

ELDER ABUSE IN THE HEALTH CARE SERVICES IN KENYA

**A study carried out by HelpAge International – Africa Regional Development
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Prevention of Elder Abuse (INPEA)**

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LIST OF ABBREVIATIONS

FGDs	Focus Group Discussions
HAI-ARDC	HelpAge International - Africa Regional Development Centre
HAK	HelpAge Kenya
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immunity Deficiency Syndrome
INPEA	International Network for the Prevention of Elder Abuse
NGO	Non-governmental Organisation
STIs	Sexually Transmitted Infections
WHO	World Health Organization

ABSTRACT

This study has analysed views on elder abuse in the health sector in Kenya. Data has been collected using focus group discussions and some in-depth interviews. Information gathered from focus group discussions reveal that elder abuse does exist not only in the health sector but also in the wider community in Kenya. Type, causes and consequences of elder abuse that were vividly described in focus group discussions clearly reveal that older persons are denied a range of rights. The abuse is therefore the antithesis of the spirit of the United Nations Principles for Older Persons: independence, participation, care, self-fulfillment and dignity. There are a number of interventions in society but overall, they were deemed inadequate (by discussants) given the magnitude of the problem. It is strongly recommended that further research be undertaken so as to enable better understanding of the problem and planning for its intervention. The survey would include an analysis of the magnitude and various dimensions of elder abuse, an assessment of the effectiveness of existing interventions and the status of implementation of global and national policy/action instruments in Kenya.

Recommendations on intervention include:

- a. Establishment of specialist facilities for the elderly (geriatric units/institutions) and other patients.
- b. Special and/or additional training for health workers in the area of geriatrics.
- c. Possibility of the government of Kenya providing free or highly subsidized health care scheme for the needy elderly.
- d. Support for the care of the elderly in institutions and at home.
- e. Collaboration, integration and partnerships beyond the health sector.
- f. Development of long- and short-term packages of intervention.

1 INTRODUCTION

1.1 The Challenge of Elder Abuse in the Health Sector

Elder abuse refers to the mistreatment of older people by those in a position of trust, power or responsibility for their care (Swanson 1999). This is a global problem that is likely to intensify in view of the increasing number of older people and the changing socio-economic and environmental conditions worldwide (Randel et al. 1999).

Through out the experience of HAI, access to health care has always been of major concern to elderly. HelpAge International (n.d.: 8) has strongly emphasized: “Access to health services is not a benevolent act but is a basic human right for any human being regardless of age”. Earlier evidence adduced that the attitude and behaviour of some health workers towards older people was negative. Elderly respondents taking part in focus group discussions reported that public health providers utter discouraging remarks, for example: “Wewe si mgonjwa, shida yako ni uzee”, translated into English as: “You are not sick, your problem is old age” (Ochola et al. 2000: 55).

Viable intervention strategies, we opine, must have basis on multi-sectoral approaches with primary focus on attitudes and the community.

Table 1: Categories of Elder Abuse¹

Type	Description	Examples
Physical	Inflicting physical discomfort, pain or injury.	Slapping, hitting, punching, beating, burning, sexual assault and rough handling.
Psychological	Undermining the identity, dignity and self-worth of older persons.	Name calling, yelling, insulting, threatening, imitating, swearing, ignoring, isolating, excluding from meaningful events and deprivation of rights.
Financial	Misuse of money or property.	Stealing money or possessions, forging a signature on pension cheques or legal documents, misusing the power of attorney, and forcing or tricking an older adult into selling or giving away his or her property.
Neglect	Failure of a caregiver to meet the needs of an older adult who is unable to meet those needs alone.	Denial of food, water, medication, medical treatment, therapy, nursing services, health aids, clothing and visitors.

Source: Swanson (1991)

¹ The categorization of elder abuse presented in Table 1 is not mutually exclusive. The reality is that an abused older adult may experience more than one type of abuse at any given time (Swanson 1999). The categories presented in Table 1 are based on research carried out in the highly industrialised countries. They need to be treated with caution, especially when applying them to developing countries as context in the highly industrialised countries is not the same as that prevailing in developing countries.

1.2 Research Purpose

The purpose of this study is to analyse views of older people and health workers on indicators, context, causes and interventions in elder abuse in primary health care in Kenya. This study is aimed at helping one understand the dynamics of abuse of older persons' rights within the primary health care system in Kenya. The report is thus largely a collection of 'voices' on elder abuse. The issues raised by these voices require further investigation to enrich the empirical evidence on elder abuse.

1.3 Research Methodology

The following procedures have been followed in carrying out this study: preparatory work, data collection and data analysis.

1.3.1 Preparatory Work

Preparatory work was carried out between 2nd and 17th August 2001 and included:

- Formation of a research team, consisting of HelpAge International – Africa Regional Development Centre (HAI-ARDC) personnel, HelpAge Kenya (HAK) personnel, a consultant and two co-consultants.
- Review of project documents and literature.
- Training of the research team.
- Securing research clearance: permit from the Government of Kenya.
- Developing a guide for focus group discussions.

1.3.2 Data Collection

The initial step in data collection was selection of sites (hospitals) for focus group discussions. Selection of the sites was governed by the need to gather information from different socio-economic settings. The following four hospitals were purposely selected: Nanyuki District Hospital, Nakuru Provincial Hospital, Kenyatta National Hospital and Misyani Health Centre. Kenyatta National Hospital, Nairobi, is the national referral and teaching hospital. Nanyuki hospital, a district hospital, is located in an arid and semi-arid region of central Kenya. It serves mainly migrant pastoralist and agricultural communities. Nakuru Provincial Hospital serves communities in districts within the Rift Valley Province who are involved mainly in agriculture. Misyani Health Centre, is located in an arid District. It serves a population engaged mainly in subsistence agriculture. Given the inadequacy and unreliability of the rainfall, famine is often experienced in the region. The hospital is managed by missionaries.

A prior visit was made by HelpAge International and HelpAge Kenya officers to each of the four selected hospitals between 13th and 17th August 2001 and preparatory discussions held with the hospital administrators.

Themes covered during the focus group discussions were:

- The main problems faced by older women and men.
- Older people's roles within communities.
- Perceptions of what elder abuse is and its different forms.
- Perceptions of the contexts in which abuse occurs, and its perceived causes.
- Situations where different acts of abuse are acceptable or unacceptable.
- Situations where it is appropriate for institutions such as family, community, law and other formal and informal institutions to intervene.
- The consequences of elder abuse for older people, their families and the community.
- Perception on the incidence of elder abuse in the area and why.
- Whether there are "seasonal" influences or patterns on abuse
- Perceptions of elder abuse as a health issue and as an issue of concern for health care workers.
- Identification of existing/needed health and social services and community support in relation to violence and abuse.

Table 2: Characteristics of Focus Group Discussions

Date	Venue	Composition of focus group discussion	Number of participants	Duration in minutes
22 nd August 2001	Nanyuki Hospital ²	Health workers	6 (5 women, 1 man)	90
24 th August 2001	Kenyatta National Hospital	Health workers	5 (3 women, 2 men)	60
24 th August 2001	Kenyatta National Hospital	Mixed: men and women	7 (2 women, 5 men)	90
27 th August 2001	Nakuru Provincial Hospital	Mixed: men and women	5 (2 women, 3 men)	35
27 th August 2001	Nakuru Provincial Hospital	Women	6 (all women)	35
27 th August 2001	Nakuru Provincial Hospital	Health workers	9 (6 women, 3 men)	90
27 th August 2001	Nakuru Provincial Hospital	Women (patients)	5 (all women)	60
29 th August 2001	Misyani health centre	Men	6 (all men)	90
29 th August 2001	Misyani health centre	Women	6 (all women)	90
		Health workers FGDs = 3 Women FGDs = 3 Men FGDs = 1 Mixed men and women FGDs = 2 Total FGDs = 9	Women = 35 Men = 20 Total participants = 55	

Source: Fieldwork (August 2001)

² A planned focus group discussion of male and female patients could not be held because most of the participants were immobile. Instead, the participants were interviewed individually to gather their views on elder abuse.

1.3.3. Data Processing and Analysis

Data processing and analysis included:

- a. A detailed write-up of each focus group discussion based on notes taken and listening to tape recordings of the focus group discussions.
- b. A detailed write-up of each interview conducted.
- c. Deriving, categorizing and highlighting, from the detailed notes, themes that emerged from focus group discussions. The analysis took mainly the form of content analysis.

1.4. Limitations

The scope of the study was limited by financial constraints. Funds permitting, a wider and greater-depth study would have been undertaken.

Also, during the research, most health institutions did not permit the tape-recording of interviews and focus group discussions proceedings. This limited our ability to analyse audile, the statements from participants.

2. FINDINGS AND DISCUSSIONS

2.1 Objective

The objective of the study was to gather empirical evidence of elder abuse within the healthcare system so as to use the information in formulating appropriate strategies for intervention. It is part of a broader strategy to intervene in the major rights issues of concern to older persons.

The study was intended to answer questions such as:

- a. Does abuse occur in the hospitals
- b. Is abuse or some form of it unique to older persons
- c. How does this abuse affect the older persons
- d. What causes this abuse (policy, structure, economics, social-such as attitude)
- e. Who perpetrates the abuse
- f. Can anything be done to intervene and if so, what is it that can be done?

2.2 Findings

The following are a summary of the findings of the research.

2.2.1 Role and importance of the Elderly in the Community

Despite the changing socio-economic structures of the African societies, the socio-economic roles of the elderly remain very important within the family and the community. It is worth noting however that their roles are often unrewarded and grossly undervalued today.

A female discussant in Misyani noted that “In the olden days, the old people used to stay with their younger children and were, therefore, well taken care of. But nowadays, the young have to migrate away from home in order to search for survival and they leave the old at home.”

In all the nine focus group discussions carried out, participants emphasized the importance of older people’s contribution to communities and singled out the following roles:

a. Caring for the Vulnerable

Older persons often care for the children while the younger adults are out of the homestead in economic pursuits. Health workers also reported that older persons often accompany children to hospital and with children who have been admitted. This role is evident in the following remarks:

Older women usually take care of grandchildren especially the orphaned (Misyani women, 29-8-2001; Nakuru women, 27-8-2001; Kenyatta National Hospital mixed, 24-8-2001).

Women play a great role in nursing the sick by preparing meals for them, cleaning their linen, washing their bodies and turning those who are immobile, conducting deliveries (Nakuru women, 27-8-2001; Misyani women, 29-8-2001; Kenyatta National Hospital mixed, 24-8-2001; Female O.I. Nanyuki District Hospital, 21-8-2001).

The role of older persons in caring for the vulnerable has become ever so important in the face of the ravages of HIV/AIDS. Participants in ALL focus groups discussions lamented that older persons face the multi-faceted tragedy of losing economic support of their children who are infected, economically having to support their children who are infected (and their children's families), nursing their children when infection turns to full-blown AIDS, losing their children and having to care and support their orphaned grandchildren.

In the course of the survey, we encountered an eighty-five year old woman at Misyani Health Clinic who was taking care of four grandchildren orphaned by HIV/AIDS has to share her food ration (which is barely adequate for one adult) with four of her grandchildren. She summarized her situation thus:

My daughter died and left behind four orphans. She was unmarried and her brothers have refused to take responsibility over the orphans. As their grandmother, I could not stand aside and watch them suffer. I decided to take care of them. Unfortunately, I do not have enough strength to till land and generate food and money for our up-keep. I rely on assistance from the Misyani HelpAge, which provides some food and medical assistance to me. I am forced to share the little food I get with my grandchildren since I cannot eat alone as they watch (Misyani women, 29-8-2001).

b. Advising and Resolving Conflict Within Family and Community

Older persons (within the family and the community) are often called upon to advise and to resolve conflict. Their roles as conflict resolvers is vitally important in the face of a rapidly changing society. With the advent of multi-party politics, tribal conflicts have taken a political dimension apart from the traditional dimensions of cattle rustling, land conflicts and conquests. The following statements evidence this vital role:

The elderly provide advice to family members on what to do at different stages of life including what to do when they are away from the homestead (Misyani men, 29-8-2001; Nakuru mixed, 27-8-2001; Male O.I. Nanyuki District Hospital, 22-8-2001).

They resolve conflicts in the society between husbands and wives, fathers and sons as well as ethnic conflict within and between communities such as the cattle rustling conflict between the Samburu and the Borana (Misyani men, 29-8-2001; Nakuru mixed, 27-8-2001; Male O.I. Nanyuki District Hospital, 22-8-2001).

c. Caretakers

Older persons often watch over homesteads while the rest of the family members are away.

d. Entrepreneurs

Older persons often contribute to economic development through their involvement in farming, business, handicraft, trade and formal employment (e.g. teaching). The performance of domestic chores by women such as cooking, washing, gardening and looking after livestock often goes on until very late into old age. A focus group discussion noted:

Whether old or not, women do most of the domestic chores like cooking washing, gardening, grazing, and watering domestic animals kept by their husbands (Misyani women, 29-8-2001).

e. HealthCare Providers

With the paying system introduced in government hospitals in the country, many citizens cannot afford formal healthcare. The first form of healthcare that the majority of the sick seek in the villages is from traditional healers. These roles of traditional healers, midwives and serving as African traditional religion's specialists are usually carried out by older persons:

I have never been to hospital in 14 years. It is too expensive. I get most of my medicines from the healer. His prices are lower and payment terms are negotiable. (male, Misyani hospital).

Most people first try the healer. When they do not get better is when they go to hospital. It is very risky to mix traditional medicines with modern medicines. (male, Misyani hospital).

The elderly serve as traditional healers and also preside over traditional rituals (Male O.I. Nanyuki District Hospital, 22-8-2001).

It is evident from the focus group discussions that female discussants pointed out roles in the domestic sphere while male discussants identified roles in the public sphere. However, certain roles are played by both male and female older persons. Such roles include watching over homesteads while the rest of the family members are away, contributing to economic development through involvement in farming, business, handicraft, trade, provision of healthcare services and serving as religious specialists.

2.2.2 Issues of Elder Abuse Identified In The Research

The survey delineated several issues. While it is impossible to categorize all of them, the most concerning (for older persons) were identified as:

a. Abandonment

The survey concluded that abandonment was the most impacting issue in elder abuse in both healthcare context and in other social contexts.

The African family structure has changed and as such, fewer younger people are willing to care for the older family members. This has led to an alarming number of older persons being abandoned in hospital without any family member responsible. This has serious healthcare implications for older persons given that they (or their families) are expected to pay for healthcare before it is provided.

According to the chief nursing officer in Nanyuki, 3 in every 10 older persons are abandoned at hospital. At Kenyatta national hospital, the matron of a 65 patient unit estimates the ratio of abandoned older persons to be 3 in every 20. However, these ratios do not include older persons who had already been abandoned at their homes or on the streets and were brought to hospital by good Samaritans, charitable institutions and emergency services. Even some of those whose fees are being paid by family, are not visited as often as they would like.

Abandonment at the hospital puts a toll on the older persons physically – because Medical care is delayed as the bureaucracy investigates to establish whether the patients merit fee waiver, and mentally – the patients feels like unwanted burden on their families.

Those with urgent medical needs deteriorate tremendously or die while they wait for fee waiver. An elderly woman at Misyani hospital waited 6 hours for medical attention because she did not have the medical fees required. When a Good Samaritan eventually intervened and paid the requisite fees, the illness and the stress had taken its toll on her and she succumbed and died 30 minutes later.

In Nanyuki, the Chief Nursing Officer observed that 90% of abandoned older people go into depression. In Kenyatta national hospital, the matron revealed that the depression makes older persons uncooperative in the treatment process. The medicines are thus rendered ineffective and they often refuse to sign for necessary procedures that require their permission.

Much as the hospital environment is not comfortable for most older persons, some still prefer the hospital because it is less hostile than the home environment:

My children are not visiting me in hospital. The hospital takes care of me better than the care I receive at home (Female O.I. Nanyuki. 22-8-2001).

Explaining why some older persons do not want to be discharged from hospital the matron of the ward stated that:

“The majority of young people have moved to urban centres with their children leaving the elderly miserable at home with no one to provide the basic needs they require” (Kenyatta National Hospital mixed, 24-8-2001).

Other comments corroborating the same included:

Some relatives abandon the elderly in hospitals leading to the problem of destitution upon discharge. (Kenyatta National Hospital health workers, 24-8-2001; Nanyuki District Hospital health workers, 22 –8-2001; Nakuru Provincial Hospital health workers, 27-8-2001).

I would like to stay longer at the hospital because there is nobody to take care of me at home. What am I going to do there? (An eighty-five year old woman at Nanyuki District Hospital, 22-8-2001).

The common trend of abandoning older persons in the rural homes was also observed to become apparent in the urban areas too:

Old people are not necessarily left in the rural areas alone. Relatives could be around but are too busy with their own chores to care about the welfare of the elderly (Nakuru women, 27-8-2001).

b. Attitudes of Healthcare workers being a reflection of the attitude of society

With the changing structure of society, the older persons have lost their traditional roles and respect. The extreme economic conditions have made economic considerations ever more important. Older persons are thus increasingly marginalised within communities as they are viewed as a waste of scarce resources.

A male discussant in an FGD in Misyani observed that his son has not visited him for 18 years and is simply ‘waiting for him to die so that he can inherit the land’. A woman discussant also at Misyani observed that the daughter in law would only serve her food either in times of ‘surplus’ or ‘merriment’.

However, a old female discussant in an attempt to defend the young, was a reflection of how deeply our communities are entrenched in ageism:

It is not that children do not love their aged ones but the economic conditions force them to behave the way they do. If you have limited funds, do you help the young or the old? If anything, retrenchment has hindered parents from fully supporting their own children (Kenyatta National Hospital mixed 24-8-2001).

In all hospitals visited, ALL hospital staff concurred that 50%-70% of the conditions of older persons was brought on or aggravated by malnutrition. The malnutrition is usually brought about by lack of adequate food. This is because in the face of scarcity, our increasingly ageist society prioritizes the elderly last. This societal attitude that older persons were an added liability that one could avoid is reflected in healthcare workers attitudes towards older persons:

Older people face malnutrition manifesting itself in the form of anemia and pneumonia (Kenya National Hospital health workers, 24-8-2001; Nanyuki District Hospital health workers, 22-8-2001; Nakuru Provincial Hospital health workers, 27-8-2001).

In Nanyuki hospital, the nurses in an FGD observed that whenever an older person was admitted, they would warn each other that “there is trouble on bed x”.

In Misyani, a female discussant observed that she has often been turned away with the reproach that ‘you are not sick, you are just old’. A male discussant observed that he has often heard paramedics at a district hospital discuss how much of a waste of precious drugs, old people are.

I have been sent away by the staff of Kangundo District Hospital twice. The health staff said that I am not sick but just old. Treating me is a waste of drugs (Discussant, Misyani women, 29-8-2001).

Sometimes, the elderly are injected with water instead of the purchased drugs so that the drug could be used on “a younger deserving patient” (Misyani women, 29-8-2001).

In Kenya, the nurses in the FGD observed they preferred working with younger people because older people were ‘difficult’. In ALL hospitals, the management staff recommended specialist geriatric facilities not in the spirit of desiring for better care for older persons, but so as to get the older persons out of their systems. In a confidential interview with the head of one of the hospitals, he confided that ‘older people are a big headache and a waste of scarce resources, the biggest favor you could do to me as an Older People’s Organisation is to get them out of my hospital’.

An example of abusive utterances at older persons include:

Nurses in the maternity sector are too cruel to mothers who get children at old age. I was told that I am silly and wasting the chance that should be used by my children (Nakuru women, 27-8-2001).

c. SAP/Economy

With cost sharing introduced in the hospitals, the abuse of older persons' rights within the healthcare system has taken a new economic dimension.

With the introduction of SAP, the smaller satellite health facilities were abandoned giving regional hospitals greater catchment populations to serve. The healthcare system of the country is often stretched beyond capacity with the staff working under very difficult conditions. In Kenyatta, the admission to the wards in the year 2000 was at 135% of capacity. Under such conditions, the vulnerable groups such as the old are even more vulnerable. All resources are sorely inadequate. A 63-year old male patient interviewed at Nanyuki District Hospital stated thus:

Some of the staff here are very good and they go an extra mile to take care of us. The main problem is that they are working under a difficult environment of resource scarcity. We share a bed with one you do not know which disease he is suffering from (O.I. Nanyuki. 22-8-2001).

A female discussant in Nakuru observed that older patients are often immobile, the insufficiency of staff to help them move around often makes them stay in bed too long and thus develop bed sores. The hospital, she added, was so crowded that they were often forced to share beds and linen. There was 'absolutely no privacy even when the most embarrassing of medical procedures was being carried out'.

Immobile patients are denied good care with regard to being assisted to feed and attend to bathroom issues. In fact, many elderly people refrain from going to hospitals fearing bedsores as a result of urinating on the bedding without bedding being changed. The elderly prefer to remain at home where they hope that the family members will handle them with the compassion and respect they deserve (Misyani men and women, 29-8-2001; Kenyatta National Hospital mixed, 22-8-2001; Nakuru mixed, 27-8-2001).

I share a bed or sometimes sleep on the floor when my bedmate urinates on the bedding (Discussant, Kenyatta National Hospital mixed, 24-8-2001).

I was involved in a road traffic injury while riding a bicycle in Siaya District. The staff of Siaya District Hospital transferred me to Kenyatta National Hospital for specialized treatment. Although I was promised better treatment, I dislike how I am handled by the hospital staff. They have confined me into a room because inability to control my bowels. This discrimination makes me feel unwanted at this hospital" (O.I. Kenyatta National Hospital. 24-8-2001)

In Nakuru, a female discussant observed that while she has to buy all her medical provisions, they are often taken away from her by paramedics without her permission and used on other patients. Discussants also observed that the fees that one now has to pay at these public hospitals increased the tendency for families to abandon them at hospitals.

Nurses at Nanyuki and Nakuru hospital confessed that since it is in the back of their minds that fees paid to the hospital go towards improving their working conditions and 'benefits', they do not look kindly upon older persons who have a problem settling their medical bills.

Many discussants in all the focus group discussions lamented that they could not understand why the government stopped subsidizing health care in the 1990s, instead of offering free health care as had been the case previously. Due to the charges that are required in hospitals, many elderly persons have little or no access to health care. There is a need to inform the elderly (as stakeholders) on the processes that have led to this transition.

Given that most of the Kenyan economy is agricultural or pastoral, the economic situation of communities is heavily dependant on favourability of the climatic conditions. In Nanyuki, it was reported that some of the abandoned older persons in hospitals were Turkanas (a pastoralist community) who had been left behind by their families when they moved to new sites in search of water and grass for their livestock (Nanyuki health workers, 22-8-2001). In Misyani, it was reported that low and unreliable rainfall leads to low or no agricultural produce (Misyani men, 29-8-2001). During drought, there is immense loss of livestock. Poor crop yields and loss of livestock bring about low or no income (poverty), which in essence means that there will be no money for health care service and other basic needs for members of households, including older persons.

d. Hospital policies and Structures

In Misyani an older woman and an older man stated that they had observed physical abuse 'of hitting patients' at a district hospital.

In Nanyuki and Nakuru, the staff observed that it would be difficult, if not impossible, to police abuse of older persons within the current hospital policy frameworks. It would be next to impossible to punish perpetrators.

In Kiambu District Hospital, the sick are slapped, rudely rebuked and pushed by health workers. Again, some health workers close their sections as early as 3 p.m. whilst official closing time is 5.30 p.m. One day a dying child accompanied by an older person was denied medication at 3 p.m. because the section concerned had already been closed (Discussant, Kenyatta National Hospital mixed, 24-8-2001).

I witnessed a case whereby an elderly woman was charged one and a half times the usual rate for medicine at the Kangundo District Hospital. She waited for six hours for the medicine as health workers attended to other issues and cases. A Good Samaritan paid for her because she was incapable of raising the required money for medication. Even after someone had paid for her the inflated charges,

she waited for so long and died four hours later before receiving the medication (Misyani men, 29-8-2001).

In Kenyatta, the nurses confessed that the attitude with which they treated patients in general and older patients in particular was very individualistic. There was no guiding policy or even tradition. This left older persons vulnerable to the whims and mood of the staff.

Results of tests are at times not disclosed to patients. The patients are merely given reports to hand over to doctors who prescribe medicine without explaining to the elderly what the problem could be. Medical students carry out procedures like taking out blood samples without supervision. The procedure takes long, is painful and ineffective.

Incidents of corruption and conflict of interest were mentioned in all the hospitals surveyed. It was reported that many senior nurses and doctors have opened their own clinics and some of the respondents alluded to the fact that the medicine and other materials that disappear in public hospitals end up in these private clinics. Another interesting observation was that when these doctors and nurses are in their private clinics or working as consultants in private hospitals, they handle patients with a lot of care and professionalism compared to when they are in public hospitals.

Some health workers expect some bribe before they can attend to patients. In my case, I did not have any money. So I waited and when I got tired, I returned back home (Discussant, Misyani women, 29-8-2001).

we have to queue for long hours and are only treated at district hospitals if we give the clerks some little cash to entice them. Given that the elderly are poor, they are turned away before seeing the doctor (Misyani women, 29-8-2001)

According to mixed discussants at Kenyatta National Hospital, some health workers at district hospitals close their clinics earlier than stipulated in order to go and attend to their own personal clinics. (Kenyatta National Hospital mixed, 24-8-2001).

Some health workers close up so that they could go to generate money from private clinics that are more paying (Misyani women, 29-8-2001; Nakuru health workers, 27-8-2001).

Upon recovery, abandoned/homeless elderly patients are forcibly evicted 'to create room for other patients' (Discussant, Kenyatta National Hospital health workers, 24-8-2001). When elderly persons are evicted without proper arrangements on where they will live and continue receiving the required medication, their recovery is not sustainable.

e. Training of healthcare workers

The current training of health workers is not sufficient to prepare them enough to provide the kind of care expected by older persons. This is evidenced in the comments of health workers about dealing with older persons:

The majority of old persons are very stubborn. They refuse to take medication and food preferring to die to avoid further suffering (Kenyatta National Hospital, 24-8-2001; Nanyuki District Hospital health workers, 22-8-2001; Nakuru hospital health workers, 27-8-2001).

The physiotherapist at a district hospital observed that while he can manage therapy for older persons ‘very well’, he does not know how to deal with the ‘extra demands, for attention and so on, by older persons’. This inability to cope with the extra needs of older persons makes him ‘prefer working with younger patients who come in, bear the pain without complaining, heal in time and are soon out of hospital’.

Health workers when asked if they think that their training is enough for them to deal with older persons generally answered affirmatively. But when they were asked to equate that geriatrics training with training in other specialized medical fields, they reckoned that:

the quality and depth of training in geriatrics was equal to the training in other specialized fields such as pediatrics.

Yet they felt that their training for pediatrics was not enough to enable them effectively perform in THAT specialized field.

f. Remuneration and morale of Healthcare workers

In Nakuru hospital, the staff observed that what they were being paid was not sufficient to sustain them and their families. They thus felt generally unmotivated in their work. They observed that with the low morale as a result of ‘low’ pay, they found it difficult to go the extra mile to cater for the ‘additional’ needs of older patients.

A female discussant in Nakuru with trauma to the arm had not had any form of medication in 24 hours. It had taken 6 hours to get an x-ray done on her injured arm. This was because the paramedic responsible was not at his post for that long even though he was officially “on duty”. The staff confessed that they take every opportunity available to augment income by taking on assignments outside the hospital.

g. Gender perspective

The abuse of older persons within the healthcare system was observed to be taking on a gender dimension. The Social worker at Nanyuki observed that the 60% to 70% of the abandoned older patients were male. This was generally attributed to their having abandoned their families during their youth. The perception is that they squandered their youth and because of that negative attitude they get even less favorable treatment than their abandoned female counterparts.

Some elderly persons are destitute because of having divorced their first wives or husbands to remarry. When the second relationships fail, they are left single. Their former spouses refuse to accept them even if they so wish to re-unite (Nanyuki District Hospital health workers, 22-8-2001; Nakuru women, 27-8-2001).

One discussant noted: “History repeats itself even in old age. Elderly widowers, for example, want to continue being taken care of as usual. This makes their life unbearable unlike women who are able to easily cope with the changes” (Discussant, Kenyatta National Hospital health workers, 24-8-2001).

Also, due to traditions (of men keeping emotional distance from their children) and the tendency towards extravagant habits such as alcohol, the children often tend to support their mothers more often and better than their fathers. This was observed in a focus group discussion of older males in Kenyatta, Misyani and Nakuru Hospitals.

Some children, especially sons refuse to give money to their fathers because the former spend their entire pension on alcohol. As a result of only supporting mothers economically, conflicts ensue among the elderly parents (Discussant, Kenyatta National Hospital mixed, 24-8-2001).

In the same discussions, the participants also observed that female children were more supportive of their parents than the male ones.

2.3 Consequences of Elder Abuse

The following table summarizes the consequences reported by respondents.

Table 3: Consequences of Elder Abuse on

Older people	Families	Community	Health sector
Deterioration in health and incidence of ill health (diabetes, hypertension, arthritis, loss of teeth, eye problems etc)	Generates and intensifies conflicts. Economic strain.	Community raises funds to deal with effects of abuse, e.g. hospital bills. Of course a few persons exploit such efforts for selfish interests.	Increases demand for space: some patients share beds and others sleep on the floor.
Emotional stress, leading to depression, loss of appetite and earlier deaths. Feelings of loneliness	Strained relationships between family members (e.g. between daughters-in-law and the rest of the family, stepchildren).	Increases the use of traditional/herbal medicine.	Increases demand for fee waiver: hospitals unable to waive fee for all needy cases.
Loss of self esteem; embarrassment	Abandonment and neglect by family.	Weakens social cohesion and networks.	Places extra demands on staff: time, skills and care.
Physical hurt, injury and death	Family instability. Police interventions and court cases	Poverty cycle is intensified.	Facilities for their rehabilitation which are expensive and limited.
Destitution and begging (street aged)	Disaffection by children towards parents, especially the perpetrator of abuse	Response to remove the abuse or/and its consequences: some individuals and organizations are moved to intervene, e.g. Church-based groups.	Burden of care is increased on hospitals.
Withholding vital information; some develop dislike for hospitals and negative feelings towards health workers and hospitals	Financial burden because of costs incurred in seeking redress	Inter-community tension and revenge, e.g. in the case of cattle rustling. Loss of girls and young women through abduction.	Difficulties in tracing families of abandoned older persons.
Increases physical weariness and frailty	Loss of property	Embarrassment	Relational problems with older patients
Decline in nutritional status (malnutrition)	Loss of respect and honor in society	Curses	Demand for specialized services for the elderly, e.g. wards, mobility aids

3. INTERVENTIONS

This section summarizes the interventions currently available and those that are recommended.

3.1. Interventions Available

Though some forms of interventions currently exist in the community and within the hospitals, discussants opined that these interventions were not sufficient to protect older persons from rights abuse within the healthcare context.

3.1.1 Interventions Within The Community

While older persons prefer to spend their lives within their communities and families, a worrying trend today is the ease with which the community is willing to commit its old to institutions. Whilst older persons were (culturally) taken care of within the communities, today, family members often try to get them committed to institutions. These institutions are already stretched beyond capacity due to the high number of abandoned older persons whom they try to absorb. Commenting on how the community cares for the elderly today, discussants observed:

Some destitute elderly persons are taken to homes of the aged around Nairobi town (Kenyatta National Hospital health workers, 24-8-2001).

The elderly who are physically dependent cannot be admitted into the available homes. There are no facilities to support such elderly in need of constant medical attention (Kenyatta National Hospital health workers, 24-8-2001).

Elderly persons loiter the streets in this area because they have no families to turn to for support. There is a great need for an old people's home. (Nanyuki District Hospital health workers, 22-8-2001).

A good number of families, however, still take care of their old within the family.

In this area, elderly persons just remain in their own homes where members of the extended family support them. Grandchildren direct their blind grandparents (Nakuru mixed, 27-8-2001).

Religious institutions also often intervene to care for the destitute (in general) within the communities.

There are church programmes in this area whereby Christians visit fellow members of the community. During such visits, people with needs are identified and their needs looked at and solutions provided. For instance, those without food are provided with food. When the groups come across elderly persons, they

identify their needs and purchase food for them and the children, among other things (Misyani women, 29-8-2001).

There are also charitable institutions that exist within communities and provide support to the needy in the community.

Kenyatta National Hospital League of Friends provides wheel chairs to immobile patients. The elderly form a large percentage of the immobile patients. Hence, the majorities benefit from such donations (KNH health workers 24-8-2001).

Apart from the above formal institutions, there are also informal institutions that exist within communities that can intervene. The efficacy of such institutions (in intervention) today are however very doubtful given the changing community structures.

In the old days, the things that our children do would warrant ostracisation. Today, even the clan elders are tired of calling clan meetings to warn the errant children. (Misyani women, 29-8-2001).

3.1.2 Interventions Within Health Institutions

Very few interventions exist within hospital structures that specifically address the needs and rights of older persons. Whilst policies exist to protect the rights of the everybody in general, they are sorely lacking in serving the elderly because of the (negative) attitudes with which older persons are viewed.

Compounding the inadequacy of the existing policy is their insensitivity to the unique needs of older persons as a vulnerable group. So while a policy might be quite efficient in serving the rights of a young male, it would be grossly wanting in protecting the rights of an older person.

But the existence of these policies have somewhat improved the situation among older persons:

Many social workers exist in public hospitals to investigate the situation of patients with financial needs and who require support. In many cases, the elderly who have been abused by relatives turn to these social workers to help in placing them into the homes of the aged (KNH health workers 24-8-2001).

3.2. Interventions Recommended by Discussants

Due to limitations apparent above, discussants offered the following recommendations:

- More homes should be established in Kenya to cater for the ever increasing number of the elderly. Again, such homes should be equipped with geriatric medical facilities so that even the invalid could be admitted into the homes (Kenyatta National Hospital

health workers, 24-8-2001; Nakuru Hospital health workers, 27-8-2001; Misyani women, 29-8-2001; Nanyuki health workers, 22-8-2001).

- Interventions in the abuse of older persons need to take into account the social structure in Kenya. Home-based care should be promoted so that only the very desperate and abandoned older persons are institutionalised. Concerted efforts should be made to ensure that the elderly in homes have regular contact with children such as orphans and the youth to enhance a good relationship between the old and the young as was the case in the indigenous cultural setting.

When asked how the health needs of the elderly are addressed, discussants observed that:

Indigenous healers are the most important people in provision of health care in communities. They are visited first before any other option can be considered. Doctors in the public and private sectors are only approached if the former fail to arrest the problem (Kenyatta National Hospital mixed, 24-8-2001; Nakuru mixed, 27-8-2001; Nanyuki District Hospital, O.I. 22-8-2001).

We prefer indigenous healers because they are social and charge less money compared to doctors in public and private hospitals (Nakuru women, 27-8-2001).

We need specialized and additional training in geriatrics to enable us cope with the health demands of the elderly in Kenya (Kenyatta National Hospital health workers, 24-8-2001, Nakuru health workers 27-8-2001, Nanyuki health workers 22-8-2001).

Given the crucial role that indigenous healers play in addressing the health needs of the elderly, this study recommends that the healing activities of these healers should be regulated and co-ordinated by a formal or government body. There should be increased collaboration in the work of doctors and that of traditional healers. The government should however ensure that it protects its citizens like the elderly from abuse by unscrupulous healers.

Discussants also made the following suggestions:

- There is need for the elderly to have separate wards so that their health needs are addressed separately from those of other patients (Kenyatta National Hospital health workers, 24-8-2001; Nakuru health workers, 27-8-2001). This approach will ensure that the rights of the elderly to privacy are respected. The elderly will have more room to discuss issues that affect them in their youthful days, thereby rejuvenating their spirits rather than making them feel outdated amongst youthful patients as is the case today.
- There is need for health workers in Kenya to have special training in the areas of handling the elderly (geriatrics) instead of the current training where there is only limited coverage of this subject in the general training (Kenyatta National Hospital health workers, 24-8-2001; Nakuru health workers, 27-8-2001). Such training would equip health workers with skills to enable them to handle the elderly in a more humane manner

than is the case today where some health workers abuse rights of the elderly through verbal, physical and psychological abuse.

3.3. Recommended Interventions

The following is a summary of the recommendations adduced from the study:

- a. It is recommended that there is need for the government to initiate the establishment of healthcare policies and structures that ensure the protection of the rights of ALL citizens while being especially sensitive to the rights of the older persons and other vulnerable sections of the community.
- b. Hospital administration should come up with policies and systems to monitor the work of health workers to ensure that patients are handled well. Again, these hospitals should borrow a leaf from Kenyatta National Hospital and provide special diet for the elderly that is full of protein food such as eggs and milk instead of giving them same as those for general patients. Such a strategy would help in improving the nutritional needs of the elderly.
- c. It is suggested that the government of Kenya should review the cost-sharing programme in public hospitals. Paid healthcare as recommended by the structural adjustment programme (SAPs) is beyond the majority of Kenyans. It is way beyond the mainly incomeless older persons of this country.
- d. It is further recommended that non-governmental organisations (NGOs) step up to the need to sustainably improve the lives of the elderly in Kenya rather than leaving the task to the government and charitable foundations. Other interventions that need to be strengthened are legal redress system and community arbitration system. The provincial administration, ministry of health, social services and the judiciary are other channels through which elder abuse can be tackled.
- e. There is need for older people's organisations to input into the training curricula of the health care workers to ensure that the rights and special needs of older people are addressed at every level of the healthcare delivery system.
- f. It is strongly recommended that further research be undertaken so as to enable better understanding of the problem and effective planning for its intervention. The survey would include an analysis of the magnitude and various dimensions of elder abuse, an assessment of the effectiveness of existing interventions and the status of implementation of global and national policy/action instruments in Kenya.

REFERENCES

- Bennet, G. 2001. **World Health Organization: Elder Abuse Study**. Working Paper Draft. Ref.: Prof./GB/SC/0565.
- Daichman et al. **Health Professionals Perception of and Responses to Elder Abuse**. Latin American Committee for Prevention of Elder Abuse: Buenos Aires, Argentina.
- Frazier, B. H. and Hayes, K. C. 1991. **Selected Resources on Elder Abuse: An Annotated Bibliography for Researchers and Educators**. University of Maryland: USA Department of Agriculture.
- Hancock, G. 1995. **Lords of Poverty**. Reading: Cox and Wayman Ltd.
- HelpAge International n.d. **United Nations Principles for Older Persons**.
- HelpAge International. 2001. **Addressing Violations of the Rights of Older Men and Women**. Project Document.
- Levin, S. P. n.d. **Focus Groups as a Tool for Assessing Perceptions on Elder Abuse among Older People and Primary Health Care workers**. WHO.
- Ngugi, R. 1999. **Health-Seeking Behaviour in the Reform Process for Rural Households: The Case of Mwea Division, Kirinyaga District, Kenya**. Nairobi: African Economic Research Consortium.
- Ochola, S, Wagah, M. and Omalla, J. N. K. 2000. **An Assessment of the Nutritional Status and Socio-Economic Contributions of the Elderly in Nairobi and Machakos Districts**. Nairobi: HelpAge International – Africa Regional Development Centre.
- Randel, J., German, T. and Ewing, D. (Eds.). 1999. **The Ageing and Development Report: Poverty, Independence and the World's Older People**. London: Earthscan Publications Ltd.
- Swanson, S. M. 1999. **The National Clearinghouse on Family Violence**. Ottawa: Health Canada, Ontario.
- White, L. 1990. **The Comforts of Home: Prostitution in Colonial Nairobi**. Chicago: The University of Chicago Press.