 (2005) points out that currently many institutional care settings offer activities for older people that are designed to pass time and for enjoyment but that they often lack a learning and personal development structure to them. It states that as these activities are not a course of learning, they can lack continuity and do not build on previous sessions. It further states that the benefits from taking part in activities are usually short term, whereas a more structured learning approach has longer-term benefits and that learning can help to change people's mindsets, leading to stronger relationships between carers and those being cared for.

Learning is not just about skills and qualifications that help people get on in life. Learning also helps improve the lives and wellbeing of everyone who participates and helps to build a better society. Learning for older people in care settings is a mixture of fun, challenge and mental stimulus, and helps in the maintenance of social, physical and mental skills. Learning can take many forms; for example, chair-based exercise, watercolour painting, digital photography, reading groups, gardening and poetry. It can bring massive improvements to individuals' health, wellbeing and confidence (Learning for Older People in Care Settings, 2014).

In his study on Elderly Institutionalisation in China, Simone (2008) contends that various classes for personal development, interest and entertainment should be initiated for the elderly. He explains that very often, the elderly feel very lonely, particularly when they are

staying in a place with lots of strangers, such as an old people's homes. He proposes different classes to teach computing, Chinese typing and use of internet which he says could help the elderly in their personal development. He adds that other classes focusing on Chinese drama, calligraphy, chess and instrumental music should also be initiated and that social services could be added in elderly care homes with counselling provided to those in need. Old people's homes in Zambia could learn from the Chinese experience by adopting some of the strategies used in service provision and enhance the lives of residents in these homes.

The China National Community on Ageing (1999) report states that China had over 17,000 universities or schools for the aged persons with an enrollment of over 1.5 million and about 1000 specialities. These specialities mainly included calligraphy, painting, private tutoring, cuisine, health care and body building. The report states that more than 30 million aged persons took part in body building activities in China and that formal and non-formal programmes were tailored to suit different objectives.

According to Enhancing Informal Adult Learning for Older People in Care Homes (2010), the following key principles will help older people in care settings, such as old people's homes, have good experiences of learning:

- Give older people the opportunity to enjoy stimulating activities, take exercise, acquire new skills and share existing ones, irrespective of any impairments or differences in ability.
- Let older people choose whether or not to participate in learning.
- Encourage older people to get involved in planning learning activities, ask for feedback and take account of it.
- Find out what the people in your care want to learn, how they want to learn and when they want to learn.
- Choose learning experiences that enhance quality of life and allow opportunities for greater autonomy and independence, so that the learning can make a positive difference.
- Recognise and value achievements, however small, and celebrate success.
- Build on older people's existing skills and interests.
- Make learning interesting, challenging, rewarding and, above all, enjoyable.

It is, therefore, important that people responsible for providing services to the aged in old people's homes carefully plan and implement programmes, including educational programmes, that will benefit the residents in a variety of ways so that they do not feel confined and sidelined. The aged in old people's homes should, as much as possible, be encouraged to participate in activities which will keep them active and intellectually engaged.

### 3.15.10 Educational Activities that could be Beneficial to the Aged in Old People's Homes

The literature reviewed highlighted some activities that could be beneficial to the aged in an institutional setting such as old people's homes. Grandal (2008) proposes a variety of educational-type activities that may be offered to residents in elderly care facilities. He explains that residents in these facilities can benefit from educational sessions provided by a vast array of experts. Table 1 below shows the experts and the type of educational activity they could deliver to the aged in an institutional set-up as proposed by Grandal (2008):

**Table 1: Educational Activity Ideas in Elderly Care Homes**

<b>Expert/Staff</b>	<b>Educational Activity/Topic</b>
Staff Educator/Nurse	Flu shots, infection control, ageing, Alzheimer's, cancer, smoking, medications, various diagnostic/critical pathways such as stroke, heart disease, pain management, and other health education.
Social Worker	Residents' rights, Advanced Directives Living Will, dealing with difficult residents, adjustment to a facility life, cultural diversity, getting along with a roommate and coping with grief.
Hospice Staff	Death and dying.
Clergy	Religious/spiritual support and education.
Food and Nutritionist	Cooking and demonstrations or cooking tips, nutrition, various types of diets, diabetes.
Rehabilitation Staff	Physical fitness and exercise.
Maintenance Staff	Fire and safety.

Source: Grandal (2008)

According to Grandal (2008), other educational aspects that could be provided to the aged in an elderly care setting could include the following:

#### (a) Technology Classes

Grandal (2008) states that it is important to provide residents with an opportunity to keep up with today's evolution of technology. He explains that Web television, internet access and

computer use are great ways in which the elderly can maintain contact with friends and family. He says it is, therefore, important to enable the elderly have greater access to current events as well as to expand their leisure skills. However, in an environment like Zambia, such a provision may be a pipe-dream as old people's homes may not have access to technological equipment and accessories being proposed, though the idea is very good.

**(b) Leisure Education**

Grandal (2008) points out that leisure education is a service that is often overlooked in old age care facilities and explains that the primary purpose of leisure education is to enable individuals to enhance their quality of life through leisure. He states that many elderly individuals would greatly benefit from this type of programming and many traditional activities can be transformed into a leisure education session. He gave examples of games such as *bingo*, activity A-Z (name an activity that begins with each letter of the alphabet), Leisure Word Scramble and so on. In the Zambian context one can think of games like *nsolo*, which is a traditional game that people play using stones.

Additionally, Lloyd and Gladdish (2005 In NIACE Briefing Sheet 67, 2005) came up with a Draft Code of Practice for care providers and agencies to use as guidelines when organising learning activities in care settings, whose goal was active engagement of the elderly. The following are the guidelines:

- i. It is a basic human right that all older people should have the opportunity to engage in stimulating mental activity; acquiring new skills and sharing existing ones; it is integral to a good quality of life and promotes health and well-being.
- ii. Different modes of mental activity should be recognised; they can range from passive to the creative; older people should have varying control over the learning activities in which they participate.
- iii. Past skills and interests of older people and their hopes for new interests and skills should be recorded in personal files and assessment reports.
- iv. Older people should be fully involved in the maintenance of their past skills and interests, and in developing new ones, of their choice. They should be involved in the creation of care packages and support plans. Action to achieve learning goals should be recorded and targets set.

- v. All older people in care homes, sheltered schemes, care agencies and those in domiciliary care should have access to a local directory of activities.
- vi. Residential units, care homes and sheltered schemes should encourage older people to maintain contact with the local community by facilitating residents to attend outside learning activities and inviting outsiders to participate in home activities.
- vii. Managers and care staff should be trained to achieve engagement of residents. Training courses must contain one or more modules/units covering the aims of learning and implementation of programmes.
- viii. Care staff should receive recognition and reward for their special additional skills or tasks.
- ix. Local authorities, local service providers and other stakeholders must address the issues of funding for tutors, transport, accessible venues and resources.

It can be noted that although not all the above guidelines may be relevant to old people's homes in Zambia, most of them provide valuable insights into what caregivers and other stakeholders should have in their minds as they come up with educational programmes and activities for the aged. The guidelines also emphasise the need for training of caregivers who work with the aged in an institutional setting if they are to provide better care to the residents.

#### **3.15.11 Learning Barriers and Adaptations among the Aged**

The literature review also revealed learning barriers that hinder the aged from effectively participating in educational programmes. Ala-Mutka and Punie (2007) point out that the major problem related to the participation of older people in learning activities is that learning is traditionally often designed for younger people's learning needs. Grandal (2008) posits that there are many barriers that recreation professionals or "teachers" may have to overcome before an elderly person has a successful learning experience. He explains that many of the adaptations utilised for the traditional recreational programming can be utilised for the elderly learner as well but that the most obvious barriers to learning are physical changes that often occur as people age. Grandal further explains that individuals with hearing or vision loss, decreased mobility, motor coordination and so on will need their learning experience adapted. He adds that for those with visual impairments, it is important to: utilise large print materials with appropriate thickness, simple styles and contrasting colours such as black on white; speak slowly, repeat main points and paraphrase; utilise verbal and physical

cues; provide bright non-glare lighting and utilise other forms of sensory such as touch, sound and smell.

Grandal (2008) states that desire, interest and/or attitude are also potential barriers to learning and that it is not uncommon for elderly people to feel threatened by the idea of learning new information, especially technology. He states that elderly persons may claim that they are too old to learn or that they have learnt enough. He points out that it is crucial to identify the reasons for such resistance and then try to break down those barriers. He explains that the facilitator must have a positive, enthusiastic demeanor, give choices and encourage active participation among the elderly persons and that it is important to set goals that are realistic and start off slow, if needed. Grandal goes on to state that it is important to offer informal educational sessions on a one-to-one basis to establish a rapport and to spark an interest in the elderly persons, make the learning experience fun and interactive and provide extensive praise and encouragement.

Courtenay (1994) points out that the study of instruction for older adults involves research into the circumstances affecting learning and that the practical aspect of educational gerontology includes opportunities for the elderly to enhance their knowledge and skill in order that they might have a more enjoyable life and meet the challenges of contemporary society. Alan-Mutka and Punie (2007) point out that it is important to carefully develop both the content and conditions of the learning opportunities for older people. They assert that there is evidence that older people want to learn, but meaningful and real opportunities for this desired learning are scarce at the moment.

Bélangier and Falgás (1997) assert that studies on learning capacity according to age show no significant decline before 75 years of age. The elderly learn as well as the young, but according to different strategies, relying on their previously acquired knowledge and their ability to structure and analyse information on the basis of past experience. Success with older adults can be observed in all fields of education, namely, vocational training, physical education, artistic training and language learning. Bélangier and Falgás (1997), however, lament that despite these new currents, older people continue to be denied learning opportunities or they are rejected on the belief that it becomes more difficult to learn with

age. They point out that even if older people are living longer and show real capacity for self-development, they find themselves being pushed aside more rapidly and permanently.

The literature review has indicated that educational programmes are important in the lives of the aged, just like other age groups. However, the literature has also revealed that most of the studies on education for the aged are mainly concerned with adult education provided to the aged in their community and not necessarily in institutional set-ups like old people's homes. This is a gap which this study sought to fill. This study considers extending educational programmes to the aged residing in old people's homes in order to keep them busy, active, intellectually stimulated and more productive.

### **3.16 Policy Framework on Ageing in Zambia**

Sapru (2004) defines a policy as a purposive course of action taken or adopted by those in power in pursuit of certain goals or objectives. He explains that the concept is not a precise term and that it denotes, among other elements, guidance for action. He further explains that policy may take the form of: 1. a declaration of goals; 2. a declaration of course of action; 3. a declaration of general purpose; and an authoritative decision. In the context of institutional care such as an old people's home, a policy may be defined as an operational statement of intent which helps staff make sound decisions and take actions which are legal, consistent with the aims of the home, and in the best interests of service users (Care Homes for Older People: Minimum Standards, 2003).

The Ministry of Community Development and Social Services (MCDSS), at the time of the study, the Ministry of Community Development Mother and Child Health (MCDMCH), is mandated through an Act of Parliament to produce and implement programmes that provide and facilitate social support services to vulnerable persons in Zambia. MCDMCH is also responsible for Zambia's Policy on Ageing (Mapoma, 2013). The Ministry embarked on the formulation of the policy as early as 2008 with a view to having it enacted and operational in the shortest possible time. However, at the time of data collection for this study the policy was just in draft form and hence, not operational. The following are the major features of the draft national policy on ageing.

#### **Vision**

The vision of Zambia's National Policy on Ageing is: "Ageing with Dignity by 2030".



## **Rationale**

Older persons are faced with conditions of extreme poverty, added burdens of being caregivers and bread winners due to the effects of HIV and AIDS, abuse, stigma as being advents of witchcraft and misfortune and generally as a nuisance of society. In addition, older persons have been marginalized from many developmental interventions and access to the means of production. As such the lives of older persons have been difficult at this stage in life when they are supposed to be enjoying old age. Furthermore, the lack of programmes to prepare citizens for life in old age has contributed to the difficulties being faced by older persons.

The development of the National Policy on Ageing arises from government's realisation of the need to address the phenomenon of ageing and the challenges being faced by older persons. The government has also seen the need to have in place a comprehensive regulatory framework which will not only provide guidance to government but also to Non-Governmental Organisations and other stakeholders in addressing issues of the ageing population.

The policy once put in place, will be used as a guiding instrument not only for government committing itself to the plight of older persons, but also for purposes of allocation and expenditure of public resources. Further, having a policy on ageing will assist in enhancing the mainstreaming of ageing issues in national development. The policy will further pave way for legal reforms that could enhance realisation of rights of older persons and create an enabling environment that takes into consideration the needs of the ageing population. Additionally, the policy will facilitate the domestication of International Conventions relating to older persons. This is in line with Vision 2030 which states that the nation Zambians aspire for should be characterised by "Access for all to good quality basic human necessities such as shelter, titled land, health and education facilities and clothing." (Vision 2030, 2006:2)

## **Guiding Principles of the National Policy on Ageing**

The National Policy on Ageing in Zambia was developed on the basis of the following seven guiding principles:

- i. Participation - Older persons have the right and duty to actively participate in the economic, social, cultural and political affairs of the nation as well as in the formulation of policies affecting them. They have the responsibility of sharing knowledge with younger generations and are free to form associations that further their interests. They should also be valued for their socio-economic contributions.
- ii. Dignity, Security and Freedom from Exploitation - All Zambian citizens are born free, equal with dignity and rights. They are entitled to all rights and freedoms contained in the Bill of Rights as enshrined in the Republican Constitution. It follows, therefore, that older persons should live in conditions of dignity and security and must be free from all forms of marginalisation, discrimination, exploitation and abuse. They must be treated fairly and with respect.
- iii. Family and Community Care - Older persons should benefit from the care, support and protection provided by the family, community and government.
- iv. Partnership - The provision of care and support to older persons is an enormous task that requires the involvement of all stakeholders; government should further embrace partnerships and collaborate closely with the private sector, civil society, cooperating partners and older persons themselves in addressing the needs of the ageing population.
- v. Availability and Accessibility - Older persons should have access to food, water and sanitation, shelter, clothing, health care, work and other income generating activities, education and training and life in a safe environment.
- vi. Intergenerational Solidarity - This policy recognises and promotes strong links between generations to enhance cultural, social, economic and traditional values. There is need to recognise the need to strengthen solidarity among generations and intergenerational partnerships keeping in mind the particular needs of both older and younger ones, and to encourage mutually responsive relationships between generations.
- vi. Research, Information and Development - In order for the policy to effectively achieve its intended goals and objectives, the generation, analysis and dissemination of data on ageing should be a priority.

It can be noted that the draft national policy on ageing is quite comprehensive and covers various aspects of ageing and welfare of the aged. However, it does not say much specifically

on old people's homes in Zambia, which seems to be consistent with government stand that these homes should be a measure or option of last resort. The reality, nonetheless, is that these institutions have played and continue to play an important role in providing for some needy elderly people in the country.

Government policy on homes for older people in Zambia is a typical example of a self-contradictory policy. The government does not support the massive construction of homes for older people. It believes that the extended family system is the best organ for looking after older people, children and other disadvantaged individuals in the community. Taking the responsibility of looking after older people from the extended family to the government is not looked at favourably in Zambia. This apparent contradiction in the provision of homes for older people can cause confusion among existing service providers and potential supporters of ageing issues and older people (The Situation of Older People in Zambia, 2006).

### **3.17 Social Protection for the Aged in Zambia**

The literature reviewed in this section gives a description of social protection mechanisms that exist for the aged in Zambia. Social protection is concerned with preventing, managing, and overcoming situations that adversely affect people's well being. It consists of policies and programmes designed to reduce poverty and vulnerability by promoting efficient labour markets, diminishing people's exposure to risks, enhancing their capacity to manage economic and social risks, such as unemployment, exclusion, sickness, disability and old age (Age and Security: Leading Global Action on Ageing, 2008).

As poverty deepens in the developing world, there is a growing interest in the role that social protection measures can play in enhancing poor people's capacity to manage risks and promote their development capacities to 'lift' themselves out of poverty. There is also increasing recognition that the 'right to development' enshrined in the 1986 UN Declaration on the Right to Development requires government and civil society to explore with greater energy the means by which all poor people can access their basic rights including that of social protection. Ensuring a secure income in old age is seen as a major challenge for governments facing fiscal problems and competing priorities. Some countries are increasingly worried whether they will be able to pay for pensions and whether they will

ultimately be able to prevent a rise in poverty in old age, particularly in countries where the majority of older persons are employed in the informal sector (HelpAge International, 2012).

The Zambian government has made several efforts to address the needs of the disadvantaged citizens including older persons. The Draft National Policy on Ageing (2011:11): states:

Since independence, Zambia has made several efforts to address the needs of the disadvantaged citizens including older persons. Some of these efforts include the introduction of the Social Cash Transfer (SCT) Scheme, Public Welfare Assistance Scheme (PWAS), Food Security Packs (FSP) Programme, Home Care Institutions for older persons, Mobile Health Facilities and creation of more pension funds. Some of the other significant strides that have been made are introduction of the exemption from paying user fees in health institutions, free health care in rural areas and the commemoration of the International Day of Older Persons.

The following are among the social protection mechanisms that the Zambian government, with assistance from cooperating partners, has been able to put in place over the years with a view to improving the welfare of the aged and other vulnerable groups in society:

#### **i. Social Cash Transfer Scheme**

The Social Cash Transfer Scheme is a universal pension scheme which targets older persons, 60 years and above and provides them with cash transfers. The Scheme started in Kalomo in 2003, Kazungula in 2005, Chipata in 2006, Monze in 2007, Katete in 2007, Kaputa, Shang'ombo, and Kalabo in 2010 and Luwingu and Serenje in 2011, and then Zambezi in 2012. The implementing partners in the Social Cash Transfer Scheme were the Department for International Development (DfID), UNICEF, Irish Aid and Finland. Since inception, the programme had been receiving overwhelming interest and support from various donor partners such as German Technical Cooperation (GTZ), Care International and other Civil Society Organisations (Brief on Cash Transfer Scheme in Zambia, 2012).

In addition, the Ministry of Community Development, Mother and Child Health implemented the inclusive model of cash transfer where the incapacitated and extremely poor households were targeted regardless of their age. In areas such as Kalomo, Monze, Kazungula and Chipata districts where the Inclusive Model was implemented, 60 % of the beneficiaries were older persons. In Serenje and Luwingu districts where the multiple categorical targeting was being implemented, most of the beneficiaries were older persons who provided care to orphans and vulnerable children and apart from being out of employment, had limited self-

health potential. In addition, the Child Grant Scheme, which was being implemented in Kalabo, Shangombo and Kaputa districts targeted older persons keeping orphans and vulnerable children under the age of five years. As a government programme, aimed at reducing poverty in communities and the country as a whole, the social cash transfer has helped alleviate the suffering of some vulnerable and needy people, including the aged. However, the biggest challenge with the scheme is that it is not a national programme. As a result, it has not benefitted many elderly people. Furthermore, the scheme is highly donor dependent with government contributing only about 10 % of the total budget (Brief on Cash Transfer Scheme in Zambia, 2012).

## **ii. Public Welfare Assistance Scheme**

The Public Welfare Assistance Scheme (PWAS) is one of government's major social safety nets or social assistance programmes aimed at mitigating the adverse effects of the socio-economic situation of the most vulnerable. PWAS categorises older persons as being vulnerable, especially in rural communities in order for them to benefit from its provisions. It targets older persons for assistance in form of food, health care, social assistance and educational support for their grandchildren. The Scheme is being implemented throughout the country and is administered with the help of Community Welfare Assistance Committees (CWACs) which are responsible for identifying clients, prioritizing and delivering the assistance. However, the Scheme does not directly target the aged. They only benefit from it by virtue of being classified as vulnerable (Brief on the Department of Social Welfare, n.d.).

## **iii. Food Security Pack Programme**

The Food Security Pack (FSP) programme is aimed at empowering the targeted low capacity or vulnerable but viable farming households. The programme provides these households with agricultural inputs in order to ensure that they become self sustained through improved productivity and household food security. The selection matrix for the beneficiaries under the FSP has "the aged" as one of its categories, hence the programme captures a number of elderly persons especially in rural areas where most of them have settled and have limited sources of assistance. In addition, most elderly persons are also benefitting from the programme under the category "household keeping orphans" as most of these orphans and vulnerable children are being looked after by their grandparents, having lost their parents mostly from HIV/AIDS. Apart from increasing food and nutritional security at household

level for elderly persons, the programme has further enhanced their household income through the sale of surplus agricultural related produce and services. This has in turn helped to address the various financial needs of their families. However, various stakeholders have observed that this programme has at times not reached the right targeted clients because it has offered policies that have favoured those that can afford, at the expense of the deserving poor, therefore, defeating the whole purpose (Report of the Committee on Health, Community Development and Social Welfare, 2011).

#### **iv. Homes for the Aged**

The first set of government programmes established after the second World War were the homes for the aged (Kamwengo, 2004), which implied institutional care for needy elderly persons. The government and the private sector have continued running homes for the aged in the country. Institutional care is, however, still a measure of last resort. The number of old people's homes is still small in Zambia. This maybe a result of very little resource allocation towards their expansion, or it may mean simply that ageing is still a non-pressing and non-priority area (Mapoma, 2013). Homes for the aged were the focus of this study.

#### **v. Exemption of Older Persons from paying Medical User Fees**

Under the Ministry of Health, older persons, 65 and above, are exempt from paying user fees. This exemption, however, only allows older persons to access primary health care services. Older persons are prone to chronic diseases associated with old age such as diabetes, hypertension, poor eye-sight, memory lapses and arthritis which require adequately equipped and trained medical personnel in health centres. However, due to most health centres being poorly equipped, older persons are forced to procure or seek medical services from other sources which require payment (Report of the Parliamentary Committee on Health, Community Development and Social Welfare for the First Session of the Eleventh National Assembly, 2011).

#### **3.17.1 Efforts made to improve Social Protection in Zambia**

The literature reviewed also indicated that the Zambian government had made some effort aimed at improving social protection and the general welfare of the aged in the country by learning from other countries' experiences. In this regard, the Parliamentary Committee on Health, Community Development and Social Welfare comprising five Members of

Parliament undertook a foreign tour to the Republic of Mauritius from 29<sup>th</sup> April to 6<sup>th</sup> May, 2011 for the purpose of learning the best practices and share experiences with regard to improving maternal health and ensuring quality social protection for the aged.

The Parliamentary Committee reported that Mauritius had developed a national policy on ageing whose main objective was to enhance the quality of life of the elderly. The policy was frequently updated in order to define new programmes and strategies concerning the welfare of the aged. This was in contrast to Zambia, whose national policy on ageing had been in draft form since 2008. The Committee also reported that the Mauritian government offered training in gerontology not only to people working with the elderly but also those wishing to pursue careers in this field. In addition, the government ensured that people working with elderly persons in care homes were trained caregivers.

The Committee also visited some old people's homes which it described as well equipped, well funded and well sourced. The homes were owned in partnership by government and NGOs. The Mauritian government's position of institutionalisation of the aged was that it should be part of the overall care for the aged but that the mainstay should be the family, implying that old people's homes should be the last resort. This is in agreement with the Zambian government's position on old people's homes.

The Committee reported that the Ministry of Social Security and Reforms Institutions of Mauritius was funding 21 homes for elderly persons and among these was the Centre for the Severely Disabled Elderly Persons. This centre catered for 32 severely disabled elderly persons who were bed ridden. The Ministry ensured strict control over these institutions with a view to ensuring that legal norms and standards were respected. Further, Private Residential Care Homes were provided under the Residential Care Homes Act 2003. It was mandatory under the appropriate regulations of the Act to have a license to run a home registered by the Ministry. These Residential Care Homes were strictly monitored in order to ensure that they abide by the expected standards. If the standards were not met, immediate closure was recommended by the Ministry.

Arising from its findings and experience in Mauritius, the Parliamentary Committee on Health, Community Development and Social Welfare (2011) recommended that:

- i. The Zambian government should increase the budgetary allocation to the MCDMCH in order to facilitate implementation of various programmes and policies for the aged.
- ii. The National Policy on Ageing should immediately be approved by Cabinet to implement coordinated efforts to address the plight of the aged. This policy should be frequently updated in order to define new programmes and strategies concerning the welfare of the aged.
- iii. The government should emulate the Mauritian government by creating a medical unit at the MCDMCH.
- iv. The government should offer training in gerontology and ensure that people working with elderly persons in old age homes are trained caregivers.

It can, therefore, be noted from the foregoing that the Zambian government has tried to put up programmes that seek to uplift the living standards of the vulnerable in society, including the aged. However, all the above social protection programmes or mechanisms have not incorporated the issue of educational programmes for the aged in old people's homes, which is what this study sought to do, hence making it significant and relevant.

### **3.18 Summary**

This chapter focused on the literature that was considered relevant to the present study with a view to examining the care provided to the aged in old people's homes and implications for adult education programmes. Among the issues discussed were the concepts of age and population ageing, global population ageing, global action and progress on ageing. It also discussed the living arrangements for the aged in the world and care for the aged in the world and in Zambia. The literature also analysed information and studies on factors that lead to institutionalisation of the aged, services provided to the aged in old people's homes, challenges faced by the aged in the community and old people's homes and those faced by caregivers. It then discussed the policy framework and social protection for the aged in Zambia. Preliminary information and suggestions on how care for the aged in old people's homes could be improved through provision of programmes have also been highlighted. Critical consideration of the literature reviewed indicates that there is little information on institutional care of the aged in Zambia and no studies exist on the extent to which adult education programmes are provided to the aged in old people's homes in Zambia. The



literature has revealed that most of the studies on institutional care of the aged are based on Western and Asian contexts, with very few on the African and Zambian contexts. Furthermore, the literature reviewed has shown that most of the studies on education for the aged have focused mainly on the aged living in communities and not those residing in an institutional setup, hence the relevance of this study. The next chapter presents the methodology of the study.

## **CHAPTER 4**

### **METHODOLOGY**

#### **4.0 Overview**

This chapter presents the methodology that was used in the study. It comprises the following components: research design, population and study areas, sample and sampling technique, data collection procedure, instruments of data collection, data analysis, data quality, piloting of data collection instruments, challenges encountered during data collection and ethical considerations. It ends with a summary.

#### **4.1 Study Epistemology**

Epistemology is the beliefs on the way to generate, understand and use knowledge that is deemed to be acceptable and valid. It refers to a model for undertaking a research process in the context of a particular paradigm (Wahyuni, 2012). This study was guided by the interpretivist/constructivist research paradigm and searched for experiences of people living in old people's homes and their caregivers in Zambia. Flowers (2009) states that in the social world it is argued that individuals and groups make sense of situations based upon their individual experiences, memories and expectations. Meaning is, therefore, constructed and over time constantly re-constructed through experience.

#### **4.2 Research Design**

A research design is a general term that covers a number of separate, but related, issues associated with research. It includes the aims of the research, the final selection of the appropriate methodology, the data collection techniques one intends to use, the chosen methods of data analysis and interpretation and how all this fits in with the literature (White, 2000). The function of a research design is to ensure that the evidence obtained enables us to answer the initial questions as unambiguously as possible. Obtaining relevant evidence entails specifying the types of evidence needed to answer the research question, to test a theory, to evaluate a programme or to accurately describe some phenomenon. "When designing research we need to ask: given this research question (or theory), what type of evidence is needed to answer the question (or test the theory) in a convincing way?" (Des Vaus, 2001:4).

Des Vaus (2001) states that research design deals with a logical problem and not a logistical problem. He explains that a research design is different from the method by which data are collected and that many research methods confuse research design with methods. Des Vaus goes on to point out that it is not uncommon to see research design treated as a model of data collection rather than a logical structure of the enquiry.

This study used a descriptive survey research design in which both qualitative and quantitative methods were used. The major purpose of the descriptive research design is description of the state of affairs as it exists. The researcher reports the findings. Descriptive studies are not only restricted to fact finding, but may often result in the formulation of important principles of knowledge and solutions to significant problems. They are more than just a collection of data. They involve measurement, classification, analysis, comparison and interpretation of data (Kombo and Tromp, 2006). Survey research systematically gathers information about a situation, an area of interest, a series of events or about people's attitudes, opinions, behaviour, interests or practices. Survey research is predominantly descriptive. It is for this reason that the terms descriptive and survey research are sometimes used interchangeably (Chilisa and Preece, 2005). "Descriptive survey is a method of collecting information by interviewing or administering a questionnaire to a sample of individuals" (Kombo and Tromp, 2006:71).

The descriptive survey research design was, therefore, chosen in this study because it enabled the researcher to give an accurate account of the state of affairs in old people's homes in Zambia. It sought to describe the characteristics of the aged in old people's homes, their living conditions, assess the services provided to them and establish the challenges faced by both the aged and caregivers. It further sought to establish the extent to which adult education programmes and activities were provided in old people's homes. Des Vaus (2001) points out that although some people dismiss descriptive research as a 'mere description', good description is fundamental to the research enterprise and that it has added immeasurably to our knowledge of the shape and nature of our society.

#### **4.3 Population and Study Sites**

##### **4.3.1 Population**

According to Kombo and Tromp (2006) a population is defined as a group of individuals, objects or items from which samples are taken for measurement. It refers to an entire group

of persons or elements that have at least one thing in common The population for this study consisted of all the aged in old people's homes in Zambia, officers in the Social Welfare, Planning and Training units of the Ministry of Community Development, Mother and Child Health (MCDMCH) headquarters, Provincial and District Social Welfare Officers, caregivers, the Parliamentary Committee on Health, Community Development and Social Welfare, and staff of the Senior Citizens Association of Zambia (SCAZ).

#### **4.3.2 Study Sites**

The study was undertaken in all nine old people's homes located in eight districts, representing five provinces in Zambia. The districts were Lusaka, Livingstone, Sesheke, Senanga, Ndola, Luanshya, Mufulira and Solwezi, while the provinces were Lusaka, Southern, Western, Copperbelt and Northwestern. The districts and provinces represented both urban and rural parts of the country and were selected because that is where old people's homes are located. It would be helpful to give a brief background of each home that was visited for the study.

##### **i. Mitanda Old People's Home**

Mitanda old people's home, which is located in Ndola, was the first home for the aged to be established in Zambia. The premises on which it is located now was an army mess during the Second World War. After the war the premises became a government hostel. In 1948 the hostel was transferred to what is now called insakwa probation hostel. Mitanda was then turned into a home for the aged. Soon after it became a home, it was handed over to the Salvation Army to run it on behalf of the government (Kamwengo, 2001).

##### **ii. Maramba Old People's Home**

Maramba old people's home, which was established in March 1963 (Kamwengo, 2001), is found in Livingstone. It was initially meant for the reintegration of people who had gone to South Africa and Zimbabwe, then Southern Rhodesia, for work during the colonial era but later returned. As these people were returning and reintegrating into the community, some did not have anywhere to go and could not trace their relatives. They, therefore, sought shelter at the home and became permanent residents there. Maramba was then turned into an old people's home. It is a government-run old people's home.

### **iii. Chibolya Old People's Homes**

Chibolya old people's home is found in Mufulira. It was established in September, 1963 to care for the elderly who had no relatives to look after them. The building in which it is housed was once used as a hostel for job seekers under the Ministry of Labour. Then in 1963 it was given to the Department of Social Welfare so that it could be turned into a home for the aged. Chibolya is also a government-run old people's home (Kamwengo, 2001).

### **iv. Divine Providence House**

Divine Providence House is a privately run home for the aged in Chawama compound in Lusaka. It started as an effort by the local Christian community to accommodate a stranded old woman. A house was built for her but when more people started coming for help, the local priest, Father Angelo Pazica, and the local Christian community applied for a plot on which the present-day home was built. Funds for the construction of the home came from the European Community. In 1992 the home was officially opened by the Member of Parliament for the area. In 1994 the house was handed over to the Catholic Holy Family Sisters who are still running it (Kamwengo, 2001).

### **v. Kandiana Old People's Home**

Kandiana old people's home is located in Mwandi Mission in Mwandi district. At the time of the study, Mwandi was under Sesheke district but was also later declared a district. It was initially a leprosy centre starting from the 1940s. However, in the early 1980s it started operating as an old people's home to take care of ostracised elderly persons. These were vulnerable adults who had been rejected by their families and the community, mainly on grounds that they had been practicing witchcraft or the belief that they were 'unclean' owing to the leprosy ailments they had. The home is run by the United Church of Zambia.

### **vi. Chibote Old People's Home**

Chibote old people's home is located in Walale township in Luanshya. It was set up in 1980 for the purpose of taking care of needy elderly persons who had no one to look after them. Initially, its mandate was only to take care of destitute and needy elderly persons from the surrounding community within Luanshya. However, with the passage of time and increase in demand for the services, the home started admitting the elderly from other parts of the

country. Chibote old people's home is run by the Catholic Franciscan Mission Sisters of Assisi.

**vii. St. Therese's Village**

St. Therese's Village is found in Ndola. It was opened in 2004 to take care of the neglected and abandoned elderly in society. It currently provides shelter to the elderly who have no family support due to factors such as loss of carers or would-be carers. The home is run by the Ndola Ecumenical Hospice Association (NEHA), a faith-based organisation registered with the Registrar of Societies, which was founded in 1996 by four churches in the Ndola area, namely: the Anglican Church, the Catholic Church, the Reformed Church in Zambia and the United Church of Zambia.

**viii. Likulwe Old People's Home**

Likulwe old people's home, which is located about 10 kilometres from Senanga district, was set up in 1958. It is run by the Catholic Church. Likulwe was initially a centre for former leprosy patients but later transformed into a home for the aged. After being discharged, the former leprosy patients could not be reintegrated or accepted back into the communities they had come from. They suffered stigmatisation and rejection by the relatives and friends despite being cured of their ailments. The government, therefore, had to find a way of looking after them following their discharge from Senanga district hospital. It, therefore, became a permanent home for the aged.

**ix. Nkulumazhiba Old People's Home**

Nkulumazhiba old people's homes, which is located about 75 kilometres west of Solwezi, was established in 2010 to care for the elderly who had been rejected, neglected or abused by their communities. Most of the residents had been accused of practicing witchcraft in their home villages and had to be brought to the home for their own security and safety. Others were admitted to the home because they had no one to take care of them. It is run by the Peace Embassy Ministries, whose headquarters are in Solwezi. Table 2 below shows all old people's homes in Zambia, the districts and provinces in which they are located and the agencies that run them.

**Table 2: Location of old people's homes by district, province and agencies running them**

No	Old People's Home	District	Province	Run By
1.	Chibolya	Mufulira	Copperbelt	Department of Social Welfare (GRZ)
2.	Mitanda	Ndola	Copperbelt	Salvation Army
3.	Chibote	Luanshya	Copperbelt	Catholic Church
4.	St. Therese's Village	Ndola	Copperbelt	Ndola Ecumenical Hospice Association
5.	Maramba	Livingstone	Southern	Department of Social Welfare (GRZ)
6.	Divine Providence	Lusaka	Lusaka	Catholic Nuns (Sisters of Mercy)
7.	Kandiana	Sesheke	Western	United Church of Zambia
8.	Likulwe	Senanga	Western	Catholic Church
9.	Nkhulumazhiba	Solwezi	North-Western	Peace Embassy International

Source: Field Survey, 2013.

#### 4.4 Sample

A sample is a finite part of a statistical population whose properties are studied to gain information about the whole (Kombo and Tromp, 2006). It is a small proportion of a population selected for observation and analysis. It is a collection consisting of a part or subset of the objects or individuals of population which is selected for the purpose of representing the population. By observing the characteristics of the sample, one can make inferences about the characteristics of the population from which it is drawn (Sidhu, 2006). A total sample of 201 respondents participated in this study. The number of respondents was broken down as follows: 165 aged persons in old people's homes, 3 officers in the Social Welfare, Planning and Training units of the Ministry of Community Development, Mother and Child Health headquartes, 5 Provincial Social Welfare Officers, 8 District Social Welfare Officers, 17 caregivers in old people's homes, the Chairperson of the Parliamentary Committee on Health, Community Development and Social Welfare of the National Assembly of Zambia and 2 officers from the Senior Citizens Association of Zambia.

#### 4.5 Sampling Technique

Sampling technique refers to that part of the research plan that indicates how cases were selected for the study. It is the process a researcher uses to gather people, places or things to study on. It is a process of selecting a number of individuals or objects from the population such that the selected group contains elements representative of the characteristics found in the entire group (Kasonde-Ng'andu, 2013). Purposive sampling was used to select all the respondents in this study. In purposive sampling the sample units are chosen because they

have particular features or characteristics which will enable detailed exploration and understanding of the central themes and puzzles which the researcher wishes to study. These features may include socio-demographic characteristics, or may relate to specific experiences, behaviours and roles (Ritchie and Lewis, 2003). Kasonde-Ng'andu (2013) adds that in this sample method, the researcher purposely targets a group of people believed to be reliable for the study. Purposive sampling was, therefore, used in this study because the researcher believed that respondents included in the sample would be in a position to provide relevant information.

#### **4.6 Data Collection Procedure**

Data collection refers to the gathering of information to answer research questions. In research, the term 'data collection' refers to gathering specific information aimed at proving or refuting some facts (Kasonde-Ng'andu, 2013). Researcher-administered semi-structured questionnaires comprising both closed-ended and open-ended questions were used to collect data from the aged in old people's homes. Given the low levels of literacy among this category of respondents, there would have been many difficulties and disadvantages if self-administered questionnaires were used to collect information from them. Trained research assistants who were fluent in the local languages, which the researcher was not familiar with, helped in administering the questionnaires in some study areas. During training and pretest, interviews were held in the local languages spoken in the study areas. This was done to ensure that standardisation is maintained and the questions asked in the local language maintained the same meaning as those in English (Mapoma, 2013). Semi-structured interview guides comprising mostly open-ended and few closed-ended questions were used to collect data from officers at the MCDMCH headquarters, provincial and districts social welfare officers and caregivers in old people's homes. Additionally, an unstructured interview guide was used to collect data from the Chairperson of the Parliamentary Committee on Health, Community Development and Social Welfare and officers from the Senior Citizens Association of Zambia, while an observation checklist was used by the researcher to observe various aspects of elderly care in old people's homes. Information from interviews was both recorded in note form and tape-recorded.



## **4.7 Research Instruments**

Research instruments refer to the tools that the researcher uses in collecting the necessary data. The most common research instruments used include questionnaires, interview schedule observation checklist and focus group discussion guide (Kasonde-Ng'andu, 2013). In order to collect data, three different instruments were used, namely: researcher-administered semi-structured questionnaires, semi-structured interview guides, unstructured interview guides and an observation checklist. The instruments are briefly described below:

### **4.7.1 Questionnaire**

According to Buchi (1974), a questionnaire is a written document comprising questions seeking answers on a particular subject. It is a predetermined set of questions used to collect data, which comprises clinical data, socioeconomic status and related aspects. The instrument is either administered by an interviewer in an interview situation or is self-administered by a subject (WHO, 2004). In this study a researcher-administered semi-structured questionnaire was the main instrument of data collection. It enabled the researcher to collect information on the background characteristics of the aged respondents and various aspects of care and services provided in old people's homes in Zambia. The benefits of using a researcher-administered questionnaire are that the respondents are able to answer most or all the questions they are asked during the session. Since the responses are not centred on an individual, anonymity of the respondents is enhanced. There is also a high questionnaire retention rate and reduced chances of loss and spoilage. Furthermore, closed-ended questions in the questionnaire are easy to analyse. White (2000:50) adds: "Questionnaires generate data in a very systematic and orderly fashion".

### **4.7.2 Interview Schedule**

The second instrument used in the study was the interview schedule. Kasonde-Ng'andu (2013) defines an interview schedule as a written list of questions or topics that need to be covered in an interview. According to White (2000), interviews are a popular form of data collection and provide, when properly conducted, a rich source of material. Interviews either take place with individuals or groups. Interviews with individuals are known as personal interviews and can either be structured or unstructured. In a structured personal interview the interviewer has a list of prescribed questions for the interviewee. The advantage of this technique is that one can conduct a larger number of interviews since the data collected is

easier to interpret. In unstructured personal interviews the interviewer directs the conversation by identifying a number of topics and allows the interviewee to talk them through in their own time.

Sidhu (2006) highlights the importance of interviews by stating that the interviewer can probe into causal factors, determine attitudes, discover the origin of the problem, involve the interviewee in an analysis of his/her own problems and secure his/her cooperation in the analysis. Sidhu adds that the interview is particularly appropriate when dealing with young children, illiterates, those with language difficulty and those with limited intelligence.

#### **4.7.3 Observation Checklist**

The third instrument used in this study was the observation checklist. Kasonde-Ng'andu (2013) states that an observation checklist is a tool that provides information about actual behaviour. She explains that direct observation is useful because some behaviour involves habitual routines of which people are hardly aware and that this method allows the researcher to put behaviour in context, thereby understanding it better. Leedy and Ormrod (2005) point out that observations in a qualitative study are intentionally unstructured and free-flowing. This means that the researcher is free to shift focus from one thing to another as new and potentially significant objects and events present themselves provided he/she does not waste time observing things that are not important and, consequently, overlooking those that are central to the question.

Observation is a technique for gathering data that are almost impossible to obtain with other methods. Researchers observe and record information relevant to the research questions (McMillan and Schumacher, 2006). Additionally, observation offers the opportunity to record and analyse behaviour and interactions as they occur. This allows events, actions and experiences and so on to be 'seen' through the eyes of the researcher, often without any construction on the part of those involved. It is a particularly useful approach when a study is concerned with investigating a 'process' involving several players, where an understanding of non-verbal communication are likely to be important or where the behaviour consequences of events form a focal point of study (Ritchie and Lewis, 2003).

The researcher made field notes during the observation of various aspects of care for the aged in old people's homes. Field notes provide an opportunity to record what researchers see and

hear outside the immediate context of the interview, their thoughts about the dynamic of the encounter, ideas for inclusion in the later field work and issues that may be relevant at the analytical stage. They may simply involve rough jottings, but generally some stimulation of the issues for consideration and consistency between researchers in the coverage of field notes will be required (Ritchie and Lewis, 2003). The researcher used a note book to record all pertinent observations made during the period of data collection with the help of an observation checklist.

#### **4.8 Data Analysis**

Data analysis refers to examining what has been collected in a survey or experiment and making deductions and inferences. It is a manipulation of the collected data for the purpose of drawing conclusions that reflect on the interests, ideas and theories that initiated the study. It involves uncovering underlying structures, extracting important variables, detecting any variance and testing any underlying assumptions (Kasonde-Ng'andu, 2013). Since this study employed the descriptive survey research design which goes along with descriptive techniques, it used descriptive or summary statistics to analyse numerical data. Kasonde-Ng'andu states that descriptive analysis entails the use of measures of central tendencies, (mean, median and mode) and measures of dispersal (range, standard deviation and variance). "Descriptive statistics are used when the purpose of the research is to describe the data in the study." (Chilisa and Preece, 2005:125). The Statistical Package for the Social Sciences (SPSS) Version 20 was used to process descriptive statistics and present data using frequency tables, percentages and graphs. Non-numerical data was analysed qualitatively by identifying and categorising emerging themes and presenting key concepts and narrations. Kumar (2005) states that qualitative data analysis is a process of analysing the contents of an interview in order to identify the main themes that emerge from the responses given by the respondents.

#### **4.9 Data Quality**

In order to enhance the quality of collected data the following measures were taken:

- i. A tape-recorder was used to ensure accuracy of information that was collected.
- ii. The process of triangulation was employed. Triangulation involves the use of different methods and sources to check the integrity of, or extend inferences drawn from the data. It has been widely adopted and developed as a concept by qualitative researchers as a means of investigating the 'convergence' of both the data and the conclusions derived from them

(Ritchie and Lewis, 2003). Chilisa and Preece (2005:167) add: “Triangulation is another strategy for enhancing the credibility of the study. It is based on the assumption that the use of multiple methods, data sources or investigators can eliminate biases in the study.” In this study three forms of triangulation were employed. The first one was triangulation of nature of information, which entailed a combination of primary data and secondary data as well as data that came in numeric form and non-numeric form. The second form was triangulation of methods, which involved the use of researcher- administered questionnaires, interviews and observation. The third form was triangulation of sources, which entailed collecting information from various sources who included the aged in old people’s homes, caregivers, officers in the Social Welfare, Planning and Training units at the MCDMCH headquarters, provincial and district social welfare officers, the Chairperson of the Parliamentary Committee on Health, Community Development and Social Welfare of the National Assembly of Zambia and officers at the Senior Citizens Association of Zambia. Triangulation enabled the researcher to collect comprehensive data and get views from a cross section of respondents in different parts of the country.

iii. Analysed all the questions in the instruments to ensure comprehensiveness and completeness of data.

iv. Conducted a pilot study where questions were tested and modified if they were seen not to be addressing the problem or issue.

v. Before commencement of the study, research assistants were given an orientation and trained to ensure uniformity in the understanding and administration of the research instruments in old people’s homes. Additionally, the researcher was always present in situations where research assistants administered questionnaires in case they needed help or guidance.

#### **4.10 Piloting of Data Collection Instruments**

The term pilot studies refer to mini versions of a full-case study. Pilot studies are a crucial element of a good study design. Conducting a pilot study does not guarantee success in the main study, but it does increase the likelihood of success. Pilot studies fulfil a range of important functions and can provide valuable insights for other researchers. One of the advantages of conducting a pilot study is that it can give advance warning about where the main research project could fail, where research protocols might not be followed, or whether proposed methods or instruments are inappropriate or too complicated (Van Teijlingen,

2002). Failure to pilot the study may contribute to haphazard work in the field. This is mainly because a pre-test helps to identify some shortcomings likely to be experienced during the actual study. A pre-test of the questionnaire and field procedures is the only way of finding out if everything will ‘work’ during the actual work (Kombo and Tromp 2006).

Questionnaires and interview guides for this study were subjected to validation and testing in two ways. Firstly, they were given to two colleagues within the University for Peer Review who made observations, comments and suggestions which were incorporated into the final instruments. Secondly, the instruments were used for pilot testing at Matero Aftercare Centre in Lusaka, which was not one of the study areas. Questions were tested and modified if they were not addressing the problem. It should be pointed out that Matero Aftercare Centre is not necessarily a home for the aged. It is a transit home where stranded people and destitutes are kept before being repatriated to their home areas. But because a large number of the residents are elderly, it has been included among the homes for the aged (Kamwengo, 2001). The participants in the pilot study, therefore, had similar characteristics as those in the actual study. After the pilot study, corrections were made and unclear or ambiguous questions and statements were rephrased.

#### **4.11 Ethical Considerations**

Ethics in research should be an integral part of the research planning and implementation process, not viewed as an afterthought or a burden (Mertens, 1998). According to Mertens, The National Commission for the Protection of Human Species in Biomedical and Behavioural Research (1978) identified three ethical principles and six norms that should guide scientific research in a landmark report titled “The Belmont Report”. The three ethical principles included the following:

- i. Benefice: Maximising good outcomes for science, humanity and the individual research participants and minimising or avoiding unnecessary risk, harm or wrong.
- ii. Respect: Treating people with respect and courtesy, including those who are not autonomous, such as small children, people who have mental retardation or senility.

- iii. Justice: Ensuring that those who bear the risk in the research are the ones who benefit from it; ensuring that the procedures are reasonable, non-exploitative, carefully considered and fairly administered.

The six norms of scientific research, according to Mertens (1998), included the following:

- i. Use of a valid research design: Faulty research is not useful to anyone and is not only a waste of time and money, but cannot be conceived of as being ethical in that it does not contribute to the well-being of the participants.
- ii. The researcher must be competent to conduct research.
- iii. Consequences of the research must be identified, procedures must respect privacy, ensure confidentiality, maximize benefits and minimize risks.
- iv. The sample selection must be appropriate for the purposes of the study, representative of the population to benefit from the study and sufficient in number.
- v. The participants must agree to participate in the study through voluntary informed consent, that is, without threat or undue inducement, knowing what a reasonable person in the same situation would want to know before giving consent and explicitly agreeing to participate.
- vi. The researcher must inform the participants whether harm will be compensated.

White (2000) advises that if one was not provided with any set guidelines or code of practice, the following consideration may help when carrying out research work:

- i. Only involve people with their consent or knowledge. Participants should always have enough information about the research to make an informed decision as to whether to take part or not. During the research participants should retain the right to draw back and remove consent if they so wish.
- ii. Never coerce or persuade people to participate in research. Participants have the right to choose for themselves whether to be the subjects of one's research.
- iii. Never withhold information on the true nature of the research. Explain to all what it is all about.
- iv. Tell the truth about the research and never deceive participants in any way.
- v. Never induce participants to do things which could destroy their self-confidence or self-determination.

- vi. Never expose people to situations which could cause mental or physical stress.
- vii. Respect a participant's right to privacy. If anonymity and confidentiality are guaranteed, this should always be maintained.
- viii. Treat all groups in the same research project alike, with consideration and respect.
- ix. When you write up your research, you should present the evidence with honesty and integrity and never knowingly allow anyone to misuse or misinterpret your work.

Having considered the issues raised by Mertens (1998) and White (2000), the following actions were undertaken by the researcher to make the study ethical:

- i. The study topic was approved by the Directorate of Research and Graduate Studies after being considered at both department and School levels. Further, as is a requirement when conducting research on human subjects, clearance for commencement of the study was sought from the University of Zambia Humanities and Social Sciences Research Ethics Committee.
- ii. Written clearance and permission were obtained by the researcher from the Ministry of Community Development, Mother and Child Health, specifically, the Department of Social Welfare. The researcher went on to pay courtesy calls on Provincial Social Welfare Officers in charge of provinces where the study was conducted, namely, Lusaka, Copperbelt, Western and North Western, who were also among the respondents in the study.
- iii. Prior informed consent was obtained from all the respondents who participated in the study. Informed consent is a critical concept in ethical considerations as it involves ensuring that potential participants have a clear understanding of the purpose of the study, the funder, the organisation or individuals conducting it, how the data will be used and what participation will mean to them. Accordingly, the purpose and procedure of the study was explained to all respondents in this study. They were also assured that the information they would provide was purely for academic purposes.
- iii. The respondents were informed that their participation in the study was voluntary and that they were at liberty to withdraw at any time without necessarily having to give an explanation. Additionally, permission to tape record the interviews was sought from the respondents before commencement of interview sessions.

- iv. In terms of anonymity, respondents were informed that their participation in the study would remain anonymous and that their identity would not be disclosed to anyone.
- v. Respondents were assured of confidentiality of information they would provide. Confidentiality means avoiding the attribution of comments, in reports or presentations, to identify participants. The researcher, therefore, handled all information that was collected with maximum confidentiality and ensured that no names of respondents appeared in the final report.

#### **4.12 Challenges Encountered During Data Collection**

The researcher faced a number of challenges during the data collection which started on 15 August 2012 and ended on 13 March 2013. Firstly, securing permission from the Ministry of Community Development, Mother and Child Health and agencies in charge of old people's homes was not an easy undertaking. The researcher had to wait for a number of weeks before receiving permission to proceed for data collection.

The other major limitation of this study was the inadequacy of literature, especially studies conducted in Africa and Zambia, in particular, on institutionalisation of the aged as well as education for the aged. The other major challenge was language barrier, especially in three of the homes, namely Maramba, Kandiana, and Likulwe where the language of interview was predominantly Tonga and Lozi. However, this challenge was overcome with the help of trained research assistants who helped with the administration of the questionnaires to the aged. The other challenge was the slow pace of administering the questionnaires, which entailed that the researcher had to stay in these study areas longer than planned at a higher cost. Some elderly respondents had hearing problems, so one had to speak very loudly in order to be heard, which was rather strenuous.

Despite the above challenges, the researcher gathered comprehensive, useful and insightful information on caring for the aged in old people's homes in Zambia and implications for Adult Education programmes. The researcher did not face the problem of respondents refusing to participate in the study and all the aged and other respondents showed willingness to participate as long as the purpose of the study was explained to them.

#### **4.13 Summary**

This chapter has presented the research methodology of the study. The study employed the descriptive survey research design which enabled the researcher to examine the care and



services that were provided to the aged in old people's homes in Zambia and their implications for adult education programmes. The chapter has also described the study population and study areas, sample and sampling technique, data collection procedure, instruments of data collection, data analysis, data quality, piloting of data collection instruments, challenges encountered during data collection and ethical considerations. It has ended with a summary. The next chapter presents the findings of the study.

## **CHAPTER 5**

### **FINDINGS**

#### **5.0 Overview**

This chapter presents findings of the study on caring for the aged in old people's homes in Zambia and implications for adult education programmes. These findings are presented according to the objectives of the study which were to: establish factors that led to the aged moving to old people's homes in Zambia, assess services provided to the aged in old people's homes in Zambia, identify challenges faced by the aged in old people's homes in Zambia, ascertain challenges faced by caregivers in old people's homes in Zambia and establish the extent to which adult education programmes were provided in old people's homes in Zambia. Verbatim excerpts from the transcribed interviews were used to support themes that emerged from the data to provide a richer picture of the situation (Namakando, 2004).

#### **5.1 Categories of Respondents**

Information for the study was collected from four categories of respondents. The first and major category of respondents comprised the aged living in old people's homes. The second category consisted of caregivers in old people's homes while the third comprised government officers namely; Provincial and District Social Welfare Officers in provinces and districts where old people's homes are located and senior officers in the Social Welfare, Planning and Training units at the MCDMC headquarters in Lusaka. The fourth category consisted of the Chairperson of the Parliamentary Committee on Health, Community Development and Social Welfare and officers of the Senior Citizens Association of Zambia (SCAZ).

#### **5.2 Background Characteristics of the Aged Respondents**

As earlier pointed out, the aged were the main respondents and a total of 165 aged persons participated in the study. Table 3 below shows the distribution of the aged respondents by province, old people's homes and gender.

**Table 3: Distribution of the aged respondents by province, old people's homes and gender**

Province	Old People's Home	Gender					
		Male		Female		Total	
		Count	Table N %	Count	Table N %	Count	Table N %
Copperbelt	Chibolya	10	6.1%	11	6.7%	21	12.8%
	Chibote	8	4.8%	5	3.0%	13	7.8%
	Mitanda	9	5.5%	9	5.5%	18	10.9%
	St Therese' Village	9	5.5%	9	5.5%	18	10.9%
Lusaka	Divine Providence	9	5.5%	8	4.8%	17	10.3%
North-Western	Nkulumazhiba	2	1.2%	8	4.8%	10	6.0%
Southern	Maramba	27	16.4%	15	9.1%	42	25.5%
Western	Kandiana	9	5.5%	3	1.8%	12	7.3%
	Likulwe	6	3.6%	8	4.8%	14	8.5%
Total		89	53.9	76	46.1	165	100.0

The Copperbelt Province had the majority 70 (42.4%) of aged respondents followed by Southern province with 42 (25.5%). The next was Western province with 26 (15.8%) while Lusaka had 17 (10.3%). North-Western Province had the least number with only 10 (6.0%). It should be noted that the Copperbelt province had four old people's homes while Western Province had two. Lusaka, North-Western and Southern provinces had one each. Furthermore, the Table indicates that 89 (53.9 %) of the elderly respondents in old people's homes were males while 76 (46.1 %) were females.

#### 5.2.1 Nationality of the Aged Respondents

The study sought to establish the nationality of the aged respondents in old people's homes in Zambia. Table 4 below shows their nationality:

**Table 4: Nationality of the aged respondents**

	Frequency	Percent
Zambian	150	90.9
Angolan	6	3.6
Malawian	2	1.2
South African	2	1.2
Zimbabwean	2	1.2
Congolese	1	0.6
Mozambican	1	0.6
Polish	1	0.6
Total	165	100.0

As can be seen from Table 4 above, it was not only Zambian nationals that resided in old people's homes, but also nationals from other countries within Africa and beyond.

### 5.2.2 Age of Elderly Respondents

The study also sought to establish the age of elderly respondents in old people's homes. Table 5 below shows their age ranges

**Table 5: Age of elderly respondents**

Age Range		Frequency	Percent	Valid Percent
	71 years and above	102	61.8	75.0
Valid	60-70 years	34	20.6	25.0
	Total	136	82.4	100.0
Missing	Not stated	29	17.6	
	Total	165	100.0	

One hundred and two (61.8%) of the elderly respondents were aged 71 years and above, while 34 (20.6%) were aged between 60 and 70 years. Twenty nine (17.6%) did not know their exact ages but caregivers indicated that they were all above 60 years. The average age of the respondents was 77.24 years, with the oldest being 99 years and the youngest being 60 years old.

### 5.2.3 Educational Attainment of the Aged Respondents

The aged respondents were asked to indicate their level of education. Table 6 below shows their responses:

**Table 6: Highest level of education attained by the aged respondents**

Level of Education	Frequency	Percent
Never been to school	81	49.1
Primary	66	40.0
Secondary	15	9.1
Tertiary	3	1.8
Total	165	100.0

Eight-one (49.1%) of the aged respondents stated that they had never attended school in their lives, 66 (40.0%) indicated that they had attained primary level of education, with 15 (9.1%) stating that they had attained secondary level. Only 3 (1.8 %) reported that they had attained tertiary level of education. This means that majority of the aged in old people's homes in Zambia had never attended formal education.

#### 5.2.4 Length of Stay by the Aged Respondents in Old People's Homes

This study established that the longest stay by the aged respondents in old people's homes was 32 years while the shortest was one month. The average stay at old people's homes was 6.6 years. Fifteen percent of the aged respondents had been staying at old people's homes for at least five years. As can be noted, some elderly respondents had been living in these homes for a long time. This implies that old people's homes are not a temporal phenomenon in Zambia.

#### 5.3 Factors that led to the Aged Moving to Old People's Homes

The first objective of the study sought to establish factors that led to the aged moving to old people's homes in Zambia. The aged respondents were asked to state the factors that led to their moving to old people's homes. Table 7 below shows the responses:

**Table 7: Factors that led to the aged moving to old people's homes**

<b>Factors</b>	<b>Frequency n = 165</b>	<b>Percent</b>
Lack of family members	70	42.4
Abandonment related to illness and old age	60	36.4
Destitution	35	21.2
Harassment	18	10.9
Disability	13	7.9

The majority 70 (42.4%) of the respondents cited lack of family members as the factor that led to their moving to old people's homes in Zambia, while 60 (36.4%) said that they were abandoned by their families on account of illness and old age. Thirty five (21.2%) cited destitution while 18 (10.9%) reported that they moved to old people's homes because they had suffered harassment from members of their families and community, mainly on suspicion that they were practicing witchcraft. Thirteen (7.9%) of the respondents attributed their moving to old people's homes to disability. The factors are briefly described below.

##### 5.3.1 Lack of Family Members

The most important factor that led to the aged moving to old people's homes was lack of family members. Most respondents stated that they had no family members to support or take care of them and, therefore, the only option for them was to move to old people's homes,

where they were assured of support, care and security. For example, a female respondent at Chibolya old people's home said:

*I lost my husband and all my five children. So I had no one to take care of me. That is how I approached my pastor and explained my situation to him as I was having difficulties coping on my own. The pastor then brought me here and this is now home.*

A male respondent at Maramba old people's home also put it as follows:

*I lost touch with my people in the village when I moved to town for work a very long time ago. I stopped writing letters to them when I started working on the farms. So I had nowhere to go after retirement as I could not trace any one of them.*

One male respondent at Divine Providence Home was a former teacher who had graduated from the University of Zambia with a degree in Education. He explained that after retiring from the Ministry of Education, he settled in Kasama where he engaged in farming. However, his wife and two children died and he ended up being admitted to Kasama General Hospital and later the University Teaching Hospital for a long time with depression. Upon being discharged, he had nowhere to go as he had no other family members remaining. So a Catholic priest took him to Divine Providence Home.

The above view was supported by some caregivers who stated that the aged moved to old people's homes because they did not have anybody to support them and that the HIV/AIDS pandemic had claimed the lives of many young people who were breadwinners. A caregiver at Chibote old people's home said:

*...Some children have died of AIDS leaving their ageing parents without support. These parents become stranded and those who are lucky find themselves in old people's homes.*

### **5.3.2 Abandonment Related to Illness and Old Age**

The second factor that contributed to the aged moving to old people's homes was abandonment of the aged by their family members due to illness and old age. Some respondents indicated that they had been ill and hospitalised for a long time and that family members who had earlier been visiting and supporting them, eventually stopped doing so and abandoned them. One male respondent, on a wheel chair, at Chibolya old people's home explained:

*I was admitted to Liteta Leprosarium in 1963, a year before we got independence. I was discharged from there in 1980 after a doctor from the United Kingdom certified that I was completely cured of leprosy and could not transmit it to others. However, after noticing that no one had been coming to visit me, they sent me to*

*Social Welfare in Lusaka, who sent me to Matero Aftercare, a transit home. In 2000, I was brought to Chibolya home, where I have been ever since.*

A female respondent at Divine Providence Home also said:

*I was very ill and hospitalised at UTH for four years and when I was discharged I had nowhere to go. I could not go to any of my relatives as they all had abandoned me. In fact, when I was in hospital no one ever visited me. So Sister brought me to Divine Providence Home on the recommendation of the Minister of Community Development, Madam Catherine Namugala.*

Furthermore, a male respondent at Mitanda old people's homes emotionally explained that when he was working in the mines, he took care of many of his relatives for his entire working life. He supported many of them in their education but that when he stopped work and got very sick, they all deserted him, including his own wife. He lamented:

*A person is like a fly. When you have plenty, you will see him/her around you but when you have nothing and become incapacitated, you will be shocked how you will be deserted.*

### 5.3.3 Destitution

The third factor that contributed to the aged moving to old people's homes was destitution. The aged respondents indicated that they had no means of livelihood and survival and faced many difficulties. Some became homeless as they could not afford house rentals. A male respondent at Divine Providence Home made the following statement:

*I had nowhere to go after losing my employment. I, therefore, became a destitute. I had no money, no house and no support from any one. I started loitering until one priest who had earlier known me heard of my situation. He then brought me to this place. Otherwise, I would have long died.*

Additionally, a male respondent at Maramba old people's home said:

*I came to this home because of suffering. I had nowhere to go after retiring from work. The retirement benefits I had been given were meagre and could not find another job. So I became stranded and a destitute. I was brought here by Social Welfare. I thank God and the government that I was allowed to live here.*

The Provincial Social Welfare Officer for Lusaka also asserted that since the world was becoming global, people were finding it easy to settle anywhere. She explained that some parents spent all their resources sending their children for studies abroad, but that some of these children never return to their countries of origin. They get jobs, stay there and forget about their parents who had spent all their fortune on them. She said this led to some parents

retiring with nothing, becoming destitute and ending up seeking refuge in old people's homes.

The caregiver at Maramba old people's home, however, blamed the aged for finding themselves in a desperate situation, resulting in some of them seeking admission to old people's homes. He said:

*There are some elderly people who did not prepare for their future. They were simply irresponsible when they were young. For example, there is one whom we recently received here at Mitanda. When he was working; he never cared for anybody. He fathered children here and there and never cared for them. He was very abusive to his relatives. So when you grow old, who will take care of you?*

#### 5.3.4 Harassment

Harassment of the aged by family members and communities in which they lived on suspicion that they were practicing witchcraft was the fourth factor that contributed to their moving to old people's homes. The respondents reported that they had suffered harassment in their communities after being falsely accused of practicing witchcraft. For example, a female respondent at Nkulumazhiba old people's home explained:

*...they tied my legs, put me in a sack and were about to throw me into the Kabompo river after accusing me of practicing witchcraft. This followed the death of one of my grandchildren. Some good Samaritans rescued me and that is how I ran to this home. I will never return to the village. I am very happy here.*

The above sentiments by the woman were confirmed by the caregiver at Nkulumazhiba old people's home who pointed out that the main factor that contributed to most of the aged moving to the home was harassment due to suspicion that they were witches or wizards. He said:

*Three quarters of the residents at this home were chased from their villages, accused of practicing witchcraft. One old woman was almost killed by villagers. She was badly beaten after being accused of having bewitched a young person in the village. They put her in sack and wanted to throw her into a river so that she drowns. She was only rescued by some sympathisers within the village and then she ran to this place. She was terribly traumatized, but we have so far helped her and she has settled down well.*

The same caregiver at Nkulumazhiba lamented that there was a tendency for some people to think that just because someone had lived long and reached old age, he or she was a witch or wizard. He stated that it was a very bad cultural belief because it led to some innocent elderly people being abused and sometimes killed. He pointed out that the scourge was unfortunately still widespread in Zambia.



A female respondent at Maramba old people's home explained that she had been accused of practicing witchcraft and chased from her village in Petauke. She said she started sleeping in the bush with no one to assist her. She then decided to approach some church members, as she was almost dying of hunger, who took her to Maramba old people's home through the department of Social Welfare. She said: "I was a very sad person with a lot of body pains as I was leading a very hard life, but the government has really helped me. I thank God for the kind people who rescued me." A caregiver at Maramba old people's home highlighted the same factor when he stated that quite a good number of the elderly persons admitted to the home were victims of witchcraft accusation in their communities.

### 5.3.5 Disability

The fifth factor which contributed to the aged moving to old people's homes in Zambia was disability. The respondents indicated that they found themselves in old people's homes because they were unable to take care of themselves due to disability which made it difficult for them perform activities of daily living. This included some that had been incapacitated by leprosy. One female respondent at Likulwe old people's home explained:

*I was incapacitated after suffering from leprosy for a long time and could not engage in productive activities or take care of myself and could not go back to my village due to hostility. So, I was brought here where I have been all along. I cannot cultivate nor do anything productive because of my condition. The government and the church have been looking after me all these years.*

Similarly, a wheel chaired male respondent at Mitanda old people's home said:

*I came to this home because of disability. I used to work as a truck driver but was involved in a road traffic accident and lost both my legs. I was treated at Mansa General Hospital but the condition did not improve. I was then transferred to Ndola Central Hospital where I was admitted for one year. After being discharged I went back to Mansa, but life became difficult as I could not look after myself or do any productive work. So, Social Welfare brought me to Mitanda, whose existence I was already aware of as I used to pass near here when I was working as a driver.*

The Provincial Social Welfare Officer for Lusaka province added that some aged persons were taken to old people's homes on account of being mentally unstable. She explained that their family members were afraid of taking them back even after treatment, believing that they were not completely cured and would hence be a bother. She said such people were

admitted to Matero Aftercare in Lusaka, but that they were later sent to old people's homes, especially those run by the government, namely, Maramba and Chibolya.

Additionally, the Solwezi District Social Welfare Officer pointed out that neglect of the aged by their children was one of the factors that contributed to the aged seeking shelter in old people's homes. She explained that her department faced a big challenge as many young people in the district were going away to work on the mines, leaving their aged parents behind by themselves, some of whom ended up in the only old people's home in the province. She went on to suggest that there would be need to have two or three homes in the province because her office was daily experiencing a situation where police were bringing stranded elderly persons in need of shelter and care, but that the only available home had limited capacity.

The Chief Planner at the MCDMCH headquarters attributed the moving of the aged to old people's homes to a combination of factors. He said:

*Some elderly persons are neglected by their families and they become destitute. Others turn themselves in because they have nowhere to go and have no one to look after them. Some are chased from home by their relatives or caregivers on the pretext that they are wizards or witches who caused the death of some family members. Others lose their caregivers to HIV/AIDS and hence seek shelter in old people's homes.*

The researcher also interviewed the Chairperson and the Executive Director of the Senior Citizens Association of Zambia (SCAZ) to get their views on what they considered to be factors that led to the aged moving into old people's homes in Zambia. The officers attributed the moving of the aged to old people's homes mainly to poverty, which they said had ravaged many households in the country. They also said that some elderly persons lacked support from family members and that the extended family system was fast weakening. The Executive Director said:

*It is because really they have nobody to take care of them. The social structures in Zambia have broken down, mainly due to poverty levels. Some of those old people could have relatives, if not their own children who could look after them, but if they are impoverished themselves, there is nothing they can do for an elderly person. Some have lost all their children to diseases such as HIV/AIDS. It is not a desirable situation but it can't be helped because our social structures have broken down terribly. The extended family system is no longer in place or is barely in place, especially here in town. People left their villages a long time ago; they have stayed here; they have lost touch with their villages, may be where they*

*could go back and be looked after. So they find that if they do not have children, who have passed away, they have nowhere to go and end up in old people's homes.*

It can be noted from the foregoing that the aged in Zambia move to old people's homes due to a variety of factors. The major factors cited included, in order of frequency, lack of family members, abandonment related to illness and old age, destitution, harassment mainly arising from suspicion that the aged were practicing witchcraft and disability. In addition to the factors given by the aged, key informants indicated that some aged persons never planned for their future, while others lived reckless lives when they were still in employment or engaged in unproductive activities and ended up being destitute.

#### **5.4 Services Provided to the Aged in Old People's Homes in Zambia**

In relation to the second objective, the study sought to assess the services provided to the aged in old people's homes. The services were categorised as food, shelter, health care, entertainment, clothes, religious and spiritual support and counselling. The study established that from the perspective of most of the aged respondents, the services provided in old people's homes were generally adequate. However, from the perspective of caregivers, provincial and district social welfare officers and observations made by the researcher, the services were generally inadequate. Below are the findings on the services provided to the aged in old people's homes in Zambia.

##### **5.4.1 Food**

The aged were asked to describe the food provided to them. They had to rate the food by stating whether they considered it good, fair or poor. Table 8 below shows the responses they gave:

**Table 8: Description of the food provided**

		Frequency	Percent	Valid Percent
Valid	Good	102	61.8	62.2
	Fair	37	22.4	22.6
	Poor	25	15.2	15.2
	Total	164	99.4	100.0
	Not stated	1	0.6	
Total		165	100.0	

The majority 102 (61.8.2%) of the respondents described the food provided to them as good, while 37 (22.4%) stated that it was fair. Twenty five (15.2%) of them described the food as poor. This finding implies that the majority were generally satisfied with the food that was provided.

A follow-up question was asked to establish the reasons given by the respondents who had indicated that they were satisfied with the food provided. Among the reasons they gave were that they were assured of meals on a daily basis and never starved. Other reasons were that the food was well prepared, adequate and delicious.

A male respondent at Divine Providence Home said:

*We are provided with three meals a day; that is breakfast, lunch and supper. We are able to eat and don't starve all year round. So we can't complain.*

Similarly, a female respondent at Mitanda old people's home stated:

*We have enough food; we eat like caterpillars or pigs here. There is good food for everybody. Hotels also deliver some food to us once every week, which we enjoy very much.*

The respondents who had stated that they were dissatisfied with the food provided were also asked to give reasons. Among the reasons they gave were that the food lacked variety, was inadequate and sometimes not well cooked. A male respondent at Maramba old people's homes said: "The food we eat here is not well cooked and I have chewing problems, especially meat. Some of us with teeth problems do not usually enjoy the meat as it is too hard." A female respondent at Chibolya old people's home also lamented that the quality of

food provided to them was poor and that they did not have any choice on what they should eat.

Interviews with caregivers indicated that most of them agreed with the aged respondents that the food provided in old people's homes was generally adequate. Ten out of 17 caregivers interviewed stated that the food was good, 2 stated that it was fair while 5 said that it was poor. A caregiver at Mitanda old people's home explained that they were able to provide a balanced diet to the residents, which comprised three meals a day. Furthermore, a caregiver at Nkulumazhiba old people's home also said that the residents were assured of meals every day.

However, caregivers who had stated that the food provided to the aged was inadequate explained that although they managed to feed them every day, the food was usually not enough due to budgetary constraints. For example, a caregiver at Chibote old people's home said:

*The food that we provide at this home is usually not enough. Even these 13 old people you see here, they are not having enough to eat and are starving. We do not have enough food to feed them due to poor funding. Things can only improve if we are well funded.*

Similarly, a caregiver at St. Therese's Village explained that they tried by all means to provide a balanced diet to the aged but that the food was inadequate due to poor funding. She stated that they had had, for example, to remove midmorning and afternoon tea which they previously used to provide because they lacked the financial capacity to do so.

#### **5.4.2 Shelter**

The aged were asked to describe the shelter that was provided to them. By shelter was meant the hostels or rooms they were living in. Table 9 below shows their responses:

**Table 9: Description of the shelter provided**

		Frequency	Percent	Valid Percent
Valid	Good	76	46.1	46.3
	Fair	43	26.1	26.2
	Poor	45	27.3	27.4
	Total	164	99.4	100.0
	Not stated	1	0.6	
Total		165	100.0	

The majority 76 (46.1%) of the respondents described the shelter provided as good, while 43 (26.1%) stated that it was fair. Forty-five (27.3%) of them indicated that it was poor. The study, therefore, established that the aged were generally satisfied with the shelter provided to them.

Respondents who were satisfied with the shelter were asked to give reasons. Among the reasons they gave were that they had somewhere to sleep, the rooms had comfortable beds and enough beddings, the rooms afforded them privacy and that the rooms were generally clean. A male respondent at Nkulumazhiba old people's homes said:

*I can't complain about accommodation because we have more than we need here. Each one of us has a room to himself/herself with some rooms still not occupied. At the moment, the shelter we are provided with is adequate, except for lack of electricity. We would be happier if electricity was connected to this home.*

A female respondent at Mitanda old people's home stated:

*Our rooms are always kept clean as you can see for yourself. The workers here make sure that our rooms are clean. We also help in the cleaning of our rooms from time to time.*

The respondents who were dissatisfied with the shelter provided were also asked to give reasons for their views. Among the reasons they gave were that the rooms were too small, had no electricity, the buildings were too old and dilapidated, there was poor ventilation and the rooms were poorly furnished.

However, most of the caregivers interviewed gave contrary views to those given by majority of the aged. They indicated that the shelter provided in old people's home was inadequate.

Eleven of the 17 caregivers indicated that the shelter provided in the homes was poor, with 4 stating that it was fair. Only two said it was good. A caregiver at St. Therese's Village said:

*Although all the old people have shelter, it is shared accommodation that is provided at this home. There are two residents in each room, with only a few of them living alone. It is not a good idea to make big people share these small rooms, especially that this is a permanent home for some of them.*

A caregiver at Maramba old people's home also stated:

*I can say that the shelter provided to these people is poor. The rooms they occupy are not supposed to be shared but because of increased demand for admission, we are forced to make them share. Bathing and toilet facilities are outside the hostels and they are communal. This is a big challenge.*

A caregiver at Likulwe old people's home pointed out:

*The structures are very old and almost falling. There is urgent need to build modern infrastructure in terms of hostel accommodation. Electricity should also be installed here at Likulwe to make the lives of the residents better.*

A caregiver at Chibote old people's home described the shelter provided at the home as poor and inadequate. She explained that all the elderly residents had to share rooms because infrastructure at the home had remained the same while demand for shelter had increased over the years. She explained that they had to convert one of the rooms into office accommodation for staff, which further contributed to the shortage of rooms, but justified the move by stating that they had no way out. Additionally, a caregiver at Mitanda old people's homes pointed out that the general infrastructure at the home was very old and required urgent repair and maintenance.

The researcher observed that most old people's homes in Zambia provided shared rooms to the residents. Bathing and toilet facilities were also communal and outside the hostels or rooms and in some cases a distance away. In line with this observation, the Provincial Social Welfare Officer for Lusaka stated:

*If you want to provide proper care to elderly persons in institutions, it must have very good facilities. However, what is obtaining on the ground is not so good. In some cases, the elderly live in a pool house which is like a boarding house. They are not comfortable at all. Things should change if we are to give dignity and respect to these senior citizens.*

It is evident from the information gathered from caregivers, Provincial and District Social Welfare Officers as well as from observation by the researcher that the shelter provided to

the aged in most old people's homes fell short of the expected standards due to a number of challenges, although from the perspective of the aged, it was generally adequate.

### 5.4.3 Health Care

The aged respondents were asked to describe the health services provided to them in old people's homes. Table 10 below shows their responses:

**Table 10: Description of the health services provided**

		Frequency	Percent	Valid Percent
Valid	Good	63	38.2	39.1
	Fair	65	39.4	40.4
	Poor	33	20.0	20.5
	Total	161	97.6	100.0
	Not stated	4	2.4	
Total		165	100.0	

The majority 65 (39.4 %) of the aged respondents indicated that the health services were fair while 63 (38.2%) stated that they were good. Thirty three (20.0%) of them said that the services were poor. The findings indicate that the aged were generally satisfied with the health services they were provided with at old people's homes.

Respondents who had indicated that they were satisfied with the medical services provided at the homes were asked to give reasons for their position. The reasons they gave were that they received the necessary medication when they got ill, medical personnel at the clinic were helpful and caring, they were given preferential treatment at the clinic with some stating that they had a clinic within the premises of the home. A female respondent at St. Therese's Village stated:

*I can only thank the nurse at this home for looking after me so well. Even the sores I had before coming here have gone after she gave me medicine. God will bless all those taking care of vulnerable elderly persons like me.*

However, the respondents who had stated that they were dissatisfied with the medical services provided to them also gave a number of reasons. They stated that they were made to queue at the clinic before getting medical attention together with young people and that lack



of medical facilities in most old people's homes meant that their immediate health needs were not attended to. They also stated that there was a tendency by some caregivers to ignore their health needs by delaying in taking them to the clinic or the hospital. Some indicated that clinics were far away from the homes. A female respondent at Likulwe old people's home stated:

*It is not easy for elderly people like me to get to the clinic or hospital when we are ill, especially that these facilities are far away. It would have been better if we had at least some health facilities and medical personnel just here at the home. If this is not possible, medical staff from Senanga should be coming here regularly to attend to our health needs.*

The study established that Mitanda old people's home and St. Therese's Village had clinics within their premises. The caregiver at Mitanda explained that the clinic which was run by a qualified full-time nurse, who was also the Assistant Administrator of the home, was well stocked with drugs and handled all minor ailments. She also explained that a clinical officer visited the home once every week to screen the elderly residents for ailments and check on their health status. She stated that serious cases were referred to Ndola Central hospital, which is 2 kilometres away from the home. Similarly, the clinic at St. Therese's Village was run by a qualified full-time nurse.

The study also established that Kandiana old people's home was well catered for when it came to health services. This was because the home is located within the Mission hospital premises as part of the establishment and is serviced by the health personnel who work for the hospital. Kandiana is owned and run by the United Church of Zambia who are also the proprietors of the Mission Hospital. A caregiver stated:

*The health facilities at Kandiana are excellent because the home is within Mwandi Mission and the aged are exposed to all the facilities. There are various medical professionals including psychosocial counsellors who look into the health of elderly residents.*

The remaining 7 old people's homes had to take their elderly residents who fell ill to the clinic or hospital as they had no medical facilities within their premises. The study established that most of the caregivers and District Social Welfare Officers interviewed contradicted the favourable views given by the aged respondents on health care and indicated that the health services provided to the aged in old people's homes in Zambia were generally inadequate. Eleven of the 17 caregivers said that the services were poor, while 4 said they were good. Two said that they were fair. A caregiver at Maramba old people's home said:

*There are no medical services readily available to the aged at this home. They are taken to the nearest clinic in the nearby community where they endure long queues and poor services. These people frequently get sick. Every day there is someone who is sick. We sometimes keep old people who are terminally ill but there is no one to look after them, especially in the night.*

A caregiver at Divine Providence old people's home stated:

*Health services for the aged are not so good, especially for those who have medical conditions. We take the sick residents to Chawama clinic which is usually congested. Serious cases are referred to the University Teaching Hospital. Some cases are referred to the Italian hospital and Chilanga hospice.*

A caregiver at Likulwe old people's home explained that the aged had difficulties in accessing medical services because the clinic was very far away from the home and medical staff from Senanga district rarely visited the place mainly because of lack of transport. He pointed out that there was no first-line medication for the elderly because there was no health post at the home and some residents could not walk on their own as they were incapacitated. The researcher also observed that Likulwe old people's home was located in a remote area with a narrow sandy road, making access to the place quite a challenge. The immediate health needs of the aged at the home were, therefore, not adequately met.

The Chairperson of the Committee on Health, Community Development and Social Welfare of the National Assembly of Zambia contended that the elderly in old people's homes should have a comprehensive programme of health care which encompasses both prevention and treatment and recreation in special resorts with appropriate facilities. He stated that the health needs of the aged living in homes for the aged should be given higher priority so that they do not have to struggle to access the much needed medical services.

#### **5.4.4 Entertainment**

The study further sought to assess the types of entertainment provided to the aged in old people's homes. It started by identifying the main types of entertainment provided by each home. The study revealed that the main types of entertainment provided were television, radio, indoor games, traditional dances and drama. Table 11 below shows the type of entertainment per home:

**Table 11: Types of entertainment provided**

Old people's Home	Type of Entertainment
Chibolya	Television, radio
Chibote	Radio
Mitanda	Television, radio, indoor games (e.g. table tennis)
St. Therese's Village	Television (faulty), radio
Divine Providence Home	Television, radio
Nkulumazhiba	Traditional dances, drama
Maramba	Television, radio
Kandiana	Radio
Likulwe	Traditional dances, drama

It can be noted from Table 11 above that the main sources of entertainment provided in old people's homes were radio and television. Others were traditional dances and drama performances. However, three of the homes, namely Chibote, Nkulumazhiba and Likulwe, did not have electricity and hence could not provide television to the residents. Kandiana old people's home, on the other hand, had electricity but did not provide a television set at the time of the study.

The aged were asked to describe the entertainment provided to them in old people's homes. Table 12 below shows their responses:

**Table 12: Description of the entertainment provided**

	Frequency	Percent	Valid Percent
Valid			
Good	27	16.4	19.4
Fair	79	47.9	56.8
Poor	57	34.5	23.7
Total	163	98.8	100.0
Not stated	2	1.2	
Total	165	100.0	

Seventy nine (47.9%) of the aged respondents indicated that the entertainment provided was fair, while 57 (34.5%) said that it was poor. Twenty seven (16.4%) stated that it was good.

The findings indicate that most of the aged were generally satisfied with the entertainment provided to them.

One female respondent at Maramba old people's homes stated:

*In terms of entertainment, we do not have much of a problem. We have been provided with a TV in the common room and those of us with poor eyesight, listen to the radio. A few of our colleagues have radios in their rooms.*

Caregivers at two of the old people's homes, namely Divine Providence and Mitanda indicated that entertainment they provided to the aged was generally good. For example, a caregiver at Divine Providence Home explained:

*Entertainment is not a problem at this home. The presence of children keeps the elderly busy and entertained. There are also different occasions when staff and the elderly residents come together to celebrate certain events and they feel very happy. Television is there for them and so is radio, though the elderly prefer radio.*

Similarly, a caregiver at Mitanda old people's home pointed out that for entertainment, the aged watched television, listened to the radio and played indoor games such as table tennis. She described the entertainment provided as good. She also explained that the aged also engaged in exercises from time to time, with help from caregivers.

However, most caregivers and District Social Welfare Officers indicated that the entertainment provided in old people's homes was inadequate. Twelve out of 17 caregivers stated that entertainment available to the aged was poor, while 4 said it was good. One said it was fair. For example, the caretaker at Kandiana old people's home said:

*Entertainment or recreation at this home is almost non-existent. Kandiana has no television set for the aged to view despite the home having electricity. There is only one radio which all the residents listen to, which is obviously inadequate.*

Similar sentiments were expressed by the caregiver at St. Therese's Village who said:

*In terms of entertainment, there isn't much that goes on here, due to the financial challenges we are facing. For example, the only TV we have developed a fault a couple of weeks ago. You have to make a decision whether to repair the non-functioning TV or buy vegetables for the residents. So we resorted to buying two radios; one for males and another one for females as we scout for funds to repair the only television set.*

A caregiver at Nkulumazhiba old people's home lamented:

*It is sad that we cannot provide appropriate and adequate entertainment to our elderly parents. These people may die fast because of being idle and thinking about negative things. So if we can have solar power, they can have a television set to watch and be entertained. Currently, we do not have power and residents only have to entertain themselves through song and dance, which is done only once in a while.*

The Chairperson of the Senior Citizens Association of Zambia observed that some people in Zambia believe that the aged do not need entertainment, which she said was not correct. She stated: "It is usually assumed that old people don't need to be entertained, let alone those living in institutional homes. The truth is that they do; everybody does." She stated that the aged in all old people's homes needed to be provided with a variety of entertainment facilities and activities in order to improve their welfare and wellbeing. She indicated that currently, most old people's homes did not provide suitable and adequate entertainment to their elderly residents.

#### 5.4.5 Clothes

The other service provided to the aged in old people's homes in Zambia comprised clothes. The study revealed that old people's homes received clothes for the aged from the government through the Department of Social Welfare, churches, individual well-wishers and charitable organisations. However, the clothes provided were mostly second-hand and in form of donations from a number of sources. The caregiver at St. Therese's Village stated:

*Clothes that we provide to elderly people here are mostly donations from well-wishers. We cannot afford to buy new ones for them. However, socks and underwear as well as diapers are bought by ourselves from the little funds we manage to raise.*

The caregiver at Maramba old people's home also said:

*The elderly are provided with clothes by the home which come as donations from various sources and well-wishers. We cannot afford to provide them with new clothes as there is no provision for such in the budget.*

Additionally, the District Social Welfare Officer for Senanga stated that the aged at Likulwe old people's homes were never given any new clothes. He explained that all the clothes were provided by the church and well-wishers through donations. He observed that church

members in the district were particularly generous when it came to donating clothes to the needy elderly at the home.

It can be noted from the foregoing that much as old people's homes did manage to provide clothes to the aged, they could not afford to buy them new ones mainly due to financial constraints. The aged in old people's homes in Zambia, therefore, mostly received second-hands clothes from well-wishers in nearby communities and beyond. The very fact that the aged had to depend on second-hand clothes implies that this service was inadequate, though the recipients themselves were grateful for the provision.

#### 5.4.6 Religious and Spiritual Support

The study also sought to establish the kind of religious and spiritual support provided to the aged in old people homes and how they practiced their religious faiths. The aged were, therefore, asked to indicate how they practiced their religious faiths. Table 13 below gives their responses:

**Table 13: How the aged practiced their religious faith**

Response	Frequency	Percent
We are free to go to churches of our choice	130	78.8
Prayers are conducted at old people's homes	23	13.9
I pray on my own	8	4.8
I do not participate in any prayers	4	2.4
Total	165	100.0

The majority 130 (78.8%) of the respondents indicated that they were free to go for prayers at churches of their choice in nearby communities, while 23 (13.9%) stated that they attended prayers which were conducted within old people's homes. Eight (4.8%) said that they prayed on their own while 4 (2.4%) indicated that they did not participate in any prayers.

One female respondent at Mitanda old people's home stated:

*We praise God and put all our needs before him. He is kind to us and takes good care of our daily needs. So we always have to worship him. None of us is stopped from practicing our religious beliefs. I would be lying if I said so. This home belongs to the Seventh Day Adventist church, but we are given the freedom to worship as we please in our respective denominations.*

This view was also supported by a caretaker at Kandiana old people's home who explained that the spiritual and religious needs of the residents at the home were taken care of through bible study, prayer meetings and church services. He explained that preachers from the sponsoring church also came to the home from time to time to offer spiritual support to the elderly and encourage them to lead positive and fulfilling lives despite being in an institutional setting.

Furthermore, a caregiver at St. Therese's Village explained:

*We offer religious and spiritual support to the aged in a numbers of ways. Firstly, we try to make them understand the meaning of life; specifically that God loves them because they need this kind of assurance and encouragement. That is done every day when we go into the chapel. We encourage those that are sick, pray for them and give them some counselling. We have prayers every morning. Then we have full mass on Tuesday. On Thursday, the elderly have bible sharing among themselves. They, themselves choose who leads the sharing session. On Sundays, those who are able, go and congregate wherever they want.*

The study established that church-run old people's homes offered more religious and spiritual support to the residents than government-run homes. The reasons given were mainly that religious activities were already embedded in the routines and programmes of church-run old people's homes, such as morning prayers, meal time prayers and so on as per requirement by sponsoring churches. This was not the case with government-run homes, as prayer sessions were not necessarily programmed or emphasised. However, in both cases, residents of old people's homes were free to exercise their religious and spiritual freedom.

#### **5.4.7 Counselling**

The study went on to assess the counselling services provided to the aged in old people's homes in Zambia. The study established that there was little counselling going on in old people's homes. In the 2 government run old people homes, counselling services were provided by caregivers who had undergone training in psychosocial counselling. However, only 2 out of the 7 privately owned homes had caregivers who were trained in psychosocial counselling and who were in a position to offer appropriate counselling services. The study, therefore, established that most old people's homes did not provide adequate counselling services as they lacked trained counsellors with necessary skills and competencies in this field. For example, at 1 privately run home, the researcher was informed that counselling services were provided by a Committee of Bishops and Pastors who occasionally offered the

services, but that the counselling mainly came in form of spiritual support. None of the five Bishops and Pastors had had any formal training in psychosocial counselling.

Nine out of the 17 caregivers stated that counselling services provided to the aged in old people's homes were poor, while 5 said that they were good. Three of them said the services were fair. A caregiver at Divine Providence Home said:

*We don't have professionally trained counsellors to effectively offer counselling services to the aged. We need that. Sisters do counsel the aged in a simple way, but that is not enough. The aged need appropriate counselling services to help them live more positively in this institutional set-up, in most cases, away from family members.*

A caregiver at Maramba old people's home also said:

*Counselling services here are inadequate. A lot of elderly residents are stressed and have psychosocial problems. So we need appropriately trained counsellors to offer the service. It would be helpful if all caregivers were provided with knowledge and skills in counselling through formal training. If this was not possible, already trained counsellors could be employed or seconded to the homes, but I doubt if the latter can work out due to employment restrictions and financial constraints.*

A caregiver at Chibote old people's home also stated that there was very little counselling going on at the home. He explained that Sisters did try to provide some counselling to the aged whenever possible and when they visited the home, but that they were usually too busy attending to other church matters and activities.

#### **5.4.8 Outreach Services**

The study also established that apart from providing care to the aged residing in old people's homes, some homes were also taking care of vulnerable aged persons in surrounding communities by reaching out to them with some assistance. Three of the homes, namely Divine Providence Home, Maramba and Likulwe had extended their services to local communities by supporting some needy elderly who were not necessarily residing in these institutions. For example, besides caring for the institutionalised elderly persons, Maramba old people's home was also supporting 13 elderly persons from the nearby Maramba compound. The home provided food and groceries on a monthly basis to these people as a way of alleviating their suffering, without necessarily admitting them since it had limited capacity. Similarly, Divine Providence Home took care of 15 vulnerable elderly persons from Chawama compound



who had no means of livelihood and subsistence. The elderly persons collected food rations once a week from the institution while remaining in their own homes. Likulwe old people's home was also providing food items to desperate and needy elderly persons in the nearby community.

The findings of the study indicate that the main services provided to the aged in old people's homes included food, shelter, health provision, entertainment, clothes, spiritual support, and counselling. From the perspective of the aged, the services were generally adequate although they also highlighted some challenges they faced, which will be presented in the next section. However, from the perspective of caregivers, provincial and district social welfare officers and observations made by the researcher, the services provided to the aged in old people's homes were generally inadequate.

### 5.5 Challenges Faced by the Aged in Old People's Homes in Zambia

The third objective of the study sought to identify challenges faced by the aged in old people's homes in Zambia. The aged respondents were asked to state the challenges they faced in their day-to-day lives in the homes. Table 14 below shows the challenges in order of significance:

**Table 14: Challenges faced by the aged in old people's homes**

Challenges	Frequency n = 165	Percent
Inadequate shelter	55	33.3
Boredom due to lack of creative activities	38	23.0
Lack of medical facilities for the aged in old people's homes	36	21.8
Poor sanitation	23	13.9
Lack of electricity	21	12.7
Lack of food variety	18	10.9
Lack of pocket money	9	5.4

Fifty-five (33.3%) of the respondents identified inadequate accommodation as first challenge they faced in old people's homes. This was followed by 38 (23.0%) who cited boredom due to lack of creative activities and 36 (21.8%) who cited lack of medical facilities for the aged at old people's homes as challenges they faced. Twenty-three (13.9%) of the respondents mentioned poor sanitation, while 21 (12.7%) found lack of electricity in old people's homes

to be challenges. Eighteen (10.9%) cited lack of food variety, while 9 (5.4%) mentioned lack of pocket money as challenges. The challenges are described below:

#### 5.5.1 Inadequate Shelter

Inadequate shelter was identified by the aged respondents as the most significant challenge they faced in old people's homes. The study established that the aged in most homes shared rooms. Two to three residents shared small rooms and it was rare to find residents living alone. The researcher observed that only Nkulumazhiba old people's homes had enough rooms for the elderly residents to live alone, with a few rooms to spare. A male respondent at Chibolya old people's home said.

*We are usually overcrowded and forced to share rooms. It is not good because some room-mates suffer from diseases which they may pass on to others.*

Another male respondent at Maramba old people's homes said:

*The problem is that there are so few rooms at this home and we are forced to share these same small rooms, which have small windows with little fresh air coming in. The government should think of putting up more shelter at the home, especially that we keep receiving more people.*

Furthermore, a caregiver at Maramba old people's home observed:

*The facilities that we are currently running as government are not adequate. Maramba, for example, was meant to accommodate about 40, but we are almost hitting 50. We don't seem to have adequate accommodation. The volatile nature of the elderly requires good, modern facilities. The current facilities are old and below standard.*

Additionally the Provincial Social Welfare Officer for Lusaka observed:

*Most structures in old people's homes are not suitable. Old people share accommodation, which is not good for their age and condition. They should not sleep like in a boarding house. They should have a room each, which is self-contained so that they can at least have some dignity. You know, human beings, once you are aged, you need some privacy and not in a big group.*

The District Social Welfare Officer for Sesheke also explained that Likulwe old people's home had inadequate shelter for the residents because no new structures had been built at the home in a very long time. He stated that the negative financial situation compounded the problem as there was no funding for capital projects such as infrastructure building. The researcher also observed that shelter in most old people's homes was inadequate for the number of elderly residents and required renovation and better maintenance.

### 5.5.2 Boredom Due to Lack of Creative Activities

Boredom due to lack of creative activities was another challenge cited by the elderly respondents. They indicated that they did nothing and were idling most of the time. They explained that authorities in old people's homes did not provide them with activities that would keep them busy and engaged, although they had the strength and desire to do so. A male respondent at Maramba old people's home stated:

*It is very boring here, I am telling you. We just sit and wait for 'nshima' to be ready. They just keep us.*

A female respondent at Chibote old people's home said:

*We are bored here because there is nothing much to do apart from eating and sleeping. The way you have found us, just sitted is all we do most of the time. When we move from here, it is going to eat and nothing else. We need activities to keep us busy. We are confined to the compound most of the time, doing nothing the whole day.*

The above sentiments expressed by the aged respondents were also supported by caregivers in most old people's homes. A caregiver at Chibolya old people's home explained that the elderly did nothing most of the time and that all they did was just sit, chat, wait for meals and then sleep, which he said was not good for their health. The District Social Welfare Officer for North-Western province said: "I have been to quite a number of old people's homes in Zambia and I have noted that the aged just sit most of the time and do nothing, which is not good for their wellbeing." The researcher also observed that the aged in most old people's homes were found doing nothing, while some were relaxing, chatting to colleagues or sleeping during the study.

The Director of the Department of Social Welfare indicated that old people's homes were expected to involve the aged in activities to keep them busy and productive. He, however, pointed out that there were those who were so physically and mentally challenged that they could not be expected to participate in certain activities. He observed that some were quite advanced in age and frail. He also stated that some elderly residents of old people's homes simply refused to participate in activities and opted to just sit and loiter, but that these were very few.

### 5.5.3 Lack of Medical Facilities for the Aged in Old People's Homes

Despite having expressed general satisfaction with the health services provided, some aged respondents cited lack of medical facilities within the homes as a challenge they faced. The study revealed that lack of access to appropriate medical care and therapies was a fundamental problem affecting the aged in old people's homes in Zambia. A female respondent at Likulwe old people's home said.

*One of the biggest problems we have here at Likulwe is that there are no medical facilities at the home or nearby. Imagine, we have to go very far to Senanga for medical services. The distance to the clinic is just too much and visitations by medical personnel from Senanga are very rare. We don't even have a community health worker. It is not easy for elderly people like me to get to the clinic or hospital. It would have been better if we had at least a health centre at the home. A nurse is needed here to look into our health needs. A doctor is also needed here.*

A caregiver at St. Therese's Village also said:

*We would like to have a physiotherapist attached to the home. The elderly complain of pains, backaches, etc. They ask for rub-on to ease the pain and we give them to apply on their own. If we had a physiotherapist, he or she would be scheduling sessions for men and women where they would be doing some light exercises, massage and so on.*

Furthermore, a caregiver at Maramba old people's home said:

*The main challenge faced by the elderly at Maramba old people's home is in the area of medical services for those who have medical conditions. In future it is our desire to have a nurse permanently stationed at the institution to take care of their health needs as opposed to the current situation where the aged are taken to the hospital where they are treated as out-patients and hence, not given priority. In fact we wrote to the Ministry to ask for the services of a nurse but have not got a response yet.*

The District Social Welfare Officer for Senanga stated that lack of medical facilities at Likulwe old people's home was one of the major challenges the aged faced and that accessing medical services was usually a problem. He explained that good number of elderly persons could not easily walk to the clinic as it is quite a distance away. He pointed out that the Ministry of Health had promised to build a health post at the centre but that nothing had happened. He further explained that towards the close of 2012 the Deputy Minister of the Ministry of Community Development, Mother and Child Health had also indicated that a clinic would be built within the home in order to alleviate the suffering of the elderly persons, but that nothing had happened yet.

Additionally, the Executive Director of the Senior Citizens Association of Zambia (SCAZ) stated that the health delivery system in Zambia was not aged-friendly and as a consequence, the aged found themselves blocked from going to medical centres. She explained that although the National Health policy stipulated that people aged 65 years and above should have free access to medical services, the policy only went up to consultation and provision of fairly cheap medicine but when it came to specialised and expensive services like echo sound, scan and others, the aged were expected to pay.

#### 5.5.4 Poor Sanitation

The other challenge faced by the aged in old people's homes was poor sanitation. The elderly respondents stated that most of the toilet and bathing facilities in old people's homes were not age-friendly and not suitable for them. A female respondent at Maramba old people's home said:

*Sanitation here is very poor. Imagine, all the toilets and bathing facilities are outside our rooms and a distance away. This makes it difficult for us to access them, especially in the night. It is also dangerous for people of our age.*

A caregiver at Maramba old people's homes explained that the home was initially meant to accommodate people who had gone to work in Zimbabwe, then Northern Rhodesia and South Africa and that at that point consideration was not so much about accommodating older persons. He explained that the infrastructure was, however, eventually turned into an old people's home without modifying it to suit the needs of the elderly. He said that as a result, the infrastructure was not user friendly to most of the aged, pointing out that there were no ablution blocks which were within the hostels and that the aged had to leave their blocks to access toilet and bathing facilities. The researcher also observed that most old people's homes had toilets outside the hostels and were in some cases a distance away. Toilet and bathing facilities were also communal. At two privately run homes pit latrines were used, which was rather dangerous for the elderly who were advanced in age. Similarly water was supplied from wells and mono pumps at the same homes. However, some old people's homes such as St Therese's Village and Mitanda had flushable toilets and showers and they were in good condition, though they were also located outside the hostels.

#### 5.5.5 Lack of Electricity

Lack of electricity was cited by the aged as another challenge they faced in old people's homes. The study established that 3 of the 9 old people's homes, namely, Chibolya, Likulwe and Nkulumazhiba, did not have electricity connectivity. This was a big challenge because it entailed cooking food using firewood or charcoal, which was cumbersome and involving. Additionally, the elderly residents were unable to have evening or night activities or use gadgets that needed electricity. A female respondent at Likulwe old people's home stated:

*We do not even have radios or TV because there is no electricity. Batteries are too expensive for us. The government has been promising to bring electricity here but that has not happened. May be it is because we are considered too old and useless.*

A caregiver at Chibote old people's home also said:

*We need electricity at this home. Candles, which the elderly are currently using are very dangerous. The rooms may catch fire and the occupants may end up being burnt to death, though it has not happened yet. Should such a thing happen, who would be blamed? Obviously it is us caregivers. We need electricity to enable the residents watch television and listen to the radio. Cooking will also be made easier. Why can't the government provide the home with electricity?*

The researcher learnt that at Chibote old people's home, a Community-Based Organisation (CBO) had donated a television set as part of entertainment provision for the aged, but which was never used because the home had no electricity. The brand new television set was just packed in a box as residents and caregivers hoped power would be connected to the home as they had been promised by the sponsoring agency. A caregiver at Nkulumazhiba old people's home also explained that since the home was permanently providing a service to the needy elderly in the province, there was need for provision of power. He stated that solar power would be cheaper to install since chances of hydro-power reaching the premises was far-fetched, looking at the remote location of the home. He further explained that solar power would enable them to power television and radios and enable the residents access modern entertainment.

#### 5.5.6 Lack of Food Variety

The other challenge faced by the aged in old people's homes was lack of food variety. Most of the elderly respondents indicated that they were generally satisfied with the food provided to them. However, some complained that the diet provided was rather monotonous. They pointed out that the food items that they consumed at breakfast, lunch and supper were

predictable and that they had no say or choice on what they should eat. One male respondent at Maramba old people's home said:

*We eat the same kinds of food without change day in day out. Every other day, it is Kapenta, beans, cabbage and when we are lucky, chicken or meat. This is not good for our health. We need to have food variety with enough fruits and vegetables. The government should seriously look into this issue of food variety.*

At St. Therese's Village, a caregiver pointed out that the home used to provide the residents with a wide variety of foodstuffs but was no longer able to do so. She stated that the aged had been served with tea and snacks at 10.00 hours and at 15.00 hours every day, but that this provision was discontinued due to financial difficulties arising from poor funding by sponsoring agencies. She explained that the aged had complained of the withdrawal of this service, but that there was nothing the home could do as they had to live within the available means.

#### **5.5.7 Lack of Pocket Money**

Some aged respondents considered lack of pocket money as a challenge and expressed the wish to have this provision. They stated that they needed some pocket money to spend on small items such as vaseline, lotion and food stuffs. A male respondent at Likulwe old people's home said:

*We need some pocket money from time to time so that we buy small things such as scones and bans instead of waiting for everything from caregivers. People think that just because we are old and live here where they provide us with food and a few other necessities, we do not need money. Please tell the government to give us some pocket money because no one else will.*

A male respondent at Divine Providence Home also said:

*We have always asked for some pocket money but we are never given. The Sisters fear that once they give us money, we will end up using it to buy beer, which is not true. Let me tell you, here we are not allowed to drink beer. As a result, one feels as if he is in prison. Once you have been found drinking, it is like you have killed somebody. However, the truth is that we need some pocket money to buy bans fritters and other small items.*

However a caregiver at the same home (Divine Providence Home) clarified that the elderly residents were given pocket money from time to time. She explained that cash in terms of pocket money was sometimes provided to the elderly on request but that there

was no system of disbursement. She also explained that most of the aged did not even need the money as they would not use it, adding that it would instead be stolen from them. Additionally, a caregiver at Maramba old people's home explained that the problem with some of the elderly persons at the home was that once they were given pocket money, they misused it by going out to drink beer in surrounding communities, while some bought cigarettes, which was against the health regulations. He said: "Some of the elderly even become a nuisance after drinking sprees. I am sure you saw that old man who was dancing at the gate of the home so early in the day. One even wonders who gave him the money to buy beer". Caregivers in other old people's homes also indicated that there was no budget line for this kind of provision due to financial constraints.

The study established that the main challenges faced by the aged in old people's homes in Zambia included inadequate shelter, boredom due to lack of creative activities, lack of medical facilities at most old people's homes, poor sanitation, lack of electricity, lack of food variety and lack of pocket money. The challenges had a negative effect on the overall provision of services to the aged in the homes.

## **5.6 Challenges Faced by Caregivers in Old People's Homes in Zambia**

The fourth objective of the study sought to ascertain challenges faced by caregivers in old people's homes in Zambia. The challenges identified included inadequate and erratic funding, low staffing levels, lack of training opportunities for caregivers, absence of a national policy on ageing, lack of transport, lack of information communication technologies (ICTs) and high demand for admission of the aged to old people's homes. The challenges are described below.

### **5.6.1 Inadequate and Erratic Funding**

The study established that the funding system to old people's homes in Zambia was in two main types. Government run homes were directly funded through monthly grants from the Ministry of Finance that is, from the government treasury, while privately run homes had to source their own funds but also received occasional grants from government to supplement these resources. This was confirmed by the Chief Planner at the Ministry of Community Development, Mother and Child Health headquarters who said:

*Each government home is given a monthly grant as a block sum for its operations. The Ministry of Finance directly funds the homes in order to expedite the*



*disbursement process, unlike in the past when grants came to the now Ministry of Community Development, Mother and Child Health before they were distributed to the homes, hence causing unnecessary delays. The Ministry, through the department of Social Welfare budgets for the homes and sends the request to the Ministry of Finance for funding. This applies to government sponsored homes. Privately run homes have to source their own funds while the government just supplements their income.*

All caregivers, Provincial and District Social Welfare Officers indicated that inadequate funding was the biggest challenge they faced in the running and operation of old people's homes in Zambia. The two government run homes received monthly grants from the Ministry of Finance, which implied that they were assured of funding, but which could barely meet the basic daily needs of the aged. The study established that although privately run homes also expected supplementary grants from government for their operations, the funds were not only inadequate, but also erratically disbursed or not disbursed at all in, some cases. This situation is highlighted by a caregiver at St. Therese's Village who stated:

*Funding to privately run homes from government is very erratic and inadequate. It would be helpful if it became more consistent and predictable to enable us plan and better operate. For example, grants should be received monthly or quarterly. At the moment one cannot be sure of anything. With poor funding, we are restricted on what we can do. It is just food, food, food, food...*

Additionally, a caregiver at Mitanda old people's home stated:

*Government grants to the home are erratic. For example in 2012, nothing has so far come through. Even from the Salvation Army, it is inadequate. So we have to supplement the income. Mitanda has a deficit of eleven million kwacha per month. The biggest challenge we have here, therefore, is poor funding.*

A caregiver at Chibote old people's home pointed out that the Catholic church raised its own funds for operations of the home and that the government was supposed to disburse quarterly grants. He explained that the disbursement was, however, irregular. He gave an example of the year 2012 when the home was only funded once by the government. The caregiver lamented that the elderly seemed to be a neglected segment of the population and that their needs were not considered a priority in financial resource allocation.

Similarly, a caregiver at Kandiana old people's home said:

*We are financed through grants from government, the church and well-wishers. However, the funds are too erratic and little. For example, the government is supposed to give 75 % of funding to the home and the church 25%, but a lot of times it is the other way round. We last got funding from government last year*

*(2011) during election time. At the moment I am paying the cook. I have to find money to pay the cook because there has been no funding. More funds should be allocated to the home, not only for food, but also other projects to make the lives of the aged better.*

The study further established that one of the seven privately run old people's homes, St. Therese's Village, was predominantly funded by international donors and individuals. This caused a threat to its existence as it solely depended on this source of income for its operations. At the time of data collection, the home faced eminent closure. A caregiver at the home lamented:

*Poor funding is a major problem because we are heavily dependent on grant aid and individual donations. Next year we are going to close this home because we had donors who were helping us, but they have stopped. December 2012 is the last month of funding. It has been tough going for us. And these Social Welfare offices in Ndola; we are registered with them and every month they get the statistics. There is a certain report we make, that is how many people we are keeping and so on. So we expect to get something from the Ministry of Community, Mother and Child Health but for the past three years, we haven't received anything. I think we just received one million five hundred kwacha and that was in 2010; 2011 nothing, 2012 nothing.*

The researcher made a follow-up with the caregiver, who had described the above state of affairs, six months later in order to establish whether the home had closed as anticipated. The caregiver informed the researcher that the home had not been closed and was still operating. She explained that some other funders and well-wishers had come on board to sponsor its operations and that the government had also pledged to provide grants in a timely manner.

Inadequate and erratic funding experienced by old people's homes had implications for provision of services and care to the elderly. Privately run homes were more affected by the financial constraints because they did not have regular or predictable income through grants from government as was pointed out by an emotionally charged caregiver at Divine Providence Home:

*Financial resources are a big problem. For example, in a long time we only got eight million, five hundred kwacha from Ministry of Community Development and Social Services. Can you do anything with eight million five hundred kwacha? Can you bring all the professionals you need here if you have to pay them, can you?*

### 5.6.2 Low Staffing Levels

The other challenge faced by caregivers in old people's homes was low staffing levels. The study established that all old people's homes in Zambia were understaffed. The workers were overstretched and could not adequately attend to the needs of the elderly. One caregiver at Maramba old people's home explained that because of low staffing levels at the home, sometimes the few officers had to work round the clock, even when they were supposed to knock off because of the workload. He went on to explain that the official staff establishment for the home as prescribed by the government was 7, which he said was a drop in the ocean because the home was taking care of 46 elderly residents. He said:

*...As a consequence, we don't even follow our job descriptions. If we did, there would be no work being done here. The government will never give us additional staff outside the official establishment. For example, we recently converted the watchman into a driver and in the night we have to depend on dogs. It is terrible. The problem is at policy level. We are only using volunteers to bathe, clothe and shave some elderly persons here. We would like to recruit more staff, but we are constrained by lack of financial resources and a narrow staff establishment. Staffing levels should be increased and improved. Imagine, how can one person cook for more than forty people?*

The study established that at Likulwe old people's home, there were no permanent workers and all the caregivers were volunteers who were not paid for the work they performed. The District Social Welfare Officer for Senanga pointed out that since Likulwe had no permanent caregivers, volunteers who lived within vicinity of the home, offered services to the elderly free of charge. He explained that they were occasionally given a small token whenever funds were available. He, however, stated that the volunteers sometimes demanded for payment for the services they rendered and that some withdrew their labour if it was not forthcoming.

The study further established that at Nkulumazhiba old people's home, there was only one male caregiver taking care of and doing everything for 10 elderly residents and was also working on a voluntary basis as a member of the church sponsoring the home. He was initially assisted by a lady who cooked and washed for the elderly residents but she quit her job due to non-payment of salary or any kind of remuneration. Kandiana old people's homes had only 2 caregivers, who complained of being overworked and overstretched. Mitanda old people's home had the highest number of workers at 16. However, the caregivers explained that this number was still inadequate considering the numerous activities and amount of care

that the aged needed. The caregivers stated that they wished to recruit more staff but were unable to do so because they did not have the capacity to pay them.

A caregiver at St. Therese's Village explained that the authorities had to reduce the number of caregivers because there was no money to pay them. She explained:

*Even these few who are still working here are just kind. Caregivers will eventually stop working here due to lack of payment. We recently lost a driver, who quit when he learnt that funding to the home by donors would come to an end by December, 2012. He quickly looked for an alternative job and left. The staffing levels are so low that our nurse-in-charge also sometimes takes charge of the poultry.*

The Assistant Director, Human Resources and Administration at the MCDMCH headquarters attributed the low staffing in government run old people's homes to rigid staff establishments which did not provide for recruitment of additional staff. He said that the situation was even worse in privately run homes because most of them did not even have clear staff establishments. He added that the government needed to revisit the staff establishments in old people's homes in order to increase and improve staffing levels in line with the increasing number of elderly persons in these homes. He, however, clarified that this required structural changes and government approval. He stated:

*The establishments at old people's homes are narrow, inadequate and limiting. There may be need to expand them so that more positions are created and appropriate personnel at various levels employed. There is also lack of uniformity in the establishments between government and privately owned homes. For example, there are no specific establishments in privately owned homes and no prescribed qualifications for staff.*

### **5.6.3 Lack of Training Opportunities for Caregivers**

Training is a vital component for caregivers and other personnel looking after the elderly. It is, therefore, important that they are appropriately trained for them to offer quality services. Training for caregivers was identified as an important aspect in service delivery and care in old people's homes by caregivers, Provincial and District Social Welfare Officers as well as senior officers at the MCDMCH headquarters. However, the study established that most caregivers in old people's homes lacked even basic training in elderly care and related aspects. Apart from two caregivers at government run old people's homes and another four at privately run homes who had undergone some training in psychosocial counselling, the rest

had not been accorded any chance to receive training, let alone orientation in issues of ageing and elderly care. A caregiver at Maramba old people's home remarked:

*There has been a lot of orientation and training organised by the Ministry on looking after children, but none on looking after the elderly. I think we need skills in care for the elderly, like is the case with children. We need training and capacity building. So far, we have never been called for any training. Everybody should know how these homes operate and how to run them. Government should do more for the aged living in old people's homes.*

The District Social Welfare Officer for Western province pointed out that the then Ministry of Community Development and Social Services, now Ministry of Community Development, Mother and Child Health, with the assistance of United Nations Children's Fund (UNICEF), had conducted a lot of capacity building and training of staff but that this was mainly for those working in institutions for children. She explained that not much had been done to train staff on how to care for the aged residing in old people's homes and that caregivers had been asking for capacity building and training so that they could get necessary skills in elderly care. She stated that there was no short-term or long-term training for staff working in old people's homes because there were no funds for the exercise. She lamented that caregivers in old people's homes were not accorded training opportunities unlike their counterparts in other sectors of government.

The challenge of lack of training opportunities for caregivers was also highlighted by the Chief Planner at the MCDMCH headquarters who stated:

*There is lack of trained staff, especially in privately owned old people's homes. There is also lack of specialised training for the care of senior citizens, which is badly needed. There is need for trained personnel in health and especially geriatrics to be attached to the home. Homes should have geriatric clinics with specialists in charge. These are currently missing. Besides, very few medical practitioners specialise in geriatrics in Zambia, hence this service lacks at the moment. All old people's homes should be run by trained and appropriately qualified caregivers.*

Despite the general lack of training opportunities for caregivers in most old people's homes, it was established that Mitanda old people's home had been trying, even with financial limitations, to build capacity in its staff by exposing them to some kind of training. The caregiver said:

*In terms of capacity building, Mitanda offers training programmes in aspects of residential care, catering, domestic work, gardening and maintenance to some of its workers. These trainees assist in the care of residents and property.*

Furthermore, a caregiver at St. Therese's Village explained that 2 caregivers had been trained in palliative care which she said had many components of elderly care. She explained that one of the nurses had also undergone training in psychosocial counselling. However, at Divine Providence Home, it was established that only Sisters had had chance to attend workshops and seminars on various issues of elderly care including HIV/AIDS, but others (lay caregivers) never had such a chance. At Chibolya old people's home two caregivers had been trained in home-based care and psychosocial counselling. All in all, most caregivers in old people's home were never exposed to training of any kind *vis-à-vis* caring for the aged.

#### **5.6.4 Absence of a National Policy on Ageing**

The study further established that absence of a national policy on ageing was another challenge faced by caregivers and other stakeholders in providing adequate care to the aged in old people's homes in Zambia. Caregivers, Provincial and District Social Welfare Officers as well as senior officers at the MCDMCH indicated that the absence of a national policy on ageing entailed lack of a legal framework to regulate and guide operations of old people's homes for the benefit of the aged. A caregiver at Mitanda old people's home stated:

*Lack of a national policy on ageing is a limiting factor. One cannot be resourceful, but when the policy comes into effect, provisions for the aged will be respected and legally binding like any other social protection measures. The policy will provide guidelines for the operations of old people's homes and funding.*

The District Social Welfare Officer for Luanshya also noted:

*The policy on ageing is not yet in place, but just in draft form. Consequently, older people continue to find difficulties in accessing basic social services such as health, water and social protection schemes. You see, we have programmes being formulated but there are no guidelines or policy for the implementation of these programmes. The earlier the national policy on ageing is approved and enacted, the better.*

A caretaker for Divine Providence Home also explained that there was little social support and social security for vulnerable elderly persons in Zambia largely because of lack of a policy on ageing. She elaborately said:

*Since there are no policy guidelines on ageing, there is no direction on how the programmes for the aged should be run and how capacity should be built. There is need for the enactment of the national policy on ageing. Programmes should be developed in order to keep the aged busy and engaged instead of them just sitting and waiting to die. Currently, there is lack of social support and social security for vulnerable elderly persons in Zambia, largely because of lack of a policy on ageing. I hope the policy could be enacted soon so as to streamline the operations of old people's homes in the country as they will be operating under a legal framework. The marginalisation of the aged in Zambia is reflected in the absence of a national policy on ageing since independence. Many sectors such as sports, gender, health, youth, to mention just a few, have got policies in place while that of the aged is still in draft form!*

Similarly, the Chairperson of the Committee on Health, Community Development and Social Welfare of the National Assembly of Zambia pointed out that lack of a national policy on ageing was a barrier to effective allocation of resources and regulation of the operations of old people's homes. He stated that there was an urgent need for enactment of the policy, which would be a basis for legislation and regulation of the operations of the homes.

The Director of the Department of Social Welfare at MCDMCH headquarters further explained that due to the absence of a national policy on ageing, there were no written guidelines on the establishment and operation of old people's homes in Zambia. As a result, even mechanisms to monitor the quality and adequacy of care provided to the aged were lacking. He explained that these regulatory mechanisms would be developed in order for the Ministry to better care for the aged in old people's homes once the policy was put in place. He said:

*I have not seen written guidelines specifically on old people's homes, but for children we have guidelines. May be it is because of lack of a policy on ageing and probably because more people are interested in setting up homes for children than the aged. Once guidelines are developed, there will be a standard that will be followed in the establishment and operation of old people's homes in the country. The policy will also present minimum standards of operation for old people's homes and people will be trained in elderly care and related aspects.*

#### **5.6.5 Lack of Transport**

The importance of transport to any organisation or undertaking cannot be overemphasised, and old people's homes are not an exception. The study established that only one old people's home, namely, St. Therese's Village had an institutional vehicle running, while Chibolya had one, but which had long broken down. It could not be repaired due to lack of funds.

Caregivers and District Social Welfare Officers indicated that most old people's homes lacked transport, which posed a huge challenge to their day-to-day operations. A caregiver at Nkulumazhiba old people's, home stated:

*When one of our elderly residents is very ill and can't walk, we are forced to use a wheel burrow to take him or her to the clinic. It would be helpful if we could have transport, especially a small bus to ferry the elderly who fall ill to the clinic or hospital. The same vehicle could be taking them for sight-seeing or visiting places.*

A caregiver at Divine Providence Home added that sometimes when elderly persons fell ill, she and her colleagues were forced to use their personal vehicles to take them to the clinic or hospital, which she said was expensive for them. She explained that the home could not manage to purchase a vehicle on its own because it had a lot of other competing needs, to which the meagre resources it accessed were allocated. She said delivery of goods also became expensive because they, from time to time, had to hire vehicles to deliver certain goods to the home.

#### **5.6.6 Lack of Information Communication Technology Facilities**

One other challenge faced by caregivers in old people's homes was lack of information communication technology (ICT) facilities. Most of the caregivers reported that they lacked ICT equipment and accessories such as computers, printers and internet connecting, resulting in poor record keeping and information management. Only 4 old people's homes had computers and were able to keep information on residents and other aspects of the homes in both hard and soft form. Additionally, most old people's homes had no written records on the history or background of the institutions and information on residents was poorly stored or not stored at all. For example, at one home the researcher observed that names of the residents were handwritten on pieces of paper and unsystematically stored in files, making retrieval and reference rather difficult. At two other homes, there were completely no written records of residents in terms of their background, when they were admitted to the home and related information. A caregiver at Kandian old people's home stated:

*We do not have internet facilities at this home. Communication with our cooperating partners and other stakeholders is, therefore, difficult. For example, I have to use my personal laptop and a 'dongo' to communicate because the home has no internet facilities.*



A caregiver at St. Therese's Village also explained:

*Lack of internet facilities is a very big challenge at this home. It would be great if we could have internet connectivity. We used to have internet connectivity some time ago, but now we can't afford the services any more. We also need computers and printers to make our work easier.*

#### **5.6.7 High Demand for Admission of the Aged to Old People's Homes**

The study established that the other challenge faced by caregivers was high demand for admission of the aged to old people's homes. All caregivers reported that there was a lot of pressure from various sections of society, including the aged themselves, for admission to old people's homes in Zambia. There was also constant pressure on caregivers and Provincial and District Social Welfare Officers to admit more elderly people to the homes. A caregiver at Chibolya old people's home stated:

*One of the challenges we face here is too much demand for services. Due to the escalating demand for admission, you end up putting three people in one room instead of one or two. You tell yourself, this person may die of hunger and so on, if they are not taken on and admitted to this home. It is really a problem. There is need to build more structures in order to increase capacity of the home. Currently we have a lot of people on the waiting list and languishing in communities hoping to be admitted to the home.*

The caregiver also explained that there were a lot of desperate people in communities who wished to be admitted to old people's home upon learning of the existence of these homes. He pointed out that there was now a general feeling in government circles and other stakeholders that instead of having only two government old people's homes namely, Chibolya and Maramba, every province in Zambia should have a government owned old people's home, which would cater for the desperate and needy elderly persons as opposed to them having to move to other provinces.

A caregiver at Chibote old people's home indicated that there were plans to build a new old people's home with bigger capacity than the present one owing to increase demand for admission by the needy elderly. She stated:

*We are planning to build a new home just here in Luanshya soon because the current one has very limited capacity while demand for new admissions is huge. We currently have 13 elderly people, but there are many others coming from other places seeking admission and we can't accommodate them. When we finish building another home, it will help because we shall be able to accommodate a few more genuinely needy elderly persons who are suffering out there.*

Commenting on high demand for admission to old people's homes in Zambia, the Chairperson of the Committee on Health, Community Development and Social Welfare pointed out that there was a risk of compromising the quality of services provided to the aged if the homes readily accepted to admit more residents as their capacity would be overstretched. He explained that Mauritius was experiencing a similar challenge whereby old people's homes were being pressured into taking more needy elderly persons even though the homes had limited capacity. He was also of the view that the Zambian government should not establish more old people's homes but instead strengthen the extended family system by reducing poverty through improvement of the economy and empowering the elderly within their communities. He asserted that the existence of old people's homes in Zambia was inevitable but that these homes should be a measure of last resort and hence, kept to a bare minimum.

This study has established that the main challenges faced by caregivers in old people's homes included inadequate and erratic funding, low staffing levels, lack of training opportunities for caregivers, lack of medical services at old people's homes, absence of a national policy on ageing, lack of transport and lack of ICTs facilities and high demand for admission of the aged to old people's homes. A combination of the above challenges made caregivers in old people's homes in Zambia operate under difficult conditions.

#### **5.7 Extent to which Adult Education Programmes were Provided in Old People's Homes in Zambia**

The fifth objective sought to establish the extent to which adult education programmes were offered in old people's homes in Zambia. The findings of the study indicated that there were very few adult education programmes provided in old people's homes in Zambia and that only 4 out of the 9 homes had offered any form of adult education programmes to the aged in areas such as agriculture, crafts, hygiene, nutrition education, knitting and weaving, bible study and HIV/AIDS awareness. The study established that understanding what was meant by educational programmes was a challenge on its own. This was because most of the aged, some caregivers and District Social Welfare Officers initially took adult education programmes to mean structured learning which involves sitting in a classroom with a teacher delivering lessons, which falls under the formal adult education category. The researcher, therefore, had to explain that by educational programmes in this context was meant any

learning activities that the aged engaged in without necessarily being in a classroom setting. For example, when the aged were asked whether they were provided with educational programmes at old people's homes, only 16 (9.7%) indicated that they were, while 149 (90.3%) stated that they were not.

Caregivers, Provincial and District Social Welfare Officers were then asked the extent to which adult education programmes were provided to the aged in old people's homes. It was clear from the responses that educational activities were going on in some homes except that they were not viewed as educational. For example, a caregiver at Kandiana old people's home stated:

*Formally there are no educational programmes at this home. What we try to do is to have them work with crafts. Some volunteers also come here to spend time with the elderly and teach them agriculture, bible study and issues of HIV/AIDS. There has been no formal teaching. The elderly need skills in better farming methods, nutrition and so on. Some elderly persons already have skills in basket and fishing net making and curving. They just need support and an environment conducive for them to share their skills with others. Energetic residents could easily participate in these programmes.*

A caregiver at Nkulumazhiba added:

*We are not offering any educational activities in the modern sense. May be we have never thought of it. However, we offer educational programmes in practical skills, such as knitting and weaving. The aged at this home have been making traditional mats for coffee tables, that is, table mats. They teach one another and produce these items for sale. For now we are concentrating more on building capacity among the elderly residents, that is, teaching one another so that we can have enough skills and then produce more. We also rear chickens at this home. We had plenty of chickens, but most of them have died of diseases. So again we need skills on disease prevention and control so that our projects can remain sustainable.*

A caregiver at Maramba old people's home explained that the home had made effort to provide the aged with some form of educational programmes to keep them occupied and active. He explained:

*We have just started a project with African Impact, three Basic schools and Victoria University here in Livingstone. We have come up with a programme where the elderly at the home interact with children from the three schools. The elderly tell stories to children and the children also teach the elderly about hygiene, diseases, occupational therapy and modern gardening methods. We want it to be in such a way that the aged are like just interacting and playing with children, but in the process, learning is taking place. We also want the children to learn and know that in future they will also become old. That way, they will be able to appreciate the elderly. In fact, what happened was that when the first*

*group of children came, they went and told their friends about what they had found at the home and their nice experiences with the elderly. As a result, the second group of children who came to the home was even bigger and more enthusiastic. The elderly were also very happy to see the children.*

A caregiver at Mitanda old people's home explained that officials from the Ministry of Health visited the home from time to time to deliver educational programmes to the aged. She said that doctors visited the home to give talks on health, hygiene and issues of ageing while nutritionists also gave talks on issues of food and nutrition. She added that some elderly persons at the home possessed skills in knitting, tailoring and doll making. They made garments and dolls for sale to raise some money for themselves. She pointed out that one of the residents was so skilled that she made curtains for the home whenever they were needed and that the home did not need to spend money on hiring people from outside to do this work. She went on to state that if educational programmes were well organised and supported, the aged in the homes would greatly benefit from them and be more occupied and productive.

The Provincial Social Welfare Officer for Lusaka province, however, pointed out that educational programmes for the aged in old people's homes were not considered important by caregivers and other stakeholders. She said:

*As I mentioned, the services that are currently provided at Divine Providence Home here in Lusaka are just basic care. The other link, which is education, is missing largely because it is not considered important for their welfare. So when you go there, you will find them just sitting and sometimes loitering. They need programmes to equip them with skills and keep them occupied. There is very little happening out there. Some of the elderly persons even have certain skills which are not being utilised because no opportunity has been given to them to express that. Educational provision would enrich even the other services that are given to them.*

#### **5.7.1 Participation in Educational Programmes by the Aged in Old People's Homes**

The aged in old people's homes were asked whether they would want to participate in educational programmes. The majority 85 (51.5%) indicated that they would want to do so while 71 (43.0%) stated that they would not. Nine (5.5%) could not state whether they would be willing to participate in educational programmes or not.

The respondents who had indicated that they would like to participate in educational programmes were asked to give reasons for wanting to do so. Table 15 below shows the reasons they gave:

**Table 15: Reasons for wanting to participate in educational programmes**

Reason for wishing to learn	Frequency n = 85	Percent
To keep busy and reduce boredom	36	42.3
To be informed about national and international affairs	16	18.8
To acquire new skills	12	14.1
To be productive	7	8.2
For fun	5	5.9
To enable me to read the Bible	3	3.5
To know my rights	2	2.3

Most 36 (42.3%) of the respondents who said they were willing to participate in education programmes wanted to do so to keep busy and reduce boredom while 16 (18.8%) stated that they wanted to be informed about national and international affairs. Twelve (14.1%) of the respondents stated that they wanted to acquire new skills while 7 (8.2%) said that they wanted to be productive. Five (5.9%) indicated that they wanted to learn for fun, while 3 (3.5%) stated that it would enable them read the bible, with 2 (2.3%) indicating that it would enable them know their rights.

A male respondent at Chibolya old people's home stated:

*The government would do well to involve us in learning activities from time to time. We have plenty of time here and we mostly do nothing as you have seen for yourself. So if we could have 'shibukeni', it would be very exciting and I am sure a good number of my colleagues would like to participate in the programmes.*

"Shibukeni" literary means "wake up" in Bemba and is used to refer to adult literacy. It is mainly for those who never had chance to go to school.

A female respondent at the same home stated:

*I would like to learn how to read and write so that I could be reading the bible. In fact, it would be easy for us to participate in learning activities because we have all the time to ourselves at this home since we do not do much. Besides, I have always had interest in learning.*

The respondents who had stated that they would not want to participate in educational programmes were also asked to state their reasons. Table 16 below shows the reasons they gave:

**Table 16: Reasons for not wanting to participate in educational programmes**

Reasons	Frequency n = 71	Percent
Too old to learn	46	64.8
Lack of motivation to learn	18	25.3
Poor eye sight	11	15.5
Education is not necessary	06	8.4

The majority 46 (64.8%) of the respondents said that they were too old to learn, while 18 (25.3%) said they lacked the motivation to learn. Eleven (15.5%) indicated that they would not want to participate in educational programmes because of poor eye-sight with 6 (8.4%) stating that education was not necessary for them.

A male respondent at Divine Providence Home said:

*Participating in educational programmes would not make sense to me because I am now too old to learn anything; too useless.*

A female respondent at Chibolya old people's home expressed similar sentiments when she stated:

*I am past learning age. What will I do with education at my age? All I need to do is just sit around. However, if I was given farm inputs and chance, I would like to engage in farming activities because I am still strong as you can see for yourself and I think that would be more interesting.*

A female respondent at the same home added:

*It is better to leave educational activities to young people who need them. Our days on earth are over. We are just waiting and when God opens the door, we shall go and rest in peace.*

One caregiver at Divine Providence Home was also rather skeptical about the provision of educational programmes to the aged when she said that a good number of the elderly at the home were advanced in age and that educational programmes may not be so necessary or relevant to them. She, however, pointed out that it would be a good idea if energetic and willing residents were targeted for provision of educational programmes as they would be kept busy and active. The District Social Welfare Officer for Lusaka went further to point out that it was not only the aged in old people's homes who believed that they could not participate in educational programmes, but even society in general. He stated:

*There seems to be a notion in society that people living in old people's homes are too old, weak and incapacitated and cannot do anything for themselves and hence*

*education would be a waste of time and resources. This is far from the truth as a good number of them are admitted to the homes due to poverty, destitution, lack of support and neglect, but are still very strong and energetic, as I am sure, you saw for yourself. Those people have potential. Churches can take a leading role in providing spiritual education and NGOs in health education. The aged should also exercise regularly, but we need qualified staff to plan and implement these programmes.*

### 5.7.2 Educational Activities the Aged in Old People's Homes would like to Participate in

The aged respondents who had expressed willingness to participate in education programmes were asked to indicate the subject areas or aspects they would like to participate in. Table 17 below shows their responses:

**Table 17: Educational activities the aged would like to participate in**

Educational Activities	Frequency n = 85	Percent
Practical skills such as basket making, knitting, tailoring, gardening and livestock rearing	36	42.3
Reading and writing (adult literacy)	22	25.9
Welfare and rights of the aged	11	12.9
Health education and hygiene	08	9.4
Nutrition education	06	7.0
Issues of national development	4	4.7
Religious Education	2	2.3

Thirty six (42.3%) of the respondents said they would like to acquire practical skills such as basket making, knitting, tailoring, gardening as well as livestock rearing, while 22 (25.9%) stated that they would like to acquire reading and writing skills. Eleven (12.9%) indicated that they would like to learn about the welfare and rights of the aged with 8 (9.4%) stating that they would like programmes in health education and hygiene. Six (7.0%) of the respondents indicated that they would like to learn about nutrition while 4 (4.7%) stated that they would like to learn about issues of national development. Two 2 (2.3%) indicated that they would want to learn Religious Education.

One female respondent at Chibolya old people's home stated:

*If there was someone to teach me skills in tailoring, I would be very happy. I already have knitting skills but I also need skills in tailoring so that I can be making garments for sale and become self-sufficient financially.*

The researcher also found that two female residents of Divine Providence Home were engaged in making door mats which they sold to members of the local community. They told the researcher that they also had tailoring skills but that they had no sewing machines and garments to enable them use their skills. One of them said:

*I have very good tailoring skills which I can even teach to others if I was given the necessary support in terms of a sewing machine and materials. We can then make a lot of money by selling garments. I have a lot of passion to transfer my skills to other people, but I need support.*

A male respondent on a wheelchair at Chibote old people's home said that if the government could buy him Japanese special books on flower baskets and give him space to operate from, he could teach others how to make the baskets so that they could make some money. He said: "I used to make a lot of flower baskets for the Japanese Embassy and they liked them very much. We also need reading materials here. Above all, we need different educational activities to keep all of us busy."

The District Social Welfare Officer for Luanshya explained that the aged in old people's homes needed educational programmes because institutional life was associated with confinement and hence, they needed to stay active and busy. She said:

*...Educational programmes for the aged at the home could include hygiene, sanitation, agriculture, issues on ageing, nutrition and civic education. However, these programmes should be delivered to those elderly persons who are willing and strong enough to participate in them. The programmes should also be more organised and not spontaneous.*

The District Social Welfare Officer for Senanga explained that The Minister of Community Development, Mother and Child Health had directed that educational programmes and activities to keep the elderly busy and productive be introduced at Likulwe old people's home and that plans were underway to introduce the elderly to Food Security Packs so that they could receive some farming inputs, be able to produce crops and be food secure. He stated that the aged, therefore, needed education on new methods of growing and tendering crops. He further stated that a sister department in the district was planning to establish adult literacy classes at the home and that subjects to be taught would include civic rights, health education and nutrition. He reported that the elderly themselves had particularly expressed the desire to participate in literacy classes and that they had been eagerly waiting for the commencement of the programme.



The Executive Director of the Senior Citizens Association of Zambia (SCAZ) pointed out that the association would strongly recommend that educational programmes be provided to the aged in old people's homes to keep them active and intellectually engaged. She stated that there was need to teach the aged skills which they could use to even generate some income of their own. She explained that as SCAZ they conducted a lot of training for older persons in subject areas such as HIV/AIDS, life skills, human rights, entitlements and advocacy. The Executive Director, however, clarified that the training was provided to aged persons who lived within their communities, but that it could be extended to those living in old people's homes.

### 5.7.3 Activities the Aged in Old People's Homes were engaged in

The researcher wanted to know the main activities that the aged in old people's homes in Zambia were typically engaged in and hence asked them to indicate what they did on a day-to-day basis. Table 18 below shows their responses:

**Table 18: Activities the aged in old people's homes were engaged in**

Activity	Frequency (n=165)	Percent
Nothing (just idling)	136	82.4
Cleaning	29	17.6
Gardening	15	9.1
Weaving mats	10	6.1
Making ropes and fishing nets	7	4.2
Making baskets	7	4.2
Rearing chickens	5	3.0
Sewing	3	1.8
Knitting	2	1.2
Reading	1	0.6
Repairing electrical appliances	1	0.6
Repairing shoes	1	0.6

The majority 136 (82.4%) of the residents indicated that they did nothing most of the time but just idling. However, 29 (17.6%) stated that they helped in cleaning the surroundings and their rooms, while 15 (9.1%) stated that were engaged in gardening. A further 10 (6.1%) said that they weaved mats. The rest of the activities included making ropes and fishing nets 7 (4.2%), making baskets 7 (4.2%), chicken raring 5 (3.0%), sewing 3 (1.8%), knitting 2 (1.2%) and reading, repairing electrical appliances and repairing shoes at 1 (0.6%) each.

The above finding shows that majority of the aged in old people's homes in Zambia spent most of their time idling and doing nothing. A female respondent at Chibote old people's home said:

*There is nothing much to do here apart from eating and sleeping. Sometimes I get bored and feel lonely because we do nothing the whole day.*

Additionally, a caregiver at Chibote old people's home stated:

*I explained to the Sisters that it was not good for elderly persons at the home to just be sited, doing nothing the whole day. They responded and introduced some training activities in knitting, embroidery and vegetable tendering. Unfortunately, among those who learnt the skills, some have died and others have been taken away by their relatives. The only ones remaining now are these two who sew and knit. We need help and support so that more of these people can learn the skills from other. People can also come from outside to teach them from time to time.*

#### **5.7.4 Library Facilities in Old People's Homes**

This study further sought to establish whether old people's homes in Zambia had library facilities where the aged who were able to read could borrow books. The study revealed that only 2 of the 9 old people's homes had libraries. One home, Mitanda, had a room which was specifically designated as a library and it contained a number of books and magazines. However, most of the books were old and outdated and only three residents were able to borrow books from there. The caregiver at the old people's home stated:

*Here at Mitanda we have a library with plenty of books. For those that have sight problems, some books have bigger prints to enable them to read. A few of the elderly are keen to read. However, most of the books are just packed as a good number of the aged are unable to read.*

The second home, Divine Providence Home, did not have a specific room as a library. Instead, part of the Sister-in-Charge's office served as a library. It was used to store some books which the elderly who were interested could borrow. On the other hand, Maramba old people's home was serviced by a mobile library which delivered reading materials for the aged to use. A caregiver said:

*Here at Maramba we are a bit lucky because there is a mobile library by World Impact which brings an assortment of reading materials for the aged who are able to read and have interest in reading. It would, however, be ideal to have a library of our own just here. We hope the Ministry will one day think of that possibility.*

The remaining old people's homes did not have any library facilities. The Senanga District Social Welfare Officer explained that lack of security at Likulwe old people's home made it difficult for his office to establish a library because they feared that the materials would end up being stolen by people from the surrounding community.

The study established that although most of the aged indicated that they were willing to participate in educational programmes and learn, there were very few educational programmes provided to them. The study revealed that the few adult education programmes that were provided in old people's homes were irregular and not well coordinated. It is, however, clear from the foregoing that the aged, caregivers and key informants knew and acknowledged the importance of learning activities in the lives of the aged in an institutional set-up.

#### **5.8 Suggestions made by the Aged on how Old People's Homes in Zambia could be improved**

Suggestions by the aged on how old people's homes could be improved may act as an indirect measure of the adequacy of services provided. This is because these suggestions could indirectly point to areas of need as perceived by the aged themselves. The questionnaire had a provision where the respondents were given an opportunity to make suggestions on how they thought old people's homes could be improved and their general welfare enhanced. The respondents made the following suggestions, in order of significance: More rooms should be built and existing ones improved; there should be medical facilities in all old people's homes; electricity should be supplied to old people's homes that do not have; learning programmes and activities should be provided; pocket money should be provided to the aged; more staff should be employed in old people's home; the diet should be improved and the number of meals increased; sanitation conditions should be improved; adequate entertainment and recreational facilities should be provided; old people's homes should be provided with transport; some residents in crowded old people's homes should be transferred to other homes in order to reduce on congestion; all old people's homes should be adequately funded; wheel chairs should be provided to the aged who need them; government should provide capital to enable the aged start small business ventures; government officials should be visiting old people's homes regularly; and mosquito nets should be provided to the aged in all old people's homes.

## 5.9 Summary

This chapter has presented the findings of the study. The study established that factors that led to the aged moving to old people's homes in Zambia included lack of family members, abandonment related to illness and old age, destitution, harassment mainly on suspicion that the aged were practicing witchcraft, and disability. Services provided to the aged in old people's homes included food, shelter, health services, entertainment, clothes, religious and spiritual support and counselling. Challenges faced by the aged in old people's homes included inadequate shelter, boredom due to lack of creative activities, lack of medical facilities for the aged in old people's homes, poor sanitation, lack of electricity, lack of food variety and lack of pocket money. Challenges faced by caregivers included inadequate and erratic funding, low staffing levels, lack of training opportunities, absence of a national policy on ageing, lack of transport, lack of information communication technology facilities and high demand for admission of the aged to old people's homes. The study also revealed that there were very few adult education programmes going on in old people's homes in Zambia and these were not well coordinated and were not regular. Lastly, the aged respondents were asked to make suggestions on how old people's homes could be improved and their welfare enhanced. The next chapter presents the discussion of findings.

## **CHAPTER 6**

### **DISCUSSION OF FINDINGS**

#### **6.0 Overview**

This chapter presents the discussion of findings based on the objectives of the study. The purpose of the study was to examine the care provided to the aged in old people's homes in Zambia and implications for Adult Education programmes. The objectives of the study were to: establish the factors that led to the aged moving to old people's homes in Zambia, assess services provided to the aged in old people's homes in Zambia, identify challenges faced by the aged in old people's homes in Zambia, ascertain challenges faced by caregivers in old people's homes in Zambia and establish the extent to which adult education programmes were provided in old people's homes in Zambia.

#### **6.1 Factors Contributing to Institutionalisation of the Aged in Zambia**

The first objective of the study sought to establish factors that contributed to institutionalisation of the aged in old people's homes in Zambia. The study revealed that the factors that contributed to the aged moving to old people's homes in Zambia included lack of family members, abandonment due to illness and old age, destitution, harassment mainly on suspicion that the aged were practicing witchcraft and disability. The factors are discussed below.

The first factor that led to the aged moving to old people's homes in Zambia was lack of family members to take care of them. In this study, lack of family members was associated with children and other family members having died or not being traced anywhere, leaving the aged with no support or care. Most of the elderly respondents indicated that they moved to old people's homes because they had lost members of their families who could have taken care of them. Others indicated that they could not trace their family members, as they had lost contact after coming to Zambia from other countries, with yet some indicating that they had lost contact with family members in their villages of origin. This finding is in line with Nyangulu (1990) who asserts that many elderly people in Zimbabwe had reported that they had no one to look after them and consequently slept in the open and had to be placed in institutions for the aged where they received care. Kamwengo (1997) posits that old people's homes in Zambia try to meet the needs of aged residents who are there because there is no one to care for them in the community.

Caregivers, Provincial and District Social Welfare Officers and staff of the Senior Citizens Association of Zambia also pointed out that some elderly people moved to old people's homes because they had lost all their family members who could have died of HIV/AIDS. Kamwengo (2004) further states that older people in Africa live in a continent which is devastated by the HIV/AIDS pandemic and millions of people have perished and that these include children, spouses, other relatives, church people and workers in agriculture, education, health and industry. He points out that millions others are living with HIV and every aspect of the social and economic life of the nation, every family and every community have been affected by the HIV/AIDS scourge. This implies that part of the middle population, which comprises mostly energetic and productive young people has died, leaving some aged persons with no means of survival, support or care. Kamwengo (1999) adds that the main providers of emotional support in homes for the aged in Zambia are colleagues and friends since most of them have no relatives to provide this much needed support.

Dubey, Bhasin, Gupta and Sharma (2011) assert that the aged in India moved to institutions mainly because they had no relatives to care for them. Additionally, Gupta et al. (2014) report that the most important reason for the elderly living in old people's homes, both in fee-paying (77.1%) and free homes (36.4%) in India, was lack of family members to take care of them while the second reason was poverty (20%). Other reasons included loneliness, lack of support from children, ill-treatment by daughters-in-law, death of a spouse and strained relationships with relations other than daughters-in-law. Audenaert (2003) also points out that in Belgium when frail older people can no longer take care of themselves and there is no household member (spouse or child) to rely on, many move into sheltered housing or residential care.

However, some caretakers pointed out that while it was true that most of the aged residing in old people's homes in Zambia had no family members to take care of them because they were all dead, others could be falsely claiming so when in reality they were there. They explained that most of the aged in the homes felt secure because they were provided with the basic necessities of life and had the company of fellow residents. This could possibly be expected considering that some of the aged may have been in a desperate situation due to lack of family care and support before moving to old people's homes.

The second factor that contributed to institutionalisation of the aged in old people's homes in Zambia was abandonment on account of illness and old age. Abandonment refers to the desertion of a vulnerable elder person by anyone who has assumed the responsibility for care or custody of that person. In other words, refusal to cater for the physical and emotional needs of the elderly (Mudiare, 2013). Some elderly respondents indicated that they had been abandoned by their families following long illnesses and hospitalisation. They explained that their family members stopped visiting or supporting them and left this responsibility to hospital authorities and the government. The implication of this finding is that some people had abandoned their elderly ailing family members because they considered them to be a burden, especially that long illness was associated with escalating costs in medical and other bills.

Nevertheless, Hendricks and Hendricks (1981) challenge the notion that the aged could be abandoned by their family members on account of illness and old age. They point out that one of the more pervasive myths about old age is that the elderly are abandoned by their families to face life's challenges solely through their own devices. They state that from their examination of the social and physical situations of older people in the United States of America and a few selected countries abroad, little evidence was found to support the view that the aged were abandoned by their family members. Hendricks and Hendricks (1981) explain that, on the contrary, a network of extended families appear to be alive and well, if somewhat 'modified'. Therefore, abandoning elderly family members on account of illness and old age may be an African and Zambian phenomenon, which could possibly be associated with lack of resources and high poverty levels (Oluwabamide and Eghafona, 2012; Kamwengo, 2004).

The third factor that contributed to institutionalisation of the aged in old people's homes in Zambia, according to the findings of this study was destitution. Devereux (2003:11) defines destitution as:

A state of extreme poverty that results from the pursuit of 'unsustainable livelihoods', meaning that a series of livelihood shocks and/or negative trends or processes erode the asset base of the already poor and vulnerable households until they are no longer able to meet their minimum subsistence needs; they lack access to the key productive assets needed to escape from poverty, and they become dependent on public and/or private transfers.

Some aged respondents stated that they moved to old people's homes because they lacked the means of livelihood and survival as they could not meet the basic necessities of life. They indicated that the alternative to the hardships they had faced was moving to old people's homes on recommendation by the church, the community or the police through the department of social welfare of the Ministry of Community Development, Mother and Child Health. In a few cases, the aged, themselves requested to be admitted to the homes. This finding is consistent with Nyanguru's (1991) study which established that in Zimbabwe majority of Africans and Coloureds moved to old people's homes because of destitution. However, Nyanguru's study also established that unlike Africans and Coloureds, Whites moved to old people's homes primarily for security and safety reasons and not necessarily because of destitution as they had resources to pay for the basic necessities of life. He explains that Whites had been victims of theft and violent crime when they lived in their homes. They, therefore, opted to move to old people's homes, where they believed they would be safe and secure and receive other services they needed.

There are several factors that could bring about destitution in people, including the aged. Wahab (2013) explains that the majority of the elderly in Nigeria have not really prepared themselves for their old age, physically or economically. He states that they have not made any efforts to keep themselves physically stable in terms of nutrition, medication or exercise, nor have they prepared themselves for their old age. He points out that there are few provisions introduced by the government for the benefit of the elderly but that only a very small section of the elderly is covered by these arrangements with the implication that some of them lack the means of survival and wellbeing. They, consequently, slide into destitution. Oluwabamide and Eghafona (2012) add that in African countries, many people enter their older years with limited assets and these are quickly exhausted as earnings reduce. They explain that low incomes make it difficult for people to save for their older years and families, which are often seen as the main social security system in Africa, are finding it harder to cope due to increasing poverty. Institutionalisation may, therefore, be an option for some of the aged persons in Africa.

In Zambia, the Draft National Policy on Ageing (2011) states that the social and economic conditions, including changing values and urbanisation have resulted in family being unable to care for its vulnerable members. It further states that the influence of Western culture,



which has emphasised the nuclear family, has to a large extent contributed to the weakening of the extended family system in Zambia and this has left those vulnerable older persons in a state of destitution. The Draft National Policy on Ageing (2011) goes on to suggest that there is need to promote institutional care for senior citizens who cannot be supported by their extended families.

Kamwengo (2004) contends that people are ageing in a situation where the extended family, the main organ for social and economic support, is weakening because of the strains caused by urbanisation, mass education and deteriorating economies. Rajan and Kumar (2003) also assert that the general picture that unfolds in India is that the family is still taking care of the elderly but that amidst changes in family structures and other factors. They contend that serious action for the provision of social security to the vulnerable elderly is required before things worsen. They also state that alternatives such as old-age homes may also be thought of with support of non-governmental organisations and voluntary associations. Brijnath, (2012:3) adds: “Migration, whether in-country or overseas, tends to create more nuclear family units and often older family members are left behind”.

However, Mapoma (2013) does not attribute failure by families to care for their aged in Zambia to the weakening of the extended family system. He instead attributes it to economic factors. He states:

While erosion of filial loyalty is attributed to influences brought about by migration, urbanisation, secularisation, etc., to mention but a few, this study re-enforces the fact that filial loyalty is an indelible mark for many Zambians, and where resources are available, people and families would endeavor to take care of their elderly relatives – especially those of a very close relation. Nevertheless, erosion of filial loyalty in the Zambian context is not due to westernisation or urbanisation or migration per say, it is instead a function of one’s ability to support older relatives (Mapoma, 2013:171).

Mapoma (2013) concludes that families are failing to look after or support older people due to their constrained socio-economic status and not necessarily that they are unwilling to do so. The implication is that social protection programmes and mechanisms need to be put in place by government and other stakeholders to ensure that the welfare of the aged is taken care of, especially in the absence of family support. As an illustration of the plight of the needy elderly in Zambia, the Zambia National Broadcasting Corporation (ZNBC), on its 20.00 hours Zambia News and Information Services (ZANIS) programme of Thursday, 11

December, 2014, carried a story in which a 101-year old man named Peter Munuunga, of North-Western province lamented that he was living in destitution because of lack of community and government support. He pointed out that his house was in a dilapidated state and could collapse any time and appealed to government to take care of its senior citizens who had done a lot towards the liberation of this country. He was speaking as he made a submission to the Judicial Reforms Committee, which was having its sittings in the province. This shows that there are several senior citizens in Zambia who served this nation with dedication and diligence, but who have slid into poverty, hopelessness and destitution due to lack of sustainable support structures.

The fourth factor which contributed to institutionalisation of the aged in old people's homes in Zambia was harassment by family members and the communities mainly on accusation that they were practicing witchcraft. Some elderly people reported that they were harassed, abused and banished from their communities on suspicion that they were harming other people using the powers of witchcraft. They, therefore, had to move to old people's homes for their own safety and security. This situation could be attributed to the fact that in most of Africa and, Zambia in particular, associating old age with practicing witchcraft is still widespread. It seems as if some people believe that there is a positive correlation between old age and the practice of witchcraft. The ZNBC television carried a documentary on Wednesday, 29 September, 2012 after the 19.00 hours main news in which one abused elderly man on the Copperbelt was featured. He lamented that elderly abuse was rampant in the province and that he was personally called a wizard for no apparent reason within his community. He said one would wish he/she died young in order never to experience this kind of abuse, injustice and humiliation. He went on to state that it would be better if all elderly people in Zambia were put in one place, away from society so that they could be protected from abuse. By implication, he meant that the aged should be taken to institutions such as old people's homes where they would be on their own, be protected and cared for.

A representative from the Victim Support Unit of the police service, who featured in the same documentary, pointed out that elderly people in Zambia were being harassed because they lacked knowledge about their rights and freedoms. He went on to state that it was an offence to refer to anyone as a witch or wizard under Zambian laws and statutes. He appealed for sensitisation of the general public on the evil of harassing and abusing innocent elderly

persons in Zambia. This has implications for adult education programmes in the sense that the police in conjunction with other stakeholders, such as NGOs, the Ministry of Community, Mother and Child Health and others, should be mounting awareness campaigns and programmes for both the community and elderly persons on the plight and rights of the aged and the need to treat them fairly and with respect.

The phenomenon of harassing the aged by members of their families and the community is consistent with Finch's (2013) finding which indicates that the aged in Zambia are normally abused and harassed on suspicion that they are witches or wizards. She explains that community members lack knowledge and understanding of some of the behavioural changes that result from the ageing process, such as loss of memory which could result in an aged person forgetting his or her own house and straying in someone else's house, hence being suspected of being a witch or wizard.

Finch (2013) points out that most of the aged who participated in her study were not aware of the existence of old people's homes in Zambia. She states that the aged indicated that if they had known of the existence of these homes, they would have requested to move there as they believed that they would be better off there than remain in communities where they were looked down upon, despised and abused. Kamwengo (1997) asserts that the aged in the community are more likely to be subjected to emotional and physical abuse than those in institutional homes. It can, therefore, be assumed that given chance to move to institutional facilities such as old people's homes, more elderly persons who feel neglected and abused in their communities would seek sanctuary and safety in these homes.

The Situation of Older People in Zambia (2006) observes that given the growing number of cases where older people have been abused in Zambia, there is need to launch a campaign against abuse of older persons. It states that this campaign should be continued until the legal system starts meting out severe penalties for offenders and politicians introduce legislation demanding long imprisonment terms. Mudiare (2013) adds that a course on ageing should be a compulsory part of the General Studies course in universities and that at primary and secondary school levels, some elements of ageing should be incorporated in the school syllabuses so that students can better appreciate and respect the aged. He also suggests that universities should encourage research in the study of the aged and issues of ageing.

The fifth factor that led to the aged moving to old people's homes in Zambia was disability. A disability is any restriction or lack of ability to perform an activity in the manner, or within the range, considered to be normal for a human being. The term disability reflects the consequences of impairment in terms of functional performance and activity by the individual. Disabilities thus represent disturbances at the level of the person (WHO, 2004). Some elderly respondents stated that they could not carry out activities of daily living on their own due to physical disability, hence the necessity of moving to old people's homes. This is consistent with Ndonyo (2011) who states that the number of old people admitted with disabilities in old people's homes in Zambia is increasing. The researcher observed that Likulwe old people's homes was keeping a number of disabled elderly persons who had suffered from leprosy. Steps to Entry into Residential Aged Care (2011) asserts that while older people living in care homes in the United Kingdom have different reasons for entering care, they do have one particular characteristic in common, which is the inability to perform certain activities of daily living.

Kamwengo (2004) points out that disability represents another role change among the elderly and that individuals have to adjust to this role change. He explains that disability affects other roles older people play and the reactions of people. Nyaruhucha, Msuya, and Matrida (2004) add that disability can affect nutritional status of people by impeding their participation in production, acquisition and preparation of food as well as eating. However, WHO (1991) contends that the vast majority of people remain fit and able to care for themselves in later life and that it is a minority of old people, mostly the very old, who become disabled to the point that they need care and assistance with the activities of daily living. Bland (2005) also asserts that poverty is still a major factor, as well as disability, in determining whether senior citizens can maintain their independence or find themselves being assessed as needing residential care in the United Kingdom.

Naomi, Shiroya, Fukuda and Murashima (2012), in their study titled 'Institutional Care versus Home Care for the Elderly in a Rural Area: Cost Comparison in Rural Japan' assert that elderly individuals with severe disabilities may add a social and financial burden if they were to be discharged and receive home care. This implies that the better option for such individuals is institutional care where qualified personnel would be in a position to adequately take care of their unique needs which arise from their disability. Rugh (1981)

states that caring for the aged in institutions is consistent with the ideal of family responsibility, which is that of providing alternative ways of carrying out that responsibility.

## **6.2 Services provided to the Aged in Old People's Homes in Zambia**

The second objective of the study sought to assess services provided to the aged in old people's homes in Zambia. The services considered comprised food, shelter, health entertainment, clothes, religious and spiritual support as well as counselling. Namakando (2004) posits that enhancing or maintaining the quality of life of older people is a social and moral obligation of governments and society as a whole. The Draft National Policy on Ageing (2011) also states that older people should have access to food, water and sanitation, proper shelter, clothing, health care, work and income generating activities, education and training and life in a safe environment.

The first service the study sought to assess in old people's homes was food. Most of the age respondents described the food provided to them in old people's homes as good, implying that they were generally satisfied with the food. Among the reasons they gave for this rating were that they were assured of food comprising three meals a day namely, breakfast, lunch and supper throughout their stay in the homes. They also indicated that the food was well prepared and adequate although they also complained of lack of food variety, as is reflected in the challenges they said they faced. The study established that all old people's homes were trying within the available means to take care of the nutritional needs of the aged by providing them with food despite facing the challenge of inadequate funding. This finding is consistent with Kamwengo (1997) who states that food is supplied to the homes for the aged on a regular basis. He explains that although the organisations running the homes for the aged experience inadequate funding, from time to time, efforts are made to ensure that food is available to the residents all the time. He further explains that the food is supplied not only on a regular basis, but also in adequate amounts.

Hurlock (1980) also states that one of the strengths of institutionalisation of the aged is the availability of meals. In their study Nyahurucha, Msuya and Matrida (2004) established that there was great variation between the elderly who were cared for in institutional centres and those cared for by their relatives in Morogoro Region, Tanzania, in terms of nutritional status as reflected by their Body Mass Index (BMI) levels. They concluded that the institutionalised elderly appeared to be better off than their counterparts who were cared for by their relatives

in the community. The implication is that due to socio-economic difficulties faced by some families in Tanzania, they were unable to provide adequate food to their aged relations, which was in contrast with their institutionalised counterparts who were assured of support from the government, the private sector and well-wishers through provision of various services including food.

Most of the caregivers and District Social Welfare Officers generally agreed with the views expressed by the aged respondents on the food provided in old people's homes. The caregivers explained that although they faced financial challenges, they were able to provide at least three meals to the residents every day as there was always a budget line for purchase of food items. They indicated that they were trying within the available means to provide a balanced diet. This study established that two old people's homes received supplementary food items from local hotels as part of corporate social responsibility on the part of the hotels. For example, at Mitanda old people's home, a local hotel delivered already prepared meals at lunch time to the aged every last Wednesday of the month in order to supplement what the homes provided. Maramba old people's home had a similar arrangement where a local hotel, Sun International hotel, delivered food items to the home once a month. Caregivers indicated that this provision of supplementary food went a long way in improving the nutritional status of the aged at the two old people's homes.

However this finding on food is contradicted by Cowan, Roberts, Fitzpatrick (2004) who assert that despite being preventable and treatable, malnutrition remains a problem in the developed world and the nutritional needs of many older people in long-term care settings are not usually met. Marleen (2006) also postulates that malnutrition is frequently observed in elderly people living in nursing homes and homes for the elderly in the Netherlands and that anorexia resulting in inadequate dietary intake is often a cause of malnutrition. Marleen explains that malnutrition in old age affects several aspects of functioning and that earlier research has shown that a complete dietary supplement improves the nutritional status of the aged.

The findings by Cowan, Roberts, Fitzpatrick (2004) and Marleen (2006) are quite interesting because one would not anticipate that the aged in institutional homes in developed countries like the Netherlands, with all the resources they have, would experience malnutrition. The

implication for old people's homes in Zambia is that cases of malnutrition could be recorded among the aged even if there was a constant supply of food. This is because malnutrition among the aged, especially those who are advanced in age, could also be brought about by other factors such as dementia, impaired activities of daily living, swallowing difficulties and constipation as well as some nutritional care related factors, such as eating less than half of the offered food portion and not receiving snacks (Suominen, 2007).

The second service that the study sought to assess was shelter. Ferreira (n.d.) points out that shelter is a basic need and the nature and suitability of older people's housing are key determinants to their wellbeing. Most of the elderly respondents in old people's homes in Zambia stated that the shelter provided to them was good. Among the reasons they advanced for this position were that they had a place to sleep in and were provided with a bed and beddings they needed. Others stated that the rooms provided them with safety and privacy and that the rooms were clean. This finding on shelter is consistent with Kamwengo (1997) who established that shelter in old people's homes was satisfactory, but explained that there were also some challenges, with one home having problems with the sewer system. Furthermore, Sichingabula (2000) who made an environmental assessment of Divine Providence Home in Lusaka to establish its suitability in catering for the needs of the aged concluded that the home was generally meeting the shelter needs of the residents. She nonetheless pointed out that the design of its buildings did not take into account the physical and psychological needs of the aged. This entails that although old people's homes in Zambia were trying to meet one of their objectives of providing shelter to the aged, they needed to improve upon this facility so that they could cater for some of the unique needs of elderly people.

At Nkulumazhiba old people's home, the researcher observed that all the elderly residents had a room each with some rooms not yet occupied. However, the residents complained of lack of electricity which they said was a big challenge. When the researcher asked the caregiver why there were some vacant rooms and yet the general impression was that there was high demand for admission to old people's homes in the country, he explained that the demand was there, but that inadequate financial resources had forced them to halt any new admission as they would not be in a position to provide for additional residents.

However, the views of the aged on shelter were contradicted by most of the caregivers and District Social Welfares Officers who indicated that the shelter provided to the aged in old people's homes was poor. They pointed out that most of the aged in old people's homes shared rooms which were meant for one person. The rooms were occupied by two or three elderly residents, which was not an ideal situation. Observations made by the researcher revealed that besides the shelter in most old people's homes being inadequate, toilet and bathing facilities were also communal and, in some cases, far from the quarters where the aged resided. The fact that the aged expressed satisfaction with the shelter provided to them could imply that they were comparing the situation they had been in prior to coming to old people's homes. Some could have been homeless and hence, having a roof over their heads was good enough and relief for them.

The third service provided to the aged in old people's homes was health care. One of the principles guiding the Zambian National Health policy is equality of access, which implies equitable access to healthcare for all the people of Zambia, regardless of their geographical location, gender, age, race, social, economic, cultural or political status (National Health Policy, 2012). Good health is crucial for the elderly to maintain independence, be autonomous and remain productive, which leads to improved quality of life in their old age (Ramachandran and Radhika, 2013). According to HelpAge International (2012), older people have a fundamental human right to make a claim on social services, such as health care. These claims are grounded in and justified by international law, for example, in the 1948 Universal Declaration of Human Rights. Therefore, the aged in old people's homes, just like other citizens, are entitled to appropriate and medical services and care. WHO (2004) asserts that comprehensive health care must be available to people as they age and that these services should be aimed at minimising the deleterious effects of disease and should promote the achievement of personal health potential and a high quality of life for the whole of the population.

This study established that most of the aged in old people's homes in Zambia were generally satisfied with the health services that were provided to them. Among the reasons they gave were that they received medication when they were ill and that medical personnel at health centres were generally helpful to them. This is consistent with Kamwengo (1997) who asserts that the majority of the aged in his study had indicated that the services provided to meet their health needs were to a large extent succeeding in meeting their health needs. However, the



respondents in Kamwengo's study comprised the aged in both the community and some old people's homes, meaning that the findings may not have been an accurate assessment of the service in old people's homes, hence the relevance of this study.

This study revealed that 2 out of the 9 old people's homes in Zambia had clinics within their premises which were run by full-time qualified nurses. The clinics provided health care to the aged who got sick. Serious cases were referred to hospitals in respective districts. The third home is located within the Mission hospital of Mwandi. Both the home and the hospital are owned and run by the United Church of Zambia. The aged at this home, therefore, have ready access to medical services and facilities that the hospital provides to the wider community.

However, most of the caregivers, Provincial and District Social Welfare Officers interviewed in this study indicated that the health services provided to the aged in old people's homes were poor. They attributed this to lack of medical facilities at most homes. They explained that some elderly residents had medical conditions which required immediate and sometimes round-the-clock medical care, which was lacking in most old people's homes in Zambia. This is in line with Namakando (2004) who states that her study showed that older people in Zambia were experiencing health problems relating to their individual health status and health care services. Caregivers and District Social Welfare Officers in this study further explained that services at clinics in local communities where old people's homes were located were not age-friendly as there were long queues and the aged were rarely given priority or chance by younger people to access medical care. This could be attributed to the fact that the attitude of some young people towards the aged is no longer that of compassion or respect. The young do not think the aged need any preferential treatment and hence, may ignore them, or not render any assistance. This is consistent with Oluwabamide and Eghafona (2012) who contend that one of the challenges the elderly face in modern Africa is lack of respect, especially from the young.

While the aged in this study stated that they were generally satisfied with the health care provided in old people's homes, they also identified lack of health facilities in most old people's homes as one of the challenges they faced. Caregivers, Provincial and District Social Welfare Officers stated that most of the aged in old people's homes did not receive adequate

health care due to lack of health facilities in the homes. They said that the aged would greatly benefit from health facilities provided within the homes.

The fourth service provided to the aged in old people's homes was entertainment. The study established that the major sources of entertainment provided to the aged in old people homes were radio and television. In some cases traditional dancers and drama groups were invited to perform in old people's homes although these were not regularly organised. One home was also able to provide in-door games, such as table tennis. The findings indicated that most of the aged were generally satisfied with the entertainment provided in old people's homes. However, according to caregivers and District Social Welfare Officers, the entertainment provided was inadequate. They believed that much more could be done to keep the aged engaged entertained and motivated. They argued that the entertainment amenities were too limited and only catered for a few residents in most instances. For example, in homes where there was only radio as a form of entertainment, only a handful of residents could benefit from this service at any given time. Furthermore, the aged with hearing difficulties could not find this form of entertainment very useful. Three old people's homes could not provide television entertainment to residents because they lacked electricity connectivity.

At St. Therese's Village, the main sources of entertainment was radio. The only television set had developed a fault and was just packed as the home did not have resources to have it repaired. They resorted to purchasing two radios, one for males and another one for males, but which were not adequate. Kamwengo (1997) compared two old people's homes, namely Maramba and Divine Providence Home in order to establish the kind of entertainment and pass-time activities the aged were provided with and engaged in respectively. He established that in terms of entertainment, Maramba only provided radio and television, while Divine Providence Home provided television, radio and occasionally organised parties where residents were provided with soft drinks. The aged were also taken for site-seeing. In terms of pass-time activities, Kamwengo (1997) also established that the aged at Maramba old people's home engaged in resting, sleeping and chatting with friends, while at Divine Providence Home, they were engaged in gardening, cleaning rooms, resting and talking to friends and nuns. He concluded that the number of pass-time and entertainment activities were limited in government run old homes for the aged partly due to failure by some officers to exercise initiative and imagination. He explains that there were many possibilities for

provision of these activities but that not enough effort was made to exploit the opportunities for the benefit of the aged.

However, contrary to Kamwengo's (1997) assertion that pass-time and entertainment activities were limited in government run old people's homes only, this study established that this state of affairs prevailed in almost all the homes. In fact, some privately run old people's homes offered less of these activities than government ones. For example, two privately run homes only provided radio as the main form of entertainment, while one provided traditional dances and drama only and these were occasionally organised. These homes were located in rural areas. This finding is consistent with Mapoma (2013) who states that people in rural areas have very few choices to make in terms of entertainment. He asserts that there was in fact, close to zero entertainment facilities available in rural Zambia, which he said explained why elderly people in rural areas reported greater loneliness compared to those in urban areas. Petterson and Sidenvall (2007) give the following as examples of frequent activities of daily life of an entertainment nature among the residents in a typical nursing home in Sweden: listening to the radio, watching television, reading newspapers and listening to music.

The fifth service provided to the aged in old people's homes was religious and spiritual support. The study established that all old people's homes in Zambia admitted the aged of different faiths and religious denominations without discrimination. The aged received spiritual and religious support which they needed, both in government and privately run old people's homes. The study revealed that the aged were free to practice their individual spiritual and religious faiths both within and outside the homes without hindrance. Residents, who could manage on their own, went to congregate at church denominations of their choice in the communities, if they belonged to denominations different from those running the homes in the case of church-run old people's homes.

Caregivers also confirmed that the aged were free to exercise their right to belong to denominations of their choice and congregate accordingly and that none of them was coerced into belonging to a denomination they never chose. Mass was also organised within the premises in some old people's homes for residents who were unable to go out of the homes due to disability, frailty or incapacity. Additionally, preachers occasionally visited the homes

to conduct prayers and share the word of God with the aged. In some cases, churches made arrangements to pick up their members for prayers and then bring them back after the service. The finding that most of the aged sought to maintain their religious inclinations and continue worshipping in church denominations they belonged even before moving to old people's homes is in line with continuity theory which suggests that maturing persons will develop certain habits, preferences and commitments that become part of their personalities. When an individual grows older there will be continuity of that personality, implying that the individual self or personality remains consistent despite life changes (Blackburn and Dulmus, 2007).

The researcher observed that one of the homes, St. Therese's Village, had a chapel where religious activities such as mass, prayer meetings and bible study were held. The aged were encouraged to participate in bible study and share the word of God among themselves. The home also engaged a Catholic Brother who provided pastoral care and coordinated most of the spiritual and religious support for the aged at the home. This finding is in line with Kamwengo (1997) who states that religious services are delivered by churches to provide the aged in old people's homes with opportunities for worship, reflection and deepening their faith.

The importance of spiritual and religious support in the lives of the aged, both in the community and in an institutional setting cannot be overemphasised as it is one of the coping mechanisms. Hoyer and Roodin (2003) point out that there are different views as to why religious beliefs lead to effective coping among elderly persons. They state that religion firstly provides spiritual support and secondly, it provides a belief in a compassionate higher spiritual being who cares for all people, an opportunity to gain pastoral care and the chance to participate in a variety of religious activities. They further state that a church, mosque or synagogue also provides the elderly with access to regular social support from fellow congregants. Oyediji (1992) adds that elders have been found to be more devoted to their religion and that longevity is regarded as an endowment as a result of closeness to and faith in God. Marche (2006) further posits that for a number of elderly persons, religious beliefs and practices can provide means of coping with the ageing process, a sense of meaning and purpose to life, and a system of social support.

This study, therefore, found out that caregivers and sponsoring agents considered spiritual and religious support to be among the services that were crucial to the wellbeing and welfare of the aged in old people's homes. This finding on spiritual and religious services is also consistent with Five Steps to Entry into Residential Aged Care (2005) which states that all aged care homes in Australia are required to provide care that is appropriate to the cultural beliefs and customs of residents. It explains that aged care homes are expected to acknowledge and respect the residents' cultural identity and encourage and help them maintain their existing links with cultural, national or social communities, and take part in the social life of those communities as much as they want. It further states the residents have the right to practice their religion wherever they live and that some aged care homes have their own chapels or quiet rooms for worship and reflection, while others have regular visits from clergy or can arrange transport to the religious establishments of the residents' choice.

The other service provided to the aged in old people's homes in Zambia was counselling. This study established that there was little counselling going on in most old people's homes despite its importance to the wellbeing and welfare of the aged residents. This state of affairs could be attributed to the fact that counselling may not be given priority among the services provided owing to lack of expertise in the field. This study established that most caregivers in old people's homes in Zambia lacked skills in issues of ageing and elderly care and did not have formal training in counselling. This finding is in agreement with Kamwengo (1997) who observes that there was very little counselling going on both in government and privately run homes for the aged in Zambia and that officers looking after the aged needed training in counselling skills. The implication is that there is need for caregivers to be provided with training opportunities so that they could acquire knowledge, skills and attitudes in counselling, among other skills, to enable them deliver better services to the aged in old people's homes.

The study established that 5 out of the 17 caregivers who were interviewed had done short courses as a way of building their capacity to deliver better care to the aged in old people's homes but these course were mostly in areas such as HIV/AIDS, strategic management, home-based care, orientation in social welfare and social protection. It can be noted that some of these courses were not so relevant to the welfare of the aged in an institutional set-up. There is, therefore, need for targeted courses which will equip caregivers with relevant

knowledge, skills and attitudes to enable them take better care of the aged in old people's homes in Zambia.

It can be noted from the foregoing that old people's homes in Zambia provide a number of services to the aged, namely food, shelter, health, entertainment, religious and spiritual support and counselling. Overall, the aged in old people's homes were satisfied with the services provided to them, while caregivers, Provincial and District Social Welfare Officers were of the view that the services were generally inadequate. For some elderly persons, old people's homes are the best alternative they can ever have. The Provincial Social Welfare Officer for Southern province pointed out that some elderly people had been living under trees, starving and suffering before their admission to old people's homes and as such, they greatly appreciated the care rendered to them. This could possibly explain why most of them favourably rated all the services provided.

Care Homes for Older People in the UK (2005) states that several organisations consulted during the study on care homes in the United Kingdom indicated that many older people and their relatives were reluctant to complain about the conditions in the homes because they feared that there would be consequences as a result. The report states that many residents and relatives were reluctant to raise issues or complain because they were concerned that it would result in a breakdown of relationship with staff and management in the homes. It further states that the underlying fear to complain appeared to be that complaining might result in staff in the care home providing a lower quality of care or the home might ask the resident to leave. In this study one elderly male respondent at Chibote old people's home told the researcher that he could not explain much on the adequacy of food and health services provided to them because he feared that the researcher might go and tell the caregivers about the complaint, who consequently, may become hostile and possibly send him away from the home. However, the researcher assured the respondent that as earlier indicated, the study was purely for academic purposes and that the findings may provide information that may be helpful to relevant authorities in terms of decision making and service provision to old people's homes in Zambia.

### **6.3 Challenges Faced by the Aged in Old People's Homes in Zambia**

The third objective of the study aimed to identify challenges faced by the aged in old people's homes in Zambia. The elderly, as is the case with other age groups, have needs. Their needs are many and varied. For their wellbeing and proper functioning, these needs should be met or partially met. Failure to satisfy the needs, whether partially or completely, can result in the elderly encountering problems including inability to function properly (Kamwengo, 2001). In as much as the aged in this study indicated that the services provided to them in old people's homes were generally adequate, they also highlighted a number of challenges they faced. However, only major challenges are discussed in this section and these include inadequate shelter, boredom due to lack of creative activities, lack of health facilities for the aged in old people's homes, poor sanitation and lack of food variety.

The first challenge faced by the aged in old people's homes in Zambia was inadequate shelter. The aged respondents pointed out that they shared rooms because the available accommodation was not enough for the number of residents in old people's homes. Caregivers also identified inadequate shelter as a challenge faced by the aged in old people's homes in Zambia. This finding is in line with Kamwengo (1997) who observes that at Maramba old people's home, there were at least two residents per room for males, while females were crowded in two dormitories. He proposed that dormitories at the home required renovation. The Report of Committee on Health, Community Development and Social Welfare (2011) also states that the conditions in old people's homes were deplorable, underfinanced and in most instances overcrowded. Similarly, a study by Kavita, Bipin and Geeta (2012) established that overcrowding was one of the main challenges faced by the aged in most old people's homes in India.

In his study on nursing homes in Slovenia, Habjanic (2009) points out that old people's homes in Slovenia were below the required standards and that apartments and rooms were small and overcrowded. He states that the homes offered no privacy for the residents, had no ergonomically adjusted bathrooms. He also states and the homes lacked suitable furniture and the only furniture that was there was poorly arranged and not ideal for the elderly residents. Habjanic (2009) goes on to make recommendations on how shelter and other services for the aged in old people's homes in Slovenia could be improved as follows:

Regarding the dwelling environment, my proposal for the future is to build more single-bedded and double-bedded apartments. Also newly built facilities should have modern equipped bathrooms. Installation of electronic equipment should allow easy calls to staff members for help or when the elderly person is in distress. Hospitality could be increased by providing small swimming pools and gyms for leisure activities (exercise, equipped according to the needs of the residents).

The second challenge faced by the aged in old people's homes in Zambia was boredom arising from lack of creative activities such as crafts, art, exercises and games. The respondents indicated that they lacked activities to engage in and were, consequently, bored most of the time. The inability to provide creative activities to the aged in old people's homes could be attributed to the fact that some people, including caregivers, think that the aged would not be interested in participating in these activities because they may lack the energy and motivation to do so. However, Kaplan (1953) points out that creative work and activities are essential to the well-being of older adults, whether it is by means of arts and crafts or by contributing in the community service sphere. This is in line with activity theory. He explains that homes for senior citizens should provide opportunities and guidance designed to promote this creativity. Kaplan (1953) further explains that if the resident is an active participant in planning and carrying out the programme of the home, he/she feels wanted; his/her unity with group life becomes greater than his/her conflict with the group; he/she develops a sense of personal worth and finds it easier to live in harmony with the rest of the home residents. Kaplan (1953) adds that when the residents of the homes reach this stage of adjustment through the promotion of high standards of physical and mental well-being and through an effective partnership of all resources, the home for senior citizens truly becomes a major point in the network of services to older people.

The finding on boredom due to lack of creative activities among the aged in old people's homes in Zambia as a challenge is also consistent with Sichingabula (2000), who concluded in her study of Divine Providence Home for older people in Lusaka, that lack of activity in terms of recreation made some residents feel bored. She, however, pointed out that majority of the residents felt grateful to have been given a chance to live in the home. Habjanic (2009:127) states: "Residents should be introduced to meaningful activities more frequently." Learning for Older People in Care Settings (2014) asserts that for older people, taking part in activities can improve their memory and dexterity, increase their appetite, give them greater levels of confidence, help them socialise, or just make them smile and enjoy life more.



Dubey, Bhasin, Gupta and Sharma (2011) give examples of recreational, outdoor and leisure activities among the aged residing in an old-aged home and within the family setup in Jammu, India. They say that recreational activities included listening to music or the radio, reading books, magazines and other materials and watching television while outdoor activities included visiting the temple, going shopping, and visiting any other place of interest. Leisure activities included talking to others, meditation, writing personal diaries and recapitulating memories. Old people's homes in Zambia would, therefore, do well to provide some of the above activities in order to improve the welfare of their residents.

Additionally, *Five Steps to Entry into Residential Aged Care* (2005) reveals that residents in Australian aged care homes are encouraged and supported to participate in as many activities as possible. The homes run programmes of activities, both internal and community-based, catering for many interests. Many aged care homes have activity officers or therapists who discuss the hobbies and interests of residents. The activity officers then work out how the residents' hobbies and interests can be continued in their new environment, if possible. This is consistent with continuity theory which advocates enabling the aged to continue with their interest, values and preferences they have always had as much as possible. The officers may also offer the residents other activities as they find feasible and appropriate. The above revelation is significant, considering that the largest number of the aged in old people's homes in Zambia indicated that they were idling most of the times. There is, therefore, need for deliberate efforts by caregivers and other stakeholders aimed at providing programmes for elderly residents so that they are engaged in creative activities.

The third challenge faced by the aged in old people's homes in Zambia was lack of health facilities for the aged in most old people's homes. Health is vital to maintaining well-being and quality of life in older age and is essential if older citizens are to continue making active contributions to society. The vast majority of older people enjoy sound health, lead very active and fulfilling lives, and can maintain emotional and social reserves often unavailable to younger people (WHO, 1991). However, ageing invariably means some physical deterioration and an increasing need for basic, palliative medical assistance but such services are not always available. Consequently, many of the aged suffer unnecessarily (*Life Through the Eyes of the Elderly in Zambia*, 2003).

This study established that out of the 9 old people's homes in Zambia, only 2, namely, Mitanda and St. Therese's Village had health facilities and medical personnel specifically for the aged and located within their premises. This finding is consistent with Ndonyo (2011) who indicates that residents in old people's homes in Zambia had no provision for medical support staff such as physicians, nurses, nutritionists or dieticians and medical social workers attached to them. The ideal situation, therefore, would be where the aged have easy and quick access to medical services within or near old people's homes because some of them may have health conditions due to advanced age. Nyangulu's (1991) finding also indicates that very few old people's homes in Zimbabwe had resident trained medical personnel.

This study also established that the aged at Kandiana old people's home enjoyed special status in terms of access to medical services. This was because the home is owned and run by the United Church of Zambia which also runs the Mission hospital. The home is located within the Mission premises, making access to medical facilities by the aged relatively easier compared to most other homes. However, access to medical facilities was a problem for residents of some old people's homes in Zambia because of distance to medical facilities. For example, Likulwe old people's home is located about 10 kilometres from Senanga district with a very sandy road on which mainly four-wheel drive vehicles can pass, while Nkulumazhiba old people's home is about 70 kilometres away from Solwezi district. Both these homes have no medical facilities within their vicinity, making it difficult for the aged to receive quick medical attention. This finding is consistent with Nyanguru's (1991) study on 'The Health Problems of the Elderly Living in Institutions and Homes in Zimbabwe', which established that in most old people's homes in Zimbabwe, health facilities were nonexistent and inaccessible. He explains that this situation disadvantaged the elderly residents who really needed the facilities. Nyanguru gives an example of a case where an elderly man at one of the homes was very ill and dying but could not be taken to a hospital or clinic, which was located some 50 kilometres away because the only rural bus had broken down two days earlier.

The above finding is also consistent with Namakando (2004) who contends that access to essential facilities as defined in the Health Reforms document means that people should be able to access essential facilities geographically, economically and culturally. She points out, however, that some of the health care delivery points in Zambia are situated very far from where the older persons reside and, as such, in the absence of reliable transport they cannot

access the health facilities. This was the case with some old people homes in this study, especially those located in rural areas.

This study revealed that apart from lacking medical facilities most of the aged in old people's homes in Zambia also lacked access to appropriate therapies and specialised medical care befitting their age and health status. This was acknowledged by then Minister of Community Development, Mother and Child Health, Dr. Joseph Katema in his speech to commemorate the International Day of Older Persons on 1<sup>st</sup> October, 2012, whose theme was 'Longevity: Shaping the Future', in Luangwa district. He said:

...I am aware that specialised medical facilities in the field of geriatrics are currently almost not available in the country. However, my government, recognising the importance of medical services, especially for older persons, will not spare any effort to ensuring that these are also made available in the foreseeable future.

Some of the aged respondents complained that due to the absence of medical facilities in old people's homes in Zambia, their immediate health needs were ignored or trivialized by caregivers who consequently delayed in taking them to the clinic or hospital, sometimes when it mattered most. Wim JA van den Heuvel (2012:295) makes a similar observation when he states: "In health care, there is the danger of under-diagnosis and under-treatment in old people because health problems and symptoms in old people may be overlooked or dismissed as part of the normal ageing process." This implies that there is a general tendency by caregivers to downplay some complaints of a medical nature from the aged on the assumption that the ailments complained about are typical of ageing and the aged. In view of this, Ndonyo (2011) recommends that nurses should be attached to old people's homes so that they can provide medication and also make clinical assessment of those who may have terminal ill-health and give appropriate advice.

The fourth challenge cited by the aged as a challenge they faced in old people's homes in Zambia was poor sanitation. The study established that most old people's homes in Zambia did not have age-friendly toilet and bathing facilities and these facilities were communal. For example, the caregiver at Chibote old people's home pointed out that the home faced the challenge of failure to provide proper sanitary facilities in a long time and observed that there was need for authorities to build modern toilets and bathrooms at the institution. The researcher also observed that the aged in 3 of the 9 old people's homes used pit latrines as toilets with no permanently built bathing facilities. The other homes had flushable toilets, but

which were located outside the hostels or rooms. In some cases, the toilets and bathing facilities were located quite some distance away from the rooms, making it difficult for the aged to access them, especially those with physical and mobility challenges.

Bland (2005) also states that elderly residents in her study criticised the inadequacy of toilet provision in care homes in England on grounds of numbers, size and privacy afforded in cubicles. She explains that one home had toilets with sliding doors that had no locks and that narrow toilets made it difficult or impossible for people using walking frames or wheelchairs to use the toilet independently and in private. She further points out that not only were the numbers of toilets provided for residents' use insufficient, they were also poorly located, particularly in relation to dining rooms and lounges.

Therefore, one of the areas that need attention in terms of infrastructure improvement in old people's homes in Zambia is sanitary facilities. Mapoma (2013) attests to this need when he points out that good sanitary facilities as well as good and reliable sources of water are good makers of health to elderly persons. It is an undeniable fact that as people advance in age, they need to have access to age-friendly facilities, including sanitary facilities and this includes the aged in institutional homes. The aged in these homes deserve better facilities befitting their needs and requirements. However, as Sichingabula (2000) observes, the prevailing economic conditions in the country, coupled with budgetary constraints, may not allow modifications to buildings and facilities in old people's homes in the foreseeable future. The researcher is of the view that something should still be done to improve sanitary facilities in all old people's homes with the help of stakeholders and well wishers.

The fifth challenge the aged faced in old people's homes in Zambia was lack of food variety. For older people, as for the general population, the maintenance of good health depends on safe, affordable and appropriate foods. Eating a balanced diet high in fresh fruit and vegetables and low in fat gives some protection against heart disease, stroke, some cancers, obesity and arthritis (Recommendations for a National Food and Nutrition Policy for Older People, 2000). Lack of food variety and choice is also a measure of food adequacy as eating the same kinds of food over and over may entail monotony. The challenge of lack of food variety in old people's homes in Zambia is confirmed by Kamwengo (1997:59) who asserts: "The amount and variety of food and number of meals available in the government run

homes for the aged are limited. As a result, it is not uncommon to find residents remarking that portions of food are not enough. The problem of food is due to inadequate funding.” Kamwengo (1997) adds that there were no snacks provided during the day in government run homes. However, this study established that contrary to Kamwengo’s assertion that this problem was peculiar to government run homes, it also existed in most privately run old people’s homes. Caregivers also pointed out that lack of food variety was not good for the nutritional status of the aged in old people’s homes.

The Draft National Policy on Ageing (2011:6) also acknowledges the problem of lack of food variety and nutrition for the aged when it states:

The majority of older persons fail to access good nutrition; as a result some of them are malnourished and can barely afford a meal a day. This situation has been compounded by the trend towards children, lactating mothers and the younger population groups. In addition, the lack of appropriate food stuffs for older persons result in them not having a balanced diet suitable for their nutritional needs and age.

Five Steps to Entry into Residential Aged Care (2005) points out that care homes in Australia are expected to offer residents a varied, healthy and well-balanced diet that takes into account individual preferences and medical needs. It states that care homes should also take into account the residents’ dietary customs according to religious or cultural beliefs. This implies that the residents have a choice on which food to consume and have a say on how their meals should be prepared, which was not the case in most old people’s homes in Zambia. The Draft National Policy on Ageing (2011) states that currently there is insufficient information regarding nutrition for the ageing population and older people on how to care for them in old age in Zambia. It further states that most training curricula in food and nutrition tend to leave out topics that deal with care for older persons in this area. Therefore, Ndonyo (2011) suggests that there is need to attach professionals such as nutritionists or dieticians who would monitor the quality of the food provided to the aged and advise on the variety required.

By and large, the aged in old people’s homes in Zambia seemed to be saying that the homes gave them some safety and peace besides meeting their daily needs through provision of various services, such as food, shelter, medical care, clothes and entertainment which they otherwise may not have accessed in their respective communities. However, they also

acknowledged and highlighted some challenges that they faced in their day-to-day lives, the major ones of which have been discussed above.

#### **6.4 Challenges Faced by Caregivers in Old People's Homes in Zambia**

The fourth objective of the study ought to ascertain challenges faced by caregivers in old people's homes in Zambia. The challenges faced by caregivers, according to the findings of this study, included inadequate and erratic funding, low staffing levels, lack of training opportunities for staff, absence of a national policy on ageing, lack of ICT facilities and high demand for admission of the aged to old people's homes. The challenges are discussed below.

The first challenge faced by caregivers was inadequate and erratic funding. The study established that all old people's homes experienced financial problems which negatively affected provision of services and overall care for the aged in old people's homes in Zambia. Caregivers, Provincial and District Social Welfare Officer as well as the Chief Planner at the MCDMCH headquartes indicated that funding to both government and privately run old people's homes was inadequate. Government run old people's homes received monthly grants from the Ministry of Finance for their operation, implying that they were assured of money supply though it was said to be inadequate. Nonetheless, privately run homes did not necessarily receive the grants from government monthly. They instead received them quarterly and sometimes after a long time, implying that the funding was unpredictable. Government funding to privately run old people's homes was, therefore, not only inadequate but also erratic. This financial situation is confirmed by Kamwengo (2001:85) who states:

The department of Social Welfare provides a supportive role to the homes for the aged. It registers the homes on behalf of government. From time to time, it also gives out financial assistance to some of the privately owned homes. On the other hand, the government run homes receive all their supplies, funds and personnel from the department.

The Chief Planner informed the researcher that initially funding from the Ministry of Finance to old people's homes was channeled through the department of Social Welfare of the MCDMCH but that this system was discontinued because delays were experienced in the disbursement of the funds. The Ministry of Finance, therefore, started funding the homes directly in order to avert the delays experienced earlier. This study revealed that owing to the inadequate financial environment in which old people's homes in Zambia operated, some

privately run homes had taken measures and initiatives to raise additional funds to supplement what they received from their sponsors and government. For example, a caregiver at Divine Providence Home explained that every year they undertook fundraising walks to raise some additional funds from well wishers in order to offset operational costs which she said were very high. She stated that with the money they had collected from the fundraising walk the previous year (2011), they were able to start a chicken rearing project. They sold the chickens to people in the surrounding community. Similarly a caregiver at Mitanda old people's home informed the researcher that since they did not have permanent income to depend on, they raised some supplementary funds by renting out the self-contained flats which belong to the home and are located within its premises to members of the public at fairly low rates.

The Chief Planner attributed the inadequate funding to old people's homes to the general economic malaise in the country which resulted in poor financial resource allocation to various sectors including social services. However, the challenge of inadequate funding towards the welfare of the aged is not peculiar to Zambia. Glendinning (2012) reports that long-term care in England is widely acknowledged to be seriously under-funded relative to levels of need. He explains that despite sharing demographic pressures common to all European countries, there has been a continuing political failure to achieve a comprehensive, sustainable and equitable basis for funding social care in England and that since 1998, several official and independent committees of enquiry have proposed funding reforms, but failed to secure the necessary political commitment.

The second challenge faced by caregivers in old people's homes in Zambia was low staffing levels. Caregivers in all old people's homes pointed out that they faced the problem of staff shortage in all areas of service provision and care for the aged. Consequently, the staff were overworked, became tired and, in some cases, demotivated. This is consistent with Habjanic (2009) who states that due to low staffing levels, people working in nursing homes in Slovenia were not satisfied with their working conditions and reported that they suffered from physical and mental fatigue. In this study Provincial and District Social Welfare Officers and caregivers also highlighted the challenge of inadequate staff in old people's homes in Zambia, which they said called for serious attention.

The study revealed that at Nkulumazhiba old people's home, there was only one male caregiver against 10 male and female elderly residents. He was performing a number of tasks for the aged ranging from cooking to washing clothes and several others. A female caregiver who had been working with him had quit due to non-payment of salary and the home could not employ additional staff because of financial constraints. Harrington (2001) points out that there is a relationship between nursing home outcome and staffing levels. She explains that the lack of staffing, skill-mix, training and services leaves the elderly people at risk of harm. She suggests that care facilities should make a greater investment in staff training and professional development to reduce high turnover of staff.

Murphy, O'shea, Cooney, Shiel and Hodgins (2006) further point out that appropriate staffing levels and skill-mix in long-stay care facilities such as old people's homes are critical to the quality of life of residents. They explain that findings in their study revealed that low staffing levels and inappropriate skill-mix were major barriers to the provision of quality care. The study also revealed that it was increasingly difficult to recruit and retain staff for care institutions mainly because of poor remuneration and strenuous working conditions.

Ensuring a stable supply of manpower is vital to the success of institutional care for the aged. According to Simone (2008), there are several ways to minimise the labour shortage problem in institutional homes. Firstly, training for elderly care should be organised by the government. He says elderly care should for example, be added to the curriculum of employee re-training programmes organised by government to maintain a consistent supply of skilled labour. Secondly, regulations on minimum salaries or subsidies from the government for care or nursing workers should be enacted to increase the competitive power of the elderly care industry. Thirdly, it would be helpful to develop care giving skills as professional knowledge through a licensing system or educational system, just as nursing is now recognised as a specialist profession.

Simone (2008) further explains that there are several ways to improve the level of elderly care services. Firstly, the staff-to-elderly ratio should be increased so that basic level personal care such as feeding and bathing can be improved, which will also relieve the work burden of staff. He points out that many comments about the poor services provided by elderly residential care services stem from overburdened servicing staff and that the heavy work load



leads to poor service levels and poor staff attitudes. He adds that an increased staff ratio would allow more personal care services like talking with the elderly and handling their daily needs. In this study, caregivers indicated that they hardly had time to develop closer interpersonal relationships with the residents in their care because they were preoccupied with daily routine tasks owing to understaffing.

Habjanic (2009) asserts that in a situation where there is a critical shortage of permanent staff to care for the aged in institutional homes, part-time employees could also help in routine interventions like accompanying residents and making beds. Caregivers at Maramba old people's home indicated that from time to time they engaged part-time staff from the surrounding community to help with tasks such as bathing and shaving some residents but that this was not sustainable as there was no budget-line for such expenditure. However, for most old people's homes in Zambia, this arrangement was difficult because of financial constraints. Likulwe and Nkulumazhiba old people's homes were using volunteers from the community to care for the aged, except that some would withdraw their services even without notice, hence causing some disruption in service provision.

The third challenge faced by caregivers in old people's homes in Zambia was lack of training opportunities. This study revealed that most caregivers working in old people's homes in Zambia had no knowledge and skills in caring for the aged as they lacked training in this area. This is confirmed by Kamwengo (1999:ix) who asserts: "Many caregivers in both the community and homes for the aged lack skills and knowledge for effectively working with and for the aged. These include counselling skills, skills in handling the aged and knowledge about the needs, demands and expectations of the aged." In emphasising the need for training caregivers who work with the aged in old people's homes, McGivern (2006) states that there is a need to train staff in long-stay care homes and an overwhelming need for nutrition and dietetic services to advise and assist with menu planning, appropriate prescribing of nutritional supplements and weight management of residents.

In this study, one female caregiver complained that her superiors, who were Sisters, had denied her opportunity to undergo any form of training despite having worked for the institution for a very long time and asking them for support and sponsorship. She explained that the Sisters were scared that if she acquired appropriate knowledge, skills and attitudes in

the area of elderly care and related aspects, she may quit her job to go to and work in other institutions where they would pay her more. She pointed out that despite all her hard work and being the longest serving member of staff, her pay was nothing to talk about. However, in a separate interview, one of the superiors contradicted the caregiver's sentiments by stating that they wished to have trained staff working for the home but that they could not sponsor them for training because of financial constraints. Nyanguru (1991) points out that there is need to train people who work with the elderly in institutional homes. He states that they need simple physiotherapy skills, simple occupational therapy skills, general supervision of the elderly to prevent malnutrition and related aspects. He further states that there is need for better understanding by staff of what constitutes proper nutrition for older people. However, Hannan, Norman and Redfern (2001) observe that educational and training programmes must be relevant to the needs of staff in old people's homes and residents if they are to have a positive impact or outcomes.

It was clear from the findings of this study that the training of caregivers was not considered a priority in most old people's homes supposedly mainly because those that were caring for the aged were thought to be doing a good job under the circumstances, notwithstanding financial challenges. However, the need for appropriate training for caregivers was apparent.

The fourth challenge faced by caregivers was absence of a national policy on ageing. Caregivers and Provincial and District Social Welfare Officers, senior officers in the welfare and planning departments at the Ministry of Community Development, Mother and Child Health headquarters, the Chairperson of the Parliamentary Committee on Health, Community Development and Social Welfare as well as staff of the Senior Citizens Association of Zambia all observed that the absence of a national policy on ageing in Zambia posed a challenge to the status of the aged and their welfare as well as operations of old people's homes in Zambia. They stated that the absence of the national policy on ageing entailed lack of a regulatory framework on the welfare of the aged. This study established that there was no operational national policy on ageing in place though the process of coming up with one had started as early as 2008. At the time of data collection for this study, the policy was just in draft form, awaiting approval by Cabinet and subsequent ratification by parliament. This is confirmed by *The Situation of Older People in Zambia* (2006:41) which states: "...Furthermore, an ageing policy is not yet put in place. As a result, older people continue to

find difficulties in accessing basic social services such as health, water and social protection schemes.” Therefore, the absence of a national ageing policy was a major source of concern among caregivers and other stakeholders. The Situation of Older People in Zambia (2006:86) further states:

Many older people, public officials and other stakeholders have been asking for an ageing policy. They have demanded that a policy be established as a matter of urgency. The government has been willing and ready to pay for the development of an ageing policy. That has been good news for many people.

The Draft National Policy on Ageing (2011) indicates that the policy on ageing, once put in place, would be used as a guiding instrument not only for government committing itself to the plight of older persons, but also for purposes of allocation and expenditure of public resources. It further indicates that having a policy on ageing would assist in enhancing the mainstreaming of ageing issues in national development and that it would further pave way for legal reforms that could enhance realisation of rights of older persons and create an enabling environment that takes into consideration the needs of the ageing population.

The importance of having a policy on ageing in any country, Zambia included, cannot be overemphasised. Ageways: Practical Issues in Ageing and Development (2014) gives an example of the Fijian experience when it states: “Older people in Fiji now have a national policy, bringing them a range of financial benefits and a national council to protect their interests, thanks to sustained campaign.” Furthermore, in emphasising the significance of a national policy on ageing, Mudiare (2013) asserts that the idea of keeping old people in institutional care still sounds strange for many Nigerians, yet it is increasingly difficult for families to cater for them in the absence of any welfare benefits. He points out that even those who are on monthly pension will at some point in time require assistance either from a caregiver or a professional health caregiver. He, therefore, recommends that policy makers expedite action on the policy implementation of provisions for the care of elderly people. Mudiare (2013) adds that more awareness campaigns on the problems of ageing need to be mounted in schools and in the media, which would be strengthened if there was a policy direction and framework on ageing.

Relatedly, the Director of the Department of Social Welfare at the MCDMCH headquarters explained that the Ministry did not have written guidelines on the establishment and operation of old people’s homes in Zambia owing to lack of a policy framework. He also

explained that the Ministry did not impose or prescribe qualifications for officers running privately run old people's homes. He, however, stated that the Ministry had been working on the guidelines which he said would be strengthened with the enactment of a national policy on ageing. He added that the guidelines would prescribe the minimum standards of care for the aged in old people's homes and spell out the minimum qualifications that caregivers, counsellors and others who render service to the aged in all old people's homes should possess.

The fifth challenge faced by caregivers in old people's homes in Zambia was high demand for admission of the aged to the homes. Caregivers, Provincial and District Social Welfare Officers submitted that there was very high demand for admission of the aged to old people's homes. The department of Social Welfare and caregivers were particularly under massive pressure from communities, churches, NGOs and the police to admit more elderly persons to old people's homes. In some cases, the elderly persons themselves requested to be admitted to the homes. This finding is in line with the Report of the Parliamentary Committee on Health, Community Development and Social Welfare (2011) which states that old people's homes in Zambia are very limited in number and cannot cater for all the old people that need care. It further posits that Mauritius faced a similar challenge where there was increasing demand for services provided by old people's homes in comparison to existing institutions. Kamwengo (2001) also points out that institutions created to provide care for the elderly in Zambia are few. He attributes this state of affairs to the official government policy which discourages institutional care in favour of the extended family care while accepting to retain the already established homes for the aged.

Diana (1999) points out that as the number of elderly people moving into residential care homes continues to escalate in Hong Kong, increasing attention has been drawn to assisting these elderly people go through the new experience with dignity and success. Care Homes for Older People in the UK (2005) also explains that demand for residential and nursing care places in the United Kingdom is influenced by two key factors, namely; demographic and government policy. It points out that in an ageing population, it is reasonable to expect that demand for care home places will increase but this has to be set against changes in government policy. It explains that the government in the United Kingdom places more emphasis on providing alternative forms of care in people's own homes in order to enable

people carry on living independently for longer. However, Persistent Challenges to Providing Quality Care (2012) states that the population of England is ageing and people are living longer with long-term conditions and disabilities, resulting in increasing care homes needs.

Kofod (2008) posits that the present and future demographic trends predict substantial increase in the number of elderly people within the next forty years in Denmark and other industrialised Western countries and that researchers and policy makers predict that this increase will intensify the demand for nursing care. He explains that as a consequence, a larger number of elderly people will be in transition and eventually become nursing home residents. Simone (2008) adds that with advancing age and prevalence of chronic illnesses in the population in Hong Kong, the majority of whom are frail and vulnerable, continuous and rapid growth of residential care services for the elderly is expected. He states that this creates a favourable market for the development of a flourishing private residential care service for the elderly that provides personal and/or nursing care for older people.

Kavita, Bipin and Geeta (2012) assert that in India, children are the main support for parents in old age in India, but that the physical ties of the elderly men and women with their adult children have weakened. They explain that the results of their study suggest that the state should be prepared to meet the needs of good institutional living arrangements for the elderly as demand for such care is likely to rise in future.

In anticipation of rising demand for institutional for the aged in Zambia, the Committee on Health, Community Development and Social Welfare (2011:16) made the following recommendation on old people's homes in Zambia:

The government, through the Ministry of Community Development, Mother and Child Health, should come up with a robust programme to provide Old People's Homes in all parts of the country. Furthermore, incentives should be considered to attract private companies to sponsor Old People's Homes.

## **6.5 Provision of Adult Education Programmes in Old People's Homes in Zambia**

The fifth objective aimed to establish the extent to which adult education programmes were provided in old people's homes in Zambia. The study established that there were very few adult education programmes provided in old people's homes. This was because out of the 9 old people's homes in Zambia, only 4, namely, Mitanda, Maramba, Kandiana and Nkulumazhiba, offered any form of adult educational programmes in areas such as agriculture, hygiene, nutrition education, knitting, HIV/AIDS awareness and religious

education. These programmes fall under the rubric of non-formal adult education. According to Nafuko, Amutabi and Otunga (2005), non-formal adult education is learning that takes place outside formal learning institutions and is specifically meant for adult learners. It involves the education provided to adults by non-governmental and private organisations, for those adults interested in acquiring specific knowledge and skills for life improvement.

Realistically, one cannot think of the aged in old people's homes going into a formal adult education programme in Zambia as it may be unsuitable for them. The kind of adult education programmes provided in old people's homes mainly came in form of talks, presentations and demonstrations by experts from ministries such as the Ministry of Health, MCDMCH, NGOs, local and international volunteers and churches mostly on the above stated subject areas for the purpose of keeping them engaged busy, active and engaged. This is in line with Alfageme (2007) who asserts that educational programmes aimed specifically at older people could be in the non-formal learning environment and that these programmes could not necessarily be provided by education or training centres.

Although few old people's homes in Zambia provided educational programmes to the aged, there was a general agreement that these programmes were and would be quite beneficial to them. Education for the aged in old people's homes is meant to enhance the quality of their lives and keep them active. This is in line with Ala-Mutka and Punie (2007:2) who state: "In general, older people's learning motivation is related to improving their everyday lives, to keeping themselves active and to sharing their knowledge and to connecting with other learners." This was acknowledged by most of the caregivers, Provincial and District Social Welfare Officers and other key informants in the study who indicated that the aged in old people's homes in Zambia would benefit from educational programmes as long as these programmes were relevant, well planned and coordinated and responded to the interests, needs and abilities of the learners.

However, a few caregivers were apprehensive about the prospects of providing educational programmes to the aged in old people's homes because they believed that such programmes would not add much value to their lives and were not so necessary. They also believed that the aged would not have the interest or motivation to take part in these programmes by virtue of their age. The view by such caregivers is also highlighted by Munoz (2010:77) who states:

“Adult people’s lack of opportunities and social exclusion stems from the structural response of the system that regards them as ‘useless’ as education subjects, as they already performed their assigned role in the dynamics of the globalised world.” This implies that some members of society, who include some caregivers, generally regard the aged as people who have lived their lives and for whom provision of educational programmes would not yield many social and financial returns. Boulton, Gillian and Purdie (2003) point out that the capacity of older adults to remain physically, mentally and socially active is dependent on continued participation in learning and education. They, however, contend that older adults are often not considered as likely candidates for learning by society.

When the aged in old people’s homes in Zambia were asked whether they would want to participate in educational programmes, most of them said that they would want to do so. The main reasons they gave were that they wanted to keep busy, to be informed about national and international affairs, to be acquire new skills, to be productive, for fun, to enable them read the bible and know their rights. This is consistent with Grandal (2008) who points out that many elderly individuals demonstrate great interest and ability to learn new information and that ageing should not be seen as purely a time for decreased abilities but rather as an opportunity for growth, increased wisdom and the attainment of new skills. Shikur (1997) adds that the important principle of adult education relates to the strong belief in the educability of humankind and that adult education basically negates the belief that learning is possible only in childhood and not later in adult life. Shikur explains that every experience one undergoes, particularly in the process of attaining maturity in physical, emotional and intellectual sense, enlarges this repertoire of knowledge which affects or modifies his/her future behaviour. He points out that it is evident that regardless of their age, adults have an inert ability to learn.

On the other hand, some elderly respondents indicated that they would not want to participate in educational programmes and the main reason they gave was that they were too old to learn. This is in line with Grandal (2008) who asserts that despite new currents and thinking *vis-à-vis* education and ageing, older people continue to be denied learning opportunities or they reject them themselves on the belief that it becomes more difficult to learn with age. The other reasons the aged gave for not wanting to participate in educational programmes was that they lacked the motivation to learn, had poor eyesight and that they did not find education to be necessary so late in their lives. However, Oyedeki (1992) contends that adults,

in spite of the impairments they suffer, do accumulate experiences in their social, political, economic, cultural, religious and other interactions and these experiences appreciate to more than make up for the physiological and mental impairments. He explains that investigations have shown that adults can learn at any age up to cessation of life if their sociological maturation is intensified, if they are not timed in their learning activities, if they are allowed to participate in the planning process and evaluation of the learning activities and if learning is directed towards providing solutions to their identified problems, needs and interests.

The aged in old people's homes in Zambia who had expressed willingness to participate in educational programmes were asked to indicate the subject areas they would like to participate in. Most of them indicated practical skills such as basket making, knitting, tailoring, gardening and livestock rearing which they said would directly benefit them. This showed that adults, including the aged, are mostly interested in learning things that are relevant to their lives and are of practical use. Ala-Mutka and Punie (2007) state that tasks such as organising transport, taking care of one's health or managing money stood out as learning needs among the elderly whom they studied. However, the elderly persons they studied lived in communities and not necessarily in institutional care. Furthermore, Courtenay et al. (1983) state that when undereducated older adults were asked to report what they would be most interested in learning, health topics such as checking blood pressure and reading a thermometer ranked first. This implies that in coming up with educational programmes for the aged, it is important to firstly identify their learning needs and interests and also involve them in planning for these programmes. The aged should not be coerced into participating in educational programmes against their will. Instead, they should be encouraged to do so if they have the ability and desire and made to appreciate the need to learn.

The other subject area that the aged in old people's homes in Zambia stated that they would like to participate in was adult literacy. For example, at Likulwe old people's home, the researcher was informed by the caregiver that most of the aged had expressed interest in learning adult literacy. Consequently, a sister department in Senanga district was planning to introduce adult literacy classes and among the subject areas they were to offer were health, nutrition, civic rights and craft making. According to Adult Education and Development (2013), literacy is an indispensable foundation that enables young people and adults to



engage in learning opportunities at all stages of the learning continuum. It points out that the right to literacy is an inherent part of the right to education. It is a prerequisite of personal, social, economic and political empowerment and an essential means of building people's capabilities to cope with the evolving challenges and complexities of life, culture, economy and society.

Indawa and Mpofu (2006) assert that basic adult literacy education is a programme meant to provide an opportunity for the acquisition of skills of reading, writing and numeracy at basic levels, in a particular language, local or foreign. Sumbwa (2013) further states that basic literacy programmes enable adults who may or may not have had the opportunity of accessing formal education to be able to understand the problems of their immediate environment. It also sensitises participants to their rights and obligations as citizens and individuals.

When caregivers and Provincial and District Social Welfare Officers were asked to indicate the educational subject areas which they considered important and beneficial to the aged in old people's homes in Zambia, they mentioned hygiene, agriculture, nutrition and health education. According to Nafunko, Amutabi and Otunga (2005), health education is concerned with community benefits of disease prevention, basic hygiene, diet improvement, family life education, environmental education and the most current health concern HIV/AIDS education. Health education would be particularly relevant to the aged residing in old people's homes because it would have a direct bearing on their health and wellbeing. For example, they would be taught the importance of keeping themselves and their surroundings clean as a way of preventing diseases. Namakando (2004) recommends that older people should be educated about age-related problems, health care practices and their rights to access quality care and services.

Ala-Mutka and Punie (2007) point out that learning is a way for older people to stay active, to participate in society and to share the knowledge and experience gained in their lives. They also state that learning can enrich the quality of life for older people as well as the people interacting with them and learning from them. This is line with activity theory. Therefore, learning opportunities should be provided for the willing and capable older persons to participate in. *Enhancing Informal Adult Learning for Older People in Care Homes* (2010:2)

states “For older people, taking part in activities can improve their memory and dexterity, increase their appetite, give them greater levels of confidence, or just make them smile and enjoy life more.”

This study also revealed that some elderly persons residing in old people’s homes in Zambia possessed knowledge and skills in areas such as tailoring, knitting, sewing and embroidery which they were willing to share and pass on to others. What they lacked, however, were resources and opportunities to do so. They wished to continue with the activities and interests they had even before moving to old people’s homes and contribute to the wellbeing of others. This is in line with continuity theory. Raju (2011) acknowledges this need when he says: “Given the changes in the socioeconomic profile of the elderly, there is need to recognise them as a resource group and to develop suitable policies and programmes for their integration into the development process”. This implies that when provided with an enabling and supportive environment, the aged in old people’s homes who possess certain skills and talents can be used as resource persons to teach others and share experiences. In agreeing with this notion Ala-Mutka and Punie (2007) point out that personal objectives for participating in learning activities can also emphasise something other than gaining new knowledge and skills. They states that learning can be seen as a way to keep one’s mind active and to come in contact with other people. They also explain that some older people want to participate in learning activities as a way to give back and share the knowledge and experience gained during their life.

Offering educational programmes to the aged in old people’s homes may have some financial implications. However, Enhancing Informal Adult Learning for Older People in Care Homes (2010) asserts that providing learning opportunities for older people in care institutions need not cost a lot of money. It advises caregivers to think creatively about how learning opportunities can be built into an existing activity programmes as well as into everyday routines or to draw on the support and services of local organisations and groups.

It can be noted from the foregoing that the aged in old people’s homes would like to participate in education programmes except that most of them were not given the opportunity to do. The aged could benefit from learning activities by way of keeping intellectually stimulated, busy and productive. In fact, the researcher observed that a good number of the

aged residing in old people's homes in Zambia were quite healthy and energetic and could hence participate in creative and educational programmes if these were provided. As has been earlier highlighted, a good number of the aged were admitted to these homes, not because they were physically or mentally incapacitated, but because they lacked support and care, besides other factors earlier discussed. The next section discusses the implications of institutionalisation of the aged for adult education programmes.

## **6.6 Implications of Institutionalisation of the Aged for Adult Education Programmes**

This study examined the care provided to the aged residing in old people's homes in Zambia and implications for adult education programmes. Given the far-reaching and enduring nature of factors that led to the institutionalisation of the aged and the projected increase in population ageing, the phenomenon of old people's homes in Zambia is likely to continue. It is, therefore, important that the aged in these institutions are provided with adequate services including adult education. This section, therefore, discusses the implications of institutionalisation of the aged for adult education programmes. The section discusses these implications at four levels, namely; the aged in old people's homes, caregivers, adult educators and the government. It also looks at strategies that can be adopted in the provision of adult education programmes in old people's homes in Zambia.

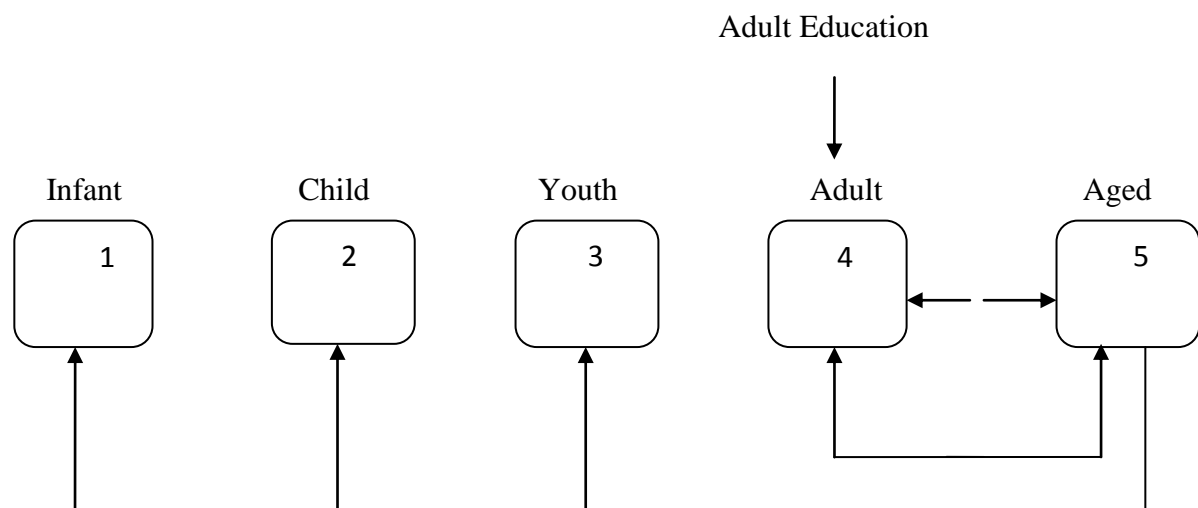
### **6.6.1 Implications for the Aged in Old People's Homes**

The findings regarding the status of old people's homes and the services provided indicated the need for creative activities and adult education programmes for the aged. Coping with being cared for in an institutional set-up may be enhanced by well designed programmes and activities, including adult education programmes. One of the key findings of this study showed that lack of activity and idling were much of a concern to the largest number of the aged and caregivers in old people's homes in Zambia. The study established that the aged in most old people's homes spent much of their time doing nothing and were hence bored. Therefore, there is, therefore, need for provision of appropriate creative activities and educational programmes to keep the aged intellectually stimulated, engaged and active. This is in line with activity and continuity theories which state that successful ageing occurs when older adults stay active and maintain social interactions, skills and interests.

One of the principles of adult education is that there is no age limit to learning and everyone is capable of learning unless they are impeded by factors such as illness or incapacity. Here, we are talking about learning and keeping the mind active. Education is a life-long process and comes in different forms.

However, the aged are generally viewed negatively in society as people who are tired, finished and dependent and who should be cared for by others. The challenge has been the inherent disconnection between the aged and adults and between adults and youth, children and infants and how the aged could creatively interact with other age groups in relation to adult education. This is illustrated in figure 3 below:

**Figure 3: The Aged in relation to Adult Education**



Source: Field Survey, 2013

The view that the aged are passive recipients of care and charity as they spend their last days on earth is not supported by this study. The aged should instead be considered as resource persons who have hopes and aspirations and possess different skills and talents which they could share with others. As custodians of culture, wisdom and values, the aged could contribute to making society better by serving in a new capacity as facilitators, ‘social academics’ and consultants. They could share their valuable knowledge, skills and experiences with others and be part of the solution to societal problems. That way they will also be kept busy and engaged and will not feel bored or left out.

Oyedeki (1992) asserts that elders should be taught various things including issues of ageing in order to prepare them for economic self-sufficiency, to integrate socially and to cope with physiological and mental changes that are inevitable in their lives but which can be seen as challenges to be experienced gracefully. Additionally, in his study titled 'Forms of Community Adult Education Practices and Challenges of Implementing them in Chongwe District', Sichula (2012) recommended that adult literacy education should be an active aspect of all adult education programmes in all communities in Chongwe district. Therefore, adult literacy could be among the subject areas provided to the aged in old people's homes as it was one of the important educational aspects that they, themselves, identified and indicated they would like to learn or participate in.

There is, therefore, need for adult education programmes in areas such as health and hygiene, nutrition, arts and crafts, games, basket and mat making, bible study, new gardening and farming methods, carpentry, tailoring, knitting, among others, to be provided to the aged in old people's homes in Zambia. However, the aged should not be treated as passive recipients of the programmes. They should, instead be active participants as well as facilitators based on their interests and ability. Ala-Mutka and Punie (2007) point out that it is important to carefully develop both content and conditions of the learning opportunities for older people. They state that more attention needs to be paid to developing relevant and accessible learning opportunities and more user-friendly tools adapted to older people. They add that supporting learner-centred opportunities and personal learning skills is becoming part of life-long learning for everybody in the knowledge society, where older people make up one group of learners and mentors, interacting and integrating with others.

Kamwengo (2002) asserts that discussions on the educational needs of the elderly should lead to recognition of the importance of basing the educational programmes on the needs of the elderly themselves. He further states that educators need to come up with creative programmatic responses that can effectively and efficiently address the needs of the elderly regardless of their role, sex, creed or socio-economic status. Therefore, the aged in old people's homes in Zambia should be accorded chance to participate in creative and educational programmes which would be relevant and useful to them. The welfare of the aged in old people's homes should not only entail provision of adequate food, shelter, health care, entertainment, religious and spiritual support and counselling, but also provision of creative and educational programmes so that their welfare could be enhanced.

### **6.6.2 Implications for Caregivers**

The study established that most caregivers in old people's homes were handling the aged and yet did not have necessary knowledge, skills and competencies on how to handle them. The results of the study showed that education and training was one of the prominent issues and concern among caregivers. In fact, they, together with Provincial and District Social Welfare Officers mentioned lack of training opportunities as one of the challenges they faced. There was also a general feeling that taking care of the aged was quite a difficult undertaking and, therefore, there was need for caregivers to be trained in issues of ageing and elderly care. They pointed out that handling the aged in an institutional setting was a specialised field and hence, those who take care of the aged in such an environment should not do so, or continue to do so without some relevant training or orientation. Adult education providers such as UNZA, in conjunction with other stakeholders, such as staff of the Social Welfare department of the Ministry of Community Development, Mother and Child Health and NGOs should design training programmes that deal with issues of ageing, elderly care and counselling. Exposure to training would enable caregivers better understand and appreciate the unique needs of the aged and, ultimately, provide them with better care. These training programmes, once designed, could, for example, be run in provinces or even in districts, alongside existing programmes under the Department of Adult Education and Extension Studies of UNZA.

Caregivers in old people's homes in Zambia need a wide range of training processes and products. They need in-service training, Continuing Professional Development (CPD), which can be in form of short-term courses, seminars, conferences and workshops, in various aspects of elderly care. They can also benefit from on-the-job training and in-house training on how to manage the affairs of the aged in institutional homes. This study established that most of the caregivers indicated that they needed training in psychosocial counselling so that they could acquire skills to better assist the needy elderly cope with life in old people's homes as a matter of priority. Psychosocial counselling deals with emotional distress and behaviour difficulties which arise when individual struggle to deal with developmental stages and tasks. It deals with purely personal problems of psychological nature and interpersonal relationships (Van Niekerk and Prins, 2001). Other areas or aspects of training from which caregivers in old people's homes in Zambia could benefit from include adult development,

ethics and ageing, preventing falls, personal care and safety of older persons, among others.

This is consistent with Kamwengo (1997:xi) who asserts:

The government must encourage the University of Zambia to request departments of Social Development Studies, Adult Education and Extension Studies and Post-Basic Nursing to formally start a gerontology programme to train people who will be working with the aged.

The department of Adult Education and Extension Studies at UNZA offers a course in gerontology in its Bachelor of Adult Education degree programme. However, there is need to offer this course at even lower levels such as diploma and certificate in order to cater for caregivers who may not necessarily wish to acquire a degree in adult education. Wadensten (2006) points out that it is of great value for staff working with older people to be acquainted with different theories of ageing so that they can develop a nuanced understanding of older people and adjust treatment of the aged in old people's homes. Gerontology as a course provides such as opportunity.

Furthermore, newly recruited caregivers should be taken through effective orientation programmes before they commence their duties in old people's homes in order to give them some basic knowledge and insight into what goes on in the homes and the challenges they may face. Moriarty, Kam, Coomber, Rutter and Turner (2010) point out that training can improve the way staff working in care homes communicate with older people. They point out that refresher sessions and regular feedback are needed to maintain these improvements. They observe that training works best when it is part of a wider commitment to quality improvement.

### **6.6.3 Implications for Adult Educators**

Adult educators perform a variety of educative functions including teaching, counselling, advocacy, programme development and administration (Mbozi, 2006). However, to start with, one may want to know who an adult educator is. According to Mbozi, an adult educator is a person who, equipped with a theoretical and technical understanding of the adult learners' predicament, engages in a directive form of adult education. Adult education accompanies development whether conceived as adult literacy, extension work or training. The main goals of adult education are poverty alleviation and personal, community and economic development. This means that adult educators should act as catalysts, facilitators

and change agents in the process of planning, designing and implementing adult education programmes and activities in different settings, including institutional homes.

Mbozi (2006) points out that basic functions of adult educators are instruction, counselling, programme development and administration. She explains that programme development refers to the design, implementation and evaluation of educational activities. She further explains that the programme development process involves assessing learner needs, setting objectives, selecting learning activities and resources of learning, making and executing decisions necessary for learning activities to take place and evaluation of outcomes. This implies that adult educators at the UNZA, for example, should build capacity in those who would be training caregivers by taking up their role of trainer of trainers and offer programmes such as gerontology, counselling and related subject areas. Adult educators need to come up with targeted courses for caregivers on identified needs in order to enhance their capacity to deliver better care to the aged in old people's homes.

What became apparent in this study was that educational and training programmes were neglected components of service provision in old people's homes in Zambia. Adult educators should, therefore, ensure that this particular aspect is given due attention. It is the mandate of adult educators, in conjunction with other stakeholders, to respond to the identified educational needs of adults including the aged in old people's homes within the framework of life-long learning. Therefore, one of the things adult educators should be doing is to address the prevailing inactivity and boredom among the aged in old people's homes by planning appropriate educational programmes for caregivers, who in turn would also be in a better position to organise educational activities for the aged.

This study further established that there were no clearly stipulated basic or minimum qualification requirements for caregivers in charge of faith-based old people's homes other than their predominant training in ministry, faith and church membership. This provides an opportunity for adult educators to design in-service training programmes which would benefit some of these caregivers. The University of Zambia could design diploma certificate courses at provincial, even district level for caregivers. The content, format and structure of the training to be designed should respond to the needs of caregivers. The courses could even be offered through the distance education programme in order to cater for those who may not be in a position to train by full-time or part-time.



#### 6.6.4 Implications for the Zambian Government

As a key stakeholder in national development, which includes taking care of and promoting the welfare of the aged in the country, the government is expected to provide the necessary structural support for educational programmes in old people's homes to succeed. The government is also expected to create an enabling environment in which education for all people, including the aged, should flourish through appropriate policy formulation, provision of operational guidelines and allocation of adequate financial resources.

Government's official position on old people's homes in Zambia is that keeping the aged in old people's homes should be a matter of last resort and that the aged should be taken care of by their relatives in communities. However, the literature reviewed and finding of this study indicate that there will always be some elderly persons who will lack support and care due to one reason or another and for whom institutionalisation may be the only option. This means that old people's homes will remain a permanent feature in the welfare and provision of care for the aged in Zambia. In her study Bland (2005) posits that residential care homes in the United Kingdom has become some people's *de facto* homes and having accepted this, they have expressed the wish and hope to end their days there. She states that this has resulted in people taking a much broader view of the home, namely a place to live, rather than a place to stay briefly.

Policy implications of the findings of this study and the literature reviewed are that the quality of life of the aged in old people's homes in Zambia could be enhanced through improvement of service delivery and care. Therefore, interventions through a number of programmes, including educational and training programmes should be put in place for the benefit of the aged in old people's homes and their caregivers. Adult Education and Development (2010) states that policies and legislative measures for Adult education need to be comprehensive, inclusive and integrated within a life-long and life-wide learning perspective, based on sector-wide and inter-sectoral approaches, covering and linking all components of learning and education.

It would be helpful if the Zambian government came up with policy measures and regulations which will stipulate that people who handle adults in old people's homes should

be trained in the various aspects of elderly care. The policy should also prescribe the minimum qualifications and competencies that people in charge of all old people's homes should possess. The development of adult learning requires partnership between government departments, intergovernmental and non-governmental organisations, employers and trade unions, universities and research centres, the media, civil and community-level associations, facilitators of adult learning and adult learners themselves (Adult Education and Development, 2013). Therefore, the government should take the initiative to educate people on elderly knowledge and caring skills (Simone, 2008) by creating a favourable policy environment in which all stakeholders will find it relatively easy to participate and make a meaningful contribution towards the welfare of older persons including those residing in institutional homes in Zambia.

## **6.7 Summary**

This chapter has discussed the findings of the study on various aspects of caring for the aged in old people's homes and implications for adult education programmes. Among the aspects discussed are factors that contributed to institutionalisation of the aged in Zambia. It is clear from the findings that several factors contributed to this phenomenon, some of which are related. However, the major factors included lack of family members, abandonment related illness and old age, destitution, harassment mainly on account of suspicion that the aged were practicing witchcraft and disability. The chapter has also discussed the services provided to the aged in old people's homes, namely food, shelter, health care, entertainment, clothes and religious and spiritual support and counselling. From the perspective of the aged, the services provided in old people's homes were generally adequate. However, from the perspective of most caregivers, Provincial and District Social Welfare Officers and observations made by the researcher the services were generally inadequate. The chapter further discussed the main challenges faced by the aged in old people's homes which included inadequate shelter, boredom due to lack of creative activities, poor sanitation, lack of medical facilities for the aged in old people's homes and lack of food variety. The major challenges faced by caregivers, on the other hand, included inadequate and erratic funding, low staffing levels, lack of training opportunities for caregivers, absence of a national policy on ageing, lack of ICT facilities and high demand for admission of the aged to old people's homes. It has finally discussed the implications of institutionalisation of the aged for adult education programmes

at four levels, namely, the aged in old people's homes, caregivers, adult educators and the government.

The researcher believes that discussion of various aspects of caring for the aged in old people's homes could assist in addressing some of the challenges faced by these institutions and, ultimately, lead to the improvement and enhancement of the welfare of the aged and their caregivers. The next chapter presents the conclusion and recommendations of the study.

## **CHAPTER 7**

### **CONCLUSION AND RECOMMENDATIONS**

#### **7.0 Overview**

This chapter presents the conclusion and recommendations of the study in line with the findings and discussion on caring for the aged in old people's homes in Zambia and implications for adult education programmes. The objectives of the study were to: establish factors that led to the aged moving to old people's homes in Zambia, assess services provided to the aged in old people's homes in Zambia, identify challenges faced by the aged in old people's homes in Zambia, ascertain challenges faced by caregivers in old people's homes in Zambia and establish the extent to which adult education programmes were provided in old people's homes in Zambia.

#### **7.1 Conclusion**

The study concluded that the phenomenon of old people's homes in Zambia is likely to continue owing to the enduring nature of factors that led to the aged moving to old people's homes in Zambia, namely, lack of family members, abandonment related to illness and old age, destitution, harassment of the aged mainly on suspicion that they were practicing witchcraft, and disability as well as projections on population ageing from previous studies (e.g. World Population Ageing, 2007; Mapoma, 2013). Old people's homes in Zambia have been in existence since the post Second World War era and their total number at the time of the study was 9. The implication is that since the phenomenon of old people's homes, as one of the social welfare and social protection mechanisms for the aged in Zambia is a reality, the need to ensure adequate provision of services, including education to the institutionalised aged becomes critical.

The study also concluded that although old people's homes were offering important services to the needy elderly and demonstrated some capacity to deliver them, the care provided was generally inadequate because certain services and provisions which were central to their wellbeing such as health facilities for the aged, counselling, creative activities and educational programmes, were missing or lacking in most old people's homes in Zambia. Although most of the aged in old people's homes indicated that they were generally satisfied with the services provided to them, caregivers, Provincial and District Social Welfares as

well as observations made by the researcher indicated that the care was generally inadequate and much more could be done to improve the conditions.

The study further concluded that although old people's homes in Zambia were providing the much needed services to the aged who would otherwise not access them in their communities, they also faced a number of challenges. The study identified challenges at two main levels, namely challenges faced by the aged and those by caregivers. The major challenges faced by the aged included inadequate shelter, boredom due to lack of creative activities, lack of medical facilities for the aged, poor sanitation, lack of electricity in some homes, lack of food variety, and lack of pocket money. The major challenges faced by caregivers included inadequate and erratic funding, low staffing levels, lack of training opportunities for caregivers, absence of a national policy on ageing, lack of transport, lack of ICT facilities and high demand for admission of the aged to old people's homes.

Additionally, the study concluded that there were very few adult education programmes provided in old people's homes in Zambia and the educational and training needs of the aged and caregivers respectively were not given priority. Only 4 out of the 9 old people's homes in Zambia were providing any form of adult education programmes in areas such as agriculture, hygiene, nutrition education, knitting, HIV/AIDS awareness and religious education. This education came in an indirect way through activities such as talks, presentations and demonstrations by experts from relevant Ministries, NGOs, volunteer organisations and churches. The study also concluded that most of the aged in old people's homes were ready and interested in participating in educational programmes if they were provided with the opportunity to do so. Similarly, the need for training of caregivers working with the aged was apparent.

Maintaining or improving the quality of life of the aged in old people's homes in Zambia would require comprehensive programmes or interventions that should take into account the health, socio-economic, psychosocial, spiritual, emotional, cultural and above all, educational needs of the aged. There was general agreement in the responses given by the aged and other stakeholders on what needed to be done to improve the welfare of the aged and their caregivers in old people's homes. This study ultimately concluded that old people's homes were playing a major role in providing basic necessities of life and caring for the aged amidst a number of challenges. Literature and findings of this study has indicated that the

phenomenon of old people's homes exists in the world, including Zambia and this reality has to be accepted. Given this reality, therefore, it is important to work towards providing adequate and appropriate care to the aged residing in old people's homes in Zambia.

The outcomes of this study could be used to inform policy makers, adult educators, health professionals, planners and other stakeholders about the needs, challenges and aspirations of the aged residing in old people's homes and their caregivers. The information may also be used by trainers and programme designers to develop guidelines for caregivers on the theory and practice of elderly care in institutional homes in Zambia and beyond. The vulnerable and needy elderly in old people's homes should not be looked at as people in quarantine and forgotten about by wider society. They should, instead be provided with relevant programmes which will encourage them to remain active and productive for as long as possible by participating in creative and educational activities, among others, in line with activity and continuity theories.

This was the first study to undertake a large-scale survey on institutionalisation of the aged in Zambia *vis-à-vis* their welfare, services and programmes, with emphasis on educational provision. It has also highlighted the challenges faced by the aged and their caregivers in old people's homes. The study has implications for other African countries which may have institutional homes as one of the living arrangements or options for the aged. They could gain some insight into the practice of institutional elderly care from the global and Zambian perspectives. The study has also contributed to the existing body of knowledge on institutional care for the aged and the role that adult education programmes could play in enhancing their wellbeing.

## **7.2 Recommendations**

Arising from the findings of the study, the following recommendations are made:

1. The government and other sponsoring agencies should increase funding to old people's homes to enable them provide adequate care in terms of food variety, shelter, medical services, entertainment and counselling as well as meet some operational challenges.
2. In order to improve access to medical care by the aged, the government should provide medical facilities and attach personnel to all old people's homes. This would make it easy for the immediate and long-term health needs of the aged to be met.

3. In order to reduce boredom and idling among the aged in old people's homes, caregivers, Provincial and District Social Welfare Officers and other stakeholders should ensure that there is provision of a variety and appropriate leisure and pass-time activities, in line with activity theory. This will keep the aged busy and uplift their morale and health.
4. There is need for the government and other agencies running old people's homes to employ more staff in order to improve service delivery and enhance the welfare of the aged in old people's homes as well as avoid overstretching the few available caregivers.
5. The Ministry of Community Development, Mother and Child Health, in partnership with the Ministry of Education, Science Vocational Training and Early Education, UNZA, NGOs, civil society, churches and other volunteer organisations, should ensure that adult education programmes are among the services provided to the aged in old people's homes in order to keep them intellectually stimulated and active.
6. The government and partner agencies such as UNZA should ensure that caregivers are trained in various forms of adult education which deal with issues of ageing, elderly care, elderly safety, psychosocial counselling and gerontology to enable them better care of the aged in old people. Additionally, Continuing Professional Development activities such as workshops, seminars, on-the-job training and short courses should be organised for caregivers to ensure that they are up-to-date with new practices in caring for the aged.
7. There is need for Parliament to expedite the enactment of the national policy on ageing in order to provide guidelines, regulate and improve service provision and operations of old people's homes and give the policy a legal framework.
8. In order to ease the movement of the aged and caregivers as well as procurement of goods and services, the government and other sponsoring agencies should provide transport to all old people's homes.
9. The government should embark on sensitisation and awareness campaigns, using various various fora and media on various aspects of ageing in order for the public to develop a more positive attitude towards the aged and treat them with respect and dignity. This may also discourage people from abusing and harassing the aged and from calling them witches or wizards. The campaigns could be heightened during the commemoration of the Elder Abuse Awareness Day and the International Day of Older Persons, which fall on 15 June and 1 October every year respectively, in order to provide public education about ageing.

### **7.3 Suggestions for Future Research**

The following themes are suggested for future research:

- i. The attitude of the aged residing in communities towards institutionalisation in Zambia.
- ii. An investigation into the extent of elderly abuse in old people's homes in Zambia.



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## Appendix 1: Questionnaire for the Aged in Old People's Homes in Zambia

Name of old people's home.....

Name of district.....

Name of province .....

- [illegible]

6. Why did you come to this home? .....

7. Who brought you to this home? .....

8. (a) How would you describe the food that is provided to you at this home?

1. Good [ ] 2. Fair [ ] 3. Poor [ ]

(b) Give reasons for your answer above.....

9. (a) How would you describe the shelter that is provided to you at this home?

1. Good [ ]      3. Fair [ ]      3. Poor [ ]

(b) Give reasons for your answer above.....

10. (a) How would you describe the health services provided to you at this home?

1. Good [ ]    2. Fair [ ]    3. Poor [ ]



(b) Give reasons for your answer above.....

11. (a) What kind of entertainment is provided to you at this homes?.....

(b). How would you describe the entertainment provided?

1. Good [ ]      2. Fair [ ]      3. Poor [ ]

(b) Give reasons for your answer above.....

12. (a) Are you provided with clothes to wear?    1. Yes [ ]    2. No [ ]

(b) If Yes, who provides the clothes?.....

13. (a) Do you freely practice your religious faith at this home? 1. Yes [ ]    2. No [ ]

(b) If Yes, how do you practice your religious faith?.....

(c) If No, please explain.....

14. What other services are you provided with at this home?.....

#### **Section D: Challenges faced by the aged in old people's homes**

15. What challenges do you face at this home?.....

16. What do you think should be done to improve your welfare at this home?.....

#### **Section E: Adult Education programmes provided in old people's homes**

17. (a) Are you provided with educational programmes at this home?

1. Yes [ ]    2. No [ ]

(b) If Yes, what kind of programmes are they?.....

18. (a) Would you like to participate in educational programmes given the chance?

1. Yes [ ]    2. No [ ]

(b) If your answer is Yes, give reasons and specify the activities you would like to participate in .....

(c) If you answer is No, give reasons.....

19. What activities do you normally participate in on a daily basis at this home?.....

20. Do you have anything else to say or suggestions you wish to make on the subject?

.....

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**Thank you for your cooperation**

## Appendix 2: Interview Schedule for Caregivers

- Name of old people's home.....
- Name of district.....
- Name of province .....
- Date of interview.....
1. Sex of respondent.....
  2. Current position held.....
  3. What is your highest professional qualification? (Please specify the field in which you obtained the above qualification) .....
  4. (a) Have you undergone any training/capacity building relating to your present job?  
1. Yes [ ] 2. No [ ]  
(b) If Yes, describe the nature of the training.....
  5. What qualifications should an officer in charge of this home possess? .....
  6. (a) How many members of staff work for this home?.....  
(b) What are their responsibilities?.....
  7. (a) Are the staffing levels adequate? 1. Yes [ ] 2. No [ ]  
(b) If No, explain.....
  8. Have you and your other staff undergone training relating to their work? 1. Yes [ ]  
2. No [ ]  
If Yes, specify the type of training.....  
.....
  9. When was this home set up? .....
  10. What was the purpose for establishing the home? .....
  11. Does this home belong to government or is it privately owned? (If privately owned please specify).....
  12. (a) How many elderly people are kept at this home? .....
  - (b) How many are male?.....
  - (c) How many are female? .....
  13. Why do the elderly come to this home?.....

14. How do the elderly come to this home? .....
15. What criteria are used to admit the elderly to this home? .....
16. How would you describe the services provided to the aged at this home in terms of?
  - (a) Food.....
  - (b) Shelter.....
  - (c) Health care.....
  - (d) Entertainment.....
  - (e) Clothes.....
  - (f) Spiritual and Religious Support.....
  - (g) Counselling/Psychological support.....
17. What other services are provided to the aged at this home?.....
18. What kind of activities do the residents of the home engage in on a daily basis (typical day)?.....
19. (a) Who provides funds for the running of this home? .....
- (b) Are the funds adequate? 1. Yes [ ] 2. No [ ]
- (c) Explain your answer above.....
20. What challenges do you face at this home?.....
21. Do you provide any educational programmes to the elderly at this home? 1. Yes [ ] 2. No [ ]
- (b) If Yes, describe the kind of programmes.....
- (c) If No, give reasons.....
22. What kind of educational programmes do you think should be provided to the aged at the home (specify the areas/fields)?.....
23. (a) Does this home have library facilities? 1. Yes [ ] 2. No [ ]
- (b) If No, what could be the reason(s).....
24. Is there any other information or suggestions that you may wish to provide or share on the subject which we have not covered in the interview?.....

**Thank you for your cooperation**

### Appendix 3: Interview Schedule for District Social Welfare Officers

- Name of district.....
- Name of province.....
- Place of interview.....
- Date of interview.....
1. Sex.....
  2. Current position held.....
  3. What is your highest educational attainment?.....
  4. What is/are your professional qualification(s)? (Please specify the field(s) in which you obtained the qualification(s).....
  5. (a) Have you undergone any other training in terms of capacity building besides your initial training? 1. Yes [ ] 2. No [ ]  
(b) If Yes, describe the type(s) of training.....
  6. How many old people's homes are there in your district?.....
  7. Are they/Is it government owned or privately owned (please specify)?.....
  8. What was the purpose of establishing the home(s)?.....
  9. Are there regulations or guidelines pertaining to the establishment of old people's homes in Zambia? Yes [ ] No [ ]  
Please give reasons for your answer above.....
  10. What qualifications should an officer in charge of an old people's home possess?.....
  11. What factors lead to the aged moving to old people's home(s)?.....
  12. What criteria are used to admit the aged to old people's home(s)?.....
  13. a. How is/are the home(s) funded? .....
  - b. Is the funding adequate? Yes [ ] No [ ]  
If No, please explain.....
  14. What kind of services are provided to the elderly in people's home(s)?.....
  15. How would you describe the services you have just outlined?.....
  16. What challenges do/does the home(s) for the aged in your district face?.....

17. What kind of programmes are offered to the aged in the home(s) for the aged?.....
18. Are there any educational programmes provided in old people's home(s)?  
Yes [ ] No [ ]  
If yes, describe the kind of programmes.....  
If No, give reasons.....
19. Would you support the introduction of educational programmes for the aged in the home(s) if there is none Yes [ ] No [ ]  
If Yes, which areas or kind of educational programmes do you think should be provided?  
If No, please explain.....
20. Are caregivers in the home(s) provided with training opportunities?  
Yes [ ] No [ ]  
If Yes, what kind of training is provided?.....  
If No, please explain why.....
21. Is there any other information that you may wish to provide or share on the subject which we may not have covered in the interview?.....

**Thank you for your cooperation**

#### Appendix 4: Interview Schedule for Provincial Social Welfare Officers

Name of province.....

Place of interview.....

Date of interview.....

1. Sex                    1. Male    ☐    2. Female        ☐
2. Age .....years.
3. Current position held.....
4. What is your highest level of educational attainment?.....
5. What is/your highest professional qualification(s)? (Please specify the field(s) in which you obtained the above qualification).....
6. How many old people's homes are there in your province.....
7. Are they/Is it government owned or privately owned (please specify)?.....
8. What was the purpose of establishing the home(s)?.....
9. What factors lead to the aged moving to old people's homes?.....
10. Are there regulations or guidelines pertaining to the establishment of old people's homes in Zambia?    Yes    ☐    No    ☐  
Please explain.....
11. What qualifications should officers in charge of old people's homes possess?.....
12. Are staff working in the home(s) provided with training opportunities?.....  
If Yes, what kind of training is provided?.....  
If No, please explain why.....
13. What criteria are used to admit the aged to old people's home(s)?.....
14. How is/are the home(s) for the aged funded? .....  
Is the funding adequate?    Yes    ☐    No    ☐  
If No, please explain.....
15. What kind of services are provided to the elderly in people's home(s)?.....
16. How would you describe the services you have just outlined?.....
17. What is government's position on old people's homes in Zambia?.....

18. What challenges does/do old people's homes in your province face?.....
19. Are there any educational programmes provided for the elderly in old people's home(s)?      Yes    ☐    No    ☐
- If yes, describe the kind of programmes.....
- If No, give reasons.....
20. Would you support the introduction of educational programmes for the elderly in the home(s) where they don't exist      Yes    ☐    No    ☐
- If Yes, in what kind of educational activities do you think should be provided?.....
- If No, please explain.....
21. Is there any other information you may wish to provide or share on the subject which we may not have covered in the interview?.....

**Thank you for your cooperation**



**Appendix 5: Interview Schedule for Assistant Director, Human Resource and Development, MCDMCH Headquarters**

1. Sex of respondent.....
2. Current Position held .....
3. (a) Is there a training policy in your Ministry?.....  
(b) If Yes, what does it say on the training of staff?.....  
(c) If No, what could be the reason(s)? .....
4. What criteria are used by the Ministry to select staff for training? .....
5. What are the training prospects for staff working in old people's homes in Zambia?.....
6. Is there any deliberate effort to train staff working in old people's homes in Zambia?  
Please give reasons for your answer above.....
7. What training challenges do caregivers in old people's homes in Zambia face?.....
8. What challenges does your Ministry face in its effort to train human resources?.....
9. Please provide any other information or comments on what we may not have covered in the interview.....

**Thank you for your cooperation**

## **Appendix 6: Interview Schedule for Chief Planner, MCDMCH Headquarters**

1. Sex of respondent.....
2. Current Position held .....
3. What was the purpose of establishing old people's homes in Zambia?.....
4. Are there regulations or guidelines pertaining to the establishment of old people's homes or can anyone establish these homes?.....
5. How do the aged find themselves in old people's homes?.....
6. What criteria are used to admit the aged to old people's homes?.....
7. a. How are old people's homes funded? .....
- b. Is the funding adequate? Yes [ ] No [ ]
- If No, please explain.....
8. What is the Government/Ministry's position on old people's homes in Zambia?.....
9. What challenges do old people's homes in Zambia face?.....
10. Please provide any other information or comments on what we may not have covered in the interview.....

**Thank you for your cooperation**

**Appendix 7: Interview Schedule for Director, Department of Social Welfare,  
MCDMCH Headquarters**

1. Sex of respondent.....
2. Current Position held .....
3. What was the purpose of establishing old people's homes in Zambia?.....
4. (a) Is there a policy on ageing in place in Zambia?.....  
(b) If No, what could be the reason(s) .....
5. Are there regulations or guidelines pertaining to the establishment of old people's homes or can anyone establish these homes?.....
6. How do the aged find themselves in the homes for the aged? .....
7. What criteria are used to admit the aged to old people's homes?.....
8. How are old people's homes for the aged funded?  
(a) Government owned.....  
(b) Private/Faith-based.....
9. What is the Government/Ministry's position on old people's homes in Zambia?.....
10. What challenges do old people's homes in Zambia face?.....
11. Please provide any other information or comments on what we may not have covered in the interview.....

**Thank you for your cooperation**

## **Appendix 8: Interview Schedule for the Chairperson, Parliamentary Committee on Health, Community Development and Social Welfare**

1. Sex .....
2. Current position held .....
3. Organisation .....
4. You undertook a trip to Mauritius, I presume, on the welfare of the aged persons and related aspects, what was the exact purpose of your visit?.....
5. What services are provided to the elderly in terms of social security/social protection, especially those in institutional homes in Mauritius?.....
6. Did you have chance to visit any old people's home in Mauritius?  
1. Yes [ ] 2. [ ]  
If Yes, what was your impression of the institution(s)? .....
7. Who owns old people's homes in Mauritius?.....
8. Is there a policy on ageing in place in Mauritius? .....
9. What is the Mauritian government's position on institutional care for the elderly?.....
10. What lessons did you and your team learn from your visit to Mauritius on institutional care and general welfare of the elderly? .....
11. What is the status of the national policy on ageing in Zambia?.....
12. Is there any other information or observation that you may wish to provide/make on the subject which we may not have not covered in the interview?.....

**Thank you for your cooperation**

**Appendix 9: Interview Schedule for Officers at the Senior Citizens Association of Zambia (SCAZ)**

1. Current position held .....
2. When was the Senior Citizens Association formed?.....
3. What was the purpose of forming SCAZ?.....
4. What kind of support does your Association render to the aged in Zambia in general and those residing in old people's homes in particular?.....
5. What problems/challenges do the elderly generally face in Zambia?.....
6. Why do you think some elderly find themselves in old people's homes in Zambia?.....
7. What is the Association's position on old people's homes in Zambia?.....
8. What programmes are provided to the aged in old people's homes?.....
9. Would you support the provision of educational programmes in old people's homes in Zambia and if so, which programmes or areas would you advocate? (please give reasons for your position).....
10. Please comment or make suggestion on any other aspects of the above subject that we may not have covered in our interview.....

**Thank you for your cooperation**

## Appendix 10: Clearance by the Ethics Committee



**The University of Zambia**  
**DIRECTORATE OF RESEARCH AND GRADUATE STUDIES**

HSS/ED/LAW/INESOR RESEARCH ETHICS COMMITTEE

Telephone: 290258/291777  
Fax: +260-1-290258/253952  
E-mail: drgs@unza.zm  
IRB: 00006464  
IORG: 0005376

P O Box 32379  
Lusaka, Zambia  
Your Ref:  
Our Ref:

20<sup>th</sup> June 2012

Mr. Moses Changala  
University of Zambia  
School of Education  
Department of Adult Education and Extension Studies  
P O Box 32379  
LUSAKA

Dear Mr. Changala

**Re: EXEMPTION FROM FULL ETHICAL CLEARANCE**

With reference to your research proposal entitled:


**Caring for the Aged in Old People's Homes in Zambia: Implications for Adult Education Programmes**

As your research project does not contain any ethical concerns, you are hereby given an exemption from full clearance to proceed with your research.

Please note that you must also obtain express written authority from the Permanent Secretary, Ministry of Health, before conducting your research. The address is: Permanent Secretary, Ministry of Health, Ndeke House, P O Box 30205, Lusaka. Tel: +260-1-253040/5; Fax+260-1-1253344.

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Finally, please also note that you are expected to submit to the Directorate of Research and Graduate Studies Secretariat (a) a Progress Report Form (which can be obtained from the Secretariat) every six months and (b) a copy of the full report on completion of the project.

  
Dr. Augustus Kapungwe  
Acting Chairperson  
Humanities and Social Sciences Research Ethics Committee

Cc    The Director, Directorate of Research and Graduate Studies  
      Assistant Director, Directorate of Research and Graduate Studies  
      Assistant Registrar (Research), Directorate of Research and Graduate Studies

## Appendix 11: Permission Letter from the MCDMCH

Telephone: (260) 211 235343  
Fax: (260) 211 235343



REPUBLIC OF ZAMBIA

### MINISTRY OF COMMUNITY DEVELOPMENT, MOTHER AND CHILD HEALTH

DEPARTMENT OF SOCIAL WELFARE  
COMMUNITY HOUSE  
P.O. BOX 31958  
LUSAKA

*In reply please quote:*

*No:.....*

DSWHQ/9/7/1

04<sup>th</sup> July, 2012.

Mr. Moses Changala  
School of Education  
Department of Adult Education and Extension Studies  
P. O. Box 32379  
**LUSAKA.**

Dear Sir,

**RE: PERMISSION TO CARRY OUT RESEARCH IN OLD PEOPLE'S HOMES FOR PHD STUDIES**

Reference is made to your letter dated 27<sup>th</sup> June, 2012 in which you requested for permission to conduct a research study for the Aged in the Old People's Homes in Zambia in view of assessing the implications for Adult Education Programmes.

I am pleased to inform you that the Ministry has no objection to your request to undertake your research study in the following institutions provided authority is sought from the organisations/churches running these institutions:

1. Maramba old People's Home in Livingstone
2. Chibolya in Mufulira
3. Divine Providence in Lusaka
4. Mwandi and Likulwe in Senanga
5. Mitanda in Ndola
6. Chibote in Luanshya
7. And St. Theresa in Ndola.



I wish you all the success in your research study and pursuit for your PhD programme.

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke extending to the right.

S. Michelo

**A/DIRECTOR – SOCIAL WELFARE DEPARTMENT**

**For/PERMANET SECRETARY**

**MINISTRY OF COMMUNITY DEVELOPMENT, MOTHER AND CHILD HEALTH**