

A COMPARATIVE STUDY OF THE CULTURE OF SKILLED NURSING FACILITIES IN HIGH AND LOW DENSITY AREAS: A CASE FOR MASVINGO URBAN IN ZIMBABWE

Louise Stanley Madungwe, Isabel Makwara Mupfumira and Winnet Chindedza
Curriculum Studies Department, Great Zimbabwe University

ABSTRACT

The purpose of the study was to do a follow-up of the study done by the researchers on a skilled nursing facility in a high density area. In this study, the researchers made a comparison of two skilled nursing facilities, one in the low density and the other in the high density urban areas of the Masvingo city in Zimbabwe. Data was collected using in-depth interviews with both residents and administrators at the two facilities. The study has established that there are vast differences between the two skilled nursing facilities with regard to infrastructure, funding, food and services, reasons for staying at the facilities and generally, life at the facilities. The differences are necessitated mainly by the funding patterns at the facilities. Where there is adequate funding, residents live a comfortable life and are emotionally at ease. Where there is inadequate funding, as in the case of the high density facility, it is mere survival for the residents. Generally, the study showed that the culture of sending the elderly to skilled nursing facilities is alien to black Zimbabweans, while it is acceptable to whites. This was quite evident to the residents' different emotional states, where most whites appeared to be at ease while blacks seemed to be in a traumatic state. If it were possible for the government to provide a grant for the elderly, then the blacks would take care of their parents in their own homes, rather than sending them to skilled nursing facilities, a culture that strips them of their identity.

Keywords: Residents; Elderly; Aging; Skilled Nursing Facility; Institution; Residential Homes; Culture; High/Low Density Area.

INTRODUCTION

Aging is a broad concept that includes physical changes in our bodies over adult life, psychological changes in our minds and mental capacities, and sociological changes in how we are viewed, what we can expect, and what is expected of us (Atchley, 1985). Aging can also be defined in terms of chronological age, functional age, and life stages.

The World Health Organization says the following about the elderly,

“Most developed world countries have accepted [the] chronological age of 65 years as a definition of ‘elderly’ or older person but, like many westernized countries, this does not adapt well for Africa. While this definition is somewhat arbitrary, it is, [at] many times, associated with the age at which a person can

begin to receive pension benefits. At the moment, there is no United Nations standard numerical criterion, but the UN agreed [that the] cut off is 65+ years to refer to the older population” (WHO, 2010).

Functional age is difficult to assess because it varies from one environment to another. For example, a tennis or soccer player may become functionally old at 30 or 35 years, while a judge can be functionally capable at 90. It can be defined in terms of physical appearance, mobility, strength, coordination, and mental capacity. In terms of the life stages, we use physical and social attributes to categorize people, for example, adolescence, adulthood middle age, later maturity, and old age, that is, the late 70's (Atchley, 1985). For the purpose of this study, chronological age will be used to define the elderly, that is, those who are 65 years and above.

The elderly, as defined above, are the ones that are sometimes sent to skilled nursing facilities although other people in other ages needing care can also be sent to these facilities. Although in Zimbabwe, homes for the elderly are referred to as skilled nursing facilities.; in some instances they are given different names. For example, there is Boggie Trust in Gweru, Borrowdale Trust in Marondera, Brocklehurst Trust in Chivhu, Jacaranda Trust in Bulawayo, Greendale Senior Citizens in Harare, Pioneer Cottage in Masvingo, etc., where whites are housed. In other countries, like the USA and the UK, homes for the elderly are referred to as residential homes, adult foster/family homes, personal care homes, or group homes. According to Atchley (1985), these homes are classified into two categories, independent households and group housing. For the independent households, residents can be fully independent or semi-independent. For the fully independent, the household is self-contained and self sufficient and residents do 90% or more of household chores. The semi-independent household is self-contained but not self-sufficient, that is, residents may require some assistance with household chores. The second category is the group housing which comprises congregate housing, personal care, and skilled nursing facilities. In congregate housing, the household may still be self contained, but not entirely self-sufficient. This is some form of a retirement community. In the personal care home, the resident unit is neither self-contained, nor self-sufficient. The residents need total assistance; it is a home for the aged. The skilled nursing facility is where residents need total care, including health, personal, and household functions.

Some researchers say, in the USA, they have another alternative for the elderly; instead of putting them in an institution, the relatives send their elderly to daycare centers during the day, while they go to work and, in the evening, they are together with them at home.

In South Africa, some sources say that there is YADE Caring Action, a Christian organization which caters only for elderly whites. Its sole purpose is mainly to uplift white elderly and white people with disabilities (Some elderly blacks are put in skilled nursing facilities, but in the majority of cases, they are kept in the family home and they receive an “elderly grant” from the government. Roebuck (1979) says, “This grant used to be a monthly payment from the government, now called an old age grant for people who are 60 or older”. The grant is given to the elderly who are not living in a state institution, like a state’s skilled nursing facility. One has to undergo a test called a

'means test' in order to qualify for it. If one cannot look after him/herself, and need full time care from someone else, they can also apply for a grant to aid, in addition to the old age grant. This situation makes it easier for children and relatives to care for their elderly at home since there is no economic burden involved.

In Zambia, the situation is almost similar to that in South Africa where, for elderly blacks, children and relatives consider the elderly as part of their households. Kambisa (2010) had this to say after a comparative study he made, "In the Netherlands, our elderly are considered a nuisance and are being put away in 'homes' in which they lack the potential to do the things [that] they are still capable of and in which they tend to starve from loneliness, lack of food, diapers, or simply water". He goes on to say that in Zambia "the elderly are part of their children's households; they take care of their grandchildren and great grandchildren and those of neighbors....the elderly have a role to play, which keeps them sound and healthy". Mweetwa also said "Traditionally, African culture has regarded elderly people as a source of wisdom. Grandmothers and grandfathers were cherished by their tribes and families. Bu today, more and more elderly people, especially those with disabilities, are neglected, abandoned, or abused by their families" (Mweetwa, 2010). However, a report by Irin News (20.09.2010) said, "Zambia's elderly populations are faced with a double jeopardy: they are shunned by communities as witchcraft practitioners, or with little or no understanding of the disease, [and] are burdened with caring for HIV/AIDS orphans" (This brings in the dimension that some people may not want to take care of their elderly if they suspect that they practice witchcraft.

In Zimbabwe, skilled nursing facilities are a new phenomenon as there is no equivalent for them in the local culture (Katanga, 2010). There are no classifications for the institutions for blacks, but for whites. In the same institution that houses elderly blacks, the home caters for all categories, those who need partial or total assistance and the sick. Daycare centers do not exist. Skilled nursing facilities for the blacks include Mucheke in Masvingo, Bumhudza in Mature, Nazareth Shelter in Chinhoyi, Sunningdale in Harare, and Batanai in Gweru, among others. For the blacks in Zimbabwe, the homes cater for the old and destitute, mainly from neighboring countries, those who had neither a family nor an income for their various physical needs.

In the past, homes for the aged in Zimbabwe catered for whites and alien blacks. For whites, they were more of retirement homes where residents would have saved for their retirement or relatives paid for their upkeep. According to Atchley (1985) and Silin (1998), studies from the USA and the UK show that this is an acceptable practice in their western culture, where the elderly are put in homes where they get total or partial assistance with household chores.

Nowadays, black Zimbabwean nationals are also found in old people's homes. This was not culturally practiced, hence the proverb "*chirere chigokurerawo*", (meaning one has to look after one's children so that they will look after him/her at an old age). This practice is now breaking the social thread that binds children with their parents and relatives. This has a bearing on the Zimbabwean culture since it alienates blacks from their cultural norms and values, hence the concept of a 'borrowed culture'. In the Zimbabwean culture, the elderly live in the family home

and are taken care of by their children and relatives. The elderly are referred to as “*Mumvuri*”, (a shade, meaning a custodian of our culture). Their presence in the home means safety for the family. For this reason, it is taboo to send one’s parents away from home.

Purpose of the study

The purpose of the study was to compare sociological trends in skilled nursing facilities in high and low density areas of the Masvingo urban. The study is a follow-up to the study done on Mucheke skilled nursing facility in the high density area of Masvingo urban. The researchers wanted to find out how this facility compares with its counterpart in the low density area of Masvingo urban. The objectives of the study were to compare and contrast the high and low density skilled nursing facilities with regard to: administration of the centers; demographic data; reasons for staying in the homes; and life at the homes.

METHODOLOGY

A comparative study of two skilled nursing facilities in the Masvingo urban was carried out. One is located in the high density area and caters for blacks, while the other is in the low density suburbs and caters mainly for whites, A comparative study “is the act of comparing two or more things with a view of discovering something about one or all of the things being compared. This technique often utilizes multiple disciplines in one study” (Wikipedia, 2010). The researchers chose the two skilled nursing facilities because they are the only two facilities located in the urban area, and within the two settings that were of interest to the researchers.

The population at the high density facility is comprised of 17 residents, two administrators, two cooks, and two general hands. Eleven residents, one administrator, one cook, and one general hand were interviewed. The method used for sampling was accidental; those interviewed were those who were present on the day of the visit. The researchers also observed residents carrying out their daily routine activities, that is, household chores, socialization, and leisure activities. The researchers also looked at the facilities at the institution, that is, the kitchen, the dining hall, and the bedrooms.

At the low density home there are 27 residents, 2 permanent administrators (nurse and bookkeeper), 10 ancillary staff, and one part-time nurse. Purposive sampling was used to select the two administrators and convenience sampling was used to choose one resident. The nurse and the bookkeeper were chosen because they were the best people to provide the required information. Fraenkel and Wallen (1996) say “purposive sampling is different from convenience sampling in that researchers do not simply study whoever is available, but use their judgment to select a sample that they believe, based on prior information, [and] will provide the data they need”. According to Leedy and Ormrod (2005), purposive sampling is used to choose people for a particular purpose, while convenience sampling is taking a sample of people or units that are readily available, in this case, one resident. So, the researchers selected respondents who were available and/or willing to participate.

PRESENTATION AND ANALYSIS OF RESULTS

In this section, data is presented under the following headings: administration of facilities, demographic data, reasons for staying at the facilities and life at the facilities.

Administration of the facilities

The low density facility was originally a maternity home, annex of the General Hospital, which was later converted to a skilled nursing facility. The home was run by trustees and is administered by a bookkeeper and a state registered nurse. The nurse also holds a diploma in psychiatric nursing, and has some experience in taking care of both geriatrics and psychiatric patients. The bookkeeper has catering experience and, therefore, is also in charge of the kitchen at the facility. There are 8 caregivers who have Red Cross training, which means they have skills in caring for the elderly. There are two experienced cooks, who are responsible for the meals at the facility. The facility is funded by trustees, donor agencies, and individuals. In addition, totally dependent residents pay a monthly fee of \$275, which caters for food, lodging, and laundry. Independent residents pay rentals of \$55 per month.

At the high density facility, the two administrators did not receive specialist training in caring for the aged. One is a qualified teacher, while the other attended workshops on elderly care. There are some Red Cross volunteers who occasionally come to help with household chores, in addition to two cooks. The home was built in 1980 by missionaries on a stand that belonged to the senior administrator. This home depends wholly on donations from non-governmental organizations, churches, and individuals. The residents do not pay anything for staying at the home.

Demographic data

At the high density facility, 11 residents and the two administrators were interviewed. Of the 11 residents interviewed, 9 were female and 2 male. One of the reasons for why there were more females could be the cultural. In the Zimbabwean culture, when a husband dies, the wife may be asked to leave. In the case of the wife passing on, the widower is free to live at his home. Men can also marry in later life and can be looked after by their young spouses. Another reason could be loss of income. Atchley (1985) says widows are more likely to encounter income problems in later life than married women. This could be due to the fact that most women are not employed and will have no pension in later life. Women also live longer than men so there are more widows than widowers.

At the low density facility, there are 9 totally dependent and 18 fully independent residents, one bookkeeper who also works as a housekeeper, 9 Red Cross trained caregivers, two nurses (one part-time), and two cooks. Of the 9 totally dependent residents, 4 were male and 5 female, and there was one couple. Among the 18 fully independent residents were two couples. Just like at the high density facility where there were two also. The residents ranged in age from 65 to 93 years. At the low density facility, people are normally admitted at age 65, except in special circumstances, especially those with health problems. For example, one resident was admitted before reaching 65 because he had become blind and could not be managed at home.

The residents at the high density facility ranged in age from 61 to 90 years. Nine fell in the age group of 80 years plus and 2 in the 60 to 65 group. There are no residents in the 66 to 79 age group. It is noted from the data that some of the residents at the facility have not yet reached 65 years, what Atchley (1985) refers to as the dominant legal age of retirement, which defines when a person becomes old. Of the 11 residents interviewed at the high density facility, 5 joined the facility before attaining the age of 65. So, according to Atchley (1985), these residents were not yet old because he says old age is characterized by extreme physical frailty. Chronologically, the onset of old age typically occurs in the late seventies.

The length of stay at the high density facility ranged from one to 30 years. Five had been there for between 1 and 5 years, 2 between 10 and 15 years, 2 between 20 and 29 years, and one has been there since the inception of the center, 30 years ago. At the low density facility, 90% of residents stay there until death. Sometimes, some residents would leave the center when relatives move out of town or out of the country.

The study established that at the high density facility, there were two couples, one couple having got married at the center. Five were widowed and 2 were divorcees. Six of the residents were Zimbabwean nationals, 3 South Africans, one Malawian, and one Zambian. It seems that Zimbabweans now dominate, unlike in the past when foreigners dominated. In both facilities, there was no discrimination on the grounds of race, one chooses to go where one wishes, or on affordability grounds, as in the case of the low density facility, where one has to pay for his/her stay. The low density facility is dominated by whites, whereas the high density facility is characterized by blacks.

The inmates came to the facilities through different means. At the high density facility, most came through the Department of Social Welfare; they did not choose to come, but were forced to by circumstances. On the other hand, at the low density facility, residents apply and are interviewed for familiarization and affordability purposes.

Reasons for Staying at the Facility

All the residents came to the facilities under different circumstances. Various reasons were advanced for staying at the high density skilled nursing facility. Some childless widows alleged they had been chased away from their matrimonial homes by their in-laws. In the Shona culture, if one has no children, they are considered unproductive and of no use to the clan. Some came because their families could not take care of them due to the deteriorating economic situation. The daughters-in-law especially found it difficult to care for the aged mothers-in-law. One was quoted as having said, “*handinetswi naamai vasiri vangu. Hamubetseri imi, hamubiki, hamurimi*”; which means “I cannot be bothered with someone who is not my mother, you are of no assistance to me, you cannot cook or help in the fields”. In addition to being childless, foreigners (especially Malawians) were chased away by the spouse’s relatives who claimed they would not be able to handle the foreigner if he died due to the foreigner’s peculiar burial procedure, “*vanhu vechirudzi vanonetsa kuzoviga kana vafa*”. Some of the foreign women could have gone back to their home country, but they had lost touch with their families. On being asked why she did not go back to her home country, one resident said she had left her home decades ago and did not know where her children now lived.

In contrast, at the low density skilled nursing facility, most residents take the facility as their retirement home. The majority came voluntarily since, in their culture, it is acceptable to stay in skilled nursing facility. After their children get married, they move out and start their families apart from the parents. So when the parents get old, they are put in retirement homes and the children can pay for their parents' stay at the home and occasionally come to visit them. The administrator indicated that the residents apply and are put on a waiting list. They are then interviewed so that they get familiar with life at the facility. In other words, the interview is not a screening process, but more of a familiarization meeting. Other residents come as an emergency, especially the destitute and those who have developed health problems and cannot be cared for at home. One resident who was interviewed said, "I fell and broke my hip and could not manage to run my household. My husband is forgetful, so we decided to come to the home". One other emergency case, quoted by the administrator, was of a man who had not reached the retirement age, but became blind and could not cope with his condition. He did not accept or adjust to his condition and was allegedly very difficult to manage.

The above presentation shows that some black elderly go to the skilled nursing facilities because of negligence by their children and relatives. It is a desperate move. One such elder, quoted by Katanga in the *Sunday Mail* (2010) said, "They packed my bags in 2005 and forcibly left me at this old people's home. They rarely visit; ever since I came here five years ago they only came twice". They go through the Social Welfare Department for accountability purposes because when they die, the government has to account for them. When some people get old, their children shun them because they are either very old, unrepresentable, or they have become a burden. However, traditionally, people take it as their responsibility to look after parents and grandparents when they get old, but at times the elderly end up at such facilities because of poverty. The presentation has also shown that one other underlying reason for neglecting parents was due to the influence of the western culture where nuclear families are upheld and the economy is declining.

Life at the Facility

The institutions provide for the physical, social, health, and emotional needs of the residents. At both facilities, most residents take the institution as their home. At the low density skilled nursing facility, residents are housed under two categories of shelter; that is, independent households and group housing. The former have self-contained cottages where the residents are fully independent. They do their own household chores, but in some cases, can employ an aide. The latter accommodates residents who require total care, including personal and household functions, and in some cases, healthcare. They have trained helpers. This type of housing is similar to that presented by Atchley (1985). Residents stay one per room in group housing and one per cottage in independent households, except for married couples who share a room/cottage. As the residents become less independent due to age or illness, they voluntarily move to group housing. This situation is similar to what happens in developed countries, as reported by Bernsten in Atchley (1985), where the elder person and his/her family recognize the need for a more

responsive setting and take responsibility in finding alternative accommodations, where frequent medication and monitoring is provided.

At the high density skilled nursing facility, housing is not categorized. There are units comprising bedrooms where two residents share a room. There is no distinction between those who require total care and those who are independent. They do most of their household chores, except cooking, which is done in a common kitchen. Those who require total care are paired with the more able for assistance.

Food at the low density facility is provided for those who need total care, while those who are fully independent provide their own food. At the high density facility, all residents are given food from the common kitchen, except in cases where one cooks his/her own relish when he/she wishes. There is a vast difference between the types of food provided at the two facilities. At the low density facility, a balanced diet is assured, including a pudding at every meal; while at the high density facility, the main meal is characterized by sadza and vegetables most of the time, lacking in protein, which is essential for the aged. This difference can be attributed to the fact that at the low density facility residents pay for their food, whilst at the high density facility, they depend on donations.

At the high density home, healthcare is provided through the Masvingo General Hospital and the Council Clinics. There, the aged are treated for free, the government caters for that as a service to the aged, since they cannot afford to pay their medical expenses. The situation is different at the low density facility, where the residents or their relatives pay for their medical expenses, although they are free to access free treatment at the General Hospital as well. There are trained medical personnel at the low density facility who take care of the residents' health problems. The institution does not provide medicine; residents have to buy from pharmacies.

At the high density skilled nursing facility, inmates who pass on are usually given a pauper's burial through the Department of Social Welfare. Relatives who bring them to the facility hardly collect them for burial at home, let alone attend the funerals. Although, in some cases, they indicate that they would like to be informed, but when informed they just say "*Chengetai ikoko*" (just bury him/her there). The administrator takes the responsibility of informing the Social Welfare Office, who, then, arranges for the pauper's burial. The case is different from that at the low density facility, where the dead are buried by their relatives, or the local European community in the case of the destitute. Recently at this facility, one resident who died and had no relatives was given a proper, decent burial by the community.

There is a sharp contrast in the way the elderly look at illness and death at the two homes. Weisman (1972) said most dying persons are afraid of being abandoned, humiliated, and lonely at the end of their lives. This was the case for residents at the high density facility, as indicated by one resident who said "*Zviri nani kuva pano pane kumusha. Pano tinochengetwa zvakana takarindira*" (it's better to be here than at home. Here we are well-looked after while we await death). Relatives of these residents cannot provide them with a descent burial; a pauper's burial is a

humiliation. In contrast, the residents at the low density facility are aware that they are awaiting death, but the majority is happy that they have relatives to check on them. The crucial factor for many residents in their adjustment is the relationship with their families. When they continue to feel involved and part of the family, when they do not feel abandoned, when they feel important, then they can manage living in a care facility more easily.

At both facilities, they have leisure time; however, aging gives limits to activities that can be done by residents because of changes in physical functioning (Atchley, 1985). This may restrict residents' activities to the institutional environment to the extent that they spend most of their time in the facility, without physical contact with the outside world.

At the high density skilled nursing facility, female inmates spend their leisure time crocheting, knitting, and weaving, using old yarn, plastic sacking, and old garments. They sell these items to visitors who come to the facility to get pocket money. Some male residents do odd jobs outside the facility. There are, however, some residents who spend their time sitting, doing nothing, reminiscing about their past lives. They hardly have leisure activities outside the facility and they do not seem to be involved in any community activity.

At the low density skilled nursing facility, residents spend their leisure time in different ways too. One female dependent resident goes out every morning to clean the street adjacent to the facility. She also knits jerseys for an orphanage. Another female independent resident, a former missionary, is involved in charity work. She teaches free Bible lessons and also knits and sews clothes for the same orphanage. These two residents are involved in what they call the Gender Club and the Women's Institute. According to Atchley (1985), these residents give meaning to their lives through service to others. One totally dependent male resident has become forgetful and spends most of the time daydreaming. The administrator says he is 'away with the fairies'. The residents can go to watch plays performed by the Masvingo Drama Circle. In addition, they have a library and can watch television in the lounge for entertainment.

At both facilities, residents establish new relationships with each other. This means that they have a change as far as their actual relationships are concerned. At the high density facility, the residents are encouraged to associate with residents in the facility, itself, rather than with outsiders. This is done to protect them from contracting infectious diseases, like TB and HIV (for those who are sexually active). Most of the activities are decided for them. This type of life is a deviation from the norms and values of the Zimbabwean social life, where the elderly are the ones who instruct, teach, guide, and preserve the culture. In these institutions, the elderly are robbed of their identity and responsibilities. When one lives in one's home, what they put in their mouths, the condition of their home, everything, is decided (to a great extent) by the individual. The individual makes the rules.xxxx The situation is different when one is in an institution. They had to let go of activities that they used to do at their homes. Their friends stopped visiting them and many no longer had social networks. Although they are provided with 'everything' that they need, they still do not have a sense of belonging.

Loneliness is a great challenge for these residents. The elderly hardly have any contacts with their families and the outside world. The situation is somewhat similar to that for the totally dependent residents at the low density facility, except that these ones still maintain ties with their families. In contrast, the residents in the fully independent housing at the low density facility are free to associate with anyone they want. They are independent and are very conscious of their independence. As one administrator put it, “they want their privacy” and have to be consulted if there is going to be some departure from the norm; it is like they have just changed homes.

At the high density skilled nursing facility, the inmates expressed that they were happy and contented. But, according to the administrator, she does not discuss their views and feelings about the facility as she is afraid to open old wounds. On their part, the residents may be afraid to say anything negative about their stay in the facility for fear of disappointing the caregivers whom they take as their savior. On the other hand, at the low density facility, the residents are free to speak out because they pay for their stay and they do not feel abandoned because they have contact with their relatives.

Church services at the high density skilled nursing facility are held at the facility and are compulsory, although those who attend other denominations are free to go out to their churches in their own time. At the low density facility, they hold interdenominational church services every Sunday afternoon, but these are not compulsory. In both cases, the facilities try to provide for the residents’ spiritual life, especially for those who are not able to go out to churches of their choice.

Challenges

At both skilled nursing facilities, there are some challenges that the caregivers have to contend with. At the high density facility, there are times when food gets finished and the administrators have to sound an S.O.S. with the donor community.

At the low density facility, they use the rent paid by the inmates to buy foodstuffs and, occasionally, some well-wishers bring lunch to share with the residents. There can also be drug shortages, which are normally provided by the residents’ relatives.

At the low density facility, one problem they have to deal with is that of uncooperative residents. Some residents who came under special circumstances may prove to be very uncooperative, refusing to talk to the caregivers except when they cannot help it. Such residents appear to be bitter about something, which they may or may not disclose to the caregivers, and it takes a lot of patience on the part of the caregiver to be able to manage such a character. Occasionally, they get an odd resident who refuses to accept that he/she can no longer manage on his/her own, and would rather send other residents to do his/her chores, like shopping, rather than move into the totally dependent quarters.

Another challenge for the caregivers at the low density facility is the fact that some residents need total care. There is one resident who is bedridden and another one who cannot speak, both having suffered from a stroke. The caregivers, thus, need extra skills to handle those residents.

CONCLUSION

The research has established that there is a vast difference in the way the two facilities are managed. One big difference noted is that there are whites only at the low density skilled nursing facility and there are blacks only at the high density facility. The white residents at the low density facility have made a choice to come to the facility; some even saved money to come and retire at this home. It is in their culture, so they come willingly to the facility. On the other hand, residents at the high density skilled nursing facility came because they were forced to by circumstances, such as poverty and negligence by children and relatives.

The two centers presented differences because of their financial circumstances. The high density facility depends totally on donations from agencies and well-wishers, whereas at the low density facility, residents pay for their stay. This, then, accounts for the differences in accommodation, the type of food offered at the centers, administration, entertainment, and life, in general, at the facilities. There seems to be a balanced diet at the low density facility as they are provided with a variety of food, as compared to the high density facility, where the diet consists of sadza and vegetables most of the time. Accommodations at the two facilities differ in the sense that at the high density facility, residents share bedrooms in pairs, while at the low density facilities, they do not share rooms, except for married couples. There is more privacy at the latter than at the former facility. There is no entertainment provided at the high density facility; residents entertain themselves by singing and talking about their past experiences, brooding over their lost identity; whilst at the low density facility, residents have a television in the lounge and a library, and they can go out to watch plays at the theatre.

From the analysis of the two skilled nursing facilities that were studied, it appears money changes everything. Even in South Africa, relatives prefer to keep their elderly at home because they get an old age grant, which the children or relatives can manage. Katanga sums it all up in the *Sunday Mail*, when he said that a gulf separates retirement homes. It appears that skilled nursing facilities are a haven for whites, and mere survival for black destitutes.

In conclusion, sustainable development needs to uphold good cultural practices where the aged remain part of the family structure. , In any culture, the elderly are considered as custodians of the culture and their role is to pass on the cultural values to the younger generations. Such values like respect of self and others, maintaining one's identity and being human, what in Zimbabwe the Shona call "unhu", and in Ndebele, "ubuntu".

RECOMMENDATIONS

The study recommends that the State establishes a social fund where the elderly get an old age grant to cater for their basic needs. If this is done, it would be easier for children and relatives to take care of their elderly in their homes, for they would no longer be an economic burden, thereby keeping the family intact. There is also a need to sensitize blacks on the need to support the skilled nursing facilities.

REFERENCES

- Atchley, R.C. (1985). *Social Forces and Aging*. California: Wadsworth Publishing Co.
- Bernsten (1985). In R. C. Atchley, R.C. (Ed.), *Social Forces and Aging*. California: Wadsworth Publishing Co.
- Fraenkel, J.R. & Wallen, N.E. (1986). *How to Design and Evaluate Research*. New York: McGraw Hill.
- Hopkins, J. (n.d.). *Nursing Homes: The Family Journey*. Retrieved from: www.NursingHomesBook.com accessed May 20, 2010.
- Kambisa Report. (2010). *Child Care, Elderly and Emancipation – Netherlands vs Zambia*. Retrieved from: www.kambisa.com/index.php, on August 18, 2010.
- Katanga, T. (2010). Gulf Separates Retirement Homes: A Haven for Whites: Mere Survival for Black Destitutes. *The Sunday Mail*, pD3.
- Leedy, P.D. & Ormrod, J.E. (2005). *Practical Research: Planning and Design*, (8th Ed.). New Jersey: Pearson Education, Inc.
- Mweetwa, D. (2010). Retrieved from: www.globalpressinstitute.org/global, on August 25, 2010
- Silin, P. (1998). *Alone in a Crowd- social isolation of seniors in Care facilities*. Vancouver, B.C.: Peanut Butter Publishing. Retrieved from: www.ec-online.net, on May 20, 2010
- Weeisman, A.D. (1972). *On Dying and denying*. New York: Behavioral Publications.
- Liberia-Cote D'Ivoire: Hope, Hardship, and Hospitality. (2011). Retrieved from: www.irinnews.org/Report.aspx, on May 20, 2010.
- Roebuck. (1979). Retrieved from: <http://www.who.int/healthinfo/survey/ageingdefnolder/en/index.html>, on August 18, 2010.
- WHO. Wikipedia definition. Retrieved from: www.who.int/./index.html, on August 18, 2010.
- Wikipedia definition. Retrieved from http://www.en.wikipedia.org/wiki/comparativeresearch#research_defined, on September 15, 2010.

ABOUT THE AUTHORS:

Louise Stanley Madungwe is a lecturer in Mathematics; Isabel Makwara Mupfumira is a lecturer in Home Economics; and Winnet Chindedza is a lecturer in English, all at Great Zimbabwe University, Faculty of Education, Department of Curriculum Studies.