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SITUATION ANALYSIS ON HEALTH AGEING PROGRAMME IN ZAMBIA

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A REPORT FOR THE WORLD HEALTH ORGANIZATION

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SUMMARY

Ageing population is a critical area of concern requiring immediate action due to rapid demographic changes involving a revolution in age longevity. Globally, the number of the ageing population 60 years and above has increased drastically, with no exception to the Zambian population. Demand for critical health care is therefore imperative. Although the effect of ageing population results on account of a decline in the population of children and young people, thereby providing an increase in the proportion of older persons, it is a progressive and generalized impairment of functions. This impairment of bodily functions can result in the loss of adoptive response to stress and increasing the risk of age-related diseases. The overall effect of these alterations is an increase in the probability of dying, which is evident in the rise in age-specific death rates in the population. Even though the cause of ageing remains unknown, efforts should be made to prolong the life span of this risk group. It is on this account that enacting active ageing policies and programmes that enhance the health, participation and security of older citizens be enforced to lengthen the life expectancy of these populations.

The purpose of the study was to respond to the global concern and the United Nations Plan of Action on health ageing urging countries to consider this stage as a lifelong process and to focus on improving the wellbeing of people as they age. It was recommended that health promotion should aim at promoting activities, initiatives and structures which would enhance the wellbeing, health choice, independence and quality of life for all ages. Efforts should be made to prevent or delay the onset of chronic diseases and disabilities. The objectives of this baseline data was to provide a documentary analysis of information on policies and guidelines on healthy ageing programmes in Zambia, determine an insight perspective view of health needs of older persons in order to provide recommendations that will strengthen Healthy ageing programmes and policies in the country.

The methodological approach of this situation analysis involved documentary review and analysis of existing policies, guidelines

and programmes related to the health and social needs of older people 60 year and over. Use of questionnaires and discussion guides were developed to supplement insight perspective views of Key informants and selected elderly persons themselves.

The findings have demonstrated the significant demand for the health needs of policies and programmes for older people in the country. There is lack of appropriate structures in the health care systems to address the needs of elderly people. Only one sector (MCDSS) that has attempted to provide limited structures and enacting a national policy framework on ageing in Zambia. Health policies and programmes have not set priorities to address issues of geriatric medical care in the health system. Lack of effective coordination between the health delivery system and the social services in the provision of health needs for the elderly people has been found to be a major challenge in the provision of care among older persons with chronic disabilities. The need to redesign the policy framework guidelines to facilitate development of the Healthy Ageing programme in Zambia within the framework of PHC is highly recommended in this study.

ACKNOWLEDGEMENTS

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ACRONYMS

WHO : World Health Organization

UN : United Nations

ICPD : International Conference on Population Development

UDI : Human Development Index

MDGs : Millennium Development Goals

PHC : Primary Health Care

CHAZ : Churches Health Association of Zambia

GDP : Growth Domestic Product

FNDP: Fifth National Development Planning

BHCP: Basic Health Care Package

NDP: National Decentralization Policy

NAPSA: National Pension Scheme Authority

PWAS: Public Welfare Assistance Scheme

MCDSS: Ministry of Community Development and Social Services

SCT : Social Cash Transfer

STIs: Sexually Transmitted Infections

T.B: Tuberculosis

HIV: Human Immuno Virus

AIDS: Acquired Immuno Disease Syndrome

SITUATION ANALYSIS

ON

HEALTHY AGEING PROGRAMME

IN ZAMBIA

PREFACE

Population ageing is one of humanity's greatest demand and challenge. Brundtland (1999)'[2] had emphasized on the importance of population ageing in increasing economic and social demands on all countries, stating that: "population ageing is the first and foremost a success story for public health policies, as well as social and economic development." This statement recognizes the valuable contribution which population ageing would make to social and economic development of any given state or country, if their health receives special attention. While older people are a previous resource, quite often their recognition that makes an important contribution to the complexity of societies is ignored. Population ageing being referred to as age 60 to describe "older" people may seem young in the developed countries and in those developing countries where major gains in life expectancy have manifested.[2] It is observed that what ever age is used within different contexts, it is important to acknowledge that chronological age is not a precise marker for the changes that accompany ageing. There are variations in health status, participation and levels of independence among older people of the same age.[3]It is therefore important to take this variation into consideration when designing policies and programmes for the older population.

Definition of Ageing Population

The World Health Organization[2] has defined population ageing as a decline in the population of children and young people, thereby providing an increase in the proportion of people age 60 and over. In a scientific term ageing is the progressive and generalized impairment of functions resulting in the loss o adaptive response to stress and increasing the risk of age-related diseases. The overall effect of these alterations is an increase in the probability of the dying, which is evident from the rise in age-specific death rates in the population. The cause of ageing remains unknown. The World health Organization (WHO) has further argued that countries can afford to get old, if governments,

[1]Cro Harlem Brundtland, Director General, World Health Organization, 1999: in WHO Active Ageing: Policy

international organizations and the civil societies enact "active ageing" policies and programmes that enhance the health, participation and security of older citizens. Governments were therefore urged to plan and that time to act was now:

" In all countries, and in developing countries in particular, measures to help older people remain healthy and active are a necessity, not a luxury."
(WHO 2002)

In developing these policies and programmes should be based on the rights, needs, preferences and capabilities of older people. They also should embrace a life course perspective that recognizes the important influence of earlier life expectancies on the way individual age[2]. It is in this vision that this situation analysis was urged for developing a policy framework for a friendly healthy and active ageing programme in Zambia. This was realized on the account of The United Nation's International Plan of Action on Active and Healthy Ageing in 2002 considering ageing as a lifelong process and placed focus on improving the wellbeing of people as they age.[2] The United Nations World Assembly on Ageing held in April 2002, Madrid, Spain placed emphasis on recommending a policy framework that should aim at promoting activities, initiatives and structures which would enhance the wellbeing, health choice, independence and quality of life for all ages. In this respect, efforts should be made to prevent or delay the onset of chronic diseases and disabilities. It was therefore essential to provide an analysis of the Healthy Ageing programme in Zambia, with the particular focus on review of policy guidelines and strategies to provide direction for re-structuring a better policy framework to address health promotion and care for the people as they age.

Scope and Methodology

The scope and methods of Zambia Healthy Ageing Programme review emerged from the World Health Organization (WHO) initiative to provide a critical documentary analysis of policies and Healthy Ageing programmes in

[2]Health Care of the Elderly: A Manual for Trainers of Physicians in Primary and Secondary Health Care Facilities.

Zambia. The terms of reference for the review process encompassed review of relevant policies, guidelines and health programme documents including other studies conducted that addressed issues of healthy ageing in the country. The study focused onreviewing existing relevant health and social policies and programme documents and other studies conducted locally on healthy ageing population 60 years and above in Zambia. The assessment further involved discussions with various relevant stakeholders and the elderly persons residing in old people's homes to determine their perceptions of home care institutions and challenges faced in these homes. A semi-structured questionnaire was used to respond to the fundamental strategic questions related to the health and social needs, challenges and seeking possible solutions to improve the health care, social security systems and extent of their participation in healthy promotive activities (see annex 1).

This report therefore provides this analytical situation conducted during the periods of December 2010 to January 2011, respectively. The report is organized into four main Sections. Section One deals with the profile of the global and national context of population ageing in relation to the demographic evolution, the concept of population ageing and active ageing, and rationale. Section Two provides a holistic understanding of the current evidence on health policies and services including the social security system surrounding population ageing in Zambia. Section Three deals with challenges of healthy ageing population needs related to: burden of diseases; increased risk of disability; provision of care for ageing population; feminization of ageing; ethics and inequities; the economics of an ageing population; health and social policy gaps; and the lessons learnt for forging ahead to a new dimensional approach of primary health care for initiating Healthy Ageing programme in Zambia. Lastly, section Four is concerned with the recommendations for action directing to policy, programme and research implications, and conclusion.

GLOBAL CONTEXT AND THE CONCEPTS OF ACTIVE AND HEALTHY AGEING POPULATION

The United Nations has recognized standard age 60 to describe "older" people. Moreover this may seem young in the developed countries and in those developing countries where major gains in life expectancy have manifested. However, whatever age is used within different contexts, it is important to acknowledge that in whatever order age occurs is not a precise marker for the changes that accompany ageing[2]. There are dramatic variations in health status, participation and the level of independence among older people of the same age.[2,3] This is some form of a warning to the policy decision makers to take it into account when designing policies and programmes for their "older" populations. Enacting broad social policies based on chronological age alone can be discriminatory and counter production to the well-being in older age.[2,3]

Demographic Revolution of Ageing Population

Worldwide, the proportion of older people age 60 and above is growing faster than any other population. The projected population ageing between 1970 and 2025 has demonstrated a growth in older persons of some 694 millions or 22.3 percent that should be expected.[4] In 2025, there will be about 1.2 billion people over the age of 60 and by 2050 there will be a total of about 2 billion with 80 percent of them expected to live in developing countries.[4,6,8]

The age composition – the proportionate of children, young adults, middle-aged adults and older adults in any country- is an important element for policy- makers to take into account. As population age, the triangular population pyramid of 2002, for example, is predicted to be replaced with more cylinder like structure in 2025.[2,3] This suggests that there will be a greater increase in population ageing than it was in earlier time. Furthermore, the decreasing fertility rates experienced in many countries world wide and increasing longevity ensure the continued "greying" of the world's population. Sharp decreases in fertility rates are being observed throughout the world.

The old age dependency ratio (i.e. the total population age 60 and over divided by the population age 15 to 60) is also changing quickly to higher numbers by 2025.[11] Old age dependant ratio is used to fore cast the financial implications of pension policies and those concerned with management and planning of caring services. In Japan, for example, there are currently 39 people over age 60 for every 100 in the age-group 15-60. This figure is likely to double to 66 per 100 by 2025.[2,12]

In Africa, population ageing is also increasing to an alarming figure. It is estimated that the number of Africans 60 years and over will grow from 22.9 million in 1980 to 101.9 million in 20 25[14,15]. This is an increase of 4.4 percent, where as the elderly population in developed countries will increase by 2.1 percent only[8,17]. The proportion of Africa's elderly population 65 years and over on average stands at about 3.0 percent. It is the lowest of any world region. Nevertheless, the proportion of the age group 65 and older is expected to increase enormously by 2025.[15,16] Sub Saharan Africa's elderly population will increase to about 82 percent and between 2000 and 2020, it is expected to increase by 93 percent.[9,17,21] The most rapid growth will be experienced in Western and Northern Africa whose elderly population are projected to increase by 5 percent between the period 1980 and 2025.[17] In western Africa of Ivory Coast's older population is expected to increase by 5.4 percent and Cape Verde by 5.3 percent during the same period.[17,15] Of relative importance to note is the fact that the numbers of the very old in Africa is also expected to grow at a very fast rate.

Most of the older people in all countries continue to be a vital resource to their families and communities. If many older people continue to work in both formal and informal sectors (as an indicator for fore casting population ageing needs, the dependency ratio is of limited value, but rather independently. In such circumstances, old age dependent ratio is likely to decrease and promote welfare of the population in general.

Active ageing policies and programmes are therefore required to enable people to continue working according to their capacities and preferences to grow older and prevent or delay disabilities and chronic diseases that are costly to individuals, families and health care systems.

Concepts of Active and Healthy Ageing population

World Health Organization has adopted the term "active ageing" to express the process for achieving the vision of " health, participation and security."[2,6] Active ageing is therefore defined as the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. It applies to both individuals and population groups. It has promotive function of allowing people to realize their potential for physical, social and mental wellbeing throughout the life span and to participate in society according to their needs, desires and capabilities, while promoting them with adequate protection, security and care when they require assistance.[2,7,10] The word " active" further refers to continuing participation in social, economic, cultural, spiritual and civic affairs, but not only the ability to be physically active or to participate in the labour force. Older people who retire from work and those with disabilities can remain active contributing agents to their families, peers, communities and national development.

It is recognized further that active ageing aims at prolonging healthy life expectancy and quality of life for all people as they age, including those who are quite well, disabled and those in need of care. Health defined as physical, mental and social well being of an individual in the absence of disease as expressed in World Health Organization (WHO) definition of health is the most important determinant of active ageing. Therefore, policies and programmes that promote mental health and social connections for enhancing active ageing are as important as those that improve physical health status.

The active ageing approach is based on the recognition of human rights of older people and the principles of independence, participation, dignity, care and self-fullfillment.[11,3] It has a principle function of shifting strategic planning away from a "need-based" approach (which assess that older people are passive targets) to a "right-based" approach that recognizes the rights of people to equality of opportunity and treatment in all aspects of life as they grow older.

[3] United Nations Principles

It further supports their responsibility to exercise their participation in their political process and other aspects of community life.

Gender, Health and Disabilities of Ageing Population

As already demonstrated earlier, population ageing is driven by two main factors: a decline in the proportion of children, reflecting declines in fertility rates in the overall population; and an increase in the proportion of adults 60 and over as mortality rate declines. This demographic transition will bring with it a number of major challenges for health and social policy planners. As population age, the burden of chronic or non communicable diseases increases. The major chronic diseases which affect older men and women worldwide are the same (see box 1).

Box 1: Major Chronic Conditions Affecting Older People Worldwide

- Cardiovascular diseases (such as coronary heart disease)
- Hypertension
- Stroke
- Cancer
- Chronic Obstructive Pulmonary Diseases
- Musculoskeletal conditions (such as arthritis and oesteoporosis)
- Mental illnesses
- Blindness and Visual impairment, and incontinence

Source: WHO [4]; United Nations [5,7]

The causes of disability in older age are similar for women and men, although women are more likely to report musculoskeletal problems. More importantly to the variation between men and women could be associated with the gender scenario of a given society related to the complex pattern of roles, responsibilities, norms, values, freedom and limitations that define what is thought of as "masculine" and "feminine" in a given time and place, has a great bearing on the health of the aged.[15,20]

The diseases of old often begin much earlier in life. The conditions that currently account for the bulk of mortality and morbidity among older people emerged from experiences and behaviours at young ages. Smocking, alcohol

[3] United Nations Principles

Smocking, alcohol abuse, infectious disease, under-nutrition and over nutrition (obesity), poverty, lack of access to education, dangerous work conditions, violence, poor health care and injuries, experiences from any of these early in life and throughout the life course can lead to poor health in later years.[2,5,6,7] In the early years, communicable diseases, maternal and perinatal conditions, and nutritional deficiencies account for causes of death and disease among this group. In the later childhood, adolescence and young adults, injuries and non-communicable conditions begin to assume a much greater role. By midlife (i.e. age 45 years) and in the later years, non communicable diseases emerge responsible for the vast majority of deaths and diseases affecting older people.

Research is increasingly showing that the origins of risk for chronic conditions, such as diabetes and heart disease begin in early childhood or even earlier.[5,7] This risk is subsequently shaped and modified by the socio-economic status and experiences across the whole life span. Evidence from developed countries, however, shows that the prevalence of chronic diseases and levels of disability in older people can be reduced with appropriate health promotion and strategies to prevent non-communicable diseases. It is of great concern that the prevalence of risk factors (such as smocking, alcohol, nutrition, physical inactivity, obesity, raised blood pressure, raised blood sugar, and abnormal blood lipids) for chronic diseases are on the increase in developing countries, especially Africa.[6] Opportunities missed by health systems to deal with or manage age-related non-communicable diseases will lead to increases in the incidence, prevalence and complications of these diseases and may take resources away from other priorities, such as child and maternal health.

Improving health systems and their responses to population ageing makes economic sense. With old age dependency ratio increasing in all countries, the economic contributions and productive roles of older people will assume greater importance. Supporting people to remain healthy and ensure a good quality of life in their in their later years is one of the greatest challenges for the health sector in both developed and developing countries.

Active Ageing Policies and Progammes

The World Health Organization (WHO) active ageing approach to policy and programme development has the potential to address many individual and population ageing challenges. It is argued that if important segments of national development, such as health, labour market, employment, education and social policies support active ageing, there will be:[2,7,9,20]

- Fewer premature deaths in the highly productive stages of life.
- Fewer disabilities associated with chronic diseases in old age.
- More people enjoying a positive quality of life as they grow older.
- More people participating actively as they age in the social, cultural, economic and political aspects of society. They will also participate actively in paid and unpaid roles within their domain, family and community life.
- Lower costs related to medical treatment and care services as they would have generated resources from their active participation in informal and formal labour markets.

Active ageing policies and programmes recognize the need to encourage and balance personal responsibility (self-care), age-friendly environments and intergenerational solidarity.[6,2,4] Individuals and families should plan and prepare for old age and to make personal efforts to adopt positive health practices at all stages. At the same time supportive environment are required to "make the healthy choices the easy choices."[2]

There are also good economic reasons for enacting policies and programmes to promote active ageing in terms of increased participation and reduced costs in care. People who remain healthy as they age face fewer impediments to continued work. The current trend towards early retirement in industrialized and some developing countries in Africa, as is the cases of Zambia and Malawi (at age 55 years), is largely the result of public policies that have encouraged early withdrawal from the labour force.[15,17] As population age, there will be increasing pressures for such policies- particularly if more and more individuals reach old age in good health, i.e. fit for work.

This may offset the rising costs in pensions and income security schemes as well as those related to medical and social care-costs.

With regard to rising public expenditures for medical care, available data increasingly indicate that old age itself is not associated with increased medical spending. Rather, it is disability and poor health, often associated with old age, that are costly.[10,15] As people age in a better health, medical spending may not increase as rapidly. This assumes that healthy ageing reduces medical care expenditures.

It is important for the policy makers to look at the picture and consider the savings achieved by declines in disability rates. For example, in the USA, such declines might lower medical spending by about 20 percent over the next 50 years.[12,2] It was estimated that between 1982 and 1994 in the USA, the savings in nursing home costs alone were estimated to exceed $17 billion (Singer and Manton 1998)[2,14]. Moreover, if increased numbers of Healthy older people were to extend their participation in the work force (through either full or part-time employment), their contribution to public revenues would continuously increase. It is, therefore, less costly to prevent disease than to treat it. For example, it has been estimated that a one dollar investment in measures to encourage moderate physical activity leads to a cost saving of $3.2 in medical costs (Centre for Disease Control 1999).[2,8,9,20]

THE NATIONAL CONTEXT OF AGEING POPULATION

In the national context of population ageing, national data has become scarce, even though most researchers have had to use chronological age to provide an operational definition of old age. [13,15] The statistical definition of old age has come to be recognized as the official retirement age of a given country, which in Africa ranges from 55-65 years of age.[14,17,21] In Zambia, retirement age is 55 years old, even though active productive population is 15-64 years as the labour force population age range.[19,33] This defined category is incongruent with African life experience for older persons in Africa and especially in Zambia, however, only a small percent of people are engaged in

the formal sector with appropriate retirement provisions. Other than the Republic of South Africa and Namibia where there are cooperative whole sales old age retirement arrangements, and there is nothing like "retirement" from work for most majority of ageing Africans who work in the informal sector, except at the age at which age or ill health makes it impossible to be active.[21,23] On the other hand, many old African people view or see ageing as work related. As retirement age in Zambia emerges at 55 begins a starting point for recognizing ageing, particularly in the formal sector.[33] Inability to work appears to be the cut off point to ageing: "Iam old, I can no longer work" or " I am useless, I can no longer work as I used to". The message has been repeated over and over in many surveys in Africa and Zambia.[17,10,20,23] In African societies and more so in Zambia, generally recognize distinct age stages as ascribed roles and patterns of human activities, which are: Childhood, Adolescence, adulthood and old age.[17,41] To these age categories are ascribed specific roles and responsibilities, defining and limiting the nature of inter-connecting rules, with different role expectations. The timing of social role transition, such as becoming a parent, grandparent and losing the ability to reproduce are used as a mark for old age.[21,22,41,42]

Demographic Change and Consideration: The Zambian Situation

Over the years, Zambia's population has changed rapidly. The demographic ageing of the Zambian population can better be appreciated if the factors most relevant to the ageing process in Zambia are also placed on a continental context as well. Results from the past four subsequent national Censuses of population and housing indicate that the population has trebled in 31 years from 5.7 million in 1980 to 9.9 million in 2000 with a population growth rate of 2.4 percent per annum.[25] This population has now substantially increased to 13 million in the recent national Census for 2010, respectively.[25] Table 2.1 provides a differential trend of population and vital statistics between the three national censuses. The decline in the economy has gradually reduced the proportion of the population in urban areas. The proportion of the population living in urban areas has decreased steadily from 40 percent in 1980 to 35 percent in 2000, leaving a larger proportion of the population residing in the rural areas.

Table 1: Selected Demographic Indicators, Zambia 1980, 1990, 2000

Indicator	Census Year 1980	1990	2000
Population in Million	5.7	7.8	9.9
Density (Pop/sq km)	7.5	10.4	13.1
Percent Urban	39.9	38.0	35.0
Total Fertility Rate	7.2	6.7	6.0
Completed family size for Women age 45-49 years	6.6	7.1	6.9
Ageing Population 60+ (Percent)	4.4	4.1	4.2
Infant Mortality Rate (per 1000 live births)	97	123	110
Life Expectancy at Birth:			
Male	50.4	46.1	48.0
Female	52.5	47.6	52.0

Sources: Central Statistics Office, [25,27,28,29,30]

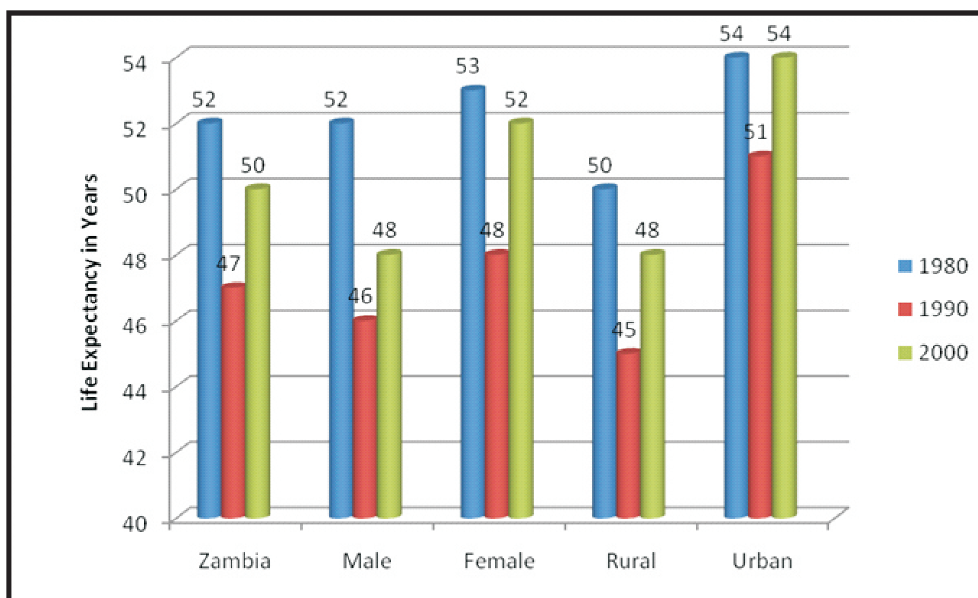
The challenge facing the country currently is that of a "youthful population" created by high fertility and substantial high adult mortality of productive population. Its youthful population is depicted by the funnel-shaped pyramid suggesting that older population is increasing at a slow pace, compared with that of the younger population. Although, there is a recipient decline in fertility rates, a Zambian woman is still expected to have six (6) children at the end of her reproductive life span, implying that fertility in Zambia is still high. The results of the 1969 and 1980 censuses that estimated increases in total fertility rates of 7.4 and 7.2 births per woman emphasized the rapidity of the population at which it was growing that would have adverse effect on development and individual welfare. This led to the development of the National Population Policy in 1989 by the government with a purpose of achieving a population growth rate that would be consistent with the growth rate of the economy.[19,31] One of the strategies emphasized was the access to contraceptive measures for fertility control and spacing births.

Fertility rates have decreased by one birth over the 27 year period from 7.2 births per woman in 1980 Census to 6.2 births in 2007.[27,29] However, in the most recent 2007 ZDHS survey data have shown a slight increase in fertility, mainly due to an increase in rural fertility from 6.9 in 2002 to 7.5 in 2007.[30] Fertility in urban areas has remained constantly low between 2002 and 2007 at 4.3 births per woman.[25,28,30]

Decline in fertility rates and steady rise in life expectancy may assume increases on the ageing population. There has been steadily increase in the older persons, 60 years and over between the inter-census period of 1990 and 2000 giving a population proportion range from 4.1 percent in 1990 to 4.2 percent in 2000 and 5.6 percent in 2010 period.[25]

Moreover, life expectancy at birth, which is also a mortality indicator, had recorded an increase between 1990 and 2000 (Figure 1).

Figure 1: Life Expectancy at Birth by Sex and Residence



Source: Central Statistics Office,[27]; Ministry of Finance & National Planning 2006-2010[19]

Life expectancy was 47 years for both males and females and increased to 52.4 years in 2000 and could be expected to increase more in the most recent Census of 2010. This means that only a smaller proportion of the population ever get to reach the older ages of 60 and over. The figures in Figure 1 further show that the female life expectancy is higher than that of males indicating 53, 48 and 52 years during the periods, 1980, 1990 and 2000 Censuses, compared with the male life expectancy recorded at 52,46 and 48 years during the same periods.[29] Life expectancy at birth for Zambians shows a distribution of 50.4 years rural and 50.2 years urban. [29] These statistics have demonstrated that Zambian women

live, on average, 4 years longer than men. It shows further that there is a likelihood of more women population ageing than men expected in the country.

Alongside Life expectancy is infant mortality rate that had declined from 123 deaths per 1,000 live births 123 in 1990 to 110 deaths per 1000 live births in 2000 Census.[18] The ZDHS estimates show a further decline in infant mortality from 95 deaths per 1,000 live births in 2001-2002 to 70 deaths in 2007.[28,30] Child survival chance is now being sustained. The statistics on trends in adult mortality observed in the 1996, 2001-2002 and the 2007 ZDHS surveys among the active population 15-49 age-group had increased between the 1996 and 2001-2002 ZDHS surveys from 10.9 deaths to 14.1 deaths per 1,000 years of exposure.[28,30] Most of the increased mortality accounted to higher mortality among women and men aged 25 and older. The increase was pronounced among women who exhibited a highest maternal mortality ratio of 729 deaths per 100,000 live births experienced in 2001-2002 ZDHS surveys, compared with a lower rate of 649 deaths per 100,000 live births during 1996 period. However, between the 2001-2002 and 2007 surveys, there was a moderate decrease in overall adult mortality from 14.1 to 12.5 deaths per 1,000 years of exposure, with the noticeable decline observed among men (i.e. from 14.0 to 11.9 deaths per 1,000 years of exposure). Maternal mortality ration also declined to 591 deaths per 100,000 live births.[30]The high levels of fertility and mortality in Zambia have resulted in the extreme youthfulness of the Zambian Population. However, changes in decline of fertility and mortality observed lately depict gradual increases in older population which should not be under estimated.

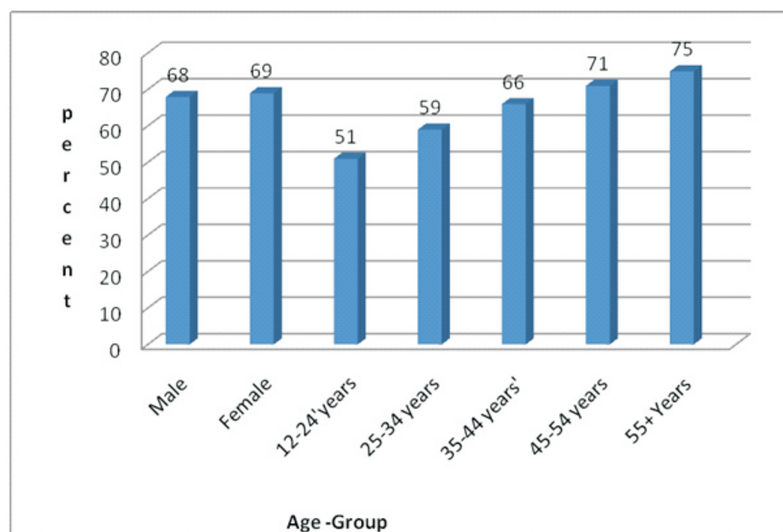
The other emerging demographic factors, such as rapid urbanization, gender concerns, Human professional brain drain and HIV/AIDS started unfolding in 1990s, thereby constituting major obstacles to ensuring improved quality of life for Zambia's population. In an effort to address these varies issues, the process of revising the population policy was initiated in December 1996 to incorporate the recommendations adopted by the 1994 Cairo

International Conference on Population and Development (ICPD). The new objectives of the policy took into account the concerns regarding HIV and AIDS, poverty, reproductive health, the environment, unemployment, gender issues and a global perspective on population and development that have a bearing on the older people's lives. However, the policy was finally revised in 2007, with a vision to improve the quality of life.[31]

Poverty, Social Security and Social development of Ageing Population

The poverty level has remained high indicating a national incidence rate of 68 percent and is more serious in the rural areas than the urban setting. The analysis indicates that the majority of the rural households in Zambia has depended on consumption of own produce.[33,35] Therefore, the high poverty level in rural areas could be associated with inadequate food by the majority of households. This has a strong bearing on the health and survival chances of older people in communities, without adequate social security. The rural areas have poor infrastructure and marketing systems while labour productivity among the small scale farmers is quite low. A further analysis of poverty by age and sex of household head has revealed high levels of poverty among households headed by elderly persons[19,33,35]. Table 2 provides a differential analysis of poverty between age-groups and sex of household heads.

Figure 2: Poverty by Sex and Age of Household Head, Zambia 2002/2003



Source: CSO, Living Conditions Monitoring Survey 2002 and 2003

Poverty rates ranged from 51 percent in the 12-24 age-group to75 percent for those in the age-group 55 years and over.[35,54] The high level of poverty among older people who are supposed to be living off their benefits is a clear indication of the poor social security system prevailing in the country. The delays in paying off terminal benefits have compounded the poverty situation for the active ageing population in the country. This poverty analysis urges for the re-construction of the policy framework to re-address the social security system of the ageing population if health and social needs intended to improve their quality life are to be met.

The dimension of poverty levels further reveals that high level of poverty were observed in households with seven or more members of family at 76 percent, compared with 35 percent household with a small family size of one to three members.[54] Sixty percent households had four to six members.[54] These results confirm that larger families are more likely to be poorer than those with a small family size. With the advent effect of HIV/AIDS increasing the number of orphans, large family sizes are unavoidable, while at the time increasing the health risks of those vulnerable, including that of the elderly persons.

The social dimensions of poverty that are also important for household welfare were analysed. The 2005 Human Development Report had ranked Zambia being 166th (out of 177 countries) on the basis of its Human Development Index (HDI).[54,55] This composite index reflects life expectancy at birth, adult literacy rate, school enrolment, and the GDP per capita. The achievement of Millennium development Goals (MDGs) by 2015 remains a challenge for the Zambian Government. The MDGs Status Report for Zambia 2005 has shown failure of some MDGs not being met.[36] These have included reducing child and maternal mortality, integrating the principles of sustainable development into the country's policies and programmes and reversing the loss of environmental resources and halving by 2015, alongside the proportion of the population without sustainable access to safe drinking water and sanitation.[36] Adult literacy rate stands at only 55.3 percent and has remained unchanged since 1990. Less than half of the rural adult

population are literate.[19,55,54,57] Further more the social security system for Zambia is only for those in formal employment.[33,60]There are no provisions for the social security system for informal population, which exposes the active older people to a higher risk exposure of poverty and other vital needs for their livelihood.

Health Status, Priorities and Programmes

Zambia's population is highly affected by a disease burden attributed by the high prevalence of HIV, high poverty levels and the poor macro economic situation in the country.[39,40,46,47,48] It should be noted that health and development are inter-related and better health contributes to economic development by increasing the worker productivity and lengthening the expected working life of human being and that of the ageing persons. Better child health and nutrition on the other hand further promote future productivity growth by helping children develop into healthier, more productive adults and healthy ageing persons, with a lengthened life expectancy. Improvements in the human capital, through improved health and education maintain the nation's human capital base for sustained economic growth and human development.

Health care in Zambia is provided by the government institutions, the mission hospitals coordinated by the Churches Health Association of Zambia (CHAZ), the Private sector hospitals and clinics, non- governmental organizations (NGOs) and the traditional healers.[38,39] For historical reasons, each of these categories of health care providers has concentrated in different parts of urban and rural Zambia, with a goal of providing quality health care and promoting the wellbeing of individuals. The number of existing health facilities for the government, mission and private facilities are tabulated in Table 2 below.

Table 2: Summary of Existing Facilities in Zambia, 2010

Type/Level	GRZ	Mission	Private	Total
Hospital	53	27	17	97
Health Centers	1,210	61	97	1,368
Health Posts	19	0	1	20
Total	1,282	88	115	1,485

Source: Ministry of Health, National Health Strategic Plan, 2006-2011

Out of 1,485 health facility, there are 1,282 government health facilities, 88 for the Mission and 115 for the private sector (i.e. the mine health facilities, parastatals, private and the defence). The government, however, provides the bulky of the health services in the country.

The structure of public health services run by the Government comprises: health posts at community level, health centres, level one hospital, level two hospital and level three or tertiary specialised hospitals provides a useful avenue for effective primary health provision for older people with disabilities. One health post should ideally cater for a population of 500 households in the rural areas and 1,000 households in the urban setting, or to be established within the 5 kilometre radius for sparsely populated areas. There are currently 20 health posts out of 3,000 health posts planned. Health centre facilities are 1,210 health facilities with a distribution of 973 rural health centres and 237 urban health centres. Urban health centres are intended to serve a catchment population of 30,000 to 50,000 people, while rural health centres should service a catchment area of 29 km radius or a population of 10,000, but the poor infrastructure and human resource developments have limited coverage to most intended catchment areas. There are currently 53 district hospitals out of 72 district hospitals, giving a short fall of 19 districts without hospitals. This has limited access to further primary 1st level referral district hospital care by some populations requiring such services.

The government is, therefore, committed to improve the quality of life for all Zambian. This commitment has been demonstrated, through the government's efforts to improve health care delivery by reforming the health sector. In 1992, the government introduced the radical health policy reforms characterized by a move from a strongly centralised health system in which the central structure provided support and national guidance to the peripheral structures.[37] The key tenets of the health reforms were decentralization of health services planning and provision to the district level and a focus on preventive emphasis rather than curative care. It emphasised the importance of community participation in the management of health services and coordination of donor support

within the framework of a sector wide approach (SWAP) initiative that involved pooling resources to finance a jointly approved health sector plan, also known as "basket funding" approach.

Since the onset of the Health policy reforms, the focus of the government has been on Primary Health care (PHC), and involved re-structuring of the Primary Health Care (PHC) programme. PHC was identified as the main vehicle for delivering health services. The reasoning behind the support for PHC initiative was due to the fact that most of the diseases in Zambia are preventable, or managed at a primary health care level, which in itself can lower the cost of referral curative care by reducing the number of people seeking services. In an attempt to promote efficient and cost-effective quality basic health care services for common illnesses as close to the family as possible in the context of PHC approach, the government further developed a Basic Health Care Package (BHCP). This package is a set of carefully selected impact interventions that is offered in the public health system freely, or at a minimum cost-sharing basis at different levels of the health care delivery system. Interventions not included in this package are offered on a full cost recovery basis. The elements for BHCP were selected on the basis of epidemiological analysis of the diseases and conditions that cause the highest burden of morbidity and mortality among the population. These have been listed as ten national health priority areas: *(1) child health and nutrition; (2) integrated reproductive health; (3) HIV/AIDS, TB and STIs; (4) malaria; (5) epidemics; (6) hygiene, sanitation and safe water; (7) human resource development; (8) essential drugs and medical supplies; (9) Infrastructure and equipment; and (10) Systems strengthening.*[38,39] Monitoring of these health events are done through surveillances system of population-based and health facility-based surveys conducted regularly and consistently to guide policy and planning. Since the initiation of the health sector reforms, the public health sector in Zambia has taken significant steps towards meeting the objectives of the reforms, particularly in improving access to health care, affordability of health services, and health systems strengthening. These health reforms established the government's commitment to improve the population's health and set targets for achievement.

The Ministry of Health in 2005 further embarked on a five year National Health Strategic Plan, 2006-2011 that aimed at reducing the disease burden among the population and accelerating the attainment of the Millennium Development Goals (MDGs) and other national priorities.[38] While it was recognized that all health care interventions were important and should continue to receive the necessary levels of support, prioritization of interventions was considered critically important as a result of limited resources available. This National Strategic Plan placed emphasis on human resource development to alleviate the crises being met, improvement in health infrastructure, fostering multi-sectoral responses to key determinants, such as nutrition, HIV/AIDS control and mitigation, control of epidemics, health education and increased access to basic environmental health facilities like safe drinking water, sanitation, electricity and telecommunication. The plan has placed greater emphasis on establishing effective sustainable partnership among all key stakeholders involved in health service delivery in Zambia. The priority areas were grouped into four main classifications: Health resources; health services delivery intervention; clinical care and diagnostic services for priority interventions; and priority integrated support systems.

However, the quality of health services has not been met to the highest expectation due to mainly increased demand for health services arising from rapid population growth and a declining economy. A review of past performance showed a marked decline in service delivery and quality of care in some health indicators, while others had a marginal improvement. Maternal mortality rate declined to 591 deaths per 100,000 live births in 2007, infant and under five year children mortality rates also declined to 95 and 168 per 1,000 live births in 2002, respectively (Table 3). HIV/AIDs have continued declining further to 14.3 percent in 2007.[30]

Table 3: Summary of Key Health Performance Indicators

INDICATOR	1992	1996	2001/2002	2007
Life Expectancy at Birth	45	46.8	51.9	52
Infant Mortality Rate Per 1000 births	107	109	95	70
Under 5 Mortality Rate Per 1000 births	191	197	168	117
Maternal Mortality Ratio Per 1000 births	N/A	649	729	591
HIV Prevalence Rate	23	20	15.6	14.3

Source: CSO, Zambia Demographic and Health Surveys, 1992, 1996, 2002, 2007

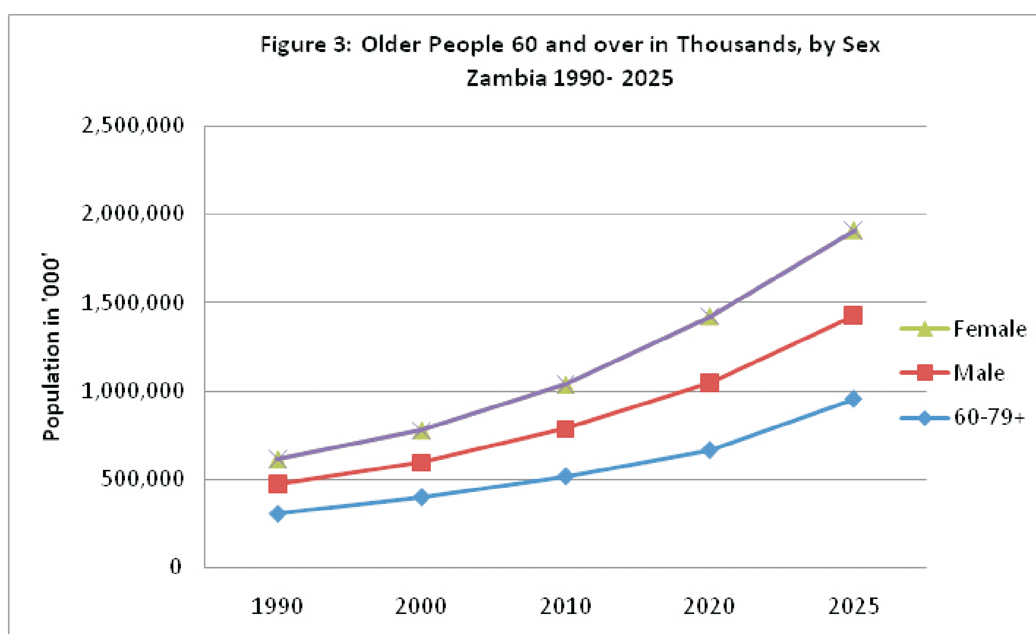
The analysis has shown a progressive improvement in health performance. Factors that led to the decline of some health indicators are attributed to the HIV/AIDs pandemic, professional brain drain, poor state of health facilities, inadequate drugs and medical supplies, and high poverty level. However, health indicators in Zambia have not improved as much as those of most other countries. While there is a remarkable improvement in some indicators, structures for providing adequate health to older persons with disabilities and in the health promotion of their quality of life are not clearly defined in the national health policies and strategic plans.[37,38] Special attention is mainly devoted to children and women in reproductive ages, where as the other group of vulnerability like older people, there are gaps in the health priorities of health care. The comprehensive framework for the provision of Primary Health Care does not include priorities health needs of older people with disabilities for care or for promoting active and healthy lifestyle in the country. Ageing should be recognized as an integral and natural part of life that has a complex phenomenon exhibiting differentiated meanings in its understanding to older persons, societies and in the scientific understanding. The complexity of care for elderly persons should be embraced within the domain of Primary Health Care (PHC).[6,13,20]

The following findings in Sections Two and Three present the current evidence on Health and social policies and programmes as they affect older people in Zambia along side exploring determinants that affect older

people in Zambia along side exploring determinants that affect health care provision to elderly persons and the challenges being faced by them.

HEALTH POLICY FRAMEWORK AND STRATEGIES

The term "elder" or "older" person in the Zambian context has raised conflicting feelings in understanding the meaning of population ageing. First, the retirement age at 55 years for the formal sector, as observed in other countries,[17,33,59,60] may suggest that population ageing in Zambia is initiated at this age. By contrast, the labour force policy terminology of defining a productive population in this country is that of the age-group 15-64 years, which entails that "old age" resumes to manifest itself at the age of 65 years onwards.[4 0,4 1,4 2,33] With reference to these two differential scenarios, this documentary analysis broadly interprets the concept of population ageing based on the United Nations standard describing 60 and over.[2,43] This provides a better understanding of a forecast direction to which population is increasing and the various needs required to promote health, participation and social security services that can easily be evaluated.



[5] Apt 1997, National Pension Scheme Authority 2009

Figure 3 presents a trend analysis of older people 60 years and above in relation to sex between the periods 1990- 2025. It shows that the demographic profile of older persons of this age-group is increasing drastically (see also statistics in Table 2.1 Annex3). Between 2000 and 2010, older people 60 and over increased from 400,261 in 2000 to 518,282 in the period 2010 Census. By 2025, the figure will be expected to rise to over a million population ageing (Figure 2.1).The distribution of this population according to sex shows an upward increase among both males and females, even though female population ageing will be expected to increase rapidly more than males between 2020 and 2025, respectively.

These figures have clearly shown that population ageing is however increasing rapidly. The rapid increase demands action for better policies to be instituted in order to enhance healthy living conditions, participation of older people in society and contributions to national development. Appropriate effective interventions should therefore be instituted to avoid the likelihood of ageing crisis in future.

Policy Definition of Older People in Zambia

The Ministries of Health and Community Development and Social Services have defined the older people as those aged 65 years and older.[37,40,43] This is the group considered eligible for accessing free medical services and public welfare assistance programme. This operational definition is clearly defined in the Ministry of Community and Social Services Policy guidelines,[44] where as in the Ministry of Health policies and strategies, this category is not documented.[37] The recognition of this category as the most vulnerable group implies that the other category of older persons aged 60-64 years are considered productive with ability to pay for medical services.[37]

Health Policy Vision and Primary Health Care

The review of the Zambian national health policy formulated in 1992 shows abroad elaborative policy emphasizing the health needs of the vulnerable populations, including that of the population ageing in its visionary approach.[37] The policy vision has focused on ensuring "equity of

access to cost- effective quality health care as close to the family as possible" to all the Zambian population.[37] It means provision of better management for quality health care for the individuals, the family and the community. The policy statement has no discrimination in providing health services to its population. To ensure attainment of this policy vision, the Zambian Government has adopted the Primary Health Care (PHC) as the most appropriate tool for enhancing healthy development. In adopting the PHC strategy, emphasis has been placed on " Health for All" that would not only mean the improvement of accessibility to health services and reduction of morbidity and mortality, but also the general improvement of quality of life for all Zambians. The approach should lead to an acceptable level of health that would permit populations to live a socially and economically productive life. It is in this connection that the Ministry of Health has taken consideration of the main determinants of health, which are:

- Environment
- Life Style
- Socio-economic, cultural and political determinants, and
- Health services

It is further emphasized that achieving a healthy society is not primarily a medical issue, but rather a political and socio-economic, and cultural matter.[37] The prominence given in the policy document to the rationale of inter-sectoral collaboration with other sectors is imperative. However, since health services play an important role in achieving population health, The Ministry of Health is urged to forge-ahead promoting preventive, promotive, curative and rehabilitation services as major elements for achieving its vision, with individuals taking responsibility for their own health. With this vision, the health of ageing population becomes imperative.

Health Policy Articulation and Healthy Ageing

The state believes that people have a right of access to affordable and quality health care and all Zambians should have the right to decide on the

future of their health care which should become more apparent than rhetoric, but this has not been the case for the older persons in the country.[38,39] The main core of the health policy strategy is to ensure management of quality health care through a District Health Management System:

"The health policy strategy shall be managing for quality care, through a District Health Management System…The district shall be the basic unit of management where botton-up planning and implementation initiatives meet the thrust of national policies."[37]

The policy statements emphasize provision of health services through a decentralized system of health care at a district level as the basic point of reference for the articulation of people's power in health care participation. Through area-health management boards and the professionals combined should ensure provision of a health care system that should be responsive to local and national interest and needs of population. This statement may also suggest inclusion of the ageing population's health needs that should be met. Another policy dimension linked to the scope of a comprehension provision of health care is the broadening of the range of professionally regulated health providers (including bio-medical technicians, nurses, mental health professionals, traditional healers and other social health providers, and the integration of private sector strengths and resources) to strengthen team work among varied health providers, both in clinical and public health settings to which older persons of society can receive health benefits. The health policy has further advocated for a health system that should be based upon humane values stating that:

First, " Zambians must assert belief and action in preventing illness, through a healthy way of life by taking full advantage of opportunities and being responsible of their own health."

Second, " the health system must be based on the rights of individuals to make their own informed decisions on health matters as well as the provision of services that allow them to maintain their dignity."

Thirdly, " assert beliefs and practice in an equitable health care system for vulnerable groups."

These broad policy statements further provide a possible avenue for the health promotion activities and gaining access to health care by also older people to ensure their healthy living practices. However, the transformation of these policy statements into the real visionary action has not been a reality for some segments of the population, especially the older persons.[37]

To sum up the overall key principles of Zambia health policies guiding the implementation of health services in the country are in the following Table 4 below:

Table 4: Key Principles of Zambia National Health Policies

Principle	Priority Function interpretation
Equity of Access :	Equal access to health care services for all the people of Zambia, regardless of their location, gender, age, race, social, economic, cultural and political status.
Affordability:	Affordable health care services to all populations, taking into account the socio-economic status of people
Cost-Effectiveness:	Efficient and cost-effective delivery of healthcare services, always ensuring value for resources used.
Accountability:	Accountability for the resources utilized services provided and to the communities served at all levels of health service delivery
Partnerships:	Partnership with all the stakeholders, taking full advantages of the synergies provided by each stakeholder group
Decentralization:	Devolution of key responsibilities, including planning, organisation, coordination and control of health care delivery system, and resources from the centre to the districts and hospitals where health services are provided.
Leadership:	Appropriate, efficient and effective leadership in the implementation of strategic plan at all stages of health care delivery system should be ensured.

Source: Ministry of Health, National Health Policies and Strategies, 1992

The key principles for the National Health Policies in Zambia further suggest availability of a comprehensive national health policy giving direction to the provision and promotion of health care approaches affecting also that are ageing to ensure better healthy living conditions in their respective communities. Issues of equity, affordability, partnerships, decentralization, and cost-effectiveness of health services are the key elements that can yield a positive impact on the disease burden affecting population and that of ageing, if

programmes are implemented in conformity with the laid down policies as indicated in the Zambian national health policies and strategies.

Health Goals and Strategies in Context of National Health Policies

The emerging issues of the Millennium Development Goals designed for achievements by 2015 have sidelined other vulnerable groups for health care priorities, such as the older persons with prominent disabilities and those for healthy ageing practices to be recognized as risk groups to receive special attention in the national health goals and strategic priority areas of interventions. The following health goals and strategies are outlined in Table 5 to provide an insight perspective view of the national health priorities that have excluded the health needs of older people in this society:

Table 5: Health Goals and Strategies

Health Goals	Strategies
Goal 1: Achieve equity in health opportunities through:	a) Provision and intensification of integrated supermarket approach of services to vulnerable groups, i.e. women and children. Such services include control of diarrhoeal diseases, child immunization, school health, safemotherhood and child health monitoring. b) Intensified nutrition promotion c) Intensified family planning promotion d) More effective education and social marketing for health. e) Assured equitable access to health services using modalities, such as health insurance, referral line of past fees and special waivers.
Goal 2: Increase the life expectancy of Zambian through:	a) Effective disease prevention programmes for both communicable and non-communicable diseases. b) Effective programmes against common causes of mortality and disability
Goal 3: Create environment which supports health through:	a) Promoting strong, supportive family relationships and communities. b) Ensuring safe working environment which supports health. c) Ensuring safe physical environment and health supportive habits.
Goal 4: Encourage life styles which support healthy conditions through:	a) Promoting healthy sexuality b) Promoting individual hygiene practices and improved food habits. c) Developing programmes combating drug misuse, drug abuse, inappropriate use of alcohol and smocking. d) Encouraging participation in increased physical activities and healthy social activities. e) Promoting safe driving and safe traffic practices, and f) Developing gender sensitive programmes that include prevention of violence and intimidation.
Goal 5: Provide Quality assured health services through:	a) Consolidation and rehabilitation of exiting health infrastructure, and health manpower development
Goal 6: Promote public policies supporting health through:	a) Coordination and collaboration, reviews
Goal 7: Improve individual and family health through:	a) Efficiently administered population control activities

Source: Ministry of Health, Zambia National Health Policies and Strategies,1992; Ministry of Health, National Decentralization Policy, 2003

The health goals and strategies presented in Table 5 show a highly priority attention to women in childbearing ages and children than that of ageing population, even though there are other goals reflected, in particular goals 2,3 & 4, that may seem to have an implicit bearing on disease prevention and promotion of healthy ageing population in the national health priorities. This may suggest that there are still policy gaps existing to address the priority health needs of ageing population to sustain healthy living

conditions of their life course. Health policy development focusing on healthy ageing programme development is an impetus to the country to grow old rather than growing young at all times.

The launching of the National Decentralization Policy (NDP) in 2008[4 5] to be implemented over a period of 10 years, respectively, has brought in another dimension to the future organization and management of health services in Zambia, with implications for planning, resource allocation, human resource management and accountability that may also envision setting health priorities for healthy ageing population. The overall decentralization policy urges for channelling and controlling of resources through the Local Authorities at a district level. While the National Decentralization Policy (NDP) aims at devolving responsibilities to the district level, the provincial level management will provide the necessary intermediate level of programme management, coordination and supervision of district authorities. Under the existing decentralized health sector, the Provincial Health Director's Offices play an important role of providing technical support, coordination and supervision to the District Health Boards and Management Teams. The on-going restructuring of the health sector would need therefore to clearly define the new roles and responsibilities of the provincial level and how management system and staffing level should be strengthened. In this situation, the implications of the new policy may require to be studied carefully to avoid severe health effects on the populations being served.

Furthermore, the documentary review of the Ministry of health strategic plans, programmes and policy guidelines show absence of specific health priority needs or services for the older people in communities, compared with other countries having positive response to the health needs of older persons.[58,20,11,13] For example, India has developed a training manual of trainers of Physicians in the health care of elderly persons (geriatric Health care) in primary and secondary health care facilities.[13] In Zambia, the situation is quite different. Geriatric health care for the elderly people is a new concept not receiving a priority health needs for care in the health system.[38]

Apart from exemption of older persons 65 years and above from payment of user fees, even though there are no current policy guidelines available in the health systems to clearly articulate the elderly persons' health needs. Aspects of exemption from paying user fees at health facilities have related to issues of epidemics, chronic infectious diseases and natural disasters, women with maternal health conditions and child health, including family planning.[38] The latter ones reflecting on women and child health, and family planning have received favourable priority attention for social action programme support more than for the aged people.

Integration of Healthy Ageing Activities with Health Programmes

The assessment of the National Health Strategic Plan 2006-2011 and other health reports have shown that the health programme priorities are driven towards "attainment of the Millennium Development Goals (MDGs)".[46,38,47] There are no existing structures or specific health service activities addressing issues of healthy ageing population 60 years and above and those presenting with disabilities drawing attention of national health priorities available in the country. Members of this group with disabilities are managed clinically like any other adult person seeking health care from a recognized health facility, suggesting that older persons are not vulnerable enough to draw attention of the health priorities. The health programme priorities have reflected issues of reproductive health and child health, HIV/AIDS/STI/TB, malaria, essential drugs and medical supplies, and other communicable diseases.

There is very little attention tonon-communicable disease control and prevention mechanisms, and such diseases are noteven reflected in the health management information system (HMIS) designed to monitor the disease burden in the country.[46,47,48 48] Issues of public health epidemics are of higher priority than the non-communicable diseases observed having more serious risks among older people. Reporting system has emphasized on aspects of communicable diseases and epidemics, rather than considering inclusion of non-communicable chronic diseases from all the annual health reports reviewed over a period of three years, 2006-2008.[46,47,48]

Yet, these are new emerging chronic diseases as "silent killers"in Africa[7] affectingolder persons more than those below this age-group.This could be a challenge for the Ministry of Health for failing to recognize the priority health needs of older people or the ageing population in the national health plan in this country. Much of the institutional health and social care services for older people who could be most vulnerable have been entirely the responsibility of the Ministry of Community Development and Social Services in collaboration with the Non-Governmental Organizations (mainly Church societies). There has been very little assistance, if not none, from the Ministry of health, in terms of providing ambulant services for health promotion activities, or medical supplies to older people's institutions, or assessment of their physical and mental conditions at these institutions to provide direction of referrals to the next level of medical care. Yet, the Ministry of Health operates within a comprehensive framework of a Primary Health Care (PHC) approach playing a role of the main 'key' institution to provide health care services to its populations. The findings have shown gaps in the health care provision of elderly persons, suggesting need for a strategic healthy ageing programme development embraced within the PHC framework approach of the Ministry of Health. This healthy ageing programme may require a collaborative effort of the Ministry of Community Development and Social Services alongside other relevant sectors or partners interested in the health care of the older persons.

Health Care Cost Scheme for Older People with Disabilities

With regards to cost sharing, the overall health policy states that, " every able-bodied Zambians with an income will contribute towards his or her health."[37,43,55] However, systems are in place to make the cost-sharing scheme more equitable, even though currently being reviewed, utilizing the following two mechanisms relating to exemption of older people 65 years and above are somehow conflicting:

- ***Exemptions***: demographic exemptions of population, i.e. children under 5 years and adults 65 years and over are exempted from paying user fees. However, the demographic exemptions of ageing population 65 years and over with economic means of support, but currently

exempted are expected to make contributions to the cost sharing scheme.[35] This suggests that active ageing people 65 and over with adequate income are not exempted from paying medical fees. The criteria for exemption of older people may require critical review. Other exemptions are disease-based conditions (i.e.Tuberculosis, HIV/AIDS,STDS, cholera and dysentery); safe motherhood and family planning services; and treatment of chronic hypertension and diabetes. While the disease-based exemptions have been difficult to implement, the vulnerable group exemption s most difficult and the scheme linked to identification and payment to be made by the Ministry of Community Development and Social Services (MCDSS) is largely non-functional.

- ***Safety Net/ Health Care Cost Scheme:*** The Public Welfare Assistance Scheme (PWAS) introduced earlier in 1952 and reviewed in 1995 was intended to address inequities in access to health care services. [44]Chronic patients, not necessarily older people only, who cannot pay are supposed to be referred to the District Social Welfare Officer for assessment, and approved fees are paid to the District Health Management Board by PWAS. However, the referral system has not functioned well and those who cannot pay failed to access services. Cumulative deaths among older people living in old People's home on account of inefficiencies in payment by PWAS to access health services have been reported (see narrative accounts under social care services section). [4,524]

Social Services and Social Security System of Ageing Population

Generally, the documentary analysis and discussions held with the key informants involved in promoting the welfare of older people in communities, especially the Ministry of Community Development and Social Services alongside other government sectors, some NGOs and the National Pension Scheme Authority (NAPSA), show that ageing population can make a great difference in promoting their lives through active participation, if they are likely to remain healthy through out their remaining life course. There are social policies and programmes available to ensure provision of social

services and care, and participation of older people in micro-economic activities to alleviate poverty and promotion of their healthy needs in communities that have been initiated by the State, through the Ministry of Community Development and Social Services (MCDSS).[49,52,57] Two basic approaches are currently applied to ensure social and health care to elderly people with disabilities and participation of active ageing in healthy sustainable measures discussed as follows (to promote the well fare of their lives and that of the members of family):

Public Welfare Assistance Scheme (PWAS) Programme[44,57]

The public welfare assistance scheme is a government's major Social Assistance programme (SAP) implemented through the MCDSS. Its aim is to provide basic necessities to the most vulnerable group, including that of the elderly people, in form of cash, food, clothing, basic shelter, education, health care support and repatriation of misplaced or stranded people[44]. The programme has targeted incapacitated households. Since its inception in 1952 during the federal periods of Rhodesia and Nyasaland, the programme has ensured the well being of its citizens and social protection remaining as one of the government's priorities. However, this programme was revised in 2008 to strengthen social services delivery to the vulnerable people including the aged persons. In facilitating implementation of the PWAS programme guidelines have been delivered to ensure quality and efficiency in service delivery and optimising the use of available PWAS resources. The programme uses decentralization approach inline with the government's decentralization policy meaning that it is owned by the community and emphasizing the principles of participation, transparency, accountability, partnership and tradition.[44,45] The community has entire responsibility of being in charge of selecting and approving potential clients that should access assistance. This is because community members are better placed to know the most needy and vulnerable in the community. The attention is to make easy access to provision of meaningful assistance to identified vulnerable persons in the community, such as the elderly, children, persons with disabilities and destitute persons to enable them lead a decent life.

The implementation of the programme is enforced by the strategic principle paths of enhancing decentralization; criteria for selecting the vulnerable group (as social qualifiers); coordination system of activities from the central level to the community level; and structured monitoring and evaluation system employing use of standardized checklist and the clients' identification matrix (see annex). However, despite having a well structured programme, there are limitations in its implementation process. Delays in disbursement of funds to the beneficiaries, distance and road infrastructure, high levels of poverty at grass root, and disease burden of HIV/AIDS in communities have affected the effectiveness of the programme. Positive impact on health and welfare of ageing population is little due to high poverty levels.

Social Cash Transfer Scheme

The social cash transfer is another model being tested in five selected rural districts with high poverty levels and increased vulnerability among the aged and children. It was introduced by the government as a response to the HIV/AIDSpandemic which has led to a growing number of households with no productive adults and households being headed by aged members, too sick, or too young.[49] It is an alternative payment in cash, ranging from ZK 40,000 to ZK 60,000 to vulnerable individuals or households, with or without children being administered by the Ministry of Community Development and Social Services (MCDSS).[49] The scheme serves two purposes:

- To provide assistance to most destitute and incapacitated households in communities meet their basic needs which are: health, education, food and shelter.
- Determine the positive and negative impact of the social cash transfer scheme as one of the social protection measure for economic livelihood in Zambia on health, education and nutrition.

Implementation process

The rural sites where the social cash transfers model is being applied are: Kalomo, Katete, Kazungula, Chipata and Monze comprising 12, 267 households in total that are unevenly distributed in all these districts. There are two main approaches applied to identify potential vulnerable groups in communities. First, involves targeting process conducted by the Community Welfare Assistance Committees (CWACs). A multi-stage participatory process is then used to identify at least 10 percent most destitute and incapacitated households in their area. The selection team comprises head persons of households, village headmen, community members not vulnerable, and the District Welfare Assistance Committee representative who then select households. Second, is a universal social pension scheme applied to all local residents aged 60 and over. Eligibility to this scheme is defined by a simple categorical criterion that ' anyone aged 60 years and older is entitled to register to receive the cash grant of ZK 40,000- ZK50,000' at bimonthly basis.[44]

Impact of the Social Cash Transfer on Health, Education, Nutrition, and Food Security

Based on the evaluation documentary analysis and discussions with key informants, the social cash transfer demonstrates that there are positive impacts on health, nutrition and food security, and improvement on livelihood assets of the beneficial vulnerable groups:[51,57]

a) Health

The health status of the social cash transfer (SCT) beneficiaries has shown some improvement due to most likely adequate nutrition. In Kalomo District, for example, the cases of self-reported illnesses in the month preceding each survey dropped from 43 percent to 35 percent, possibly due to improved disease resistance on account of improved nutrition.[57,52]

a) Nutrition and Food Security

A primary objective of all SCTs is to reduce hunger in poor households by enhancing their access to food and other basic commodities. However, food consumption by the beneficiaries increased. In one of the study sites (Kalomo), it was found that reported cases of hunger declined, while meals per day and dietary diversity both increased as a direct result of receiving cash transfers.[57]

b) Livelihoods and Assets

The cash transfers have had impact positively on beneficiaries' livelihoods by protecting household assets against distress of sales for food, enables accumulation of assets, especially small livestocks. It was further demonstrated in Kalomo survey where it showed that a number of livestocks, such as chickens and goats for their sustainable livelihood.[57]

When comparing with the earlier scheme of public welfare assistance scheme, it has very little effect on improving the welfare of older persons in communities, compared with the social cash transfer scheme initiative, particularly those in active ageing group.

Social Security Policies

There are several pieces of legislative social service policies existing that have a bearing on the welfare of older persons in Zambia. Among them is the most recent drafted national policy on ageing developed in 2008.[19,43]

National Policy Framework on Ageing in Zambia

The vision for the policy framework on ageing in Zambia is to recognize "ageing with dignity by the year 2030" developed on the basis of following guiding principles[43]:

First, is ***Participation***: the policy has placed emphasis on older persons to have the right and duty to actively participate in the economic, social, cultural and political affairs of the country.

Their involvement in the formulation of policies affecting their lives alongside responsibility of imparting knowledge to the younger generations is another major role to be played by older people. They should, also, be capable of forming associations that may advance their own interests.

Second, ensuring ***dignity, security and freedom from exploitation*****:** with a view of these related principles, it is expected that all Zambian citizens are born being free, equal in dignity and rights. They are entitled to all the rights and freedom as prescribed in the Bill of Rights as enshrined in the Republican Constitution should not be underestimated. It is therefore imperative that older people should be expected to live in conditions of dignity and ensuring their security. They should have the freedom from all forms of marginalization, discrimination, exploitation, abuse and should be treated fairly with respect, and to be valued for their socio-economic contributions.

Third, ***family and community care*****:** older people should be expected to benefit from the care, support and protection provided by the family, community and government.

Fourth, ***partnership***: considering that the provision of care is highly involving, it should require the participation of other stakeholders. The policy therefore urges the government to further embrace partnerships and enhance collaboration with the private sector, civil society, Cooperate partners and the involvement of older persons themselves in tabling the needs of the ageing population.

Fifth principle is ***availability and accessibility of basic needs:*** in this principle, older persons should have access to health care, food, water and sanitation, proper shelter, clothing, entrepreneurship activities, education, training and life in the safe environment.

Sixth, ***Strengthen research, information and development***- are cardinal to the effectiveness of the policy implementation. It is therefore imperative that generation of information, analysis and dissemination of data on

ageing be recognized as a national priority.

Lastly, seventh principle is the intergenerational solidarity: The policy has recognized and promoted strong links between generations to enhance cultural, social and economic values. The need to recognize the strength of solidarity among generations and intergenerational partnerships to differentiate the needs of older people and those of the younger ones, and to enforce mutual responsive relationships between the generation have been important aspects considered.

Policy Objectives and Measures

The overall policy objective aims at promoting, protecting and fulfilling the rights of the ageing population in order to ensure that they lead a productive and fulfilled dignified life in old age or as they age. The objectives and policy measures reflect dynamics of challenges affecting older people in relation to: poverty; employment and income security; health, food and nutrition; housing, transport and healthy environment; research, information, education and training; family care system; and the social welfare.[43]

Implementation Framework

The successful implementation of the policy on ageing envisions dependency on a sound and effective institutional framework, resource mobilization, financing, monitoring and evaluation. It has been predicted for a ten year period of its implementation phase through the National Plan of Action (NPA). Its structure has incorporated the institutional arrangement framework to enhance partnership and participation of key stakeholders to ensure successful implementation of the policy.[43]

The institutional arrangements incorporate all government sectors' functional roles that should be ensured in the implementation of this policy. The Ministry of Health has the primary responsibilities of developing health insurance schemes and health promotion strategies; establishing geriatric clinics; ensuring provision of free Anti-Retroviral therapy (ART) and nutritional

supplements to the infected older persons; and sensitization of older people on issues of health and nutrition stating[43]:

" The Ministry of Health shall:

(i) Facilitate the development of health insurance schemes which will enable older persons access free health care at all levels.
(ii) Raise awareness on diseases related to old age.
(iii) Facilitate the establishment of geriatric clinics.
(iv) Provide free Anti-retroviral therapy (ART) and nutritional supplements to the infected older persons; and
(v) Sensitize older persons on health and nutrition."

These policy statements demonstrate that the Ministry of Health has a greater responsibility for ensuring healthy ageing population in the country. Healthy programme development of this nature should be recognized as a highly priority focus. However, the National Policy on Ageing has provided a comprehensive holistic approach of promoting healthy ageing population involving all public sectors and other partners in the years to come that sound a leading transformation of Zambia to a better "old" country rather than being persistently viewed as "young" country.

The national policy framework on ageing was developed in response to action on the rapid increase of this growing population affecting not only Zambia, but many countries in the world.[58,56,15,16] The wellbeing of the aged should be recognized as a fundamental responsibility of any government or state.[62] Ageing on the other hand is a phenomenon that has experienced great difficulties. The economic difficulties Zambia has experienced compounded by the disease burden of HIV/AIDS pandemic placed a lot of stress on the majority of Zambian population. Older persons, in particular face increasing uncertainty challenges as they have limited access to meet their basic needs and services as they age.

The review of the policy objectives and measures has generally provided a platform for stakeholders' involvement in the collective

delivery of services to older persons in order to ensure that their quality of life to live in a healthy environment is greatly improved. A further provision of guidelines adjacent to this policy on the provision of services for older persons suggests direction to a more effort of developing a strategic programme on healthy ageing that will add value to a meaningful service provision to enable them lead a decent and sustainable life.

The National Policy on Ageing is therefore a reflection of the Government's intention to uplift the standard of living for its ageing population in general and life in old age in particular. It should be considered as a tool for providing guidelines for changing, maintaining and creating living conditions that are conducive to the ageing population to enable Zambians age with dignity and honour. Interventions to be developed through this policy should aim at enhancing human life in a humane condition, through the provision of improved basic needs (such as health care, food and nutrition, education, housing, water and sanitation, and other social security safety-nets) that have posed greater challenges to the life of older people in the country. Furthermore, the policy on ageing takes into account the existing pieces of legislative measures to examine, not only their adequacy, but also their relevance in facilitating the effective and efficient implementation of programmes aiming at promoting the well-being of the ageing population in the country. It is therefore the requirement that the basic needs should enable the Zambian population enjoy old age meaningfully. The aged should be left to continue participating in the social economic emancipation of the country. The following sections further examine challenges on the current status of older people reflected by views from the aged themselves, key informants supplemented by the documentary analysis of this perspective review to re-focus on programme design development.

CHALLENGES OF A HEALTHY AGEING POPULATION: CURRENT STATUS OF OLDER PEOPLE'S DETERMINANTS

The challenges being faced by older persons in Zambia are enormous and all point to the direction of comprehensive interventions of care and sustainable development. In as much as the Government and Civil society has taken measures to address some of the challenges in reducing the vulnerability among the older persons, this has been limited to welfare and health care coupled with fragile legislative policies with little positive effects on ageing population. The plight of older people requires a holistic approach that is focusing on sustainable programmes to empower older people to contribute effectively and efficiently to their societies and should be able to benefit from socio-economic, cultural and technical interventions. The following are some of the major determinants constraining the living conditions of older people in the country:

Poverty

The majority of the poor in Zambian societies have a long history of being trapped in chronic poverty that has been transmitted through the generations. In most fora, where issues of growth and development are discussed, the plight of older people is highlighted[56,61]. In this country, it is underrated because of considering old people as being incapable of contributing effectively to national development[4] [1]. Yet in some countries, such as Mauritius, Namibia, South Africa and the United States of America, older people's economic efforts have contributed to the wealth growth of these countries.[53,54,56,2] In Zambia, poverty has remained a burdened chronic disease affecting the entire population and that of the aged.

Current statistics show 64 percent of Zambia's total population is poor. Among the poor, 51 percent are the most vulnerable people with inability minimum basic food requirement, hence considered being extremely poor.[54] Poverty is evident and more severe in households headed by older persons (particularly female older persons). It has been found also that most severely pronounced poorest population is in the rural parts of

Zambia, where the majority of older people live. Almost 80 percent of households headed by older persons reported in the Living Conditions Monitoring Survey 2006 to be below the poverty line.[54] Conditions of abject poverty have also been largely coupled with the HIV/AIDS pandemic that added responsibilities of caring for the sick, orphans, vulnerable children and the elderly. In addition, the rapid rural/urban migration of young productive people in the most recent times to seek for jobs in urbanized cities has barely left older people unattended to their basic needs within the domain of family union care and support.[25,22]

Furthermore, a large proportion of the current older persons, some of whom were in formal employment, but fell victim to retrenchments due to the 1991 Structural Adjustment Programme now live in destitution.[55,19] During that time, many retrenches left employment unprepared to cope with the effects of ageing, or without having their separation packages paid on time or not paid at all. In cases where separation packages were paid, these were inadequate. It caused destitution among the "senior" citizens entering old age. The response to this destitution was the formation of the Senior Citizens Association which is being supported by the government through the Future Search Programme at the National Pension Scheme Authority[60]. The programme provides assistance to elderly retrenched and retired persons to build capacity in sustainable entrepreneurship activities for their livelihood measures. This programme initiative only supports the civil servants to prepare them for survival after being retired from employment, but does not support those in informal employment (e.g private sector, NGO alike). Addressing the issue of poverty alleviation is therefore cardinal in order to avoid risks of premature deaths and ill health among the ageing population.

Health Status and Disease Burden of Older People

Health is indeed a very important determinant of ageing and contributes positively to people's participation in sustainable community development. The current health system only exempts children below age of five years and older persons aged 65 years and above from paying medical fees (user fees). This exemption only allows this category of people to

freely access primary health care only, but not other health services. However, most of health centres lack essential medicines, appropriate clinical structures and personnel in the field of geriatric medicine. Health programme priorities are driven by the concept of achieving the Millennium development Goals (MDGs) without a specific consideration of healthy needs of older persons have worsen their health conditions. Health structures that are expected to address the issues of older citizens of society are limited or lacking in the entire health system in Zambia.

Older persons are more prone to chronic diseases of non-communicable diseases.[2,5,7] The non communicable diseases that are associated with old age, such as hypertension, heart diseases, diabetes, poor eye-sight, memory lapses, arthritis and many others are not reported as a high priority conditions affecting the population in the health monitoring system.[46,47,48] Reporting system of the health management system have been confined to the epidemiological events of communicable diseases in relation to the Millennium Development goals priorities has a serious repercussion on the health of old people, as these events are not monitored to determine the extent to which the aged are being affected countrywide. Further more age gaps in the health information management reporting system in Zambia emphasizing age category of " below five years" (referring to children) and " above five years"(referring to adults),which is meaningless to the understanding of disease burden effects on all age-groups of the entire population in a chronological order.[48]

Conditions of heart disease, stroke, cancer, diabetes and other chronic diseases reported in other studies have been thought to be public health problems of significance only in high-income countries.[5,7] In reality, only 20 percent of chronic disease deaths occur in high-income countries, while 80 percent occur in low- and middle-income countries, with no exception to the Zambian situation, where most of the world's populations live.[7] Non communicable diseases are found to be silent killers due to debilitated complications resulting in painful deaths in Africa. New cases of cancer are increasing rapidly and the most common cancers recorded in sub - Saharan Africa in 2002 were:

cervical cancer (12 %); breast cancer (10%); liver cabcer (8%); Karposi's sarcoma (5%), non-Hodgkin's lymphoma (5%); and prostrate cancer (5%). In the period 2007, the commonest cancers in males were Karposi's sarcoma and cancers of the liver and prostrate. In females, Karposi's sarcoma and cancers of the cervix and breast were observed most frequently.[7] The main risk factors for cancer are infections, such as HIV/AIDS, human papillomavirus, hepatitis or schistosomiasis (bilharzia), tobacco use, environmental pollution, unhealthy diet, excessive alcohol intake, old age, and lack of physical exercise. Diabetes prevalence rate is also increasing, with a range from 1% - 3% in countries of Angola, Namibia, Tanzania and Zambia. Higher rates of diabetes ranging from 7%-18% have affected mostly Zimbabwe and Congo DR in sub-Saharan Africa.[7] Prevention, therefore, offers the most cost-effective long term strategy for cancer. Preventive measures are doubly beneficial as they can also contribute to preventing non communicable diseases that share the same risk factors, such as cardiovascular diseases and diabetes becoming more severe in old age.

Setting up geriatric clinical structures of managing chronic diseases and prevention of risk factors are essential in the promotion of healthy living conditions of older people in the country. The current health facilities being poorly equipped compel older people to seek alternative medicines or refrain from medical care to just stay at home and wait in suspense.

Food and Nutrition

Adequate food and nutrition are other determinants that play roles in disease prevention. As a result of high poverty levels, the majority of older people fail to access adequate nutrition and food. In one study, an elderly male person in a rural district of Zambia echoes on desperation for food stating:

> " You don't need to be told. You can see what life I'm leading. My body is not too well. My legs are painful. I have nothing, and I don't know from day to day who is going to feel sorry for me and give me food. You see, hunger is my main problem." (Mr Sangambo, Kaoma, 1998)[22]

The statements demonstrate the reality of food shortages affecting

older persons in the Zambian communities. Relating further to these accounts, it shows that some older persons barely afford a meal a day and prevalence rates of malnutrition among older persons should not be underestimated.

Older persons further face challenges of failure to produce the desired adequate food in their fields due to lack of physical ability of ageing. Among those active in economic activities may fail to gain access to farming inputs and consequently subjecting them to inadequate food and nutrition supplements. Insufficient interventions on health and nutrition promotion related to ageing processes have further burdened the welfare of old people in communities. Healthy advocate structures need to be developed in order to improve the well being of the aged.

Housing, Transport and Living Environments

Adequate shelter is another basic requirement for any human being. The need is felt more among the vulnerable groups, especially older persons. The state of most houses in Zambia leaves more to be desired. In other studies on older people in Tanzania and Zambia have shown that the majority of aged persons have no adequate shelter due to socio-economic changes incurred, superstition and belief system of associating old age with evil or causing ill health of younger people or family members.[22,17,20] The discussions with older persons in communities in another study in Zambia confirm these factors.[22] One of the elderly person, 75 years provides explanations of how he was deprived of his belongings including his shelter stating:

> " I don't know what I can tell you. I had a better hut than this one, near that mango tree. But some people burnt it one night. All the things I had were burnt, and I was lucky to come out alive." (Mr Imbuwa, 75 years old, Kaoma, 1998).

Given this account, it can demonstrate that some form of older person's abuse is quite evident. Views of older persons on elderly abuse have been observed to be a global concern.[61] This account further shows the extent to which elderly people are being abused in communities in Zambia.

Consequences of elderly abuse deprive them from adequate shelter and other basic needs. The cost of rentals and other socio-economic changes are likelihood conditions affecting old people in their communities. The majority of older persons inAfrica reside in rural areas and this trend is expected to persist in the years to come. It is projected that by 2020, 64 percent of ageing population 60 years and above will live in rural areas.[17,23] The situation in Zambia is not different from that of other countries in Africa, as there is a deliberate policy in the country of " going back to the land."[32,55] However, the dilapidated housing structures built on traditional mad, wood and thatched with grass further exposes older people at higher risk of injury and collapsed structures.

Public transport and communication systems, too, have not been responsive to the needs of older persons.[56] There are no considerations for reducing transport fares for elderly people, given the nature of their conditions or disabilities. Transport fares are paid on equal basis with those of any other user. Considering that public transport is expensive beyond the means of elderly people, it would be appropriate for the private sector to enforce some considerations on the welfare of elderly persons as they move from one place to the other. It is also necessary for the government to enforce legislative measures on transport scheme of payment for transportation and communication of elderly persons.

Gender Inequality

The general view of recognizing historical and socio-cultural dominion and authority of male counterparts in most African societies has an intergenerational effect on women's access to social, economic and political prosperity, which Zambia is no exception[17,21] Gender mainstreaming is an important factor that contributes to the prosperity in the welfare of older people in the country. In this situation it is found that gender mainstreaming is lacking in recognizing the equitable services of care required for both male and female elderly persons in Zambia. There are limited priority needs for health care for elderly women compared with men. For example, the review shows that the vulnerability of elderly women to lack of based needs of access to health care, food, nutrition and clothing or economic prosperity was found highly pronounced than that of male counterparts.[57]

Research, Information, Education and Training Gaps

Research, information, education and training are important components in the development of a well-informed ageing population. Currently, there is very little research done to provide elaborate information on ageing population in the country. Strengthening research on policy analysis to guide development or amendment of existing policies is imperative to the welfare of the aged in the country. At the moment issues of ageing seem relatively new in Zambia. The absence of comprehensive information and attention to issues of ageing has resulted in inadequate resource allocation to activities pertaining to ageing.

Education and training as vital components are essential for empowering the aged to be responsive to their own needs or become self reliance to overcome some difficult situations confronting their lives.

Illiteracy

According to the UNDP Social Development index in 2000 has shown that the majority of Zambians are illiterate. A high proportion of this population is older persons. This challenge inhibits them from the active participation and contribution to the social economic development of the country and for themselves.

Family Care Disruption

Although, the family unit forms the best support system for the senior citizens, its structures are dynamic, but traditional oriented patterns of care are no longer guaranteed. The social and economic conditions are in deprivation state, changing values due to cultural diffusion and urbanisation have resulted in family unit disruption being unable to care for its vulnerable members. Older persons have been particularly the victim of such circumstances remaining without care, love and lonely[22]:

> " He used to live with his relatives in that village….then fifteen years ago, some disease struck the village and a number of people died. The surviving ones decided to move, but he was left behind, alone…" (Female Person narrating the situation of one elderly person abandoned by his family members, Senanga, 1998)

The HIV/AIDS pandemic which has affected most communities meant that older persons have taken over the primary responsibility of caring for the sick, orphans and vulnerable children in communities. In most cases, older women have been found primary carer of providing the means for sustaining their households.

Employment and Income Security

Employment and income security are critical to ageing. These factors determine whether or not a person will reach old age with adequate resources for social security. There are policies available in the country that has a bearing on the social security system of maintaining the welfare of its citizens, particularly those in the formal sector employment: (a) National SocialSecurity Policy, and (b) National Pension Scheme Act of 1996 (NAPSA).[32,60] The purpose of these policies is to provide social security to members, through membership monthly contribution compulsory for all formal sector employees in Zambia who joined service after year 2000. At age 55 years members qualify for retirement benefits, meaning therefore that retirement age is at 55 years in Zambia. Yet, the assessment on the productive ages in Zambia show ages from 15-65 years, which is creating conflicts in determining the right age of retirement and that of productive age-group in this situation. The social security policies of this country further require to be reviewed to distinguish the right age of retirement from productive age. The perception of society has associated age at retirement (which in this case is at 55 years) with ageing or "old". People retiring from formal employment are still perceived as "old people," who are being respected by acquiring nick-names for them, such as "ambuye" meaning "grand pa" or "grand ma." This perception inculcated in the minds of those affected could be feeling that they were already old and less productive in society and would need support even if they felt as members who could be active in communities. This fear can likely expose them to serious effects of mental depression and other disorders resulting in premature deaths of older people.

As older people are usually the poorest in society, the majority have no access to any social security provision. The situation positions older people in a denial of access to employment opportunities once they reach a

retirement age and after retirement. In such circumstances, it has resulted in serious repercussions on their unexpected conditions of ageing as many may not have prepared themselves on how to cope with ageing. Retrenchment of older persons to create space for young adults in employment is also high and has further placed them in difficulty situation to promote their welfare. Yet, older people have a lot more to contribute in development, if maintained in employment beyond their retirement age.

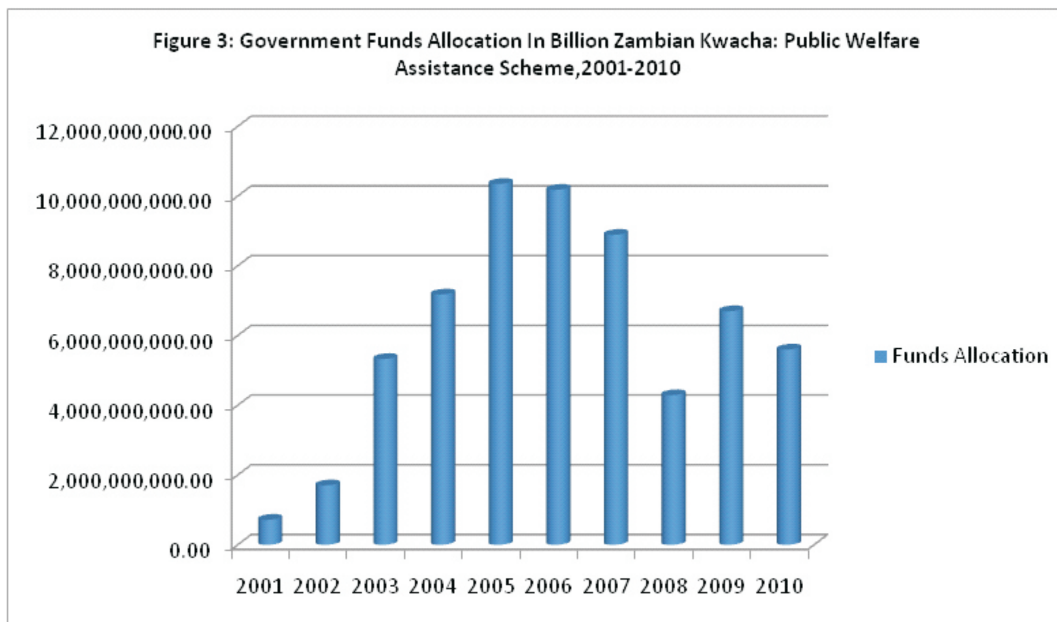
The current arrangement regarding pension schemes in the country are limited to occupational schemes, while those who retired and are receiving annuities receive very little allowances that are not linked to the current economic trends.[59,60] However, life pension is given to those who meet the criteria and a lump sum benefit is given to those who don't qualify for a pension. Invalidity (i.e. mental or physical disability) benefit is also given to members who quality for it.[59] These benefits given to old people provide income replacement to allow them continue affording descent standards of living to maintain their healthy condition, but it only sustains them for a short period of time and become poor again.

Even though the concept of Pension scheme is an excellent idea, the beneficiaries to this scheme are those in formal employment, but those in an informal sector employment (i.e. small business ventures or entrepreneurship, private organizations and others) do not qualify to be members of this scheme. Moreover, the pension schemes have experienced many challenges. Some of these include: Delays in remitting workers' contributions to public pension funds; under-funding; and poor investment policies by pension houses. As a result of these factors, most citizens enter old age with a heavy burden of dependence on creating their own initiative activities to generate their own non pensionable income for sustainability.

Social Welfare and Home Care for Older People with Disabilities

The scope of providing social welfare assistance to poor people and vulnerable groups by the state dates back from pre-independence era in 1952 has provided limited resources to those in need, including

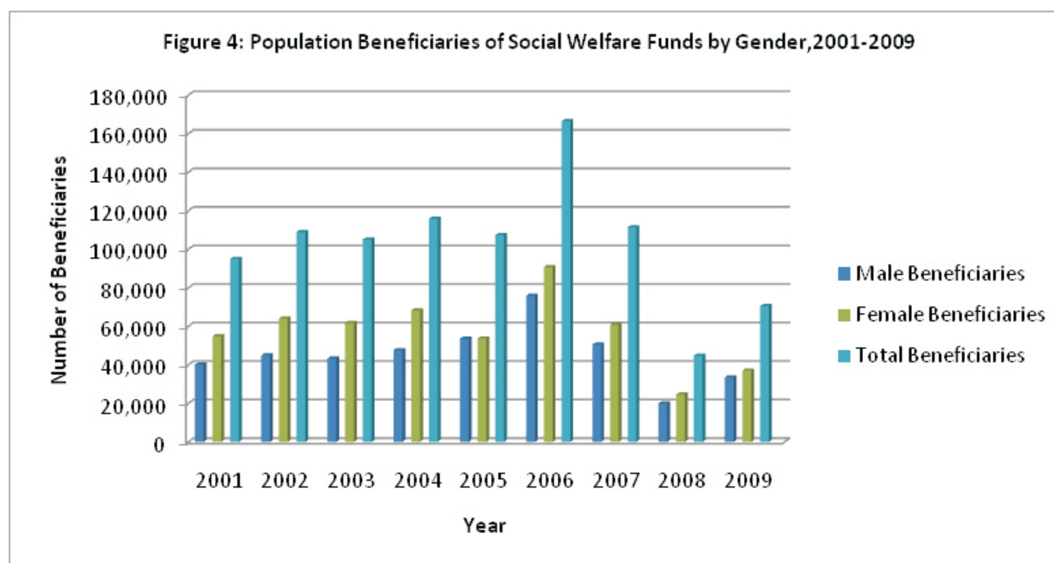
older people. This assistance ranges from provision of goods and services relating to health, education, nutrition, employment and legal matters. These interventions although well thought are limited in access and resource allocation. Figure 3 provides a summary of the government resource allocation distributed to all its beneficiaries including old people between the periods 2001-2009.



There is a general inconsistence in the allocation of public funds by the government for the public welfare assistance scheme to the beneficiaries with varied type of vulnerability, including old people's welfare assistance. From an increase peak of ZK 10.3 billion in 2005, suddenly declined substantially to ZK 4.2 billion in 2008 and then increased to ZK6.7 billion, but the funds allocation declined again to 5.6 billion in 2010 period. With this trend, the chances of declining further could be highly anticipated. Inconsistence allocation of funds could be argued that the government has either limited resources or vulnerability of population is not a highly priority area for a larger resource allocation.

With a view of assessing further the beneficiaries of these pubic funds show that the majority are mostly women. The uneven distribution of funds between men and women could be associated with high poverty levels among households affecting more women than men.[54]

Figure 4provides a summary of sex distribution of population benefitting from public welfare funds in the periods 2001-2009.



The number of beneficiaries has reduced over the years, especially among the male beneficiaries compared with their female counterparts. Highest number of beneficiaries was only observed in 2006, but thereafter started declining to almost over 44,000 beneficiaries, with the least being males indicating a figure of 20,006 beneficiaries in 2008. This could be attributed to the reduced annual funding allocation to the Ministry of Community Development and Social Services creating difficulties to cope with the increasing vulnerability of population in society. However, a recent study on the impact of social cash transfers on welfare, investment and education in Zambia has shown that 9 percent elderly persons have benefitted from the social cash transfer scheme.[57]
There are still limited institutions of home care for older people, and the government's commitment to these infrastructures is very narrow (see Table 6)

Table 6: Old People's Homes in Relation to Organization, Location, and Sex Distribution, Zambia 2011

NUMBER	HOME NAME	RESPONSIBLE ORGANISATION	LOCATION	FEMALE	MALE	DEATHS	TOTAL POPULATION
1	DEVINE PROVINCE	CATHOLIC NUNS (CHURCH)	LUSAKA	25	7	5	32
2	LUKULWE	ROMAN CATHOLIC CHURCH	SENEGA	8	7	0	15
3	MWANDI	UCZ	SESHEKE	5	11	0	16
4	MARAMBA	SOCIAL WELFARE (GOVERNMNENT)	LIVINGSTONE	18	30	0	48
5	CHIBOLYA	SOCIAL WELFARE (GOVERNMNENT)	MUFULIRA	14	17	3 Males	31
6	MITANDA	SALVATION ARMY	NDOLA	8	11	1 Male	19
7	CHIBOTE	CATHOLIC NUNS (CHURCH)	LUANSHYA	8	13	0	21
8	ST. THERESA	CATHOLIC NUNS (CHURCH)	NDOLA	7	17	2 Males	24
TOTAL				93	113	10	206

Source: Ministry of Community Development and Social services,2010 Annual Report; Divine Providence Annual Report, 2010

Generally, the findings show that home care residences for old people with disabilities are very limited in the country, with little participation of the government and private sectors. There are only eight (8) residences countrywide, in seven (7) districts of all 72 districts in the country giving a proportion of 9.7% districts providing social and health care to old people with disabilities. The majority of such providers have been the Church members providing combined services of health care and social services under very difficult circumstances. There are only two (2) old people's residences that are only provided by the government, i.e. the Department of Social Welfare in the Ministry of Community Development and Social Services. It shows that there is a limited participation of the government in ensuring structures for health care and social services for old people with disabilities in the country. The limited number of old people's homes, compared with those for children's homes can be argued further that old people's needs could be less important. It is vital to recognise ageing as a human development aspect encompassing wide ranging issues of poverty, health, food, nutrition, water and sanitation, housing, education, transport and social welfare among others that requires a holistic and comprehensive approach of care.

Despite the availability of these potential residences for the old people, there are several challenges that are being faced in both health care and social service management of these residences:

Firstly, the number of old people admitted with disabilities in residences is increasing. Table7 shows the actual capacity of residents for admission of male and female residents.

Table 7: Actual Residence Capacity of Old People with Disabilities by sex Distribution and Location

HOME/LOCATION			
Divine Providence - Lusaka	9	9	18
Lukulwe - Senanga	7	8	15
Mwandi - Sesheke	11	5	16
Maramba - Livingstone	14	25	39
Chibolya Mufulira	11	16	27
Mitanda - Ndola	11	8	19
Chibote - Luanshya	14	9	23
St. Theresa Ndola - Ndola	11	9	20
TOTAL	88	83	171

Source: Ministry of Community Development and Social Services, Annual Report,2010

With the initial plan of having considered more females (51.4%) than males (48.6%) for admission in the various residencesfor old people, the current situation has turned out to be more males being cared for with a higher proportion of 54.8 percent than females indicating 45.1 percent. It shows that older males are at higher risk of ageing disabilities than the females.
Residence capacity of all residences for old people with disabilities has increased ranging from 14% to 23 % in some homes. For example, a review of a residence home in Lusaka (Divine Providence) with a capacity of 18 residents who are elderly over the age of 60 which houses 9 males and 9 females, residents have now increased to over 30 residences. The home also cares for a further 25 old people living in the compound, but get some support from the home. Among those elderly ones with disabilities, two (2) of the residents are disabled; one (1) paralysed and is HIV positive, and on treatment; one (1) man disabled; and another resident who is also

terminally ill. All these residents need everything done for them, with very little human capacity provided. Even though, the elderly people have benefitted from these structures in some good ways, such as:

(a) Shelter
(b) Food
(c) Medication
(d) Hospitality, and
(e) Love

The residences have further no provision for the medical support staff (e.g physician, nurse, nutritionist or dietician and medical social workers) attached to these old homes leaves much more to be required to meet the health needs of elderly people in old people's homes. Even though currently there are provided with adequate shelter, with no worry for about rentals and are provided with food, care, some medications and attention, the cost of maintaining these residences has become high. Love that they would have wanted and appreciated by society is missing to a certain extent. The activities that are mainly done at the residences, in particular Divine home, are a cerebration of Easter, the International Day for the Elderly, Christmas and some, through few public holidays

However, despite the various basic needs provided to the elderly residences, homes face various challenges and the following are some of them stated by key informants responsible for old people's homes:

First, financial and erratic funding challenges-affect all old people's home aggravated by the erratic funding from the Government. As a result, a home cannot manage to sustain itself and provide the best quality care expected to the residents and non residents as well.

Second, lack of medical staff attached to residences – to attend to the residents so that what ever is incurred to the residences getting sick, they should be examined and make necessary decisions for referrals to the clinic or hospital if required. A nurse should be attached to homes to provide medications

to the residences and provide also clinical assessment to those with terminal ill-health, and ability to advice where necessary.

Third, lack of adequate and proper medication supplied from the hospitals- Most of the elderly residences with ill-health disabilities are supplied with only paracetamol tablets. It was emphasized that by law aged people over the age of 60 years are supposed to get free medication, but it has been the case in homes. If the money is not paid, there is no attention given to elderly patients at all. They would return back to homes without special treatment.

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Fourth, lack of Social workers- Homes cannot employ them because they have no capacity to pay salaries.

The perspective view of old people's homes show that there are numerous challenges extended to these limited homes country wide. All have pointed to the fact that there is very limited commitment by the government to set priority needs for old people being cared in homes. In addition, the government do not seem to realize the ultimate benefit of nursing homes for old people in the country, if they were extended to the greater participation of private sectors and the non governmental organisations (NGOs) in generating resources that would increase value to these institutions as well. However, the service related challenges stated have resulted in serious effects of negligence and death of some residences in homes. Almost a total of 4.8 % deaths have occurred in old homes in the period 2010, respectively (Table 7), suggesting further that death rate could be higher than this figure in old people's homes.

Responding to the welfare of old people in these few residences by the

residents themselves show some negative attitudes towards the quality of care being provided to them. The pertinent issues expressed by the majority of residents relate to mainly:

(i) quality of food
(ii) clothing
(iii) ill-health: poor eye sight, painful legs and other health conditions
(iv) loneliness
(v) lack of exercises
(vi) abuse

The poor quality of care expressed by most residents confirms the reality of varied challenges that are being experienced in the management of these homes by carers. Among those who expressed their views have related to poor diet which states:

> " In the morning we eat porridge and sometimes sampo, afternoon, its nshima with beans and fresh kapenta which is rotten, only on Sundays that's when they give us chicken, but the mealie meal is very bad."
> (elderly man, 80 years old)
>
> Or
>
> " The food is very bad here. They give us nshima which is rotten and fresh kapenta which is rotten, only on Sundays that's when we eat chicken…. The mealie meal is very bitter, sometimes it has worms in it….. beans is the most common food which we eat …. We feel we need better food."
> (Views of a group of elderly men and female residents, 61-77 year old)

These statements show that there is poor quality of food being offered to old people in homes. It is therefore essential to recognize the need for provision of quality balanced food to improve nutritional status and reduce risks of increased morbidity and mortality among the aged. Increasing deaths that are reported in these old homes could be more attributed to status food and nursing care being provided to them. Food for old people requires a highly standard of hygiene and attractive to their desirable test, but not in undesirable conditions on account of regarding them as being old or

elderly who do not deserve special attention or care. It is therefore important for the carers of these institutions to understand the humane feelings of old people as they are being cared, and to reflect the views of old people to themselves that they too will be ageing and would not wish being treated in a similar manner like them. The findings have further demonstrated that the attitudes of providers towards caring of old peopleare perceived negatively.

The perspective views of old people also suggest direction to re-thinking measures of including professionals, such as nutritionists/dieticians attached to old people's homes as imperative to monitor the food supplements given to the aged. Poor quality of food further entails limited food supply experienced in these homes, suggesting a further need to examine the distribution system and type of food being given or donated to old people's homes. Maintaining quality assurance of food for old people is vital.

Challenges of Fragmented Policies and Programmes on Healthy Ageing

The challenges of fragmented policies encompassing those of National Social Security Policy, National Pensions Scheme Act of 1996, National Policy on Social Welfare and the most recent drafted policy on ageing have brought about mixed feelings in understanding of who is old in Zambia. Furthermore, lack of clear definition of "old age, or older person" in most government policies has resulted in failure to provide a comprehensive social and health care services among members of this group. The health exemption policy defines "older persons" as those above 65 years. Other policies, such as the Social Welfare Policy have defined "older persons" as those aged 60 and above. The absence of an agreed definition of older persons in the country implies that some of older people are being deprived from accessing essential social and health services. Secondly, where data exist, it is not comparable, inadequate and not harmonised. This may create conflicts in understanding the concept of ageing population in Zambia. Therefore policies need to be synchronized to come up with one definition in line with the international standard definition of older persons.[2,12]

This has resulted in limited attentions drawing to priority needs for promoting healthy ageing programmes in the country. However, the

most recent holistic approach on Ageing Policy that has drawn specific policy measures aiming at involving all sectors, including the health system, to establish programme activities for promoting healthy ageing is anticipated to produce some positive impacts on the aged. WHO and others have provided guidelines for developing strategies to meet the health needs of older people.[2,20] At the moment there is very little attention to the healthy needs of the ageing population in the health system. Yet, through its comprehensive primary health care approach of delivering health services, as a key component of ensuring quality of healthy ageing programme activity implementation, monitoring and capacity to strengthen coordination with other sectors to achieve positive healthy outcomes has sidelined recognition of this important aspect. The entire responsibility of healthy ageing activities is devoted to the Social Services in the Ministry of Community Development and Social Services.

LESSONS LEARNT:

A Movement Towards "a New Dimension of Holistic Integrated PHC Approach on Healthy Ageing Programme"

Several lessons have emerged from the review of policies and programmes, and their impact on the current status of healthy ageing population in Zambia:

A Revolution in Age longevity

Generally, the number of ageing population is increasing with more demand for critical care needed. This is demonstrated through a limited number of older peoples' community or institutional care homes failing to meet their demand for social and health care needs due to increasing ageing population aggravated by poverty and the emerging chronic disease advances in old age. The most recent surveys and country census data have demonstrated that there is a rapid increase in the number of ageing population in spite of slow progress in life expectancy.[18,25,30] As world of the twenty- first century is now experiencing an extraordinary revolution in longevity, with a paradox process of socio-economic development on one hand advancing medical science and technology to prolong life and exorbitant costs on the other hand urges for prompt action to address the health needs of the aged population. However, the provision of these resources remains a major economic and social barrier for individuals and families caring for older members of the society. Zambia has not succeeded in adding years to life as demonstrated in a shortened life expectancy over the past four decades. However, it is worthwhile to realize that with this short deficient of life expectancy, ageing experiences of longevity is also becoming a reality in Zambia. Creating an environment for equal opportunity of care to a healthy ageing should therefore be considered critical to the Zambian population.

Humanitarian and Development Issues of Ageing

Government must be committed to a wide range of providing humanitarian needs for its older citizens that encompasses medical care, physical comfort and economic empowerment of those active. Emphasis should be made on the process of "socialization" with the growing population of the older citizens who are no longer economically active. Moreover, one cannot

ignore the fact that the approach to these issues concerning ageing should not be treated in isolation. It should rather form an integral part of the overall national development planning programme. In other words, the challenges and strains of the phenomenon of ageing should be studied to interact with other social and economic challenges and strains associated with an accelerated development. The increase in this segment of the population has already made ageing and the issues associated with older people a prominent theme for social development.

Ageing and Sustainable Development

Sustained development cannot take place unless there is a proper balance between the social, economic and environmental factors and changes not only in the population growth distribution, but more specifically in the population structure. The older population, as a segment of the whole population, also shares a close bearing on social development and that of the economic and social implications of ageing challenge for society. Consequently, the need for study of implications of ageing population to determine the adequate social development strategies to optimize development is also critical.

Furthermore, older people are often being greatly differentiated from the younger generations. While the latter are looked at as energetic, physically strong, mobile and healthy, the image of the older people is often facing abuses as slow, inactive, poor, weak and chronically ill or sick. The feeling of being abused is not only experienced among older persons in Zambia, but a common phenomenon world wide.[61] This directs to a critical turning point of confronting challenges and issues generated by a projected rapid growing older population and those already facing inadequate care. The phenomenon calls for the provision of economic and social support, including the required health needs, to the particular requirements of the older people. The aim of development is to improve the well-being of the entire population on the basis of full participation in the process and equitable distribution of the benefits accruing their well being. The development process, as defined by the United Nations, must enhance human dignity and ensure equity among age groups in the sharing of society's resources, rights and responsibilities.[5'6] Successful

healthy ageing will only occur when an older person's personal dignity, sense of belonging and self worth are maximized. In this context, economic growth, productive employment, social justice and human solidarity as fundamental and indivisible elements of development are the preservation and recognition of the country's sovereignty and people's identity.

Obstacles to Participation of Older People

Although the social involvement of older persons is largely a matter of personal choice, obstacles exist which could reduce their inclination to participate in field, such as politics, management, labour force, leisure, education, health promotion, etc. Attempts should be made to foster such participation wherever possible and to remove any obstacles preventing it. Such measures might include eliminating unjust age- related distinctions, creation of social networks and information campaigns. It is an undeniable fact that poverty and disease are the main opponents of longevity in Zambia. However, equally, if not more destructive, are the passivism and the feeling of oneself as a parasite. Ageism and age discrimination are very insidious concepts. They are terms which are not only prejudice-laden, but they are degrading.

Age Discrimination

The issue of age discrimination, not only takes many forms, but also occurs in various sectors of life. With the health care costs in Zambia, rising faster than productivity, certain health centres have started harbouring the idea of rationing health care on the basis of age where they say, there is no medicine for older people. The health management information system further have categorised age as, “below 5 years and above 5 years” barely discriminates older age's access to vital health information of older people in society. It must be noted that, with the increase in number of older people, especially the “elderly” ones with disabilities, the aggravated cost of meeting their medical needs becomes bigger. However, age based rationing in a country's health care system is a wrong turn on the road to reform. It has proven that limiting end-of-life treatment to older patients would not only cause the premature deaths of thousands, but would fail to account expenditures.

Without doubt, age discrimination in the work place is the most pervasive and debilitating problem and obstacle to the older people's participation in development. The pensionable age at 55 years set by Bismarck about a hundred years ago was good for that time.[55] In the most recent time, however, and given the revolution of age longevity, it causes a severe age bias. Men and women of retirement age are often in the best of healthy atmosphere, fit to resume their economic duties of contributing to national development.

The policy of mandatory retirement and consequent loss of employment at a point set only in terms of chronological order are very often does not only demoralize the older people, but may entail being sidelined by their own society. It has endangered their dependence and placing them in a precarious environment. This has also two sided effects of reducing the well-being of the older members of society and at the same time wastes valuable national resources.

Age discrimination in employment reflects the viewpoint of individuals who are denied their basic right to work. Lack of law enforcement existing that aims at protecting older workers from being fired or terminated from their place of work or their not being fired on the basis of age shows that age discrimination against older workers still exist in various forms in the country. The use of a specific pensionable age as an automatic end to work or to loss of workers' rights is in itself a discrimination per say. Retirement makes a person a recipient. It hinders him or her from being creative and productive. The non-discriminatory alternative could be the flexible retirement arguments, whereby the individual worker is allowed freedom of choice to choose to retire or not. Legislative measures should ensure that pensioners get their retirement dues on time and be allowed to increase scope of taking up paid employment after retiring without suffering any loss in pension.

Retirement, Productivity and Healthy Active Ageing

Full participation of older persons in productive employment and in economic growth should be promoted. For some, this may be

perceived as conflicting dilemmas: the new employment of youth, on the other hand, and the termination of employment of older workers on the other or producing one group of non- active persons so as to make another group be at the expense of the other. Policies aimed at accommodating both the old and the young should be justified because the social consequences of the structural adjustments, including the technological change are magnified by the effects of the ageing populations. Appropriate measures should be taken to ensure the continued participation of older workers, if they choose to do so. In this context, the quality of the working conditions of the older workers should also be protected. The right to employment should be based on their ability to perform the work assigned to them, but not on chronological age.

Healthy Ageing and Active Participation

Healthy ageing is the most determinant ingredient to active ageing participation to produce a better sustainable development of older people themselves, family and national development. Promoting healthy ageing, through preventive and curative of diseases affecting old age can result in ultimate positive effects on their health as they age. In order to promote active participation of older people should not only be by identifying and promoting opportunities, but older people should be encouraged and supported in all their spheres. In doing so, they are being helped to maximize their feelings of self worth of actively participating to development in society. Healthy ageing must therefore be demonstrated by an art of active participation and age longevity.

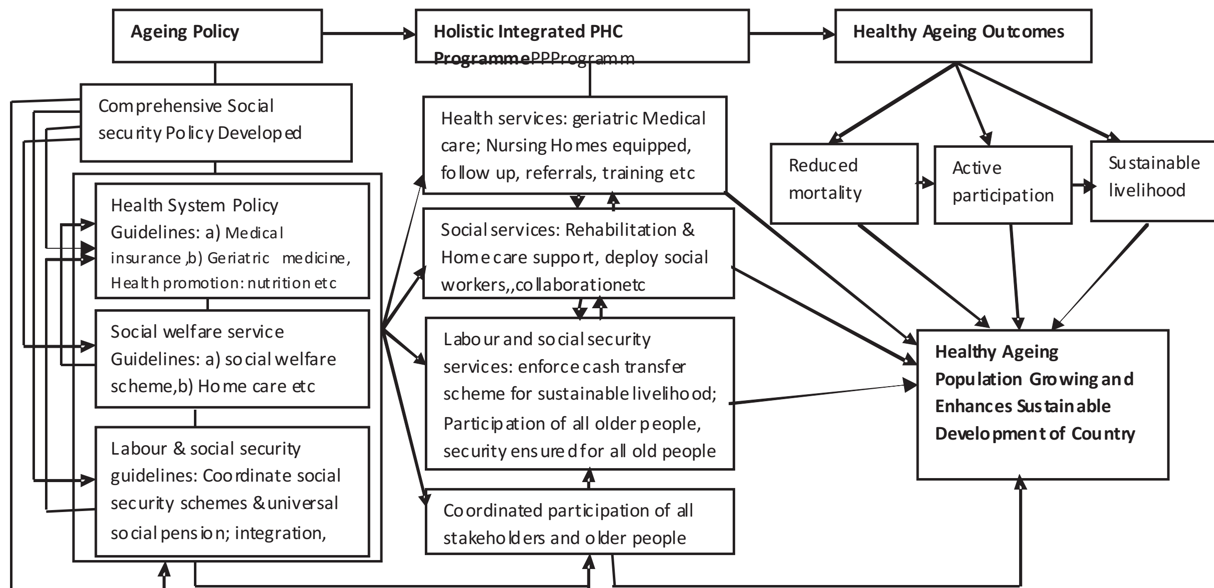
A new philosophy of healthy ageing requires a collective participation of the government, private sector and the NGOs, including the older persons themselves in promoting healthy, participation and security of the ageing populations in the country. Even though, the Government and some voluntary Agencies are now becoming more preoccupied with meeting the humanitarian issues of the process of ageing, very little emphasis has been put on the healthy developmental issues of the ageing and their participation, and contributions to the very developmental processes of the country. Such strategy has resulted in creating a rigid age differentiation, , a dependency syndrome of older persons, and worse still their

marginalization. In this regard, there is a need to break through these barriers and obstacles towards older people, and thus developing a new philosophy of healthy ageing. The attitude of society towards older people as a problem to society or community must be eliminated. Older people should be seen to participate to their fullest strength in society, but not seen as burden.

The central focus of policy must be the integration of the older citizens into society to maintain their level of contributions to healthy promotion activities and participation to their own welfare and national development process, and ensure security of their own lives. Older people should be empowered to solve their own problems. However, if they are to participate fully in development processes, they require independence, adequate income, good health, adequate services and scope for participation in work, education and community development processes, which leads them to healthy and active ageing. It is, therefore, important to build a broader base of integrated services, than the welfare state ideology which is based on a complicated system of depersonalized social services.

The new step taken to develop a comprehensive policy framework on ageing by the Ministry of Community Development and Social Services[4] [3] needs to be consolidated and supported seriously by all the Government sectors. In particular, the Ministry of Health should take up the key responsibility of developing a holistic approach of a Primary Health Care (PHC) framework for healthy ageing programme for the country that should be based on already drafted policy on ageing initiative. To facilitate this initiative, the following framework provides some form of guiding principle in developing an integrated holistic PHC approach for healthy ageing programme for the country.

Figure 5: Holistic Integrated PHC Approach for Healthy Ageing Programme in Zambia



The framework illustrated in Figure 3.3 above shows that developing a comprehensive social security policy on ageing to facilitate development of health system policy guidelines, social welfare guidelines, and the labour force and social security guidelines envision better quality of health and social services aimed at addressing the needs of older people. It further enforces health outcomes and greater participation of old people themselves to livelihood activities that will prolong their life span in a healthy environment. This contributes to the country becoming old rather than being young at all times.

The health system policy guidelines for older people should be devoted to the issues of:

a) Developing a consolidated medical insurance scheme for the aged must be coordinated adequately with the social services departments to meet the health needs of the older people.

b) Developing geriatric medical care policy guidelines to provide a strategic provision of medical care for old people.

The guidelines should provide direction to the need for training specialized people interested in geriatric medicine without any prejudice to be deployed in health facilities and old people's homes.

c) Developing health promotion guidelines to address aspects of nutrition, physical activities, such as enforcing older people to participate in leisure activities like exercises in any form are essential for healthy maintenance and prevention of ill-health. Diet is an important aspect that should be emphasized to old people as they age. Dieticians should be deployed in the management of geriatric medical care in the country. Many non-communicable diseases are preventable and conditions can be lessened by the strict adherence to type of diet recommended as well as involvement in physical exercises. These may new theories for African older people, but they need to be enforced to all ageing populations.

With a view of the provision of social services, support of social welfare scheme for old people should be enforced to those being cared in homes for old people presenting themselves with disabilities. Carers designated to the old people's homes should receive training on geriatric nursing care and be attached to the health care system. Deployment of social workers attached to old people's homes is therefore imperative to provide a collaborated link between the health system and the social welfare departments. Among the aged at household level with lesser disabilities should be rehabilitated and enforced to participate in economic activities to sustain their livelihood and that of their family members

This brings about the link to the labour and social security services where the cash transfer scheme can be enforced for older people in communities. Security systems of some form of pension schemes for older people should examine not only those who have been in formal employment, but even those in informal employment status to provide food security, assets and also their medical surety as they continue living. Age at retirement should be reviewed to accommodate participation and security of older people in formal and informal employment status..

A successful healthy ageing programme requires a stronger participation of all sectors, private sectors, agencies interested in the welfare of the aged population, and above all the older people themselves. Such holistic approach has proven to yield better results in promoting a long-term care of the ageing population, especially the elderly persons in other countries.[6,62] In doing so, the ageing population will be expected to grow healthy, with sustainable development to the country.

CONCLUSION AND RECOMMENDATION

The documentary analysis and discussions with the relevant key informants along side older people in homes themselves have shown that there are policy and programme gaps devoted to the promotion of healthy ageing population and care of old people with and without disabilities in Zambia. The philosophy of healthy ageing is relatively a new concept in Zambia. Several issues have arisen to the development of healthy ageing programme in Zambia:

a) Healthy ageing programme should be integrated in the concept of the primary health care components. As the health focus of the country is in the vision of decentralization process of health services in the context of PHC framework, with greater participation of varied stakeholders, the implementation of this programme will envision a collective participation of many organizations (Figure 3.3) in a holistic manner. Policies on ageing must demonstrate provision of guidelines to urge development of programme services on ageing that should be well coordinated among the stakeholders involved in the delivery of services for older citizens in the country.

b) Geriatric medicine is not highly prioritized in the health delivery care systems. It is important to recognize the valuable geriatric medical care in Zambia. Health professionals in primary health care system should be exposed to another integrated training dimension in geriatric medical care countrywide in order to provide a holistic PHC care to the ageing population. Guidelines in geriatric medicines should include aspects of training, services, referrals and follow up care in nursing homes for old people, and monitoring and evaluation framework are cardinal features of enhancing healthy living of older people. Health centres should be empowered to provide avenues for geriatric medical care and be linked to community care of nursing homes for old people.

a) Health promotion is lacking among older people. This may explain why increases of premature deaths are occurring among older people in this country. Health promotion should ensure cognitive aspects of nutrition and advice on type of diet for old people is important. Dieticians should be deployed in health institutions for older people. Alongside others are promotion of physical exercises or leisure for old people to enhance their physical strength and mental capacity should also be introduced.

b) Establishing country wide nursing homes for old people involving the government, private sector and NGOs will go a long way in improving the health status of old people with disabilities by minimizing risks of premature deaths that are currently observed in these limited homes. These homes should have the capacity of involving medical professionals with some form of training in geriatric medicine. Carers too should be acquainted to geriatric care. The need for medical social workers and dieticians' attachment to these homes is also imperative to social welfare and nutrition adequacy of old people.

c) Geriatric Research should be strengthened. There are very limited studies conducted on ageing. Research in this field is therefore important to provide direction to influence decisions on setting priorities for health care planning and management of old people in the country. It further determines how the ageing population is growing in terms of its contributions to population growth rate of the country and direction to a focused action.

The findings of the current situation analysis on healthy ageing programme and policy guidelines have demonstrated their implications for policy review and amendment of the current ageing policy; healthy ageing programme development in the context of PHC framework; and research. It is recommended that a comprehensive ageing policy encompassing the three dimensions of health improvement, participation and security should be developed with a wider participation of all stakeholders and old people themselves, including agencies interested in promoting

healthy welfare of the ageing population. Secondly, healthy ageing programme, through effective monitoring and evaluation system and intervention research approaches; economic empowerment and participation, and enhancing social security of older people are cardinal features of age longevity and should be promoted at country level. The strategy urges for more participation of Non-governmental Organizations (NGOs), the private sector and indeed the government to identify the needs of older people in order to effectively promote the healthy ageing population, particularly in connection to the long term care of older persons in the country[53,10].

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KEY INFORMANT QUESTIONNAIRE

SITUATION ANALYSIS ON HEALTH AGEING PROGRAMME IN ZAMBIA 2010/2011

INTERVIEW QUESTIONNAIRE GUIDE: KEY INFORMANT/STAKEHOLDER

QUESTIONNAIRE GUIDE NUMBER-- ☐☐☐

Location: --

Sector/Organization's Name: ---

Type of Sector: Specify: 1 Government....( ) 2. Mission...... ( ) 3. Private..... ( ) 4. Other: specify... ( )

Informant's designation (Profession or role in Organization):--

Department/ Directorate:--

Sex: 1. Male.....( ) 2. Female.... ( )

Age: ☐☐

Date of Interviews: ☐☐☐☐☐☐

DD/MM/YY

Introduction: The United Nation's International Plan of Action on Ageing considered ageing as a lifelong process and placed focus on improving well being of people as they age. It is recommended that health promotion should aim at promoting activities, initiatives and structures which would enhance the wellbeing, health choice, independence and quality of life for all ages. In this respect, efforts should be made to prevent or delay the onset of chronic diseases and disabilities. It is therefore important to document baseline information on the situation analysis related to policy guidelines on health ageing programme in Zambia to better Healthy ageing of older people. This study focuses on reviewing relevant policy and programme documents that address the health and social security needs for older persons 60 years and above. Interacting with various stakeholders on how they respond to the fundamental questions related to the health need, challenges and seeks possible solutions to improve the health care and social security systems of older people further forms basis for initiating action on healthy ageing programme in Zambia.

Fundamental Discussion Questions:

Section A: Availability of Policy Guidelines and Programmes for Older People:

1. What specific policies are articulated on healthy ageing in the National Health Policies and the Social security system for the older people aged 60 years and over?

a) National Health Policies:

b) Social Security Policies:

2. How have these policies been transformed to strengthen health promotion and prevent diseases for those directed to older people?

a) Policy guidelines:

b) Plans:

c) Activities:

d) Monitoring & Evaluation:

Section B: Quality of Life and Health Care

3. As people are living longer, how can the quality of life in old age be improved?

4. How can the role of the family and that of the state or government be balanced in caring for people who need assistance as they grow older?

a) Role of the family:

b) Role of the state or Government:

Section C: Effects of increased numbers of Older People

on Health Care and Social Security System:

Challenges and Contributions to National Development:

5. In what ways will large numbers of older people negatively affect the health care and social security systems in the country?

a) Negative effects on the health care system:

a) Negative effects on the social security system:

6. In what ways will large numbers of older people can positively influence the health care and social security systems in the country?

a) Positive effects on the health care system:

b) Positive effects on the social security system:

7. How do you acknowledge and support the major role that people play as they age in caring for others?

8. Any Comments to the above fundamental questions discussed with you?

(Check Availability of Records, policy documents, strategic plans, reports)

ANNEX TWO

QUESTION GUIDE FOR OLD PEOPLE RESIDENCES IN HOMES

Name:
Age:
Sex:
Residence Home Name:

1. When did you come to this Place?
2. Do you Have Relatives?
3. How did you find yourself at this place ?
4. What type of activities do you do here?
5. How is your health at the moment?
6. What problems are you facing ever since you came to this home?
7. What type of food do they give you?
8. Are you given any clothing to wear?

ANNEX THREE

ELDERLY POPULATION'S TREND ANALYSIS TABLE

Table 2.1: Trend Analysis of Population Ageing, 60 and Over by age and Sex, Zambia 1990-2025

Characteristics	1990	2000	2010[1]	2020	2025
Age:					
60-64	115,727	136,408	184,147	193,797	370,614
65-69	74,011	102,796	132,883	198,118	248,254
70-74	56,601	71,696	91,578	127,871	160,887
75-79	60,028	42,884	56,500	76,319	93,178
80+	n/a	46,551	53,500	70,122	82,612
Total	306,367	400,261	518,282	666,227	955,545
Sex:					
Male	165,243	193,206	265,760	377,771	469,715
Female	141,118	183,655	252,620	378,454	484,830
Total	306,361	376,861	518,380	756,225	954,545
Zambia Total Population	7,383,097	9,791,981	13,841,576	18,302,922	21,024,605

Source: CSO 2000 population projection

[6]Based on current 2010 Census

ANNEX FOUR

LIST OF PERSONS CONTACTED, ORGANIZATIONS AND RESEARCH ASSISTANTS

1. Dr. Mwaba, Permanent Secretary, Ministry of Health
2. Mrs. Sherry Thole, Permanent secretary, Ministry of Community Development and Social Services
3. Ms. Esther N'gambi, Senior Social Welfare Officer, Ministry of Community Dev. and Social Services
4. Mrs. Mukupa, Director, Social Welfare
5. Mr. LukwesaKaemba, Senior Planner, Ministry of Finance and National Planning
6. Mr. Chiyoka Nkandu (elderly), residence at Old People's home, Lusaka
7. Mr. Bornwell Mubita, (elderly), Residence at Old People's Home, Lusaka
8. Sister Angela, manager, Old People' Home, Lusaka
9. Ms. Christina Mwape (elderly), residence at Old People's Home, Lusaka
10. Mr. and Mrs. Ng'andu (elderly couple) residence at Old people's Home, Lusaka
11. Mrs. Monde Namanga (Elderly),residence at Old people's Home, Lusaka
12. Mrs. Mary Kaoma, US Aid Project
13. Mr. Masauso Phiri, Monitoring and Evaluation Officer, Ministry of Health
14. Mr. Trust Mufune, Principal, Monitoring and Evaluation Officer, Ministry of Health
15. Ms. BrivineSikapande, Senior Monitoring and Evaluation Officer, Ministry of Health
16. Health Promotion Officer, Ministry of Health
17. Mental Health Specialist, Ministry of Health
18. Mr. Simon Simbeye, Acting Actuarial Liability Manager, National Pension Scheme Authority (NAPSA)
19. Director, Information and Research, Ministry of Gender Development
20. Permanent Secretary, Ministry of Labour and Social Security
21. Churches Health Association of Zambia

Research Assistants:

1. Ms. Lindiwe Likwa
2. Ms. Dorcas Mutale Chanda