Elderly Care: An Examination of Shahuchi Old People's Home, Kano, Nigeria

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Abstract

In Nigeria, it is expected that children take care of their parents in their old age. However, it is increasingly becoming more difficult for children to cater for their aged parents who are not economically buoyant. Because of filial piety, the idea of putting one's parents in an institution like old people's home is an anathema for most people. Yet the need for such homes and other specialized care for the elderly is obvious in the light of the burden being experienced by women who are the major primary caregivers. This study of an Old People's Home in Kano revealed that other than the accommodation and feeding provided, there are no specialized programmes and facilities to cater for the physical, mental and social needs of the elderly. Gender segregation is enforced but no consideration is given to differences in age, physical and developmental challenges. This highlights the urgent need for the Nigerian government to take more proactive measures in its policy on ageing by making provisions for long-term care facilities, residential arrangements with assisted living facilities, and adult day care centres with competent personnel.

Keywords: old people's home, filial piety, primary caregiver, long-term care, assisted living

Introduction

Most people in Nigeria hope to live to ripe old age. In modern time, with technological advancement in medicine, better nutrition and hygiene, many diseases are being increasingly contained and improvements in environmental and living conditions have helped to prolong life. Longevity, however, comes with its challenges such as Alzheimer and other forms of dementia, diabetes, blood pressure, cardiac problems, frailty, kidney diseases, cancers, etc. These health conditions place more burdens on the health care system but much more on the family and other social support systems because of the lack of inadequacy of formal care for the elderly in Nigeria.

In order to ameliorate the challenges of long term care for elderly persons, some faith-based charity organizations establish homes to cater for the elderly in their communities. Such examples include the Regina Mundi Home for the elderly, Mushin-Lagos and Kado Elderly Home, Abuja. There are private ones like Miradora Luxury Homes, Maryland, Lagos. The government establishment like the Kano State Emergency Relief and Rehabilitation Agency in Shahuchi, is an exception in that it is government funded. However, it

admits people of all age groups with physical challenges (physical disability) and or psychological challenges (mental illness). This paper therefore seeks to understand the types and quality of facilities and care that are available to residents of the home compared to what obtains in developed countries with a view to proffering solutions within the Nigerian context.

Statement of problem

It is estimated that by 2015, there will be 64.6million elderly in the world. This figure is expected to rise to 103 million in 2030 and over 205 million by 2050 (UN, 2002). In a population of over 170 million people (C.I.A. Fact Book, 2012) and in the absence of institutional support for the care of the elderly in Nigeria, coupled with economic difficulties of unemployment, poverty, inflation, urbanization and migration, it is increasingly difficult for many families and grown up children to manage their own families of procreation let alone cater for their aged parents.

Since 2002, attempts to formulate policies to address the problem of ageing at regional and national levels such as African Union Policy Framework and Plan of Action on Ageing (2003) and the National Policy on Aging (Draft 2006) have not yielded the desired result (Ajomale, 2007). That Nigeria is yet to ratify its own 2008 Draft National Policy on Ageing is an indictment of the government's commitment to the elderly. However, as Kofi Annan, the then Secretary General to the United Nations, in his message at the Madrid Plan of Action, observed, "The problem is not the shortage of policies but the real test will be implementation." In the same vein, Asagba (2005) blames the leaders for their indifference and lack of political will to address ageing challenges. This view is shared by the Minister of Health, Professor Christian Onyebuchi Chukwu, who in a statement to commemorate the World Health Day in 2012 admitted that:

There is low awareness of the challenges and needs of the elderly people in Nigeria. This is due to the fact that they constitute a relatively small proportion of the population. In the presence of competing health needs, they are relegated to the background. Elderly people are seriously threatened by poverty, wants and needs, deprivation, abuse, ill health, social exclusion, loneliness and suffering among others (This Day Live, 2013).

The Madrid Plan of Action (2002) which was drawn up to address the wellbeing of the aged will remain a mirage if the current attitudes towards the aged persists as many people will be unable to age gracefully. This paper highlights the dearth in knowledge of facilities and care for elderly people in Nigeria despite the adoption of the Social Protection Strategy following the 2005 Social Protection Conference in Helsinki, Finland. One of the objectives of the conference is, "to provide income support for the poorest especially the

sick, disabled and retirees.” With regard to those who are above 65 years, one of the social protection interventions consists of “Establishing old people’s home for age 65 years. It should however be established as a Day Care Centre where old people can go daily and return to their homes in the evening.” All the three tiers of government in Nigeria are therefore to provide the enabling environment including logistic and financial commitments (National Social Protection Committee, 2005).

In line with this provision, the attempt by the Kano State government to establish the Kano State Emergency Relief and Rehabilitation Agency (SERERA) popularly known as *Gidan Gajiyayu* (meaning “Old people’s Home” in Hausa language), is commendable. The institution caters for a broad category of people - the old, the young, the destitute, the mentally and physically challenged, men and women. The fact that the elderly as a special category are lumped with the other people is a pointer to the flaw and dearth of facilities for elderly care. The goal of this study is to assess the functioning of this Home. The objectives of the study therefore are: to understand who runs the facility; assess the facilities in the Home; examine the category of people admitted in the home; investigate the interaction patterns among the residents; and assess the extent to which the home fulfils its function as an “Old People’s Home.”

Review of Literature

Who caters for the elderly?

The elderly, that is, those who have attained the age of 60 years are expected to be catered for both at formal and informal levels. Generally in Africa and Asian countries, the care of the elderly rests on family members. Because of the belief in filial piety, such burden is considered as normal, and this explains why intergenerational households persist (Gupta and Pillai, 2002). Sheykhi (2002) does not share this optimism but opined that filial piety or filial love puts more stress on the family members to provide for the elderly. When they are not in a position to help and if there are no means of formal assistance, then, these senior citizens will be left at the mercy of the public. With reference to Chinese society, Chow (2007) observed that filial piety ensures that parents get the care and respect they deserve and remains a strong value in Chinese society. This ideal, however, is beginning to wane due to weakened social and family bonds, materialism, migration and modernization in China.

Many Nigerian older adults are trapped in a web of poverty and neglect by family, community and society at large because formal institutions that cater for aged are virtually non-existent and where they exist, they are too small and ill-equipped. Eze (2013) decried the situation where there are only 13 Old People’s Homes in the country, out of which 5 are in Lagos, as unacceptable. This is contrary to the provision in section 16. 2.(d) of the Constitution of Nigeria which states that, “suitable and adequate shelter and suitable and adequate food, reasonable national minimum living wage, **old age care** and pensions and unemployment, sick benefits and welfare of the disabled are

provided for all citizens.” Unfortunately, the only beneficiaries are those in formal employment who have pension benefits which is only a fraction of the working population (Bailey and Turner, 2002). Even those elders who qualify for pensions are often subjected to inhuman and degrading treatment in their attempts to get their meagre benefits (Obe, 2003; Giwa, 2004 and Olori, 2004). Often this delay is due to corrupt practices in the pension scheme (Uwerunonye, 2013; Agbo, Suleiman and Uwerunonye, 2013; Yunusa, 2013; Obi, nd).

It has been observed that women form the bulk of caregivers both in formal and informal care. This could be because women generally outlive men, and they are less likely to remarry which explains the higher number of unmarried elderly women compared to the elderly men (Novak, 2012). In Nigeria, while widowers are encouraged to remarry as soon as possible irrespective of their age, widows on the other hand “marry” their children as it were, because most men would not want to inherit any liability. They prefer to marry single and younger women rather than marry women who already have children. The implication of such gender bias is that women of all ages continue to be at the receiving end. As daughters, sisters and especially wives, they continue to “baby-sit” men at all ages. Thus, while men retire from work, women never retire and their longevity does not necessarily translate to better quality of life for them.

With more women in paid employment, there will be increasing burden on both the younger and older generations of female family members to stretch themselves further, and without support from formal care givers and the government, they are placed under tremendous stress. As Narace-Waliser, Spriggs and Feldman (2002) corroborated:

Women have difficulty with care provision and balancing care giving with other family and employment responsibilities; suffer from poorer emotional health secondary to care giving and cope with care giving responsibilities by forgoing respite participation and engaging in increased religious activities.

The danger that looms is that if population declines, without formal care support, the lopsidedness of female caregivers - a phenomenon Forti, Johnson and Graber (2000), referred to as the “Sandwich Generation” - will erode the family support system eventually.

Types of Care setting for the Elderly

There are two types of care for the elderly: **Informal** care provided by families, and **Formal care** provided by professional caregivers. A professional caregiver is one who is paid to provide physical and psychological support to a frail dependent elderly person such as a doctor, nurse or home health aide (Theis and Dietrick, 1987: 85). The care settings are what Wacker and Roberto (2008)

referred to as supportive living environments designed to help elders who though independent, may still need some sort of assistance in varying degrees.

These needs are measured in terms of need for assistance with basic Activities of Daily Living (ADLs) such as personal care like bathing, toileting, dressing and feeding; and Instrumental Activities of Daily Living (IADLs) that is, help with household chores, shopping, etc., and low-tech services such as canes, meant to facilitate their functioning (Stone, 2000). In recent times, electronic gadgets like the computer called “Giraffe,” now allows elders who live alone to be monitored by their loved ones to ensure their safety.

The care facilities are available in a continuum depending on cost and choice of individuals. Professional care providers operate in the following types of care settings identified by Wanklyn (1996), Theis and Dietrick (1987), Wacker and Roberto (2008). These include:

Sheltered Housing where Senior citizens can rent or buy the flats or bungalows that have been specially designed by the developers for the elderly.

Assisted Living Communities: These are accommodations with assisted living facilities (ALFs). There are also community residential care like **In-Houses, Board and Care** (non-medical care for the poor).

Continuing Care Retirement Communities (CCRCs): Such communities provide a continuum of residential care options located within the same complex. This allows one to move from an independent to an assisted living accommodation type and finally to a nursing home as the health of the person degenerates.

Adult Foster Homes: These are homes where families volunteer to take in the physically, mentally and emotionally challenged.

Congregate facilities like the Abbey Field Houses - (large Houses run by the Abbey Field Society with up to 10 residents sharing meals together).

Residential Homes: These are homes set up by individuals for elderly people who need assistance with daily living. Some are reserved for special needs such as those with mental illness or physical disabilities. Sometimes, such facilities are reserved for people with **Special Needs** like ethnic and religious minorities or those with dietary restrictions. Residential homes can register between 4 -7 people. Where they can afford it, elderly people may employ **Home care services** which offer comprehensive care in the comfort and privacy of their own homes.

Nursing Home: This is the most dependent of all the facilities as it implies long term care. Here, elders with chronic illnesses or medical conditions that occurred at birth or during developmental stages like cases of arthritis,

dementia, diabetes and cancer require 24-hour care. Such facilities are often owned and run by private individuals or faith-based organizations. Geriatric doctors and nurses though scarce, are in high demand here.

Day Nursing Home: This is a nursing home care facility that caters for the elderly during the day and transports them back to their own homes in the evening.

Adult Respite Care: is a temporary short-term supervisory personal and nursing care provided to people with physical or mental problems. There are several types such as: **In-Home respite** care, where the caregiver comes to the home to provide services; **Adult Day care** - a community-based group programme for the functionally impaired and **Institutional Respite** care is like a temporary nursing home.

Hospices: These are facilities that provide temporary relief and comfort to the residents with terminal illness until they die (usually a few weeks or months).

Methodology

The Kano State Emergency Relief and Rehabilitation Agency - Old People's Home - Shahuchi, is one of the 13 Rehabilitation Agencies spread across the state. The institution caters for a broad category of people - the old, the young, the destitute, the mentally and physically challenged, men and women. The home, however, is more popular for its elderly occupants hence the name *Gidan Gajiyayu*, (meaning "old people's home" in Hausa language).

The study is based on both observation and interviews with staff and residents of the facility. Based on the initial pilot study, the idea of a survey was shelved because of the condition of the residents. Most had one form of impairment or the other and so the researcher relied on reports from staff who took her round the facility.

History of the Home: The home was established in 1968 but started functioning fully in 1969 as a charity home for families of the less privileged patients who came to the Murtala Mohammed Hospital for treatment. However, other categories of people were accommodated since there was enough room for more. The facility eventually housed a cocktail of cases such as abandoned children, lost persons, and destitutes of all ages; single mothers with unplanned pregnancies who could not go to their families as well as epilepsy, psychiatric and drug addiction cases.

Findings

At the time of the study (December, 2013), there was a total of 66 residents made up of 29 adult males, 32 adult females and 5 children. Also in the home,

was a young man in his late 20's who had been raised at the institution. His mother who was deaf came with him as a baby but eventually married a staff of the institution while the boy continued living in the home. He is currently a student at the Federal College of Education under the sponsorship of the Kano State government. According to the head of the institution, Oman (pseudo name) has adjusted to the institution so much so that he prefers to stay in the institution whenever he is on holidays than to live with his biological mother who lives in town.

Staffing: The staff of the institution are drawn from the Social Welfare, Medical and Administration sections. The Officer-in-charge of the facility is assisted by the following: two administrative staff, two paramedics, four kitchen staff, two tailors, four security men and eight attendants. She in turn is answerable to the Medical Director at their head office in town. Table 1 reveals that most of the staff are in the lower cadre. This is reflected in the fact only two of them have university degrees - the Officer-in-charge who has a background in education and another staff who has a degree in Sociology. Although there was no medical doctor on ground during the period of the interview and observation, we were reliably informed that qualified medical doctors and psychiatrists make routine visits to provide medical care for residents. In their absence, however, the paraprofessionals attend to the medical needs that are not life threatening.

Table 1: Staff Strength of Shahuchi Old People's Home by Gender

Staff cadre	Male	Female	Total
Administrative staff	1	1	2
Paramedical staff	1	1	2
Tailors	1	1	2
Kitchen Staff	-	4	4
Security	4	-	4
Attendants	2	6	8
Total	9	13	22

Source: Fieldwork, 2013

Admission into the Home: Admission into the home is mainly through the Medical Director at the headquarters of the Rehabilitation agency. However, the public could also bring in people who are lost like cases of fugue - a situation where someone loses track of their identity, family and location. In some cases, family members themselves apply to bring their loved ones because they cannot cope with the demands of the person's illness. Sometimes, the Social Welfare Department and some non-governmental organizations refer individuals to the home. Also, individuals may come on their own when they need assistance with accommodation and care. One elderly woman for

example, who came from Maiduguri with her son for treatment, was admitted there on account of her son's ill health (bladder problem).

When the medical doctors certify a person fit to leave the facility, the discharge is carried out in four ways:

Discharge by Repatriation: this is a situation where the person so discharged is accompanied by a staff to his or her home town. If they are from distant places, they hand them to leaders of ethnic-based voluntary associations to identify them or help locate their families in their home towns. In spite of the provisions made by the government to assist people, residents sometimes face rejection by their own families. At the time of observation, were told of a nine year old girl who lived at the facility with her mother who was HIV positive. After the demise of her mother, the young girl was able to describe her family house and even identified her former school to the staff who had accompanied her back to her community. As soon as she sighted her family house, she ran ahead of the staff in excitement but her excitement was short-lived as her family rejected her saying they did not know her. To worsen matters, the neighbours also were tight-lipped about her family and so the little girl was returned to the old people's home. The family probably found it difficult to deal with the stigma associated with HIV/AIDS.

Discharge with Home Visits: Here the person is discharged but is regularly monitored through home visits to ascertain if he or she is taking the drugs and if there is improvement in his/her condition. Where the person's health does not improve or deteriorates, such a person is readmitted.

Total Discharge: Here, it is assumed that permanent healing is impossible and so the individuals are handed over to the custody of their families who are then required to come with the "patients" for regular appointments with the professionals. Cases like epilepsy and some forms of mental illness fall within this category.

Discharge: Where the medical conditions have been successfully treated, the individuals are not expected to remain in the facility but are free to go home.

A gender analysis of the old people over the age of 60 shows that there were 24 elderly people made up of 13 women and 11 men. Their health challenges are summarized below.

The elderly men were all in their seventies with the exception of one who was in his eighties. Every one of them had one health challenge or the other. Among the three elderly men who have mental illness, one is also crippled. In one of the cases, a retiree, in his seventies, was brought to the home by his

three wives who could no longer cope with his deteriorating mental health. Among the developmentally challenged (Mentally retarded), in the case of an elderly man in his seventies, neither his wife nor children could cope with him and so his own elderly mother decided to bring him to the Old People's home so that her family could get some relief. One other man was deaf, paralyzed and developmentally challenged.

Of those who have physical challenges, one man has arthritis as a result of which he finds it difficult to move around and also suffers from high blood pressure which explains the constant headaches, eye problem and dizziness he complained of. Unfortunately, his only wife and all three children are late so his paternal uncle brought him to the home. Another man who suffers from paralysis though childless is fortunate to have a wife who visits him regularly. One man who has problems with his lower limbs was referred to the home by the Social Welfare Department. Not much is known about him. Similarly, a deaf and mute elderly man in his seventies was brought by good Samaritans to the home when they could not help him locate his family. The oldest man who was in his eighties was recovering from some wounds that incapacitated him but his family lives in Benin, Edo state.

Unlike the men, all of whom had health challenges, three of the elderly women were healthy. One of such women was in the home on account of her son who was then undergoing treatment for bladder infection. Even though she was about seventy five years, her age did not deter her from accompanying her son from Maiduguri (a distance of about six hours drive). The home makes provisions for indigent people who are referred to hospitals in Kano and who have to wait for some days/weeks to undergo treatment. Her son who had catheter was seen carrying the bag of urine in the male section of the home.

The women, like their male counterparts, have health challenges but in general, there were more elderly women in their eighties than men. Often it was their family members who took them to the home because of the difficulty of having to cater for them. Of the four cases of mental illness, only one verbally aggressive old woman in her eighties was brought by members of the public. One was brought by her sons while the other two were brought by their daughters. Like their male counterparts, mental problems constitute the bulk of the illnesses of the elderly in the facility.

Table 2 reveals that most of the elderly 29.2% (7), have mental illness and the majority, 79% (19), were brought in by their families who could not cope with the demands of the old people's health conditions.

Table 2: Characteristics of Older Residents by Gender

Major type of Illness	Male	Female	Total
Mental ill (Psychiatric case)	3	4	7
Mental Retardation	3	1	4
Normal/Healthy	0	3	3
Deaf	0	2	2
Deaf/Mute	1	1	2
Physically ill/handicapped	3	1	4
Senile/dementia	1	1	2
Total	11	13	24
Means of admission into the Home			
Referral from Welfare Office	1	1	2
Family	8	11	19
Public	2	1	3
Total	11	13	24

Discussions

With respect to the first objective of who runs the facilities, the findings reveal that Kano State government remains the major funder of the Old People's Home. According to the officer-in-charge of the facility, the local governments in which each of the other 13 Rehabilitation Centres are located are mandated to contribute their quota towards the feeding, medication and care of the residents as well as payment of staff salaries. Other sources of funding include corporate organizations, prominent citizens, non- governmental organizations, visitors and families.

In terms of facilities in the home, the compound is divided into two sections: One for the men and the other for the women. The men occupy the outer courtyard with a dormitory (Plates 3-6) and eight single rooms (4 in front and 4 behind, but the rooms behind are for those with severe conditions (Plates 8). The women have a similar pattern enclosed within an inner compound separated by a gate and an additional building with 10 single rooms in the outer courtyard (Plates 13&18). Each dormitory takes 10 single mattresses (there are no beds, except in one of the rooms in the male section); and each single room accommodates 2-3 mattresses (Plate 16).

The Home has a bus that conveys residents for outings such as visits to the government house on special occasions and medical care. There is a borehole and a temporary mortuary where the remains of those who die at night are kept before burial the following day (Plates 7 &10).

On the category of people admitted in the home, all categories of distressed people are admitted into the home but they interact minimally with each other. This may be because of the design of the home which is similar to the predominant pattern of houses where women's quarter is in the inner compound (and for those in purdah, all their activities are restricted to that

section and they rarely leave the compound), while men's quarter is in the front thus acting as gatekeepers. Such arrangement is in line with Islamic culture which explains why there is hardly any interaction between male and female residents. And even among residents themselves, interactions are minimal (See Plates 3,4,6,7,10,13,14,15,17-19).

Plates 15 & 18 exemplify the behaviour of residents to each other. No one paid attention to the woman during her epilepsy attack because they were used to such episodes and according to one of the residents, "She will get over it." Similarly, the women in Plates 14 & 17 were consistently distant from one another on two separate days of observation. The fact that many have some form of mental or physical impairments may explain the distance they keep from each other. Furthermore, though the staff make efforts to visit the residents, there is the tendency for the latter to keep more to themselves but not in an antagonistic manner as described by Goffman (1961).

Goffman (1961: 7) described antagonistic relationships in Total Institutions where staff and inmates "conceive of the other in terms of narrow hostile stereotypes, staff often seeing inmates as bitter, secretive, and untrustworthy, while inmates often see staff as condescending, highhanded, and mean. Staff tend to feel superior and righteous; inmates tend in some ways at least, to feel inferior, weak, blameworthy and guilty." No doubt there is some sort of social distance but not in a condescending manner as my impromptu visits confirm.

To what extent does the Old People's Home fulfil its mandate? This could be said to be partially fulfilled. There is more that needs to be done in terms of separating the old people from other people and providing specialized care for them according to their needs for daily assisted living, medical attention, exercises, and individual needs (medical, dietary, physical, etc.).

In general, the facility is well kept and the female wing is particularly very neat. But on close observation, especially in the male section, there seemed to be less interaction with the very old men who looked ill and the mentally retarded. Some of the mentally challenged are kept in the back rooms and they are more likely to sit around the mortuary and toilet area (Plates 7 & 10) while others relax in the open space in front of the dormitory (Plate 4). Moreover, there seems to be no visitors to the male section. In the two days we went for observation, there were female visitors who had come to spend some time with their friends or relations but we did not observe such for men.

Also, there seems to be no proper record keeping on each resident. The clerical staff need to improve on their record keeping. On a positive note, Kano State government has given laudable attention to the indigent population in the State. One of the physically disabled men testified that he could not walk when he was brought to the home but after two surgeries in Egypt, all expenses paid by the government, he is now able to move with wooden crutches. He now repairs electronic gadgets. The state government however needs to do more with particular reference to the facility and training of staff on care of the aged. There is also the need to provide recreational facilities and encourage exercises to enhance their physical, psychological and social wellbeing. As it is, there are

no such opportunities except when some of them are taken to the Government House on festive occasions like Sallah celebrations.

Conclusion

The Old People's home in Shahusi, Kano is not the ideal setting for care of the elderly. However, the government of Kano State, staff of the facility and people of Kano state should be commended for the charity work they render to different categories of mentally, psychologically and physically challenged people. These go a long way to fulfil shelter, care, feeding, medical and safety needs which some residents may never obtain outside the home. To conclude, the facility is a stepping stone to better care for the elderly in the future and gains in such small beginnings should be sustained.

Recommendations

In view of the above observations, it is recommended that staff undergo periodic training on ageing and a qualified gerontologist should be recruited to oversee the facility and social workers to assist them. Moreover, the fact that many residents lie idle calls for some form of mental and physical stimulation. Physical and mental stimulation in the form of exercises, crafts, television, games and other recreational activities should be introduced to the residents. In particular, sporting activities should be organized where all the residents can be encouraged to break barriers and interact with one another. In addition, a common room equipped with television and games and a mini gymnasium should be provided for recreational and fitness purposes under the supervision of a qualified personnel.

More importantly, the elderly should be separated from other residents and accorded befitting care in line with their health challenges. This means that there should be a section for nursing home with qualified staff and another section like day-care facility where families can afford their loved ones the opportunity of socializing with their peers during the day. Also, proper beds should be provided for the residents instead of the current situations where they sleep on mattresses on the floor. Moreover, chairs and tables should be provided for residents to relax properly rather than sleeping and sitting on bare floor.

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Appendix 1a –Photographs of the Old People’s Home, Shahuchi, Kano

Plate 1: Entrance to the Home.

Plate 4: Male residents outside their dormitory shortly after breakfast

Plate 2: Administration Building

Plate 5: Taking a nap outside the dormitory

Plate 3: A weak elderly man unable to join the others outside, remains indoors with a potty beside him

Plate 6: Inside the Male Dormitory. Note two elderly men on the extreme ends on the right side of the room and a younger man on the left.

Appendix 1b: Male Section cont'd

Plate 7: Residents relaxing in front of the toilet

Plate10: A developmentally challenged resident wraps himself up in a blanket beside the mortuary

Plate 8: Young man in fetters

Plate 11: A resident attendant with some of the children

Plate 9: Inside the female dormitory

Plate 12: Lunch time, head cook dishes out rice and beans meal

Appendix 1c: Female Hostel

Plate 13: Smaller Female Hostel (Inner courtyard)

Plate 14: Relaxing outside the female dormitory while keeping their distance. Note the isolation from each other but also tidiness of their environment

Plate 15: A female resident having a seizure

Plate 16: Inside view of one of the rooms

Plate 17: The same elderly women on a different day of observation also maintain their distance from each other

Plate 18: She recovers from an epilepsy attack. A gate in the background separates the women from the men

Plate 19: Oldest resident, she is deaf and mute. She has lived there for over 25yrs.

Plate 22: Inside the room of an elderly person

MODERN CONVENIENCES FOR THE ELDERLY FROM TEXAS, USA

Plates 20: Shower with handles

Plate 23: Shower with a fixed seat.

Plate 21: Toilet Chair

Plate 24: Toilet Stool bbbbar bar

App. 2: SENIOUR FACILITIES FROM DENTON AND LEWISVILLE, TEXAS

Plate 25: Equipment to alert a fall from bed

Plate 28: Living room and library for dependent elderly

Plate 26: Elders exercising

Plate 29: Equipment for lifting the elderly from a bed

Plate 27: Playing games at a Daycare Center

Plate 30: Swimming pool at a Day Care Centre