Population Ageing in Zambia:

Magnitude, Challenges and Determinants

BY

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DECLARATION

I Christopher Chabila Mapoma hereby declare that this Thesis represents my work, has not previously been submitted for any degree at this or any other University and does not incorporate any published work or material from another thesis or dissertation.

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Christopher Chabila Mapoma

APPROVAL

This Thesis of Christopher Chabila Mapoma is approved as fulfilling the requirements for the award of the degree of **Doctor of Philosophy in Population Studies** by The University of Zambia.

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ABSTRACT

This Study investigated the magnitude, challenges and determinants of population ageing in Zambia. Specifically, the study investigated past and future trends of population ageing; challenges older people face, determinants of active ageing and the existence and adequacy of policies for older people. The study has demonstrated that Zambia's population, like the rest of Africa is also ageing; older people are faced with several challenges occurring at individual or micro level as well as those determined by the socio-economic and demographic environment or macro level. However, the most prominent of them all is low self-esteem. Others which directly contribute to low self-esteem include health problems, functional limitations, lack of care and support – both by family and institutions, including government – constrained living arrangements and lack of opportunities for both work and income generating activities. This study has also shown that income accessibility (Economic Determinant), functional limitations (Health Determinants), low self esteem and loneliness (Personal/Behavioural Determinants), low family and peer interactions (Social Determinants) and HIV/AIDS determine active ageing in Zambia. With regard to policies, the study has demonstrated that although the draft policy on ageing is currently in place, it falls short of addressing many aspects and challenges of ageing. In view of these findings, the study recommends a paradigm shift where the family is strengthened and encouraged to continue playing its traditional, but significant role of looking after, caring for and supporting older generations. The study also recommends that the policy on ageing should be structured to reflect main determinants of active ageing in the context of Zambia.

DEDICATION

To my children:

I thank The **Lord Jesus Christ** for you little angels; to me, you will forever be my babies no matter how big or old you become; but I challenge you to excel beyond and above this piece of work; remember no obstacle is insurmountable; faith in **GOD** and *hard work* does the trick.

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CHAPTER 1: INTRODUCTION

> *"…It is not by muscle, speed or physical dexterity that great things are achieved, but by reflection, force of character, and judgment; and in these qualities old age is usually not poorer, but is even richer"* (**Marcus Tullius Cicero, Roman Senator (106-43 B.C)).**

This chapter contextualizes the problem as well as giving the background to ageing at global and regional levels. The chapter also discusses the statement of the problem, rationale, objectives and the conceptual framework.

1.1 What is Population Ageing?

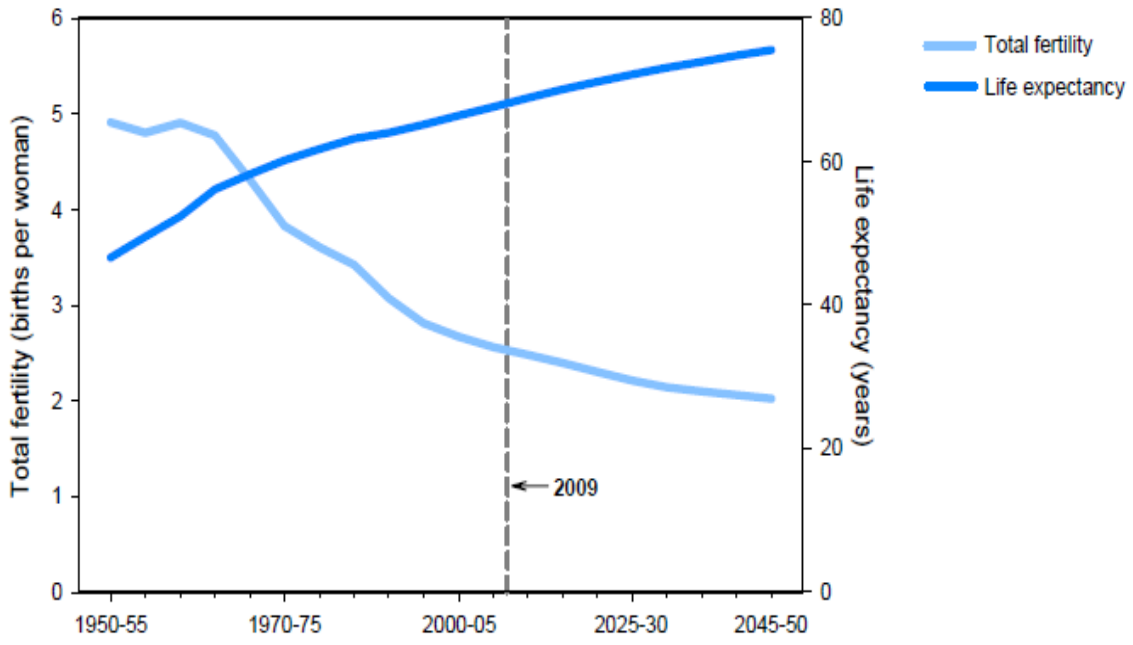
When the question 'what is population ageing?' is asked, different answers emerge. While the question is simple, it however, yields several uncomplicated but differing answers. The commonest response is that 'there is change in age structure where older people become more prominent'. Another response is 'the increase in the proportion of older people compared to younger ages'; similarly, others say it is the 'increase in the old age dependency ratios' (Kucera, 2010; Weeks, 2004; Medicare Board of Trustees, 2003; US Census Bureau, 2000; ILO/EASMAT, 1997). The common part of all these answers to this question is that when the population is ageing, there is also change in the age structure with an increasing proportion of older people in the population. According to the United Nations World Population Ageing (2009), population ageing is simply 'the process whereby older individuals account for a proportionally larger share of the population'.

1.2 Determinants of Population Ageing

Population ageing has been linked to 'demographic transition'. The reason for this linkage is because the underlying processes have been similar to the demographic transition (United Nations, 2007a). Decreasing fertility, along with increasing life expectancy, has reshaped the age structure of the population in most regions of the planet by shifting the relative weight of the population from

younger to older groups (Lesthaeghe, 2004). Figure 1 presents Total Fertility Rate (TFR) reductions experienced at global level since 1950 projected through to 2050 and life expectancy for the same period.

Figure 1: Total Fertility Rate and Life Expectancy at Birth, 1950-2050

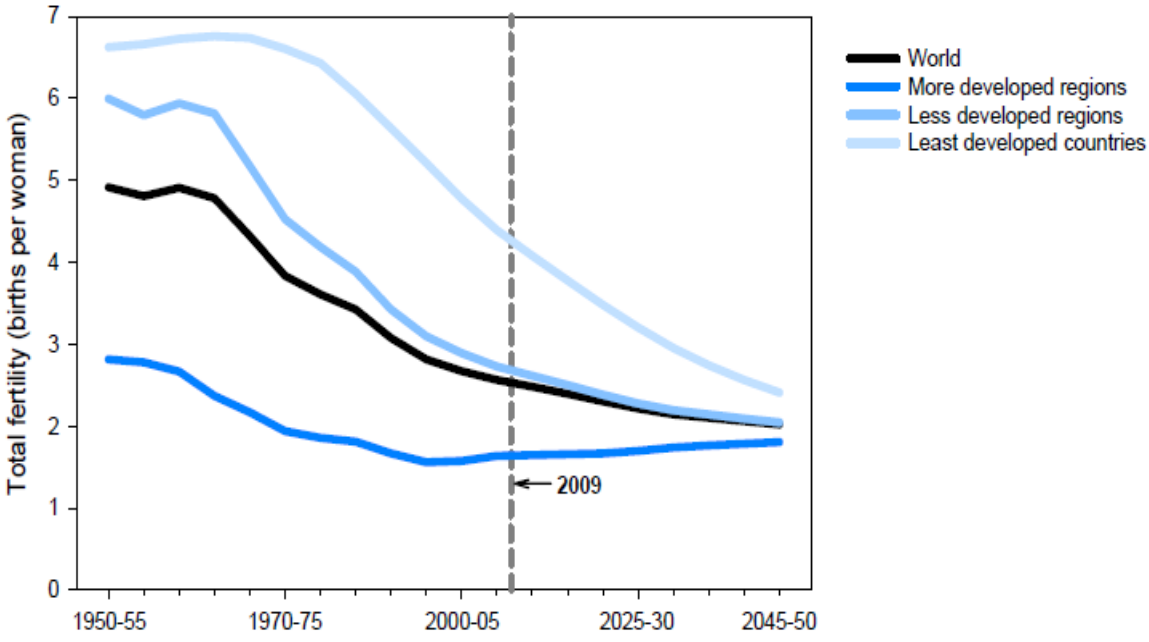


Source: United Nations – World Population Ageing, 2009

One of the prominently cited reasons contributing to population ageing in the world is fertility reduction. Decreasing fertility has been the primary cause of population ageing. As fertility moves steadily to lower levels, people of reproductive age have fewer children relative to those of older generations. Sustained fertility reductions eventually lead to a reduction of the proportion of children and young persons in a population and a corresponding increase of the proportions in older groups (United Nations, 2009). The reduction of fertility has been dramatic since 1950. At the world level, total fertility has dropped almost by half, from 4.9 children per woman in 1950-1955 to 2.6 in 2005-2010, and it is expected to keep on declining to reach 2.0 children per woman in 2045-2050 (United Nations, 2009).

Due to the continuous decrease in fertility, many countries of the world, especially the more developed regions, have been affected by having a fertility level considered below replacement. For example, total fertility in the more developed regions has dropped from an already low level of 2.8 children per woman in 1950-1955, to an extremely low level of 1.6 children per woman in 2005-2010. This level is well below that needed to ensure replacement of generations (about 2.1 children per woman). In fact, practically all developed countries are currently experiencing below-replacement fertility (*Ibid*, 2009). In less developed countries, the situation is similar. The United Nations (2007a) reports that major fertility reductions in the less developed regions occurred, in general, during the last three decades of the twentieth century. From 1950-1955 to 2005-2010, total fertility in the developing world dropped by over half from 6.0 to 2.7 children per woman (Figure 2).

Figure 2: Total Fertility Rate: World and Development Regions, 1950-2050

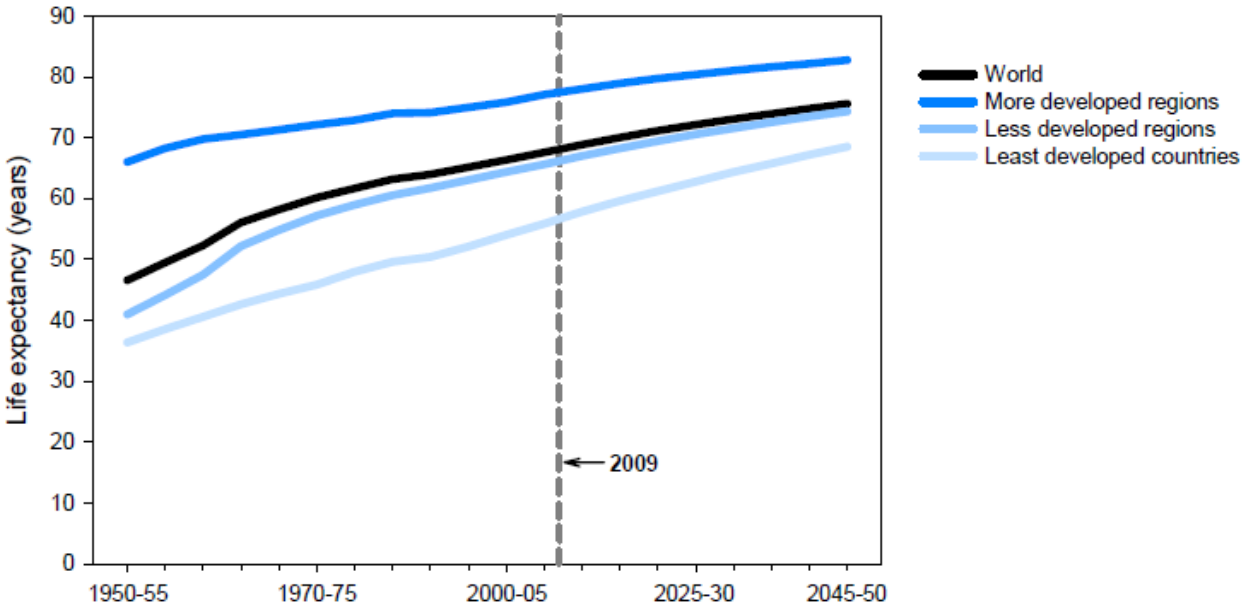


Source: United Nations – World Population Ageing 2009

However, the United Nations (2007a) notes that while the world is moving towards lower fertility experiences, there are great disparities. For example, it is reported that in least developed countries, total fertility is now 4.4 children per woman. In particular, in Eastern Africa, Middle Africa and Western Africa, total fertility is still in excess of 5.2 children per woman. Nonetheless, in Eastern Asia, South-Eastern Asia, the Caribbean and Central and South America, total fertility is below 2.5 children per woman. In thirty-one (31) developing countries, the total fertility rate is estimated to be already below replacement level. In the same way, it is further argued that with time, the noticeable disparities in fertility transitions are expected to decrease. In any case, reduced TFR (Total Fertility Rate) has contributed immensely, almost single-handedly, to the process of population ageing.

Population ageing is also affected and influenced to a large extent by the mortality situation. In fact, it has been argued that mortality has also continued to decline especially at older ages. According to Grunddy (1996), the National Research Council (2001) and the United Nations (2007a), when fertility reaches low levels and remains the same, reductions in mortality at older ages gain importance as a cause of population ageing. In developed countries, particularly where low fertility has prevailed for over three decades, increases in the proportion of the older population are now primarily caused by increasing survival to advanced ages. It is further argued that since 1950, life expectancy at birth increased globally by twenty-one (21) years, from 46.6 years in 1950-1955 to 67.6 years in 2005-2010 (Figure 3). On average, the gain in life expectancy at birth was 24.6 years in the less developed regions and 11.1 years in the more developed regions (United Nations, 2009). While variations in life expectancy exist especially in developing regions, it is still factual that in general, the world's growing life expectancies add to population ageing.

Figure 3: Life Expectancy at Birth: World and Development Regions, 1950-2050

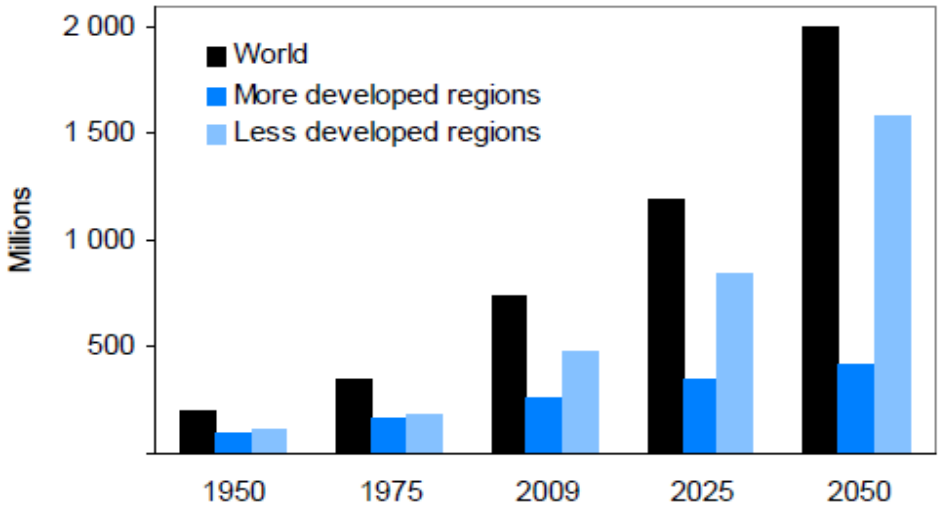


Source: United Nations – World Population Ageing, 2009

1.3 Magnitude and Speed of Population Ageing

According to the World Population Ageing Report (2009), the number of older persons has more than tripled since 1950 and it is expected to almost triple by 2050. In 1950, there were 205 million persons aged sixty (60) and above throughout the world. At that time, only three countries had more than 10 million people aged sixty (60) and above; China (41 million), India (20 million), and the United States (20 million). By 2009, the number of persons aged sixty (60) and above had increased three and a half times to 737 million, with twelve countries harbouring more than 10 million people aged sixty (60) and above, including China (160 million), India (89 million), the United States (56 million), Japan (38 million), the Russian Federation (25 million) and Germany (21 million). By 2050, the population aged sixty (60) and above is projected to increase to 2 billion (Figure 4).

Figure 4: Population Aged Sixty (60) and Above: World and Development Regions, 1950-2050



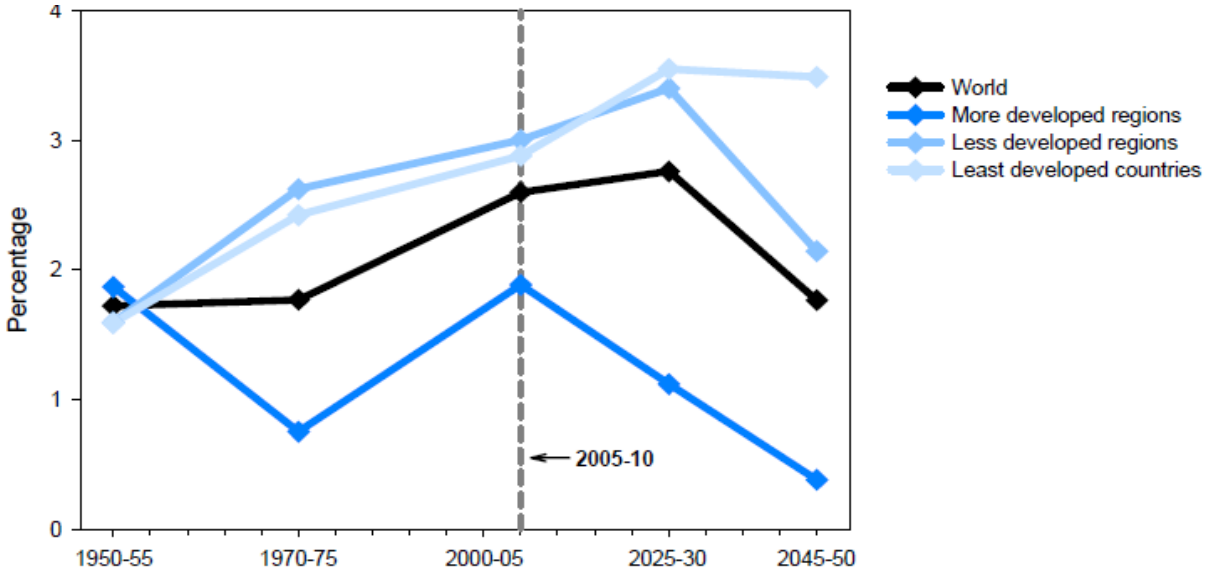
Source: United Nations – World Population Ageing, 2009

In terms of growth, the older population is in fact growing at a much faster rate compared to the entire world population. The United Nations (2009) reports that in 1950-1955, the average annual growth rate of the number of persons aged sixty (60) years and above (1.7 per cent) was similar to the rate of growth for the total population (1.8 per cent, Figure 5). Since 2000, the situation has even become more intense. Between 2005 and 2010, the growth rate of the older population, at 2.6 per cent annually, was more than twice that of the total population (1.2 per cent). Over the mid-term future, the difference between those two growth rates is expected to increase as the baby boom generation reaches age sixty in several parts of the world. By 2025-2030, the population aged 60 or over will be growing about four times as rapidly as the total population, at an annual growth rate of 2.8 per cent compared to 0.7 per cent for the total population (Figure 5). Although the growth rate of the population aged sixty (60) and above is expected to decline to 1.8 per cent in 2045-2050, it will still be more than five times the growth rate of the total population at that time (0.3 per cent).

In the same way, by 2050, the proportion of older people will double, with developed nations contributing a large percentage of the overall aged

population (United Nations, 2010). In terms of regional variations, Europe will have the highest number of older people while Africa will have the lowest; however, there is evidence that in fact, currently, older populations are growing at much faster rates in less developed regions (United Nations, 2009). More specifically, in 1950-1955, the number of persons aged sixty (60) years and above was growing slightly more rapidly in the more developed regions (1.9 per cent per year) than in the less developed regions (1.6 per cent per year: Figure 5). However, currently, the average annual growth rate of the population aged sixty (60) years and above is 3.0 per cent per annum in the less developed regions and 1.9 per cent per annum in more developed regions (Figure 5). By 2025-2030, this rate is expected to rise to 3.4 per cent in the less developed regions and to decrease to 1.1 per cent in the more developed regions. After 2030, the rate of growth of the population aged sixty (60) years and above is expected to decline in both the more developed regions and the less developed regions. Yet, by 2045-2050, the growth rate of the older population in the less developed regions is projected to be over five times as high as that in the more developed regions (2.1 per cent vs. 0.4 per cent). By 2050, twenty-two out of every 100 people will be over sixty; at this time, the population aged sixty (60) years and above will for the first time in history, surpass the number of children under age fifteen (Powell, 2005).

Figure 5: Average Annual Growth Rate of Population Sixty and Above: World and Development Regions, 1950-2050



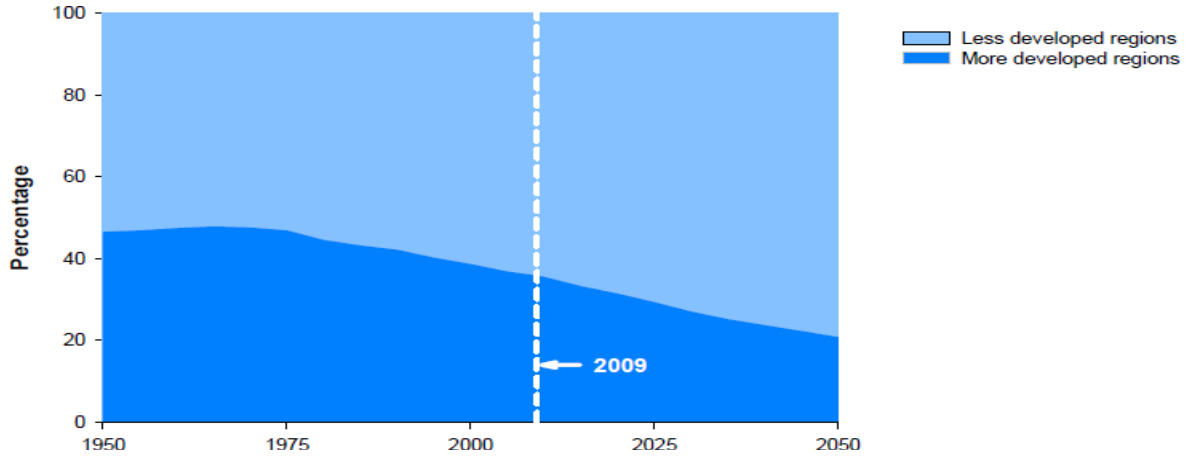
Source: United Nations – World Population Ageing, 2009

Consequently, if the status quo continues (where the speed of growth of older people is predominantly more pronounced in less developed regions compared to more developed regions), it is expected that there will be more older people living in less developed regions in the future than is currently the case. In fact the UN (2010) states that although the proportion of older persons is higher in more developed regions, the number is increasingly larger in the less developed regions. Over the next four decades, the concentration of older persons in less developed regions will intensify. The number of people aged sixty years or older living in less developed regions is expected to increase more than threefold, passing from 473 million in 2009 to 1.6 billion by 2050. In contrast, the number of older persons in the more developed regions is projected to increase by about 60 per cent, from 264 million in 2009 to 416 million in 2050. As a result, by 2050, nearly 80 per cent of the world's older population is expected to live in developing countries (Figure 6).

Africa has not been spared from global population ageing. Africa will experience a faster growth in the number of older people by 2050 compared to other regions of the world (United Nations, 2007). The number of people aged sixty

(60) years and above in Africa is projected to increase from 50.5 million in 2007 to 64.5 million in 2015, and reach 205 million by 2050. This represents a rate of increase of double the annual population growth, with the number of older people in the population increasing at an annual rate of 3.1 per cent between 2001 and 2015, and 3.3 per cent between 2015 and 2050 (*Ibid*, 2007)

Figure 6: Distribution of the World's Population Aged Sixty (60) Years and Above by Development Regions, 1950-2050



Source: United Nations – World Population Ageing, 2009

1.4 Challenges of Ageing in the African Context

Ageing populations present a challenge to all regions of the world. However, the challenge is particularly significant in Africa, heightened by the concurrent issues of the highest global levels of poverty and the HIV/AIDS pandemic, which affect the quality of life of millions of individuals and particularly impact older people (Economic Commission for Africa (ECA), 2007). Given the unique position Africa holds, highly impoverished and heavily stricken by HIV, governments within have come to recognise the global call for action on ageing and the challenges it is posing or likely to pose. The ECA (2007) reports that many countries in Africa have adopted a range of international and regional policy instruments to guide and support national policies and programmes to address the needs and challenges of people aged 60 and over.

It is indeed true that governments in Africa are currently cognisant of ageing and the challenges thereof. However, due to the underestimation of the problem at hand, it is also true that many of the interventions, compared to developed regions of the world, are still in their infancy and may be coming too late. One of the reasons this may be so is simply that Africa still has a relatively young age structure and effects of an ageing population as currently being experienced by countries in more developed regions have not really dawned (ECA, 2007). For example, Kalasa (2005) states that although Africa will remain relatively young for some time, it is clear that its old age dependency burden will increase by about 93 per cent by 2050. Further, while the ratio of the population aged 60 years and above to the population aged 0-14 years was 0.169 in 1950 and 0.212 in 1995 (a change of 25 per cent), the ratio will be 0.914 in the year 2050 (a change of 441 per cent from 1950 and 331 per cent from 1995). The change in dependency ratios between 1995 and 2050 is the highest among all the world regions. In essence, therefore, the 'window of hope' may not be as permanent as most people would like to think, and this signals the need for African countries to seriously start planning for the elderly population at policy and other levels (*Ibid*, 2005).

Africa has another unique challenge. Countries experiencing population ageing have developed government-supported welfare systems that cushion some of the effects of ageing populations; this approach is not strictly widespread in Africa. Few countries in Africa have introduced welfare systems, however, most of them are donor-dependent and also based on contributory pension systems of which a majority of people in Africa are excluded. In other words, governments in developed countries have taken centre-stage measures to help address challenges of ageing. Low (2002/3) reports that the state/government has become the traditional provider of last resort old age security even when individuals are mandated to provide maintenance and welfare protection.

This 'welfare state' (as it is commonly called) incorporates universal social insurance to provide a minimum of social security as a constitutional right and inalienable component of citizenship, redistributing wealth and helping those in need (Zijderveld, 1999). The American system, for example, is said to take responsibility for general welfare, including old age security in situations where the market and/or families have failed. European welfare is said to be universalistic (Low, 2002/2003). It assumes responsibility for a broad spectrum of social services, to which, in principle, all citizens are entitled. The Scandinavian system, on the other hand, is thought to be the most comprehensive, intensive and extensive, as it aspires to ensure maximum equality of the highest standard (*Ibid*, 2002/3).

Despite evidence of population ageing at global as well as regional levels, and despite strides made by developed nations on ageing, there is little or inadequate intervention on ageing in many developing countries, Zambia included. It was, therefore, important to conduct a study which would necessarily highlight population ageing in the Zambian context, illustrate and discuss challenges older people were/are facing, as well as examine the existence and adequacy of policies and programmes on ageing in Zambia.

1.5 Statement of the Problem

The subject of population ageing has never received attention and has been under studied in Zambia. The Magnitude of population ageing is understudied and to some extent, little is known; some or most of the challenges older people face are only known based on speculation and "common sense"; and finally, there are no known determinants of active ageing applicable to the Zambian context. However, while it is true that ageing has been understudied, it is equally important to acknowledge that some writings by eminent scholars like Colson (1975), Kamwengo (2001 and 2004), Phiri (2004), Cliggert (2005) and Toner (2007) have been done. However, it is also cardinal to recognise that not only have these writings been few, but they have also not provided impeccable

evidence or answers to the challenges and determinants of active ageing. In addition, the writings in question have also largely been based on qualitative methods with very little or no quantitative data derived from extensive and systematic investigation of ageing. In view of these weaknesses, this study, therefore, aimed at addressing and answering not only questions on ageing but also apply and use scientific data collection methodologies to articulate the magnitude, challenges and determinants of active ageing as well as critically examine current policies and programmes on ageing in Zambia.

1.6 Objectives

This study investigated the magnitude of, and examined challenges and determinants of population ageing in Zambia. The study had three main specific objectives, namely to:

1. Investigate past and future trends in population ageing in Zambia;
2. Examine challenges and determinants of active ageing; and
3. Examine the draft policy on ageing and the adequacy of the same in addressing ageing and older people.

1.7 Research Questions

This study addressed the following questions:

i. Is Zambia experiencing population ageing? What regional and/or gender disparities exist given the ageing status of the population?
ii. What socio-economic challenges do older people face? What aspects, issues, questions etc. determine active ageing in Zambia?
iii. Does the draft policy on ageing address issues of ageing in Zambia today? How adequate is it in meeting challenges of older people?

Answering these research questions helped address secondary as well as subsidiary questions raised in this study and therefore provided responses on challenges and determinants of ageing as well as providing evidence on the current policies and programs of ageing in Zambia.

1.8 Significance of the Study

The current study brings into perspective two critical significant additions to population studies and demography in Zambia. Firstly, owing to the fact that, so far, population studies in Zambia have tended to investigate almost all topics but ageing, this study is a valuable addition to the existing literature on population studies, as well as demography in general. It has given an opportunity for scholars to understand population ageing and some of the determinants in the Zambian context thereby prompting further questions and research on the topic and inevitably adding more to the body of literature in general and population studies in particular.

Secondly, the body of literature this study has generated is also intended to bring to the attention of policymakers the need to appreciate population ageing as a relevant topic, and to recognise older people as individuals in need of concerted and well-planned attention and intervention. Further, using data and information from this study, it will be possible to promote policies and programmes commensurate with specific needs of people of all ages, and older people in particular. Currently, ageing, like gender, health, youths, etc., is recognised as a development agenda and results of this study are important in providing evidence based planning for older people as well as determinants of active and healthy ageing.

1.9 Conceptual Framework

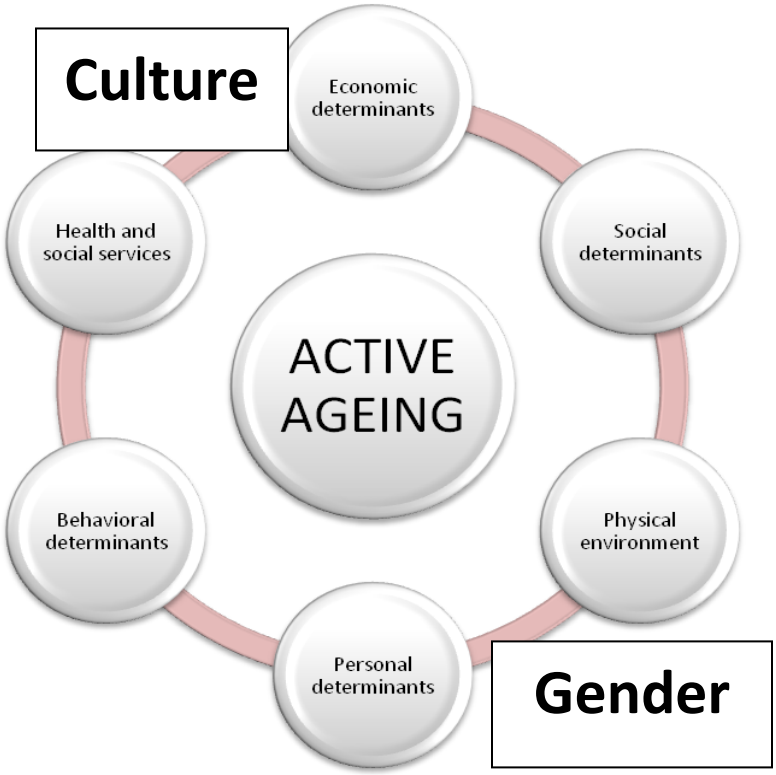
The study was guided by two conceptual frameworks, namely the World Health Organisation's Active Ageing Policy Framework of 2002, and the United Nations' Principles on Ageing. The UN Principles on Ageing have been fully operationalised through the 2002 Madrid Plan of Action Report. These documents were, therefore, interchangeably used, especially in the examination of the adequacy of policies and programmes available in Zambia. Note however that the two frameworks aim at promoting active ageing in general.

1.9.1 Active Ageing Policy Framework

The World Health Organisation's (WHO) Active Ageing Policy Framework (2002) defines 'active ageing' as a process of optimising opportunities for health, participation and security in order to enhance the quality of life as people age. The framework proposes that if ageing is to be a positive experience, longer life must be accompanied by continuing opportunities for health, participation and security. Active ageing, therefore, applies to both individuals and population groups. The concept of 'active ageing' allows people to realise their potential for physical, social, and mental well-being throughout life and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance. The word 'active', according to this framework, refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. For example, older people who retire from work, and those who are ill or live with disabilities, can remain active contributors to their families, peers, communities and nations.

The 'active ageing' process is determined by several factors. The WHO Framework states that active ageing is a function of, but not limited to the following determinants: gender and culture, economic, health and social services, social, physical environment, personal and behavioural. Figure 7 below details linkages of these determinants with the active ageing process:

Figure 7: Determinants of Active Ageing



1.9.2 Culture and Gender

The WHO (2002) states that culture shapes the way people age because it influences all of the determinants of active ageing. Cultural values and traditions determine to a large extent how a given society views older people. Culture is pivotal in determining co-residency between older and younger generations. For example, it has been established that Asians value extended families and hence in many cases embrace the practice of multi-generational household living.

On the other hand, gender has been defined as the 'lens' through which to consider the appropriateness of various policy options and how they affect the well being of both men and women. In many societies, girls and women have lower social status and less access to education, food, work and health

services. At the same time, the status of boys and men is considered more 'risky' in that they are more likely to engage in behaviour such as smoking, alcohol consumption and violence. These aspects affect the way men and women age and further determine active ageing.

1.9.3 Behavioural and Psychological Factors

Adoption of healthy lifestyles, engaging in appropriate physical activity, eating healthy food, adopting a non-smoking and non-alcohol consumption behaviour, will in turn affect one's ageing process and determine how they age. Personal behaviour affects individuals differently and this also applies to the ageing process. Similarly, psychological factors including intelligence and cognitive capacity are strong predictors of active ageing and longevity (Smits *et. al.,.*, 1999). Sometimes ageing is said to be an individual experience rather than a collective force, and hence one's psychological status can influence the way they age.

1.9.4 Social and Environmental Factors

One's physical environment plays a significant role in the ageing process. Physical environments that are 'age friendly' can make a difference between dependence and independence. It has been propagated that special attention needs to be paid to old people in rural areas where disease patterns are different due to environmental conditions and where there are no support services. On the other hand, social factors have profound effects on the ageing process. Inadequate social support is associated not only with an increase in mortality, morbidity and psychological distress but a decrease in overall general health and well-being. Disruption of personal ties, loneliness and conflicting interactions are major sources of stress, while supportive social connections and intimate relations are vital sources of emotional strength (Gironda *et al.* In Press). In Japan, for example, older people who reported lack of social contact were 1.5 times more likely to die in the following three years than those with higher social support (Sugiswawa *et. al.*, 1994).

1.9.5 Economic Factors

Three factors relating to the economic environment have particularly significant effects on active ageing: income, work and social protection. Policies on ageing need to intersect with broader schemes to reduce poverty at all ages. Access to income by the aged will enhance active ageing. On the other hand, dependency on relatives and government for handouts is unsustainable in the long run. It is, therefore, important to structure work policies that accommodate the aged. The world is slowly recognising and supporting the active and productive contribution that older people can and do make in formal work, informal work, unpaid activities in the home and in voluntary occupations. Similarly, social protection is a significant ingredient of active ageing in particular and ageing in general. In all countries of the world, families provide the majority support for older people. However, as societies develop, and the traditions of generations living together begins to decline, governments are increasingly called in to develop mechanisms that provide social protection for older people who are unable to earn a living on their own.

In view of the foregoing, it is, therefore, true and in order for us to claim that the active ageing policy framework is/was particularly central to this study, because concepts and the rationale, as well as particulars relating to determinants of active ageing, resonate(d) well with objectives of this study. On one hand, this study investigated and documented socio-economic as well as individual challenges older people face in Zambia; it also assumed to understand some of the determinants of active ageing in Zambia. The socio-economic perspectives were also examined by investigating community perceptions towards older people and ageing – in essence explaining some of the challenges through the Zambian cultural context and finally also examining policies and programmes on ageing and their adequacy as well as linking them to challenges older people face. On the other hand, the active ageing framework aims to reduce difficulties faced by older people and to offer

practical policy solutions to enhance active and healthy ageing at individual, community and population sub groups. The two – this study and the active ageing framework – were and are in tandem with each other, hence the adoption of the active ageing policy framework for our study.

1.9.6 United Nations Principles for Older People

In December 1991, the United Nations General Assembly adopted resolution 46/9 on principles for older people. The resolution was adopted to make known the important contributions older people make to their society. The background to these principles is based on the following resolutions:

(a) Recognising that, in the Charter of the United Nations, the peoples of the United Nations declare, inter alia, their determination to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small and to promote social progress and better standards of life in larger freedom.

(b) Noting the elaboration of those rights in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights and other declarations to ensure the application of universal standards to particular groups.

(c) Pursuance of the International Plan of Action on Ageing adopted by the World Assembly on Ageing and endorsed by the General Assembly in its resolution 37/51 of 3 December 1982.

(d) Appreciating the tremendous diversity in the situation of older persons, not only between countries but within countries and between individuals, that requires a variety of policy responses.

(e) Awareness that in all countries, individuals are reaching an advanced age in greater numbers and in better health than ever before.

(f) Awareness of the scientific research disproving many stereotypes about inevitable and irreversible declines with age.

(g) Convincing evidence that in a world characterised by an increasing number and proportion of older persons, opportunities must be provided for willing and capable older persons to participate in and contribute to the ongoing activities of society.

(h) Being mindful that the strains on family life in both developed and developing countries require support for those providing care to frail older persons.

(i) Bearing in mind the standards already set by the International Plan of Action on Ageing and the conventions, recommendations and resolutions of the International Labour Organisation, the World Health Organisation and other United Nations entities.

(j) Encouraging Governments to incorporate the following principles into their national programmes whenever possible:

1. Independence
2. Participation
3. Care
4. Self fulfillment
5. Dignity

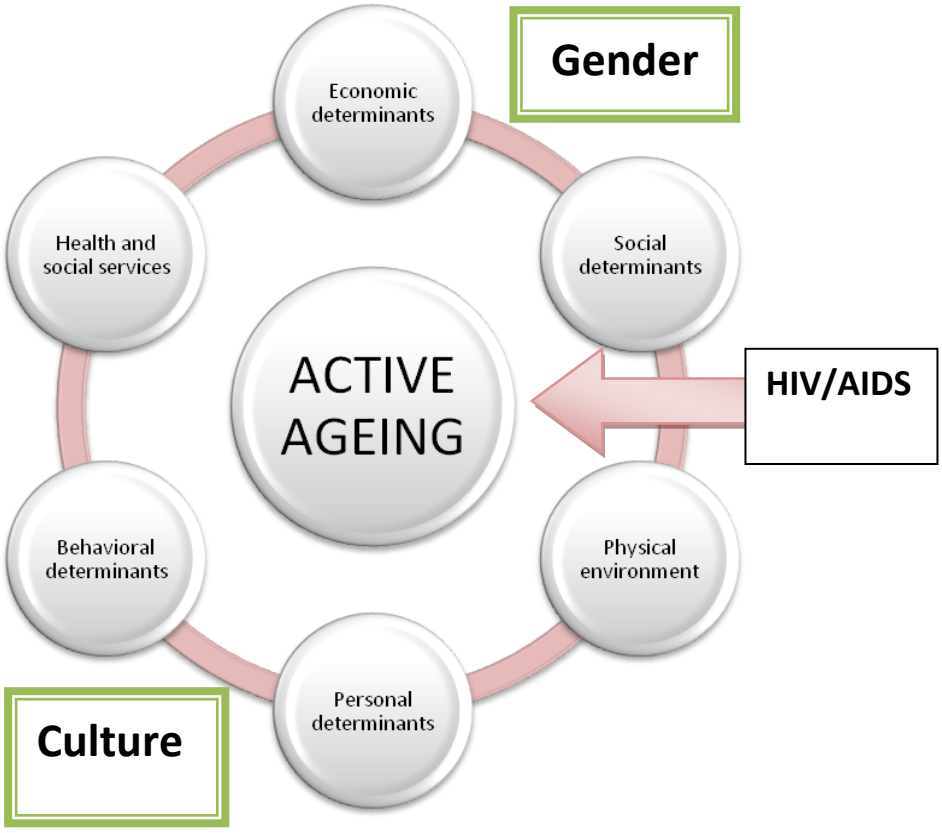
The UN Principles for older people are based on the recognition of older people's rights as individuals and shifts strategic planning away from a 'needs-based' approach (which assumes that older people are passive targets) to a 'rights-

based' approach that recognises the rights of people to equality of opportunity and treatment in all aspects of life as they grow older. These principles support their responsibility to exercise their participation in the political process and other aspects of community life (United Nations, 1991).

1.9.7 HIV/AIDS as a Determinant

Currently, it is not plausible to discuss ageing or indeed any other issue relating to population without factoring in the presence of HIV/AIDS. Our study therefore proposed to include, as one of the determinants of active ageing, HIV/AIDS so as to assess its effects as well on active ageing. In this respect therefore, our study proposed a simple modification of the WHO Framework to include HIV/AIDS in the following manner:

Figure 7a: Determinants of Active Ageing – Modified with HIV/AIDS



In making a summary of the conceptualization process of this study, we took cognisant of recommendations in the framework to national governments and individuals on the role/s and importance of older people to development. As a result, it is clear that investigating challenges older people face in any context is actually a human rights issue and no other framework could best explain these than the United Nations principles on ageing. The United Nations also implores governments to include these principles in their policies and programmes as well. Owing to the fact that this study also investigated the draft policy on ageing, UN principles were 'lenses' to help measure whether it is adequate by way of reflecting all or most of the principles on ageing.

It should be noted, however, that while it is clear that the WHO active ageing framework is a policy framework, the contents and approach is also inclusive of both population and individual experiences. In this regard, it is suited to explain not only policy aspects of ageing, but also the roles of both population sub-groups affected by ageing as well as individuals themselves. For example, the policy framework states that active ageing is determined, among other factors, by psychological and individual behaviour factors. In this example, the framework is cognisant of the important role of individuals in the process of ageing. It also has both the depth and breadth investigated in this study. As a result, considering the purpose, objectives and aims of our study – especially on challenges older people face and policy options in Zambia – this framework is therefore, appropriate.

CHAPTER 2: LITERATURE REVIEW

This chapter gathered information through the review of literature on what other studies have highlighted as challenges facing the elderly as well as determinants of active ageing in general. Some of the challenges highlighted include the problem of poverty, health, functional limitations, self-esteem, etc. Other issues looked at were old age care, living arrangements, social contacts, and generally how older people cope with ageing, given problems and challenges they faced or face as a result of HIV/AIDS, and orphan and vulnerable child care. The literature review also focused on discussing both historical and current policy documents and pronouncements on ageing which have or maybe influential in determining active ageing in general. Some of the policy documents in this case include: health, education, social cash transfer schemes, population policy etc.

2.1 Poverty: A Serious Challenge in Old age

Poverty has been sighted to be one of the most daunting challenges facing older people especially in developing countries. In fact, there is a high correlation between poverty and ageing in many developing countries (UNFPA, 2001). In this respect, the presence of inadequate living conditions, lack of access to social services, intergenerational violence and abuse, low levels of literacy, income, health and lack of awareness and access to valuable information depict a vicious cycle of social exclusion reinforced by the dependency status among older people (*Ibid*, 2001). Sometimes, actually, the poverty experienced by older people is a result of the alleged loss of social capital (Duffo, 2009). Accordingly, 'poverty rates' for older people are almost always estimated to be 5 to 15 percentage points higher than national averages (*Ibid*, 2009).

In old age (or later life), people become particularly vulnerable to changes to their income situation as well as lessened participation in income or economic

activities. For example, studies in Britain, the United States of America and much of Europe have indicated that there is a long standing correlation between poverty on one hand and old age on the other. Old age pensioners are more likely to be affected by poverty than paid workers (Ogg, 2005). In a study entitled 'Wealth of the Nation 2005', Godfield (2005) shows that both poverty and wealth correlate with a specific age structure. Whereas wealthy areas are characterised by high proportions of middle-aged families and 'empty-nesters', poor neighbourhoods have a high proportion of children and older persons (*Ibid*, 2005).

In some circles, the picture depicted by Godfield (2005) has received controversy. The British Department of Work and Pension (DWP) argues that there has been remarkable reduction in pension and income poverty in the last decade (DWP, 2005). Within the Eurozone, Germany has been singled out as an exception. Contrary to the overall trend all across Europe of increasing inequalities and poverty risks, the risk of income poverty among older Germans (65+) has declined from 13.3 in1998 to 11.4 per cent in 2002 (BMGS, 2005). In addition, the introduction of the social-insurance based on Long-Term Care Insurance Scheme has taken a lot of the previous financial pressure off families caring for older family members. The previous dependency of older people in need of professional care on Social Assistance has significantly reduced (Szivos *et al*, 2004).

While the British and European case is somewhat different from the Germany case, the situation is even more fragmented in developing countries. It is a fact that the Germany example has shown some significant differences because of deliberate measures to enhance income as well as reduce social exclusion of the elderly in society and inevitably reduce poverty experiences. This may not be so for many less developed countries. While the causes of poverty may be similar for both regions, interventions are or may be different. In any case, it stands as a fact that old age is sometimes synonymous with poverty, whether developed or less developed countries. Similarly, income and non-involvement

in economic activities, as well as social exclusion, explain to some degree why older people are poor.

In a similar manner, older people tend to be excluded from social structures that can help in the area of income as well as economic activities —factors that may enhance self-reliance for ageing individuals – which eventually exacerbate poverty amongst them and influences how active they age. Exclusion of older people from social structures has sometimes been referred to as 'social exclusion,' which has over time been defined to mean 'a dynamic process of being shut out, fully or partially, from any of the social, economic, cultural or political system which determine the social integration of a person in society' (Walker *et al*, 1997: 8). In addition, it also introduces a dynamic perspective towards understanding processes that lead to the non-realisation of civil, political and social citizenship rights (Room, 1995; Tsakloglou *et al*, 2002).

2.2 Family Relationships and Ageing

Poverty is also a function of family relationships. This is true at least in Africa. For a long time, families in developing countries have taken care of aged relatives and, therefore, helping manage their poverty levels. In Africa, Asia and Latin America, most of the elderly population lived in multi-generational households with their children. In Thailand for example, 77 per cent of older people lived and were cared for by their children and spouses (Jitapunkul *et al*, 2002). According to the UN report on population ageing in Asia-Pacific Regions, there was an overwhelming majority of elderly men and women who continued living with their children as well; similarly, over 65 per cent of families in The Republic of Korea kept an elderly relative in the 1990s (*Ibid*, 2002).

While the forgoing has always been the case, there is evidence that this was no longer widespread or the same. For example, Burgess (1954) noted that in many countries, there was a moral and legal obligation for adult children and families to support needy parents and relatives. However, even in countries like

Kenya where it is a constitutional mandate to look after older relatives, Sokolovsky (1985) reports that there are signs of neglect. India, which maintains one of the highest levels of elderly co-residence in the world, Martin (1990) notes that as early as the ninth century, the Hindu philosopher Shankaracharya spoke of the harsh dilemma of late adulthood life. In stressing the need for material detachment during the last phase of adult life, Shankaracharya said: 'Your family is attached to you as long as you can earn' – with frail body and no income, no one in the house will care for you' (Martin, 1990). Burgess (1960) again observes that the tendency for adult children to live, support and care for their ageing parents has declined tremendously. Aboderin (2004) found that material support for older people in Ghana has declined in recent years and this has inevitably exposed elderly citizens to destitution and poverty. Akungba *et al* (2003) found that there is a declining process of traditional care and support systems for the aged in Nigeria. Recent demographic indicators further show an increasing proportion of childless women, changes in divorce and marriage patterns, and the overall much smaller number of children of future cohorts of older people, all contributing to a shrinking pool of family support (Wolf, 2001). In essence therefore, this situation has not only inevitably exacerbated high poverty levels among the elderly people, but also influenced greatly their isolation and added greatly to most of the challenges they face and as such influence greatly the active ageing process.

Diminishing family support systems inevitably affected the living arrangements for the elderly; this again affects their social contacts with peers and family as well. These factors are intertwined with intergenerational living and support systems and are challenges to the elderly. Living arrangements, for example, play an important role in the well-being of older people, and if harnessed properly, improves their ageing process as well. In Africa and other developing societies, living with or near adult children has been a predominant feature, however, due to uncertainties surrounding 'living arrangements' at the

moment, it has turned out to be a real source of concern and problems for the elderly (UNFPA, 2007). The term 'living arrangements' is not very clear. While household composition has been used as one indicator, implications of particular configurations defined by such information can be ambiguous. One limitation is that these measures do not encompass information about others who live next door or very nearby, and who may still play an important role in the lives of the elderly (Knodel *et al*, 1999). Another difficulty arises because the meaning of 'living arrangements' cannot be inferred with certainty simply from their form (Hermalin, 1997). Thus, measures of composition of households in which the elderly reside can be suggestive, but they need to be interpreted cautiously. With that said, it is still true that co-residence with one or more adult children, typically in a stem family configuration, is a long standing tradition in many African countries and is viewed as essential for families to meet the needs of older dependent members (Knodel, 2007). However, it is clear that these provisions are slowly changing; this change is not only detrimental to older people but affecting active ageing in general.

2.3 Living Arrangements, Social Contacts and Networks

Another instrumental factor to old age but related a little to 'living arrangements' is social contact. Some challenges in old age are due to constraints in social contacts and networks. Older people are affected positively or negatively by the social networks or contacts and support they have with their relatives and/or the community at large. This inevitably affects whether or not they age actively or otherwise.

Several theoretical explanations try to give meaning and thereby address the influence of social networks on the well-being of older people. Some of these constructs have their origins from studies that aim at explaining the role of social networks on ageing and the ageing process in general. For example, Cohen *et al* (1985); Ell (1984) and Wenger (1984) stated that support networks really imply family and friendship ties, but may also include other role

relationships such as neighbours, colleagues and service personnel. In addition, social support networks can elicit behaviour detrimental to one's well-being, and this fact has been well underscored, particularly in old age (Baldassare, Rosenfield *et al*, 1984; Gallo, 1984; Kaye *et al*, 1991; LaGory *et al*, 1992). The absence of social contacts and networks affects active ageing, and is, therefore, a serious challenge to the elderly.

Support and social contacts networks are also a subset of larger fields of inquiry known as 'social network analyses', which systematically consider aggregate interpersonal contacts and their interrelationships (Mitchell, 1969; Wellman *et al*, 1988). Social network analysis provides the framework for consideration in terms of support-giving, such as the structure and function of the support network (Litwin, 1998). In explaining the structural aspect of support networks, House *et al* (1985) state that such networks typically include such variables as network size, composition, density and intensity; however, the functional aspect on the other hand is measured by interaction patterns such as contact frequency, direction and other substantive factors including types of assistance exchanged (*Ibid*, 1985).

In the same vein, while social networks and contacts are a big problem for the aged and a challenge in themselves, there is evidence relating social support (networks) to the physical, psychological health status, risk of institutionalisation, and mortality amongst older people (Bowling, 1991). Inadequate social support for older people is associated not only with an increase in mortality, morbidity and psychological distress, but a decrease in overall general health and well-being. Disruption of personal ties, loneliness and conflicting interactions are major sources of stress, while supportive social connections and intimate relations are vital sources of emotional strength (Gironda *et al*, In Press).

2.4 Health and Functional Limitations in Old Age

While it is clear that intergenerational support and social networks play pivotal roles in the well-being of older people, their (social networks) absence inevitably proposes other challenges bordering on both the physical health and general well-being of older people and thereby inevitably affecting whether they age actively or not. Note, however, that old age brings about its own health problems; nonetheless, these are exaggerated if or when social contacts and networks are absent or constrained.

While the concept of well-being incorporates different dimensions, none perhaps, is of more central concern to older persons than their actual physical health (Knodel *et. al.,* 2009). In all populations, biological processes ensure not only that the risk of mortality increases steadily with increasing age, but so do physical limitations and certain illnesses – some chronic, while others are common and frequent problems. These functional limitations are sometimes necessitated by older people themselves or the environment they find themselves in; thus, such situations or occurrences pose considerable differences in terms of mortality and morbidity for the aged (*Ibid* 2009).

Ageing, it has been argued, is sometimes synonymous with being unhealthy and is usually coupled with a lot of illnesses. It is not uncommon for people of a certain age to suffer from certain illnesses. The World Health Organisation (2003), reports that there are basic diseases which afflict older men and women. They include cardiovascular diseases, cancers, musculoskeletal problems, diabetes, mental illnesses, sensory impairments, incontinence, and – especially in poorer parts of the world – infectious diseases and their sequelae. While it is true that these diseases become more pronounced as people age, it is argued that they present themselves much earlier in life and are sometimes functions of certain lifestyles (*Ibid*, 2003). For example, experiences of smoking, alcohol abuse, infectious disease, under nutrition and over nutrition, poverty, lack of access to education, dangerous work conditions, violence, poor health

care, injuries, etc. early in life and throughout the life course can lead to poor health in later years (*Ibid*, 2003).

In addition, and perhaps more importantly, the gender picture of a given society – the complex pattern of roles, responsibilities, norms, values, freedoms, and limitations that define what is thought of a 'masculine' and 'feminine' in a given place and time – has a great bearing on the health of the aged (*Ibid*, 2003). As a result, it is no wonder that in societies where gender issues are balanced, health problems facing older people seem to be almost similar in nature – a situation quite different from developing countries, where gender is still unbalanced.

However, health in old age has not only to do with the presence or absence of disease; in fact, it is argued that availability and quality of care is very important. Nonetheless, care for older people especially in developing countries, is in a general sense dwindling; and, without properly developed institutional care systems supported by the state, health conditions for older people will become even more challenging, and may lead to other problems. WHO (2005), reports that older people, even those in generally good health, will eventually need more care than they did earlier in their lives. The ways societies provide or fail to provide this care will determine older people's quality of life. The questions, therefore, are: Does care allow for independence and dignity, but also social connectedness? Is it equitably accessible to all? Who provides it? How is it remunerated? Are the physical and psychological abuses of older people, or other exploitations of their vulnerability, prevented? These questions require detailed reflection, especially for state policy making organs; the questions at hand merit more than a simple 'yes' or 'no'.

A serious consequence of declining health and increased frailty associated with ageing is the difficulty of physical movement and of independently being able to carry out basic activities of daily living (UNFPA, 2008). Inability to carry out basic activities of daily living, or what is normally referred to as 'functional

limitations', may not entirely be determined by one's health; however, health status is pivotal in the determination of functional ability or limitation in old age at least. Functional limitation is a big challenge and a pertinent determinant of active ageing and is mostly exacerbated by lack of or inadequate formal or informal care systems.

There are many definitions of 'functional limitation'. According to a popular theoretical conceptualisation, functional limitation (sometimes referred to as disability) is defined as the loss of capacity to carry out usual and necessary functional tasks that allow individuals to maintain themselves within a given environment, such as rising from bed or shopping for food (Deeg *et all*, 2003; Verbrugge *et al* 1994; World Health Organisation, 1990). Verbrugge *et al* (1994) further suggest that the functional status of an individual refers to that individual's ability to perform tasks that are necessary within a particular environment, and a functional limitation can be considered as a gap between physical ability and the demands of the environment. For instance, in order to rise from bed, an individual must have a certain physical capacity, but the type of bed one sleeps in may influence performance. An individual in a poor country who sleeps on a mat on a hard floor may be more functionally limited than an individual in a developed country who sleeps on a raised bed. Subsequently, the individual sleeping on a mat on the floor may have a greater need for assistance than does another individual with similar physical abilities. Functional tasks such as shopping for food may involve a larger array of environmental circumstances, such as the location of a market and the condition of infrastructure like transportation and road conditions (Zimmer, 2005). Because functional status refers to the ability to perform necessary tasks, it is a principal indicator of well-being, and accordingly is an excellent pointer of the general health status of older people.

In the same way, WHO (2011) defines functional limitations or disability as an umbrella term for impairments, activity limitations and participation restrictions. Disability is the interaction between individuals with a health

condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports). Unlike the earlier definition by Zimmer (2005), WHO factors into focus the fact that disability is not just an individual's experience but also their social and economic environment.

Functional limitations in old age are also becoming prominent in developing countries as well. Even with such a situation, there seems to be little or no evidence of studies specifically undertaken in Africa to investigate this growing phenomenon. Nonetheless, there have been studies in other developing countries. For example, Knodel *et al* (2008) found that for the studied functional limitations in Thailand, (eating, dressing, bathing or going to the toilet), women were more likely to report any of the listed functional limitations compared to men; they also found that for both men and women, the likelihood of a disability or limitation increases substantially with age. They noted that such cases or situations called for concerted efforts in caring for older people.

Further, WHO (2005) found that while disability is affecting all people (from developed and less developed regions), it is becoming more prominent in less developed regions due to little or no intervention at all. The WHO (*Ibid*) argues that it is possible to delay the onset of disability as was the case in the United States of America, England and Sweden where there has been a significant decline in the past twenty years. This, therefore, is a litmus test for developing countries to suggest and put in place policies that may help curb effects of disability due to ageing populations and thereby promote active ageing.

2.5 Self Esteem and Loneliness in Old Age

Older people are not only affected by possibilities of being disabled, having little or no social contacts, poor quality living and environment situation, care, etc., but all these experiences also brood low self-esteem and, to some extent, loneliness in old age. And low self-esteem, it should be noted, is one of the challenges older people face and serious determinant of active ageing.

Sometimes, low self-esteem is a function of social isolation; however, several factors could be influencing such experiences.

By definition, self-esteem is the term used to describe how one feels about one's self. It is based on feelings of being valued, useful, and competent (uihealthcare.com 2005). As people age, lots of changes occur, which may affect their roles, activities and lifestyles, potentially leading to low self-esteem. It is argued that if people feel valued and useful, their self-esteem is high, while the opposite is also true: where people undervalue and underutilise others, self-esteem is inevitably lower. It is a fact also that sometimes societies undervalue and regard older people as less useful compared to those of other ages. This may result in low self-esteem and negatively affect their ageing process.

Low self-esteem could be a function of the negative attitudes and perceptions people have towards a certain grouping of individuals, in our case, the aged. To many people, ageing and the aged are a very distant topic. In some instances, segments of society rarely hold any particular attitude towards the aged. However, the negative side is sometimes prominent. Literature suggests that negative attitudes towards the ageing process and older adults themselves adversely affect their care and support, and to some extent, affects the way they view themselves. A few commonly used terms that reinforce the negative attitudes and beliefs that influence feelings and behaviours regarding older people include:

- Gerontophobia - refers to 'unreasonable fear and/or irrational hatred of older people.' (Palmore, 1972).
- Aging Anxiety - refers to a 'combination of people's concerns or fears of getting older.' (Lynch, 2000).

According to Cummings (2000), ageing anxiety as well as esteem is related to negative stereotypes of older adults and perceptions of younger adults that

these problems are likely to happen in their own future. Indicators of ageing anxiety include worrying about:

- Declining health, physical function, social losses and connectedness.
- Changing physical appearance including wrinkles, receding hair lines and grey hair.
- Declining cognitive ability.
- Depleting financial resources, etc.

It is further argued that if people hold negative views about ageing and undervalue the aged, such attitudes are likely to influence interactions with older people, and that may inevitably allow proliferation of low self-esteem (Fitzwater, 2008). Holding other factors constant (especially individual factors), mostly interrelations with peers, family, colleagues, spouses, etc., help in one way or another to maintain or even rekindle self-esteem in old age. However, it has been argued that there seems to be a general 'decline' of the much-needed familial (as well as peer) relations in many societies, and this is a challenge to the active ageing process.

2.6 HIV/AIDS and Ageing

Another challenge facing older people in Africa and active ageing in general, is the HIV/AIDS pandemic. While it is evidently clear that some older people have the virus that causes AIDS, the two biggest challenges they face as a result of the pandemic are firstly, the loss of their able-bodied children, and secondly, caring for orphans and vulnerable children as a result.

Overall, the HIV/AIDS pandemic has devastating health, economic, social and psychological impact on older people, especially women (Ferreira, 2002). The deaths of young adults are shifting the responsibility of care of orphaned and vulnerable children, as well as People Living with HIV/AIDS (PLWHAs) to older persons (Busolo *et al*, 2009). In addition, HIV/AIDS has brought about additional care burdens and defined new roles for the aged, who are

increasingly being called upon to act as carers and supporters for younger generation kin. Such care-giving, often rendered at great personal cost, has been shown to affect older people's material, psychological and physical well-being (Ferreira, 2006; Knodel, *et al* 2003). The loss of children, grandchildren or other younger generation kin impacts not only older people's emotional and mental well-being, but erodes the material or other intergenerational family support which they require for their livelihoods (Aboderin, 2009). In view of these impacts, recent years have seen mounting calls for policy responses to address the impacts of HIV/AIDS on older people.

The direct consequences of the HIV/AIDS pandemic portray themselves by affecting older people in many ways, including care giving during illness, paying for medical and living expenses, reduced or foregone economic activity, funeral expenses, loss of current and future support from the AIDS-infected adult child, and fostering orphaned grandchildren (Knodel, 2006: 3). Similarly, older people have to cope with community stigmatisation and isolation that is often associated with caring for an AIDS-affected family member (Belsey, 2005). The challenge of older people caring for people living with HIV/AIDS is further exacerbated by lack of health insurance, inadequate health care facilities, as well as the lack of individual or household finances (UNDP, 2007).

Apart from caring for PLWHA, older people are also actively looking after orphans and vulnerable children. It should be noted that from time inmemorial, many African traditional set-ups entertained situations where grandparents could keep their grandchildren while their children were somewhere else. Such care was usually supported through cash transfers to the child-minders – in this case, the grandparents. With the advent of HIV/AIDS, the situation is different. Whereas in the past it was not mandated for grandparents to look after their grandchildren, the care landscape has changed dramatically. It has become commonplace for old grandparents to take care of grandchildren because their parents have died, and there lays a double-

burden on the elderly – one of taking care of their sick children, and another of looking after uneconomically independent grandchildren.

As such, caring for grandchildren has presented a special challenge to the limited resources of older carers. It is a fact that due to this burden, older people struggle to ensure that the orphans attend school, are well fed and are not marginalised and discriminated against. Because of their age, many grandparents die before the children reach the age of eighteen, which results in further separation, loss and uncertainty for the children (UNICEF, 2006).

Knodel *et. al.* (2002: 4) also notes that how much these potential impacts actually occur remains largely for systematic empirical research to determine. They are all likely to be context-sensitive and thus vary across different settings. While comprehensive statistical data surrounding these phenomena do not currently exist, case-study material, anecdotal information and local fact-finding activities suggest that significant numbers of older people currently deal with these diverse impacts at a time when they themselves are expecting to receive old age support. In circumstances of existing poverty and age-related health issues, the extra burdens, particularly the financial impact and diversion of activities away from food production, can deplete the health of older people through poor nutrition, fatigue and worry (State of Old People in Africa Review, 2007).

Given such daunting challenges, which include limited social and material support, challenging living conditions and arrangements, care for orphans and sick children, as well as older people's own care and survival, many African countries and governments, societies and communities have come to the aid of older people, happening with full donor support.

At the community and household level, it is documented that there are a range of small-scale, effective practices and interventions that relieve the impact of HIV/AIDS on the aged even when it is in isolated areas. Although poorly documented, these interventions deserve more attention because they offer

governments and other stakeholders the possibility of practice-based evidence of effectiveness, and the opportunity to strengthen existing programmes and scale up successful strategies (Binswanger, 2000; Mutangadura *et. al.,* 1999). There have been attempts, for example, to increase HIV/AIDS-related treatment and care so as to help shoulder the burden of care borne by older people. In the same way, some communities have established 'community kitchens' where children can eat or receive aid from caregivers; they are also sometimes provided with seeds and other necessary inputs for growing food, so as to benefit households where the elderly are the main breadwinners (ECA, 2007).

In addition, some rural households have employed other community-initiated strategies to enhance food production in households where there are older caregivers and also where adults are suffering from HIV/AIDS. These include labour pooling, intra-household reallocation of labour and responsibilities, reconfiguration of time-use patterns, promotion of non-labour-intensive crops, and promotion of crops and farming systems that reduce vulnerability to ecological and social factors (ECA, 2007). Some of the projects initiated in various African countries to enhance these strategies include the following:

- Junior field schools in Eastern and Southern Africa targeting HIV/AIDS-affected households (FAO, 2004).
- In Zimbabwe, AIDS widows are being trained how to grow cotton by experienced farmers through farmer field schools (White and Robinson, 2000).
- In Malawi, junior farmer field schools for AIDS orphans and vulnerable children are also targeting fishing communities (FAO, 2004).
- In other parts of Southern Africa, HIV/AIDS issues have also been incorporated into agricultural services provision through integrated pest management training programmes (Haddad *et al*, 2001).
- Subsistence crop to diversification to low maintenance alternatives including cassava, sorghum and millet. This mitigation measure has

been recorded in Zimbabwe (FASAZ, 2003) and Cote D'Ivoire (Black-Michaud, 1997).

Still at community level, some initiatives have bordered on introducing 'community safety nets' which target women, children and orphans. These are involved in programmes such as support to HIV/AIDS sufferers at community level and also training of survivors and other household members new skills such as carpentry, tailoring, poultry farming, etc. (Mutangadura *et. al.,* 1999; FAO, 2004).

At government level, there have been interventions as well, but not as sufficient as one would expect. To emphasise this point, Turner (2001) alludes to the fact that in many African countries, universal social protection systems capable of absorbing the increasing numbers of older people do not exist. Most of the contributory social security schemes on the continent only benefit civil servants and formal sector employees. Currently, social security programmes cover less than 10 per cent of Africa's workforce. As a result, governments in Africa have continued exploiting and relying on traditional support systems such as families to provide care for older adults (Barrientos *et al* 2002; Caldwell, 1976; De Lancey, 1990; Case *et al*, 1998; Duflo, 2000). However, as previously established, family care has recently become undependable and unreliable. This has also brought into effect alternatives to family care commonly referred to as informal care systems, which inevitably go beyond family care. For example, Olivier *et al.* (2004) states that informal support systems go beyond the extended family and also include benefits in cash and kind from membership of traditional solidarity networks, co-operative or social associations such as burial societies, self-help groups and rotating savings and credit clubs, as well as from cultural associations.

2.7 Policies and Programmes: Historical Review

The earliest known intervention on ageing in Zambia (then Northern Rhodesia) took place after the Second World War when the country was under colonial (British) administration (1945 to 1963). The 'white' masters put up some homes for the aged to provide services to older white citizens who had no families or were recommended to such places by families (Kamwengo, 2004). After independence from Britain, most of these homes either became Zambian (black) government property and started serving other purposes or were adopted by church organisations to serve similar purposes.

From independence in1964 through to 1979, the government of Zambia had no clear documentation of policies and programmes on ageing. However, there is evidence suggesting that the earliest possible post-independence era response to ageing in Zambia was through the establishment of the social welfare system between 1966 and 1979 (Country Report for World Assembly on Ageing, 1982). The welfare system was established to help provide amenities such as food, clothing, house rent and rates as well as residential care to people who were either old or classified as 'destitute' (*Ibid,* 1982). In 1980, Zambia, and all countries in the world were expected to submit reports to the 1982 Vienna World Assembly on Ageing to give details on the ageing situation in their respective countries.

The 1980 report reflected the country's active concern for the potential consequences of population ageing in particular and also highlighted what the country intended to achieve with population and development in general. There were numerous dimensions to the country's propositions on the mediation of ageing, nonetheless, most proposed interventions were temporal and 'reactionary' instead of being proactive and long term. For example, government committed itself to provide food and clothes to older people in dire need of such services; it also provided temporal shelter to older people before repatriation to villages etc. (*Ibid,* 1982).

2.7.1 Early Policies and Programmes on Ageing

Even at the time when the very first report on ageing was written in 1980, there was no definite policy on ageing in Zambia. It was generally felt that older people, just like other interest groups, would also directly or indirectly benefit from a diversity of services offered by government (Zambia Report to Vienna World Assembly on Ageing, 1982). The government emphasised the need to recognise the elderly as people who were part of society and should not be isolated from either families or the general public. It was also declared that the elderly needed to be involved and be beneficiaries of services provided for the community as a whole (*Ibid,* 1982). Some of the services included health, housing and environment, social welfare and security, education, employment and helping to strengthen the family. Each of these is discussed below in some detail.

2.7.2 National Health Programme

From independence to the 1990s, the United National Independence Party (UNIP) government had a policy where health services were to be provided free of charge to all Zambians. By the end of 1983, all districts in Zambia had a district hospital (*Ibid,* 1982). The health programme was expected to satisfy all health needs of the Zambian populace. Government was of the view that provision of free medical services was vital in preparing younger people for a healthy future old age.

In order to enhance the provision of free health services to the population and more especially to the aged, communities in Zambia were encouraged to select representatives called Community Health Workers who were later trained to provide health services to the community (Zambia Report to Vienna World Assembly on Ageing, 1982). In this programme, however, particular attention was given to elderly people defined as destitute. Accordingly, these were considered more problematic for the government and communities than perhaps those who had homes or who were kept by families (*Ibid,* 1982).

2.7.3 Housing and Environment

According to the 1982 Report on Ageing for Zambia, housing, especially urban housing, was a major problem for many Zambians, and even more so for the elderly. Urban housing was tied to employment and it was government policy to encourage home ownership through special schemes where people, including those without formal employment like the elderly, could also benefit. These schemes were meant to help curb destitution. In view of this, the government established the National Committee of the International Year for Ageing, which was mandated, among other things, to educate and carry out mass campaigns to sensitise the citizenry (especially employees through their employers) of the need to own houses while they were still young and in active employment. Such a mechanism would then help serve them better in old age (*Ibid,* 1982).

2.7.4 Social Welfare Services

Social Welfare services were introduced in Zambia during the period 1971 and 1980. Services under this system were incorporated to enable the government offer assistance to destitute elderly persons.

The government, through the Department of Social Welfare (now the Ministry of Community Development Mother and Child Health) introduced a Public Assistance Scheme under which destitute persons were assisted on both short and long-term basis. Much of the assistance was in kind and included provision of food rations, clothing, payment of rentals and rates, provision of orthopaedic appliances and, in some cases, repatriation expenses. In this example, the largest beneficiary group was the elderly people.

The Department of Social Welfare was also mandated to provide assistance to older people through institutional structures. Institutional care was restricted to special needs only; for example, once it was proved that the elderly person with a problem was a destitute, institutional care was provided. In view of this, the government maintained three homes for the aged and one Geriatric Centre

for all chronically ill older persons. However, government was not particularly supportive of institutional care; it instead favoured family and community care. Institutional care was only optional in some deserving circumstances, and as a last resort (Zambia Report to Vienna World Assembly on Ageing, 1982).

2.7.5 Education

Education was also one of the interventions to the ageing problem. To some degree, interventions in education were merely proxy measures. For example, the government established the Department of Adult Education at the University of Zambia to serve people who were thought to have missed out on being educated during their youth. It was in fact government policy to provide free education from primary to university levels, and the elderly were encouraged to enroll. The government also intended to provide opportunities for retraining elderly persons in new fields to help replace obsolete skills (*Ibid*, 1982).

2.7.6 Employment

Creation of employment was another measure used to intervene on ageing. Apparently, government was of the view that if many people were in employment and were availed employment opportunities, it would then be possible to secure their future when and if they reached old age. Employment opportunities for the entire population meant also that government policy to encourage families and communities to take care of their old relatives would be attained, since many people would also have the means to support them (Zambia Report to Vienna World Assembly on Ageing, 1982).

2.7.7 Social Security

Social Security Schemes were introduced for persons employed formerly by the government (as civil servants), parastatals or the private sector. Three categories of social security schemes were introduced and these were: The

Government Pension Scheme, The Zambia National Provident Fund and The Workmen's Compensation Fund (*Ibid,* 1982).

(a) **Government Pension Scheme**: This scheme served civil servants; it was a contributory system based on calculated percentage deductions from the worker's salary every month. The state or government added another percentage contribution. Benefits in form of a pension were then paid upon reaching age sixty for males or fifty-five for females. In situations where an employee resigned before attaining retirement age, pension was paid promptly as a lump sum. Ideally, this scheme was meant to help retired civil servants live honourably even without being in formal or full time employment (Department of Social Welfare, 1990).

(b) **Zambia National Provident fund (ZNPF)**: ZNPF was established as a contributory scheme for workers in parastatals and the private sector. It was also open to self-employed workers and those in the informal sector. Unlike the civil service pension scheme, ZNPF contributors were entitled to claim benefits when they reached fifty or fifty-five years. ZNPF also made payments called 'old age retirement' and 'emigration payments'. This meant that upon retirement, people became entitled to old age retirement benefits and where repatriation to their home villages was needed, payments were made to facilitate their movement (*Ibid,* 1990).

(c) **The Workmen's Compensation Fund (WCF)**: The WCF was not established as an old age scheme. It was intended to serve persons injured during the course of work or duties. The scheme would then be used to help them throughout their life span (*Ibid,* 1990).

2.7.8 Other Interventions on Ageing by the UNIP Government

In 1982, government formed a National Committee on Ageing which was represented in all provinces through Provincial Committees. The national committee came up with practical steps, functions and activities to respond to challenges of ageing at that time. The following were some of the functions:

(i) Promote and assist programmes aimed at strengthening the family as the primary unit for care of the aged, and educating families and communities to care for elderly members in order to fulfill the national philosophy of Humanism. This would in turn obviate or minimise as much as possible, pressure on institutional care;

(ii) Develop meaningful activities within the widest range of civic, cultural, recreational and educational programmes; promote vocational and occupational programmes for the elderly to prepare them for their future lives so that they remain economically productive as long as possible;

(iii) Request and encourage voluntary agencies to include programmes for the aged in their plans in order to assist in the identification and establishment of volunteer services where the knowledge and skills of the retired elderly persons could be utilised to promote efficient community services;

(iv) Establish an Old Age Pension Scheme covering all people above age fifty-five who have no income so as to cater for majority elderly people especially in rural areas where income is scarce. In addition, introduce legislation to exempt elderly persons above fifty-five years from paying;

(v) Expose the elderly to primary health care services and influence the creation of pre-retirement services, such as counseling, so that people could retire in good health, in honor and dignity after years of contributing to the social and economic development of the country;

(vi) Conduct series of national and local seminars in all parts of the country; promote and encourage research on ageing; mount public campaigns to help understand and change certain negative attitudes towards the

elderly and, through the mass media, keep all agencies and organisations serving the elderly well informed; and

(vii) Assist relevant voluntary organisations in supplementing government efforts to improve conditions in institutions providing accommodation and care for the aged.

As a way forward, government prioritised the following programmes and projects for immediate implementation:

(a) Improve the quality of services offered by institutions catering for older persons;

(b) Establish Day-Care Centres where older people could gather to exchange ideas or engage in meaningful activities; such centres would also act as temporary shelters for stranded elderly persons or for those awaiting repatriation to their home villages;

(c) Encourage the involvement of elderly persons in village industries where they could engage in useful pursuits such as crafts, which would not only keep these senior citizens occupied but would also assist in the preservation of the nation's cultural heritage; and

(d) Involve the elderly in traditional cultural activities such as traditional ceremonies etc.

2.8 Recent/Current Policies and Programmes on Ageing

The Ministry of Community Development and Social Services (MCDSS), now The Ministry of Community Development Mother and Child Health (MCDMCH) is mandated through an Act of Parliament to produce and implement programmes that provide and facilitate social support services to the vulnerable persons in Zambia. MCDMCH is also responsible for Zambia's Policy

on Ageing. However, currently, Zambia does not have an approved policy on ageing. Much of what is discussed here are other ratified pieces of policies under the MCDMCH and other line ministries such as health and labour.

2.8.1 Public Welfare Assistance Scheme (PWAS)

The Public Welfare Assistance Scheme (PWAS) is amongst major safety nets government has continued administering. The PWAS has been revised twice, in 1996 and 2000. PWAS is not a scheme for the aged only, but for other categories of vulnerable individuals as well, including the disabled, chronically ill persons, people in homes headed by single parents, orphans/vulnerable children, and people displaced by disasters such as floods (Social Welfare Policy, 2000). For any person to be considered under PWAS, one has to meet certain conditions, which include:

- Evidence of no support from relatives;
- Inability to work;
- No known assets used in production;
- Evidence of having insufficient food availability; and
- Having a below-standard housing unit.

The Public Welfare Assistance Scheme is currently operational in all districts of Zambia and is mandated to provide the following services:

- Cash and non cash provisions (goods and services). This service targets at least 200 000 beneficiaries every year. However, this goal is mostly not reached;
- Bursary schemes for orphans and vulnerable children;
- Health care cost scheme especially for OVCs; and
- Provision of food security packs through the Programme Against Malnutrition to vulnerable groups such as women, children and the elderly.

According to the MCDSS ministerial briefs (2010), the Department of Social Welfare is currently reviewing PWAS guidelines to strengthen its supervision and implementation.

2.8.2 Social Cash Transfer Scheme (SCTS)

The Social Cash Transfer Scheme (SCTS) was introduced in 2004 as a Pilot Scheme to Siavonga and Kazungula districts of Southern Province. Initiators of this scheme were the MCDMCH and the Germany Technical Corporation.

Prior to the implementation of the scheme, a National Household Survey was conducted and results of this survey suggested that about 10 per cent of the households or 6.9 per cent of the population was found to be 'destitute' in these districts (Schubet *et al*, 2004). The term 'destitute' in this respect was defined to include those individuals who were unable to access adequate livelihoods without external support and who were incapable of withstanding shocks. They had no assets, had limited productive capacity due to their circumstances, normally suffered from socio-political exclusion - that is, did not have any credibility, voice or platform in their communities due partly to low self-confidence - and were dependent on public and/or private transfer of resources (*Ibid,* 2004).

The Social Cash Transfer Scheme is a constituent of a more broad approach to enable poor households to better manage key risks associated with food security, destitution, and HIV/AIDS. The scheme has three specific objectives:

(i) Reduce extreme poverty, hunger and starvation in the 10 per cent most destitute and incapacitated households in the target districts (Siavonga and Kazungula);

(ii) Focus mainly (but not exclusively) on households that are headed by the elderly and are caring for OVCs because the breadwinners are

chronically sick or have died due to HIV/AIDS or due to other reasons; and,

(iii) Strengthen community-driven social protection strategies

Target groups are households (not individuals) that meet the following criteria:

(a) They are critically poor and being poor in this respect was defined to mean people who only afforded one meal per day, were most of the times begging from neighbours, children were malnourished and were not going to school, had very poor shelter and clothing, were unable to afford medical treatment etc.; and

(b) They have no adult household member able to work or for big households had a dependency ratio of more than 300.

The Scheme was designed to work through the PWAS structure consisting of community welfare assistants that help identify households meeting the targeted criteria.

Currently, the Social Cash Transfer Scheme pilot has been expanded to include more districts such as Kazungula, Monze, Chipata and Katete.

Originally, the SCTS was designed to target poor households which met the criteria described above; however, the scheme in Katete was planned to target households where the head of the household was at least sixty years and above. As a result, while the SCTS incorporates all vulnerable groups, it has a mechanism to also respond to ageing (Schubet *et al*, 2004).

According to the Ministry of Community Development and Social Services (Mother and Child Health) *ministerial briefs* (2010) the Social Cash Transfer Scheme has also uplifted standards of living of beneficiary groups. The

criterion used to include older people has also indirectly helped them look after themselves and their dependents with less difficult.

2.8.3 Institutional Care

The government has continued running homes for the aged. Institutional care is, however, still the last resort. The number of old people's homes is still small in Zambia. This maybe a result of very little resource allocation towards their expansion, or it may mean simply that ageing is still a non-pressing and non-priority area.

There are eight homes for the aged in Zambia. Two are entirely run by government while the rest are under churches. Government's role has largely been the provision of grants to these institutions to help in caring for the elderly. In addition, government also runs shelters called 'Places of Safety'. These are institutions providing temporary shelter, food and care to stranded and destitute persons. They include Bwacha in Kabwe and Matero in Lusaka (Kamwengo, 2004).

2.8.4 The Population Policy

The first attempt to recognise the importance of population in the development process came through the adoption of the 1989 Population Policy. The policy tried to affirm government's commitment to adopting and implementing appropriate strategies to manage population resources in a manner consistent with Zambia's ultimate objective of accelerating the rate of economic development (Population Policy, 1989). Since then, there have been several fora where population issues have been discussed, assessed and incorporated in development agendas.

The population policy of 1989 was the main population document providing policy guidance on population issues until it became clear that the policy was not up to date with emerging contemporary issues such as urbanisation, gender concerns, brain drain and HIV/AIDS. As a result, since 1998 through to

2006, the Ministry of Finance, UNFPA, donor agencies and the University of Zambia were involved in several consultative meetings that finally saw the drafting and adoption of the 2007 Policy on Population for Zambia.

Like any other policy, the Zambia Population Policy is premised on a defined vision, rationale, guiding principles, objectives, targets and strategies. Ideally, the population policy should incorporate ageing either directly (emphatically) or obliquely (passively) through categorised vulnerable groups. While the focus here is to relate ageing to the population policy, it is also important to highlight what the vision and rationale of the population policy are so as to make informed conclusions on whether the policy in question does indeed reflect ageing as the case should be. The 2007 National Population Policy's vision states as follows:

> *To improve the quality of life of the people through the achievement of population trends commensurate with socio-economic development.*

The rationale is as follows:

> *Population is a primary determinant for any development; the interplay between and among population characteristics such as fertility, mortality and migration affect and are in turn affected by development, as such, they are critical, therefore, in the formulation and implementation of policies and plans which accelerate socio-economic development. As such, population policy should be viewed as an important element in the formulation and implementation of other sector policies and* programmes.

The major thrust or focus in this rationale is the significance of population issues in development and also the role that these factors play in the formulation of other policies. Analyses of aspects affecting the population in general are sometimes used as precursors for other policy pronouncements and/or documents. However, it is not clear to what extent population issues are reflected in other policies. Needless to say, topics in the population policy such as gender, youth, reproductive health, etc., have been incorporated in other policies both within and outside government (including non-

governmental organisations). Gender, for example, has its own gender policy. Reproductive Health issues are also reflected as stand-alone policies, or incorporated in the health policy as well.

The 2007 National Policy on Population has five main guiding principles and seven objectives. The following are the guiding principles:

(i) The government, stakeholders and individuals have a responsibility to have well-managed population for sustainable development and improved quality of life for all;

(ii) All groups in society and individuals should have access to appropriate and accurate information on population and development issues;

(iii) All individuals should have access to basic services such as education, health, housing, water and sanitation;

(iv) All couples and individuals should decide freely and responsibly on the timing, number and spacing of their children for manageable family size; and

(v) Government has a responsibility to facilitate people's ability to make informed choices and to create an enabling environment in which they can effectively manage their lives.

These principles document issues that benefit all interest population groups. It is actually clear that all people have to have access to information on population, education, health, housing and water sanitation. These principles also recognise the role government plays in the creation of environments where all people can effectively manage their lives. However, they seem not to address ageing.

As stated earlier, the seven main objectives in the population policy address distinct subjects. Each of these objectives has other themes of interest; some of them include reproductive health, HIV/AIDS, morbidity and mortality, adolescent fertility, creation of a national population database and the need to evenly distribute the population between urban and rural areas (National Population Policy, 2007: 13). The policy advocates for a reduction in morbidity and mortality, especially maternal mortality, infant and child mortality and adolescent fertility. In general, it could be stated that the policy touches indirectly on ageing because the approach it takes is general. For example, there is emphasis on 'all people' having access to reproductive services, meaning that even older people have such access.

2.8.5 Health Policy

National Health Policy was drafted to guide the development and implementation of health activities in the country. It is a subject of discussion in this study because health is one of the programmes upon which ageing is extolling insurmountable effects. At the world level, attempts are being made to document effects of ageing societies on health, especially health expenditure and financing. For example, Kinsella (2005) reports that an important aspect of older people's standards of living is on their health care and the costs involved. The 2002 WHO World Health Report was devoted to identifying, quantifying and reducing disease risk factors associated with ageing. Data from the European Community Household Panel Surveys (since 1990) has also begun to show the intricate interplay between ageing and health and the effects of the former to the latter. Studies within Africa also suggest that, as populations age and undergo certain health and economic transitions, their disease patterns change and, therefore, responsive health policies are cardinal (Kahn *et. al.*, 1999; Kahn *et al*, 1999a).

The Health Policy is the umbrella document upon which health sector sub-policies were formulated. After 1991, the health reform policy framework was

designed and in 1994, the national health strategy framework was also developed, followed by revisions in 1997 and subsequently between 2001 and 2005. In 2006, another national health strategic plan was launched for the period 2006 to 2010. This plan was designed to, among other things, respond to the UN MDGs. Its vision is:

> *'… Towards Attainment of the Millennium Development Goals and National Health Priorities…'*

Originally, the health policy stipulated that all citizens in Zambia should have equal access to healthcare services regardless of their location, gender, age, race, social, economic, cultural and political status (National Health Strategic Plan, 2006-2010). While the vision of the first policy on health stipulated 'equity to health access' and all services provided free of charge, the 1991/2 health reforms led to the reformulation of equity and 'all able-bodied' Zambians with capacity to earn income were now expected to contribute to the cost of health care (Kalumba, 1997). In essence, what this meant was that compulsory/private health insurance schemes were now put in place. User fees/charges were also introduced, and community financing became an important component of health financing (*Ibid,* 1997: 29). It is in line with health financing reforms that issues of ageing were also considered.

In 1996, government came up with the 'Second Agenda' in health where health security was a consequence of 'healthy public policy' and not merely the effect of medical services (*Ibid,* 1997). As such, the government's second agenda on health reforms tried to address four key areas, namely:

(i) Integrated community health development under a reformed district health system;

(ii) National essential health packages of care for sustainable health;

(iii) The quality of life and health security of specific population groups; and

(iv) Accountability for health in public policy.

'Second agenda' policy parameters identified population groups such as women, children and the elderly as special interest sectors in need of special attention, and it became clear that certain groups, though able bodied, were not capable of paying hospital user fees. The suggestion to set an agenda to accommodate groups such as women, infants, the aged, etc., was premised on the need to reduce maternal and infant mortality, as well as to develop services that would help improve the quality of life, especially in old age (*Ibid*, 1997: 32).

The Health Policy is by no means expected to guarantee expressly issues of ageing in totality. It is a policy whose aim is to improve the health status of all citizens irrespective of the socio-economic standing. As stated already, the policy initially stipulated that all able-bodied persons should be able to contribute to the cost of their health. However, in its current form, exceptions were included, and the following statement shifted the paradigm:

> *'Every able-bodied Zambian with an income should contribute to the cost of his or her health'. However, the following groups are exempted: children under five and adults over sixty-five; those with diseases such as TB, HIV/AIDS, STDs, Cholera and dysentery; safe motherhood and family planning services; immunisation; and chronic problems such as hypertension and diabetes and other related factors'* (Kalumba, 1997).

Since 1991, the health policy has remained the same. What the Ministry of Health (MoH) has adopted has been the development of strategies to operationlise its implementation. Even with this approach, what is clear is that issues of ageing are not as distinct as other interest groupings like child health, reproductive health etc. For example, the 2006-2010 National Strategic Plan currently being implemented by the MoH has the following vision:

'Equity of access to assured quality, cost-effective and affordable health services as close to the family as possible'

It should be stated that while the National Health Policy is not expected to outline all aspects of ageing in detail, it is in any case expected to respond to basic ones. As a way of summarising, it is clear that both the 1991 health reforms and subsequent strategic plans have not transformed significantly to respond to ageing adequately. Further, it is also true that while the health policy recognises ageing and the aged in general, this is only so at the point of service delivery, in this case, health centres.

2.8.6 National Employment and Labour Market Policy

Current debates and arguments on the need to ensure older persons are integrated back into society hinge on many essential aspects, among them 'labour'. The National Employment and Labour Market Policy, or simply the Labour Policy, is a very important instrument which should guide processes and procedures on how elderly persons would be provided opportunities to participate on the Zambian labour market front. The main committee of the 2002 World Assembly on Ageing (Madrid Plan of Action) adopted several resolutions. Pertinent among them were Articles 6 and 12 (Report of the Second World Assembly on Ageing; Madrid, 8-12 April 2002). The two articles stress commitments world leaders made to ensure integration of older persons into all aspects of development including opportunities to participate in the labour force. Article 6 for example provides for the full inclusion and participation of older persons in society. It states:

The modern world has unprecedented wealth and technological capacity and has presented extraordinary opportunities: to empower men and women to reach old age in better health and with more fully realised well-being; to seek the full inclusion and participation of older persons in societies; to enable older persons to contribute more effectively to their communities and to the development of their societies; and to steadily improve care and support for older persons as they need

it. We recognise that concerted action is required to transform the opportunities and the quality of life of men and women as they age and to ensure the sustainability of their support systems, thus building the foundation for a society for all ages. When ageing is embraced as an achievement, the reliance on human skills, experiences and resources of the higher age groups is naturally recognised as an asset in the growth of mature, fully integrated, humane societies.

Article 12 stipulates that older persons should have opportunities to work as long as they wish and are able to, and should also continue to have access to education and training opportunities. Article 12 states that:

The expectations of older persons and the economic needs of society demand that older persons be able to participate in the economic, political, social and cultural life of their societies. Older persons should have the opportunity to work for as long as they wish and are able to, in satisfying and productive work, continuing to have access to education and training programmes. *The empowerment of older persons and the promotion of their full participation are essential elements for active ageing. For older persons, appropriate sustainable social support should be provided.*

Articles 6 and 12 articulated in the 2002 Madrid Plan of Action Report targets both the Policy on Ageing as well as the Labour Policy.

Since 2003, the Labour Policy has been undergoing major transformations. These transformations have resulted in the production of what is referred to as Parts I and II of the Labour Act (Labour Policy, 2004). The current Labour Policy's main objective is to:

'Create adequate and quality jobs under conditions that ensure income, protection of workers and basic human rights'.

From independence to 1991, Zambia had not been operating with well documented and coordinated employment and labour market policies. It was decided that such a situation, which manifested itself through problems perpetrated by falling levels of employment, effects of HIV/AIDS on

productivity, and an unreliable social security system, required a statutory instrument to guide government in terms of roadmaps, programmes and projects whose main thrust would be to salvage problems mentioned above (*Ibid,* 2004).

The Labour Policy is guided by a set of seven principles and ten sector employment and labour market policies. There are three critical areas: Employment Creation, Social Protection/Security provision and Mainstreaming Special Interests and Vulnerable Groups.

Under the sub policy, Employment Creation, the policy subjects itself to the International Labour Organisation (ILO) Convention**,** which binds member countries like Zambia to pursue an active employment policy designed to promote the goal of full, productive and freely chosen employment (ILO Charter, Convention 122). All possible areas of employment are categorised in this section and the policy seeks to ensure that they respond to challenges Zambia was facing especially on the economic front.

Most of the strategies on employment creation aim at strengthening these specific areas so that it is possible to among others, absorb youths out of employment and, thereby, foster economic growth. However, there is nothing specific on the need to provide employment opportunities to older people as well.

The goal of the Social Protection/Security sub policy is to enhance the efficiency and comprehensiveness of the social security system in the country. It aims at improving on the levels of benefits, coverage and delivery of the social security system. This sub policy basically targets individuals who are in formal employment, but also aims at mobilising the informal sector so that it forms what is referred to as 'mutual aid societies', which would collect contributions from members to be accessed if and when need arose. Whether these mutual aid societies are operational is a different subject altogether; in any case, the

social protection advocated for here does meet some requirements to incorporate ageing, especially after retirement and for the 'out of work' people.
Another critical component the labour policy addresses is to mainstream special interest and vulnerable groups. The policy identifies five groups of persons classified either as special or vulnerable. These groups include: Gender, Youths, Retrenches, those with Disability and People Living with HIV/AIDS (PLWA). Gender in this case is synonymous with women because the policy discusses gender with women in focus, and not necessarily as it is defined in the real sense (Gender is a socially defined concept which applies to both males and females).

For each of the groups identified, specific strategies have been developed to meet their needs. For example, in order to address problems of the youth, the policy proposes to provide micro-financing for youth self-employment (Labour Policy, pp.52). Consequently, this policy has further been operationalised through the Youth Empowerment Project where government identifies and provides soft loans to deserving youths so they become self reliant. Similarly, women have also been brought to the limelight through advocacy to employment opportunities, especially formal employment. In fact, all government ministries have 'a gender focal person' to help promote women employment in government. Certain legal barriers which clearly or inadvertently discriminate against women have also been removed and replaced with those that are gender sensitive. However, the sub policy does not address ageing at all. It is devoid of specific reflections addressing ageing as a special interest area and older people as a special group as well.

2.8.7 Other Long-Term Policies – Vision 2030

Zambia has several policies which seek to address both the social and economic concerns the country is currently facing. In order to articulate long-term development objectives, Zambia has in place a document called 'Vision 2030', which states:

'Zambia to become a prosperous middle income country by the year 2030'.

The 2030 vision inevitably calls for policies that would help accelerate and sustain economic growth so that the poor may also be accorded opportunities to participate and benefit from the growth process of the country (FNDP; MFND, 2006).

To achieve Vision 2030, government re-introduced five-year development plans with the first being the Fifth National Development Plan or FNDP and currently the Sixth National Development Plan - SNDP.

The World Assembly on Ageing (2002) recommended that ageing should be placed in all development agendas particularly, Article 7 of the 2002 Report of the Second World Assembly on Ageing says:

> *At the same time, considerable obstacles to further integration and full participation in the global economy remain for developing countries, in particular the least developed countries, as well as for some countries with economies in transition. Unless the benefits of social and economic development are extended to all countries, a growing number of people, particularly older persons in all countries and even entire regions, will remain marginalised from the global economy. For this reason, we recognise the importance of placing ageing in development agendas, as well as in strategies for the eradication of poverty and in seeking to achieve full participation in the global economy of all developing countries* (Second World Assembly, 2002).

Vision 2030 is guided by embodying values of socio-economic justice underpinned by principles of gender-responsive sustainable development, democracy, respect for human rights, good traditional and family values, positive attitudes towards work, peaceful co-existence and private-public partnerships. It highlights three scenarios outlining development options, namely the baseline, the preferred and the optimistic.

Examination of the FNDP, SNDP and Vision 2030 shows that these long-term development agendas do not also clearly respond to ageing. While it is true that the subsection on Social Investment and Human Development of Vision 2030 (Annex II, pp.32) attempts to include some aspects of ageing under the food and nutrition sector, provisions are not specific. For example, one of the targets of the Food and Nutrition Sector is to strengthen nutrition care practices for vulnerable groups, including young children, adolescents, women of reproductive age, PLWA and those affected by non-communicable diseases such as diabetes, hypertension, coronary heart diseases, and cancer. Similarly, under the social protection sector, an attempt again is made to include the aged alongside those classified as vulnerable groups. The social protection sector has three targets, one of which aims at strengthening contributions towards the social security of all vulnerable Zambians by ensuring that incapacitated and low capacity households have sufficient livelihood security to meet basic needs and are protected from the worst impacts of risks and shocks (*Ibid*, pp. 32). These two examples are the closest the vision comes to in addressing ageing.

2.9 Summary of the Literature

Critical interrogation of the literature reviewed here shows that very little or no information is directly discussing studies conducted on Zambia in particular. Similarly, while there are examples where studies have been conducted to produce the literature in reference, it is also true that majority of what has been reviewed is more theoretical rather than actual empirical studies on ageing. In other words, there is very little evidence to support most or all of the theoretical as well as conceptual 'claims' made here. In the same way, a review of several policy documents discussed above shows that they lack adherence to tenets and principles of active ageing both as prescribed by the United Nations and the WHO. This, therefore, also goes on to show why it was important to conduct this study. This research therefore helped to provide or enhance both

literature in theoretical terms as well as evidence on the actual determinants of active ageing as well and the challenges facing older people in an African setting and Zambia in particular.

CHAPTER 3: METHODOLOGY

The purpose of this chapter is to describe the methods that were selected and used for this study. The chapter includes descriptions of the research design, target population, sampling and sample size, data collection techniques and analysis, ethical considerations and limitations.

3.1 Research Design

In undertaking this study, a cross-sectional, non-experimental survey design was used. The study used triangulation to generate the required data. It should be noted that in the social sciences fraternity, triangulation is often used to indicate that more than two methods are used in a study with a view to double (or triple) check results. This is also called 'cross examination' (Cheng, 2005). The use of 'cross examination' in the real sense is farfetched, but was used to collate data that was generated using different methods. Most importantly, methods used can be defined in terms of qualitative and quantitative procedures.

3.2 Target Population and Study Areas

3.2.1 Working Definition of an 'Old Person'

Defining old age or an old person is not easy. Although there are commonly used definitions, the World Health Organisation (WHO) states that there is no general agreement at which age a person becomes old. In fact, as far back as 1875, in Britain, the Friendly Societies Act voiced the definition of old age as 'any age after 50'; yet pension schemes mostly used 60 or 65 for eligibility (Roeback, 1979). The United Nations (UN) states that even up to now, there is no standard numerical criterion for the definition of old age**;** however, the UN has agreed to use 60-years plus as the cut-off year to refer to older population. In the same way, this study adopted the UN agreed criterion where an old

person is simply anyone who has attained at least age 60. In view of this definition, the target population was all individuals in the selected study sites who were 60 years or over.

3.2.2 Study Areas

The study was conducted in five districts representing four provinces out of the nine in Zambia, namely Western, Southern, Lusaka and the Copperbelt. The districts are Sesheke, Livingstone, Lusaka, Ndola and Mufulira. These represented a rural-urban mix although only Sesheke is predominantly rural.

These districts were purposefully chosen. One very distinct factor influential in the choice of these provinces and districts is that they all have homes for the aged; and since the study's target audience included both institutionalised and non-institutionalised older people, it was, therefore, logical to make a selection of sample areas that have these homes and were also relatively easy to access.

Currently, there are seven government and private-run homes for the aged in Zambia. These are Maramba in Livingstone (Government), Mitanda in Ndola (Salvation Army), Chibolya in Mufulira (Government), Devine Providence House in Lusaka (Government), Kandiana in Sesheke (Mwandi Mission), Matero Transit Home in Lusaka (Government) and Sepo and John Chulu in Mongu (the Catholic church). For this study, Kandiana, Maramba, Matero Transit, Mitanda and Chibolya were selected. These homes for the aged were selected because they are situated in the sample districts where the study was undertaken.

3.2.3 Study Area Details

Sesheke – Kandiana Home for the Aged: Sesheke is a border town in the Western province of Zambia. It lies on the northern bank of the Zambezi river which forms the border with Namibia's Caprivi Strip at that point. According to the 2010 census of population preliminary results, Sesheke has a population of

about 94 600. Kandiana Home for the Aged is a privately-run home situated at Mwandi Mission. It has a capacity of housing up to sixteen residents. Sesheke provided a sample from the community as well as from the home for the aged.

Livingstone – Maramba Home for the Aged: Livingstone is a historic colonial city and present capital of the Southern province of Zambia, a tourism centre for Victoria Falls (Mosi-oa-Tunya), lying 10 km north of the Zambezi river. It is a border town with road and rail connections to Zimbabwe on the other side of the Falls. Its population is estimated to be 142 000 (2010 Census of Population and Housing Preliminary Report). Maramba Home for the Aged was established in March, 1963. It has a maximum capacity of forty and is run by the government.

Lusaka – Matero Transit Home: Lusaka is the capital and largest city of Zambia. It is located in the southern part of the central plateau of the country, at an elevation of 1279 m. It has a population of 1.7 million (*Ibid*, 2010). It is a commercial centre as well as a centre of government. Matero Transit Home is not necessarily a home for the aged; it is a halfway house where stranded old people and destitutes are kept before repatriation to other homes. However, it is due to a large number of old-age-residents that has earned it classification as a home for the aged. Although the transit home has a capacity of forty residents, it usually houses over 100 people per month. Lusaka, like Sesheke, provided a sample for interviews from the community as well as from the home itself.

Ndola – Mitanda Home for the Aged: Ndola is the third-largest city in Zambia, with a population of 455 000 (*Ibid*, 2010). It is the industrial and commercial centre on the Copperbelt, Zambia's copper-mining region and capital of the Copperbelt province. Ndola lies just 10 km from the border with DR Congo. Mitanda was the first home for the aged to be established in Zambia. Its current location was an army mess during the Second World War, but was later turned into a government hostel after the war. In 1948, the hostel was

transformed into Mitanda Home for the Aged. It is being run by the Salvation Army Church.

Mufulira – Chibolya Home for the Aged: Mufulira is a city (population 161,600) on the Copperbelt province of Zambia. It began in the 1930s around the site of the Mufulira Copper Mine on its north-western edge. The city is sixteen km from the border with the Democratic Republic of the Congo and is the start of the Congo Pedicle road connecting the Copperbelt to Luapula province. A tarred highway to the south-west connects Mufulira to Kitwe (40 km) and Chingola (55 km), and another to the south-east connects to Ndola (60 km). Chibolya Home for the Aged was established in September 1963. It was opened to care for elderly people who had no relatives. Currently, Chibolya is being run by the Department of Social Welfare under the Ministry of Community Development, Mother and Child Health (MCDMCH). Mufulira was included to provide a sample for the institutionalised old people.

3.2.4 Sampling, Selection of Respondents and Sample Size

Purposive as well as snow-ball sampling techniques were employed in identifying respondents. Purposively, all residents in existing old people's homes in the selected districts were targeted for inclusion in the study. Older people, herein defined as anyone aged 60 years and above were selected through snow-ball sampling (Goodman, 1961; Salganik and Heckathorn, 2004). Snow-ball sampling was employed because the target population has no known sampling frame. This technique is also used for 'hard to reach' or a 'not readily available groups' such as nomads or sex workers. The Snow-Balling technique involved identifying households with older people and interviewing them. After interviews, respondents (older people) were asked to indicate or show the research team where else other older people resided within their community. Once such households were identified, interviews were held and the process took through the same approach until the desired sample size was reached.

Establishing whether or not a respondent was indeed at least 60 years old involved firstly asking the respondent if they were 60 years and above and then writing down the response and going ahead with the interview. However, in situations where the respondent could not state with certainty their age, a calendar method was used; this involved asking respondents to mention any historical event associated with their birth. For example, some respondents stated that they were born at the time the First or Second World War started or ended. If some historical calendar event could not be recalled, estimates were used; for some difficult and isolated instances where age of a respondent could not be established, consultations were made with either relatives or close neighbours to help estimate their ages.

In this respect, therefore, the study aimed at achieving a sample size of at least 700 respondents. This sample size had enough cases from which to establish meaningful analysis. Fraenkel *et al* (2003) argue that a minimum of 100 is recommended for descriptive studies, while for correlational studies, a minimum of 500 is recommended. In all these examples, and using the minimum of 500 as a yardstick, our sample was representative of the older people in Zambia and was therefore large enough to perform some statistical inferences.

In order to collect community perceptions on ageing, focus group discussions (FGDs) were held with some of the members of the same community. Selection of FGD participants was done with the help of Neighbourhood Health Committees. One Focus Group Discussion was held in each of the three study areas and the number of participants was: Sesheke (n=9), Lusaka (n=12) and Ndola (n=10). While the groups were heterogeneous in terms of age and sex, homogeneity was achieved in that all participants knew and were looking after an old person in their household. It is also important to note that confidentiality in a FGD is almost never guaranteed especially by the

researcher; however, discussants were encouraged not to divulge any or part of the discussions as their views were strictly confidential.

3.3 Data Collection Instruments and Techniques

3.3.1 Instruments

A questionnaire with closed- and open-ended questions was designed and used to collect quantitative data on challenges experienced by older people. As Borg *et al* (2003) note, questionnaires are excellent instruments to help gather data on facts, attitudes and sometimes perceptions. Secondly, a discussion guide was also developed and used to collect qualitative data by soliciting for views and perceptions about older people and ageing in particular. In terms of data-collection techniques, quantitative and qualitative data collection methods were used and details of the same are outlined below:

3.3.2a Quantitative Data

Quantitative data was generated in two ways. Firstly, in order to understand the magnitude, growth rates and proportions of the aged in Zambia, both backward- and forward-projections were performed. Projections for the period 1950 to 2000 were modelled on UN data using reverse projections based on the 1969 Zambia Population Census. Projections for the period 2000 to 2050 were based on the 1990 census. All projections were modelled in SPECTRUM.

Secondly, a semi-structured questionnaire was developed to gather quantitative data for individual respondents. This instrument contained both open- and close-ended questions. Open-ended questions in the questionnaire were included to yield qualitative data as well. The instrument was administered to institutionalised (those found in old people's homes) as well as non-institutionalised older people living in study areas. The purpose of this instrument was to gather information on issues related to socio-economic living

conditions of the elderly in order to determine the challenges of ageing and the aged in Zambia.

3.3.2b Qualitative Data

Qualitative data was collected in two ways:

1. Firstly, Focus Group Discussions (FGDs) were conducted in all three districts. They were composed of people living within target areas but were by definition not classified as old. The FGD guide and method were designed to gather information on perceptions and attitudes towards ageing and the aged by members of the community who themselves were not old (as defined in this study), but were assumed to have information on the situation of the aged or in some cases were themselves looking after old persons.
2. Secondly, a detailed review of the draft policy on ageing was also. The purpose of conducting a detailed ageing policy review was to examine its adequacy in terms of responsiveness to both the UN Pricnciples on Ageing and the 2002 WHO Active Ageing Framework.

3.3.2c Data Collection Procedure

A group of 10 interviewers was recruited and trained for this study. Two were selected as supervisors. It comprised of six males and four females. The tools (both the questionnaire and the FGD guide) were never translated. However, all interviewers were recruited on the basis of being able to speak languages spoken in sampled areas. During training and pre-test, interviews were held in the local languages spoken in study areas. This was done to ensure standardization is maintained and the questions asked in the local language maintained the same meaning as those in English.

Focus Group Discussions were conducted by the supervisor and another member of the team. The supervisor was actually the lead interviewer while

another member of the team was a note taker. Data collection using the questionnaire was based on a one-on-one interview. In some cases, interviews were held in-doors while in others, in the open. However, in all these situations, confidentiality was upheld and maintained.

3.4 Data Analysis

In order to analyse quantitative data, univariate, bivariate and multivariate analyses were performed using STATA. The draft policy on ageing was examined by comparing its consistency with UN principles on ageing, WHO Active Ageing Framework and the 2002 Madrid Plan of Action and how it resonates with provisions of these documents. Analysis of Focus Group Discussions (FGDs) was based on key thematic areas and their application to the WHO Active Ageing Framework. FGD data were transcribed, typed and arranged by key thematic areas commensurate with specific objectives of this study.

3.5 Ethical Considerations

Ethical clearance was sought from The University of Zambia Ethics Committee. Before visiting homes for the aged, clearance was also sought from institutions in charge of such homes. Most importantly, however, a written consent from participants was solicited.

For those that could not read or write, a verbal consent based on the written consent was sought and research assistants signed on the form after permission was granted. This was done to ensure that persons interviewed were fully aware of the aims of the research, and that confidentiality was maintained and assured, and that information solicited was to be treated anonymously (Bowling, 2002). This consent also gave participants information about their freedom to withdraw at anytime if they felt so. This approach was included to ensure freedom of participants to choose to participate in the

research or not, and also safeguard against possible future legal liabilities (*Ibid*, 2002).

3.6 Challenges of Data Collection

Several challenges were experienced during the data collection process which started on 23 August 2009 and ended on 10 September 2009. These included language barriers, slow pace of interviews, slow process of getting permission to conduct interviews especially in areas where chiefs had to consent, delays in getting access to homes for the aged, etc.

While it is recognizable that frames to capture older people exist through the Census and also from studies conducted on large scales such as Demographic and Health Survey and Sexual Behaviour Survey, the process of selecting the sample for our study was difficult because older people are classified as "hard to reach". This is due to their low proportions in the population (Bless *et al*, 1995; de Vaus, 2002). Funding was also inadequate, thereby limiting the number of study districts as well as the sample size.

Further, in spite of detailed explanations about the purpose of the study and assurances about confidentiality, some participants refused to take part in the study. Despite all these challenges and limitations there was only about 1 percent non-response rate and as such, the study gathered useful information on the magnitude, challenges and determinants of population ageing in Zambia.

3.7 SPECTRUM Model Methodology[1]

DemProj (the main projections software in SEPCTRUM) calculations are based on the standard cohort component projection modified to produce a single year projection. The inputs to the demographic projection are:

[1] Adopted as presented in the Demoproj Spectrum System Policy Manual prepared by John Stover and Sharon Kirmeyer (2009)

- Pop5 (a, s): Population by five year age groups (a) and sex (s) in the base year
- TFR (t): Total fertility rate by year
- ASFR (a, t): Distribution of fertility by age by year
- SRB (t): Sex ratio at birth by year
- LEB (s, t): Life expectancy at birth with AIDS by sex and year
- Model life table
- Migration (a, s, t): Net in-migrants by age, sex and time

The assumption here is that the base population is a mid-year estimate and that the rates (TFR, life expectancy and migration) are calendar year averages. The first step in building the model is to split the base year population, which is in five-year age groups, into single ages. This is accomplished by using the Beers procedure (Beers, 1945). This procedure uses a series of polynomial equations to divide the population in five-year age groups into single year age groups while maintaining the population total and providing a smooth transition from one age to the next. This produces a base year population by single age: Pop (a, s, to).

The age distribution of migration is also specified in five-year age groups. Migration is also split into single age groups using the Beers procedure. Mortality is specified as life expectancy at birth by sex, and is shown on a model life table. The life tables provide survival rates by single year of age for certain values of life expectancy, such as 20, 25, 30, 35, and so on. DemProj interpolates between these index values to find the age specific survival rates for the exact life expectancy specified for each year.

Model life tables are provided in five-year age groups. These are split into single age survival rates, S(a, a+1), using the life table indicators for nLx (the number of person years lived between ages x and x+n by an initial cohort of 100 000 people) and lx (the number of survivors at age x out of an original cohort of 100 000 people). The following are some of the equations in the model:

1. Spop(0) = 1L0
2. Spop(1) = (l1 + l2) / 2
3. Spop(2) = (l2 +l3) / 2
4. Spop(3) = (l3 +l4) / 2
5. Spop(4) = (l4 +l5) / 2
6. Spop(5..80+) calculated by applying Beers procedure to nLx values
7. Calculate S (a,a+1) = Spop (a+1) / Spop(a)

The number of deaths from midyear to midyear is calculated as:

Deaths (a,s,t1,1) = (Pop(a1,s,t1) + [migration(a1,s,t1) +migration (a1,s,t))/2] * (1 – [S(a1,a,t1) + S (a1,a,t))/2])

The number of deaths during the calendar year t is:

[Deaths(a,s,t1) + Deaths(a,s,t)]/2

The population is projected by age and sex for ages 0 to 79 as:

Pop(a,s,t) = Pop(a1,s,t1) + [migration(a1,s,t1) + migration(a1,s,t)]/2 – deaths(a,s,t1,t)

The number of births from midyear to midyear is:

Births (t1,1) = Σa=15,49 [Pop(a,female,t1) + Pop (a,female,t)]/ 2 * [TFR(t1) + TFR(t)] / 2 * [ASFD (a,t1) + ASFD(a,t)] / 2

The number of births during the calendar year is:

[Births(s,t1) + Births(st)]/2

The population of age 0 is:

Pop(0,s,t) = (Births(s,t1) + Births(s,t))/2) * Spop(0)

3.7.2 Projections Assumptions

Before these projections were finally done, there were few assumptions taken into account. These assumptions are based on local conditions in Zambia, but more also using the United Nations assumptions for making future population

projections. To project the population for some desired time in the future, the United Nations uses assumptions regarding future trends in fertility, mortality and international migration. Because future trends cannot be known with certainty, a number of projection variants are produced. The following are a summary of the variants commonly used by the UN:

A. Fertility assumptions: convergence towards total fertility below replacement level. These fertility assumptions are described in terms of the following groups of countries:
   - High-fertility countries: Countries that until 2010 (previous UN projections) had no fertility reduction or only incipient decline;
   - Medium-fertility countries: Countries where fertility has been declining but whose level was still above 2.1 children per woman in 2005-2010; and
   - Low-fertility countries: Countries with a total fertility at or below 2.1 children per women in 2005-2010.

Projections in this study were based on the medium variant assumption where Zambia has shown some decline in TFR from about seven children per woman to about five (mostly in urban areas), but above a TFR of 2.1.

B. Mortality assumptions: increasing life expectancy except when affected by HIV/AIDS – this assumption was critical in making projections on Zambia since the country has an HIV prevalence greater than one per cent and, therefore, life expectancy and adult mortality are heavily affected;
C. International migration assumptions: Zambia's international migration data is very difficult to derive due to poor data on the subject; as a result, the assumption on migration is presumed to be zero migration.

3.7.3 Data Input and Justification

Projections were based on the 1990 Zambian census of population and housing. The justification to project the population of Zambia using the 1990 census is that the re-analysis report with details of the extent of census errors is or was readily available. For example, the Post Enumeration Survey (PES) undertaken in December 1990 showed that the undercount of the national population was about 5.5 per cent (Wotela, 2008). In addition, the Central Statistical Office used both the Myers Index and the United Nations age-accuracy index to evaluate the quality and accuracy of age reporting. The Myers Index for males was 6.8 and 7.0 for females. From these analyses, it was concluded that for the 1990 census, the most preferred digits were zero, two and eight (*ibid*, 2008).

3.7.4 Other Input Assumptions

Projections were disaggregated by sex, age and residence. Reverse projections for the period 1950 to 2000 were also based on the 1990 census data. This is so because there is no complete data for Zambia for 1950 until 1969 when a complete census was undertaken which included all people residing in Zambia. Population indicators such as Total Fertility Rates (TFR), Life Expectancy (LE) etc. are all based on the 1990 census of population results.

Individual population indicators adopted based on the 1990 census findings included the following (medium variant):

Total fertility rate:	6.7
Age Specific fertility rate:	1990 Census Adjusted Estimates
Sex Ratio at Birth:	103.0
Life Expectancy (Males):	46.1
Life Expectancy (Females):	47.6

Model Life Table:	Coale-Demeny-North; the North Model was used since in 1990, Zambia's IMR was about 147/1000
International Migration:	0.00

Note that the current data on international migration is not usable and the collection of this data is very unreliable. Currently, some international migrations data are being collected at points of entry and exit. However, the process is inconsistent and much of the data collected has never been processed.

CHAPTER 4: FINDINGS

This chapter presents findings of the study. They are divided in four broad sections. The first part (I) highlights results from projections showing both past and future population ageing trends; the second and third parts (II and III) dwell on findings relating to background characteristics of respondents as well as challenges they face. This chapter also highlights determinants of active ageing based on actual statistical tests and outcomes (multiple regression), and lastly, the fourth part (IV) concentrates on the Draft Policy on Ageing.

PART I PROJECTIONS

4.1 Projecting the Older Population- Zambia: 1950 To 2050[2]

Projections were performed for two periods. The first period contains projections for the years 1950 to 2000, while the second runs from 2000 to 2050. Subsequently, comparisons in terms of differences and similarities between these two periods were also made.

Figure 8 shows projections for people aged 60 years and over (60+) using the medium variant. In 1950, the total population of Zambia was about 2.3 million; the population aged 60+ was about 50 000; by 1970, the total population of Zambia was 4.2 million, however, the population of people aged 60+ more than doubled to around 100 000; this took just about twenty years. From 1970 to the year 2000, the population of people aged 60+ in Zambia more than quadrupled, from around 100 000 to over 330 000, representing a percentage increase of over 300 per cent. By gender desegregation, from 1950 to 1965, the growth of male and female populations aged 60+ was almost the same; after

[2] Projections in this section were conducted using actual 1990 census data – the methods and processes are in the Methodology Chapter (3)

this period, Figure 8 suggests that the population of females compared to males started to increase faster.

Figure 8: Population of Zambia 60+, 1950 - 2000

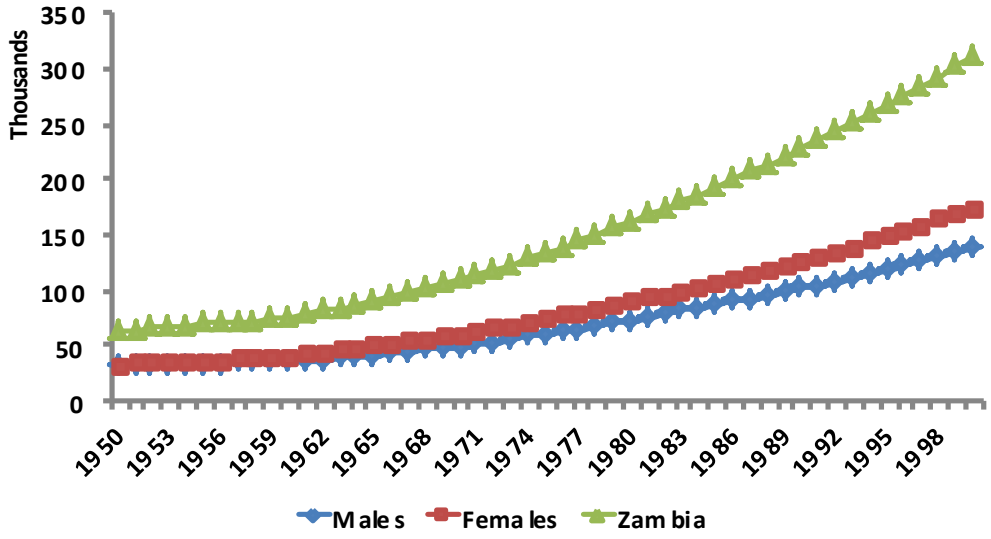
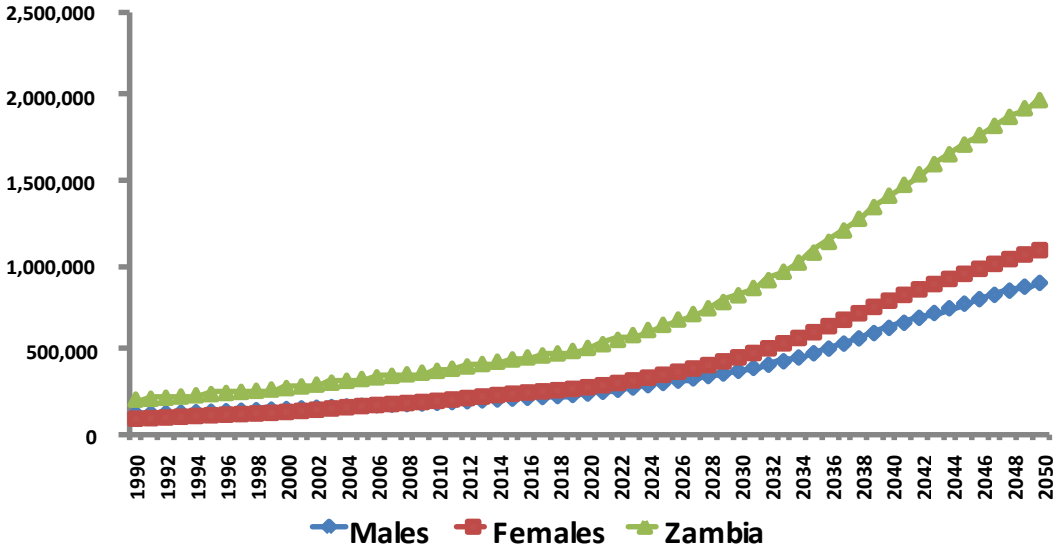


Figure 10 shows projections of the population of people aged 60 and above for the period 2000 to 2050. The pattern of increase for the aged 60+ is not very different for the periods 1950 to 2000 and 2000 to 2050 respectively. The increase in the number of people aged 60+ has been gradual since 2000, just under half a million (but more than the 1950 to 2000 period). However, Figure 10 suggests that the population aged 60+ is expected to grow to about 1.8 million by the year 2050.

Figure 10: Projected Total Population 60+; 2000-2050



In terms of growth rates for the period 2000 to 2050, the population aged 60 years and over is expected to grow between 2 and 5.1 per cent per annum. Overall, the growth will oscillate around 3 per cent. The peak growth will be realised around 2035 and progressively settle around 2.5 per cent per annum by 2050, which is relatively higher than the overall actual population growth to be experienced for the same period (UN, 2007b)

4.1.1 Patterns and Trends of Ageing Differentials by Projection Periods – 1950 to 2000 and 2000 To 2050

Figures 12 and 13 show percentage contributions of people aged 60 and over against the entire population of Zambia for the periods 1950 to 2000 and 2000 to 2050. For the period 1950 to 2000, approximately 2 to 3.1 per cent of Zambia's population was aged 60 and above with females having a higher share compared to males (3.1 against 2.5 per cent). Figure 12 also suggests that for the period 2000 to 2050, the trend is likely to be similar to that of the period 1950 to 2000. For example, between 2008 and 2020, the percentage

composition of the population aged 60+ against that of the entire Zambia population will be around 2.5 per cent.

From 2020 onwards, the population aged 60+ will grow significantly faster and the percentage composition will be around 3.3 per cent in 2030 and close to 6.5 per cent by 2050. Zambia's population is projected to reach 38 million by 2050 and about 2.47 million of this figure will be aged 60 years and above. This also shows that by 2050, there will be one person aged 60 and over in every fifteen persons. In addition, Figure 13 further suggests that females will outnumber males by close to about 1.5 percentage points (7.3 and 5.8 per cent respectively).

Figure 12: Percentage of Older Population 60+ Against the Total Population; 1950-2000

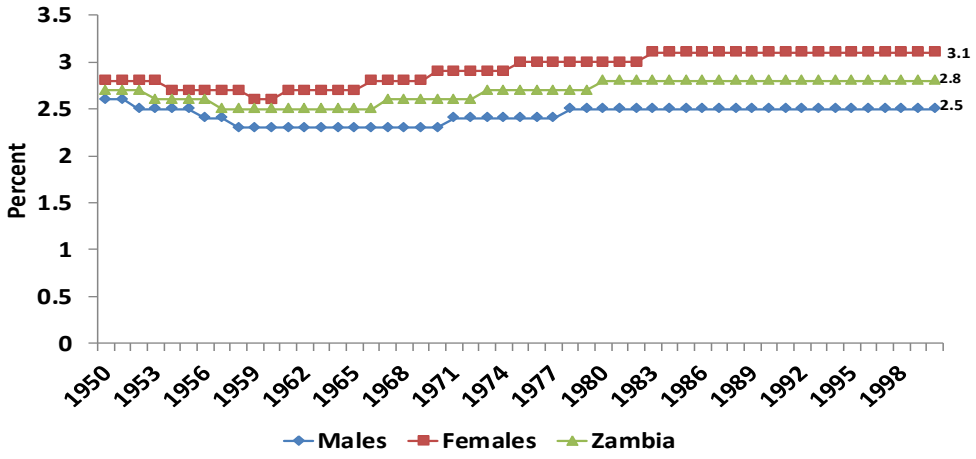
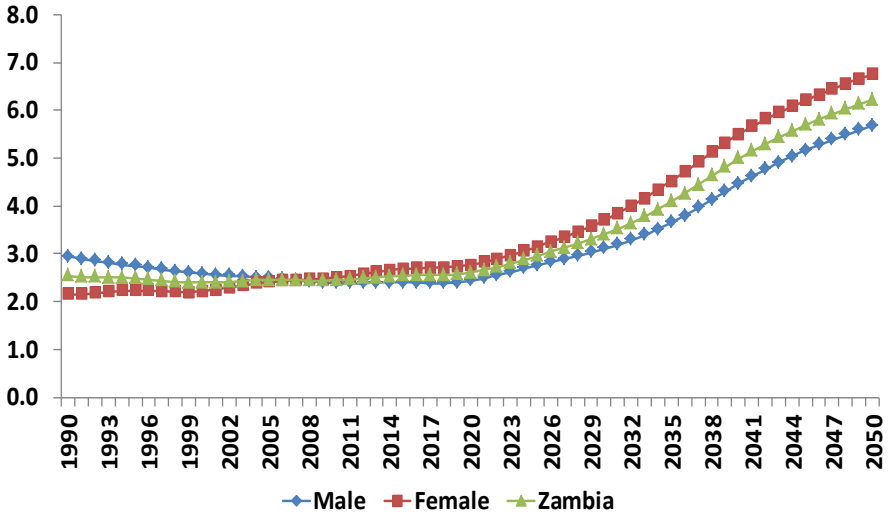
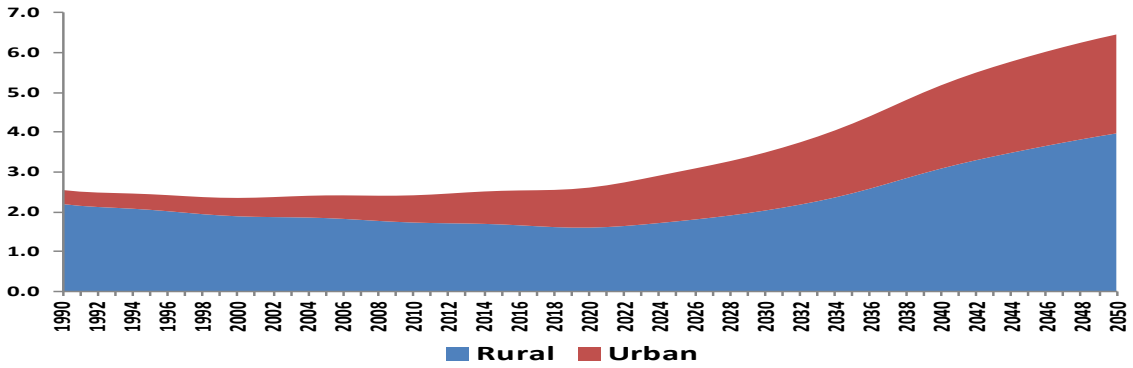


Figure 13: Projected Proportions of the Population 60+ for Zambia 2000-2050



There are also different growth rates and percentage compositions for rural and urban areas. Between 2000 and 2030, the urban population aged 60+ will grow more than the rural population. Projected growth rates for urban areas will be around 7.1 per cent per annum from 2000 to about 5.8 per cent per annum by 2030. During the same period, the rural population aged 60+ will grow from 2.5 per cent per annum to about 5.7 per cent per annum. From 2035, population aged 60+ in rural areas will surpass that of urban areas. Projections indicate that on average, the rural population aged 60 and above will be growing by at least 6 per cent per annum but later drop to about 3.8 per cent per annum by 2050. For the same period, the urban older population will grow by about 5.1 per cent per annum and later drop to about 2.8 per cent. In terms of percentage composition, Figure 15 confirms further that much of the population aged 60+ will be found in rural areas. The same pattern is expected to continue up to the year 2050; in fact, the number of older people aged 60+ in rural areas is expected to be double the current figure.

Figure 14: Projected Proportions Rural/Urban Population 60+; 2000-2050



SUMMARY of PART I

The forgoing sections have shown that Zambia, like many other countries in the developing regions of the world, is also undergoing rapid population ageing. Despite uncertainties that necessarily underlie population estimates and particularly projections for the future, there is no doubt that population ageing in Zambia is becoming a demographic reality. As observed earlier, this pace of population ageing is many times faster than experienced historically by the more developed countries and therefore requires serious attention. While bearing in mind that proportions of people aged 60+ could be low even until 2050 (6.5 percent), in absolute terms, this figure is quite insurmountable; as such, the need to discuss and analyse ageing in view of the challenges and determinants of active ageing as well as investigate policy measures in place to look at ageing cannot be over-emphasised.

PART II CHARACTERISTICS AND CHALLENGES

4.2 Social, Demographic and Economic Characteristics of Respondents

This section describes demographic, social and economic characteristics of the aged. Background characteristics are foundational aspects influencing analysis and interpretation of other variables. Some of the background information contained in this section include among others, age and sex of respondents, marital status, education and residence.

4.2.1 Background Characteristics - Sample and Respondents

In total, there were 700 respondents. However, ten were dropped from the analysis due to missing information on sex and age. Of the 690 in the data set, 284 were males while 406 were females (41.2 and 58.8 per cent respectively). The majority of respondents were from urban areas (81 per cent) while the rest were from rural areas (18 per cent). Lusaka contributed the largest (42 per cent) to the sample, followed by Ndola and Sesheke respectively. Other towns represented were Livingstone (3.5 per cent) and Mufulira (7.3 per cent). Summaries of these characteristics are in Table 1.1.

Table 1.1: Background Characteristics of Respondents

	Males (n)	Females (n)	Males (%)	Females (%)	**Total**
Residence					
Urban	245	319	86.3	78.6	**564 (81.7)**
Rural	39	87	13.7	21.4	**126 (18.3)**
Town of interview					
Livingstone	18	6	6.3	1.5	**24 (3.5)**
Lusaka	131	165	46.1	40.6	**296 (42.9)**
Mufulira	23	27	8.1	6.6	**50 (7.3)**
Ndola	74	121	26.1	29.8	**195 (28.3)**
Sesheke	38	87	13.4	21.4	**125 (18.1)**
Length of stay at current location					
<5 years	40	38	14.4	9.5	**78 (11.5)**
between 5-9 years	15	23	5.4	5.8	**38 (5.6)**
>10 years	223	338	80.2	84.7	**561 (82.9)**
Age					
60-69	106	193	37.3	47.5	**299 (43.3)**
70-79	102	151	35.9	37.2	**253 (36.6)**
80-89	66	47	23.2	11.6	**113 (16.3)**
90-99	9	14	3.2	3.4	**23 (3.3)**
100-108	1	1	0.4	0.4	**2 (0.2)**
Total	**284**	**406**	**41.2**	**58.8**	**690**

Majority (43 per cent) of respondents were aged between 60 and 69 years, followed by those between 70 and 79 years (37 per cent); and the rest (19.8 per cent) were aged 80 years and over. The sample also shows that there were slightly more females in the age category 90 to 99 years than males; on the other hand, there were slightly more males (23 per cent) than females (11 per cent) in the age group 80-89.

4.2.2 Other Socio-demographic Characteristics

Table 1.2: Marital Status, Living Children and Education Attainment by Age, Gender, Residence and Current Place of Stay

	Age			**Sex**		**Residence**		**Place of stay**		**Total**
	60-69	70-79	80+	Males	Females	Urban	Rural	*Comm	*OPH	**(%, n)**
Marital status										
Married	43.1	34.3	22.4	56.3	21.4	37.4	28.6	15.2	39.3	**35.8 (247)**
Widowed	40.1	53.7	59.4	26.4	64.7	49.1	48.4	53.5	48.2	**48.9 (338)**
Divorced	12.7	6.7	12.3	11.9	9.3	9.4	15.1	22.2	8.5	**10.4 (72)**
Separated	1.0	1.1	0.7	1	0.9	0.7	2.4	3.0	0.7	**1.0 (7)**
Never married	3.0	3.9	5.0	4.2	3.4	3.4	5.6	6.1	3.4	**3.7 (26)**
Total	**299**	**253**	**138**	**284**	**406**	**564**	**126**	**99**	**591**	**100 (690)**
Education attainment										
Primary	56.2	51.8	43.5	55.6	49.5	51.1	56.4	34.3	55.0	**52.0(359)**
Secondary	21.1	8.3	7.3	22.5	7.4	15.3	6.4	9.1	14.4	**13.6(94)**
Tertiary	3.0	1.2	2.2	3.2	1.5	2.0	3.2	3.0	2.0	**2.1(15)**
No education	19.7	38.7	47.1	18.7	41.6	31.7	34.1	53.5	28.6	**32.1(222)**
Total	**299**	**253**	**138**	**284**	**406**	**564**	**126**	**99**	**591**	**100 (690)**
Number of living Children										
No children	1.2	1.5	8.2	2.2	2.8	2.8	1.2	4.9	2.4	**2.5(14)**
1-5 children	67.3	70.1	71.4	60.2	75.2	66.2	84.7	87.8	67.5	**69.0(379)**
6-9 children	29.1	23.4	17.4	31.0	20.7	27.4	11.8	7.3	26.4	**24.9(137)**
10+ children	2.4	5.1	3.1	6.6	1.2	3.7	2.4	0.0	3.7	**3.5(19)**
Total	**254**	**197**	**98**	**226**	**323**	**464**	**85**	**41**	**508**	**(100)549**
Mean Number of Children Reported: 4.2										

***Comm = Residing in community** ***OPH = Residing in old people's home**

Marital status has important socio-economic implications that contribute significantly to the well-being of older people. In some respects, spouses can be primary sources of material, social and emotional support and can also provide personal care during times of illness and frailty (UNFPA, 2008). Thus, living with a spouse typically has advantages (*Ibid*, 2008). Table 1.2 shows that less than one in ten (3.7 per cent) respondents reported never having been married before. Close to half (48.9 per cent) were widowed and close to two in five (35.8 per cent) were married. One in ten (10.4 per cent) were divorced and about 1 per cent reported that they were separated. Amongst those who were married, the proportion reduces with increasing age; in the same way, widowhood also increases with age.

In terms of gender, more males (56.3 per cent) compared to females (21.4 per cent) reported being married. Females were more likely to report being widowed (64.7 per cent) than males (26.4 per cent). This is also true with regard to the place of residence. Similarly, while over 60 per cent of females were widowed, only about a fifth of males reported the same. Table 1.2 further shows that there were more (37.4 per cent) elderly people in urban areas who were married compared to rural areas (28.6 per cent). The percentage of respondents who were widowed is almost the same for both urban and rural areas (49.1 and 48.4 per cent respectively); in addition, there were slightly more (15.1 per cent) respondents in rural areas who were divorced compared to those in urban areas (9.4 per cent). Generally, over half (61.2 per cent) indicated that they had been in their current marital status for more than twenty years.

With regards to educational attainment, majority (52.0 per cent) had primary school education. About 13.6 and 2.1 per cent reported having attained secondary and tertiary level education respectively. About 32.1 per cent of respondents reported that they had no formal education. There were variations in education attainment by age, sex and residence. In terms of age, about one in five (19.7 per cent) aged between 60-69 had never attained formal schooling while amongst those aged 80 and above, close to half (47.1 per cent) had no formal education; in general, education attainment is inversely related to age; at all levels – primary, secondary and tertiary – the older the respondent was, the lower the level of education attainment.

Gender differences in education were also pronounced especially at higher levels. Overall, Table 1.2 shows that while the difference between males and females at primary level were marginal (55.6 per cent vs 49.5 per cent) there were noticeable differences at secondary level. Males were three times (22.5 per cent) more likely to have attained secondary level education compared to females (7.3 per cent). Similarly, there were more females (41.6 per cent) reporting no schooling compared to males (18.7 per cent).

Respondents from rural areas and those living in homes for the aged were slightly more likely to report having attained primary level education compared to urban respondents and those living in communities respectively (56.4 and 55.0 per cent compared to 51.1 and 34.3 per cent respectively). While differences in the proportion of respondents reporting no education were relatively minimal between urban and rural areas (31 and 34 per cent), urban respondents were substantially more likely (15.3 per cent) than their rural counterparts (6.4 per cent) to have attained secondary level education. Similarly, those living in old people's homes were more likely to report having attained higher education than those in communities. Over half (55 per cent) of elderly persons residing in Old People's Homes (OPH) had primary level education compared to those living in communities (34.3 per cent). There are also more respondents reporting having attained secondary education in OPH (14.4 per cent) compared to those living in communities (9.1 per cent). Conversely, respondents living in communities were more likely (53.5 per cent) to report 'no education' compared to those in OPH (28 per cent).

As for the number of children, Table 1.2 shows that the mean number of children per elderly person was 4.2. Overall, 2.5 and 3.5 per cent of respondents respectively reported that they had no living children or had more than ten children. Majority (69 per cent) had at least one child while about 24.9 per cent had at least six children respectively. Generally, the number of children reported reduced with increases in the respondent's age. Further, results in Table 1.2 show that male respondents and those in rural areas reported having more children than female and urban respondents respectively.

4.3 Challenges Faced by Older People

Data on challenges were in form of self-reports using a questionnaire administered to older persons aged 60 years and above. This was triangulated with Focus Group Discussions (FGDs) with members of the community.

Challenges were indentified at both individual and socio-economic or environmental levels.

4.3.1 Individual Level Challenges

The main individual level challenge amongst older people is or was 'low self esteem and loneliness'. In fact, throughout this discourse, it is clear that almost all other challenges both at micro and macro levels feed into the exacerbation of 'low self esteem and loneliness'. Other individual or micro level challenges investigated include reported 'health problems' and 'functional limitations'. Sections 4.3.2 to 4.3.5 discuss details of these challenges.

4.3.2 Self-esteem and Loneliness

The psychological state of older people is cardinal to measure active life. Active life is a significant contributor to the physical, emotional and spiritual well-being of the elderly and is sometimes determined by one's self-esteem (WHO 2002 – Active Ageing Framework). Self-esteem is not only critical in understanding ageing but is also central to the many challenges older people face. Low self-esteem also precipitates loneliness; if one's self-esteem is low, it is possible that one has fewer interactions with friends and colleagues, and therefore, are lonelier compared to those that do interact. In fact, literature suggests that loneliness accelerates and contributes to age-related decreases in physiological resilience, influencing health behaviours, stress exposure, psychological and physiological stress responses, and restorative processes that replenish physiological reserves and fortifies against future stress (Palmore 1972; Lynch *et al* 2000).

In this study, the main indicators used to measure self-esteem were feeling hopeless and useless. Others, which largely depend on these two and are considered to be consequences rather than actual indicators of self esteem, are loneliness and unhappiness.

Table 1.3: Self-esteem and Loneliness by Age, Gender and Residence

	Age			Sex		Place of stay		Residence		Total
	60-69	70-79	80+	Males	Females	OPH*	Comm*	Urban	Rural	%, n
Self-esteem indicators and loneliness										
Hopeless	27.1	31.2	34.1	27.1	32.0	33.3	29.4	26.4	46.0	**30.0 (207)**
Useless	22.7	26.9	37.7	23.9	29.5	36.4	25.7	23.7	42.9	**27.2(188)**
Unhappy	39.8	45.4	54.3	40.1	48.0	49.4	43.9	41.4	59.5	**44.7(309)**
Lonely	43.1	54.9	67.4	47.5	55.6	55.6	51.7	47.7	73.0	**52.3(361)**
Total	**299**	**253**	**138**	**284**	**406**	**99**	**591**	**564**	**126**	**690****

Note: while the row (n) total add up to the total sample (n=690), the column totals (per cent and n) do not because only the 'yes' answer category was considered

It is evident from data in Table 1.3 that about 30 and 27 per cent of respondents felt hopelessness and uselessness, respectively. It is also clear that the older the respondent was, the higher the likelihood of reporting hopelessness and feeling useless. For example, about 34.1 and 37.7 per cent of respondents aged 80+ reported that they felt hopeless and useless compared to about 27.1 and 22.7 per cent of those aged 70-79 and 60-69, respectively. In the same way, feeling hopeless and useless was also more pronounced among female respondents (32 and 29.5 per cent) than among male respondents (27 and 23.9 per cent respectively). Respondents in old people's homes and those in rural areas were also more likely (33.3 and 46; 36.4 and 42.9 per cent) to report feeling hopeless and useless compared to those in communities and those in urban areas (29.4 and 26.4; 25.7 and 23.7 per cent respectively).

While it is clear that the prevalence of feeling hopeless and useless is quite high among older people, unfortunately how these indicators are prevalent in the general population is difficult to determine due to lack of data. In addition, due to reported cases of feeling hopelessness and uselessness, respondents also reported that they were lonely (52.3 per cent) and unhappy (44.7 per cent).

Being unhappy and lonely varied by selected socio- economic and demographic characteristics. For example, at least three in five (67.4 per cent) of those aged 80+ reported that they were lonely; this is different from those aged between 60

and 79. Specifically, those aged 70-79 were also more likely (54.9 per cent) to report being lonely compared to those aged 60-69 (43.1 per cent). In this example, although the 70-79 group reported high experiences of loneliness, it is not as pronounced as that reported by those aged 80 and above. Similarly, over half of female respondents (55.6 per cent) reported that they were lonely. This of course is higher than what males reported (47.5 per cent). This disparity could be due to the fact that more males are still married compared to females.

People in old people's homes reported experiencing more loneliness (55.6 per cent) compared to those in communities (51.7 per cent). This, however, is not out of the ordinary since majority of people in homes for the aged are restricted or less free compared to their counterparts in communities. Additionally, data in Table 1.3 suggests that residence is pivotal in determining loneliness. Close to three-quarters (73 per cent) of respondents in rural areas reported that they were lonely compared to about 47.7 per cent in urban areas. What is clear in this case is the fact that irrespective of residence, sex or even age, older people in general are faced with the challenge of feeling lonely. This was confirmed by focus group discussions (FGDs) as the following typical excerpts illustrate:

> '*Yes, old people are lonely. In fact, they spend a lot of their time crying and complaining; even those that have children still feel lonely'* (FGD, Mwandi - Sesheke)

> *'Those who live alone are lonely, but those who live with other people are not lonely at all'* (FGD, Matero - Lusaka)

Other self-esteem indicators do not depart extensively from the pattern observed above. They are affected by age, sex and residence disproportionately as well. For example, slightly over half (54 percent) of respondents aged 80+ reported that they were unhappy; close to half (48 per cent) of those reporting being unhappy were female. In addition, majority (59.5 per cent) of respondents reporting being unhappy were from rural areas. Older respondents (80+), mostly females and those residing in rural areas reported that they felt more

useless (37.7, 29.5 and 42.9 per cent respectively) and more hopeless (34.1, 32.0 and 46 per cent respectively) compared to other ages, being male and residing in urban areas, respectively.

Low self-esteem, feeling lonely and unhappy amongst older people are attributed to many factors including the way society looks at and 'treats' old people. Discussants in the FGD also confirmed that old people are humiliated, laughed at, accused of witchcraft and are also viewed generally as difficult people to be with:

> *'Humiliation is one other big problem these people face every day. Most people think all old people practice witchcraft, and this depresses these people a lot. Some people even go to an extent of just laughing at old people'* (FGD – Masala, Ndola)

> *'People laugh at them, especially those who are very old; Like my brother said earlier on, people like accusing old people of practicing witchcraft'* (FGD – Matero, Lusaka)

> *'The other thing is that matters of the aged are mostly linked to witchcraft, which is not fair, because it is not all old people who are involved in witch craft; there are even young ones who are involved in this vice'* (FGD, Masala – Ndola)

> *'Even when we would want to keep such people, their life style is very difficult; they are very choosy, especially with food. You can imagine, there are times when my wife prepares nshima with vegetables only, the old person I keep at my home says her teeth hurt when she eats vegetables, but she is the first one to start eating when meat is prepared. They are very difficult people to keep'* (FGD, Masala – Ndola)

4.3.3 Self-esteem, Loneliness and Selected Characteristics

Table 1.4 presents data showing the relationship between selected respondent characteristics and measures or indicators of self-esteem. These characteristics include marital status, presence of or having children and the frequency of interactions of respondent with their peers. Studies have shown that marital status, having children, and frequent interactions have some effect on the self-

esteem of older people (Hawkley *et. al.,* 2007; Seeman, 2001; Namakando, 2004).

Table 1.4: Self-esteem and Loneliness and selected Characteristics

	How they feel				**Total**
	Hopeless	Useless	Unhappy	Lonely	**%, n**
Marital status					
Married	28.0	23.4	27.8	24.4	**35.8(247)**
Widowed	52.7	56.4	56.3	60.1	**48.9(338)**
Divorced	11.6	10.6	9.7	9.7	**10.4(72)**
Separated	2.4	2.7	1.3	0.8	**1.0(7)**
Never been married	5.3	6.9	4.9	5.0	**3.7(26)**
Total	**207**	**188**	**309**	**361**	**(100)690**
Has children					
same community	39.2	41.4	35.2	37.9	**33.7(161)**
same town, different comm.	25.3	25.2	28.1	27.8	**29.8(142)**
different town, diff.comm	54.6	49.6	56.6	57.4	**63.1(301**
Frequency of interaction with peers					
Everyday	40.7	40	34.1	37.2	**35.9(212)**
At least once weekly	32.5	31.3	36.8	36.2	**42.6(251)**
At least once monthly	4.1	5.3	3.1	3.2	**2.7(16)**
Never interact	22.6	23.3	25.9	23.4	**18.7(110)**
Total	**172**	**150**	**258**	**304**	**100(589)****

Note: Only the answer 'yes' was considered, as such rows as well as columns may not add up to the total (n)

It is clear from results in Table 1.4 that there is some interplay between one's marital status and self-esteem. However, variations were visible amongst marital status categories. Respondents who reported being married (35.8 per cent), widowed (48.9 per cent) and divorced (10.4 per cent) were also more likely to report that they experienced at least all or most of the indicators of low self-esteem and loneliness compared to those who were either separated (1 per cent) and those who reported that they have never been married before (3.7 per cent). In the same way, respondents who were divorced were more likely (60.1 per cent) to report that they were lonely compared to other marital statuses. In fact, respondents who reported that they were divorced also seemed to experience more of the investigated self-esteem indicators compared to other marital statuses.

In the same way, there also seems to be connections between having children and self-esteem indicators. However, there were variations, especially on

account of whether the child lives in the same community or same town but different community, or a different town and community from the respondent's. Respondents reporting that they had children living in a different town and different community were more likely (63.1 per cent) to report low self-esteem in the form of being hopeless, useless, unhappy and lonely compared to those who reported that they lived in the same town but different community (29.8 per cent) and those who lived in the same community (33.7 per cent) with their children respectively. Normally, it would be expected that respondents who were living with children in the same community would also report "little" low self-esteem, nonetheless, data in Table 1.4 shows that it was not the case with respondents in this study. This, however, depends on the relationship children had with their parents and not necessarily where they stay.

Table 1.4 also shows that while interactions amongst peers are important in determining self-esteem, the frequency of these interactions is actually what makes the difference. Respondents who reported that they interacted once a month with peers were also far much less likely (2.7 per cent) to report experiencing feeling hopeless and unhappy compared to those who interacted everyday (35.9 per cent), once a week (42.6 per cent) and those who never interact at all (18.7 per cent). Whereas it is expected that daily interactions could have higher positive effects on one's self-esteem rating, the data suggests otherwise, meaning, therefore, that daily interactions do not necessarily help alleviate feelings of hopelessness, uselessness, unhappiness and loneliness. In any case, it is possible that the frequency of interactions may not really be a factor in determining self-esteem but rather the relationship between the elderly person and their children or relative.

In sections above, it has been mentioned that low self esteem and loneliness are caused not only by individual factors (micro level) but are also functions of the socio-economic, demographic and environmental factors (macro level). In subsequent sections, we discuss factors that directly or indirectly affect self

esteem and loneliness amongst older people, both at individual as well as at macro levels.

4.3.4 Health Status

While the concept of well-being incorporates many different dimensions, perhaps none is of more central concern to older persons than their physical health (Knodel *et al*, 2009). In all populations, biological processes ensure not only that the risk of mortality increases steadily with increasing age but so do physical limitations and certain illnesses (*Ibid* 2009). These health problems are sometimes necessitated by older people themselves, or the environment they find themselves in. Such situations or occurrences pose considerable challenges for the aged.

A number of questions were asked to determine self-assessments of health status of respondents using indicators like ailments or illnesses experienced in the twelve months preceding the study and whether or not these had increased since they turned 60 years old. Table 1.5 is a summary of the responses:

Table 1.5: Illnesses by Age, Gender and Residence

	Age			Sex		Residence		Total
	60-69	70-79	80+	Males	Females	Urban	Rural	%, n
Ill in past 12 months	54.5	66.8	69.6	52.1	69.0	58.8	76.2	**62 (428)**
Reported ailments								
Arthritis/Feet problems	0.0	4.1	3.1	2.0	2.5	1.2	6.3	**2.3(10)**
General Body Pains/Headache	32.5	37.3	36.1	29.1	38.4	36.6	30.2	**35.2(151)**
Backache	5.5	5.3	8.3	4.1	7.1	5.4	8.3	**6.0(26)**
Respiratory infections	8.6	8.9	14.4	14.2	7.8	10.2	9.4	**10.0(43)**
Sight Problems/Blindness	3.1	8.9	11.3	9.5	6.1	5.1	14.6	**7.2(31)**
Malaria	23.3	9.5	5.2	14.2	13.5	14.7	10.4	**13.7(59)**
Diabetes	5.5	2.4	1.0	2.0	3.9	4.2	0.0	**3.2(14)**
High Blood Pressure	11.7	13.6	5.2	8.8	12.1	11.1	10.4	**10.9(47)**
Had a Stroke	1.8	2.4	2.1	2.7	1.8	2.7	0.0	**2.1(9)**
RHEUMATISM	0.6	2.4	2.1	2.7	1.1	1.8	1.0	**1.6(7)**
Ulcers/Stomach Problems	5.5	5.3	7.2	8.1	4.6	5.7	6.3	**5.8(25)**
Cancer	0.0	0.0	2.1	1.4	0.0	0.3	1.0	**0.5(2)**
Kidney Problems	1.8	0.0	2.1	1.4	1.1	0.9	2.1	**1.1(4)**
Total	**163**	**169**	**96**	**148**	**280**	**332**	**96**	**428**
Situation of ailment after age 60								
Increased	55.2	68.1	80.4	64.9	66.6	66.1	65.6	**65.9(282)**
Decreased	25.8	20.7	13.4	18.2	22.4	20.7	21.9	**20.9(90)**
same	19.0	11.2	6.2	16.9	11.0	13.2	12.5	**13.0(56)**
Total	**163**	**169**	**96**	**148**	**280**	**332**	**96**	**428**

Overall, 62 per cent of the respondents reported that they had been ill in the twelve months prior to the study. The tendency to report being ill increases with age (from 54.5 to 66 and 69.6 percent amongst those aged 60-69, 70-79 and 80+ respectively). Female respondents (69 per cent) and those residing in rural areas (76.2 per cent) were also more likely to report having been ill compared to their male counterparts (52.1 per cent) and those resident in urban areas among whom 58.8 per cent reported having been ill twelve months prior to the study.

The main ailments reported, which accordingly were actually perpetual problems – not just restricted to the 12 months prior to the study – included general body pains and headache (35.2 per cent), backache (6.0 per cent), respiratory infections (10 per cent), sight problems (7.2 per cent), malaria (13.7 per cent), high blood pressure (10.9 per cent) and stomach problems (5.8 per cent). Others included non-communicable diseases such as diabetes (3.2 per

cent) and stroke (2.1 per cent). Some of the problems reported herein could be a result of old age or simply what maybe obtaining in communities; however, due to lack of data to compare with, it is highly possible that such ailments maybe more common and more prominent among older people. If these findings are a reflection of reality, it is, therefore, possible that health problems become more prominent in old age and are major challenges.

In response to the question on whether the frequency of the ailment or illness they had reported, irrespective of the type had increased, decreased or remained the same since the age of 60 years, more than six in ten (65.9 per cent) indicated that the frequency of the problem or ailment they reported had increased. About 20.9 and 13 per cent respectively thought that the ailment they had experienced decreased and remained the same respectively. Generally, those aged 80+ were more likely (80.4 per cent) than those aged 60-69 (55.2 per cent) and 70-79 (68.1 per cent) to state that the ailment they had reported had increased since age 60. Further, although the difference is quite minimal, females were more likely (66.6 per cent) to report an increase in the experience of reported ailments since turning age 60 compared to males (64.9 per cent). In the same way, rural respondents were slightly more likely to report that the frequency of reported ailments had increased since turning age 60 compared to respondents in urban areas. It is clear that over half (65.9 percent) of respondents who reported that they had health problems of one sort or another indicated that the health problems had actually increased since they turned 60 years; inevitably, being ill and experiencing increases of such problems in old age could also be linked to the low self esteem experienced by older people in general.

4.3.5 Functional Limitations

Another notable challenge older people face is their ability to perform certain functions considered important in day-to-day living. It should be mentioned that functional limitations are mostly a consequence of declining health.

Increases in functional limitations require increases in care giving as well. Table 1.6 is a summary of responses on functional limitations.

Table 1.6: Functional Limitations by Age, Gender and Residence

	Age			**Sex**		**Place of stay**		**Residence**		**Total**
	60-69	70-79	80+	Males	Females	OPH*	Comm*	Urban	Rural	**%, n**
Functional Limitation										
Put on clothes alone	3.0	1.9	2.9	3.5	1.9	3.0	2.5	3.0	0.8	**2.6(18)**
Use toilet alone	2.3	2.0	4.4	3.5	2.0	4.0	2.4	2.8	1.6	**2.6(18)**
Bath alone	2.3	1.9	5.8	4.2	1.9	7.1	2.2	3.4	0.8	**2.9(20)**
Clean house	14.1	30.8	47.8	34.9	21.4	32.3	26.1	27.8	23.0	**26.9(186)**
Able to squat	19.7	32.0	42.8	25.3	31.3	37.4	27.4	30.1	23.0	**28.8(199)**
Walk without difficulty	17.4	28.8	34.1	21.1	27.6	30.3	24.0	25.7	21.4	**24.9(172)**
Total	**299**	**253**	**138**	**284**	**406**	**99**	**591**	**564**	**126**	**690****

Note: while the row total add up to the total sample (n=690), the column totals (per cent and n) do not because only the 'no' answer category was considered

Although relatively few respondents reported being unable to perform basic day-to-day activities such as putting on clothes (2.6 per cent), using the toilet alone (2.6 per cent) and bathing (2.9 per cent) functions requiring more physical exertion were reported more. For example, about 26.9 per cent, 28.8 per cent and 24.9 per cent of respondents were unable to clean the house, squat and walk without difficulty respectively. Reported inability to perform these tasks varied by age, sex and residence. For example, close to half (47.8 per cent) of respondents aged 80+ reported that they were unable to clean their house compared to 30.8 and 14.1 per cent amongst those aged 70-79 and 60-69 respectively indicating that functional limitations increase with increasing age. More male respondents (34.9 per cent) reported being unable to clean their houses compared to female respondents (21.4 per cent). Urban respondents were also more likely to report being unable to clean their houses compared to their rural counterparts – 27.8 and 23 per cent respectively. Differences between urban and rural respondents' ability to perform these functions can be attributed to differences in life styles where rural residents generally perform more physical functions such as farming, gathering of firewood and other active chores than their urban counterparts. In the same way, people in urban areas are better educated generally and therefore less likely to have

occupations that require a lot of physical exertion. In any case, functional limitations, whether more prominent in urban or rural areas, or more pronounced in females than males can also result in low self esteem for older people. This is because in many instances, they have to depend on other people to perform such functions some of which are very basic.

4.4 Challenges due to the Socio-economic Environment

Apart from individual challenges, older people also experience challenges which come as a result of their socio-economic as well as demographic environments. It should be emphasised also that challenges due to the environment, to some extent, also affect individual challenges especially self esteem. Several questions were asked to determine most of the challenges which could be attributed to one's environment. We began this section by asking respondents to give simple descriptions of their housing units. It is argued that the quality of one's house or dwelling unit is important for measuring one's socio-economic status as well as the quality of life itself (ZDHS, 2007). Tables 1.7, 1.7.1 and 1.7.2 present information on sanitary facilities, sources of water and main materials used to construct housing units for older people in the study.

Table 1.7: Sanitary Facilities by Age, Sex and Residence

	Age			**Sex**		**Residence**		**Total**
	60-69	70-79	80+	Male	Female	Urban	Rural	**%, n**
Type of sanitary facility								
Flush/Pour Flash	45.2	44.0	37.9	45.9	42.3	54.0	1.7	**43.6(258)**
Pit latrine	52.0	52.9	56.3	52.7	53.1	45.6	82.9	**52.9(313)**
No facility	2.9	3.1	5.8	1.4	4.6	0.4	15.4	**3.3(20)**
Total	**281**	**223**	**87**	**220**	**371**	**474**	**117**	**591**

4.4.1 Sanitary Facilities

Good sanitary facilities as well as good and reliable sources of drinking water are good markers of health not only to the community but to elderly persons as well and can be a source of health challenges if not available. Over half (52.9 per cent) of respondents reported that they used pit latrines as toilet facilities. While it is recognized that this finding is consistent with findings from the 2007 Zambia Demographic and Health Survey (ZDHS), where the commonest

sanitary facility available to most households is the pit latrine (39 per cent) it also demonstrates that senior citizens are more likely to use pit latrines compared to the general population. About 3.3 per cent reported no access to any type of toilet facility. Respondents aged 80+ were almost twice as likely (5.8 and 3.1 per cent respectively) to have no toilet/sanitary facility compared to those aged 60 to 69. There were also more (15.4 percent) rural respondents with no sanitary facilities compared to urban respondents (0.4 per cent).

4.4.1a Sources of Water

Table 1.7.1 shows the main sources of water for older people in the study

Table 1.7.1 Main sources of Water

Main Sources of water	Age			Sex		Residence		Total
	60-69	70-79	80+	Male	Female	Urban	Rural	%, n
Piped water	86.1	79.8	72.4	87.3	78.4	96.4	22.2	**81.7(483)**
Borehole	9.6	8.1	11.5	6.4	11.1	1.5	41.0	**9.3(55)**
Well	0.7	3.6	1.2	2.7	1.4	2.1	0.9	**1.8(11)**
River/Lake	3.6	8.5	14.9	3.6	9.2	0.0	35.9	**7.1(42)**
Total	**281**	**223**	**87**	**220**	**371**	**474**	**117**	**591**

The data shows that about eight out of ten (81.7 percent) respondents said piped water was their main source of drinking water. Borehole, rivers and lakes were also some of the sources of drinking water (9.3 and 7.1 per cent respectively) mentioned. There were differences on the sources of drinking water between urban and rural respondents. More than nine out of ten (96.4 per cent) of respondents in urban areas indicated that piped water was their main source of drinking water compared to about one out of five (22 per cent) among respondents in rural areas. While it is clear that majority of older people have access to piped water, it should be mentioned that this is mainly due to a large urban sample compared to the rural sample; this, therefore, may not be reflective of the general situation especially in rural areas. However, it is still evident that some respondents draw their drinking water from unsafe sources and as such could still be exposed to health challenges.

4.4.2 Housing Quality

The quality of one's housing unit can be a source of several challenges including low self-esteem. For example, if one's house is by any standard not fit for human occupation, it poses several health challenges, among others. Cement and burnt bricks were the commonest observed main materials for household units. However, there were differences between urban and rural housing units. About 77.8 per cent of respondents in rural areas lived in units whose main wall material is mud brick. Similarly, there were more (23.7 per cent) female respondents living in housing units whose main wall material is mud brick compared to males (16.8 per cent). Respondents aged 80 and above seemed to be living more (29.9 per cent) in households whose main wall material is mud brick compared to those aged 60-69 (16.4 per cent) and 70-79 (23.8 per cent). Details are in table 1.7.2.

Table 1.7.2 Main Housing Materials

Main housing materials	Age			Sex		Residence		Total
	60-69	70-79	80+	Male	Female	Urban	Rural	%, n
WALL								
Cement/Burnt Blocks	82.6	75.8	67.8	82.7	74.9	94.3	11.1	**77.8(460)**
Mud and Poles	1.1	0.5	2.3	0.5	1.4	0.0	5.1	**1.0(6)**
Mud Bricks	16.4	23.8	29.9	16.8	23.7	5.7	83.8	**21.1(125)**
Total	**281**	**223**	**87**	**220**	**371**	**474**	**117**	**591**
FLOOR								
Concrete	70.8	63.2	52.9	69.6	62.8	78.5	12.0	**65.3(386)**
Mud	18.5	25.6	31.0	18.2	25.9	7.4	86.3	**23.0(136)**
Tiles	10.7	11.2	16.1	12.3	11.3	14.1	1.7	**11.6(69)**
Total	**281**	**223**	**87**	**220**	**371**	**474**	**117**	**591**
ROOF								
Iron/Asbestos sheets	92.2	89.7	82.8	92.7	88.1	99.8	49.6	**89.8(531)**
Grass	7.8	10.3	17.2	7.3	11.9	0.2	50.4	**10.2(60)**
Total	**281**	**223**	**87**	**220**	**371**	**474**	**117**	**591**
Comparison of housing unit								
Same as other	33.5	31.8	32.2	40.9	27.8	36.7	16.2	**32.6(193)**
Better off	27.4	29.2	33.3	30.9	27.8	26.5	38.5	**28.9(171)**
Worse off	39.2	39.0	34.5	28.2	44.5	36.7	45.3	**38.4(227)**
Total	**281**	**223**	**87**	**220**	**371**	**474**	**117**	**591**

As for the main material for the floor, majority (65.3 per cent) reported concrete, followed by mud (23 per cent) and the least reported were tiles (11.6 per cent). However, the main flooring material for majority of rural respondents was mud (86.3 per cent). Similarly, whereas the main material for the roof in urban areas was either iron or asbestos (99.8 per cent), close to half (50.4 per cent) of roof material in rural household units was grass. This again shows differences in terms of development between urban and rural Zambia as well as different challenges faced by older people from rural compared to urban areas.

In the same way, respondents were asked to state how they perceived their housing unit in relation to others within the community. In fact, the question was phrased in this manner: Do you think your housing unit is: Better off, Worse off or Same as other in this community? Results suggest that respondents in rural areas were of the view that their housing unit was better off (38.5 per cent) compared to their urban counterparts (26.5 per cent). Overall, more respondents (38.4 per cent) reported that their housing units were worse off compared to those who reported that they were either better off (28.9 per cent) or same as others (32.6 per cent) respectively.

4.4.3 Work and Sources of Income

The terms “work” and “employment” were used interchangeably and the work solicited for here was both formal and informal. Respondents were asked whether they worked at the time of the study and if not, whether they had been employed in the 12 months preceding the study. Accurate assessment of employment status can be difficult because some work, especially on family farms, family businesses, or in the informal sector, is often not perceived as employment and hence not reported as such (ZDHS, 2007). To avoid underestimating a respondent’s employment status, the study asked respondents questions to probe for their employment status and to ensure complete coverage of employment in both the formal or informal sectors. Employed individuals are those who reported that they were currently working (i.e., had worked in the past 7 days) and those who had worked at any time during the 12 months preceding the survey. In terms of work and sources of

income, results in Table 1.8 indicate that about 12.5 per cent of respondents worked twelve months prior to the study and only about 6.2 per cent reported that they were working at the time of the survey (past 7 days). Two patterns were also evident. Firstly, proportion of respondents who worked in the last twelve months prior to the study declined as age increased. Overall, close to one in five (15.7 per cent) of those aged 60-69 worked in the twelve months prior to the study compared to about 12.2 per cent of those aged 70-79, and about 5.8 per cent of those aged 80+ respectively. It should be mentioned, however, that due to the mandatory statutory requirement where people are expected to retire from formal employment, it is not surprising that majority of respondents in our study were actually not working.

Males were more likely to report having worked twelve months prior to the study compared to females (16.9 and 9.4 per cent respectively). Similarly, there were differences between rural and urban areas in this respect. Among urban respondents, about 13.5 per cent compared to 7.9 per cent in rural areas worked in the twelve months prior to the study. Respondents aged between 60 and 69, mostly male and those residing in urban areas, were more likely to report that they were working compared to females and those in rural areas.

Table 1.8: Work Related Activities and Sources of Income by Age, Gender and Residence

	Age			Sex		Residence		Total
	60-69	70-79	80+	Males	Females	Urban	Rural	%, n
Worked during past 12 months	15.7	12.2	5.8	16.9	9.4	13.5	7.9	**12.5(86)**
Currently working	8.4	4.4	5.1	8.4	4.7	6.5	4.7	**6.2(43)**
Reasons for not working								
Health problems	8.8	17.4	13.0	13.5	12.4	12.5	14.2	**12.8(83)**
Old age	66.8	74.8	83.2	75.8	71.3	74.6	66.7	**73.1(473)**
Can't find a job	24.5	7.9	3.8	10.8	16.3	12.9	19.2	**14.1(91)**
Total	**274**	**242**	**131**	**260**	**387**	**527**	**120**	**647**
Opportunities for work	37.5	17.8	12.3	25.3	25.1	26.8	18.2	**25.2(174)**
Access to income	29.8	21.7	9.4	29.9	17.7	25.2	11.9	**22.7(157)**
Sources of income								
Selling	41.6	38.2	30.8	32.9	47.2	36.6	66.7	**39.4(62)**
Relatives/Children	4.5	12.7	7.7	8.2	6.9	8.5	0.0	**7.6(12)**
Rentals	33.7	36.4	23.1	29.4	38.9	37.3	0.0	**33.7(53)**
Pension	6.7	5.5	15.4	10.6	2.8	7.0	6.7	**7.0(11)**
Work	13.5	7.3	23.1	18.8	4.2	10.6	26.7	**12.1(19)**
Total	**89**	**55**	**13**	**85**	**72**	**142**	**15**	**157**
Brewing 'kachasu' (illicit beer)	18.2	23.8	17.6	19.0	21.0	20.7	18.5	**20.2(105)**
Begging/well wishers	47.9	52.5	50.0	53.7	47.9	52.0	42.6	**50.0(254)**
Farming	33.9	23.8	32.4	27.4	31.1	27.3	38.9	**29.7(154)**
Total	**242**	**202**	**74**	**190**	**328**	**410**	**108**	**518**
Adequacy of income	35.2	40.0	38.5	34.1	40.9	39.0	20.0	**37.2(58)**
Total	**88**	**55**	**13**	**85**	**71**	**141**	**15**	**156**

Respondents who were not working at the time of the study were asked to state why they were not working. Majority (73.1 per cent) stated that 'old age' was the main reason they could not work. This is also true by gender and residence. In the same way, respondents were asked to state opportunities they thought they had to get a job or work, or simply, what chances they stood to find work. Only a quarter (25.2 per cent) indicated that they had opportunities to work in their communities. Respondents aged 60-69 had more or better opportunities to work compared to other age groups. Participants in the FGDs also confirmed that older people have no opportunities for employment and they generally do not work. To some extent, this situation also explains why they have quite low self esteem and are generally lonely:

> *'They do not get any employment opportunities. This has resulted in many of their children turning to the streets to look for food'* (FGD, Masala - Ndola)

In terms of income accessibility, respondents were again asked to state whether they had or could at least access income irrespective of the source. About one in five (22.7 per cent) stated that they could at least access income. It is also evident from the data that income accessibility diminishes with increasing age in such a way that those aged between 60-69 were more likely to report access to income than other age groups (Table 1.8).

Sources of income were also varied. Majority of respondents reported 'begging' (50 percent), 'selling' (39 percent), 'rentals' (33 percent) and 'farming' (29.7 percent) as their main sources of income. Other sources were '*kachasu'*[3] brewing' (20.2 percent), 'work' (12.1 percent), 'pension' (7 percent) and 'relatives or children' (7.6 percent).

In terms of selling, persons aged 70 and above were less likely to report selling as a source of income compared to those aged 60 to 69. In addition, small differences exist between male and female respondents in relation to income sources. For example, there were more men (18.8 per cent) compared to women (4.2 per cent) citing work as a source of income. In the same way, more male respondents (10.6 per cent) indicated pension as their source of income compared to females (2.8 per cent). However, more female respondents (38.9 per cent) reported rentals as sources of income compared to males (29.4 per cent). This is an interesting result but suffice to say that it may relate to the fact that since more females reported to be widowed, it is therefore possible that they assume responsibility of their late husbands' properties. However, this may require more interrogation and further research.

As indicated above, about half of respondents reported begging and receiving donations from well-wishers as one of their main sources of income. While it is expected for people especially in rural areas to engage in farming for their livelihoods, it is however out of the ordinary for older people to rely on begging and 'kachsu' brewing as sources of income. This is so because 'begging' and

[3] 'Kachasu' is a locally brewed illicit alcohol brand common in high density areas or shanty compounds. It is brewed from maize and has high ethanol content.

'kachasu brewing' are unconventional methods of income generation; further, not only are these means unconventional but illegal, painstaking and embarrassing as well. Inadvertently, this also explains why older people have quite low self esteem. However, it should be noted that due to lack of data to make comparisons in terms of what maybe obtaining in the general population, this result maybe synonymous with old age and ageing in general. 'Farming, 'begging' and 'brewing kachasu' were also reported to be some of the main sources of income for older people by participants in the focus group discussions. The following excerpts illustrate these sentiments:

> *'There are those who do piece works; and also through farming for those old people who still have the strength to farm'* (FGD, Mwandi – Sesheke)

> *'But there are also some who just involve themselves in kachasu brewing and begging, and that is how they make their money' (*FGD, Matero – Lusaka)

Other details, reflecting differential in terms of age, sex and residence in relation to the sources of income were also observed. Giving *'kachasu'* brewing as an example, it is evident from the data that those aged 70-79 were more likely (23.8 per cent) to report brewing *'kachasu'* as a source of income compared to those who were 60-69 (18.2 per cent) and the 80+ (17.6 per cent).

As for begging or receiving donations from well-wishers, there were extremely minimal differences especially by age. For example, about 50 per cent of those aged 80+ reported that their income depended on begging while about 47.9 per cent of those aged 60-69 and 50.5 per cent of those aged 70-79 also reported begging as a source of income. In the same way, the age group 70-79 was less likely (23.8 per cent) to report farming as a source of income compared to those aged 60-69 (33.9 per cent) and those aged 80+ (32.4 per cent).

In terms of sex differentials, female respondents were more likely to report illicit beer brewing (21 per cent) and farming (31.1 per cent) as income sources compared to their male counterparts (19 and 27.4 per cent respectively).

However, male respondents were more likely (53.7 per cent) to engage in begging or getting handouts from well-wishers compared to their female counterparts (47.9 per cent). In the same way, except for farming where more rural respondents seem to engage in (38.9 per cent vs 27.3 per cent), urban respondents were more likely to report illicit beer brewing (20.7 per cent) and begging/donations from well-wishers (52 per cent) compared to their rural counterparts.

For almost all sources of income, it is clear that respondents in rural areas were less likely or not at all able to report any income source compared to their urban counterparts. For example, no rural respondent indicated rentals, children or relatives as sources of income. Nonetheless, and interestingly so, rural respondents were considerably more likely (26.7 per cent) to report work as their source of income. However, the context of this work should be understood to mean engagement in agricultural activities which inevitably helps to secure some income for rural communities. This also reflects the tendency for rural people to remain economically active longer in life especially in agriculture where retirement is more likely to be a gradual process and not subject to a prescribed retirement age (Knodel *et. al.,* 2008).

It should be stressed that begging is quite high amongst older people and therefore a cause for concern. In particular, there is no normalcy and dignity for senior citizens to survive through begging. This finding shows also that not only are societies failing to help and look after older people but also the dysfunction of some or most of the policies aimed at addressing older people. In fact, this finding could only be compared to challenges that confront people with disability. For example, it is not uncommon for people who are blind, lame etc to be begging on the street; however, old age is not “disability” and under normal active ageing, older people should be able to fend for themselves (WHO, 2002).

4.4.4 Care, Living Arrangements, Social Contacts and Coping Strategies

This section presents information based on the examination of care for the elderly, their living arrangements and social contacts with family, relatives and society at large. It also details challenges experienced by elderly persons living with orphans.

Care and living arrangements are also important aspects contributing to the challenges of people who are ageing. For example, it is said that if and when older people feel not cared for, this is a source of concern and weighs negatively on their self-esteem.

Traditionally, in Africa, the aged were cared for by both close relatives and the community. They drew both material and social support from social networks within community structures (Namakando 2004). They lived with and were cared for by families and always occupied a defined high status in society. In fact, in Zambia as well as Africa and the developing world in general, informal systems of social and economic exchanges play a crucial role in determining the well-being of older people (World Bank, 1994). Of particular importance are the intergenerational exchanges of services and material and social support between elderly parents and their adult children, as well as the living arrangements with which they are inextricably entwined (UNFPA, 2007).

4.4.5 Care for the Aged

Table 1.9 is a summary of the care elderly people receive from various sources, including family, homes for the aged, distant relatives, and in some cases, spouses. Information in the table further highlights the type of care received and the actual relationship existing between the caregiver and the receiver.

Table 1.9: Care-giving by Age, Gender and Residence

	Age			Sex		Place of stay		Residence		Total
	60-69	70-79	80+	Males	Females	OPH*	Comm*	Urban	Rural	%,n
Caregiver availability, type of caregiver and relationship to care caregiver										
Caregiver available	48.4	64.4	78.2	59.5	60.8	81.8	56.7	58.5	68.2	**60.2(416)**
who is care giving										
Family member	88.2	81.0	56.3	64.3	85.6	0.0	99.1	73.5	89.8	**76.7(337)**
other (no relation)	0.0	1.2	0.8	0.6	0.8	0.0	0.8	0.9	0.0	**0.6(3)**
Total	**152**	**168**	**119**	**182**	**257**	**99**	**340**	**351**	**88**	**439**
relationship with caregiver										
Spouse	34.3	19.9	9.7	42.7	13.0	6.7	24.1	26.3	13.6	**23.3(83)**
Son	12.4	14.4	8.3	15.3	10.8	0.0	12.9	13.1	9.9	**12.3(44)**
Daughter	25.6	37.0	50.0	21.0	42.9	13.3	36.2	34.7	37.0	**35.2(125)**
Child-in-law	0.7	0.0	0.0	0.8	0.0	0.0	0.3	0.4	0.0	**0.2(1)**
Other relative	27.0	28.8	31.9	20.2	33.3	80.0	26.5	25.6	39.5	**28.7(102)**
Total	**137**	**146**	**72**	**124**	**231**	**15**	**340**	**274**	**81**	**355**
Type of care or assistance rendered										
Cooking	75.4	81.2	89.7	89.0	76.1	0.0	80.5	78.9	86.1	**80.5(274)**
Washing	72.4	79.0	88.2	36.3	40.2	0.0	78.2	77.0	82.3	**78.2(266)**
Drawing water	72.4	78.3	83.8	89.0	70.7	0.0	77.1	74.7	84.8	**77.0(262)**
Cleaning house/room	73.9	76.8	83.8	88.1	71.2	0.0	77.1	75.5	82.3	**77.0(262)**
Total	**134**	**138**	**68**	**118**	**222**	**0**	**340**	**261**	**79**	**340****

Note: multiple response question where only 'yes' answers were considered, rows and columns may not add up to n and 100 per cent respectively

Three in five (60.2 per cent) respondents stated that they had a caregiver. Those aged 80+ were more likely to report being cared for (78.2 per cent) compared to the other age categories. There were no major differences by sex of respondent in terms of care. People in rural areas reported having more caregivers (68.2 per cent) compared to urban areas (58.5 per cent).

Family members were the largest providers of care (76.7 per cent). From this proportion, it is clear that the family is still an important source of care-giving in Zambia. People in communities sometimes assume this role as well. Nonetheless, very few people would take care of older people they are not related to. In fact, participants in the FGDs indicated that while they could keep an old person, it was not possible given the socio-economic situation in Zambia. Some of them had this to say:

'To tell you the truth, the cost of living has become very expensive. A long time ago, life was affordable, but not now. Very few of us can stay with old people who are not our relatives' (FGD, Mwandi – Sesheke)

'Life now is very expensive, who can manage to keep someone who is not even their relative? For me, I can only stay with my relative' (FGD, Matero – Lusaka)

For those respondents who reported that their caregiver was a family member, a follow up question was asked to establish the actual relationship.

Daughters were the most (35.2 per cent) frequently mentioned caregivers, followed by 'other relatives' (28.7 per cent) and spouses (23.3 per cent) respectively. Data in Table 1.9 also show that sons (12.3 per cent) and children in-law (0.2 per cent) also provide care, but this is quite minimal comparatively.

In terms of age groups, those aged 60-69 were more likely to report spouses (34.3 per cent) as caregivers compared to those aged 70-79 (19.9 per cent) and 80+ (9.7 per cent) respectively. Male respondents reported being cared for more by their spouses (42.7 per cent) compared to female respondents (13 per cent). Low spousal care reported by female respondents could be due to many reasons, but some studies have shown that females bear the brunt of care-giving compared to males. For example, a study on elderly care in Nigeria established that majority caregivers were women (Abidemi, 2005). Care-giving is also looked at as 'a traditional role' for women (Namakando, 2004). It is also assumed that women remain unmarried in their old age and are, therefore, unlikely to have spouses to take care of them. In the section on socio-demographic characteristics of respondents, it is discussed that there were more female respondents who reported being widowed compared to males.

Respondents were also asked to state the type of care they were mainly given. Much of the care or assistance reported was in kind and included such activities as helping with cooking (80 per cent), washing (78.2 per cent), drawing water and house or room cleaning (77 per cent).

In terms of age, the data show that the help given or care rendered increases with age, with those aged 80+ generally indicating that they were receiving more help in the aforementioned activities (cooking, washing, drawing of water and house/room cleaning) compared to those aged 60-69 and 70-79 respectively. The differences, especially between the 70-79 and the 80+ groups, were minimal.

Except for washing, males were generally more likely to report receiving help in terms of cooking, drawing of water and house/room cleaning compared to females. Further, respondents in rural areas were also more likely (86.1 per cent) to receive help in these areas compared to respondents in urban areas (78.9 per cent). This disparity could be due to the perceived strong ties and bonds between residents in rural areas compared to urban areas. It is argued that urban areas have become polarized with such influences as secularlisation and nuclear family bonds, a situation not so prevalent in rural areas (Havens, 1989).

The proportions presented in Table 1.9 may look like 'good' news to people reading them. For example, when one observes proportions on the type of care rendered, one may conclude that actually, older people receive meaningful assistance in as far as their daily chores are concerned. However, these proportions may show the extent of incapacitation amongst older people in the study. Basic chores like cooking, washing etc should under normal circumstances be performed by older people themselves, nonetheless, it is clear that this is not so in our study. In fact, inability to perform these basic functions could also result in low self-esteem amongst the elderly

4.4.6 Living Arrangements

Recently, living alone has become synonymous with ageing (Knodel, 2008). Many reasons are given for this situation. Participants in the focus group discussions said people are afraid to keep older people because older people are generally not respected and people think that they tend to practice witchcraft.

For whatever reason, it is common to find old people living alone. Even when they are staying with other people, most often these 'other people' are actually dependents. FGDs participants had this to say:

> *'I can't live with them; very few people respect the aged. Most young ones do not have respect for the aged, so how can they live with them? Because of that reason, I cannot keep an old person because even my neighbours will be saying that am keeping a witch in the neighborhood*' (FGD, Masala – Ndola)
>
> *When one is old, it is like that person has a curse, people will run away, and whenever there is a funeral nearby, they will say its that old person who has killed. So yes, being old, you have to prepare yourself to suffer and to stay alone sometimes* (FGD, Matero – Lusaka)

A summary of living arrangements by age, gender and residence are presented in Table 2.0. Living arrangement measurements were arrived at by asking who the respondent was staying with at the time of data collection.

Table 2.0: Living Arrangements by Age, Sex and Residence

	Age			**Sex**		**Residence**		**Total**
	60-69	70-79	80+	Males	Females	Urban	Rural	**%, n**
Currently who they are living with								
Alone	11.4	14.4	5.8	8.6	13.5	11.4	12.8	**11.6(69)**
With any older relative	40.2	37.7	32.2	44.6	34.2	38.2	37.6	**38.0(225)**
Total	**281**	**223**	**87**	**220**	**371**	**474**	**117**	**100(591)**
Currently living with a son or daughter								
Son	54.4	49.2	43.5	64.4	42.1	52.7	44.1	**51.1(92)**
Daughter	45.7	50.8	56.5	35.6	57.9	47.3	55.9	**48.9(88)**
Total	**92**	**65**	**23**	**73**	**107**	**146**	**34**	**100(180)**
Currently keeping orphans								
Total	**281**	**223**	**87**	**220**	**371**	**474**	**117**	**591****

Note: Only 'yes' was considered

The number of respondents living alone was quiet low (11.6 per cent). About six per cent of those aged 80+ indicated that they lived alone. However, for the other two age categories, the proportion was much higher than that reported by those aged 80+; in the same way, about 11.4 (60-69) and 14.4 per cent (70-79) respectively stated that they were living alone. This shows that the number of older people who may be living on their own decreases with increasing age.

Female respondents were more likely (13.5 per cent) to report staying alone compared to male respondents (8.6 per cent). This could mostly be attributable to the fact that majority of older women in this study were widowed. In the same way, while respondents in rural areas were more likely (12.8 per cent) to report staying alone compared to those in urban areas (11.4 per cent), the difference was actually minimal.

There were also differences on the response category of staying 'with any older relative' by age, gender and residence. Those aged 80+ were less likely to report staying with any older relative (32.2 per cent) compared to those aged 60-69 (40.2 per cent) and those aged 70-79 (37.7 per cent).

Respondents who reported that they had adult children were asked to state whether they were staying with them at the time of data collection.

Co-residence between sons or daughters in our study was about average. Overall, about 51.1 and 48.9 per cent of respondents reported that they were living with a son or a daughter. To some extent, this finding challenges the common view that co-residence with adult children is most common in least developed societies (Asis *et. al.,* 1995). In our study, while there is evidence of co-residence, it is just about average.

In terms of age, the proportion of respondents reporting co-residence with sons diminishes with increasing age. However, the opposite is true with daughters. For example, about 54.4 per cent of respondents aged 60 to 69 reported that they were residing with their sons while about 43.5 per cent of those aged 80+ reported similar living arrangements. On the other hand, about 45.7 per cent of respondents aged 60-69 reported that they were co-residing with daughters with those aged 80+ reporting more of this living arrangement (56.5 per cent) compared to other age categories.

Clearly, care for the aged and co-residence with adult children are determined to some extent by gender. From these results as well as data from other

studies, it could be suggested that not only do women carry most of the responsibilities to look after children, husbands and other relatives, but they also seem to have an upper hand in providing care to older people. To support this line of thought, a study on family care-giving of the elderly in Botswana by Shaibu, *et. al.* (2002) concluded that care-giving was mostly a woman phenomenon; men are just dragged in the process because of the circumstances. One man stated as follows:

> *'The only thing is that I am a man; if I were a woman, there would not be much of a problem. You see, a man cannot take care like a woman. You see, we usually leave care giving to women, but seeing we are doing this together, we do it the female way'* (Shaibu *et. al.,* 2002).

While it may be recommendable that majority of older people in our study seem to be staying with their sons or daughters, it should be borne in mind that this situation may not encourage independence and self-reliance amongst the elderly. In this example, it may not be quite expected for older people in their sixties to be staying with their children unless under special circumstances for example where the older person is sick, lame or incapacitated in a way or another and requires some special care. Our study shows that currently however, this is not the case and one can only speculate the physical and psychological impact that this situation may have on older people themselves – explaining further why most of them seem to have quite low self-esteem.

4.4.7 Social Interactions

Some of the challenges identified with old age are due to limitations in social interactions and networks; older people are either affected positively or negatively depending on their social contacts, especially with relatives and/or the community at large. Several theoretical explanations also try to address the influence of social networks on the well-being of the aged. In any case, social contacts are also highly determined by the socio-economic environment.

In relation to the social network analysis framework research (Mitchell 1969, Wellman *et al* 1988), this study focused on the functionality of social networks where social contacts were examined in terms of frequency of physical contacts or visits to the respondent by their adult child who was not living with them at the time of the survey as well as interactions between and among the elderly themselves. Proximate measures translated into daily, weekly, monthly or yearly contacts with children and also frequency of interactions with peers.

Daily or almost daily interactions may signify high social contact with family members or children; a 'once a year contact' or 'never' response may also show little or no social interactions. However, this may not be as straightforward as put here. This is because social contacts and interactions depend on the relationships between the relatives and the older persons. It should be noted further that the question on interactions was restricted to those respondents who reported that they were not residing together with either their relatives or their children; in the same way, those who reported that they were living with their relatives, the same question was asked on social contacts with their friends or peers. The results are presented in Table 2.1.

Table 2.1: Social Interactions with Relatives and Peers

	Age			**Sex**		**Residence**		**Total**
	60-69	70-79	80+	Males	Females	Urban	Rural	**%, n**
Interactions with relatives								
Daily or almost daily	11.2	9.3	3.7	11.0	8.5	8.4	14.3	**9.4(39)**
Weekly	7.3	5.3	3.7	4.3	7.3	7.2	1.3	**6.0(25)**
Monthly	42.2	37.8	27.8	41.1	37.1	42.2	23.4	**38.6(159)**
Once a year	24.3	34.4	46.3	32.5	29.8	28.4	41.6	**30.9(127)**
Never	15.1	13.3	18.5	11.0	17.3	13.8	19.5	**14.8(61)**
Total	**206**	**151**	**54**	**163**	**248**	**334**	**77**	**411**
Interactions with peers								
Daily	39.8	35.9	24.1	36.7	35.6	35.5	37.9	**35.9(212)**
Weekly	43.4	42.6	40.2	45.9	40.7	44.4	35.3	**42.6(251)**
Monthly	2.2	3.1	3.5	2.3	3.0	3.0	1.7	**2.7(16)**
Never	14.7	18.4	32.2	15.1	20.8	17.1	25.0	**18.7(110)**
Total	**279**	**223**	**87**	**218**	**371**	**473**	**116**	**589**

The most reported interactions to respondents occur monthly (38.6 per cent); yearly interactions were reported by about 30.9 per cent of respondents

signifying the next most frequent contact period or time. About 14.8 per cent of respondents who had adult children or relatives living elsewhere reported that their children never visited them at all. This view was also expressed by participants in the FGDs; some mentioned that there were cases of neglect of older people not only by their own relatives, but also society as whole, saying:

> *They have families quite alright, but at some point, children neglect their parents, especially if they get married to a wrong person* (FGD, Masala – Ndola)

> *Old people are also abandoned by society; they are not valued.* (FGD, Mwandi – Sesheke)

Table 2.1 further shows that about 9.4 and 6 per cent of respondents reported that they were visited by their children/relatives on a weekly and daily or almost daily basis respectively. Again, this may indicate the fact that while children may have moved physically out of their parents' homes, they could still be in the same neighbourhoods or somewhere near.

In terms of age, except for those respondents who reported that they were visited once a year or 'never at all', the frequency of visits reported reduces with increasing age. Of those respondents who reported that they were visited on a daily basis, those aged 60-69 were visited more (11.2 per cent) compared to those aged 70-79 (9.3 per cent) and those aged 80+ (3.7 per cent). This pattern is also similar to respondents who indicated that they were visited weekly with the age group 80+ reporting the least of such visits (3.7 per cent). Respondents aged 60-69 were more likely (42.2 per cent) to report being visited by children/relatives compared to those aged 70-79 (37.8 per cent) and 80+ (27.8 per cent) respectively. On the other hand, respondents aged 80+ reported being visited more (46.3 per cent) on a yearly basis compared to those aged 60-69 (24.3 per cent) and those aged 70-79 (34.4 per cent). Amongst those who reported that they were never visited, majority were the 80+ (18.5 per cent).

Social contacts by sex and residence seemed to have no consistent pattern either. For example, male respondents were more likely (11 per cent) to report

that they were visited more by children/relatives on a daily basis compared to females. They were also likely to report being visited more on a monthly (41.1 per cent) and yearly basis (32.5 per cent) by their children or relatives compared to females (37.1 and 29.8 per cent respectively). However, female respondents were more likely to report receiving weekly (7.3 per cent) visits compared to males (4.3 per cent). Similarly, more female (17.3 per cent) respondents reported that they were never visited by their children or relatives compared to males (11 per cent).

Besides social contacts within families the study also examined the existence and frequency of contacts among peers and friends. This was also guided by assertions in literature of the importance of social contacts amongst the elderly persons themselves. The other argument is that friend or peer interactions have other value additions not feasible in other social interactions, especially those of a family nature. It is argued that friendships foster feelings of attachment that are based on equalitarianism, consensus and sharing of good times (Crohan *et. al.*, 1989).

In general, Table 2.1 shows that majority (42.6 per cent) of respondents interacted weekly with peers or friends. About 35.9 per cent reported that they interacted daily while close to one in five (18.7 per cent) reported that they never interact. Amongst those reporting that they never interact with peers or friends, majority (32.2 per cent) are those aged 80+. In addition, females (20.8 per cent) and respondents from rural areas (25 per cent) had a higher proportion of respondents who never interact with peers or friends. It is clear that interactions or social contacts with peers or friends especially for respondents aged 80+, females and those in rural areas are quite minimal and may be a source of unhappiness and low self-esteem among senior citizens generally.

4.4.8 Material and Other Forms of Support

Children and relatives can be important sources of economic support to elderly parents through providing money, food and goods (Knodel *et. al.,* 2007). However, support to older people, including those with children is one of the most challenging experiences of old age because lack of food especially and other life supporting amenities seem to be more pronounced in old age than other age groups. Participants in the FGDs highlighted at least two major challenges old people face: lack of food and generally lack of support. These aspects contribute greatly to the sum of issues that may lead to low self-esteem amongst the elderly. Some of the discussants had this to say:

> *They cannot even afford mealie-meal; it is very expensive for most of them; they lack basics, like food; this is the biggest problem they have* (FGD, Masala – Ndola)

> *'They cannot support themselves adequately; they also do not have support from other people; that's one other problem they face'.* (FGD, Masala - Ndola)

In this study, support was operationlised using a set of questions asking respondents to state whether or not they were receiving any "materials" including food, clothes, blankets and/or money. Any "Yes" response meant that they were in general receiving some form of support of one kind or another; a "no" meant the opposite. Similarly, other forms of support were classified to be "Spiritual" – any form of encouragement from religious groupings; "Social" – any help they received in the form being helped to clean the house, washing clothes etc., and "Emotional" – any psycho-social support to help with their emotional state. This information is presented in Table 2.2.

Table 2.2: Material, Monetary and Other Forms of Support

	Age			Sex		Residence		Total
	60-69	**70-79**	**80+**	**Male**	**Female**	**Urban**	**Rural**	**%, n**
Support from sons/daughter and other relatives								
Sons/Daughters (own children)	68.8	75.0	0.0	73.7	64.0	64.8	73.3	**66.6(46)**
other relatives	24.7	32.7	39.1	29.8	29.9	28.8	34.5	**29.8(176)****
government and institutional								
Government	3.3	5.5	15.2	9.9	4.2	6.4	7.1	**6.5(45)**
Non-governmental organization	2.7	7.5	13.8	9.9	4.4	7.3	4.0	**6.6(46)**
Church	12.4	19.4	38.4	25.7	16.3	21.5	14.3	**20.1(139)**
MCDSS	2.3	3.2	20.3	11.6	2.5	6.7	4.0	**6.2(43)**
Community Group	6.0	8.7	22.5	14.1	7.6	11.0	7.1	**10.2(71)**
Total	**299**	**253**	**138**	**284**	**406**	**564**	**126**	**690*****
social, emotional and spiritual support								
Social	29.0	32.9	38.2	43.1	26.1	24.3	60.0	**32.4(57)**
Emotional	27.5	34.3	44.1	38.5	30.6	27.2	55.0	**33.5(59)**
Spiritual	79.7	64.4	58.8	76.9	64.9	71.3	62.5	**69.3(122)**
Total	**69**	**73**	**34**	**65**	**111**	**136**	**40**	**176*****

Note: the two variables were independent questions and hence have no common total
****Note: multiple response questions independent of each other's totals; and only 'yes' was considered***

About 66.6 per cent (n=46) of respondents reported that they received support from their children and also from relatives (29.8 per cent). Support rendered increases marginally with age except for those aged 80+ who reported 'no support' from own children. Male respondents and those in rural areas were more likely (73.7 and 73.3 per cent) to be supported by their children compared to females (64 per cent) and those in urban areas (64.8 per cent) respectively. Those aged 80+ were more likely (39.1 per cent) to receive support from relatives than those aged 60-69 (24.7 per cent) and 70-79 (32.1 per cent). In addition, there seems to be little or no difference between male and female respondents reporting being supported or getting support from relatives. Nonetheless, it is clear that respondents from rural areas were also more likely (34.5 per cent) to report getting support from relatives compared to those in urban areas (28.8 per cent). Generally, while 66 percent may seem high, one needs to pay attention to the sample or the absolute number of those represented by these proportions. It is clear that monetary and material

support to older people from either children or relatives is quite low and a source of concern.

In terms of institutional support, data in Table 2.2 shows that the church (20.1 per cent) and community groups (10.2 per cent) provide more support compared to other institutions. Government in general and the Ministry of Community Development and Social Services (MCDSS, now MCDMC) provide just about 6.5 and 6.2 per cent support to older people respectively. Focus group discussants also confirmed that the church was a little more active in supporting old people in communities compared to other institutions:

> *'But the church here (UCZ) helps them a lot with things like shelter and food'* (FGD, Mwandi – Sesheke)

Overall, institutional support is minimal and is mainly concentrated on those aged 80 years and above, mostly males and respondents from urban areas. In fact, FGDs participants even alleged that institutions that provided support to older people were very selective. This may explain why few older people seem to be receiving support from institutions. One FGD participant had this to say:

> *'The organisations that help are very selective and some older people remain complaining every day. Maybe this is due to the fact that support systems are not many, if at all any'* (FGD, Mwandi – Sesheke)

4.4.9 Social, Emotional and Spiritual Support

Social, emotional and spiritual support were other forms of support investigated in this study. Majority (69.3 per cent) of respondents were receiving spiritual support. In terms of age, those aged 60-69 were more likely (79.7 per cent) to report being supported spiritually compared to other age groups. Also, about 33.5 and 32.4 per cent of respondents reported that they were being supported emotionally and socially respectively. Both social and emotional support seems to increase with age and was reported more by males and respondents in rural areas. For example, those aged 80+ were more likely

to report that they were supported socially (38.2 per cent) and emotionally (44.1 per cent) compared to those aged 60-69 (29 and 27.5 per cent respectively) and those aged 70-79 (32.9 and 34.3 per cent respectively). Similarly, male respondents were more likely (43.1 per cent) to report being supported socially compared to female respondents (26.1 per cent).

This section has demonstrated that whatever form of support – be it from children, relatives, institutional, social, emotional and spiritual – rendered to the elderly is quite insignificant to say the least and probably a source of low self-esteem and unhappiness.

4.4.9a Orphan and Dependent Child Care

Older people have a huge challenge of taking care of orphans. This is one of the most difficult challenges faced by older people in the 21st century especially in Africa and quite frankly a source of low self-esteem and unhappiness. Looking at orphans for example, there are strong indications that they have come about mainly due to effects or deaths by parents attributed to HIV/AIDS. While it is argued that the phenomenon of orphanhood has been in existence for a long time, it is also true that the advent of the HIV/AIDS pandemic has exacerbated the problem and old people have been caught up at the receiving end. A study in Iringa, Tanzania, conducted by HelpAge international (2004), found that older people's role in caring for these groups (orphans and sick adult children) has a variety of economic costs and effects on their livelihoods. In the first instance, the old are forced to redirect their resources from their own needs to those of people under their care, especially to pay for health care and food. This development was taking place under the backdrop of already challenged people in caring and providing for themselves. In the same way, not only has HIV/AIDS brought about challenges of orphan care, but also predisposing older people to infections as well. In the hope of seeking resources to support

vulnerable children, some older people have also been infected by the HIV virus[4]. One discussant in the FGD had this to say:

> *'Sometimes, because of having many problems like looking after orphans, some old people sleep around for money so that they can buy food, soap and so on and hence contract the virus and eventually get sick'* (FGD – Mwandi, Sesheke)

Participants in the FGD also stated that due to HIV/AIDS, some roles for older people have changed; they were now seriously and actively involved in providing for orphaned children as well as themselves. This is due to the fact that most of their breadwinners (their children) have died. Some participants had this to say:

> *'I do believe that AIDS has changed the roles of the aged in societies. Previously, they just used to sit at home waiting for their children to provide for them; but now, their children are dead because of AIDS; so if they just sit at home they will die from hunger; they are now actively looking for food'* (FGD – Masala , Ndola).
>
> *'To some extent, they have been kept busy in that they have to look for food in order to feed the orphans they look after'* (FGD – Masala, Ndola)

Table 2.3 presents data on respondents who said they were keeping orphans; it shows also whether these children were going to school and if not, why they were not in school.

[4] This is a controversial statement especially considering the age of respondents; however, in January 2012 MUVI TV carried a story of an older lady (64 years) caught having "sex" with a 25 year old man.

Table 2.3: Orphan Care

	Age			Sex		Residence		Total
	60-69	70-79	80+	Males	Females	Urban	Rural	%, n
Reasons for keeping or staying with children								
Orphans	97.2	99.1	98.9	98.2	98.1	98.1	98.3	**98.1(580)**
Parents working/in another town	2.9	0.9	1.2	1.8	1.9	1.9	1.7	**1.8(11)**
Total	**281**	**223**	**87**	**220**	**371**	**474**	**117**	**591**
Do these orphans go to school?								
Yes	87.0	88.0	89.3	86.0	88.8	87.8	87.6	**87.7(501)**
No	13.0	12.0	10.7	14.0	11.2	12.2	12.4	**12.2(70)**
Total	**270**	**217**	**84**	**214**	**357**	**458**	**113**	**571**
If not going to school, why not?								
Cannot afford taking to school	88.6	88.5	100.0	90.0	90.0	92.9	78.6	**90.0 (63)**
children don't want school	11.4	11.5	0.0	10.0	10.0	7.1	21.4	**10.0(7)**
Total	**35**	**26**	**9**	**30**	**40**	**56**	**14**	**70**

Majority (98.1 per cent) of respondents who were keeping dependent children stated that these children were actually orphans. Table 2.3 further shows that irrespective of age, sex and residence, it is clear that many older people were taking care of orphans and vulnerable children. In the same way, close to nine in ten (87.7 per cent) of respondents also indicated that the children they were keeping were going to school, and again, this was true by age, sex and residence. Out of the seventy respondents who reported that some of the children they were keeping were not going to school, 90 per cent stated that the children in question were not going to school because they could not afford to take them to school. Only one in ten (10 per cent) reported that some children did not actually want to go to school.

4.4.9b Community Perceptions on Ageing

Data for this section was gathered through Focus Group Discussions with members of the community. Understanding perceptions of community members towards older people and ageing in general is important because it shows how older people are cared for by both the community and relatives. If perceptions are positive, this may enhance the active ageing process for older people. If on the other hand, perceptions seem negative, this simply adds to the many challenges they face. In fact, Fitzwater *et. al.* (2008) asserted that

perspective is a powerful influence on attitudes and behavior; "If we hold mostly negative views about ageing, this perspective will influence our interactions with older people as well and may be a huge source of the many challenges they face" (*Ibid* 2008). Community views, convictions, perceptions and attitudes towards ageing and the aged are critical in appreciating and understanding how the aged are living in society in general and what challenges they may be facing in terms of achieving the active ageing process. In the same way, low self-esteem and unhappiness are more likely to be visible amongst older people if communities exhibit negative perceptions towards them.

To start with, discussants were asked to express their views on what they thought about the topic of ageing and what interests them on discussions around ageing. Their views were more on the negative than the positive side. The FGD revealed that very few people in these communities discussed or even talked about ageing. They contended that ageing was not an interesting topic compared to others. One participant said:

> *'For me, I see that as a topic that most people are not interested in, people would rather talk about other things, like taking children for under five clinics and so on'* (FGD, Masala - Ndola)

Discussants also revealed that people generally think ageing was a time to suffer and that old people were into witchcraft. To some extent, these views inform perceptions and hence explain why old people are sometimes not supported by society, or why they seem to have low self-esteem. Some discussants said:

> *'Because of the problems these people go through every day, yes, ageing is now seen as a time of suffering. It is a time of suffering and old people are not respected since they are also accused of being witches'.* (FGD, Mwandi – Sesheke)

However, not all discussions indicated that all or most of the people were not really interested in matters affecting the aged. On the contrary, some said that they were interested in discussing issues of ageing and wanted to participate in solving problems affecting older people; they indicated that although they were interested in these matters, they had no means to address them adequately:

> *'We are interested, but we don't know where to take our grievances about the aged. We were once asked to write down names of all the aged in this constituency, but up to today nothing has been done. This community has over 400 old people* (FGD, Mwandi – Sesheke)

In the same way, discussants were asked to make some comparison between the manner older people were addressed by society in the past and the current times. They highlighted that old people and issues of the aged drew special interest and attention in the past compared to current times. In the past, older people were respected by both their children and society; they were also cared for better:

> *Old people were kept very well a long time ago compared to nowadays,* (FGD, Mwandi, Sesheke)

> *People have just lost respect. A long time ago, people would even move off the road so that an old person could pass, not now, you can even find a young expecting an old person to leave the road for them; morals in societies have really gone down* (FGD, Masala, Ndola)

They further highlighted that in the past, children were expected to house their old parents, a different scenario compared to current times, where older people are considered a burden. However, discussants felt that in current times, there were many reasons driving such negative attitudes towards older people, including lack of employment for children and western cultural influences. On the other hand, FGDs participants reported that wealthy older people were or are respected by society. This again is a source of low self-esteem especially for the majority older people who may not be rich or wealthy:

'Old people are suffering regardless of whether they have children or not. This is because their (children) are unemployed, [and] they are also suffering' (FGD, Mwandi – Sesheke)

'Old people are not respected or supported because of this western culture that has come in. When they see an old person in dirty clothes, they don't even want to go near that person' (FGD, Mwandi – Sesheke)

'And nowadays, for you to be respected in society, you need to have wealth. If you don't have, you are considered to be nothing; rich people, even if they are old are respected' (FGD, Matero – Lusaka)

Discussants were also asked to indicate whether they were, at the time of the discussion, keeping an old person at their home and whether or not they could keep or look after any older person who was not a relation. Some indicated that they were keeping older people, most of whom were actually relatives.

While some stated that they could keep or look after an old person, they also said it was not easy with the prevailing conditions in the economy. They reported that the cost of living was high and this made it difficult to look after older people, especially non-relatives.

They noted further that keeping or looking after older people was a big challenge because older people are generally considered difficult. For example, some indicated that not only were older people very choosy with food and other such things, but they are also perceived to be extremely demanding. Given this background, only few people would be willing to keep or look after them and as a result, older people live quite unhappy and sometimes lonely lives.

Discussants also felt that not only were older people difficult, choosy and demanding, they were also generally stressed; they complain, worry and cry most of the times. Some discussants went on to state that older people were full of themselves and did not care much about problems faced by others:

'For me I do not keep any. These people think a lot about their problems, they are stressed, and they are always complaining and worrying. Others cry a lot. They just want to die' (FGD, Mwandi – Sesheke)

Because of these and many other complaints, discussants were of the view that it was no wonder older people had so many challenges, including living alone, loneliness, low self-esteem and generally lacking support:

'*Yes, old people are lonely. In fact, they spend a lot of their time crying and complaining, even those that have children still feel lonely because of lack of support. When you visit them, they all complain of the same things, they have no clothes, blankets and so on'* (FGD, Mwandi - Sesheke)

In addition, discussants said that few people were willing to keep or look after older persons because of witchcraft accusations from other members of the community. Accusations of witchcraft further exacerbate the lack of respect old people go through:

'On my own, I can keep an old person even though they are not my relation, but the thing is that most people think that when one is old, then they are witches and also disrespect them' (FGD, Masala – Ndola)

On the other hand, while many people consider the elderly difficult and choosy, others think that they were helpful in certain circumstances. For example, some discussants felt that staying with an old person was a blessing while others said that older people helped in taking care of the children, and in some cases they even helped to educate young people through story-telling and advise:

'Yes, me I can stay with them. Keeping someone like that can be a blessing' (FGD, Mwandi – Sesheke)

'Without old people there can never be youths; these people are important because they give advice to young people. For instance, if you take our first president Kenneth David Kaunda, he should not be put aside because he's old; he can still

advise these other presidents who have come in. They also tell a lot of good stories to young ones' (FGD, Mwandi – Sesheke)

SUMMARY PART II

Clearly, these FGDs indicate that while there are few exceptions where older people are respected, cared for, supported and valued, it is, however, notable that society's perceptions of older people and ageing in general is skewed towards the negative. To some extent, this also explains some of the challenges older people experience at individual level especially on low self esteem exhibited by being 'unhappy, feeling 'hopeless', 'useless' and 'lonely'. This situation does not encourage active ageing and definitely not in tandem with the United Nations Principles on Ageing.

PART III DETERMINANTS OF ACTIVE AGEING

4.4.9c Active Ageing in Zambia

Discussions on the challenges as well as perceptions of ageing have given indirect insights on some of the determinants of active ageing in the Zambian context. These revelations are in themselves inconclusive and may not help much in terms of explaining with confidence what the determinants of active ageing in Zambia really are. In view of this challenge, and also in older to link these findings to the Active Ageing Framework, our study aimed at using indirect determinants of active ageing – hereafter called challenges – to construct variables that would help measure directly the most influential determinants of active ageing in Zambia. However, it should be noted that so far, there are no studies that have categorically pointed out the extent of influence of the named determinants in the active ageing framework on active ageing itself. In fact, it is assumed that the body of evidence available only suggests that these are the most likely determinants of active ageing in the world and among older people (WHO, 2001).

According to the Active Ageing Framework, active ageing depends on a variety of influences or "determinants" that surround individuals, families and the nation (Ibid, 2001). These determinants are broad based and are known to affect active ageing differently. They include Gender and Culture as overarching; others are Economic, Health, Social, Physical Environment, Psychological or Behavioral and Personal Determinants. We also added HIV/AIDS due to its significant influences on the lives of older people not just in Zambia, but much of Africa as a whole. We excluded "physical environment" determinant because the context in which it is used in developed countries is very different from what could be referred to as physical environment in an African setting. For example, the determinant in question proposes that for people to age actively, there is need for buildings – houses, places of work etc - to take into account their physical limitations; for example, all buildings should have "escalators" and not just stairs. This accordingly may promote accessibility and active ageing

It should also be borne in mind that Active Ageing is not a concept measurable using a single variable - it is a complex concept to measure and understand fully. Using the definition of the concept itself, active ageing should include: Independence, Participation, Self-fulfillment, Dignity and Care. Out of these, four – independence, participation, self-fulfillment and dignity – were operationalised in the data collection process. Independence for example was operationalised by asking the respondent to state whether they were free to make their own decisions without being coerced or forced; participation was also measured by asking respondents to state whether they were free and allowed to participate in community activities such as church gatherings, community meetings etc. Any "Yes" response to these questions meant that they were participating in community activities and therefore fulfilling partly the active ageing process. Care however is more inclined towards determinants of active ageing rather than an indicator. In fact, care falls under social determinants of active ageing.

4.4.9c.1 Model for Determinants of Active Ageing

Determinants of active ageing were measured using proxy indicators based on challenges discussed already in this chapter. Gender on one of the overarching determinants was measured by sex (male or female) while Culture was measured by residence (rural or urban).

In order to measure Behavioural and Personal Determinants, respondents were required to say either "yes" or "no" to the statements as follows: Do you feel: Hopeless, Useless, Unhappy or Lonely? (q206d, q206e, q206f and q206g).
Health and Functional Determinants were measured using the question on whether or not they had been ill in the past 12 months prior to the study (q204) as well as to say either "yes" or "no" to statements such as: Can you squat? Can you walk freely? And can you clean your house by yourself? (q201j, q201k and q201g)
Economic Determinants were measured using questions on whether or not the respondent had worked in the past 12 months (q106), whether or not they have opportunities for work (q107b) and whether or not they have a steady flow of income (q108)
Social Determinants (which include care as well) were measured using questions such as: do you have someone who takes care of you? (q301), who are you living with? (q331), how often do you interact with peers? (q414) and do you receive any support – monetary or otherwise? (q406).
Finally, HIV/AIDS as a Determinant, unique to Zambia and Southern Africa in general, but not reflected in the Active Ageing Framework (WHO, 2002) was measured using the question on whether or not the respondent was keeping dependents and how many of these are or were orphans? (q335).

In this model, as well as the Active Ageing Framework, these determinants were or are treated as "Independent variables" while Active ageing (measured by participation, self fulfillment, independence and dignity) was treated as a

"Dependent variable". Table 2.4 shows descriptive statistics of determinants of active ageing and indicators of active ageing.

Table 2.4 Percent distribution of Determinants of Active Ageing and Selected Indicators of Active Ageing

Determinants of Active Ageing	*N*	Selected Indicators of Active ageing			
		Participation	Self Fulfillment	Independence	Dignity
Gender					
Male	286	88.8	16.1	79.7	72.6
Female	409	91.9	5.3	72.1	67.5
Culture					
Urban	566	92.1	10.2	76.8	70.6
Rural	129	84.5	7.7	68.2	69.2
Personal/Behavioural					
"Feels" Hopeless	210	87.6	10.0	63.8	68.4
Useless	191	83.8	12.5	60.2	70.7
Unhappy	311	87.5	10.9	68.2	75
Lonely	364	86.8	11.5	70.8	73.3
Health/Functional					
Ill past 12 months	433	88.6	10.3	71.5	76.2
Can squat	487	93.0	8.8	85.2	83.1
Walk freely	522	91.9	9.3	81.6	79.7
Clean house	499	93.4	8.8	81.9	77.9
Economic					
Work past 12 months	86	91.8	2.3	86.1	71.4
Opp/work/income gen	176	93.7	5.6	87.5	76.4
Monthly income	158	96.2	2.5	91.7	60
Social					
Has caretaker	417	87.2	12.4	66.9	78.5
Living with anyone	523	90.2	0.2	77.4	50
Interact with peers	480	93.5	100.0	80.6	50
Receives support	176	85.8	100.0	64.2	52.1
HIV/AIDS					
Keeps Orphans	293	93.8	0.0	83.9	50

Data in table 2.4 shows that for almost all indicators of active ageing, the primary determinants seem to have influences. In this case for example, the respondent's gender influences how older people participate (88.8 and 91.2 percent for males and females respectively) in communities; it also influences how independent (79.7 and 72.1 percent for males and females respectively) they are as well as whether they live dignified lives or not (72.6 and 67.5 percent for males and females respectively). In the same way, for almost all determinants of active ageing, self-fulfillment seems to be the least affected amongst indicators of active ageing. Except for "receiving support" (100

percent), and “interacting with peers” (100 percent), other influences are all under 16.1 percent reported by the male gender.

In the same way, except for participation where the female gender seems to be more (91.9 per cent), males seem to be more self-fulfilled (16.1 percent), more independent (79.7 percent) and more dignified (72.6 percent).

In terms of culture, the table shows that residents in urban areas participate more in community activities (92.1 against 84.5 percent), are a little more self-fulfilled (10.2 against 7.7 percent) and more independent (76.8 against 68.2 percent) compared to their rural counterparts respectively. However, in terms of dignity, older people in both rural and urban areas seem to enjoy similar treatment (70.6 and 69.2 percent respectively).

Other determinants play quite important roles as well in terms of influencing active ageing. While data shows that their influences are quite high, there are few or exceptional variations amongst and between them.

In terms of behavioural and personal determinants, at least four out of every five respondents demonstrate that these determinants affect the way they participate. Being unhappy and reporting loneliness for example are highly associated with the respondent’s independence (68.2 and 70.8 percent respectively) and dignity (75 and 73.3 percent respectively).

Health Determinants also show indications of associations with active ageing indicators relating especially to participation, independence and dignity. For example, about 88.6 percent of respondents stated that while they were ill in the past 12 months prior to the study, they however also reported that they were free to participate in the affairs of society.

Economic determinants, especially having a monthly income is highly associated with active ageing indicators of participation (96.2 percent) and independence (91.7 percent). In the same way, social determinants also affect active ageing indicators differently. However, this association is more visible with participation and independence.

HIV/AIDS (93.8 percent) seem to affect participation more compared to other determinants. The data also shows that HIV/AIDS has no influence on the active ageing indicator of self-fulfillment. In other words, one's report that they are affected by HIV/AIDS or are taking care of HIV/AIDS orphans does not in any way affect whether they would live self-fulfilled lives.

Much of what has been discussed here is not conclusive and the following section gives statistical tests of the influence of each of the proxy measures of determinants of active ageing on indicators of active ageing.

4.4.9c.2 Influence of Determinants on Active Ageing

In order to measure the influence of each of the determinants on indicators of active ageing, a multiple regression model was used. All outcome and Independent variables remained as they appear in the descriptive table above (table 2.4). Details of these relationships are shown in table 2.5.

Table 2.5 Multiple regression results showing the influence of determinants of active ageing on active ageing indicators

Determinants of Active Ageing		Selected Indicators of Active ageing			
			Self		
	N	Participation	Fulfillment	Independence	Dignity
Gender	690	-0.0312	***0.1070	*0.0759	0.0497
Culture	690	**0.0755	0.0250	*0.0863	0.0794
Personal/Behavioural					
"Feels" Hopeless	210	*0.0762	-0.0664	-0.0101	-0.1470
Useless	191	*+-0.1305	*0.0793	**-0.1727	0.0317
Unhappy	311	-0.0062	-0.0030	-0.0751	0.0481
Lonely	364	*-0.0601	0.0340	0.0048	-0.0566
Health/Functional					
Ill past 12 months	433	-0.0204	0.0077	0.0086	0.0382
Can squat	487	0.0392	-0.0326	***0.2559	0.1806
Walk freely	522	-0.0274	0.0161	0.0486	0.0384
Clean house	499	***0.1163	-0.0098	*+0.1246	0.0043
Economic					
Work past 12 months	86	-0.0186	-0.0530	0.0237	-0.0265
Opp/work/income gen	176	0.0172	-0.0082	*0.0860	0.0974
Monthly income	158	*0.0681	**-0.0781	***0.1690	-0.2300
Social					
Has caretaker	417	***-0.0938	,-	***-0.2081	,-
Living with anyone	523	0.0358	,-	**0.1600	,-
Interact with peers	480	***0.1499	,-	***0.1732	,-
Receives support	176	-0.0325	,-	**-0.1113	,-
HIV/AIDS					
Keeps Orphans	293	**0.0690	-0.0033	***0.1405	,-

****P< 0.0001 *P<0.05 **P<0.01 *+P<0.001*

Opp/work/income gen >= opportunity for work or income generating activity

Associations in the table show that gender determines active ageing indicators of independence ($p<0.05$) and self-fulfillment ($p<0.0001$). However, there is no statistical association between one's gender and active ageing indicators of participation and dignity. Reasons for this finding are unclear; but most likely, it is possible that in the Zambian for anyone to participate in any activity – going to church for example and also for one to enjoy dignity, one's gender is not a factor. On the other hand, culture has no bearing on older people's dignity and self-fulfillment, but is statistically associated with both participation ($p<0.01$) and independence ($p<0.05$). Reasons for this finding can only be speculative, but suffice to say that for anyone older person to enjoy

dignity or even feel self-fulfilled, they do not have to be of certain cultural orientation; in other words, culture could inevitably engender both dignity as well as self-fulfillment.

Personal/Behavioral determinants of active ageing are statistically related to active ageing indicators of participation, self-fulfillment and independence. In this example, almost all measures of personal/behavioural determinants are related statistically to the active ageing indicator of participation (hopeless = $p<0.05$; useless = $p<0.001$; lonely = $p<0.05$) except for that of "being unhappy". In other words, there is no relationship between being unhappy and being able to participate in community or society's activities. In the same way, the relationship between the personal/behavioural determinant indicator of "feeling useless" is statistically significant with both the active ageing indicators of self-fulfilment ($p<0.05$) and independence ($p<0.01$). Given these results, it is clear that the main problem in as far as older people are concerned is low self-esteem. This low self-esteem inhibits their full participation in several activities happening at either community or society level.

The active ageing framework proposes that health and functional abilities have substantial effects on ageing in general. Results in table 2.5 show that the there is no relationship between the respondent's report of being "ill in last 12 months prior to the study" and any other indicator of active ageing. This finding is quite contrary to propositions in the active ageing framework, where health is a key determinant. However, this may mean that ill health may only affect active ageing if and when it is experienced over a long period of time. Functional ability of being able to "clean the house" is statistically related to the active ageing indicator of "participation" ($p<0.0001$) and independence ($p<0.001$); while the functional ability of "being able to squat" is only significant with the active ageing indicator of "independence" ($p<0.0001$). In other words, while health affects how older people age, this relationship can best be measured by a life course approach and is more factual when it relates to actual physical abilities where older people have to perform functions requiring more physical exertion, rather than just the report of being ill for certain

periods. As a result, while it could be argued that health is a significant challenge in old age, the effects it has on the actual active ageing process is minimal except where one has lifelong or chronic health challenges such as hypertension, diabetes etc.

Economic determinants are also said to have a bearing on the active ageing process. However, the economic determinant indicator of whether or not someone "worked in the last 12 months prior to the study" has, according to results in table 2.5, no statistical relationship with any of the active ageing indicators associated with active ageing. In the same way, the economic determinant indicator of "having opportunities for work or income generating activities" has no bearing on almost all active ageing indicators except that of independence ($p<0.05$). This result suggests that respondents' report on having or not having opportunities for work and/or income generating activities affects mostly their independence. The main economic determinant indicator influencing participation, self-fulfillment and independence significantly is "monthly income". In fact, respondents' report of having a steady "monthly income" affects their participation ($p<0.05$), self-fulfillment ($p<0.01$) and also their independence ($p<0.0001$). While the relationship between income and active ageing indicators of participation and independence is positive, the relationship between income and self-fulfillment is actually negative (coef = -0.0781) meaning therefore that lower income is associated with low self-fulfillment in our context.

Apart from the forgoing, table 2.5 also shows relationships between social indicators of determinants of active ageing and active ageing indicators. Data in this example suggests that self-fulfillment and dignity are not in any way affected by social determinants in the active ageing framework. However, all, except for two of the measured indicators of social determinants of active ageing (living with anyone and receiving support) seem to affect significantly the active ageing indicators of participation and independence. Participation is statistically affected by whether or not a respondent has a caretaker ($p<0.0001$) and whether or not a respondent interacts with peers ($p<0.0001$); these

relationships are quite strong. In the same way, the active ageing indicator of independence is significantly related to all social determinants of active ageing with "having a caretaker" ($p<0.01$) and "receiving support" ($p<0.0001$) having a negative relationship.

Lastly but not least, our study looked also at the effect HIV/AIDS is having on active ageing. This situation is not proposed through the active ageing framework but thought through to have a significant effect on active ageing. The main indicator for the presence of HIV/AIDS amongst the study group was a question on whether or not they were keeping orphans. Data in table 2.5 shows that HIV/AIDS is statistically related to the active ageing indicator of participation ($p<0.01$) and independence ($p<0.0001$). However, the data suggests that HIV/AIDS has no bearing on one's self-fulfillment and dignity. In other words, old people's report that they keep orphans affects how they participate in community activities as well as their independence. What this clearly shows is that older people keeping orphans are not as independent to be able to do what they want and whenever they want because they have to take care and look after orphans. This, as we have seen already, is a serious and daunting challenge affecting older people in Zambia and other African countries where the HIV/AIDS pandemic is highly pronounced.

In summary, data in table 2.5 suggests that indeed, active ageing is a function of most of the determinants proposed in the active ageing framework or model. Even with the presence of HIV/AIDS, the relationship with indicators of determinants of active ageing and indicators of active ageing itself is quite strong and in many instances statistically significant.

Discussions above may not be conclusive. As a result, for the study to accurately establish which of the determinants of active ageing are more significant, and also to establish "pathways" affecting active ageing significantly, we generated a composite variable compressing all indicators of active ageing into a variable called "Active Ageing".

The input variables for all or most of the indicators of active ageing were generated by “Yes” and “No” responses. For example, for us to investigate whether any respondent was “participating” in community activities, we asked them to confirm (yes) or disapprove (no) whether they were given chances to participate in community activities such as going to church; being given positions of authority; being considered to heard community groupings etc. Any “Yes” response to such a statement meant that a respondent was participating while a negative outcome meant the opposite. This process was followed through for other indicators of active ageing - self-fulfillment, independence and dignity. In order to finally come up with the outcome variable of “Active Ageing”, all “Yes” responses to the preceding conditions or questions meant a respondent was enjoying active ageing while “No” responses meant the opposite. This process, we believe gave us a demonstration of determinants of active ageing and their pathways with significance influences on active ageing relating to Zambia. Table 2.6 shows multiple regression results of indicators (or pathways) of determinants of active ageing and active ageing as a single outcome variable.

Table 2.6 Multiple Regression Results showing the influence of determinants of active ageing on active ageing

Determinants of Active Ageing	*N*	Active Ageing	Beta Coef.	R Squared
Gender	690	-0.0070	-0.0173	
Culture	690	***0.0923	0.1796	0.0320
Personal/Behavioural				
"Feels" Hopeless	210	*0.0517	0.1189	
Useless	191	***0.0965	-0.2156	0.0389
Unhappy	311	-0.0307	-0.0765	
Lonely	364	-0.0137	-0.0343	
Health/Functional				
Ill past 12 months	433	-0.0194	-0.0474	
Can squat	487	*0.0438	0.1005	0.0415
Walk freely	522	-0.0054	-0.0116	
Clean house	499	**0.0564	0.1263	
Economic				
Work past 12 months	86	-0.0156	-0.0257	
Opp/work/income gen	176	0.0199	0.0432	0.0109
Monthly income	158	*0.0402	0.0843	
Social				
Has caretaker	417	**-0.0614	-0.1409	
Living with anyone	523	0.0413	0.0615	
Interact with peers	480	*+0.0754	0.1359	0.0499
Receives support	176	-0.0303	-0.0641	
HIV/AIDS				
Keeps Orphans	293	**0.0496	0.1151	0.0132

****P< 0.0001 *P<0.05 **P<0.01 *+P<0.001*

Opp/work/income gen >= opportunity for work or income generating activity

Table 2.6 shows that gender does not influence active ageing, even if it does influence some individual indicators of active ageing (table 2.5). This finding defies propositions given in the Active Ageing Framework where gender is an overarching variable influencing active ageing in general. While this finding may be unique to Zambia and possibly difficult to explain why, this could be an avenue for further research. Culture, however influences active ageing significantly ($p<0.0001$; Beta=179); confirming also what the active ageing framework proposes; It should also be noted that actually, even after controlling gender against culture and vice versa, the relationships between gender and active ageing on one side and culture and active ageing on the

other, remained the same – gender does not influence active ageing while culture does significantly. However, the Pseudo R2 is not very strong (32 percent). Simply meaning that, while it is true that culture influences active ageing, this association is not very strong. To some extent, this revelation marries well with the Active Ageing Framework assumption stating the uncertainty with which one can predict or point out direct causation of anyone determinant on active ageing (Active Ageing Framework pp. 19). It is also suggested that more research is needed to clarify and specify the role of each determinant, as well as the interactions between determinants in the active ageing process. In fact, the framework proposes that for such studies, a life course approach is required so as to take advantage of transitions and "window of opportunity" for enhancing health, participation and security at different stages (Ibid pp. 19-20).

Results in table 2.6 also show that amongst personal/behavioural determinants of active ageing, only feelings of "hopelessness" ($p<0.05$) and that of "uselessness" ($p<0.0001$) explain variations on the outcome variable of active ageing. Actually, this model predicts that feeling useless is negatively related to active ageing (Beta=-215). Other indicators of personal/behavioural determinants of active ageing have no bearing on the process of ageing in general.

In the same way, health and some functional disabilities do not affect active ageing. However, ability to squat ($p<0.05$) and clean the house ($p<0.01$) affect older people substantially and this relationship is statistically significant. In terms of economic determinants, the model suggests that only "having a steady monthly income" ($p<0.05$) affects active ageing and this relationship is statistically significant. Other measures or indicators of economic determinants have completely no bearing on active ageing.

Our model also suggests that the major social (determinants) contributors to active ageing, which are statistically significant are "having a caretaker" ($p<0.01$) and "interacting with peers" ($p<0.001$). Others, such as "living with

other adult children" and "receiving any form of support" do not affect active ageing as far as the Zambian context is concerned. In the same way, HIV/AIDS, a special situation prominent in Africa and Zambia in particular, is significantly associated with active ageing ($p<0.01$). Even after controlling for other determinants (already discussed), the relationship between HIV/AIDS and active ageing still remained statistically significant. This is a confirmation that HIV/AIDS is a serious challenge in old age and has significant bearing on the active ageing process in Zambia.

SUMMARY OF PART III

Using data derived from this extensive investigation of challenges and determinants of active ageing, it is clear that in the Zambian context, culture, personal/behavioural determinants relating to "feeling hopeless and useless", health/functional determinants relating to ability "to squat and cleaning one's house", economic determinants relating to "whether one has a monthly income or not", social determinants relating to "having a caretaker and interacting with friends or peers" as well as HIV/AIDS, influence the active ageing process significantly. What is clearly different in these findings is that unlike the active ageing framework, our study confirms that in the Zambian context and also in countries with a generalized HIV/AIDS pandemic, active ageing will for a long time be affected by HIV/AIDS; this we believe is not categorical in the active ageing framework.

PART IV PUBLIC POLICY

4.5 Adequacy of the Draft Policy on Ageing in Zambia

Zambia, like most countries in Africa, has recognised the need to make practical interventions on ageing. This is evidenced by a variety of international and regional policy instruments that have been ratified, domesticated and used to guide and support Zambia's policies and programmes addressing needs or challenges for the elderly people. These have included, among others, The

United Nations Principles on Ageing, The Madrid International Plan of Action, African Union Policy Framework, and the Plan of Action on Ageing.

This section focused on the draft policy on ageing in Zambia and how adequate it is in terms of reflecting UN principles on ageing (1991) and the WHO Active Ageing Framework (2002).

While it is true that the Government of Zambia has drafted a policy on ageing, the policy has not yet been ratified by Cabinet and, therefore, is still non-functional. However, it was subjected to analysis in our study because it is a substantive pre-curser of the policy to be ratified and later implemented by government through the Ministry of Community Development, Mother and Child Health (MCDMCH).

In 1991, the United Nations came up with eighteen principles on ageing which were meant to facilitate the '*addition of life to the years that had been added to life'*. These principles became the *modus operandus* and mirror for any policy formulation at global, regional and national level. In order to make these principles workable, the World Assembly on Ageing of 2002 re-emphasised the need for National Governments to operationalise and domesticate them through the Madrid Plan of Action.

The eighteen UN Principles on Ageing have been broadly categorised to include the following: Independence, Participation, Care, Self-fulfillment and Dignity.

According to both the Minister and Permanent Secretary at MCDMCH (Ministerial Briefs, 2010), a number of processes were followed and consultations made before the final draft on ageing was written. The Permanent Secretary stated that:

> *'The preparation of the National Policy on Ageing was preceded by a series of consultative workshops with stakeholders to put together all the views and identified gaps to be addressed by this policy. The spirit of consultation was very useful in the finalisation of the policy'* (Draft policy, 2008)

Stakeholders involved and consulted during the drafting of the policy included among others, the following: Government line Ministries, Non-Governmental Organisations and Cabinet Office (PAC); others are the Retirees Welfare Bureau of Zambia, Senior Citizens Association of Zambia, Zambia Aged People's Association and HelpAge International.

The Government of Zambia saw the need to come up with a National Policy on Ageing as urgent because absolute numbers for older people at global and regional levels were increasing (Second World Assembly on Ageing, 2002). What became eminent, therefore, was to link ageing to social and economic development, as well as human rights (Draft Policy on Ageing, 2009).

In view of the foregoing, the National Policy on Ageing was seen as a reflection of Government's intention to uplift the standard of living of its ageing population in general and life in old age particularly. It was a tool for providing guidelines for changing, maintaining and creating living conditions that were conducive to the ageing population so that Zambians would be able to age with dignity and honour (*Ibid,* 2009).

The Draft National Policy on Ageing is based on Vision 2030 objectives (Zambia should be a middle income country by 2030), where government would want to see *'People Ageing with Dignity by 2030*'. The policy is also anchored on evidence from studies conducted by government and non-government agencies such as the Central Statistical Office, Ministry of Finance and HelpAge International. The rationale is premised on the following assumption:

> *'Older persons of today are faced with conditions of extreme poverty, added burdens of being care givers and bread winners due to the effects of HIV and AIDS, abuse, stigma as being advents of witchcraft and misfortune and generally as a nuisance to society. In addition, older persons have been marginalised from many developmental interventions and access to means of production. As such the lives of older persons have been difficult at the stage in life when they are supposed to be enjoying old age. Furthermore, the lack of* programmes *to prepare citizens for life in old age has contributed to the difficulties being faced by older persons of today'* (Ageing Policy Draft – Zambia, 2009).

Given this assumption, the rationale for the National Policy on Ageing was based on ensuring that:

(i) Government addresses challenges faced by elderly persons;

(ii) there is a regulatory framework to guide both government and non-governmental organisations in addressing issues of the aged;

(iii) the policy would be the legal justification to allocate more resources to issues of ageing and finally; and

(iv) International conventions on ageing are or will be domesticated.

In order to pursue this rationale, government came up with 'Guiding Principles' to help in the drafting of the policy. While there is a great deal of democracy in policy development, it is always important that countries have a point of reference, especially in terms of domestication of policies and programmes. Ideally, it is expected that the UN Principles on Ageing and the Madrid Plan of Action should basically be the 'guiding principles' for all policies on ageing, however, in some cases, countries choose to adopt what is relevant to their situation and Zambia is not an exception. The following principles have been adopted in the draft policy on ageing:

Participation: Older persons have the right and duty to actively participate in the economic, social, cultural and political affairs of the nation as well as in the formulation of policies affecting them.

Dignity, Security and Freedom from Exploitation: All Zambian citizens are born free, equal in dignity and rights. They are entitled to all the rights and freedoms contained in the Bill of Rights as enshrined in the Republican Constitution.

Family and community care: Older persons should benefit from the care, support and protection provided by the family, community and government.

Partnership: As the provision of care and support to older persons is an enormous task that requires the involvement of all key stakeholders, Government should further embrace partnerships and collaborate closely with the private sector, civil society, cooperating partners and older persons themselves in addressing the needs of the ageing population.

Availability and Accessibility to Basic Needs: Older Persons should have access to food, water and sanitation, proper shelter, clothing, health care, work and other income generating activities, education and training and life in safe environment.

4.6.5 Objectives, Measures and Implementation Strategy for the Policy on Ageing

The draft Policy on Ageing has one major objective and several other specific objectives stated as themes. It also provides measures to operationalise these objectives, including specific roles to be undertaken by all line ministries as well as Cabinet. The policy highlights roles of civic and non-governmental organisations in the implementation of policy objectives. The main objective states:

> *To promote, protect and fulfill the rights of persons in order to ensure that they lead a productive, fulfilled and dignified life in old age.*

The following specific objectives, also referred to as sub-themes, take or took precedence:

- Poverty eradication;
- Employment and Income Security;
- Health, Food and Nutrition;
- Housing, Transport and living Environment;
- Gender;

- Rights;
- Research, Information, Education and Training;
- Family; and
- Social Welfare

Each of the stated specific sub-themes (objectives) has other sub objectives and measures for implementation. Clearly, some objectives reflect recommendations suggested by the UN Principles on Ageing and the 2002 Madrid Plan of Action report. For example, fighting poverty and advocating for the rights of the elderly are some of the objectives appearing in both the Zambian draft Policy on Ageing and the 2002 Madrid Plan of Action on Ageing.

Under the Poverty sub-theme, the draft policy seeks to ensure that poverty among the people of Zambia reduces dramatically and more especially among elderly persons. It is also intended to show that policies on poverty reduction are cognisant of needs of older people, which may require different strategic efforts.

While this sub-theme aims at fighting poverty, especially among older people, some of the objectives and the proposed measures are not clearly stated. For example, objective (c) states: to ensure [that] socio-economic reforms which result in people being separated from employment [do] not cause mass destitution; and the measure to achieve this objective states: engage older people in consultative processes on issues that affect them (draft policy on ageing, 2008: 17). In this form, therefore, it is difficult to point with clarity the relationship between the expressed objective and the measures proposed to achieve it.

The sub-theme on Employment and Income Security has three objectives and four measures. According to the draft policy, employment and income are closely related to poverty – the assumption being that when one is not employed and has no income, one may most likely experience poverty or may be poor. The two objectives resonate with the intended measures. Under the

same sub-theme, the policy advocates for a deliberate policy to create jobs specifically for older people.

Health, food and nutrition are presented under one sub-theme whose main objective is to establish a national health insurance for all citizens, but particularly health services that are open to specific requirements of older persons. It further states that government would develop curricular to improve nutrition and health for older people. This would be achieved through formation of partnerships with interested organisations and by ensuring that older people have access to health insurance. The policy does not provide practical examples and mechanisms of how such a system would work. While it may not be possible to outline all procedures in one policy document, the mere statement of intent without a clear description of how the scheme would work is not very helpful.

The draft policy documents intent by government to help elderly people access housing, transportation and also to live in an environment that is responsive to their needs and requirements. This aspect is also clearly lucid in the Madrid Plan of Action on ageing (2002).

Other objectives include the recognition of the family in the care of the elderly, strengthening the social welfare system and promotion of research, information, education and training.

Discussions above clearly show that the draft policy on ageing is quite comprehensive. However, a few observations may suffice. Any policy, as expected, should aim at providing guidance in the formation of other more specific programmes and projects to facilitate quick and focused implementation. Frankly, while the objective of this study is not to discuss implementation of policies and programmes, it is important to highlight that this policy will take even longer to fulfill. This is so because there is no strategic plan in place.

Similarly, observations on some of the objectives in the draft policy suggest that there is no clear relationship with measures intended to achieve them. Consequently, this may prove difficult to implement as a result. For example, the draft policy advocates for the creation of employment for older people. While this sounds good, it may not be possible, let alone adequate. The policy does not highlight, for example, categories of jobs to be created which would specifically serve the aged alone – in fact, technically, it is very difficult and almost impossible to have jobs which can only be done by people of a certain age group. In addition, the objective in question falls short of current debates and interrogations on ageing at the international scene level. The 2002 Madrid Plan of Action Report states that older people should be re-integrated in society – not necessarily creating a separate empire for them. The objective in question is also problematic, to say the least; firstly, creating jobs specifically for older people may interpreted to mean that older people are incapable of doing what other age groups are capable of doing - thus receiving special "handicapped" treatment; secondly, creation of jobs should be for all citizens as long as they are willing and able to offer the needed labour. This will and can help integration and blending of the old and the young – engendering an ideal society accommodating all ages.

The policy also suggests that elderly people should have access to health insurance schemes. This objective is very critical because some ailments afflicting the elderly require specialised interventions. However, it is a known fact that health insurance is based on monetary contributory terms. In any case, some of the objectives under the health thematic area are also outlined in the health policy where people aged sixty-five years and above access medical services free of charge. The challenge is that some of the services being accessed may not provide specialised geriatric services for older people; this is because currently, training in medicine is concentrated on Primary Health Care and not so much special areas like geriatrics.

Another aspect the policy addresses is housing. The policy proposes the need to provide housing to the elderly. It emphasises prioritisation of housing provision for the elderly. While this objective is well intended, it may be a challenge to achieve and implement because it will be exigent to convince stakeholders in housing schemes to give priority to older persons while there are other interest groups which could be needier than the group in question**.** The youth, for example, would argue that they actually need more opportunities to have access to housing than the elderly do. In this respect therefore, housing should be viewed as a national problem, which requires a holistic approach.

Given the fact that much of ageing in Zambia should be explained and implemented through the Draft Policy on Ageing, it is imperative that it also addresses all or most of the issues which could be missing even when clearly, it is apt in so far as ageing is concerned. For example the draft policy should be "allowed" to incorporate other policies which in this case seem to be replicas of what the draft policy proposes. For example, policies such as the Social Cash Transfer Scheme and the Public Welfare Assistance Program should be merged into the policy on ageing.

In the same way, the draft policy on ageing is silent on the role of the family on ageing. In view of this, the policy on ageing should be re-cast to provide avenues to propel a paradigm shift advocating the placement of the family as a powerful alternative to government interventions on ageing. This, we believe will help promote active ageing through family unions and re-unions and inevitably improve self-esteem through peer and family interactions (significant social determinant/s). In this example, the family should be strengthened, encouraged and empowered to continue playing its known traditional role of taking care of vulnerable groups including the elderly by both government and other interested institutions such as the church and NGOs. This could be done through sensitizations, workshops, media programmes etc to spring messages

that enable the family realize this important role of taking care of their older relatives. This will inevitably strengthen the (draft) policy on ageing in Zambia.

SUMMARY OF PART IV

In summary, the Draft Policy on Ageing is the sole model document addressing almost all concerns on ageing; this is so because it has been aligned to both the UN Principles on Ageing and also the 2002 Madrid Plan of Action. What the draft has attempted to achieve is basically document all or at least most of the recommendations in the two international protocols and relate them to the Zambia situation or simply, domestication. It is also important to point out that the draft policy on ageing is a detailed and comprehensive document which, if implemented, would not only be adequate in representing issues of ageing but also help solve or address most of the challenges of ageing in Zambia. Whether or not the policy can be implemented is not subject to discussion in the current study as this may prove ambitious and presumptive. What is critical to acknowledge, however, is that in the current format, the draft policy, if actualised is adequate in fulfilling requirements of the UN principles on ageing. However, much of this will be more profound if or when it takes cognisant of the role of the family on active ageing in general. This is the proposition based on findings in this study.

CHAPTER 5: SUMMARY, DISCUSSION AND CONCLUSION

The main objective of the present study was to investigate demographic trends of population ageing as well as challenges of ageing in Zambia. Specifically, the study investigated past and future trends in population ageing; examined challenges faced by older people as well as determinants of active ageing proposed through the active ageing framework; and lastly, examined the draft policy on ageing in Zambia.

5.1 Summary of Main Findings

5.1.1 Demographic Estimates and Projections

Developing regions will experience rapid population ageing in the near future. While the number of older people, 60 years and above will remain static proportionally, the absolute growth will be significant (Kinsella *et. al.,* 2005). In the same way, Zambia is also currently experiencing population ageing. Projections in our study have shown that the growth rate of people aged 60+ is ranging between 2.5 and 3.3 per cent per annum for the period 2000 to 2015. From 2020 to 2050, the population of older people will grow between 2.5 and 5 per cent per annum respectively. By 2050, there will be approximately 38 million people in Zambia and about 8 per cent or 3,040,000 of these will be aged 60 and above. In general terms, although Zambia's population will remain predominantly young, the number of older people will continue growing.

5.1.2 Challenges and Determinants of Ageing

The study has highlighted the many challenges older people are facing. At individual or micro level, the main challenges older people reported include: health problems and increases in the number and frequency of health related ailments; increases in functional limitations with female respondents reporting more compared to males. One of the main findings at individual level was that of low self-esteem and loneliness.

There were also a number of challenges reported classified as 'macro level challenges' or problems older people face due to the socio-economic as well as demographic environments. For example, very few respondents reported that they were working. In fact, results show that they have very few opportunities for work. In terms of care, the family plays a major role although there were cases of respondents who live alone. Respondents also reported very few social interactions amongst themselves, their relatives and also with community members. In terms of material and monetary support, the situation was the same. Older people reported low support from relatives, community, government and other interest organisations such as the church. Lastly, older people are also faced with challenges of looking after or caring for orphans and other dependent children.

In terms of determinants of active ageing – as proposed by the Active Ageing Framework – our study found that in Zambia, Culture, personal/behavioural determinants, health/functional determinants, economic determinants and HIV/AIDS as a determinant have significant influences on Active Ageing in general.

5.1.3 Policies and Programmes on Ageing

Basically, several policies and programmes exist in Zambia. Through literature review, we looked at a few and they include: population policy, health policy and the labour and national employment policy. We also looked at long-term policies such as the fifth and sixth national development plan and vision 2030. In addition, the study also reviewed other programmes currently being implemented by government. These include the Public Welfare Assistance Scheme and the Social Cash Transfer Scheme. However, the main focus was to examine the draft policy on ageing and how it reflects UN Principles on ageing in general.

5.2 Discussion

Given the findings in this study, what, therefore, are the implications? Findings in this study have several implications. Some of them may require a paradigm shift in the manner ageing and older people are currently looked at.

Information or data on projections has indicated that the number of older people will continue rising. This situation is prevalent in most developing countries of which Zambia is also part (UN Population Division, 2000; National Research Council, 2000). Consequently, the need to plan for older people especially in the near future cannot be overemphasised. This situation calls for measures to ensure older people live lives far from ridicule and are guaranteed optimisation of opportunities for health, participation and security, to enhance quality and active ageing (WHO, 2002).

Several challenges, classified as individual or micro level, were reported by respondents. As people age, they come face to face with health problems, functional limitations and they generally have quite low self-esteem. This situation has been revealed not only by our study but by other studies as well (Gorman, 2002; National Research Council, 2001; Palloni, *et al* 2002; Restrepo *et al* 1994). This situation, therefore, calls for intervention in terms of health

services provision to help mitigate or delay the onset of health problems in old age. In fact, one of the United Nations principles on ageing states that:

> *Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness* (WHO, 2002)

Health problems – such as high blood pressure and general body pains - and functional limitations – such as inability to walk properly and squat - in older people are more prominent and more pronounced amongst females compared to males. These results are consistent with other studies as well. For example, in a study on interactions between socio-economic status and living arrangements in predicting gender specific health status among the elderly in Cameroon, Kuate-Defo (2006) found that significantly higher proportions of female respondents reported being in poor health, having functional limitations or both than male respondents. In the same study, results indicated that older respondents (70+) who were not working reported significantly poor health and functional limitations compared to those who were a little younger and in employment. These variations could be emanating from several causes. However, as Kuate-Defo puts it, these discrepancies, which seem to especially disadvantage females, may be explained by certain socio-economic status relative to males. For example, it is true the world over, and especially in developing countries like Zambia, that males are better educated than females, better placed to work than females, and are sometimes more exposed to better opportunities than females. These aspects contribute significantly both to the poor health status and functional disabilities of older people.

Apart from health problems and functional limitations, the study examined self-esteem and loneliness as well. Self-esteem is important for active ageing and is also one of the most important psychological/Behavioural or Personal tenets proposed by the 2002 WHO Active Ageing Framework. Self-esteem provides insights on people's psychological well-being and is important in aiding or ailing the process of ageing. Some of the self-esteem proxy indicators

used in this study have also been used in other studies (Knodel, 2007). They include self-reported feelings of hopelessness, uselessness, unhappiness and loneliness. In general, our study found that respondents have quite low self-esteem and are generally lonely. These findings also show that, self-esteem and loneliness are determined by the socio-economic, demographic and regional variables existing in communities where older people live.

The socio-economic, demographic and regional variables affecting self-esteem and loneliness amongst respondents pose significant challenges. Suffice to say, they indicate inherent structural, social and economic differences existing between the social strata in question. For example, people in rural areas have very few choices to make in terms of entertainment. In fact, there is close to zero entertainment facilities available in rural Zambia, explaining why elderly people in rural areas report greater loneliness compared to urban areas. By the same token, feeling useless comes about probably due to perceived definitions of the elderly by society. Whereas society may feel obligated to 'spare' old people from certain important activities and assign them to 'lesser ones', the old may feel resigned to very low, unimportant activities. In some instances, their roles are confined to caring for the very young and the sick and their importance is only recognised when needed to perform functions considered unimportant. For example, since there is superstition associated with funerals, they are mostly relegated to older people and it is in such instances older people's roles and opinions become important. These factors may not satisfactorily explain the negative feelings. Some explanations provided through the FGDs, confirmed the low self-esteem of the elderly, and this definitely affects how actively they age. Low self-esteem is also at variance with the UN principles on ageing since such a state does not support participation and to some extent reduces the feeling of being a dignified member of society.

Other challenges, classified as socio-economic and environmentally driven and which manifest themselves in low self-esteem were also reported extensively by respondents in the study; they include access to work and opportunities

available for older people to work, challenges associated with care, living arrangements, social contacts, material and monetary support and the burden of orphan care and support.

Findings concerning work show that very few respondents were working or had worked twelve months prior to the study with majority reporting that the main reason for not working was due to their age. In this example, it is not unusual to find people at this age not working. In fact, most of them, by Zambian standards, would have reached retirement age. However, there is no data for Zambia in this area to make intelligent comparisons and analysis. In the same way, older people have very few or no opportunities for work. Implications of this finding can be viewed from two perspectives. Firstly, if people cannot work or have few or no opportunities to be employed, it means they will have less access to income and this, therefore, builds more on the challenges they already have. Secondly, the finding shows departure from the United Nations stipulations where older people are expected to be given opportunities to work and should, on their own also determine when to disengage from active employment. Clearly, this is not the case in our study and certainly infringes on active ageing principles.

On the other hand, the study found that access to income or availability of income is very limited amongst older people. Ideally, apart from respondents themselves, older people are expected, under normal circumstances, to be helped financially by family members or spouses or indeed any member of society. This, however, is not the case. In this example, very few (7 per cent) respondents received income from children or relatives. This situation suggests that there is some degree of erosion of traditional support systems for older people in Zambia as well. In the same way, whereas other studies found that spouses are reliable sources of income, it is not so in our study. In comparison, it was found that close to half (47 per cent) of Thai married elderly women reported that their source of income was their spouses; for married elderly men, at least one in three (30 per cent) stated that spouses were their sources

of income (UNFPA, 2008). Similarly, while vulnerable people such as the elderly receive what is called 'elderly allowance' in middle income countries, there was no evidence of this allowance in our study. In Zambia, the Ministry of Community Development and Social Services has policies to provide income to people they consider vulnerable. However, these policies seem inadequate and probably not widespread. In any case, this again is a loadable contrast to other studies where older people have elderly allowances (Knodel, 2008).

The socio-economic challenges investigated also involved looking at the quality of living conditions of the elderly, especially their housing conditions. Findings indicate that at least close to four in ten of respondents feel or felt their housing unit was worse off compared to others. The comparison in question may not be taken in isolation and is subject to many interpretations. However, this may show levels of dissatisfaction amongst the elderly if and when they compare their lives to those of their neighbours. It could be deduced that a large number of elderly people in Zambia feel that their lives and lifestyles are worse off compared to others in the same community. Subsequently, such feelings affect their self-esteem and as a result, they do not age actively contrary to United Nations Principles on Ageing.

Looking further at macro level or environmentally determined challenges facing older people, it is a fact that most of them, if not all, have more to do with how they are cared for, how they are living, how they are materially and socially supported by family and friends, and also how they are coping given the socio-economic environment prevailing. These factors contribute greatly to the process of ageing and determine whether older persons would age actively or not.

The Active Ageing Framework (WHO, 2002) and UN Principles on Ageing (UN, 1991) propose that support, opportunities for education and lifelong learning, peace, and protection from violence and abuse, independence, participation and self-fulfillment are key factors that can enhance a dignified ageing process. These features may be enhanced if the elderly are cared for properly, live in

supportive and conducive environments, have health and frequent social contacts with both family and peers and are able to cope with minimum difficulty in the absence of support from families, institutions or well-wishers.

In terms of care, our study reveals that the family is still important in taking care of older persons. This is also consistent with some of the studies conducted in South East Asia where care for older people is still attached to the family (Knodel, *et al* 2007). However, as for most developed countries, the situation is different – care for older people is highly institutionalised (Low, 2002/2003). In the same way, the study has established that few (one in ten) older people still live alone and the trend shows that the older one was or is, the more likely that they were living alone. While it could be argued that the proportion of older people living alone in our study is quite low comparatively, it is, however, a little out of the ordinary for the 'very old' (80+) to be staying alone. In fact, in many African traditions, Zambia inclusive, the probability of finding older people living by themselves is almost zero. Living alone could be due to one's choice or one may have no children/relatives or in some cases they may have been suspected of practicing witchcraft and, therefore, 'forced' to live alone.

Another aspect investigated in our study was how older people interacted with their peers, the community and the family. Interactions in this respect were aimed at measuring social contacts. It is argued in literature and also amplified by our conceptual framework – the Active Ageing Framework – that inadequate social support is associated not only with an increase in mortality, morbidity and psychological distress of older people but also decreases their general health and well-being (WHO Active Ageing Framework, 2002: 28). What the framework does not provide, however, is the definition of 'inadequate social support'. Simply put, while it is accurate that social support is indispensable in the active ageing process, it is not clear what really amounts to 'adequate social support'. Interactions with close family members were average (38.6 per cent); however, one striking finding suggests that contact or interactions between

children and their parents decreases with age. There seems to be no clear explanation as to why this is so, however, it is possible that migration may be playing a significant role, and it is also possible that as children age, they consider their situations to be similar to their parents. Results also show that frequency of interactions with peers decreases with increasing ages of respondents. This could be due to mortality experiences within similar cohort/s, leading to more isolation. Or simply, the dying of peers from the same cohort necessarily engenders fewer contacts in that cohort and this may foster more isolation for surviving members. These results indicate that there is/was minimal interactions with their peers and to some extent their relatives and children and this, may explain the low self-esteem they experience.

Another very important component of the challenges facing older people is material support. It has been documented in this study and others as well that support for older people has lessened in recent years. Undoubtedly, respondents also confirmed that despite them being recipients of forms of support, such is actually very minimal irrespective of the source. However, it should be noted that rarely do people consider support in 'kind' as really support in reality. In fact, people consider monetary support to be appealing, and when rendered, people easily refer to it. Similarly, it is possible that when the question on support was asked, respondents were biased towards monetary support rather than other forms available as well. The aforementioned discussions are tentative and probably not very satisfactory; in our study however, for whatever form of support, results show that it was minimal and a possible source of low self-esteem.

Our findings indicate further that institutional support is almost non-existent except for such provided by either the Church (20 per cent) or Community Groups (10.2 per cent). Male respondents benefited more from institutional support compared to females. The reason for this disparity is unclear, suffice to mention, however, that it is possible that males may be more active in local organisations or community programmes than females, or organisations could

be working on the basis of family involvement rather than individuals, and, due to the cultural and traditional setting, males necessarily dominate. Differences in education levels also (between males and females) give males better information and opportunities, thereby getting more benefits compared to females. Whatever the case, it is obvious that support by institutions is also quite minimal and a source of concern in old age.

Another challenge investigated was in line with older people caring for orphans and vulnerable children. Our study findings confirm what has been written extensively in literature on the effects of HIV/AIDS on older people as well. What is clear also is that the burden of orphan care, if not supported by other means such as family or institutions, mostly works against active ageing, since most times the carer is almost always stressed due to pressure to look after the orphans. What we have seen in our discussion above is that older people have quite little or no support and HIV/AIDS is just one other aspect exacerbating their problems.

The absence of support from families, institutions or well-wishers has inevitably forced some of the older people to engage in other survival strategies. This reaction has also been supported by studies conducted in some other African countries (Mutangadura, *et al* (eds.), 1999). In our study, older people resort to begging (50 per cent), farming (29.7 per cent) as well as brewing illicit or illegal alcohol or *kachasu* (20.2 per cent). Begging is a huge source of low self-esteem because the act or procedure is also embarrassing especially for older people. While there is nothing sinister about farming, brewing *kachasu* is illegal but is considered one of the easiest forms of coping strategies. This is so because brewing *kachasu* requires little amounts of capital and has readily available customers. While it is difficult to place illicit alcohol brew within the active ageing framework and the UN principles on ageing, it shows that given a little more support, older people can survive on their own, and this may encourage independence and self-reliance. It would be valuable to encourage

this self-entrepreneurship strategy to help older people cope with minimum effort.

5.2.1 Lessons from Challenges on Ageing

A careful investigation of the findings in our study seems to suggest that the major challenge in old age is having or experiencing low self-esteem and loneliness.

Low self-esteem and loneliness are both functions of or are determined by socio-economic, demographic as well as environmental factors present in communities where older people are also part. However, individual characteristics also play a significant role. Nevertheless, the data has shown that individual variables or challenges are driven more by nature rather than by outside or environmental factors. For example, older people suffer from a number of health problems. Such challenges or health problems are mostly determined by the biological make up of individuals affected, and not necessarily by the socio-economic and environmental factors. Similarly, functional limitations discussed in this study are mostly driven by the physiology of the people concerned, much less by the environment. This however, does not mean that outside variables have no effect on individual challenges; for example, one's health is not only a function of biological factors but the state of health facilities available and how accessible they are to older people. It may also be a function of the quality of care given at those health facilities. In any case, the point is, does the environment, socio-economic opportunities etc., support or recognises special needs affecting older people? Do people in communities give special attention to problems facing older people?

From our data, answers to these questions suggest that very little effort is made to ensure older people live independent, self-fulfilled and dignified lives. But why do we suggest that low self-esteem and loneliness are the main challenges facing older people and which inevitably lessens active ageing? The

argument is based on the assumption that challenges of a socio-economic, demographic and environmental nature exacerbate low self-esteem and may engender loneliness in general.

It is clear from our study that in general terms, communities or societies have what may be classified as 'negative' perceptions of older people; according to society's observations, old age is synonymous with suffering. Older people are perceived to be very difficult and are labeled as 'wizards' or 'sorcerers'. Such negative attitudes engender not only isolation and low self-esteem but loneliness as well.

Other challenges also seem to help explain why low self-esteem and loneliness seem to be prominent. The study has shown that older people cannot work or, have very few opportunities for work. For example, on 31st January 2012, Finance Bank Zambia Limited ran an advert soliciting applications from qualified Zambians to fill positions of trainee managers. One of the qualifications was for the candidate to be less than 30 years of age (*The Post*, 2012). This shows practically that opportunities for work for older people are extremely slim. In any case, it could be argued that looking at their ages, older people have passed their working time or have attained retirement. However, who decides when to stop work? According to the United Nations Principles on Ageing (1991), older people should be given opportunities to decide when to disengage from the labour force without being forced, ignored or coerced. Whether this requirement is considered or not is not subject to discussion here. Further, majority of respondents have little or no income to support themselves. They get very little support whether from families, communities, government or non-governmental organisations. This means they cannot adequately look after themselves. Such a condition may translate in low self-esteem and to some extent loneliness and subsequently a significant hindrance to active ageing.

For older people needing care, especially from family members, our data suggest that such is very minimal and in some situations non-existent. This further adds to the feeling of low self-esteem. In the same way, data also show that there is little interaction between older people and other people within the same communities. In fact, there is also quite little interaction between older people themselves. This suggests, therefore, that older people live very lonely lives which do not support active ageing. Our conclusions therefore that low self-esteem and loneliness seem to be the major challenges at individual level are well supported.

Apart from these shortcomings and challenges, older people are also bearing the burden of taking care of orphans and vulnerable children. They have, in some cases been reported to be looking after other sick relatives – especially their adult children (Mutangadura *et al* 1999) – some of whom have actually died. These aspects explain why they have low self-esteem and are lonely and hence a minus to the active ageing process.

In concluding this section, it is clear from revelations above that individual challenges as well as those driven by the socio-economic situation explain the low self-esteem and loneliness experienced among older people in general. While individual factors have a lot to offer in determining low self-esteem and loneliness, our findings also show that in fact, low self-esteem and loneliness are highly determined by socio-economic, demographic as well as environmental factors. In other words, external factors seem to affect older people more negatively compared to individual factors.

As such, as long as there is no work for older people, little or no opportunities for work, little or no care, little or no support, accusations of witchcraft and generally negative attitudes towards older people, then older people will almost always have very low self-esteem of themselves and will spend much of their remaining lives lonely and even miserable in some situations; certainly, this will not '*add life to the years that have been added to life'* (UN 1991; Resolution

no. 46/91) and will not promote active ageing (WHO, 2002) in general, contrary to the wishes of the world as a whole and older people in particular.

5.2.2 What Really Determines Active Ageing in Zambia?

It has been observed in this discourse that while issues on challenges have been outlined extensively, they only contribute indirectly to the Active Ageing Framework proposed and used in this study. However, what exactly determines active ageing in Zambia currently, notwithstanding the challenges discussed already. Our findings have indicated that active ageing in Zambia is affected by culture, personal or behavioural determinants, health and functional determinants, economic determinants and also by HIV/AIDS as a determinant.

The Active Ageing Framework proposes that active ageing is affected and determined by a wide range of factors which include – Culture and Gender, Economic, Personal and Behavioural, Social, Physical Environment and Health. Our study however proposed that in addition to the forgoing, Africa in general and Zambia in particular is faced with problems of HIV/AIDS and older people are faced with this challenge and therefore is also a potential determinant of active ageing. In addition, it should be pointed out that we purposively selected those determinants we thought were commensurate with the Zambian situation; in this regard therefore, we thought that the context in which Physical and Environmental Determinants are discussed in the Active Ageing Framework does not reflect the Zambian context and maybe too ambitious an adventure, otherwise everything else remained the same.

Our study has revealed that Gender is not a factor as far as active ageing is concerned; this is a departure from several other studies as well as the active ageing framework; it has been observed that ageing is a gendered agenda and one's sex determines one's active ageing process. The reason for this finding is unclear; however, it is possible that much or most of the challenges reported by older people in our study have no significant difference whether they be experienced by males or females. On the other hand, culture is a significant factor on active ageing; and this also confirms propositions by the active ageing

framework as well as already existing literature (Knodel, 2008; Sugiswawa et al 1994; WHO, 2000).

In terms of other determinants, our data has shown that economic determinants are only significant in terms of actual "income" gained by older people. In other words, in the Zambian context, while the presence of economic determinants are well articulated, the relationship only exists on whether or not older people have access to income – this is the main factor that is or was statistically significant as far as economic determinants are concerned. This outlook may indicate the need to promote policies that help older people have access to income. In the same way, social determinants influence active ageing through peer interactions as well as having a caretaker. This finding is consistent with the active ageing framework and other studies as well. For example, Wilkinson (1996) found that older people who interact with peers were more likely to live longer (2.5 times as likely) compared to those who never interact. This finding was also highlighted by Sugiswawa (1994) in Japan.

Health and functional abilities affect active ageing. In this respect, our study found that long term health conditions may affect active ageing more as opposed to short term health challenges. This factor is also well articulated by the framework where it is recommended that to understand this aspect, a life course approach is necessary to help understand with certainty effects of health challenges on active ageing. In terms of functional abilities, only indicators of "ability to squat and ability to clean one's house" affect active ageing significantly. This finding maybe unique to Zambia since so far, there seems to be no study or studies that have found with certainty the effect of these two functional limitations on active ageing. The closest this comes to were results obtained by Knodel (2008) where it was found that some older people in Thailand were unable to "squat or clean their housing units". However, there were no statistical tests to establish whether this finding was significant and whether this relationship was linked to the active ageing framework. On the other hand, personal and behavioural determinants were found to be affecting active ageing significantly. These determinants manifested

themselves through low self-esteem; that is feeling "hopeless and useless". This finding is also consistent with already existing literature. In their press release entitled: "preventing loneliness and isolation in adulthood" Gironda *et at* (In Press) found that older people reported very low self-esteem of themselves manifested through "feeling lonely, hopeless, useless and unhappy". Our results show categorically that feeling hopeless and useless are effective determinants of active ageing.

It has been observed consistently in this study that HIV/AIDS is not only a challenge in old age but also a unique determinant of active ageing in Zambia and countries with a generalized HIV/AIDS pandemic. Our study proposed that the active ageing framework, in its current form was not sufficient to explain problems faced by older people in countries such as Zambia. In view of this, we proposed to add, in addition to the determinants proposed in the framework, HIV/AIDS as a major determinant of active ageing. Results show that indeed, HIV/AIDS is a significant factor in determining active ageing. These results are not only consistent with literature on ageing and AIDS, but also value addition to studying ageing. This, we believe is an additional aspect contributing to studies on ageing in general and to the determinants of active ageing proposed by the WHO Active Ageing Framework specifically.

5.3 Active Ageing and the Family – The Zambian Context

This study has shown that the number of older people has been increasing steadily over the past few years and will increase much faster in the next couple of years. It is also true that active ageing is determined by several factors as well as several challenges, both at individual and socio-economic and environmental levels. These challenges are taking place at a time when there is very little care and support from families, communities and government. Consequently, the challenge of ageing is here to stay and if no adequate interventions are designed, older people will continue facing most of the problems discussed here. In fact, we anticipate that challenges older people are facing will become even more pronounced in the near future due to the fact

that the number of older people is likely to be double the current one. Given this background, this study examined the draft policy on ageing and also through literature review, discussed some of the policies and programs that may have some inclination, directly or indirectly on ageing.

Clearly, there is a linkage between challenges faced by older people in our study and the draft policy on ageing currently available in Zambia. However, It is also true that a policy on ageing which will help promote or incorporate economic determinants (such as income generating), personal and behavioural determinants (such as those promoting self-esteem), health and social determinants (such as those promoting health ageing as well as family and peer interactions) will be instrumental in promoting general active ageing in Zambia. This component in the draft policy on ageing is quite or silent. In addition, some programmes reviewed through our literature such as Public Welfare Assistance Schemes, Social Cash Transfer Schemes etc do provide services aimed at promoting active ageing, however, they are limited in application and are highly unsustainable because they depend on hand outs. In addition, Zambia's economy has also not grown to a level where it can sustain these programmes.

As a result, there is need to have a paradigm shift in as far as planning and looking after older people is concerned. This paradigm shift will require emphasis on the role and importance of the family in taking care of older people – this we believe will help in the interim to promote active ageing and alleviate most of the challenges reported by older people. The proposed paradigm shift should also be anchored in the policy on ageing.

In light of the proposal to have a complete paradigm shift to ensure the family takes center stage, we make deliberate efforts to analyse and interpret aspects of ageing and the family in light of the Zambian context and as determined by findings in this study. We take this approach because studies in Africa and other parts of the world attribute certain challenges older people are facing to

changes brought about by urbanisation, secularisation, modernisation and so on and so forth (Aboderin 2004). Nonetheless, our data gave a different perspective. Findings from our study suggests that in fact, communities and families in Zambia are still intertwined through natural as well as traditional codes. This again departs from what has been established by other studies where traditional roles of families in taking care of their older relatives is eroding or diminishing (Abiodum *et al* 2003). We also take this approach because results on determinants of active ageing can best be handled at family level in the short term while taking cognizant of the role of government and other stakeholders in the long term. We feel the family is cardinal in helping older people resolve income problems, interaction challenges, helping with household chores, helping in uplifting their self-esteem by continuous assurances that they (older people) are "not useless and not hopeless". The family is also very instrumental in terms of looking after orphans thereby mitigating the impact of HIV/AIDS on the active ageing process.

The current study has shown that while there are several aspects determining the active ageing process, active ageing in Zambia could greatly be influenced and enhanced by the socio-economic status of immediate family members, especially if they work or have steady sources of income – which income they may share with their older relatives (economic determinant). This contention is premised on the understanding and also findings discussed earlier where filial loyalty and support for the elderly are not necessarily diminishing due to reasons outlined and debated widely in literature (urbanisation, secularilisation, westernisation etc.). In Zambia, there are strong adages prominent amongst almost all tribal or linguistic groupings that explain the importance of care for older people by the family. Some of them state as follows:

'Ngulelenu nayami nawa nanguka kulela' (Luvale)
'Amuniute nina nika miuta' (Lozi)
'Mayo mpapa naine nkakupapa' (Bemba)

Directly translated as:

> *'Mother or father, aunt or grandparent, "carry me now" or "take care of me" and I will do the same one day'.*

These saying attest to the fact that filial loyalty towards the elderly, especially close relatives like mothers and fathers is still actively present. While findings suggest that support rendered to older people by family members is quite minimal, this in itself suggests or is indicative of people's willingness to support and care for their relatives. Suggestions that filial loyalty in Africa and several other countries including Zambia is losing ground are only correct to a certain extent. However, while some studies have attributed this downfall to many factors (e.g. changes in the perceptions of ageing, western influences, diminishing extended family ties, urbanisation, women entry into the labour force, migration and secularisation etc) (Abiodum *et al* 2003), this study has established that support for older people, especially from close relatives, is influenced by the well-being of younger relatives such as children and also by their ability to render such support – a view also reflected by Macwan'gi *et. al* (1997) in their study of "consequences of rural-urban migration on support for the elderly in Zambia".

In the same way, other paradigms aimed at helping older people have been suggested. For example, the UN Principles on Ageing propose that for people to age actively, there is need to help them continue working as well as ensuring they continue participating in family activities (Economic Determinant). The principles in question also advocate for older people to continue being on social protection programmes, supported by individual governments. While ideas to ensure older people continue working and also continue getting the necessary training and be given more opportunities for re-training so as to support them age actively are well intended, this aspiration may be farfetched and may prove difficult, almost impossible to be supported by developing economies like that of Zambia. For example, public social protection mechanisms like homes for the aged are highly underdeveloped in most developing countries and there is

no evidence of improvement, at least not in the near future. As a result, these measures may not work as expected or as efficiently as what currently obtains in more developed economies.

While the proposal to enable older people to continue working is attainable to a certain extent, there is a limit to which older people can work continuously. This is because as people age – not all of them but majority – they become constrained to perform some functions. This assertion is further exacerbated by beliefs that older workers are less suited to demands of the modern workforce and, therefore, discriminated against (De Vos, *et al* 2005).

Debate on this subject has continued; in fact several countries in the Euro zone and the Americas have in the past decades been increasing retirement age. These measures have of course been met with serious resistance from the citizenry who feel retirement age should remain where it is (Low, 2002/2003). Debates on proposals to enable older people continue working have also spiraled towards developing countries with the government of Zambia already proposing to increase the retirement age from the current 55 years to 65. This again has been received with mixed feelings, with certain sections of society expressing serious reservations.

However, for older people to continue working, they will require among other things, training and retraining so as to have the necessary new skills applicable to demands of modern industry. This paradigm has, however, produced less desired results due to the fast pace at which new technologies and labour market fundamentals have moved, rendering such training inadequate as some or most of the target audience – older people – have not adapted as quickly as possible to these demands and requirements. For example, in a paper entitled 'Workforce Ageing: Challenges for the 21st Century Management', Patrickson *et al* (2004) state that there are new and competing skills in demand in consequence of technological advances, and that there are conditions under which employment for older workers could be maintained.

Patrickson *et al* (*Ibid*) further argue that while the Australian government is telling older workers to keep working and telling employers to retain and retrain older workers, employers do not want older workers or are unwilling to explore alternative conditions under which their employment may be of benefit.

The question, therefore, is: if this is the case in a developed country, how do both governments and employers in developing countries work around such a proposal given the prevailing level of economic as well as industrial development? The proposal in question has not performed to the best of expectations even in more developed economies or countries. This shows the limited applicability of both the proposals to enable older people work for a much longer time as well as continuously train them so that they adapt to demands of industry currently. In view of this, the family in Zambia and Africa in general still remains the best institution to contribute effectively to the welfare of older people, and strengthening this role will help alleviate some of the challenges associated with ageing populations and generally promote active ageing.

In the same line of thought, proposals have been made to allow older people participate in income-generating activities (significant economic determinant) and also be accorded opportunities to acquire credit schemes. This would inevitably help mitigate some of the challenges they are currently facing thereby promote active ageing. While this proposition is brilliant, unfortunately, applying it to developing countries may prove difficult and almost impossible to some extent. Although there are suggestions to ensure that more and more older people are independent, can care for themselves, have opportunities for participation, are self-fulfilled and enjoy the dignity they deserve (Active Ageing), it is not currently very possible for all these to take place in Zambia. This, therefore, places families at a greater opportune advantage to provide the care and support to enhance the active ageing process.

In view of what has been discussed so far, it is clear that the family in Africa, and Zambia in particular will continue playing a fundamental role in as far as active ageing is concerned. This is so in view of what has been discussed as well as findings on the major determinants of active ageing in Zambia. While the importance of paradigms used before and elsewhere such as allowing older people to continue working, retraining etc. cannot be over emphasised, it is clear from literature that they have not performed to produce expected results. This study has demonstrated that filial loyalty in Zambia is evident and as result, traditional support systems for older people are still intact and can be explored for better. Moreover, even where influences of urbanisation, migration, secularisation etc are visible, it is our view that such influences had or have not destroyed the interconnectedness of extended family systems – especially for close relations such as children and their parents in Zambia. Therefore, families are failing to look after or support older people due to their constrained socio-economic status and not that they are unwilling. In the same way, it is also clear that relying on government or other institutions or organisations to continuously support not only older people but other vulnerable groups is not a sustainable approach so far since the models used have been based on providing handouts. In fact, the first republican president of Zambia once said:

> *'The idea that the state or some voluntary organisation or agency should look after older people is anathema to Africa'* (Kaunda, 1976)

The family therefore should be encouraged and empowered to continue playing its traditional role while governments or other institutions work on modalities of strengthening family value systems and where possible continue providing opportunities and an environment where the family will survive better. In this example, the policy on ageing should have aspects of family strengthening into account so as to encourage and empower families look after older people. For example, opportunities for work and other income generating activities should readily be available to families. This is a more sustainable approach to help mitigate some or most of the problems older people are facing and in the long run, encourage to a certain extent, the much talked about active ageing.

It is important to emphasise that the role of the family in Africa and Zambia in particular will remain extremely important for a long time to come. And the policy on ageing should reflect this important aspect. The data has also demonstrated that no child would want to see their parents suffer if they are able to help. As a matter of fact, Cadwell (1976) and De Lancey (1990) also found that across generations in Africa, younger people support older generations; this enhances further the '*Mayo mpapa naine nkakupapa*', or *'Ngulelenu nayami nawa nanguka kulela'* or *'Amuniute nina nika miuta'* adage. In view of this conclusion, it is our considered perspective that the need to provide opportunities to both older and younger generations, as well as ensuring families continue cultivating their noble traditional role of caring and looking after older generations, and thereby help promote active ageing cannot be over-emphasised.

5.4 Conclusion

The population of Zambia, like global and regional populations, is undergoing unprecedented experiences of ageing. While Zambia may not be classified as an ageing country due to its youthful population, the process has already been initiated, and the absolute number of people aged 60 and above is growing tremendously. The question is, *'What should be done about this situation?'* This study has highlighted and provided evidence of most of the challenges older people are facing currently in Zambia. However, this is only a 'tip' of what they may face in the absence of a decisive and active policy on ageing.

The study has also interpreted provisions of the Active Ageing Framework using data from a developing country. While the framework provides adequate information on the tenets of active ageing, the aspect of empowerment of people that take care or support the elderly (especially in Zambia and Africa) should be strengthened so that the family takes center stage.

In addition, while erosion of filial loyalty is attributed to influences brought about by migration, urbanisation, secularisation, etc. to mention but a few, this study re-enforces the fact that filial loyalty is 'an indelible mark' for many Zambians, and where resources are available, people and families would endeavor to take care of their elderly relatives – especially those of a very close relation. Nevertheless, erosion of filial loyalty in the Zambian context is not due to westernisation or urbanisation or migration per say, it is instead a function of one's ability to support older relatives.

This study has further demonstrated that the main determinants of active ageing in Zambia are income accessibility (Economic Determinant), functional limitations (Health Determinants), low self-esteem and loneliness (Personal/Behavioural Determinants), low family and peer interactions (Social Determinants) and HIV/AIDS. This therefore requires a thorough reflection of these tenets in the policy on ageing to promote active ageing in general.

On the other hand, evidence from a detailed examination of the draft policy on ageing as well as other policies and programmes shows that there is no pragmatic commitment in addressing ageing altogether. The main challenge has been the inadequacy of operationlisation of most of the recommendations of aligning both UN Principles on Ageing (1991) and the Active Ageing Framework (2002). Undeniably, there are responses to ageing in general, but almost no strategy in place to achieve or strengthen the responses. Putting it succinctly, the draft policy on ageing has not been put into practice to reflect recommendations stipulated by the United Nations and also ratified by the Government of the Republic of Zambia.

Research on ageing in Zambia is limited. What this study has brought to demography and population studies discipline – using data from Zambia – is evidence upon which other more focused studies could be based. The need to promote studies that will help understand dynamics of family relations and how they can be strengthened to support active ageing cannot be over-emphasised. While many Zambians agree that development is cardinal, it is

also important to state that an agenda that emphasises the importance of one group of individuals over others may not necessarily achieve the intended development.

5.5 Future Research Areas

In order to study ageing comprehensively and appreciate the contribution of each of the mentioned or studied determinants on active ageing in general, this study proposes a few areas of concentration:

- To effectively tackle the effects of the determinants of active ageing on the ageing process, and using the 2002 Active Ageing Framework, a longitudinal study on ageing is required. This is so because effects of some of the determinants may not be understood or take effect over a short period of time. They require a longer period of observation rather than based on a one-time-exploratory study as has been the case with the current study; and secondly,

- Conduct a study or studies that will help understand dynamics of family relations and how they can be strengthened to support active ageing over a longer period;

- In the Zambian context, Gender seems to be a non-factor as far as active ageing is concerned; studies elsewhere have demonstrated that ageing is a gendered agenda and that it is also one of the over-arching determinants of active ageing. It will be critical to formulate detailed studies that may help explain why gender is not a factor on active ageing in Zambia; and

- At National level, indicators on ageing should be part and parcel of surveys such as DHS and other surveys; this will help document issues on ageing and the changes that come as a result. This will undeniably continue enriching literature on ageing and thereby contributing routinely to both policy formulation/adjustment and/or implementation.

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APPENDICES

Appendix 1: Individual Questionnaire

FINAL QUESTIONNAIRE:
Population Ageing in Zambia:
Magnitude, Challenges and Determinants
BACKGROUND CHARACTERISTICS

IDENTIFICATION

NAME OF COMMUNITY: _____
NAME OF TOWN: _____
TYPE OF RESIDENCE: 1. URBAN 2. RURAL
PLACE OF INTERVIEW: 1. HOME FOR THE AGED 2. COMMUNITY
NAME OF INTERVIEWER: _____
LANGUAGE OF INTERVIEW: _____

INTRODUCTION AND CONSENT

***READ OUT**: Hello, my name is _____. I am working with The University of Zambia, collecting information pertaining to your well being as an elderly citizen of this country. Please be assured that everything we discuss will be strictly confidential and no information will be shared or leaked. May I continue?*

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
Q101	CIRCLE SEX OF RESPONDENT	MALE----------1 FEMALE----------2	
Q102	How old are you?	AGE IN YEARS [|]	
Q102a	When were you born (Year)	_____	
Q102b	When did you turn 60?	_____	
Q103	Have you ever attended school?	YES ----------1 NO----------2	→104a
Q104	What is the highest level of school you attended: primary, secondary, or higher?	PRIMARY ----------1 SECONDARY ----------2 HIGHER ----------3	
Q104a	Do you ever have access to appropriate training and educational programs in this community?	YES ----------1 NO ----------2	
Q105	How long have you been living continuously in (NAME OF VILLAGE/TOWN/CITY)?	YEARS ----------[|]	
Q106	Have you done any work in the last 12 months?	YES ----------1 NO----------2	
Q107	Are you currently working?	YES ----------1 NO ----------2	
Q107a	Why are you not working?	Health problems ----------1 Old age ----------2 Cant find a job due to age ---3	

		Cant find a job --------4 Other (specify) ----------	
Q107b	Do you ever have any opportunity to work or have access to income generating activities in this community?	YES ----------1 NO ----------2	
Q108	Do you have a continuous monthly flow of income?	YES ----------1 NO ----------2	→ Q110
Q108a	Where do you get or who gives you this income?	Source _____	
Q108b	Do you think this income is adequate?	YES ----------1 NO ----------2	
Q109	What is your average monthly income?	Amount in ZMK ----------	
Q110	Have you ever been married or lived with a woman or man as if you were married?	YES ----------1 NO ----------2	
Q111	What is your current marital status?	MARRIED ----------1 WIDOWED ----------2 DIVORCED ----------3 SEPARATED ---------- 4	
Q111a	How long have you been in this marital status	Years: ---------- Months: ----------	
Q112	Do you have children?	YES ----------1 NO ----------2	→Q114
Q113	Have you ever had children?	YES ----------1 NO ----------2	
Q114	How many children do you have/have you ever had?	NUMBER OF MALES ----[|] NUMBER OF FRMALES -[|]	
Q114a	How many family members do you have who are alive?	NO: ----------	If non → Q116
Q114b	Where are they?	Same community ----------1 Same town but different com.-2 Different town --------3 Other (specify) _____	
Q115a	How many adult children of your own are still alive?	Number: ----------	If "00" → Q116
Q115b	Where do they live?	Same community ----------1 Same town but different com.-2 Different town --------3 Other (specify) _____	
Q116	Observe type of housing _ main material for the wall, floor and roof	Wall ---------- Floor ---------- Roof ----------	
Q116a	How does your house compare with other houses in this community?	Same ----------1 Better off ----------2 Worse off ----------3	
Q117	Observe type of sanitary facility (if not sure, ask)	Flush or pour toilet -------1 Pit latrine ----------2 No facility/bush -------3	
Q118	What is the main source of your drinking water?	Piped water ----------1 Borehole ----------2 Well ----------3	

		River/Lake ----------4 Other (specify) ---------- --	

ACTIVE LIFE EXPECTANCY FOR THE AGED

NO	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP
201	I'm going to read some statements about what you are able to do on day to day basis: please tell me if your response is "yes" or "no" with each statement. Can you:		YES	NO	
	a. Eat alone b. Put on clothes on your own c. Go to the toilet by yourself d. Bath without any assistance e. Wash your face f. Brush your teeth	EAT PUT ON CLOTHES GO TO TOILET BATH ALONE WASH FACE BRUSH TEETH	1 1 1 1 1 1	2 2 2 2 2 2	
202	Please say either "yes" or "no" to the following statements. Can you:		YES	NO	
	a. See clearly b. Hear clearly	SEE HEAR	1 1	2 2	
203	Please say either "yes" or "no" to the following statements. Can you:		YES	NO	
	a. Squat b. Walk for 200-300 meters c. Climb stairs d. Use public transport	SQUAT WALK CLIMB STAIRS PUBLIC TRANSPOR	1 1 1 1	2 2 2 2	
203	Have been ill in the past 12 to 24 months?	YES ----------1 NO ----------2			
204	What has been your ailment?	RECORD NAME OF AILMENT _____			
205	Please say "yes" or "no" to the following statements. Are/do you:		YES	NO	
	a. Lacking appetite b. Stressed up c. Moody d. Feel hopeless e. Feel useless f. Unhappy g. lonely	NO APPETITE STRESS MOODY HOPELESS USELESS UNHAPPY LONELY	1 1 1 1 1 1 1	2 2 2 2 2 2 2	
206	Do you take alcoholic drinks	YES ----------1 NO ----------2			 →Q209
207	In the last 4 weeks, on how many days did you drink an alcohol-containing? (ENTER '00' IF NONE OR NEVER)	NUMBER OF DAYS ---- [|]			
208	Do you smoke?	YES ---------- 1 NO ---------- 2			 →
209	How many times do you smoke in a day? (IF NONE OR NEVER, RECORD '00')	NUMBER OF TIMES OF SMOKING IN A DAY ----[|]			

CARE, LIVING ARRANGEMENTS AND SOCIAL CONTACT WITH CHILDREN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301	Do you have someone who takes care of you?	YES ----------1 NO ----------2	 →
302	Who is your care giver?	FAMILY MEMBER----------1 HOME FOR THE AGED--------2 DISTANT RELATIVE ----------3 NO RELATION ----------4 OTHER (SPECIFY)----------8 _____	→
303	What is your relationship with this family member?	SPOUSE ----------1 SON ----------2 DAUGHTER ----------3 CHILD IN-LAW ----------4 OTHER RELATIVE ----------5	
ASK Q304 TO THOSE WHO ARE STAYING OUTSIDE HOMES FOR THE AGED			
304	Who are you living with?	WITH ANY CHILD---------1 ALONE----------2 WITH ANY RELATIVE (NOT SON OR DAUGHTER----------3 OTHER (SPECIFY) ---------8	→306
305	What is your relationship with this child	SON ----------1 MARRIED SON ----------2 DAUGHTER ----------3 MARRIED DAUGHTER ---4 OTHER (SPECIFY) ----------8 _____	
306	Do you have a child staying somewhere else?	YES ----------1 NO ----------2	 →
307	How often does this child visit you?	DAILY OR ALMOST DAILY ----1 AT LEAST WEEKLY ----------2 AT LEAST MONTHLY ----------3 ONCE DURING A YEAR -------4 NEVER ----------5	

SOURCES OF INCOME AND MATERIAL SUPPORT

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Have you done any work in the past week?	YES ----------1 NO ----------2	 →404
402	What sorts of work have you been doing?	EMPLOYED ----------1 WORK FOR PAY OR PROFIT --2 UN PAID FAMILY WORKER ---3 PART OF DAILY CHORES -----4 OTHER (SPECIFY) ----------8 _____	
403	How many days do you work in a week?	NUMBER OF DAYS ------[|]	
404	Why haven't you been working?	TOO OLD ----------1 HEALTH PROBLEM ----------2 NO WORK IN THE INSTITUTION ----------3 HAS PENSION ----------4 NO NEED TO WORK ----------5 OTHER (SPECIFY) ----------8	

		_____			
405	Do you ever get any income?	YES ----------1 NO ----------2			
405	Where do you get this income? Please say either "yes" or "no" to the following:				
			YES	NO	
	a. children b. own work c. elderly allowance d. spouse e. savings f. rent g. other relatives	CHILDREN WORK ALLOWANCE SPOUSE SAVINGS RENT RELATIVES	1 1 1 1 1 1 1	2 2 2 2 2 2 2	
406	Do your close or distant family members support you in any way?	YES ----------1 NO ----------2			
407	What sort of support do you receive from these family members?	FOOD ----------A MONEY ----------B GOODS AND CLOTHES------C OTHER (SPECIFY)			
408A	Can you state exactly how often this support is:	MONEY: HOW MUCH _____			
			YES	NO	
		DAILY AT LEAST WEEKLY AT LEAST MONTHLY	1 1 1	2 2 2	
408B	FOOD:		YES	NO	
		DAILY AT LEAST WEEKLY AT LEAST MONTHLY	1 1 1	2 2 2	
408C	GOODS AND CLOTHES		YES	NO	
		DAILY AT LEAST WEEKLY AT LEAST MONTHLY	1 1 1	2 2 2	

STATUS OF RALATIVES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	Do you have any working relative?	YES ----------1 NO ----------2 DON'T KNOW ---------8	
502	Do you any relative who stays in any urban area?	YES ----------1 NO ----------2 DON'T KNOW ------8	
503	What is your relationship to this relative?	_____	
504	Do you have any relative who used to	YES ----------1	

	stay with you but shifted to another town or village?	NO ----------2 DONT			
505	Do you know why they shifted?				
506	During the time they were staying with you or near where you stay, were they helpful in terms of: CLOTHES FOOD MONEY		YES	NO	
		CLOTHES FOOD MONEY	1 1 1	2 2 2	
507	During this time that they have been away or stay very far, do they still provide for you clothes, food or money?	YES ----------1 NO ----------2			
508	What do they provide most?	CLOTHES ----------A FOOD ----------B MONEY ----------C OTHER (SPECIFY) -----X			
509	Do they ever invite you to visit them	YES ----------1 NO ----------2			
510	How often does this happen?	EVERY WEEK ----------1 ONCE A MONTH ------2 AT LEAST EVEY YEAR -3 NEVER ----------4			
511	How would you describe your relationship with these relatives?	VERY CLOSE --------1 QUEIT CLOSE ------2 DISTANT ----------3 OTHER (SPECIFY)			
512	Has your relationship remained the same since you they left?	YES ----------1 NO ----------2			
513	Do you have any relative who used to work but now they are not?	YES ----------1 NO ----------2			
514	During the time they were working, were they supporting you?	YES ----------1 NO ----------2			
515	How often was the support?	VERY OFTEN ----------1 NOT SO OFTEN -------2 ERATIC ----------3 VERY ERATIC ----------4 NEVER ----------5			
516	Are they supporting you now?	YES ----------1 NO ----------2			
517	Is there any difference between the support they gave when they were working and the one they give while not working?	YES----------1 NO ----------2			
518	Would you attribute this change to the fact that they are now not working?	YES ----------1 NO ----------2			

STAYING OR LIVING ALONE

ASK THESE QUESTIONS TO OLD PEOPLE FOUND LIVING ALONE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	Currently, who do you live with?	ALONE ----------1 ANY RELATIVE -------2	
602	Check Q503 If has sons or daughters, proceed, otherwise go to section //		
603	You said you have sons and/or daughters, where are they currently?	IN ANOTHER RURAL AREA ---1 IN ANOTHER URBAN AREA---2 IN THE SAME COMMUNITY---3 DON'T KNOW ----------4	
604	Why don't you live with your sons/daughters?	_____ _____	
605	Do you get any support from your sons/daughters?	YES ----------1 NO ----------2	
606	Apart from your sons/daughters, do you have any relative in this community?	YES ----------1 NO ----------2 DON'T KNOW -----8	
607	Why don't you stay with them?	_____ _____	
608	Do you receive any support from your relatives?	YES ----------1 NO ----------2	
609	In general, how do you manage to support yourself?	FARMING ----------1 WORKING ----------2 BEGGING----------3 TRADING ----------4 OTHER (SPECIFY) ----	
	INSTITUTIONAL OR ORGANISATIONAL SUPPORT		
610	Have you ever received any help from any organization?	YES ----------1 NO ----------2	
611	Which organization is this?	_____	
612	In the past 12 months, have received any help from government?	YES ----------1 NO ----------2	
613	What sort of help did you receive from government?	MONEY ----------1 FOOD ----------2 GOODS/CLOTHES ----3	

KEEPING CHILDREN BELOW AGE 15

NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
701	Do you keep any children who are below 15 years of age?	YES ----------1 NO ----------2	
702	How many are they?	NUMBER _____	
703	How many of these are your own?	NUMBER _____	
704	How many of these are not your own?	NUMBER _____	
705	Of these children you are keeping and are not your own, how many have their mothers/fathers alive?	MOTHER ALIVE ---------- FATHER ALIVE ----------	
706	For any number in Q704, calculate difference with Q705 and identify one child with either no mother or father and ask questions that follow	Name of child without either mother or father or both _____	
707	If one of the parents alive, ask where	ANOTHER URBAN AREA ------1	

	they live, if both dead, go to Q710	ANOTHER RURAL AREA ------2 VILLAGE ----------3 SAME COMMUNITY ----------4 DON'T KNOW ----------8	
708	Does (name's) father/mother come to visit you or (name)?	YES ----------1 NO ----------2	
709	How long has name's father/mother been away from this household?	DAYS AGO WEEKS AGO MONTHS AGO YEARS AGO	
710	How long ago did name's father/mother (parents) die?	DAYS AGO WEEKS AGO MONTHS AGO YEARS AGO	
711	During the last 12 months before name's father/mother (parents) die, how long were they bed ridden (unable to do anything)	DAYS ---------- WEEKS ---------- MONTHS ----------	
712	Can name's father/mother's (parents) death be attributed to HIV/AIDS?	YES ----------1 NO ----------2 DON'T KNOW -----8	
713	What do you do to take care of this family?	WORK----------1 TRADE----------2 RECEIVE HELP --------3 NOTHING ----------4	
714	Are any of these children going to school?	YES ----------1 NO ----------2	
715	Do you receive any support from relatives in taking care of these children?	YES ----------1 NO ----------2	
716	Have you ever received any help from a church or an NGO to help take care of these children?	YES ----------1 NO ----------2	
717	Are you currently receiving any support from a church or an NGO to help take care of these children?	YES ----------1 NO ----------2	
718	What church or NGO is this?	_____	
719	Have you ever received any help from government or any government institution?	YES----------1 NO ----------2	
720	Are you currently receiving any support from government or any government organization to help in keeping these children?	YES ----------1 NO ----------2	
721	What kind of help are you receiving?	MONITORY FOOD CLOTHES/GOODS	

THANK THE RESPONDENT AND END THE INTERVIEW

Appendix 2: Focus group discussion guide

FOCUS GROUP DISCUSSION GUIDE
FOR: COMMUNITIES IN SELECTED SAMPLE DISTRICTS

INTRODUCTION: Hello, my name is _____ from the University of Zambia carrying out research on ageing in Zambia as a fulfillment for A PhD dissertation. Am interested in gathering information from you as members of this community on issues relating to ageing and the aged in Zambia. May I continue?

---

1. From your own observations and perceptions, do you think the number of old people has/is increasing? Why do you say so?
2. When people see or talk about the aged, what comes to your mind and why?
3. Do you see ageing as a time of suffering? Are the aged respected? Do you think the aged consider themselves as being in the time of suffering?
4. Apart from your close relatives, can you stay with an old person? Why?
5. Do you keep old people? If so, how do find their lifestyle? (boring, difficult etc)
6. Do you think old people are lonely people? Who makes them lonely? What do you do to help?
7. Are there people or indeed organizations really interested in matters of the aged? Are you interested? Do you think issues of the aged are a waste of time compared to say youths, women and children? Why do you say so?
8. What challenges, socially and economically affect old people? How do they cope with these challenges? And what help does this society render to the aged?

9. What do you think are the major causes of the socio-economic conditions old people find themselves in? (no family, no children, abandoned etc)
10. Do you think old people are affected by issues of HIV/AIDS? How are they affected?
11. Old people are usually classified as tired people, do you think HIV/AIDS has changed their roles in society? If so, what roles have been changed?
12. Are there old people keeping children known to be orphans? Are they HIV/AIDS orphans? How do they cope with this arrangement?
13. Do they ever receive any help and from who? Do you think the help is enough?
14. How do you think old people could be helped since all of us will one day age?
15. Do you know any organization dealing with issues of the aged? How does this organization deal with the aged?
16. Do you know of any program/policy by government of any organization dealing or addressing issues of the aged and ageing? have you ever come across or read any document championing issues of the aged?
17. What best can improve the living conditions of the aged, according to your suggestions and observations?

Thank you for your participation