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CHANGING RESIDENTIAL COMPOSITION IN A HOME FOR THE ELDERLY? THE CASE OF BUMHUDZO HOSPITAL HOME IN CHITUNGWIZA, ZIMBABWE

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ABSTRACT

The paper was a study of institutional living arrangements for the elderly at Bumhudzo Hospital Home situated in Chitungwiza, Zimbabwe. The research was an attempt to understand whether composition of residents at the home is changing towards Zimbabwean born residents, hence documenting the main factors behind this changing composition of elderly residents at Bumhudzo Hospital Home in favor of local people compared to pre-independence Zimbabwe when black people from neighboring countries found their way into the home after having reached the peak of their working time. The research, thus, sought to find and document the main reasons for this changing resident's composition along indigenous residents. To achieve this, the use of life histories was the main method of data gathering used. The findings reveal that indigenous Zimbabwean black elderly are being admitted into this institution that had previously been set-aside for destitute labor migrants.

Key Words: Elderly, Institutional care, Indigenous residents, Hospital Home, Ethnography

INTRODUCTION

In Zimbabwe, old-age social security has undergone transformation due to various factors, such as elders' lack of control of essential resources that were scarce and hence considered strategic, like land, livestock, and the skills they imparted to the young. Control of these resources enabled the elders to lay claim to care from the young in society (Rwezaura, 1989; Clarke, 1977). Elders' lack of control of these assets has significantly transformed the power relations and, hence, threatened old-age social security. As the extended family ties and the weakening of the family structure is ongoing due to factors, such as urbanization and the increasing geographical spread of relatives, the position of the elderly is, thus, being made precarious (Oppong, 1976). These changes are, thus, affecting networks of the traditional nuclear and extended family and in the process undermining the potential for old age social security.

Hampson (1982) has argued that most Africans in Homes for the elderly in Zimbabwe are non-indigenous and mostly destitutes from the streets who came to Zimbabwe as labor migrants. The family support scheme has been presumed, until now, to have managed to work for most citizens of Zimbabwe by catering for their elderly at home compared to institutional care. The non-indigenous people have always been assumed to be in need of extra or institutional care when they reach old age as a result of being further away from relatives than local people. Bourdillon (1991) and Ncube et al (1997) argued that there is a cultural barrier against placing elderly relatives in homes for the elderly. Consequently, Zimbabwean black elderly with family are taken care of by their families at home. Customarily it is expected that the youngest son among the Ndebeles will look after their elderly parents. Thus, incoming daughter-in-laws are expected to care for the day-to-day needs of the elderly in the family (Ncube et al, 1997: 172).

BACKGROUND TO THE STUDY

Townsend (1962) traced the development of institutional forms of care to the east where they were established by the Church in the third and fourth centuries. By medieval times, there were infirmary almshouses and houses of pity for the elderly, sick, destitute, and disabled in England up to the setting up of the Poor Relief Act of 1601. The principle of these poor houses was basically an attempt to prevent people from destitution and neglect. The result was that up to 1962, before the Nuffield Survey Committee's recommendations, old people were living in large institutions known as public assistance

institutions. The Nuffield Survey Committee's recommendations were to make these institutions smaller in an attempt to make old people live pleasantly and with dignity.

As most developing countries like Zimbabwe are former colonies of the developed countries, it also meant that these developed countries somehow influenced, controlled, and transferred their economic, social/cultural, and political values to their colonies. The result is that present day models of care of the elderly in Zimbabwe to some extent bear a resemblance to those found in Britain. Thus, colonialism and its legacy of migration, education, urbanization, and industrialization brought about the breakdown of the extended family, which had all along acted as a social security mechanism for the elderly in society (Rwezaura, 1989; Clarke, 1977). These processes impacted tremendously on traditional pre-colonial society. One may also hasten to add that the impacts of these processes are virtually irreversible. Consequently provision for old age has emerged as a "problem" largely because of the loosening of family ties and the insistence on individual rights and privileges to the exclusion of obligations and duties to others. The care and attention, which the family used to provide for the elderly, must now be provided in some other way. Besides, this industrial, mobile culture does not deal kindly with the extended family. Modern education has also had an impact on old age social security as modern education is neither equally accessible nor advantageous to the elderly, for example schools are mostly targeted at the young, and in this rapidly changing society, younger generations quickly acquire more information and more relevant skills than their elders. Thus, unlike preliterate societies where elders were of necessity the conservators and transmitters of culture, now when the history and lore of a society is now confined to books and where vocational skills and knowledge are also taught in schools rather than in households, parents, and elders seem to lose significance in their roles as teachers and culture transmitters.

Under the colonial government in the then Rhodesia (now Zimbabwe), a very efficient system of care was established for the elderly whites compared to black people. Some elderly whites were in institutional care, for those living at home, there were pensions, day centers, visiting district nurses, and well person clinics catering specifically for the needs of the white elderly. These were divided into three categories. Namely the A scheme, B scheme, and C scheme. Waterston (1982) observed that the A schemes (i.e. Fairways in Harare) provided sheltered accommodation in which the person lived independently in their own house, but there was a warden at hand to help in any difficulty; B schemes

(or hostel accommodation) provided meals, laundry service, and general care; C schemes (i.e. Fair Ways in Harare) were for the handicapped elderly and provided nursing care and assistance with activities for daily living, such as toilet and dressing. However, a point to note is that the schemes at these centres were not mutually exclusive as the centres had more than one scheme or all schemes as in the case of Fair Ways Old People's Home.

For the black section of the community during the colonial times, formal care was provided only at Bumhudzo Hospital Home in Chitungwiza. Possibly the assumption then was that the extended family was playing its part in taking care of the black elderly. Since independence in 1980, a number of schemes have been opened for the black elderly. The result is that the formerly white residential homes are now open to the black elderly. The concept of institutional care can be seen as a Western approach that has found its way into Zimbabwe, like in most African countries, as a result of the colonial experience.

OBJECTIVES OF THE STUDY

General Objective

To find out the main reasons why local Zimbabwean elderly people are being admitted to institutional care at Bumhudzo Hospital Home in Chitungwiza.

Specific Objectives

- To document the admission process of residents into residential care.
- To find out whom the residents are by documenting their individual life histories.
- To understand factors leading to changing composition of elderly residents along local Zimbabweans at Bumhudzo Hospital Home.

METHODOLOGY

The methodology used in this study is qualitative/ethnographic with a major bias on life history documentation. The research adopted a broad interpretation of ethnography based on Davies' (1999: 4-5) argument that ethnography should be seen as a research process based on fieldwork using a variety of (mainly qualitative) research techniques. Davies (1999) argued that the most common way in which life histories are collected is through interviewing. The simple life histories of the residents are products of a

series of interviews, largely unstructured. All the five life histories and casual conversations with residents were all done wholly in Shona[1]. However, there are methodological limitations when it comes to translating a wholly Shona interview into English. As Shaw (1930: 22) argued, a translation of the study from the language of the interview, in most cases, greatly alters the original meaning. As a result, the translations may miss some of the real meanings of the original language in the text and, hence, may unintentionally distort the original intended meaning. It should also be noted that residents could have distorted intentionally or unintentionally their life histories by omitting some information that they thought was insignificant but could have proved significant in the construction of their life histories. When the research was conducted there were 76 residents at Bumhudzo Hospital Home. Out of these, 27 were females and 49 were males. Of the 49 males, 21 were Zimbabweans by birth and 28 were from South Africa, Swaziland, Mozambique, and Malawi who had come as labour migrants. The sampling was purposive as information rich sources were targeted. That is, the researchers only interviewed those residents who could still engage in meaningful conversations, as well as only those residents who were born in Zimbabwe, in attempts to achieve the study's objectives. Some residents could no longer hear well or speak loudly to make conversation a possibility. Some residents are now deaf and dumb. As a result of these limitations, only those residents who could converse well were interviewed. Five residents (three females and two males) were interviewed as part of documenting the life histories. Mbuya[2] K (not real name) is currently staying in the "C" section, as she is blind. Mbuya C (not real name) and Mbuya F (not real name) are staying in the "B" section. Of the two male respondents, only Sekuru[3] M (not real name) is staying in "C" as he is also blind. Sekuru H is staying in "B".

The researchers also employed the use of documentary research, which entailed perusal of institutional documents for information on individual records of residents in attempts to ascertain the main reasons for respondents' admission, their dates of birth, and the year they were admitted. Asking for diaries and letters from the residents proved to be futile as the majority of residents did not have such documentation. Most residents also did not have identity cards, as these could have proved useful in ascertaining the residents' dates of birth and exact places of birth.

[1] A local language spoken in Zimbabwe
[2] A Shona honorific name for grandmother
[3] A Shona honorific name for grandfather

Ethical Considerations

The nature of the study involved an intrusion into the lives of the elderly at Bumhudzo Hospital Home. That is, into their life histories, activities, and their records. Informant's anonymity and confidentiality is protected through the use of pseudonyms for all respondents. Respondents' participation in the study was predicated on the notion of informed consent as no one was forced into the study.

PRESENTATION OF FINDINGS

Location of the Study

The study was carried out at Bumhudzo Hospital Home for the elderly situated in Chitungwiza. The home is run by the Salvation Army Church and was opened on October 26, 1974 after the realization that quite a number of migrant African laborers, having reached the end of their working life and in the meantime having lost all connection with their families, suddenly found themselves without proper care and support in old-age (Hampson, 1982). Bumhudzo is divided into two sections, namely "B" and "C" schemes. "C" scheme is for the very handicapped elderly and provides nursing care and assistance with activities for daily living, such as toileting and dressing. For example, those who are blind or those who are confined to wheelchairs stay in "C". Those elderly residents who are still active and not in need of constant supervision and help are accommodated in "B" scheme at Bumhudzo.

The hospital section, which forms the "C" section, was opened on the 29th of October 1984. This necessitated the name change from Bumhudzo Old People's Home to Bumhudzo Hospital Home. When Bumhudzo was initially opened in 1974 it was made up of three blocks for accommodation. The plans were that these residential blocks would be designated to residents according to marital status. One outer block was to be for single men, the middle block was to be for married couples, the other outer block was to be for single women. These arrangements were later abandoned, as married couples were not keen on coming to Bumhudzo. The middle block that had been reserved for couples was then given to males. These initial three blocks now form the "B" scheme were those who are still active and not in need of supervision are accommodated. Two blocks in "B" are for men and one block is for women. This overall outnumbering of females by males can be seen as a result of the colonial legacy of labour migration that tended to encourage male labour migration than female labour migration. The majority of residents at Bumhudzo are from neighboring countries and came to Zimbabwe as labour migrants and as unmarried migrants, they found themselves with no family to look after them upon retirement as they

could no longer return to their country of origin as most would have lost contact with their relatives back home.

Admission to Bumhudzo: A Historical Perspective

The information on the Historical admission process to Bumhudzo was obtained after looking at the institution's admission procedures documents, as well as from interviews with the current administrator. Previously the main requirements for admission into Bumhudzo were that the applicant:

i) Must have reached retirement age (60 years).

ii) Must be without land or property in the then Tribal Trust Lands (TTLs).

iii) Must have no family member who is able and willing to care for them.

Those wishing to be admitted to the home had to fill out an application form for admission. Usually friends, employers, clergymen, and social workers sponsored the applicants. The application form was then sent to the Salvation Army Headquarters in Harare and the prospective resident was then interviewed in an attempt to ascertain whether they did not have relatives to look after them. About once every month there was a meeting to consider applications by the Home's Admissions Panel. A place was then offered or denied as a result of these deliberations. For the successful applications for admission, arrangements were then made to notify their sponsors and have the prospective resident transported to the home. On admission, residents had their personal belongings stored away and they would have their hair shaved, washed, and given institutional clothes and allocated a room to sleep.

The current Admission Procedure to Bumhudzo Hospital Home

The Social Welfare District offices are now handling all applications for admission. Bumhudzo no longer accepts residents if they have not been vetted by the Social Welfare Department. The minimum age for admission to Bumhudzo is still 60 years. However, the administrator acknowledged that with the opening of the hospital section, which forms the "C" section, some people under 60 years are now being admitted, especially those people whose health status makes it difficult to live outside a hospital setting, for example those who are epileptic and under 60 years.

Prospective residents can come to Bumhudzo to make an initial inquiry for vacant places. If there is a place they are then told to go to the District Social Welfare offices for vetting. After successful vetting they are then recommended for admission by the Social Welfare officers. Prospective residents are still

asked to fill out an application form for admission when they come to Bumhudzo. This application form makes up the residents' first part of files at Bumhudzo. Bumhudzo Hospital Home is now also recruiting residents even if they have family. This is quite a shift from the previous admission regulations, which stated that only people without relatives could be admitted.

On admission to Bumhudzo all new residents are now first admitted to "C" in order to assess their physical and mental abilities. If they are found to be in need of constant attention, they remain in "C". If they are assessed and found to be physically and mentally fit they are transferred to "B". All new residents on admission are also shaved, bathed, and given institutional clothes if they do not have clothes of their own, or if they are made to remain in "B"**.** Those with belongings have their belongings stored for them in the storeroom at Bumhudzo. According to the administrator, once admitted residents are told to "rest" as Bumhudzo will be their last home. Relatives and friends are allowed to pay residents a visit and they are allowed to bring goodies or money for their resident friend or relative. The money or goodies are usually kept for safe keeping by the home if the resident is staying in "C". Those staying in "B" keep their own things under lock and key in the lockers in their rooms.

Case 1: Mbuya F (Not Real Name)

Mbuya F was born on September 13, 1929 in Mutare, Zimbabwe in a family of five: four girls and one boy. Her father, who was a pastor in the Methodist Church, died when she was very young. As a result she never attended school. Mbuya F was once married to a Methodist pastor and only came to the then Salisbury (now Harare) in the 1970s (she no longer remembers the exact year) after her husband was shot and killed one morning by the Rhodesian Forces on allegations of supporting the Liberation War. She remembers that she was already a widow when Zimbabwe became independent in 1980 and that life was extremely difficult for her. Mbuya F says when she came to Salisbury she was penniless. She first lived in Seke Unit "O" in Chitungwiza selling tomatoes. Some people who used to see her selling tomatoes advised her to go to the Makoni Social Welfare offices in Chitungwiza for help. She was initially placed under the Public Assistance Program by the Social Welfare and was advised to look for a room to rent in Chitungwiza. Later she was told that she was going to be sent to a place where she would be "kept". So the Makoni Social Welfare offices facilitated her admission to Bumhudzo Hospital Home in the year 1989 at the age of 60 as she says she was almost destitute.

Mbuya F used to be a Methodist church member, now she is a member of the Salvation Army as she says she saw that God was present at Bumhudzo. She always attends church services at Bumhudzo and always takes time to give testimonials at all Sunday services because she says she is glad God guided her to Bumhudzo where she has found everything. She is one of the longest staying residents at Bumhudzo. Mbuya F works in the laundry at Bumhudzo every day from 10am to 12pm in return for some money. The former superintendent also gave her a garden where she grows vegetables, which she sells to the staff members and occasionally to members from the Chitungwiza community. Mbuya F does not have children of her own. Her late three elder sisters' children occasionally come to visit her. Staff members claim that these visitors are her real children. However, she stated that if she had children of her own she would probably not be at Bumhudzo. She considers all children in Zimbabwe to be hers because she says she is well kept at Bumhudzo.

Case 2: Mbuya K (Not Real Name)

Mbuya K does not remember her date of birth. However, she was born in Mutoko, Zimbabwe in a peasant family of seven children: three boys and four girls. Only two children are surviving: Mbuya K and her brother. Mbuya K is widowed with only one son who lives in Borrowdale. She says her son is an engineer who is very learned. Her daughter in law teaches in Borrowdale. Mbuya K lost her sight in 2001. She used to stay with her brother in Murehwa; however, she says the living arrangements were not encouraging. So she came to Bumhudzo Hospital Home on the 5th of June 2004 because she says there was no one prepared to look after her as her daughter in law spends most of the time at her workplace. Mbuya K says that her son is the one who facilitated her admission to Bumhudzo. She says if she had a choice she would have wanted to stay at the old people's home in Mutoko as it is nearer to her relatives. Her application for admission forms state the need for a home and nursing care as the major reason for her admission; as a result she is currently staying in "C".

She spends the days just sitting on the verandah. Her son and her relatives visit her frequently. A look at the visitors' logbook shows that she has the highest number of recorded visits. Her frequent visitors usually bring her goodies and she usually shares these with some residents.

Case 3: Mbuya C (Not Real Name)

Mbuya C was born on April 13, 1936 in Murehwa, Zimbabwe. Her father had 13 wives and her mother had seven children: three girls and four boys. Of the seven children only two are surviving. Mbuya C's mother left the family when she was still very young. As a result, she could not finish her education, as she had to take care of the other children. She is widowed with two children, a boy and a girl. She came to Bumhudzo Hospital Home when she was 61 years old because she had tuberculosis. As a result of her being ill, she was initially admitted in "C" and was subsequently transferred to "B" where she is presently staying. She says if she had not come to Bumhudzo she could have died long back of tuberculosis (TB). She was initially admitted for six months for treatment and she just decided to stay after being cured because she says she liked the place then. She was once readmitted to "C" after she had diarrhoea, which scared everyone at Bumhudzo after she had eaten chicken, which she is allergic to.

Mbuya C is a devout Roman Catholic. Although she walks slowly with a limp she goes to church every Friday, Saturday, and Sunday. She says she only attends the Bumhudzo church service as and when she feels like attending. She spends most of her days tending her vegetable garden.

Mbuya C once lived at Melfort Old People's Cooperative where she was a traditional healer. She says people came from all over Zimbabwe to be cured by her. She left all traditional healing behind when she became a Roman Catholic; however, she occasionally helps some people at Bumhudzo, as well as some from her church who may need traditional healing. When she then left Melfort she went to work as a farm laborer in Chiweshe picking cotton. The owner of the farm in Chiweshe is the one who brought her to Bumhudzo as a result of her deteriorating health. She says she was not chased from home. Furthermore, she is also expressing her willingness to leave Bumhudzo some time in the future. Mbuya C's son is a builder and lives in Epworth. She last saw her son in 1995, two years before she was admitted to Bumhudzo. She blames her daughter in law for all this long silence as she alleges her daughter in law must have given her son some love potion so that he could forget her. She says because of this she sometimes ends up thinking that maybe those without children are better off.

Case 4: Sekuru M (Not Real Name)

Sekuru M was born in Kadoma, Zimbabwe on August 16, 1947. His mother died when he was a month old. He does not know his father because he never saw him. So he literally grew up as an orphan being kept by his three sisters. He was the only boy in the family and he never went beyond primary level at

school. Sekuru M first had a home in Shurugwi and separated with his first wife in 1987. He left Shurugwi and worked for three years in Highlands as a domestic worker and managed to buy a rural home in Mutoko and three cows in 1987 to start farming. Unfortunately, during the early 1990s drought all three of his cows died. So he came back to Harare in the year 1993 and worked for some time doing odd jobs. By this time, he had begun to have eyesight problems. He decided to go back to the rural areas in 2000, tried to farm once more but decided to come back to Harare as he said he was finding it increasingly difficult to relate with his wife over the family's sustenance.

So he worked on temporary jobs like cutting grass in Harare. Then he left Harare for Norton to become a "fishmonger". As a result of his failing sight, he could not make it as he had previously anticipated. His near destitute state led the pastors at the Roman Catholic Church he was attending in Norton to make arrangements for him to be admitted to Bumhudzo Hospital Home in November 2003. When he came to Bumhudzo he could still see, but now he is totally blind. He now moves around with a walking frame as he fell from one of the avocado trees at Bumhudzo one morning in March 2004 and broke some ribs and fractured his left arm. Currently, Sekuru M is staying in "C". When Sekuru M was admitted to Bumhudzo he was first admitted to "C" for three days and was then transferred to "B". He only returned to "C" as a result of the fall and his failing sight. He spends the days just sitting outside on the verandah. His second wife is still alive and still staying in Mutoko. He also has three children with this wife. He has never seen his children and wife since he was admitted to Bumhudzo. He said he told them he never wanted visits from them as he did not want to become an unnecessary, extra burden to them.

Case 5: Sekuru H (Not His Real Name)

Sekuru H was born in Murehwa, Zimbabwe on the 1st of April 1923 in a family of six: three boys and three girls. His parents were peasant farmers in Murehwa. He was educated up to Advanced Level mainly through correspondence. During World War II he worked in the Internment Camp Corps at Beatrice Cottages for Italian prisoners of war. After the Second World War he worked as a storekeeper for Koffman Sons and Company. Then he briefly worked for the Dairy Marketing Board as a Depot Manager. He married his first wife in March 1950. During these times he says he was already a politician as he was involved in the City Youth League. Because of his increasing political activities he was now finding it increasingly difficult to secure formal employment. So he started a building contracting company in the 1950s and managed to build several houses in Belvedere, Harare. He began

experiencing problems with the Salisbury City Council because he was building without City Council authority and insurance. As a result of his increasing political activities he was arrested and detained for a year at Hwahwa Prison after the banning of one of the Nationalist movements. During his stay in prison the Rhodesian government repossessed his Highfield home. He continued with his education whilst in prison and Amnesty International and Christian Care paid the expenses. After his release from Hwahwa Prison in 1968 he was restricted from going outside a 15-mile radius of the Salisbury City Post Office. As a result of his involvement in politics, Sekuru H held leading positions in the nationalist movements. He was the Organizing Secretary when one of the Nationalist movements was formed in the 1960s and was also part of the delegation that went to the Lancaster House Conference representing the Home Front and was in the United Kingdom for four months during the negotiation process and came back on December 24, 1979. He later became a member of Parliament under the block constituencies in 1980 and was also among the 100 people awarded Liberation War Medals by the President of Zimbabwe, R.G. Mugabe, at Rufaro Stadium.

Sekuru H has three surviving children. One of his sons died at Chimoio in Mozambique during the War of Liberation. He had some businesses in Mashonaland East. He says his fortunes took a nosedive after he married a young second wife after the death of his first wife. He suffered two successive strokes and was confined to a wheelchair and had to be admitted to Bumhudzo Hospital Home in January 1989, he left Bumhudzo in October 1989. He also fractured his hip in January 2001 and as a result he had to be sent to Chitungwiza General Hospital for the operation and was confined to a wheelchair and once more had to be readmitted to Bumhudzo Hospital Home in October 2001 because he says he found it challenging to be escorted to the toilet by his daughter-in-law.

The main reason why Sekuru H is at Bumhudzo is because he was once wheelchair bound as a result of his fractured hip. Now he can move around with a walking frame. Sekuru H says that he hates it when people say that all people at Bumhudzo are “destitute”. He says he is far from being a destitute and is hoping to leave the place soon to the *real* destitutes. He claims that he is no longer on friendly terms with the administrator at Bumhudzo because he once confronted him in front of some visitors who had come to make some donations. Staff members also say that he stood up and complained, accusing the administrator of ill-treating the residents in front of these visitors. Since then he says he is no longer

allowed to speak when there are visitors around. He further says that he is a true politician and, thus, has to speak and act on behalf of those at Bumhudzo who cannot stand up for their rights.

DISCUSSION

The Need for Hospital Care

The five life histories of the residents in this article mainly reflect the need for care under the supervision of qualified health professionals as the leading factor favoring the increasing number of local Zimbabweans into institutional care. As Bumhudzo is a hospital home for the elderly it is easier for the elderly to be admitted to institutional care when care under the supervision of qualified health personnel becomes a necessity. As a result, admission to institutional care further lightens the burden of caring for an elderly relative to both the immediate and extended family members. In a sense, this lightens the female relatives' workload as women usually find themselves being the chief caregivers to sick and frail relatives either as wives, mothers, daughters, or daughter-in-laws (Ncube et al, 1997). The fact that Mbuya K and Sekuru M are staying in "C" shows that they need constant care and supervision under qualified personnel. Relatives may find it challenging to provide this special care under this industrially mobile society. The end result is the option of institutional care, where qualified personnel will guarantee care round the clock. This is also consistent with Brearely's (1990) observation that the main reason behind institutional care for the elderly is the need for care under qualified personnel. The cases of Mbuya C and Sekuru H (who was initially admitted in January 1989 when he suffered a stroke and left the same year, only to return when he fractured his hip and still expressing the desire to leave) shows that some local Zimbabwean elderly with relatives who are prepared to look after them do not view institutional care as their last place of refuge as they have the means (financial and familial) to comfortably live outside institutional care. The cases of Mbuya K, Mbuya C, and Sekuru H all reflect that they are not destitute but rather they are at Bumhudzo as a result of the need for nursing services. Any assumption of them being destitute is further invalidated by their observations that they are in a position to pay for their upkeep at Bumhudzo Hospital Home had that been a condition for one to be admitted.

For Mbuya K, the need for nursing care is further reflected in her application for admission form, which states the need for nursing care as the major factor behind her being in institutional care. In the case of Mbuya C, she actually confirmed that she was not chased from home and only the need for care then under qualified personnel led her to be at Bumhudzo Hospital Home.

Destitution

There are also some cases of Zimbabweans who are at the home as a result of being destitute or near destitute. The cases of Mbuya F and Sekuru M also illustrate this. In the case of Mbuya F, who became destitute after the death of her husband in the 1970 during the Liberation War, thus, reflects the challenges that women currently face as individuals as well as a group. A women's position is usually made precarious after the death of the husband in instances where the woman is childless. According to Langan and Day (1992), women as a group are likely than men to be very poor if widowed. The result of widowhood is that due to the patriarchal nature of Zimbabwean society, women often lose their property as a consequence of outliving their husbands. This then literally drives them to destitution, or near destitution, as they no longer have anyone to look after them. As a result, the extended family's incapacity to look after elderly people is further reflected in Mbuya F's case, as she was literally thrown on the street and subsequently found her way to Bumhudzo as she had become destitute.

Urbanization and Caring for Relatives

From the study, the phenomenon of urbanization is one of the factors leading to Zimbabwean elderly people being admitted to institutional care. The case of Mbuya K, who had to be admitted to institutional care, is reflective of this. Mbuya K in her life- history revealed that she was forced to be at Bumhudzo Hospital Home because her daughter-in-law who was employed fulltime, as a teacher could not adequately care for her, as she spent most of her time at work. This is also consistent with assertions from Ncube et al (1997) that the care giving roles fall disproportionately on women as daughters, daughter-in-laws, wives, etc. As a result of the increasing presence of women in formal employment, women increasingly face a dilemma when it comes to dividing their time between their career aspirations and their traditional care giving roles. The result is a contradiction between individual aspirations and obligations/duties, which more often leads to insistence on individual aspirations leaving the elderly with no caregiver and, hence, making them potentially good candidates for institutional care, as reflected in Mbuya K' s case.

Aging, Women, and the Law in Zimbabwe

The Older Persons Bill of 2002 by the Zimbabwean government seeks, among other things, to prevent discrimination against older persons on the grounds of their age, encouraging the care of older persons within their own communities, social environment, and the general wellbeing of the elderly. In general, the bill seeks to improve the social and economic status and condition of older persons and to advance their interests (GOZ, 2002). Considering that the bill was tabulated in 2002 and that it has not yet been passed into an Act of Parliament by the year 2008, one can safely conclude that there is not yet any specific policy that looks into the care of the elderly in Zimbabwe. The elderly seem to be occupying a very peripheral position, regardless of the fact that they are increasing in their numbers. One can also argue that the current trend in Zimbabwe towards an aging population is likely to result in a problem over caring for the elderly: not for the state if it does not evolve adequate policies, but for women. This is because women tend to perform automatically the task of caring for elderly relatives as an extension of their traditional roles as wives, mothers, sisters, and daughter-in-laws while they are also increasingly being drawn into paid employment in the external economy. There is, thus, a pressing and urgent need for a concrete policy on care of the elderly if women are to be spared from caring for this segment of the population.

CONCLUSION

The research conducted was an attempt to understand whether composition of elderly residents in institutional care is changing along indigenous residents and also documenting the main reasons behind this trend. To achieve this, Bumhudzo Hospital Home in Chitungwiza was chosen as a case study. Findings reveal that institutional care at Bumhudzo for black elderly people is no longer exclusively for those people who originally came to Zimbabwe as labour migrants from neighboring countries. It can, thus, be argued that although some homes for the elderly had been specifically set aside for black destitute people before and after independence, the same can not be said of these homes in the 21st century. In the case of Bumhudzo Hospital Home, the home is no longer only open to black destitute people who had come to Zimbabwe as labor migrants. Rather, at present, some elderly people from well-to-do Zimbabwean families are finding their way into the home as a result of varying reasons. Chief being the need for hospital care under the supervision of qualified health personnel as well as destitution. As such institutional care in Zimbabwe can now be seen as unavoidable for some local

elderly people as a result of health conditions that are associated with ageing, which often calls for institutional care, as reflected in this article.

These cases can never be representative of all the main variations of Zimbabwean born residents at the home who year by year have been admitted to or have left Bumhudzo. However, the findings in the final analysis can be viewed as reflective of other homes for the elderly and, hence, can generalize to other residential homes in Zimbabwe.

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