

Guest editorial

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Research for practice and development in Africa

In 1993, I attended the Sixteenth Congress of the International Association of Gerontology in Budapest, Hungary. In the programme was a session which focussed on Africa, in which the likes of Adrian Wilson and Nana Apt read papers. Many positive lessons were to be learnt during the Congress. However, for someone from a country like Zimbabwe, which in 1992 had been subjected to the worst drought in living memory and where many older people had died from starvation and disease, there were also disappointing moments. The majority of the research papers gave me no hope that the problems of poor people in my part of the world would ever be addressed. So disappointed was I that when in the HelpAge International (HAI) session I was given a chance to speak, I complained: "I am shocked by the fact that the world is concentrating on researching the behaviour of mice when, in Africa, we are grappling with real problems being faced by older people."

My perception of research at that time may have been fairly naïve. Yet might we not still question how research is being used today? Might we not ask to what extent research carried out in Africa is translated into action and produces benefits for the subjects of the research? The translation of research into action is a salient message in this special issue of *SAJG*.

Issues of ageing in Africa

Population ageing

According to demographic projections, the world population aged 60 years and above is increasing rapidly. Whereas in 1950 it was 200 million, by 1975 it had increased by 75% to 350 million and by 1999 it had shot up to nearly 600 million (UN, 1991; US Bureau of the Census, 1999b). It is projected that by 2025, the world population will reach 1.2 billion and by 2050, 2 billion. At that time, it is expected that the world older population will for the first time in history be greater than the population of children under 15 years (US Bureau of the Census, 1999b).

The largest increases in the size of older populations will occur in the developing countries. The older population of Africa, currently estimated to be slightly over 38 million, is projected to reach 212 million by 2050. Thus, Africa's older population will increase sixfold in five decades (US Bureau of the Census, 1999b).

Although the AIDS epidemics are projected to reduce life expectancy in affected countries, the older population of Africa will continue to grow (US Bureau of the Census, 1999a). The bureau projects that both the number and proportion of older persons in the population of Africa will increase. In South Africa, the older population is expected to double, from 3.1 million in 2000 to 5.9 million by 2030, representing

an increase in the percentage of older persons in the total population from 7 to 11.5%. Despite AIDS, the majority of people in Africa will thus grow older and will in all probability live longer than previous generations (US Bureau of the Census, 1999a).

Large increases in the number of older people in African populations will therefore continue to put pressure on society, industry, governments and available resources.

Definition of old age

The United Nations defines older persons as those aged 60 years and above. However, in Africa, formal retirement age (approximately 10% of the working-age population is employed in the formal sector) ranges between 55 and 65 years. The definition of old age in Africa also differs to that in the developed countries. In many African settings the UN definition is inappropriate or irrelevant. In rural situations, where birth registration is poor or even unknown, physical features are commonly used to estimate a person's age. The colour of a person's hair, failing eyesight and diseases such as arthritis are some features used to define an older person. More complex definitions, which embrace a host of social and cultural issues, include, for example, the person's seniority status within his/her community and the number of grandchildren which he/she has (UN, 1991). When I worked among Mozambican refugees in Zimbabwe in 1988, I learnt that women who can no longer bear children are described as old.

The problem of the definition of old may seem fairly obvious and unimportant but this is not so. The work with Mozambican refugees was problematic for HAI social workers, who found it difficult to decide whom to include and not to include in the relief programme. For three months, I unwittingly included a man of about 30 years in the older people's programme, because when he registered for the programme his hair was totally grey. We later learnt that he had "made himself up" to look old. It was only after HAI workers had interacted with him for some while that it became apparent that he was young and not old.

In Zimbabwe, during the drought of 1992, persons aged 70 years and over were provided with food relief from the Government. HelpAge Zimbabwe workers in many parts of the country found that a good number of older persons were not being targeted for assistance although they may have been eligible for it. Most painful to them was that some persons whom they knew to be younger than 70 were being assisted. They were being assisted because the date of birth recorded on their national identity cards had been determined according to whether they could recall landmark events such as World War I or the influenza plague of 1918. Accordingly,

the ages of some individuals were estimated as being older (or younger) than the individuals' true age.

The plight of older people in Africa

The majority of older people in Africa are faced with a host of problems: economic, health, HIV/AIDS, social and cultural, conflict and disasters. Some of the problems are described briefly.

Economic

In the majority of countries world-wide, older people are typically the poorest members of society and live far below the poverty line (ILO, 1997). They usually have no source of regular income and do not enjoy social security provision – particularly in developing countries. The distribution of resources among vulnerable groups tends to disfavour older people generally. Very little effort is usually put into ensuring that older persons gain better access to resources of the private and public sectors. For example, concessions are not given to older persons when they purchase medications – which they are increasingly likely to need as they grow older. Very few countries offer them transport concessions; instead, they must jostle with persons in younger age groups, who are stronger than they, to access and pay for scarce transport means.

In almost every country, older persons are denied employment opportunities and are likely to be the first victims of retrenchment when economic changes occur (see Mupedziswa, 1999). Nor is any effort usually made to keep older persons in active employment beyond their retirement age.

Why is it so difficult for employers to revise the work schedules of individuals who have served them well and have earned them millions of dollars over the years? I see numerous strong, muscular young men who sit at shop entrances, whose sole task is to stamp "Checked" on customers' receipts – which type of job could easily be done by older persons.

Health

Although some diseases are common in old age, like individuals in other age groups, not all older persons are prone to attack by any disease. However, due to a lack of means to provide adequately for themselves, even the simplest and most preventable of diseases may attack them.

By far the biggest problems which older people face in the area of health are the cost of health care and access to health services. Access includes knowledge regarding prevention and management of common diseases, as well as access to curative services. In Africa, the attitude of health personnel towards older clients is by and large so negative that the clients prefer to die rather than to go to a clinic for treatment.

In 1997, I visited the village of Zuva in the Buhera area of Zimbabwe. In the village, Ambuya Chitambinda (85 years) was very ill with what appeared to be malaria. Concerned about her, I tried to rush her to hospital but she flatly refused to go. "The last time I went to the clinic," she told me, "the nurses scolded me and said that I was not ill but suffering from old age. They said I was finishing drugs for the young people." Mrs Chitambinda died a few months later.

When I visited Cameroon in 1999, the Minister of Social Welfare, Dr Fouda, told me a story which went as follows:

An old woman went to the clinic and informed the nurse that her left leg was very painful. In typical fashion, the nurse said that the old woman was not ill, she was only suffering from old age. The old woman said: 'My grandchild,

why is it that my old age is only in the left leg and not the right leg, or any other part of my body?'

Another problem is that health-care facilities are often situated a long way from where older persons live. In a number of instances these persons will neither have the energy to walk to the centres nor the money to pay for transport.

In 1996, I visited older people in the Shamva area of Zimbabwe. An old woman, in Bushu village, was slowly being blinded by cataracts. She only had a blurred vision of what was not more than a metre or so in front of her. I informed her that she should not let herself be blinded by the cataracts as they could be removed in a quick and simple operation. Her reply was:

My son. Don't talk as if I have not tried to get the cataracts removed. I borrowed money from my neighbour, travelled to Parirenyatwa Hospital in Harare, spent the whole day in the queue and when the doctor saw me, he said he was not going to operate me that day. I should go back home and come back another day. I came back and it took me months to repay the money I had borrowed from my neighbour. To go back there I have to borrow again, spend the whole day in the queue and obviously come back another time. No. I would rather be blind.

Older people are likely to suffer from malnutrition as food availability becomes problematic. Even in cases where food is available, changes in their metabolic functioning, such as failure to taste, chew and digest food properly, will contribute to poor nutritional status.

According to Craig (1992), social changes which take place around older individuals induce considerable worry, fear and anxiety in them. Coupled with the realities of increasing loss of independence, loss of income, fear of death and loneliness, and in many cases abuse suffered at the hands of younger persons, the changes may lead to psychological problems for them.

HIV and AIDS

The AIDS epidemics continue to pose many challenges to governments and societies throughout the world but the challenges are greatest in the developing countries. In Zimbabwe, current estimates are that between 700 and 1000 people die from AIDS-related illnesses each week (*Financial Gazette*, 1999). Addressing delegates at an AIDS conference held in Nairobi, Kenya in October 1998, Harold Wackman of the World Bank said that at least 60 people in Kenya are newly infected with HIV every day. In Kenya, one in every eight adults is HIV positive (*Sunday Standard*, 2000). Such high rates of HIV infection appear to be a trend throughout Africa.

AIDS has and will continue to have a huge impact on older persons in Africa. Like persons in any other population group, they may become infected with the virus, yet are not targeted in education campaigns. As more persons of working age die, older persons are robbed of their main sources of support. When their adult children die, they are left to fend for themselves and often to take care of orphans, without kin support. By this time, they will be likely to have disposed of whatever resources they had in efforts to find a cure for their dying child or children.

Social and cultural

World-wide, some older people suffer neglect, abandonment, destitution, homelessness, diminished participation and loss of status (UN, 1991). In Africa, factors which contribute to these states include the fact that the majority of older persons have not been able to attain formal education, have worked in

low-paid jobs, and where employed in the formal sector, have retired with little or no pension income and hence have no regular income. (South Africa, Botswana, Mauritius and Namibia are the only countries in Africa to operate a universal, non-contributory, but means-tested old-age social pension system.)

In developing regions, the weakening of family support structures has increased the vulnerability of older persons. Changing societal norms and values threaten their livelihood. Their human rights are neither recognised nor valued in the way in which they were previously. In some African countries, older persons suffer abuse, assault and murder at the hands of those from whom they expect support and protection in their old age (see HAI, 1999; Forrester Kibuga, 1999). To make matters worse, society appears to remain mute on these matters.

Conflict and disasters

When nations are caught up in political strife, conflict and coups, older persons' well-being and security are threatened. Disasters such as earthquakes, droughts and other natural calamities heavily disrupt the survival patterns of communities and groups. Older persons are invariably the hardest hit by such calamities (Apt, Bester & Insley, 1995). When they are displaced and live in camps as refugees, their specific needs and circumstances are seldom given due attention. When I started working in refugee camps in 1988, I was surprised to find that although younger persons were given poles to construct huts, no poles were given to older persons. An old woman, Maria Kampira, was sharing a tent with four older men. "To be a refugee is distressing enough, but to be an elderly refugee is double agony, the most tragic fate imaginable" (Blavo, 1995: 29).

At times of resettlement, it is frequently found that former living patterns of these persons are irretrievably changed. In post-conflict situations the status of older persons is altered, with traditional roles being ignored and family structures weakened (HAI, 2000).

Research on ageing in Africa

Along with the multiple, urgent and pressing issues and problems which older persons in Africa face, there is a concomitant urgent need for research to inform interventions for implementation at different levels of society. Unfortunately, it appears that only a limited amount of research which could be used for this purpose is being carried out in the continent. This could be due to several factors.

First, as asserted by Ferreira (1999), far too few studies of a micro-level or a qualitative nature are conducted in Africa. I would go further and assert that compared to the number of studies carried out among persons in younger age groups, studies on various areas of ageing are too few in general.

Second, one wonders whether an assertion that researchers in Africa are neither prepared to work with nor to share their work with others holds water? By implication, one may ask whether researchers expend too much effort on doing one another down, or outshining each other?

Third, it is noted that studies undertaken at universities and colleges are hardly consulted, nor the findings used. One would expect that studies conducted by students, from a first-degree level to a doctoral level, should be of a high enough standard to warrant reference to these studies, and the utilization of the research findings in policy and practice. According to Kaseke (personal communication, 2000), a total of nine dissertations based on studies on ageing have so far been written at the School of Social Work affiliated to the University of Zimbabwe.

Fourth, the "rural tourism" referred to by Chambers (1999) continues to occur across the continent. (The term "rural tourism" refers to research where investigators typically enter a rural area, speak to one or two persons, and then produce a report – as if an intensive research project has been carried out.) Persons who engage in such research ("rural tourism") typically have very little knowledge, understanding and feeling about real issues which affect older people in the region (cf. Ferreira, 1999).

Whilst accepting that research on ageing in Africa is limited, it may also be argued that the studies which have been conducted have not been adequately collated, disseminated and shared. It is fair to say that the research which has taken place since the 1970s and the number of researchers who have conducted studies are reasonably substantial. Researchers in anglophone African countries include Zimbabweans, South Africans, Ghanaians, Botswanans, Ugandans, Kenyans, Nigerians and Tanzanians. Under a joint programme of the Organisation for African Unity (OAU) and the HAI Africa Regional Development Office, work has started to develop an annotated bibliography of research on ageing in Africa. From South Africa alone, we have so far received a list of 1115 research publications in southern Africa, dating back to 1970 (cf. Ferreira, Esterhuysen, Sewell *et al.*, 1995). For someone who has worked in the field of ageing in Africa since 1988, I am only now coming across much of the work.

Accepting that some research on ageing has been and is being done in Africa, albeit not as frequently and as comprehensively as one might hope, a pivotal question then seems to revolve around the dissemination, sharing and employment of the research results. In short, the question begs to be asked: Why are we conducting research in Africa?

Selltiz, Wrightsman and Cook (1976) raise interesting points on the use of research and hence the reason why social research is conducted. "Social science research expands perception by formulating problems and [finding] solutions which are beyond the pale shadow of common sense," the authors state (1976: 6). The purpose of social science research, they argue, is to provide decision makers, public policy makers (present and future) and individuals with substantive advice about what to decide and how to act. Above all, research should be useful in that it should seek to improve the quality of life of people. However, research may be used negatively, the authors argue – for instance, by condoning stereotypes.

It is frustrating that much guesswork goes on around extremely important issues in Africa at the moment. For example, in the majority of countries it is simply guessed what the number of older persons is. Statements such as "about 5% are older people" and "approximately 3% are older women" are common. The situation of older people in many countries is also left to speculation. Sweeping statements are made about the nature of family structures; the so-called extended family system (which I would argue is referred to incorrectly, since in Africa distant relatives are still family and are therefore part of a family structure) is said to have broken down or to be in the process of doing so. Have these structures broken down, or are they merely weakening due to various socio-economic pressures? The co-operation and mutual assistance which is harnessed at funerals and weddings suggest to me that family structures have not broken down. When we at HAI show that in the onslaught of AIDS, the lives of older persons and children are inescapably interwoven – older persons become the carers of AIDS orphans, many across the continent are quite surprised. With AIDS as serious a problem as it is, it is a wonder that the burden which the epidemics are placing on older persons, and

their need for information and education, are hardly ever talked about.

In this issue

In this special issue of *SAJG*, an attempt is made to demonstrate how a selection of studies were conducted and how the research outcomes have been translated into action.

Heslop, Agyarko, Adjetey-Sorsey and Mapetla give us a paper in which they have evaluated the methodology used in studies in Ghana and South Africa to determine the contributions of older people. After long periods of implementation and learning, this participatory-research methodology has become synonymous with HAI's research work. The authors take us through the methodology, describe the studies carried out in the two countries, and provide us with a vivid picture of not only the problems which older people in the countries face, but also the immense contribution which they make to the well-being of other people. The impact which this work has had in both countries is notable. Older participants in the studies have taken it upon themselves to advocate their rights, and the governments in the two countries have started to put measures in place to address some of the problems identified in the studies.

The paper by **Van Vuuren and Groenewald** examines the pattern of expenditure of pension income by black pension beneficiaries in the Free State Province of South Africa, against a backdrop of these persons' living circumstances. It goes into detail about issues regarding the payment of pensions, pension sharing within households and expenditure of pension money on specific items, and challenges allegations that pensioners are frequently robbed of their pension money and that they lose this income to loan sharks.

Some of the findings of this paper contrast with the findings of the HAI studies conducted with partners in the Northern, Gauteng and Kwazulu-Natal provinces of South Africa (see the first paper in this issue by Heslop and colleagues).

In their paper, **Kowal, Wolfson and Dowd** point out that there is a dearth of empirical and credible data on older people in Africa. Although some research has been conducted on this population, the authors note that by and large the available data derive from small samples, are scattered, and have neither been widely disseminated nor shared. The authors further note a lack of common approaches to data collection. Realising these gaps, the World Health Organisation arranged a workshop in Harare, Zimbabwe in January 2000, to begin a process to develop a minimum data set (MDS) for use by researchers in Africa. An overall aim of the MDS project is to provide data to influence policy and decision makers in various areas which affect older persons.

Needs-driven research on nutrition and ageing, carried out by HAI in collaboration with the London School of Hygiene and Tropical Medicine, is reported by **Busolo, Ismail and Peachey** in their paper. Nutrition and ageing in developing countries is an area which has received scant attention. The nutritional requirements of older persons in these countries have not only been inadequately investigated but as a result, nutrition practitioners in various settings simply shoot in the dark. The authors take us down the path which the research took, from how the needs were identified, to how the research was conducted, to how an intervention programme was set up. They give us some key findings of the research, describe the dissemination process and the application of the findings, and suggest a way forward. An Africa-wide programme currently being implemented as a direct result of this work is aimed at providing knowledge and information on the nutritional requirements of older people to key nutrition institutes,

older people's organisations, NGOs (particularly those working in emergency situations), donors and governments.

HelpAge International earlier conducted research in the Magu district of Tanzania on the plight of older women who are victimised on suspicion of their being witches (cf. Forrester Kibuga, 1999). **Forrester Kibuga and Dianga** now draw on this work in their paper. The authors take us through facts pertaining to the witchcraft-related killings, some of the problems which older people in the district face, the changing roles of older people in that area, beliefs and customs of the communities, and the stance of the government and the church on witchcraft. The dynamics of gender issues are also discussed. Following on this research, HAI designed and is now implementing a programme aimed at addressing some of the factors which lead up to these killings and developing sustainable structures to protect older people from violence.

In his paper, **Gorman** draws on the work of HAI in various parts of the world, particularly in Africa – including Tanzania, Ghana, South Africa and Kenya. He argues that violence against older women and men in Africa cannot be attributed to a single, straight-forward problem but must be understood within a complex web that touches on history, family structures, and social and economic factors. He makes practical suggestions on what needs to be done to deal with the problem of violence. HelpAge International will soon be implementing an Africa-wide programme as a response to some of the issues which have been raised in its research on violence.

While there is a clear need for more research on ageing in Africa, the research should not be done in a vacuum. There is a simultaneous need for greater collaboration and sharing of research results, and perhaps most importantly, for more action based on research outcomes. At the end of the day researchers should never forget that they have an ethical commitment to their subjects, to society and to their colleagues.

Thanks

Thanks are due to **Karen Peachey** and **Alex Dianga** in the HAI Africa Regional Development Centre for the co-ordination of this special issue. Special thanks are due to **Monica Ferreira** for dedicating the issue to the experience and work of HAI, and for her commitment to addressing issues pertaining to ageing in Africa. She has worked tirelessly to ensure the success of not only this issue of *SAJG* but of previous issues as well. I have found her a pillar of support and a pleasure to work with.

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HelpAge International is a global network of not-for-profit organisations with a mission to work with and for disadvantaged older people world-wide to achieve a lasting improvement in the quality of their lives.