SELECTED PSYCHOSOCIAL FACTORS AFFECTING WELLNESS OF THE ELDERLY: A CASE OF HOMES FOR THE ELDERLY IN NAIROBI COUNTY

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DECLARATION AND RECOMMENDATION

Declaration

I hereby declare that this research thesis is my original work and has never been submitted in any institution or college for any academic purposes.

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Recommendation

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DEDICATION

This research thesis is dedicated to my family for their support and encouragement during the entire program.

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ABSTRACT

Changing family values and migration into cities has seen many Kenyans live away from their aging parents making it hard to fulfil their traditional role of caring for them. This has contributed to the rapid growth of homes for the aged in the country especially in Nairobi County. The purpose of the study was to investigate selected psychosocial factors affecting wellness of the elderly persons admitted in homes for the elderly in Nairobi county.The study focused on three psychosocial factors; loneliness, inactivity and dependence. The researcher aimed to explore how these factors affect the wellness of the old persons in homes for the aged and what interventions can be applied to improve their wellbeing. The study was guided by the psychosocial theory of human development, Cognitive behavioural theory (CBT) and the Maslow's hierarchy of needs theory. The study employed a survey descriptive research design. The target population was the five homes for the elderly in Nairobi County. The study used stratified sampling technique to get a sample of 122 participants. Data were collected by use of structured questionnaires semi-structured interview guides and Focus group discussions and analyzed using both descriptive and inferential statistical methods. Descriptive statistics such as percentages, frequencies were used to summarize data while regression analysis was used to infer causal relationship between variables under study using Statistical Package for Social Sciences (SPSS) version 23. Qualitative data was analysed thematically by use of content analysis and presented in narratives (verbatim). The study findings on loneliness and wellness of the elderly showed that the elderly enjoyed safety and security at the homes for the elderly; they were happier living at the homes, enjoyed the company of people at the home and they had made more friends since almost all were in same age bracket. On dependency and wellness of the elderly it was revealed that most of the residents in the homes for the elderly were not entirely dependent on the caregivers since they were in-charge of their personal cleanliness without assistance. Concerning inactivity and wellness of the elderly the findings showed that most of the elderly were not involved in sporting activities or in productive activities like knitting, painting or baking since their age was advanced and mobility was a problem. The study finding indicated that it was possible to improve the wellness of the elderly in the homes through certain interventions such as encouraging frequent participation of the elderly in physical activities, frequent counseling sessions and frequent health checkups. The study recommended that the homes should organize and encourage community visits especially from where the elderly hail from. The management should make the elderly at the homes for the elderly feel like home by encouraging openness, give the elderly the ability to choose and participate in community events.

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ABBREVIATIONS AND ACRONYMS

ADLs	- Activities of Dailiy Living
CBT	- Cognitive Behaviour Theory
FACIT	- Functional Assessment of Chronic Illness Therapy
HRQOL	- Health-Related Quality Of Life
NACOSTI	- National Commission of Science Technology and Innovation
SHARE	- Survey of Health, Ageing, and Retirement in Europe
SPSS	- Statistical Package for Social Sciences

CHAPTER ONE

INTRODUCTION

1.1: Background to the Study

The older person population has grown very rapidly all over the world. In 2017, there were 962 million people aged 60 and over in the world, who constitute 13 percent of the world's population (Ibrahimi, 2014). The population aged 60 and over increased by 3% per year. Currently, Europe has the most significant percentage of the population aged 60 and above (25 percent). Rapid aging will also occur in other parts of the world so that in 2050 all regions of the world except Africa will be almost a quarter or more of their population aged 60 and over. The number of adults in the world is expected to be 1.4 billion in 2030 and 2.1 billion in 2050, and could rise to 3.1 billion in 2100 (World Health Organisation [WHO], 2014).

Globally, Japan and Italy are the countries with the largest aging population in the world. Japan and Italy are the home of the world's oldest citizens, with Japan accounting for 26.3% of its population 65 years and over, while Italy has 22.4% of its population 65 years and older. It is estimated that almost one third of Japanese people (32.2%) will be adults by 2030. Greece is another country with a large aging population in the world, with 21.4% of its population over the age of 65. There are quite a few other countries with a high percentage of their citizen aged 65 years and above. Some of these are Germany, Portugal, Finland, Bulgaria, Sweden, Latvia and Malta. Their statistics indicate that 21.2%, 20.8%, 20.5%, 20.0%, 19.9%, 19.4% and 19.2% of their relative population are aged 65 and older (United Nations, Department of Economic and Social Affairs [UNDESA], 2015).

In Africa, the older people population, 60 years and older, is currently estimated at 42 million, and is projected to reach 205-212 million by 2050. More than 15% of the population of Mauritius and Reunion were 60 years of age or older in 2015, Most aged of sub-Saharan Africa. In Seychelles, 11% of the population were aged 60 and over in 2015, and the elderly comprised nearly 8% of the population of South Africa. In Uganda, the current adult population is estimated at 1.6 million (5% of the population) and is expected to rise to 5.5 million in 2050 (Uganda Bureau of Statistics [UBOS] and International Coach Federation [ICF], 2012). According to statistics available, Tanzania with a total population of 33.5 million, has about 1.4 million older people (4 percent of the population) aged 60 and over (United Republic of Tanzania National Aging Policy [URTNAP], 2016).

Kenya has about 1.2 million people over the age of 65 in the population of 38.6 million (Kenya National Bureau of Statistics [KNBS], 2011). They represent about 3.8% of the population. There are fewer men than women. About 68% of the older people population is between the ages of 65 and 75. It is estimated to rise in 2050. Kenya has no constitutional policy for older people even though the draft policy was written in 2009. The state relies mainly on the provisions of the constitution guaranteeing the rights of all human beings. Article 57 requires the State to safeguard the rights of older persons to participate in social affairs, to continue their personal development, to live with dignity and dignity without abuse, and to receive reasonable care and assistance from both the State and the family.

Up to now, Kenya has no long-term social security insurance for older people and access to private health insurance is very limited. Older people may receive medical care in government hospitals and there is no special provision or arrangements. Aging comes with many challenges. Loss of independence is one of the potential parts of the

process, as well as physical ability and age reduction. The aging process involves biological, emotional, intellectual, social, and spiritual changes. Many adults remain very independent. However, others require additional treatment. Because seniors usually do not hold jobs, finances can be a challenge due to cultural misconceptions, older people can have goals to mock stereotypes (Olson, 2009). The elderly face many challenges in later life, but they do not have to enter old age without dignity. Elderly abuse is a severe social problem, and as expected with the biology of aging, the elderly sometimes become physically weak. This weakness makes them dependent on others for treatment, sometimes for small needs such as household tasks and essential functions such as eating and toileting (Gelfand, 2011).

Elderly persons are a heterogeneous group and as people of all ages, they are individuals with varying needs, desires, abilities, lifestyles and cultural backgrounds. As our society becomes increasingly older and more diverse, dealing with this aging population requires a great deal of knowledge, sophistication, and flexibility (Papalia & Harvey, 2012). As people age, their emotional needs may change. Many elderly persons find themselves dealing with the loss of a spouse or health problems. They may not have the same support system they had when they were younger due to children moving away or retirement. Having support or a family member who cares can make all the difference to an older person (Maryann, 2014).

Areas of concern in the situation of older persons will also emerge, signs of which are already evident, resulting in pressures and fissures in living arrangements of older persons. Family ties in most countries are indeed reliable and the overwhelming majority of the elderly live with their children or are supported by them (Macht, 2009). A majority' of families engaged in various economic activities find the presence of old parents emotionally bonding and of great help in managing the household and caring

for children. However, due to the operation of several forces, the position of a large number of older persons has become vulnerable due to which they cannot take for granted that their children will be able to look after them when they need care in old age, especially in view of the longer life span implying an extended period of dependency and higher costs to meet health and other needs (Silverstone & Hyman, 2010).

Despite the increased understanding of aging and an ever-growing number of older adults, the elderly still have to deal with age-based expectations and prejudices. For instance, older people are always tagged with uncomplimentary labels such as senile, absent-minded and helpless. These negative attitudes and stereotypes (ageism), prevent intimate encounters with people in different age groups and sometimes lead to outright discrimination (Butler, 2008). As a result, those growing older often deny and dread the process, referred to as 'the age mystique.' According to Havighurst and Wilson (2009), older adults must learn to cope successfully with a range of issues such as the death of friends and spouse, reduced physical vigor, retirement and reduction of income. They have more leisure time and need to make friends as they develop new social roles. They may require changing of living arrangements or making up more satisfactory ones, at the same time dealing with grown children.

In some communities, the aged are tortured and executed on allegation of witchcraft. They are accused of various calamities e.g., death, misfortune, famine, floods and other natural disasters. They are usually killed and property destroyed. In May 2016, 11 elderly persons were killed in Kisii (8 women and 3men) aged between 80-97 years, (Mbula, 2016). Otieno, reporting to the Hivisasa of (February, 7, 2019) indicated that 29 people were killed in Kilifi (Coast) including assistant chief of the area on allegation of witchcraft. Aging is a time of both "positive and negative transitions and

transformations. Becoming a grandparent is again while losing age mates, friends, or a spouse is a loss. The form of elderly care provided varies greatly among countries and even within the same country and regions due to different cultures. While in developed countries formal social support systems exist for older people, in developing countries e.g., Kenya, it is left to self and the extended family. Traditionally, elderly care has been the responsibility of family members and was provided within the extended family home. Changes such as geographical dispersion and the tendency for women to be educated and work outside the home have caused parents (old) to be left alone. This has caused loneliness and several psychological disorders (Delhey, 2012).

Despite the low economic status of our country (Kenya), most people want to see their parents (elderly) living happy and indignity. Some employ caregivers in their homes while others take their parents to the homes for the aged. However, several elderly parents have been forgotten (especially in rural households and slums) and experience a variety of psychosocial challenges, eventually dying miserably. Employing a non-family member to take care of the aged without constant supervision makes them (the elderly) vulnerable to abuse leading up to mental illness and early death. Identifying the challenges of the homes of the aged will help people decide whether it is an alternative for their parents (Bowling, 2015).

Wellbeing is defined in terms of good or satisfactory condition of existence; a state characterized by health, happiness, and prosperity. The concept of wellbeing comprises two main elements: feeling good and functioning well. Feelings of joy, contentment, enjoyment, curiosity and engagement are characteristic of someone who has a positive experience of their life. Equally important for wellbeing is our functioning in the world. Experiencing positive relationships, having some control over one's life and having a

sense of purpose are all important attributes of wellbeing (Dodge, Daly, Huyton & Sanders, 2012). According to Dodge et al., (2012), stable wellbeing is when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge. There are different parameters for measuring wellness or wellbeing of the elderly. First is the Global Age Watch Index. Help Age's flagship product is the Global Age Watch Index, launched in 2013, which ranks countries by how well their aging populations are faring. It is based on four domains that are crucial enablers of older people's wellbeing: income, health, capabilities, and enabling environments.

Secondly is the older people wellbeing monitor. The key indicators of older people wellbeing monitor include dignity and social inclusion, independence and material wellbeing, participation, health and care, and self-fulfillment and active aging. The third is the use of senior wellness programs. The goal of top wellness programs is to improve the overall health of seniors through a variety of approaches, including increased physical activity, better nutrition, smoking cessation, and support of other healthy behaviors, education on preventive care and health. This study is going to use the following indicators to measure wellness of the elderly; level of interaction, individual interdependence, mental wellness, access to health care, increased physical activity, better nutrition and home safety (Ibrahimi, 2014).

1.1.1: Homes for the Elderly in Nairobi

The development of the elderly care system is significant as a result of the aging of the population. It becomes increasingly important for countries such as Kenya to provide home care for their elderly that is as wide and thorough as possible because of the rapidly changing age structure of the population and the high cost of hospitals. The

main focus in building more care homes for the elderly is on avoiding hospitalization; transferring elderly patients from hospitals to therapeutic homes significantly reduces the cost of medical care (Rossi, 2009).

The county government or private-owned either own care homes for the elderly. Patients whose physical condition is not good enough for them to live at home, but who do not require regular medical care, can be transferred to a care home for the elderly. Nairobi County has five homes for the elderly that include little sisters of the poor Kasarani, Kariobangi Cheshire House, Mother Teresa, Huruma, Nyumba ya wazee Ruaraka and Mji and Huruma, Runda. In these five homes for the elderly, more than 400 elderly persons were living and treated there (National Institute of Health and Welfare [NIHW], 2015). The accommodation consists of one or two-room apartments with either constant assisted nursing care or only partial assisted care. This means that nurses or caregivers can provide, for example, 24 or 12 hours a day service for elderly residents. The buildings are usually spacious and allow patients with reduced mobility to move around quickly.

1.2: Statement of the Problem

Homes for the elderly are becoming popular, as a retirement place for older people, and especially for those with no loved ones near to offer proper care. However, few studies have been conducted in relation to the wellness of the elderly persons living in the homes for the aged in Kenya.

Osongo (2012) conducted a case study in Mombasa County to understand the services offered in both the Government and faith-based eldercare institutions concerning the needs of the elderly persons in Kenya. Mutea (2011) investigated the pathways of older people into homes of the aged, in Kariobangi Cheshire Home for the Aged, Kasarani.

Mwaniki (2005) conducted a study on the risk factors associated with nutritional status among the older persons in selected homes for the aged in Nairobi and Kiambu, Kenya. None of these studies have highlighted the psychological factors that affect the wellness of the elderly persons admitted in homes for the aged in Nairobi County. Moreover, none of the studies has been done on loneliness, dependency and inactivity and how they affect the wellness of the elderly in homes for the elderly in Nairobi. Based on this, there was a need to investigate how the loneliness, dependency and inactivity affect the wellness of the elderly in homes for the elderly in Nairobi County.

1.3: Purpose of the study

The purpose of this study was to investigate how psychosocial factors affect the wellness of the elderly in homes for the elederly in Nairobi County..

1.4: Objectives of the Study

The study was guided by the following objectives:

i. To determine the influence of loneliness on the wellness of the elderly admitted in homes for the elderly in Nairobi County.
ii. To investigate the influence of dependency on the wellness of the elderly admitted in homes for the elderly in Nairobi County.
iii. To establish the influence of inactivity on the wellness of the elderly admitted in homes for the elderly in Nairobi County.
iv. To explore the interventions that can improve the wellness of the elderly admitted in homes for the elderly in Nairobi County.

1.5: Research Hypotheses

The study was guided by the following research hypotheses;

Ho: There is no significant relationship between loneliness and wellness of the elderly admitted in homes for the elderly in Nairobi County.

Ho: There is no significant relationship between dependency and wellness of the elderly admitted in homes for the elderly in Nairobi County

Ho: There is no significant relationship between inactivity and wellness of the elderly admitted in homes for the elderly in Nairobi County

1.6: Justification of the study

The focus of this study was on selected psychosocial factors affecting the wellness of the elderly admitted in homes for the elderly. The Elderly population in Kenya has increased and not much research has been done on them and especially about the psychological factors affecting wellness. Many studies have focused on youth and middle age. This study deliberated on psychosocial factors specifically loneliness, dependency and inactivity and how they influence wellness of the elderly admitted in homes for the aged in Nairobi County.

1.7: Limitations of the Study

In conducting the research, the following limitations were considered. First, the research was conducted in only five elderly homes in Nairobi, so the findings from the sampled population would not accurately be generalized to other houses of the elderly in other parts of the country. Secondly, most of the respondents in this study were aged individuals therefore some of the data collected may be scanty, biased or misconstrued due to dementia, physical illnesses and cultural prejudices likely to be found among the aged. To counter these limitations, caregivers gave information that helped validate data received from the elderly.

1.8: Delimitations of the study

The research was conducted in Nairobi county five homes for the elderly in Nairobi which include; Little sisters of the poor (Nyumba ya Wazee) Kasarani, Kariobangi Cheshire Home, Mother Teresa-Huruma, Nyumba ya wazee Ruaraka and Mji wa Huruma-Runda. Couples aged 65 and over were to be included. However, couples who were not able to communicate due to unforeseen circumstances were excluded. The survey did not exclude people on ethnic or racial grounds or spouses who had lost their partners. Same-sex partners were excluded since that type of marriage was not legal in Kenya.

1.9: Significance of the Study

The study findings would be of use to the government agencies, investors, Kenyans with elderly parents and academicians. State organizations in charge of elderly homes may use the results of this study to understand the psychosocial factors affecting individuals admitted in their homes. The findings may also be of importance to the government in designing better ways of caring for the elderly. Policymakers may utilize the findings of this research as the basis for future alignment of policies related to the care of the elderly. The research findings will be significant to academicians who might be interested in furthering the research topic under study. Kenyans who wish to open homes for the elderly may get tips on best conditions expected for the wellness of the residents. People with aging parents and who want to place their loved ones in homes will understand how psychosocial factors may affect the old persons' wellness while in these homes and what support is required from them

1.10: Assumptions of the Study

The study was based on the following assumptions; That all people residing in these homes for the aged encountered some psychosocial challenges. That the respondents of the study were cooperative and provided honest information to the best of their knowledge. That there could be interventions that can be used to help the individuals in the homes for the elderly.

1.11: Operational Definition of Key Terms

Dependency - It means those of working age, and the overall economy, bearing the burden in supporting the aging population.Dependency factors will be measured in terms of cognitive functioning, such as dementia; sensory loss (deaf, blind), morbidity and environmental mastery.

Elderly person - The aged are defined as persons with the chronological age of 65 years and above.

Inactivity - Inactivity is defined as participating in no activity beyond baseline activities of daily living. Inactivity factors will be measured in terms of physical exercises (such as games) and meaningful activities (such as knitting, painting and baking).

Intervention - A combination of program elements or strategies designed to produce behaviour changes or improve health status among individuals.

Loneliness - Is defined as a feeling of emptiness, deprivation or sadness. Loneliness factors will be measure in terms of the individual's positive relations, self-acceptance, purpose in life and personal growth.

Psychosocial relates to the psychological development of an individual in relation to his or her social environment. This study will focus on loneliness factors, dependency factors and inactivity factors.

Well-being - This is usually defined in terms of good or satisfactory condition of existence; a state characterized by health, happiness, and prosperity.

Wellness - Wellness is an active process of becoming aware of and making choices towards a healthy and fulfilling life. Wellness was measured by using the individual's life satisfaction, general health status, functional ability, positive emotions and mental health.

CHAPTER TWO

LITERATURE REVIEW

2.1: Introduction

This chapter presents theoretical review, conceptual framework and the empirical literature review. The theoretical and empirical literature on the topic related to study objectives will be reviewed to determine the research gaps inherent in the studies.

2.2: Theoretical Review

The study adopted the psycho-social theory, Cognitive behavioural theory (CBT) and the Maslow's hierarchy of needs theory. Their relevance to the study is also discussed.

2.2.1: Psycho-Social Theory of Development

This theory was developed in 1950 by Erik Erikson, a German born psychoanalyst who lived between 1902 and 1994. The theory argues that every person has his own unique identity. This identity is composed of the different personality traits that can be considered positive or negative. These personality traits can also be innate or acquired, and they vary from one person to another based on the degree of influence that the environment has on the individual. The bottom line is that as humans, we possess many characteristics and these are honed in many different aspects that eventually define who each person is (Erikson, 1950).

Erik Erikson's Theory of Psychosocial Development is a comprehensive theory that identifies a series of eight stages, in which a healthy developing individual should pass through from infancy to late adulthood. All stages are present at birth but only begin to unfold according to both a natural scheme and one's ecological and cultural upbringing. In each stage, the person confronts, and hopefully masters, new challenges. Each stage

builds upon the successful completion of earlier stages. The challenges of stages not successfully completed may be expected to reappear as problems in the future (Erikson, 1950). These stages include trust vs. mistrust, autonomy vs. shame and doubt, initiative vs. guilt, industry vs. inferiority, identity vs. role confusion, intimacy vs. isolation, generativity vs. stagnation and integrity vs. despair. These stages correspond to infancy, school age, young adulthood, adulthood and later adulthood respectively. In the study, the researcher will be exploring psychosocial factors affecting the wellness of that group of individuals who fall under the last stage of development (i.e. later adulthood). According to this theory, an individual encounter a certain crisis that contributes to his/her psychosocial growth at each of the eight stages of psychosocial development. Whenever an individual experience such crisis, he/she is left with no choice but to face it and think of ways to resolve it. Failure to overcome such crisis may lead to significant impact on his/her psychosocial development.

Each stage involves a crisis of two opposing emotional forces. A helpful term used by Erikson for these opposing forces is contrary dispositions. Each crisis stage relates to a corresponding life stage and its inherent challenges. In the field of personality development, Eric Erikson had primarily addressed the elderly's needs in his theory of psychosocial stages. He refers to the stage of maturity where the adult struggles to achieve a sense of integrity as opposed to despair. He strives to resolve this crisis in order to have a feeling of wholeness and peace as one's life is ending. Although Erikson pioneered the idea of adult development, his ideas have been of a broad nature (Arnett, 2000).

The theory will be important to the study in determining whether the elderly feel a sense of fulfilment knowing that they have done something significant during their younger years or not. When they look back in their life, they feel content, as they believe that

they have lived their life to the fullest. If they feel that they haven't done much during their life, it's likely that they will experience a sense of despair. This is in line with research objectives on psychosocial factors affecting the well-being of the aged.

It is expected that those who may not have negotiated earlier developmental stages well, might be more prone to psychosocial challenges upon being placed in homes for the aged than their counter parts. They may be the unhappy lot, who may easily experience regret, hopelessness, despair, loneliness, early dementia and eventually depression.

2.2.2: Cognitive Behavioral Theory (CBT)

Cognitive Behavioural Theory CBT was pioneered by Dr. Aaron Beck in the 1963. The theory is based on the idea that how we think (cognition), how we feel (emotion) and how we act (behaviour) all interact together (Goodyer et al., 2017). Specifically, our thoughts determine our feelings and our behaviour. Therefore, negative and unrealistic thoughts can cause us distress and result in problems.

When a person suffers with psychological distress, the way in which they interpret situations becomes skewed, which in turn has a negative impact on the actions they take. CBT aims to help people become aware of when they make negative interpretations, and of behavioural patterns which reinforce the distorted thinking. Cognitive therapy helps people to develop alternative ways of thinking and behaving which aims to reduce their psychological distress (Hayes, 2004).

Most of the unhealthy behaviours observed among those old people in the homes for the aged, may be as a result of distorted and irrational thoughts. Some of them may think that their children have damped them here since they are a bother to them. This may make them feel rejected and lonely, thus leading to anxiety and eventually depression.

2.2.3: Maslow's Hierarchy of Needs

Hierarchy of human needs theory was developed by psychologist Abraham Maslow in 1942 in United States of America. The hierarchy of needs theory remains validly today for understanding human motivation, management and personal development (Milheim, 2012). Maslow proposed that people motivated by five levels of needs; these are physiological needs, safety needs, belongingness needs, esteem needs, and self-actualization needs. According to him these needs ranging from basic to highest level and suggested that needs are never completely satisfied, and when one need met it no longer influence behaviour (Huitt, 2004). On other hand Gawel (2007) argued that people who do not meet their needs will not function efficiently.

The first in the Maslow's hierarchy are the biological/physiological needs which include the needs of food, air, drink, warmth, shelter, sleep and sex among others. In other concepts they are referred to as existence needs and without them one cannot exist. Safety needs come second and includes the need of protection, security, law, order and stability among others. The third in line are the needs of belongingness and love which comes with the feeling of being part of a family or work group, affection and relationships (Maslow & Lewis, 1987). Maslow and Lewis (1987) argue that once an individual satisfies the biological and safety needs, they would seek to satisfy the belongingness needs. At this level, people try to overcome the feelings of alienation and loneliness. Esteem needs come at the fourth level of the hierarchy and includes the needs of mastery, achievement, independence, prestige, prestige, status and managerial responsibility among others.

Maslow's theory is based on the fact that humans get motivated by unsatisfied needs and lower need have to be satisfied before higher need are satisfied. According to

Milheim (2012), biological, love and esteem are general needs and have to be satisfied before a person starts to act unselfishly. Three needs are also known as deficiency needs and as a person gets motivated by the desires of these needs, they move closer towards growth and finally self-actualization. The satisfaction of the needs contributes to the health of the individual and the art of inadequate satisfaction of the needs can lead to poor health or the individual engaging in anti-social behaviour. Therefore, for the adequate satisfaction of individuals or groups of people, group leaders need to understand the needs that are active for the individual members of the group.

In reference to the study, and looking at Maslow's hierarchy of needs, it is recognized that once the lower need is satisfied, a person focuses on satisfying the higher needs of love and belonging, self-esteem and self-actualization. This includes a need to be accepted as part of a wider group of people and having bonds with others. Being involved and contributing to a community whether that is family, friends, work or social situations heightens wellbeing. Being in a home most of the basic needs of these residents are guaranteed and their health maintenance is secured too. However, their state of wellbeing will depend on how they experience love and belonging and level of self- esteem while in these homes. This theory is in line with the purpose of the study which is to investigate the influence of certain psychosocial factors influencing the well-being of the elderly.

2.3: Empirical Review

In this section, an empirical review of past major studies on the topic will be discussed. Most of these studies will be concerned with the psychosocial factors that affect the wellbeing of the elderly citizens who are under institutionalised homes.

2.3.1: Loneliness and Well-Being of the Elderly

Loneliness is a psychological distress brought about by lack of close friends, a reliable support system and connection with the general population. And, this distress has far reaching consequences on the individual psychologically. Social interaction is as necessary as food for human folk. It is well known that without social interaction, we fall apart mentally and these effects may manifest physically (Bhuvar, 2014). As noted by Cacioppo and Hawkley (2009), amongst social creatures, humans tend to perceive a threat to their existence and legacy when on the perimeter or brink of a social structure. Social support can be defined as an interaction within a social network of family members, friends, acquaintances, care givers, and significant others. Structural measures such as frequency of social contacts and functional indicators such as quality of social network and social support are central aspects of social network. Structural measures give emphasis to assessing person's social network and indexing the total number of linkage that a person has with the community (Macht, 2009).

Situational loneliness is a major factor for old people admitted in homes for the elderly. A very common result is the development of depression. The old people gradually became more pessimistic, less satisfied and less happy. This transient loneliness is caused by the environment and can be relieved through change (Gierveld & Raadschelders, 2002). For people who are both lonely and depressed, there is the coexistence of negative feelings, and negative judgment of personal attributes. However, unlike depression, loneliness comes with a hope that the person would be one day reunited with the person they long for (Raheel, Sheikh, Tabindah & Sahil, 2014). It’s also helpful to note that for elderly people with physical ailments and disabilities, loneliness is of a much higher scale than for those without.

In a study done by Bhartia (2009), found out that depression was higher for elderly people living alone than those with families or spouses. In as much as the homes for the elderly provide an environment where these people are able to interact and socialize, they still feel that they are in a way, secluded from society. Psychological well-being in older people is associated with demographic and other variables. According to Pinquart and Teubert (2010) self-rating of physical health is significantly correlated with subjective wellbeing. Women report higher levels of negative affect than men do. Married people typically describe themselves as happier than those who are not married and small but significant positive associations with educational level are found (Diener, Zhang, Yang, Guo & Lei, 2015).

A study done by Archana and Misra (2011) was led to explore the connections among loneliness, depression and friendliness in elderly individuals. The examination was done on 55 elderly individuals. The apparatuses utilized were Beck Depression Inventory, UCLA Loneliness Scale and Sociability Scale by Eysenck. Results uncovered a noteworthy connection between lonelines and depression. A large portion of the elderly individuals were observed to be normal in the measurement of amiability and favored staying occupied with social connections.

In Switzerland, Miguel (2012) directed an examination with the intend to look at the commonness of loneliness among grown-ups and furthermore to survey the relationship of loneliness with a few physical and psychological well-being and social elements, and also to evaluate the changing impact of sex and age. Information from twenty thousand members of the cross-sectional populace based Swiss Health Survey 2012 were broke down. Logistic regression analysis was utilized to survey relationship of loneliness with physical and psychological wellness or way of life attributes (e.g. diabetes, depression, physical action). Wald tests were utilized to test for collaborations. Results shown that

desolate people were all the more frequently influenced by physical and psychological wellness issues, for example, self-revealed endless sicknesses and weakened self-seen wellbeing. Depression was essentially connected with most way of life factors (e.g. smoking. The investigation inferred that forlornness is related with poorer physical and emotional wellness and unfortunate way of life, altered by age, however not by sex. The discoveries showed the significance of considering dejection for physical and emotional wellness and way of life factors, in more established and more youthful, as well as in moderately aged grown-ups.

Lim and Kua (2011) inspected the free and intuitive impacts of living alone and loneliness on depressive side effects (GDS score) and personal satisfaction in a forthcoming 2-year follow-up associate investigation of twenty eight thousand network staying more established grown-ups (matured ≥55 years) in Singapore, controlling for standard covariates. In cross-sectional examination,loneliness was a more vigorous indicator of GDS scores than living game plans; living alone, when controlled for loneliness, was not related with GDS score. GDS score related with living alone was more regrettable for the individuals who felt lonely than for the individuals who did not feel desolate. In this manner, however living alone anticipated lower mental prosperity, its prescient capacity was diminished when loneliness was considered and depression, a more grounded indicator, declined the psychological impacts of living alone.

Loneliness and isolation among older adults was an investigation done by Ring, Barry, Totzke and Bickmore, (2015). The resaerchers portrayed a conversational specialist based framework intended to give longitudinal social help to disengaged older adults. Results from an exploratory pilot ponder shown that when the specialist proactively draws older folks into associations, it is more successful at tending to loneliness than when the operator latently depends upon older persons to initiate interactions.

Yunus, Azam and Mahadir (2013) added to this territory of research in the work entitled Loneliness and depression among the elderly in a rural settlement. The point of the paper was to portray the job of social help in the relationship among loneliness and misery. This cross-sectional investigation inspected the interceding impacts of social help among one hundrend and sixty one network based elderly in agrarian settlement of a country region in Sungai Tengi, Malaysia. Subjects were examined with De Jong Gierveld Loneliness Scale, Geriatric Depression Scale and Medical Outcome Survey Social Support Survey. Information were broke down utilizing Pearson connection, straight and various leveled relapse. Results demonstrated that social help somewhat intervened the connection between loneliness and depression. This proposed that social help influences the direct relationship between loneliness and depression in the elderly. Ibrahimi (2014) on concentrate the theme impacts of loneliness on psychological wellness of elderly individuals, the job of the attendant, discovered that loneliness can be a noteworthy reason for perception decay, poor confidence, tension, sorrow, anxiety, rest issue, liquor misuse, self-destructive conduct, feeling vulnerability and danger, social withdrawal, feeling of vacancy, modesty, negative feelings, disabled personal satisfaction, inability, higher systolic pulse, more utilization of social and human services benefits and even mortality. Loneliness can have a bidirectional association with weakness and it can relate with some wellbeing issue to create new medical issues. Medical attendants can assist the elderlies with reducing the unsafe impacts of depression through instructing them and driving them to include in more social exercises and gathering works and furthermore improving their wellbeing.

Yuchun and Chang (2011) contemplated the effect of isolation and loneliness on elderly well being. A subjective methodology was connected in the examination and substance

investigation was attempted. Information examination started with checking on writing over and again to procure topics by featuring the exact substance meaning. Four topics were gained after the investigation procedure: isolation effect, loneliness effect, well-being concerning social isolation and loneliness, intervention and prevention. The fundamental consequences of the examination demonstrated associations between social disconnection and the elderly wellbeing, and in addition between loneliness and the elderly wellbeing. In that capacity, social seclusion and loneliness emerge from communication; appropriate intercession and counteractive action effectsly affect mitigating social isolation and loneliness and additionally improving wellbeing among the elderly.

2.3.2: Dependency and Well-Being of the Elderly

Dependence is a situation many people struggle with, especially those in advanced age. This emotional distress can lead to depression and hopelessness (Maryann, 2014). When elderly people become permanent and often dependent residents and need more help with every personal activity, loss of privacy is felt (Teeri, Leino-Kilpi & Välimäki, 2006). According to (Schultziner and Rabinovici, 2012), human dignity is defined as "quality or state of being honoured, worthy or esteemed". Therefore, dignity is a crucial part of self-worth and self-esteem.

According to research material used by Rodríguez-Prat, Albert, Andrew and Cristina (2016), dignity, in a way, was seen by the patient as their identity. Therefore, dependency and fragility were in a way, seen as a factor undermining the person's dignity. Loss of self-identity encompasses the loss of the self, loss of self-worth and loss of the value they place on their physical image. For elderly people living in institutions privacy is extremely important, and personal space (territory) is a key aspect to this issue. However, studies have identified lack of privacy due to dependency as one

of the major issues affecting residents living in nursing homes (Murphy, Gabor & James, 2007). Environmental mastery is a dimension of well-being and this includes ability of an individual to control vast external activities, competence in managing environment and is able to choose and or create context suitable to personal needs and values. Residents of nursing homes do not have, either control over what goes on in the environment that they live in or opportunity to choose what they want.

Studies by Calkins and Cassella, (2007) have identified lack of privacy resulting from shared rooms and other shared spaces as an important contributor to low quality of life and negative clinical outcomes among nursing home residents leading to low well-being in elderly residents. Residents mainly had little choice about the person with whom they shared a room. The shared rooms also disrupted resident's sleep as some residents had to be checked at night more often than others and the noise woke the roommates (Choi, Namkee & Wyllie, 2008). Some studies suggest that physical environment constrain resident choices, this especially concerns environment with poor facilities. Physical environment therefore has impact on well-being of the elderly residents because it has impact on the extent to which residents are able to have privacy and personal space. Personal space is about opportunities for a resident to personalise their space which means having personal belongings like furniture and pictures. For residents living in nursing homes there was little privacy and opportunity to personalise their spaces (Murphy et al., 2007).

Another dimension of privacy is that residents felt offended if a nurse intruded into their personal space, by touching or exposing them without consent. Studies have shown that such intrusions are associated with submission, such that 39 residents whose personal space is violated during care may consent without asking questions, feeling much like passive recipients of care (Teeri et al, 2006). Another issue related to living

in nursing home environment concerned residents who were cognitively intact, and living in nursing home with the majority of other residents who were severely cognitively impaired, residents who expressed socially inappropriate behaviour, and frequent incidents of death and grief. Deaths of residents continually forced them to not only feel a sense of grief and loss but also face their own mortality issues (Choi et al., 2008). Staff shortage and turnover was also another issue that affected residents of nursing homes, according to a study by Choi et al., (2008) some residents mentioned that because they were aware of staff shortage, they did not like to ask for help. Due to insufficient number of staffs, residents were frustrated because they had to wait for long periods for any assistance they requested for.

An accomplice investigation of the impacts of older adults care dependence upon family unit financial working, in Peru, Mexico and China was an examination done by Paminto and Jemin, (2013). Families were ordered from the development of the requirements for dependence of older persons, more than two past network studies, as 'episode care', 'unending consideration' or 'no consideration', and followed up three years after the fact to learn financial results (family unit pay, utilization, monetary strain, fulfillment with monetary conditions, human services use and inhabitants surrendering work or instruction to mind). Results uncovered that family unit wage did not vary between family unit gatherings. Be that as it may, wage from paid work and government moves were bring down in care family units. Utilization was 12% lower in perpetual consideration. Family human services consumption was higher and calamitous medicinal services spending more typical in care households. The investigation inferred that building maintainable long haul care frameworks for the future will require a blend of enhanced wage security in seniority; boost of casual consideration through remuneration for direct and opportunity expenses; and

improvement of network care administrations to help, and, where important, supplement or substitute the focal job of casual guardians.

Dijkstra, Andela, Korhan and Kornelia (2012) considered wellbeing related personal satisfaction and care dependence among elderly healing facility patients: a global examination. The point of the exploration was to research the connection between between health-related quality of life (HRQOL) and the consideration reliance status among elderly healing center patients. An unmistakable review was managed to an accommodation test of 325 elderly clinic patients (> 60 years) from the Netherlands, from Poland and from Turkey. The investigation utilized the Functional Assessment of Chronic Illness Therapy (FACIT) Measurement System and the Care Dependency Scale. FACIT is a gathering of HRQOL polls that evaluate multidimensional wellbeing status in individuals with different unending sicknesses. From statistic factors, sexual orientation, age and casual consideration given by relatives were essentially associated with the consideration reliance status for the entire examples. All HRQOL factors, listening device and length of sickness corresponded with consideration reliance status. In addition, the FACIT total score (Poland and Turkey) and practical prosperity (The Netherlands) were altogether connected with the lessening in consideration reliance status. Along these lines, the FACIT factors were the most ground-breaking pointers for consideration reliance. The examination gives human services experts knowledge into enhancement of quality of care in every one of the three nations.

The examination of Mwalinge (2015) investigated the commonness of dependency and related hazard factors in the elderly. An investigation with a transversal plan, of the overview type was employed. The examination test was of 352 elderly with information gathering led in their homes between the long stretches of June and September of 2014, utilizing the Katz Index poll and the Lawton and Brody Scale. The factual examination

demonstrated that the socio-statistic qualities and wellbeing were essentially connected with dependence, and there were a few levels of pervasiveness rates of dependence among the elderly. The examination reasoned that the pervasiveness of dependence distinguished among the elderly members was higher than that announced in comparative investigations and proposed that this dependence results from the impact of the socio-statistic qualities and wellbeing exhibited these elderly.

In an examination directed in Dagoretti Nairobi, Kenya 43.7% of the investigation populace had no independent source of livelihood. In any case, 80% of them were autonomous in performing exercises of day by day living (Waweru, 2002). The examination discovered that there was a critical relationship between the social help accessible and the wellbeing status of the elderly. An investigation completed by Help Age International in 2007 demonstrated that elderly individuals in creating nations including Kenya, recognized versatility as far as inadequacy and incapacity as one of the Key issues ailing in Public awareness and information. This is on the grounds that autonomy and self-care standards of elderly individuals are generally underestimated or over and over again obscure, overlooked or damaged by the vast majority (Help Age International [HAI], 2007). As people age, the going with crumbling in capacity and the limitation in execution of activities of daily living (ADLs) serve to diminish their feeling of control.

In a study done by Lin, Wu Hsiung and Kuo, (2004) looked at the useful autonomy measure among urban and rural occupants living in long haul care facilities in Taiwan. The subjects were met to acquire the essential information, and the Functional Independent measure score. The majority of the subjects in urban and long term care facilities were males, under 80 years of age, single or bereaved, having numerous illnesses, utilizing in excess of one help gadget, and having social welfare money

related help. The outcomes demonstrated that motor ability and cognition in rural areas care facilities were altogether higher than those in urban zones as appeared in the Functional Independent Measure appraisal. It was presumed that a portion of the utilitarian execution of subjects in rural areas with long term care facilities was superior to those in urban territories. This was a similar report between the inhabitant in a country home and those in urban regions. The examination does not anyway clarify why those in the country home had higher motor and cognition abilities as compared to those in an urban home.

A paper by Morgan and Turner (2012) audited and inspected the impacts of health values on the choices made by elderly dark ladies to utilize self-care strategies. Second, the result of self-care was estimated by evaluating homecare dependence inside this gathering. The examination was grounded in the healthicization or wellbeing advancement worldview, which prescribed way of life changes for beforehand biomedically characterized occasions. An example of dark ladies more than 70 years of age was taken from the National Health Interview Survey: Second Longitudinal Study on Aging dataset. Structural equation modelling was utilized to build up causality among the three noteworthy develops of the examination with the end goal to make inductions about the example population. The structural equation modelling discoveries uncovered that elderly dark ladies with positive self-values were more averse to rehearse customary self-care, while the individuals who polished self-care were more subject to homecare services. Self-care is a route for these ladies to state their freedom, which recommends that self-care ought to be supported yet never ordered by health authorities.

Old age dependency and household finance was an investigation completed by Yanan, Guariglia and Dickinson (2013). In light of the life-cycle model, the resaerchers thought about whether the impact of dependency is affected by the improvement of social welfare frameworks, money related markets and protection inclusion. The investigation utilized the yearly information somewhere in the range of 1995 and 2013. Discoveries gave observational proof to a negative impact of the old age dependence proportion on family reserve funds, which was bring down in regions with more created social welfare frameworks, money related advancement and protection contribution. Furthermore, urban zones additionally had a lower negative impact.

2.3.3: Inactivity and Well-Being of the Elderly

It is widely reported and documented that physical exercise is an effective moderator of age related cognitive decline. As noted by Dustman, Emmerson, Steinhaus, Shearer and Dustman (2012), over just a four-month period of physical aerobic activity, the group that performed aerobic training showed improved cardio-respiratory function, along with improvements on simple RT tasks when compared to the group that did not exercise.

In as much as our homes for old people strive to provide holistic living, it cannot be assumed that the resources are stretched thin and the current facilities need to be improved to accommodate more physical training programs for the residents. To add to the lack of expansive facilities, most of the residents are already going through the motions of old age, including significant cognitive decline as well as chronic physical pains (Wang, 2010.). It's also widely acknowledged that physical exercise is a known therapy for both physical and emotional health, as well as being known to improve cognitive function greatly. Without the structured physical exercise programs, it is very likely that most residents will experience cognitive decline much faster than it would

be anticipated. Add on to the other psychological factors mentioned above, depressive symptoms will definitely remain unchecked despite the many volunteer counselors helping out (Wang, 2010).

Group physical activities are well known to boost social connectivity amongst members of the particular group. In as much as social activities are regularly planned, structural physical activities can greatly help alleviate the emotional stressors and resultant psycho-somatic symptoms, a lot still needs to be done. An increase in physical trainers who are well trained, administrators who actually facilitate these programs and willingness of the residents in participation may be just a small step towards harnessing the great potential physical activities have in managing psychological wellness of the residents.

According to Mytton, Townsend, Rutter and Foster (2012), good levels of physical and mental functioning and general health status have long been associated with perceived well-being and morale. While functional decline is associated with increasing old age, Mitchell, Zhang, Yang, Guo and Lei (2013) are of the view that regular aerobic can increase the maximal aerobic power in women aged over 79, and strength training can improve muscle strength and physical functioning. Health behaviour can influence health status and new roles and activities can be started. But as, Wang (2010) argued, it is often difficult to begin to accumulate reserves in older age.

Physical activity involves all types of being dynamic including exercise, sport and the activities that are a piece of everyday life, for example, planting, washing cars and strolling. While aging definitely carries with it decrease in useful limit because of the physiological changes that happen in the aging body (Burbank & Riebe, 2002), interest in physical movement all the time is related with enhanced wellbeing. The

physiological changes influence the speed at which certain developments are made and the scope of development at the joints.

Regular physical action has been found to postpone the beginning of degenerative conditions and unending infections, for example, diabetes, heftiness, tumors, heart related ailments, osteoporosis, and joint inflammation and to lessen the danger of falls (Cerny & Burton, 2000). Moderate and energetic force physical exercises have medical advantages, particularly in decrease of a few endless infections. Customary physical movement ought to be advanced for the general wellbeing and prosperity of more seasoned grown-ups. This will advance their utilitarian capacity and autonomous living. Research demonstrates that the elderly associated with a physical action preparing or practice preparing program encounter a lower rate of falls contrasted with the individuals who are inactive.

Physical idleness is a key hazard factor for mortality, dismalness and decreased practical capacity among more established people (Alem, Sherrard & Gillen, 2000). Among the issues influencing more established grown-ups is the issue of being dormant which regularly influences their personal satisfaction and utilitarian autonomy. As per Whyte (2003), delayed physical idleness prompts bone delicacy, which is because of demineralization in the skeletal bone structure through quickened urinary discharge of calcium. Loss of calcium can prompt osteoporosis, the danger of which increments with age especially in ladies at post-menopause.

There is considerable logical proof that regular physical action is useful in fighting medical issues and illnesses (Bird, Butaumocho, Shepherd & Start, 2000). Particularly in older persons, physical action has been discovered useful in bringing down the danger of creating wellbeing related conditions like hypertension and enhancing the capacity and stay independent even with condititions like joint inflammation (De haan,

1999). Note that customary physical action supports the capacity of older adults to live effectively and freely.

In an investigation done in Bakateyamba home for the elderly in Kampala, a multi week PAP caused critical impact on the lower body quality, the walk quality, the diastolic circulatory strain and the pulse of the elderly. Changes were likewise noted in the movement examples of the elderly. Huge upgrades were noted in the rest designs and the wholesome issues were essentially progressed. Moreover, the recurrence of unending ailment assaults lessened fundamentally. The examination presumed that the multi week PAP was protected and viable in enhancing the useful autonomy and wellbeing of the elderly. A proposal was made to urge the elderly to include in satisfactory and regular types of physical movement and exercise somewhere around three days seven days for 30-50 minutes every day (Steve, Gaston & Lydi-Anne, 2012).

Analyzing physical inactivity among older persons aged 50 years in the United States was an examination done by White, Holman, Boehm, Peipins, Grossman and Henley (2014). Results demonstrated that older persons ≥50 years detailed no physical movement outside of work amid the previous month. Inertia pervasiveness fundamentally expanded with expanding age and was 25.4% among older persons 50–64 years, 26.9% among those aged 65– 74 years, and 35.3% among those age ≥75 years. Inactivity commonness was fundamentally higher among ladies than men, among Hispanics and non-Hispanic blacks than among non-Hispanic whites, and among the older persons who revealed regularly having at least one of seven chose interminable ailments than among those not announcing one. Inactivity commonness fundamentally expanded with diminishing levels of instruction and expanding weight file.

Concerning physical latency among older persons crosswise over Europe dependent on the SHARE database, was an investigation by Draken (2013). In this cross-sectional

investigation, the examination utilized information from members aged 55 or more established in Wave 4 of the Survey of Health, Aging, and Retirement in Europe (SHARE) database, a multidisciplinary and cross-national board database covering wellbeing, financial status, and social and family arranges. People incorporated into this investigation were delegated physically dynamic or physically dormant. Clinical, psychosocial and sociodemographic factors were assessed for their relationship with physical inertia. The general predominance of inactivity among people age 55 or more established in the 16 included countries was 12.5%. The commonness of physical idleness shifted between nations, running from 4.9% (Sweden) to 29% (Portugal). Expanding age, gloom, physical constraints, poor feeling of importance throughout everyday life, social help and memory misfortune were huge factors related with physical latency.

2.3.4: Interventions to Improve Well-Being of the Elderly

An intervention may include educational programs, new or stronger policies, improvements in the environment, or a health promotion. Interventions that include multiple strategies are typically the most effective in producing desired and lasting change, through influencing individuals' knowledge, attitudes, beliefs and skills.Vulnerable groups require social protection to protect their livelihoods and each of these groups require different forms of social protection ranging from Social transfers e.g. grants to the elderly and cash transfers; social services including home-based care, education, health insurance; Social transformations- i.e. broader policy and legislative changes to ensure rights of vulnerable groups. There is need of interventions in homes for the elderly. They can be psychotherapeutic, social, behavioural, management and human resource interventions. Two experimental social psychological interventions were introduced in a nursing home setting. One intervention consisted of

giving the elderly residents an enhanced sense of control over their environment, and the other provided the residents with incentives to remember information about certain aspects of nursing home life. The therapeutic changes that occurred were attributed to the increased cognitive activity brought about by the interventions that encouraged the residents to be mindfully, rather than mindlessly be involved with their surroundings (Beck, 2002).

In a research conducted in Minnesota (Grosh, 2016), it notes that in federal regulations, nursing home social work is not clinical in nature but it is important work that serves one of the most vulnerable populations in society. Though they may not be employed by nursing homes, clinical social workers and other mental health professionals who work with nursing home residents need to know the interventions that work best with the population they serve. Reminiscence therapy and CBT were found to be effective for addressing psychological wellbeing in nursing home residents. Furthermore, educating nursing home staff on how to recognize psychological disorders in residents was rated as a first step toward prevention and treatment of depression in residents, and thus ensuring their wellbeing.

Most developed countries have standards that every nursing home has to meet. They are centred on eight themes which include person-centred care and support, effective services, safe services, health and wellbeing, leadership, governance and management, use of resources, responsive workforce and lastly use of information (Health Information and Quality Authority [HIQA], 2016). Human-rights based approach, frequent family or volunteers' visit, religion and spirituality are highly encouraged. Interaction with staff where they are treated with respect and given the freedom of choice, privacy among others will contribute further to the quality of life for the older people.

Here in Kenya, The National policy for older Persons and the ageing was enacted in Parliament in February 2009. It was reviewed and aligned to the new constitution in January 2014. The policy provides a comprehensive framework to address the unique challenges that older persons in Kenya face, and recognition of their rights, as distinct right holders and participants as per Article 57 of the Constitution. The policy provides a coordinated and harmonized mechanism for implementation of outlined interventions by the older persons and stakeholders. Some of the key principles include: Human dignity, equity and social justice, inclusiveness, equality, human rights social protection and public participation. These provide a framework in which homes for elderly people, either by state or society, should be based on.

As noted from the above discussion, different psychosocial factors affect the wellness of residents living in homes for the elderly in unique ways. Different methods of interventions should therefore be applied with the aim of improving the wellness of the individuals placed in these homes for the aged. Relatives and friends need to be encouraged to visit frequently and also be educated about the emotional needs of their loved one. Regular interaction with the outside world (e.g. organized trips, agricultural shows, shopping and leisure walks) may reduce the feeling of isolation. Flexibility in these homes allows residents to make choices thus developing independence, dignity and self- respect. They should be encouraged to carry out basic functional duties as per their capability, in order to raise their confidence. Physical exercises should be properly organised such that, all residents are encouraged to participate. They may be given an opportunity to participate in meaningful activities (e.g. gardening, cooking, washing or any other as per requirement of the home).

Many of the residents in the homes will have feelings of rejection, anger and even aggression. Others may experience loss and grief of their spouses and peers and also

fear of their own death. Psychological disorders such as anxiety, dementia and depression will obviously be common among these aged people. To help on these emotional distresses, counselling therapy will be highly required. Cognitive behavioural therapy may be best suited, so as to help them work on their beliefs, attitudes and behaviours as they live in these homes. By also integrating other counselling theories (humanistic theories), the elderly persons who maybe feeling unfulfilled and in despair, can be helped deal with their unresolved issues and move to ego integrity, thus finding satisfaction in life (Alem et al., 2000).

2.4: Conceptual Framework

A conceptual framework is a research tool which is used to help a researcher develop a better understanding of the variables under investigation (Mugenda & Mugenda, 2003) which depicts the relationship between the variables in the study. The dependent variable for the study is the wellbeing of the elderly in homes which is likely to be affected by the independent variables which include loneliness factors, dependency factors and inactivity factors. Life expectancy is the intervening variable. Life expectancy is a statistical measure of the average time an organism is expected to live, based on the year of their birth, their current age and other demographic factors.

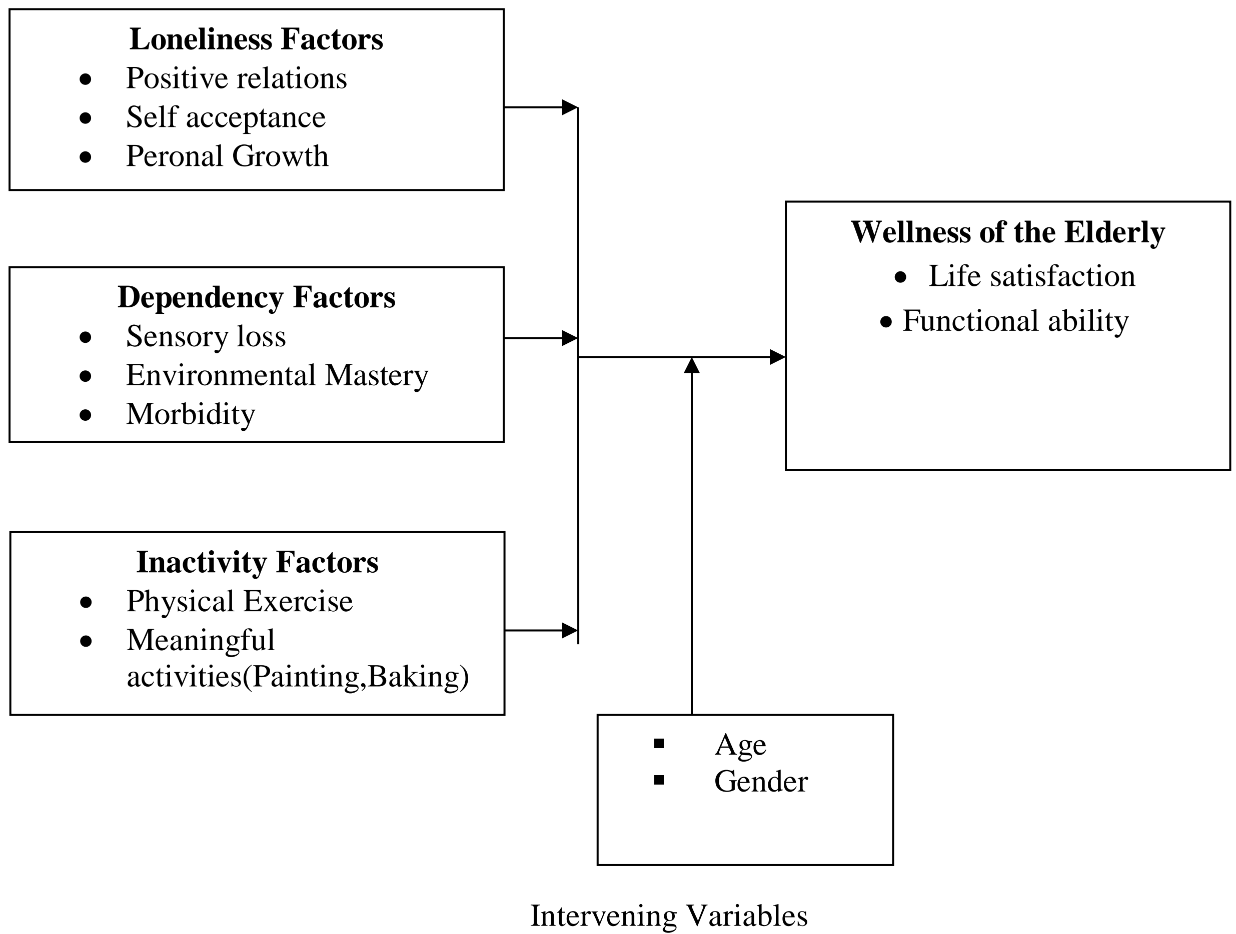

Figure 2. 1: Conceptual Framework

Selected Psychosocial Factors Affecting Wellness of the Elderly in Nairobi County.

Source; (Author, 2019).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1: Introduction

This chapter presents the methodology used in this study. It includes research design, target population, sampling techniques and sample size, data collection instruments, validity and reliability of the instruments, data analysis techniques and ethical.

3.2: Research Design

The study used descriptive survey research design. This type of design is appropriate for gathering information, summarizing, presenting and interpreting it for the purpose of clarification (Orodho & Njeru 2004). According to Orodho (2005), descriptive survey research design can generate accurate information for large number of people over a wide area using a small sample. It is used to explore relationships between variables and allows generalizations across populations. Since this study seeks to obtain descriptive and self-reported information on how certain pschosocial factors affect wellness of the elderly, the descriptive research design enabled the researcher to expose the respondents to a set of standardized questions to allow comparison.

3.3: Target Population

Nachmias and Nachmias (2008) define a population as all cases of individuals or things or elements that fit a researcher's specification. According to Mugenda and Mugenda (2003), a target population consists of all members of a real or a hypothetical set of people to which the researcher wishes to generalize the results of the study. The target population of the study was all the elderly individuals in the homes for the elderly in Nairobi County. There are five homes for the elderly in Nairobi which include; Little

sisters of the poor (Nyumba ya Wazee) Kasarani, Kariobangi Cheshire Home, Mother Teresa-Huruma, Nyumba ya wazee Ruaraka and Mji wa Huruma-Runda.

Table 3.1: Target Population

Name of Institution	Target Population
Little sisters of the poor, Kasarani	70
Kariobangi Cheshire Home	60
Mother Teresa, Huruma	105
Nyumba ya wazee Ruaraka	38
Mji wa Huruma, Runda	134
Total	**407**

Source: (Nairobi County Government Ministry of Social Services, 2017).

3.4: Sampling Procedure

A sample is a smaller group or sub-group obtained from the accessible population (Mugenda & Mugenda 2003). This subgroup is carefully selected so as to be representative of the whole population with the relevant characteristics. Sampling is a procedure, process or technique of choosing a sub-group from a population to participate in the study. It is the process of selecting a number of individuals for a study in such a way that the individuals selected represent the large group from which they are selected. The study used stratified sampling technique where by the respondents were grouped into different homes for the elderly in Nairobi. According to Mugenda and Mugenda (2003), 30% of the target population is considered reliable for the study. Therefore the number of the respondents were 122 elderly as shown in Table 3.2:

Table 3.2: Sample size

Name of Institution	Population Size	Sample size (30% N)
Little sisters of the poor, Kasarani	70	21
Kariobangi Cheshire Home	60	18
Mother Teresa, Huruma	105	32
Nyumba ya wazee Ruaraka	38	11
Mji wa Huruma-Runda	134	40
Total	**407**	**122**

Source: Researcher (2019)

Purposive sampling was used to pick the caregivers and management staff that participated in the interview. Eighteen of a Focus group discussion were purposively sampled from the elderly residents of the home comprising of both men and women while Fifteen (15) participants were selected and used for interview.

3.5: Research Instruments

The following research instruments were used to collect data in the study:

3.5.1: Questionnaires

A questionnaire is a list of questions about a particular research topic of interest arranged in some order so as to elicit responses from a respondent**.** It represents an even stimulus potentiality to large numbers of people simultaneously and provides the investigation with an easy accumulation of data. According to Orodho (2009) a questionnaire is a suitable tool for data collection because, it has the ability to collect a large amount of information in a reasonably quick space of time and respondents 'anonymity ensures that they give honest answers. Moreover, since questions are standardized all respondents get the same questions. The questionnaire had different questions aimed at establishing the influence of loneliness, dependency and inactivity on the wellness of the elderly admitted in the homes for the elderly.

3.5.2: Interview Schedule

Interviewing involves oral questioning of respondents, either individually or as a group. The aim is to gain an in-depth understanding of the underlying reasons and motivations for people's attitudes, preferences or behaviour (Hammersley, 1992). The researcher used an interview guide to conduct interview targeting the management, and care-givers in the homes. Data obtained helped to validate responses given by the elderly individuals in the questionnaires.

3.5.3: Focus Group Discussion

A focus group discussion was formed comprising of 18 elderly residents who were purposively sampled from the men and women members of the home. The focus group discussion helped get more information about the influence of the selected psycho social factors (loneliness, dependence, inactivity) on the wellness of the elderly in the homes for the aged. The responses were recorded to ensure that all of the data was captured for later transcription and analysis.

3.5.4: Validity and reliability of instruments

Validity and reliability data instruments where be as certained; Validity is the degree the research instruments measure the variables they were intended to measure (Kothari, 2004). Content and face validity of the instruments were determined before deployment. Both face and content validity are non-statistical methods used to validate the content employed in the research instrument (Orodho, 2012). Content validity refers to the representativeness of the items on the instrument as they relate with content being measured, whereas face validity is the appeal and appearance of the instrument. To check on the validity of the instruments the questionnaires, and interview guides drawn as per the study objectives was presented to the research supervisors in Kenya

Methodist University who scrutinized and adviced on them. Simple language was used in the research instrument in order to ensure that the respondents fully understand the content. The researcher constructed an interviewer's guide and tested for content validity.

Reliability of research instruments is the extent to which results are consistent over time and are an accurate representation of the population under study (Brooker & Joppe, 2014). It is a measure of the degree to which a research instrument yields consistent results or data after repeated trials. The researcher used the internal consistency method to check the reliability of the research instruments. This was done by calculating the Cronbach's alpha coefficient for all the sections of the questionnaire from the results of the pilot study which were obtained from Kivumbini Home of the elederly in Nakuru. The study established a Cronbach Coefficient instrument reliability $\alpha = 0.812$ which was deemed admissible for the study. A value of 0.7 or below of the Cronbach's alpha coefficient is generally taken to show low internal consistency, hence, requiring rephrasing or deletion and replacement from the instrument. Hence, shortcomings or clarity issues that were found in the questions at this stage were duly corrected, modified or replaced as necessary. The results of the reliability analysis were as in Table 3.3.

Table 3.3: Reliability Statistics

Variabale	Cronbach's Alpha	N of Items
Elderly loniless	0.71	4
Elderly dependency	0.73	3
Elderly inactivity	0.75	2

Source: (Researcher, 2019)

3.6: Methods of Data Collection

Data was collected using structured questionnaires and FGDs that were administered under supervision to the aged. The questionnaire was administered by the researcher. The researcher explained to the respondents the purpose of the study to enhance adequate response. The elderly filled in the questionnaires in the presence of the researcher for clarifications where needed. The researcher also facilitated the focus group discussion in order to pick the non-verbal cues. The interview schedules were conducted by the researcher and the participants were management staff and the care-takers in each of the five homes.

3.7: Method of Data Analsysis

Data analysis is the process of looking at, analyzing and summarizing data with the intent to extract useful information and develop reliable conclusions. Data obtained from the questionnaires were first cleaned and edited before being coded and subjected to further analysis. The Likert scales in closed ended questions in the questionnaires were converted to numerical codes and be scored on 1-5point scale in order of magnitude of the construct being measured, then was entered into the Statistical Package for Social Sciences (SPSS) version 23.0 computer program. The data was analyzed using both descriptive and inferential statistical methods. Descriptive analysis was done using frequency count and percentage to describe the basic characteristics of the population. Inferential statistics involved the use of Pearson’s Product Moment correlation and multiple regression models to determine the nature of the relationship between the variables. Qualitative information collected from the focus group discussions and interviews were analysed thematically and presented in a narrative form.

The multiple regression model used in this study were assumed to hold under the equation;

$$y_{ij} = b_0 + b_1x_1 + b_2x_2 + b_3x_3 + e$$

Where;
y = Wellness of the Elderly
b_0 = Constant
x_1 = Loneliness
x_2 = Dependency
x_3 = Inactivity
b_1 to b_3, are the coefficients of the variables determine by the model
e = the estimated error with zero mean and a constant variance

The results were then presented in APA tables.

3.8: Ethical Considerations

Before collecting data, the researcher got a clearance letter issued from ethical review board of Kenya Methodist University and a research permit from the National Commission for Science, Technology and Innovation (NACOSTI). Adherence to the principle of voluntary and informed consent to participate in this study was highly esteemed and upheld throughout the research. Voluntary participation by the respondent was applied in a bid to protect their rights. All respondents were assured of their confidentiality by the researcher explaining and making clear the purpose of the study being solely and purely academic, and that all information given would be treated with uttermost respect. Consequently, all respondents were expected to fill the questionnaires without use of any identification details whatsoever to maintain anonymity. Cultural values were considered and observed with respect since the homes have a variety of cultures from diverse ethnic groups. Equally religious values were given utmost respect because the homes have a mixture of different religions.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1: Introduction

This chapter presents the data analysis results and discussions. The chapter contains the results and discussions on the background characteristics of the respondents and the study variables namely; loneliness, dependency, inactivity, interventions that can improve the wellness of the elderly and wellness of the elederly admitted at homes for the elderly. The objectives of the study were to :

i. Determine the influence of loneliness on the wellness of the elderly admitted in homes for the elderly in Nairobi County;
ii. Investigate the influence of dependency on the wellness of the elderly admitted in homes for the elderly in Nairobi County;
iii. Establish the influence of inactivity on the wellness of the elderly admitted in homes for the elderly in Nairobi County.
iv. Explore the interventions that can improve the wellness of the elderly admitted in homes for the elderly in Nairobi County.

4.1.1: Questionnaire Response Rate

The response rate for the respondent is given in Table 4.4.

Table 4.4: Response Rate

Instruments issued	Instruments returned	Percentage response (%)
122	92	75.4

One hundred and twenty two questionnaires were administered to the respondents and ninety two were duly filled and useable for the study purposed. This represented 75.4% response rate and was acceptable for the study. According to Mugenda and Mugenda (2003), a response rate of over 50% is considered acceptable.

4.2: Demographic Findings of Study

The study initially sought to inquire information on various aspects of the respondents' background that is age, education level, member duration, who brought the member, life time in the home, and quality of life.

4.2.1: Age of the Respondents

The study sought to establish the age of the respondents. The age of respondents was crucial as it may help to point to some of the psychosocial factors affecting the elderly as some may be age specific. The findings on age were as in Table 4.5.

Table 4.5: Age of Respondents

Age of respondent	Frequency	Percent
60-69 years	5	5
70-79 years	23	25
80-89 years	57	62
Above 90 years	7	8
Total	**92**	**100**

The findings in Table 4.5 indicate that majority of elderly 62% in elderly homes were aged between 80-89 years. Twenty five percent (25%) of the respondents were aged between 70-79 years. This signifies the elderly at the homes were at an advanced age where their next of kin may have moved on with their families and as a result left isolated and lonely. Age may influence the wellness of the elderly in that when one grows older he/she find its difficlult to participate in various activities and exercises, thefore dimensions of wellness could be keys to a longer life.

4.2.2: Duration of Stay at Home

The study sought to know the duration the respondents had stayed in the homes for the elderly. Table 4.7 shows the duartion the respondents had stayed in the homes.

Table 4.7: Duration stayed in elderly home

Duration	Frequency	Percent
Less than 5 yrs	48	52
5-10 Years	36	39
10-20 Years	8	9
Total	**92**	**100**

The findings in Table 4.7 indicate that majority of the respondents (52%) had stayed in the homes for elderly for less than 5 years. The findings also revealed that (39%) had stayed in the homes for 5-10 years.There were 8 elderly individuals (9%) who had stayed in the homes for more that 10 years. Most of the elderly are expected to come in the homes with different health conditions which worsens with age. Others may have been more distressed in the homes than where they had come from and therefore left within a short period of stay. When this elderly persons stay at the homes for the elderly for long, they do really feel lonely and miss their lovely ones. This concurs with the study by Bhuvar, (2014) who stated that loneliness is a psychological distress brought about by lack of close friends, a reliable support system and connection with the general population. And, this distress has far reaching consequences on the individual psychologically. Social interaction is as necessary as food for human folk.

4.2.3: Who brought the residents to the Home

The study was also intreseted in finding out who brought the elderly to the homes.Table 4.8 shows the repsonses from the respndents.

Table 4.8: Who brought you to this home?

	Frequency	Percent
Relatives	52	57
Self	5	5
Hospital staffs	12	13
Neighbors	14	15
Local chief / Government rep	9	10
Total	**92**	**100**

The findings in Table 4.8 indicate that majority of the people who brought the elderly to the homes were relatives who could not afford to take care of them. A few others were brought in by neighbours (15%), hospital staff (13%) and government representatives (10%) of the total number of the residents. As shared in the FGD, most of the elderly did not opt to go to the homes but their children and relatives decided they should go there. This is reflected in the verbatim:

> "Initially it was not my wish to come here however, my children seeing that my health had deteriorated and there was no one to take care of me from home they decided to bring me here. I can comfortably say that people around this place gave me proper care and medications whenever I feel sick."

The study sought to know whether the respondents were planning to stay in the homes for lifetime. The responses were as in Table 4.9:

Table 4.9: Whether respondent was planning to stay in the home for lifetime

Response	Frequency	Percent
Yes	57	62
Undecided	14	15
No	21	23
Total	**92**	**100**

The finding in Table 4.9 shows that majority (62%) of the elderly wished to spend their lifetime at the homes for the elderly (Nyumba ya Wazee) while a small number(23%)

hoped to leave the home sometime, with 15% of the members being undecided. This indicates that the elderly would rather spend their entire life at the home, than return to their previous homestead where they may have been abandoned or neglected. This implied that majority of the elderly felt a sense of belonging in the homes and had settled to stay. This is likely to raise their self esteem and as a result improve their wellness.

Finally the study was intrested in knowing the qulality of life at the homes of eldery. Table 4.10 shows the responses from the repsondents on quality of life in the homes.

Table 4.10: Quality of life in home for the elderly

Response	Frequency	Valid Percent
Very good	12	13
Good	38	41
Moderate	16	18
Bad	26	28
Total	**92**	**100.0**

Majority 54% of the elderly indicated they were having a good quality of life. Those who felt that their quality of life at the homes of the eldely was moderate comprised 18% of the total respondents. There was a small but significant number (28%) who felt had a bad time at the homes. This indicates that the quality of life at the homes was great even though its was not perfect. This elderly prefered staying in the homes than going back where they had come from.

This was also supported by the observations made at the FGD, where most residents appeared relaxed and at times shared jokes, as they discussed their day to day activities at the home. A few however talked of their old good days when they were younger and in total control of their life. Enjoying good quality of life may make them happier and

thus improve their wellness. This study agree with the findings of Archana and Misra (2011) who found out that good quality of life makes a person free from diseases and helps improvement in his or her wellness.

4.3: Wellness of the Elderly

The study also sought to determine the wellness of the elderly admitted in homes for the elderly in Nairobi County. This was the dependent variable and was measured by asking the respondents to respond to various statements describing the level of wellness. A 5 point Likert scale ranging from; 1 = strongly agree to 5 = strongly disagree was used to measure the responses to the statements posed. These results are presented in Table 4.11:

Table 4.11: Wellness of the Elderly

Statement	SA F(%)	A F(%)	N.S F(%)	D F(%)	SD F(%)
There is satisfactory feeling of connection with people around me	0(0)	39(42)	0(0)	29(32)	24(26)
There is improved feeling of self esteem	14(15)	44(48)	0(0)	20(22)	14(15)
I need less or no help to carry out routine personal activities e.g bathing	22(24)	42(45)	0(0)	19(21)	9(10)
I rarely laugh since I came to this home	0(0)	0(0)	0(0)	78(85)	14(15)
Frequent involvement in physical exercises has greatly enhance physical wellbeing	30(32)	42(46)	0(0)	20(22)	0(0)
I am more active than when I was at home and it makes me feel good.	(29)	(43)	0(0)	(22)	(6)

N=92

The results in Table 4.15 suggest respondents (42%) were satisfied feeling of connection with people around them. The findings, further indicate that the elderly in homes of the elderly felt an improvement in feeling of self esteem (48%). Majority of the elderly (69%) strongly agreed and agreed that they needed less or no help to carry out routine personal activities e.g bathing. Most respondents were against the

view that they rarely laugh since they came to this home for the elderly (85%). Other findings also indicate that majority of the respondents agreed and strongly agreed (78%) that frequent involvement in physical exercises has greatly enhanced theri physical wellbeing. It was also observed that majority of the elderly were more active than when they were at home and it made them feel good. In summary, these findings imply that majority of the elderly in the homes of the elderly were doing quiet well in these homes as compared to when they were back at home, even though sometimes they felt they were missing some of their relatives.

In addition to the above findings, through Focused Group Discussions (FGD), it was found out that disability, illness and poverty, isolation were the main reasons as to why the elderly were taken to the homes. The study established that the aging has social, economic and physiological needs which they are unable to meet on their own unless through outside intervention.

When the researcher sought to know the level of residents' satisfaction with the services rendered in the homes in an effort to meet their needs, majority of the FGD participants agreed that they were satisfied, though there were few challenges that faced both the elderly persons and administration. Such challenges were, pain of losing their friends, ageism, chronic illness, disability, freedom of choice, lack of decision rights, and difficulties in adjusting to life in the home for the elderly. They also expressed that they felt better when they talked to someone(counsellor) about their issues. The homes administration challenges included getting and admitting genuine elderly person and lack of enough finances. The manager of the home expressed this particular challenge:

> "It's not easy to know who is in genuine need of our services, and so we have to involve administration from the government (e.g chiefs) and also visit their homes and meet

> close relatives if available. These movements, together with other related activities requires money which is not usually enough".

Most of the care givers enjoyed their work, though some of them felt that it was a sensitive job since the elderly are generally delicate to handle. One young care giver said:

> Its quite interesting to talk to the elderly as they remind me of my grandparent but at times it gets so exhausting that I have to take afew days off

Most of the elderly FGD participants felt that their wellness had greatly improved and enjoyed being with those of same age and thus sharing similar challenges and interests. However, a few viewed the home as a hospital which made them doubt their health status and thus worry at times. The physically stronger members expressed at the FGD that they felt underutilized and idle causing them frustrations. The study established that though counselling took place, it was not frequent and was often done by non-professionals. One of the care givers explained:

> "Once in a while, we get a counsellor from outside to help with their issues if needed. This usually happens when there is loss and they are helped to grief. Other common issues are simply dealt with by us".

This concurs wang (2010) who acknowledged that physical exercise is a known therapy for both physical and emotional health, as well as being known to improve cognitive function greatly. Without the structured physical exercise programs, it is very likely that most residents will experience cognitive decline much faster than it would be anticipated. Add on to the other psychological factors mentioned above, depressive symptoms will remain unchecked despite the many volunteer counselors helping out

4.4: Influence of Loneliness on Wellness of the Elderly

The first objective of the study was to establish the influence of loneliness on the wellness of the eldely admitted in homes for the eldely in Nairobi County. The responses were rated on a 5 point Likert scale ranging from; 1 = Strongly Disagree (SD) to 5 = Strongly Agree (SA). The results were as summarized in Table 4.12:

Table 4.12: Influence of Loneliness on the Wellness of the Elderly

Statements	SA F(%)	A F(%)	N.S F(%)	D F(%)	SD F(%)
Safety and security in this home is assured and this has enhanced my wellbeing.	30(32.9)	46(50)	16(17.1)	0(0)	0(0)
I fall sick more often than when I lived at home.	0(0)	18(19.7)	24(26.3)	24(26.3)	26(27.6)
I am happy living here.	26(28.9)	46(50)	0(0)	10(10.5)	10(10.5)
I enjoy the company of people in this home.	13(14.5)	35(38.2)	10(10.5)	34(36.8)	0(0)
I miss my friends and relatives most of the time.	26(27.6)	35(38.2)	13(14.5)	18(19.7)	0(0)
I am bored most of the time.	0(0)	37(40.8)	10(10.5)	33(35.5)	12(13.2)

N=92

Majority of the respondents (82.9%) agreed that they enjoyed safety and security of homes. When the respondents were asked if they fell sick more often than when they lived at home, 53.9% disagreed and strongly disagreed to the statement. When asked whether they were happy living there, majority of the respondents (78.9%) agreed. However, the elderly did not really enjoy the company of the people in the home (52.7%), these were the respondents who agreed and strongly agreed. Majority of the elderly (65.8%) agreed that they miss their friends and relatives most of the time.

At the FGD, one elderly woman emotionally expressed how she missed her loved ones:

> "At times I miss to see my children and grandchildren. They mean a lot to me. But at least they make effort and at times they come to see me here once in a while. How i miss cooking mukimo for them as I used to do. I wonder why some of them don't bother at all to see me. That really make me sad."

Finally, most of the elderly people 40.8% agreed that they felt bored while 10.5 % were not sure. This indicates that safety was key to increasing the elderly wellness additionally the elderly did not fall sick more often. It's also evident that most of the elderly people loved to live at the home even though they missed their relatives and friends at home. At the home the elderly are guaranteed food, safety and decent shelter. This concurs with Bhuvar (2014) who stated that distress has far reaching consequences on the individual psychologically. Social interaction is as necessary as food for human folk. It is well known that without social interaction, we fall apart mentally and these effects may manifest physically. This concurs with Pinquart and Teubert (2010) study which stated that self-rating of physical health is significantly correlated with subjective wellbeing. Despite being provided with the basic needs, the elderly needs and thus miss the genuine love and warmth from their loved ones. Caregivers ascertained that most of the elders felt lonely as they were used to seeing their family. They added that they talk to them and make them feel comfortable:

> "At times these elderly feel so lonely to a point they ask us to take them back to their families but we try to comfort them and encourage their families to visit them more frequently"

4.4.1: Relationship between Loneliness and Wellness of the Ederly

The study further tested the hypothesis on whether there was a significant relationship between loneliness and wellness of individuals admitted in homes for the elderly. Correlation test analysis between the dependent variable (wellness of the eledrly) and elderly loneliness was used. The results were as presented in Table 4.13:

Table 4.13: Hypothesis testing on relationship between loneliness and wellness

		Loneliness
Wellness	Pearson Correlation	0.264
	Sig. (2-tailed)	**0.04
	N	92

Correlation is significant at 0.05 level (2-tailed).

After testing the hypothesis, the results showed there is a positive correlation between loneliness and elderly wellness (r = 0.264, p = 0.04). Elderly loneliness influences their wellness. However, the positive correlation was weak at 0.264. Therefore, the study rejected the null hypothesis that there is no relationship between loneliness and wellness of individuals admitted in homes for the elderly in Nairobi County and accepted that there is a relationship between loneliness and elderly wellness. This implied that when the elderly admitted in the homes of the elderly feel lonely, their wellness is negatively impacted. This finding agree with those of Miguel (2012) who conducted the study in Switzerland and found out that desolate people were all the more frequently influenced by physical and psychological wellness issues, for example, self-revealed endless sicknesses and weakened self-seen wellbeing. The findings concurs with Psycho-social Theory of development in such that different personality traits that can be considered positive or negative. The findings shows that there is no significant relationship between loneliness and wellness of the elderly admitted in homes for the elderly in Nairobi County at 0.04 significance level.

4.5: Influence of Dependency on the Wellness of the Elderly

The second objective of the study was to investigate the influence of dependency on the wellness of the elderly admitted in homes of the elderly in Nairobi County. The responses were rated on a 5 point Likert scale ranging from; 1 = strongly disagree (SD) to 5 = strongly agree (SD). The results are summarized in Table 4.14:

Table 4.14: Influence of Dependency on Wellness of the Elderly

Statements	SA F(%)	A F(%)	N.S F(%)	D F(%)	SD F(%)
I am totally in charge of my personal cleanliness (showering, dressing etc) without assistance.	28(30.3)	22(23.7)	0(0)	42(46.1)	0(0)
I always wash clothes on my own and I enjoy it.	0(0)	30(32.9)	0(0)	37(39.5)	25(27.6)
I am able to move around without being supported.	34(36.8)	21(22.4)	0(0)	37(40.8)	0(0)
I make my own decisions, which keeps me happy.	44(47.4)	48(52.6)	0(0)	0(0)	0(0)
I do different activities that help me feel strong.	47(51.3)	18(19.7)	0(0)	27(28.9)	0(0)
I feel comfortable when care takers do everything for me.	16(17.1)	29(31.6)	0(0)	47(51.3)	0(0)
I am able to share my opinions about this home with the manager which makes me feel good.	16(17.1)	64(69.7)	12(13.2)	0(0)	0(0)

N=92

Concerning influence of dependency on wellness of the elderly a slight majority (54 % agreed that they were totally in-charge of their personal cleanliness without assistance. Majority (68.1%) of the elderly disagreed that they always wash clothes on their own. Additionally, majority (59.2%) agreed that they were able to move around without being supported. Majority (52.6%) agreed they make their own decisions, which keeps them happy. Moreover, majority (71%) of the elderly agreed they do different activities. A slight majority (51.3%) disagreed that they feel comfortable when care takers do everything for them, while majority (69.7%) of the elderly agreed that they were able to share their opinions about the home with the manager. This indicates that the elderly is not entirely dependent on the home staff since they were in-charge of their personal cleanliness without assistance. Also, most indicated that they were able to move around without being supported. Moreover, they were able to do different activities that made them feel strong. The same was noted at the Focus Group Discussion (FGD), where

most members expressed feeling uncomfortable when care takers did everything for them:

> "I would love to do all work by myself but since I'm old can't do a lot. We rely on these caregivers to wash our clothes and do some other work that we can't manage to do on our own. They cook for us, wash clothes for us and also at times when it's difficult to get outside they assist us. Strange that just a few years ago, I could travel long distances by myself."

However, a few of the challenged ones relied on the home staff for support, e.g., bathing and washing clothes. It also indicates that the management encouraged the elderly to share their opinions. This means that the elderly loved to take charge of their lives but appreciate assistance necessary.

This is in line with (Maryann, 2014) who stated that dependence is a situation many people struggle with, especially those in advanced age. This could cause emotional distress that can lead to depression and hopelessness. Additionally, Teeri et al, (2006) argue that when elderly people become permanent and often dependent residents and need more help with every personal activity, loss of privacy is felt. According to (Schultziner and Rabinovici, 2012), human dignity is defined as "quality or state of being honoured, worthy or esteemed". Therefore, dignity is a crucial part of self-worth and self-esteem.

4.5.1: Relationship between dependency and wellness

The study further tested the hypothesis that stated that there is no relationship between dependency and wellness of individuals admitted in homes for the elderly. Correlation test analysis between the dependent variable (wellness of the eledrly) and dependency was used. The results were as presented in Table 4.15:

Table 4.15: Relationship between dependency and wellness of the elderly

		Dependency
Wellness	Pearson Correlation	0.73
	Sig. (2-tailed)	**0.045
	N	92

Correlation is significant at the 0.05 level (2-tailed).

The findings show a strong positive correlation of 0.73 at 0.045 level of significance between elderly wellness and their dependency. The study concluded that the dependency level has a high impact on wellness of the elderly. Therefore, the null hypothesis was rejected meaning there is a significant relationship between dependency and wellness of the elderly. This is in line with a study that was done by (Rodríguez-Prat et al, 2016) which saw dignity, in a way, seen by the patient as their identity. Therefore, dependency and fragility were in a way, seen as a factor undermining the person's dignity. Loss of self-identity encompasses the loss of the self, loss of self-worth and loss of the value they place on their physical image.The findings concurs with Maslow's hierarchy Theory of needs in such that wellbeing of elderly will depend on how they experience love and belonging and level of self- esteem while in these homes. The findings shows that there is no significant relationship between dependency and wellness of the elderly admitted in homes for the elderly in Nairobi County at 0.045 significance level.

4.6: Influence of Inactivity on the Wellness of the Elderly

The third objective of the study was to establish the influence of inactivity on the wellness of the elderly admitted in homes for the elderly in Nairobi County. The responses were rated on a 5 point Likert scale ranging from; 1 = strongly disagree (SD) to 5 = strongly agree (SD). The results are summarized in Table 4.16:

Table 4.16: Influence of Inactivity on the Wellness of the Elderly

Statements	SA F(%)	A F(%)	N.S F(%)	D F(%)	SD F(%)
I have social or leisure activities/hobbies that I enjoy doing.	10(10.5)	52(56.6)	0(0)	30(32.9)	0(0)
If my health limits social/ leisure activities, then I will compensate and find something else I can do.	8(9.2)	58(63.2)	0(0)	26(27.6)	0(0)
I easily get bored so I always look for something to do.	0(0)	30(32.9)	0(0)	62(67.1)	0(0)
There more activities here for me than where I came from.	18(19.7)	24(26.3)	23(25.0)	27(28.9)	0(0)
I sleep most of the day time unlike when I lived at my home.	12(13.2)	38(40.8)	0(0)	42(46.1)	0(0)
Games and sports are meant for children, not adults.	10(10.5)	45(48.7)	0(0)	14(15.8)	23(25.0)
Cultural/religious events/festivals are important to my quality of life and am usually involved.	21(22.4)	61(65.8)	2(2.6)	6(6.6)	2(2.6)
I actively participate in physical exercise (such as games and sports).	14(15.8)	22(23.7)	0(0)	39(42.1)	17(18.4)
I am engaged in meaningful activities (such as knitting, painting or baking).	8(9.2)	29(31.6)	0(0)	32(34.2)	23(25.0)

N=92

Majority of the respondents (56.6%) agreed that they had social or leisure activities/hobbies that they enjoyed doing. Also, majority of the respondent (63.2%) of the elderly agreed that if their health limits social/ leisure activities, then they will compensate and find something else to do. Moreover, majority (67.1%) of the elderly disagreed they always get bored easily. Further, most (54%) of the elderly slept most of the day unlike when they were at their home. Majority of the respondents (51.3%) felt that games and sports are meant for children, not adults. Hence majority (60.5%) did not actively participate in physical exercise (such as games and sports). Additionally, majority (59.2%) were not actively engaged in meaningful activities (such as knitting, painting or baking). But majority (65.8%) believed cultural/religious events/festivals are important to the quality of life hence participated in them. This

indicates majority of the elderly were not involved in sporting activities or in productive activities like knitting, painting or baking since their age was advanced and mobility was a problem. Also, some could be harboring sickness limiting their involvement. It also indicates cultural events/ religious and events/festivals resonates with a lot of the elderly since it gives them a sense of belonging, prayer and enjoyment. This means that activities like being productive or participating in sporting activities did not contribute to their wellness. But rather participating in cultural events/ religious events/festivals improved their wellness and happiness.

4.6.1: Relationship between inactivity and wellness

The study further tested the hypothesis which stated, there was no relationship between inactivity and wellness of individuals admitted in homes for the elderly. Correlation test analysis between the dependent variable (wellness of the elederly) and inactivity was used. The results were as presented in Table 4.13:

Table 4.17: Relationship between inactivity and elderly wellness

		Inactivity
Wellness	Pearson Correlation	0.765
	Sig. (2-tailed)	**0.05
	N	92

Correlation is significant at the 0.05 level (2-tailed).

Based on the findings, the study found a strong positive correlation of 0.765 at 0.05 level of significance between elderly inactivity and their wellness. This means there is a significant relationship between inactivity and elderly wellness. Therefore, we reject the null hypothesis which states that there is no significant relationship between inactivity and wellness of elders admitted in homes for the elderly in Nairobi County and accept the alternative. These findings contradict Draken (2013), who saw that good levels of physical and mental functioning and general health status have long been

associated with perceived well-being and morale. Functional decline is associated with increasing old age. Physical activities are well known to boost social connectivity amongst members of the particular group. In as much as social activities are regularly planned, structural physical activities can greatly help alleviate the emotional stressors and resultant psycho-somatic symptoms. The findings shows that there is no significant relationship between inactivity and wellness of the elderly admitted in homes for the elderly in Nairobi County at 0.05 significance level

4.7: Interventions that can improve the Wellness of the Elderly

The study also sought to establish the interventions that can improve the wellness of the elderly while in the homes. The responses were rated on a 5 point Likert scale ranging from; 1 = strongly disagree (SD) to 5 = strongly agree (SD). The results are summarized in Table 4.18:

Table 4.18: Interventions to improve wellness

Statements	SA F(%)	A F(%)	N.S F(%)	D F(%)	SD F(%)
There is satisfactory feeling of connection with people around me.	21(22.4)	41(44.7)	0(0)	30(32.9)	0(0)
There is improved feeling of self-esteem.	10(10.5)	62(67.1)	0(0)	20(22.4)	0(0)
I need less or no help to carry out routine personal activities e.g bathing.	28(30.3)	22(23.7)	0(0)	42(46.1)	0(0)
I rarely laugh since I came to this home.	0(0)	13(14.5)	0(0)	56(60.5)	23(25.0)
Frequent involvement in physical exercises has greatly enhance physical wellbeing.	10(10.5)	72(78.9)	0(0)	10(10.5)	0(0)
I am more active than when I was at home and it makes me feel good.	38(40.8)	23(25.0)	0(0)	31(34.2)	0(0)

N=92

The study also established the interventions of wellness of the elderly admitted in homes for the elderly. Majority of the repondents (67.1%) agreed that there was a

satisfactory feeling of connection with people around them. Also, majority (67.1%) indicated that there was improved feeling of self-esteem. On frequency of physically exercises, majority (78.9%) agreed that frequent involvement in physical exercises had greatly enhanced physical wellbeing while majority (65.8%) agreed that they were more active than when they were at home and it makes them feel good. However, majority disagreed that they rarely laughed since they came to the home which shows they were happy. This indicates that connection with people at the homes, improved self-esteem, ability to carry out personal activities, laughing, involvement in physical exercises, had greatly enhanced wellness of the elderly. According to caregivers' interventions such as improving the kind of health care the elderly was given would go a notch higher in addressing their problems. Thus, according to Vincent and Cull (2009), vulnerable groups require social protection to protect their livelihoods and each of these groups require different forms of social protection ranging from Social transfers e.g. grants to the elderly and cash transfers; social services including home-based care, education, health insurance; Social transformations- i.e. broader policy and legislative changes to ensure rights of vulnerable groups. In the interview one of the Elderly respondents stated:

> "We are well taken care of here. These people(caregivers) are friendly and encourage us to play (physical exercise). The only challenge we get here is loneliness. And wish most of our family members visited us frequently."

In addition to the above findings, through Focused Group Discussions (FGD), it was found out that disability, illness and poverty, isolation were the main reasons as to why the elderly were taken to the homes. The study established that the aging has social, economic and physiological needs which they are unable to meet on their own unless through outside intervention.

When the researcher sought to know the level of residents' satisfaction with the services rendered in the homes in an effort to meet their needs, majority of the FGD participants agreed that they were satisfied, though there were few challenges that faced both the elderly persons and administration. Such challenges were, pain of losing their friends, ageism, chronic illness, disability, freedom of choice, lack of decision rights, and difficulties in adjusting to life in the home for the elderly. They also expressed that they felt better when they talked to someone(counsellor) about their issues. The homes administration challenges included getting and admitting genuine elderly person, caregiver burnout, and lack of enough finances. Most of the elderly FGD participants felt that their wellness had greatly improved and enjoyed being with those of same age and thus sharing similar challenges and interests. However, a few viewed the home as a hospital which made them doubt their health status and thus worry at times. The physically stronger members expressed at the FGD that they felt underutilized and idle causing them frustrations. The study established that though counselling took place, it was not frequent and was often done by non-professionals.

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> "It's not easy to know who is in genuine need of our services, and so we have to involve administration from the government (e.g chiefs) and also visit their homes and meet close relatives if available. These movements, together with other related activities requires money which is not usually enough".

Most of the care givers enjoyed their work, though some of them felt that it was a sensitive job since the elderly are generally delicate to handle. One young care giver said:

> Its quite interesting to talk to the elderly as they remind me of my grandparent but at times it gets so exhausting that I have to take afew days off

Most of the elderly FGD participants felt that their wellness had greatly improved and enjoyed being with those of same age and thus sharing similar challenges and interests. However, a few viewed the home as a hospital which made them doubt their health status and thus worry at times. The physically stronger members expressed at the FGD that they felt underutilized and idle causing them frustrations. The study established that though counselling took place, it was not frequent and was often done by non-professionals. One of the care givers explained:

> "Once in a while, we get a counsellor from outside to help with their issues if needed. This usually happens when there is loss and they are helped to grief. Other common issues are simply dealt with by us".

This concurs wang (2010) who acknowledged that physical exercise is a known therapy for both physical and emotional health, as well as being known to improve cognitive

function greatly. Without the structured physical exercise programs, it is very likely that most residents will experience cognitive decline much faster than it would be anticipated. Add on to the other psychological factors mentioned above, depressive symptoms will definitely remain unchecked despite the many volunteer counselors helping out

4.8: Multiple Regression Analysis

The study sought to investigate psychosocial factors affecting wellness of the elderly in homes for the elderly in Nairobi County. The factors investigated were: elderly loneliness, dependency, and inactiveness.

The regression model used was as follows:

$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon$

Whereby Y elderly wellness, X_1 elderly loneliness, X_2 elderly dependency, and X_3 is elderly inactivity. B_0 is the model's constant, and $\beta_1 - \beta_3$ are the regression coefficients while ε is the model's significance from f-significance results obtained from analysis of variance (ANOVA).

Table 4.19: Model's Goodness of Fit Statistics

R	R Square	Adjusted Square	R Std. Error of the Estimate	Durbin-Watson
.865[a]	.748	.715	.14567	1.421

a. Predictors: (Constant), elderly loneliness, elderly dependency, and elderly inactivity

Table 4.16 shows that there was a good linear association between the dependent and independent variables used in the study. This is shown by a correlation (R) coefficient of 0.865. The determination coefficient as measured by the adjusted R-square presents a strong relationship between dependent and independent variables given a value

of.715.This depicts that the model accounts for 71.5% of the total observations while 28.5% remains unexplained by the regression model.

Durbin Watson test was used as one of the preliminary test for regression which to test whether there is any autocorrelation within the model's residuals. Given that the Durbin Watson value was close to 2 (1.421), there was no autocorrelation in the model's residuals.

Table 4.20: Analysis of Variance (ANOVA)

Model		**Sum of Squares**	**Df**	**Mean Square**	**F**	**Sig.**
1	Regression	22.762	3	7.587	316.125	.001[b]
	Residual	2.132	88	.024		
	Total	24.894	91			

a. Predictors: (Constant), elderly loneliness, elderly dependency, and elderly inactivity.
b. Dependent Variable: elderly wellness.

The ANOVA statistics presented in Table 4.20 was used to present the regression model significance. The significance value of p= 0.001 was established and since the p-value was less than 0.05, the model was considered significant for the study.

Table 4.21: Regression Coefficient results

Model		Unstandardized Coefficients B	Std. Error	Standardized Coefficients Beta	t	Sig.
1	(Constant)	0.340	0.290		1.172	.248
	Elderly loniless	-0.337	0.144	0.299	-2.331	.025
	Elderly Dependancy	-0.173	0.152	0.161	-1.134	.004
	Elderly Inactivity	-0.356	0.202	0.429	-1.759	.017

a. Dependent Variable: Wellness of the Elderly

The following regression result was obtained:

$Y = 0.304 - 0.337X_1 - 0.173X_2 - 0.356X_3$

From the model, when other factors (elderly loneliness, elderly dependency, and elderly inactivity) are at zero, the elderly wellness will be .304. Holding other factors constant, a unit increase in elderly loneliness would lead to 0.337 decrease in elderly wellness. On the other hand, holding other factors constant, a unit increase in elderly dependency would lead to a 0.173 decrease in elderly wellness while a unit increase in elderly inactivity would lead to 0.356 decrease in elderly wellness.All the variables under study depict a decrease in wellness of the eldely.

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1: Introduction

The purpose of this study was to investigate the selected psychosocial factors affecting wellness of the elderly; A case of homes for the elderly in Nairobi County. This chapter highlights the summary of findings, conclusions and recommendations made.

5.2: Summary of the findings

Findings revealed that majority of the elderly were above the age of 65 years, with many of them not having more than primary school education. Also, the study established that a big number of the respondents were brought by relatives at the Nyumba la Wazee, and 63% indicated that they would like to spend their remaining part of their life, at the home. Additionally, majority of the elders indicated they were having a good quality of life.

5.2.1: Loneliness and wellness of the elderly individuals

Concerning the feeling of loneliness and isolation, majority of the elderly agreed that they enjoyed safety and security at the homes for the elderly. However, majority also disagreed that they fall sick more often. The study found out that majority of the elderly agreed that they were happier living at the homes since they had earlier lived alone, though many admitted that they missed friends and relatives most of the time. Moreover, most enjoyed the company of people at the home and had made more friends since almost all were in same age bracket. The study rejected the null hypothesis that there is no relationship between loneliness and wellness of individuals admitted in homes for the elderly in Nairobi County and accepted that there is a relationship between loneliness and elderly wellness.

5.2.2: Dependency and wellness of the elderly individuals

Majority of residents in the homes for the elderly were not entirely dependent on the caregivers since they are in-charge of their personal cleanliness without assistance. A number of them indicated that they were able to move around without being supported, and were able to participate in different activities which made them feel good. The able ones were also uncomfortable when care givers did everything for them. However, many of the elderly relied on the home staff to wash their clothes. It also indicates that the management encouraged the elderly members to share their opinions. The study found out that there was a no significant relationship between dependency and wellness of the elderly.

5.2.3: Inactivity and wellness of the elderly individuals

Majority of the elderly were not involved in sporting activities or in productive activities like knitting, painting or baking since their age is advanced and mobility is a problem. Also, some had illness that limited their involvement, as dementia was common. Some of them felt idle and non-productive though they were strong enough to do something. The study found out that there is no significant relationship between inactivity and wellness of elderly admitted in homes for the elderly.

5.2.4: Interventions To improve the wellness of elderly individuals

The study found that it was possible to improve the wellness of the elderly in the homes through certain interventions. The elderly members who frequently participated in physical activities agreed that it greatly enhanced their physical wellbeing. Interactions with people at the homes, through prayer meetings and other common activities made them feel connected, raising their self-esteem and thus improving their wellness. Talking to someone about their issues made them feel better, thus making frequent counseling sessions a necessity in the homes in order to help them deal with their

emotional needs. According to the care givers, frequent health checkups reassured the elderly of their general condition, and thus maintaining their wellbeing.

5.3: Conclusions

The study concluded that the three phychosocial factors (Loniliness,Inactivity and dependancy) had a significant relationship with the wellness of the elderly.Elderly dependency was identified as the most significant variable that influenced the wellness of the wellness of the elderly..

The study also concluded that Counselling is important for the elderly, particularly in handling of anxiety, depression and for improving subjective wellbeing.

Since most of the eldely were keen on participating in cultural events/ religious events/festivals which improved their wellness and happiness the study concluded that it was was important for them to participate in different kind of activities (Physical, social,creative). Moreover, connection with people at the homes, made them have a sense of belonging and improved self-esteem and so the study concluded it was important for their relatives and communities at large to visit them frequently.

5.4: Recommendations

The study therefore recommends that;

i. The management needs to make the Nyumba la Wazee feel like home by encouraging openness, give the elderly the ability to choose and participate in cultural events. It's also of paramount importance that the management provide comfortable living conditions, healthy food and decent shelter.

ii. The elderly deserve to be given activities of their choice. Additionally, the management should only encourage elderly to partake different sporting activities that are tailored to their physical well being.

iii. The management should encourage creative activities (e.g. knitting), cultural events or festivals that foster togetherness to increase happiness and laughter, and thus boost their self-esteem.

iv. Public should be made aware of the homes of the elderly as an alternative living place for the aged. This will avoid leaving the elderly in isolation and lonely in their homes incase their close relatives are far.

v. Competent counselors should be frequently engaged in order to help the elderly deal with their psychological issues and thus improve their wellness in the homes. This would be better done as group as well as individual counseling.

5.5: Suggestion for further research

The study suggests the following areas for further study, given the scope and limitations of this study:

i. A similar study should be carried out in some other counties with similar homes for comparative purposes.

ii. Another study should be carried out on the effects of the community on the well being of the elderly.

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APPENDICES

Appendix I: Informed Consent for the Elderly

I understand that the purpose of this study is to investigate the Selected psychosocial factors affecting wellness of the elderly; A case of Nyumba yaWazee, Nairobi County. I understand that my participation in this study is strictly voluntary and I may discontinue my participation at any time without prejudice. I further understand that any information about me that is collected during this study will be anonymously processed and that the results and interpretations of the study will be used only for the purpose of the study.

Signature of Elderly: __________________Date: __________________

Home Manager/Staff: _____________________ Date: __________________

Appendix II: Introduction Letter

Zipporah Henia,

Kenya Methodist University,

P.O Box 45240-00100,

Nairobi, Kenya.

8th February, 2018.

RE: REQUEST TO CONDUCT RESEARCH

I am a Postgraduate student at The Kenya Methodist University pursuing a Masters of Arts degree in counselling. As part of the requirements for the award of the degree, I am carrying out a research study on "**Selected Psychosocial Factors Affecting Wellness of the Elderly; A Case of Nyumba Ya Wazee in Nairobi County**."

I am in the process of collecting data from two homes of the elderly in Nairobi County. I am requesting your assistance in administering the questionnaires to the elderly people in your home. Your assistance will be highly appreciated.

Attached please find the letter from the Kenya Methodist University for your perusal.

Thanking you in Advance.

Yours sincerely,

Zipporah Henia,

0722810342

Appendix III: Research Questionnaire for the Elderly

CONFIDENTIAL **SERIAL NO: __________**

This questionnaire is made up of three sections, Section **I, II** and **III**. Please answer each question by placing a tick (□) against the appropriate box. The information will be used for the purpose of this research only; therefore, do not write your name on the answer sheet. Responses will be handled with strict confidence

SECTION I: DEMOGRAPHICS

Q1. Please tell me, how old are you?

a. 40 – 49 □

b. 50 – 59 □

c. 60 – 69 □

d. Above 70 years □

Q2. Please tell me, what is your highest level of education?

a. Completed primary school □

b. Completed secondary school □

c. Completed college/university □

d. Completed post graduate studies □

Q3. For how long have you been living in this home?

a. Less than 5 years □

b. 5- 10 □

c. 10-20 □

d. Over 20 years □

Q4. Who brought you to this home?

a. Relatives ☐

b. Self ☐

c. Hospital staffs ☐

d. Others (specify ______________)

Q5. Are you planning to continue staying in this home for as long as you live?

a. Yes ☐

b. No ☐

c. Undecided ☐

Q6. Thinking about both the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole? Your quality of life as a whole is:

a. Very good ☐

b. Good ☐

c. Alright ☐

d. Bad ☐

e. Very bad ☐

SECTION B: WELLNESS OF THE ELDERLY

The following are measures of wellness of the elderly, please indicate your agreement on a on a scale of 1-5 where (1=Strongly Agree, 2=Agree, 3=Not sure, 4=Disagree, 5=Strongly Disagree).

Statements	**1**	**2**	**3**	**4**	**5**
1). There is satisfactory feeling of connection with people around me					

2). There is improved feeling of self esteem					
3). I need less or no help to carry out routine personal activities e.g bathing					
4) I rarely laugh since I came to this home					
5). Frequent involvement in physical exercises has greatly enhance physical wellbeing					
6). I am more active than when I was at home and it makes me feel good.					

SECTION C: LONELINESS FACTORS

The following statements relate to loneliness as a psychosocial factor. On a scale of 1-5 where (1=Strongly Agree, 2=Agree, 3=Not sure, 4=Disagree, 5=Strongly Disagree). Please tick appropriately on the extent to which you agree with these statements.

Statements	1	2	3	4	5
1). Safety and security in this home is assured and this has enhanced my wellbeing					
2)I fall sick more often than when I lived at home					
3). I am happy living here					
4). I enjoy the company of people in this home					
5). I miss my friends and relatives most of the time					
6). I am bored most of the time					

SECTION D: DEPENDENCY FACTORS

The following statements relate to dependency as a psychosocial factor. On a scale of 1-5 where (1=Strongly Agree, 2=Agree, 3=Not sure, 4=Disagree, 5=Strongly Disagree). Please tick appropriately on the extent to which you agree with these statements

Statements	1	2	3	4	5
1). I am totally in charge of my personal cleanliness (showering, dressing etc) without assistance.					
2). I always wash clothes on my own and I enjoy it					
3). I am able to move around without being supported					
4). I make my own decisions, which keeps me happy					
5). I do different activities that help me feel strong					
6). I feel comfortable when care takers do everything for me					
7). I am able to share my opinions about this home with the manager which makes me feel good					

SECTION E: INACTIVITY FACTORS

The following statements relate to Inactivity dependency as a psychosocial factor. On a scale of 1-5 where (1=Strongly Agree,2=Agree, 3=Not sure, 4=Disagree, 5=Strongly Disagree). Please tick appropriately on the extent to which you agree with these statements

Statements	1	2	3	4	5
1). I have social or leisure activities/hobbies that I enjoy doing					

2). If my health limits social/leisure activities, then I will compensate and find something else I can do					
3). I easily get bored so I always look for something to do					
4). There more activities here for me than where I came from.					
5). I sleep most of the day time unlike when I lived at my home					
6). Games and sports are meant for children, not adults					
7). Cultural/religious events/festivals are important to my quality of life and am usually involved					
8). I actively participate in physical exercise (such as games and sports)					
9). I am engaged in meaningful activities (such as knitting, painting or baking)					

Thank you for your responses

Appendix IV : Focus Group Discussion

1. Who or what influenced your decision on choosing to come to stay in this home?
2. What are your daily activities while in the home and how involved are you in planning for them?
3. Let us each take a moment to step back to a time before we came to stay at this home.
    a. Tell me at least 5 activities that you did every day or day-to-day. No matter how exciting or boring or ordinary or common they were.
    b. Which of those activities do you feel that if you could do them while here they would greatly improve your stay at this home?
4. Let's do a quick activity. I want you to imagine you are marketing/advertising/selling this home to a friend or relative who might benefit from staying in a home.
    a. What would you say to them about this home?
    b. What would you advise the owners / staff members of this home to improve so that it is easier to market/advertise/sell this home to this friend or relative?
5. In general - What do you feel is the relationship between the home's staff and you - who stays here as a resident?
    a. What do you like most about the staff?
    b. What do you think can be improved?
    c. Imagine the best kind of member of staff. The one whom you would enjoy to have around you as you stay here. Describe this person to me – what they do; how they treat you; how they speak – etc.
6. How do you interact with the outside world (family visits and going out)?
7. How would you describe your wellness generally since you joined the home?

Appendix V: Interview Schedule for Caregivers and Managerial Staffs

SECTION A

Participants Code : ___________

Q1. Gender:

Male [ ]
Female [ ]

Q2. How old are you?

(30 and below) [ ]

(31 – 40) [ ]

(41 – 50) [ ]

(50 and Above) [ ]

Q3. What is your current position?

____

Q4. How long have you worked in your current position?

____

Q5. What are some of your responsibilities?

____

SECTION B

Q6. How does loneliness affect the wellness of the residents of the elderly homes in Nairobi County?

____

Q7.How does dependency affect the wellness of the residents of the elderly homes in Nairobi County?

____

Q8. How does inactivity affect the wellness of the residents of the elderly homes in Nairobi County?

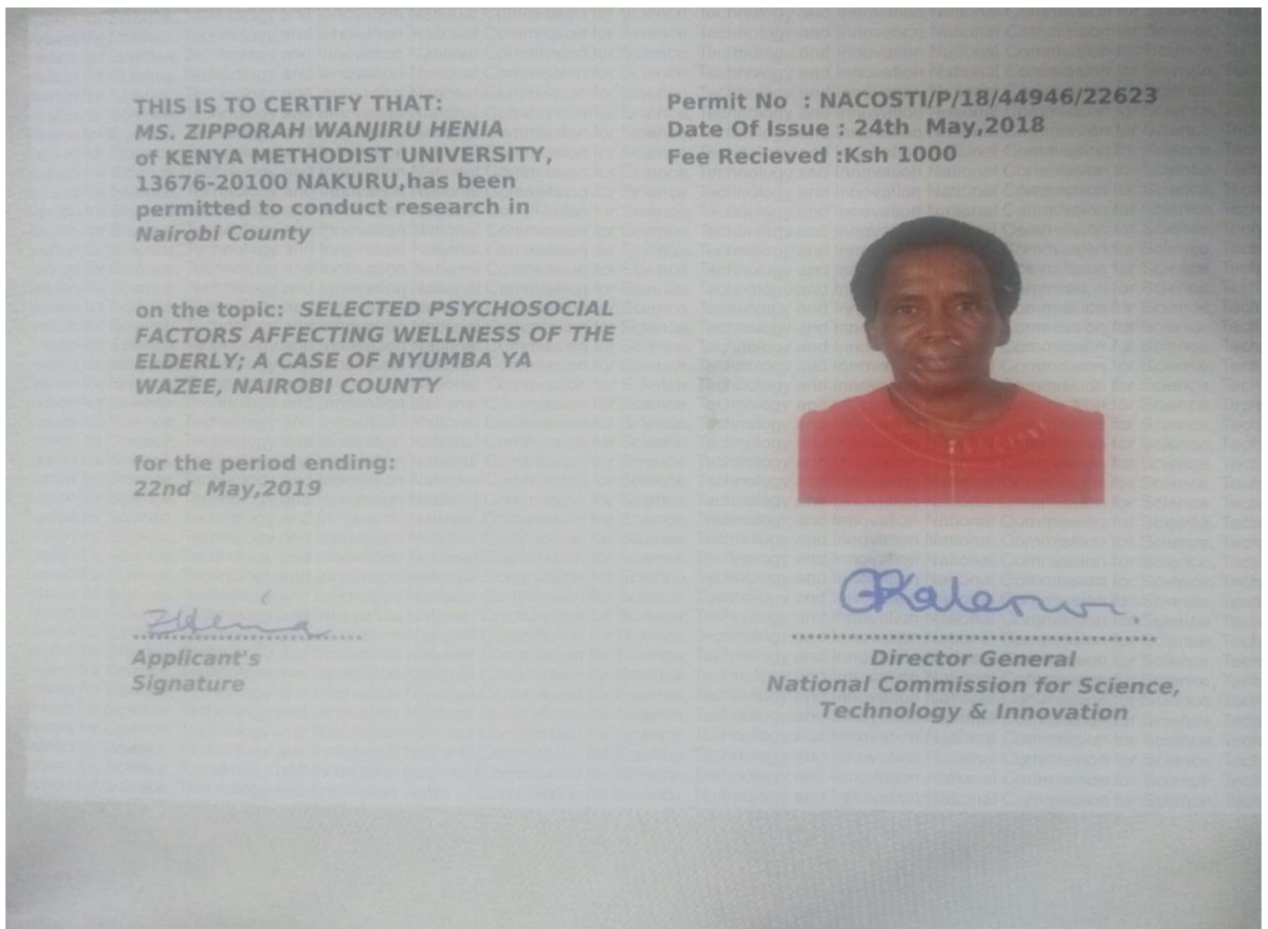
____

Q9. What interventions can be adopted to enhance the wellbeing of the elderly in elderly homes?

____

Thank you for your responses

Appendix VI: Research Permit



THIS IS TO CERTIFY THAT:
MS. ZIPPORAH WANJIRU HENIA
of KENYA METHODIST UNIVERSITY,
13676-20100 NAKURU,has been
permitted to conduct research in
Nairobi County

on the topic: *SELECTED PSYCHOSOCIAL FACTORS AFFECTING WELLNESS OF THE ELDERLY; A CASE OF NYUMBA YA WAZEE, NAIROBI COUNTY*

for the period ending:
22nd May,2019

Applicant's
Signature

Permit No : NACOSTI/P/18/44946/22623
Date Of Issue : 24th May,2018
Fee Recieved :Ksh 1000

Director General
National Commission for Science,
Technology & Innovation

Appendix VII: Ethical Clearance form

KENYA METHODIST UNIVERSITY

P. O. BOX 267 MERU - 60200, KENYA
TEL: 254-064-30301/31229/30367/31171
FAX: 254-64-30162
EMAIL: info@kemu.ac.ke

18TH APRIL 2018

Zipporah Henia
MCO-3-5542-1/2016

Dear Zipporah,

RE: ETHICAL CLEARANCE OF A MASTERS' RESEARCH THESIS

Your request for ethical clearance for your Masters' Research Thesis titled **"Selected Psychosocial Factors Affecting Wellnedd of the Elderly: A Case of Nyumba ya Wazee, Nairobi County"** has been provisionally granted to you in accordance with the content of your project proposal subject to tabling it in the full Board of Scientific and Ethics Review Committee (SERC) for ratification.

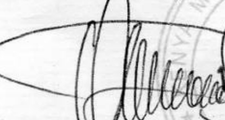
As Principal Investigator, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the project.
2. Changes, amendments, and addenda to the protocol or the consent form must be submitted to the SERC for re-review and approval prior to the activation of the changes. The Proposal number assigned to the project should be cited in any correspondence.
3. Adverse events should be reported to the SERC. New information that becomes available which could change the risk: benefit ratio must be submitted promptly for SERC review. The SERC and outside agencies must review the information to determine if the protocol should be modified, discontinued, or continued as originally approved.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by subjects and/or witnesses should be retained on file. The SERC may conduct audits of all study records, and consent documentation may be part of such audits.

5. SERC regulations require review of an approved study not less than once per 12-month period. **Therefore, a continuing review application must be submitted to the SERC in order to continue the study beyond the approved period.** Failure to submit a continuing review application in a timely fashion will result in termination of the study, at which point new participants may not be enrolled and currently enrolled participants must be taken off the study.

Please note that any substantial changes on the scope of your research will require an approval.

Yours sincerely



DR. WAMACHI
Chair, SERC

cc: Director, RI & PGS