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Population ageing in Zimbabwe: levels, patterns and trends

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Abstract

While population ageing has drawn considerable and increasing attention in developed countries, it has hardly begun to be recognized in the developing regions, where demographic change is indeed only a matter of time. Despite other pressing demographic problems in developing countries, such as high population growth rates, high infant and child mortality, and excessive urban expansion, the impact of related cultural and economic factors on older persons can no longer be ignored in government policy. This paper selectively examines population levels, patterns and trends in Zimbabwe. The socio-economic implications of population ageing in developing countries in general are discussed with reference to Zimbabwe.

Introduction

The world faces a dramatic ageing of its population in the near future (United Nations, 1994a). Due to declining fertility and mortality rates and increasing life expectancy at birth, the proportion of persons aged 60 years and over in the population will increase for all countries.

In 1950, 200 million persons world-wide were 60 years and over and constituted 8% of the total global population. The older population was evenly distributed between the developed and the developing regions. By 1975, this figure had increased by 75% to 350 million persons, still evenly distributed between developed and developing regions (United Nations, 1994b).

Since 1975, the world's older population is increasingly concentrated in the developing regions, namely Latin America, Asia and Africa. The total world older population is projected to be 616 million by the year 2000, with 62% of that population living in developing countries. In 2025, the absolute number of older persons will double, to 1.2 billion, constituting about 14% of the total population, with 71% living in developing regions (United Nations, 1994b).

As is currently the case in the developed countries, care of the aged will become an increasingly important policy concern for developing countries. The indications are that by the year 2000, life expectancy at birth in the developing regions will reach 60 to 70 years. With a major increase in the absolute number of older people, who will live longer, and the psychosocial, cultural and life-style changes that tend to accompany urbanization, many of these countries are likely to face a sharp increase in chronic non-communicable diseases at a time when infectious diseases are still not wholly under control.

This paper examines selected levels, patterns and trends in population ageing and their implications in Zimbabwe, a developing country.

Data sources

Two main data sources are drawn upon in the paper. The first source is the Zimbabwean 1992 population census conducted by the Central Statistical Office (CSO, 1995) with support from the United Nations Population Fund and the Swedish International Development Agency. The second source is United Nations' data published in *World population prospects* (1995) and *The sex and age distribution of the world population* (1994b). Data from earlier sources are used intermittently in the paper to show demographic changes over time.

Trends in population ageing

Various demographic indicators may be used to describe the ageing of populations. The following indicators are used in this paper: the relative weight of older persons in the population, the age structure of the population and the sex ratio in the older population.

According to 1982 census data for Zimbabwe, the percentage of the population aged 60 years and over in the total population was 4.7, with persons aged 0-14 years constituting 47.7% of the total population. Of this older population, 51.2% were males and 48.8% were females. The 1992 census data show an increase in the percentage of persons aged 60 years and over to 5%, with the percentage of persons aged 0-14 years reduced to 45.1%. In 1992 the older population numbered 524 726 persons.

The ageing of the population

The medium variant projections, based on United Nations' estimates shown in Figure 1, indicate the increase in the population aged 60 years and over.

Figure 1 highlights the increase in the "old-old" population, i.e. persons aged 75 years and over. As is the case in other developed and developing countries, the older age groups (75-79 years, 80+ years) within the Zimbabwean population aged 60 years and over will expand more rapidly than the younger age group (60-74 years). Women will be more numerous than men in each of these age groups.

The sex ratio

A trend in population ageing is a change in the ratio of males to females. In 1990 the United Nations (1994b) estimated that

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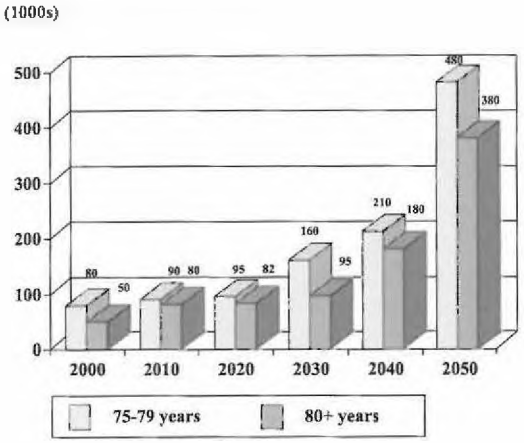
there was an average of 67 males for every 100 females in developed countries and an average of 98 males for every 100 females in developing countries. At that time, the sex ratio for Zimbabwe was 88 males for every 100 females (UN, 1994b). The CSO (1985, 1995) calculated a sex ratio of 103 males to 100 females, which according to the 1992 census had declined to 97.

Figure 1

Projected Zimbabwean population aged 75-79 years and 80+ years, 2000-2050

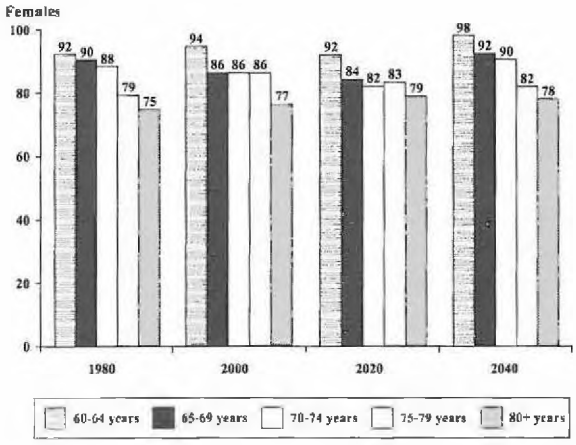


Source: United Nations, 1995.

Using the United Nations' data, the sex ratio ranges between 80 and 90 males to 100 females from 1950 and as projected to 2050 (Figure 2). Further breakdown of this data by age group shows an improved sex ratio, which is above 80 but below 90, in the 60-64-year age group, which declines with age to between 70 and 75 males per 100 females in the 80-years-and-over age group. This trend reflects a higher life expectancy for females than males, although males are nevertheless gaining more years but at a lower level.

Figure 2

Age/sex ratio of the Zimbabwean population aged 60+, in five age groups, 1980 and projected to 2040



Source: United Nations, 1994b.

An analysis of the 1982 and 1992 census data also confirms that there is a decline in the sex ratio as people grow older in Zimbabwe. The 1982 census showed a sex ratio of 118 in the 60-64-year age group and of 84 in the 75-years-and-over age group (CSO, 1985). A sex ratio of 113 males per 100 females in the 60-64-year age group and a ratio of 76 in the 75-years-and-over age category are found in the 1992 census data (CSO, 1995).

Significantly high female life expectancy is shown in the 1982 census data and this life expectancy is even higher according to the 1992 census data.

Determinants of population ageing

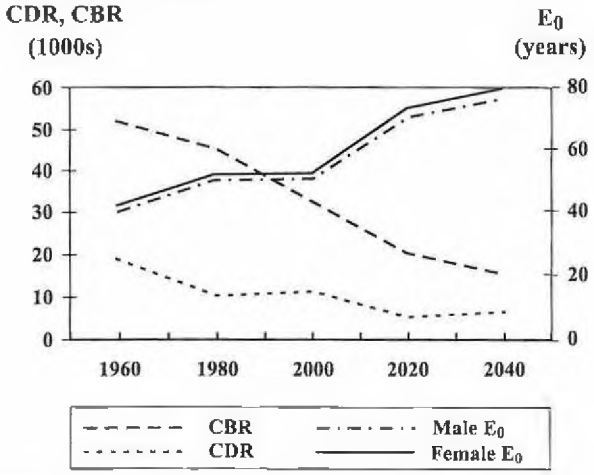
Two indicators used in determining the ageing of a population are the crude birth rate and the crude death rate, and life expectancy at birth.

Changes in crude birth and death rates

Following fertility trends from 1950 to date, the crude birth rate (CBR) has been declining from the 1950 figure of 51.8 births per 1 000 population to the current level of 36 births, and is projected to be 15.3 births by the year 2050 (Figure 3). Fertility transition has also been shown in several surveys carried out in the country (Zimbabwe Reproductive and Health Survey, 1985: Zimbabwe Demographic and Health Surveys, 1989, 1995: CSO, 1985, 1995).

Figure 3

Crude death rate, crude birth rate and life expectancy, Zimbabwe, 1960-2040



Source: United Nations, 1994a.

This decline in fertility will not only effect the ageing of the population but will also affect care systems for the elderly. A decline in the CBR will mean a decline in the number of potential caregivers to older persons.

Mortality has been following a similar declining trend until the early 1990s. The crude death rate (CDR) of 23.3 in 1950 decreased to 12 between 1990 and 1995, and it is projected that it will be at a low of 6.1 by the year 2050 (UN, 1994b).

Changes in life expectancy

Despite the AIDS epidemic and resulting mortality, life expectancy at birth is projected to increase to the extent that Zimbabwe will have a high proportion of old-old persons by the year 2050 (UN, 1994b). In 1950, life expectancy for males and females was 39.9 years and 43.1 years, respectively. Between 1995 and 2000, males will have gained 12.7 years and females 12 years. From 2015 to 2020, the life expectancy for males will be 63.9 years and for females, 67.4 years. It is projected that between 2045 and 2050 life expectancy will be 74.6 years for males and 78.9 years for females.

These projections show an increase in the number of older females compared to older males due to higher life expectancy. The higher life expectancy for females will not only mean a lower sex ratio in the older population, but for older women themselves, this may mean loss of support from a spouse and siblings, leading to economic deprivation, prolonged widowhood and greater dependence on formal support systems.

Distribution by demographic and socio-economic status

Provincial distribution

The distribution of the older population by province as a percentage of the total population residing in each province (see Table 1) shows that of all provinces, Matebeleland South (6.9%) has the highest percentage of older persons. Harare and Bulawayo provinces have the lowest percentages – 2% and 3%, respectively. The latter two provinces are city-provinces, and are a magnet for young adults seeking employment opportunities.

Table 1

Population aged 60+ as a percentage of the total Zimbabwean population, by province and by gender

Province	Males %	Females %	Total %
Matebeleland South	6.4	7.4	6.9
Mashonaland East	6.3	6.3	6.3
Matebeleland North	5.7	6.3	6.0
Masvingo	5.3	5.9	5.6
Mashonaland Central	5.8	5.2	5.5
Manicaland	5.2	5.3	5.2
Mashonaland West	5.5	4.4	5.0
Midlands	4.8	4.9	4.8
Bulawayo	4.0	3.2	3.6
Harare	3.1	2.4	2.8

Source: Central Statistical Office, 1995.

Distribution by gender

According to the CSO (1995), 50.9% of the older Zimbabwean population are females and 49.1% are males. Since women tend to outlive men generally, the number of widows in the older age groups significantly affects the social structure of older people. In addition, the age difference between spouses, which usually favours husbands, means that females are more likely to be widowed than males. Consequently, problems relating to employment, income adequacy, health and health care, living arrangements, and patterns of social interaction of older people may affect older women more than older men.

Education

In the 1992 census, the population aged 15 years and over which had completed at least a Grade 3 level of education was classified as literate. Eighty per cent of the population was found to be literate and the literacy rate was higher for males (86%) than for females (75%) (CSO, 1995).

For persons who had no schooling, 17.1% were elderly, compared to 27.4% in the 15-59-years age group. Table 2 gives a breakdown of school attendance for the population aged 60 years and over, by age and by gender.

Table 2

Percentage distribution of the population aged 60+, by age group, gender and schooling

Age group (years)	Schooling		No schooling	
	Males %	Females %	Males %	Females %
60 - 64	61.0	39.0	41.2	58.8
65 - 69	58.4	41.6	39.4	60.6
70 - 74	56.6	43.4	40.6	59.5
75+	52.0	48.0	37.1	62.9

Source: Central Statistical Office, 1995.

Rural/urban location

According to the 1992 census, the rural areas of Zimbabwe, with 6.2% of the population aged 60 years and over, have the highest proportion of older persons, compared to 2.8% for the urban areas (CSO, 1995).

Of those aged 60 years and over in the rural areas, 52.6% are females, compared to 47.4% males. Presumably, this distribution is due to gender differentials in mortality. However, in urban areas, 57.6% of the total population aged 60 years and over is comprised of males, compared to 42.4% females (CSO, 1995). In this case, even though there are gender differentials in mortality, the percentage of males in urban settings is higher than that of females – and hence the differences. This is so because males account for a larger percentage of the population in the labour market.

The greater proportion of older persons in the rural areas could be due to people retiring from formal employment and returning to their rural homes which are less expensive to manage when compared to urban accommodation. It is also more secure for individuals to retire to a rural area, where they can obtain a piece of land from the headman, for cultivation and keeping livestock, without having to worry about title deeds, rentals and rates. Another reason is rural out-migration by young and able-bodied persons, who leave sick and elderly relatives behind in rural areas.

Household headship

The 1992 census identified 2 163 289 households in the country, with a population of 10.3 million at the time (CSO, 1995). This means that the average household size at the time was five persons. Of the households, 16.2% were headed by persons aged 60 years and over (Table 3).

Table 3

Percentage distribution of heads of households aged 60+, by age group and by gender

Age group (years)	Percentage of households headed by		% of total households
	Males %	Females %	
60 - 64	70.4	32.5	5.6
65 - 69	67.5	35.8	3.1
70 - 74	64.2	39.5	3.7
75+	60.5	37.2	3.3
Total			16.2

Source: Central Statistical Office, 1995.

Of this 16.2%, 15.7% of the households were in urban areas and 84.3% were in rural areas. What is interesting, is that even though women generally live longer than men, very few households identified a woman as the head of the household. Thus a greater number of Zimbabwean households are headed by males than females.

Of the 110 500 multigenerational households identified, only 5% accommodated persons aged 60 years and over; 80.9% had persons aged 15-64 years and 14.1% had children aged 0-14 years.

An analysis of household headship data by age and marital status showed that the majority of household heads aged 60 years and over were either widowed or divorced/separated. This pattern was true for both males and females.

Economic activity

The CSO (1995) noted that according to the 1992 census, the population aged 15 years and above numbered 5 683 323 and that 62% of this population was defined as economically active. Of this economically-active population, 22% were unemployed, 24% were communal farm workers and 55% were employed.

The data show that the majority of older persons are unemployed. Of the total 38% economically-inactive population, 13.4% are aged 60 years and over. The majority of these persons acknowledged that they were inactive due to retirement, sickness or old age. Assessing this data by rural-urban location, most of the economically-active and economically-inactive persons reside in rural areas.

Implications for socio-economic development

The family as a safety net

Declining fertility results in a reduction in overall family size and in the number of kin. A decline in mortality increases survivorship between and within generations. Thus these processes mean that parents will have fewer children to depend upon. As fertility decline is often associated with delayed age at marriage, and consequently delayed age at child bearing, adults are in a position where they have to support young children and at the same time care for parents and grandparents. This situation places a very heavy social, economic and psychological burden on both a caregiver and an older person.

Faced with situations where families cannot cope with the care of their older members, governments tend to rely on institutionalized care. However, very few older Zimbabweans reside in institutions – about 1% of the older population, and then about half of these institutionalized persons are whites. Families thus need to be assisted to care for their elderly relatives and strategies need to be devised for this purpose. The strategies should draw on cultural traditions and mores which previously ensured security, honour and respect for Zimbabwean people in their old age.

Gender differences

There is a need to recognize the biological differences between men and women, and the role differences that continue to govern behaviour in old age. Men aged 65 years and over are more likely to be married, usually to younger women, while women in that age group are more likely to be widowed. Problems relating to employment, adequacy of income, health and caregiving responsibilities may affect older women more than older men. Options for dealing with the special gender-related needs of both sexes should be reviewed. Not only will this promote greater equity between the sexes, but will also improve the general welfare of both men and women as they grow older.

Lack of income security

Current social security measures in Zimbabwe are limited in coverage and extent, since only persons who retire from formal employment or who receive a private pension benefit from some form of social security.

In situations where a government pension is received, it is rarely fully indexed to inflation, so workers are poorly protected in old age. In general, publicly managed funds set aside for the old are often dissipated by poor management. According to the World Bank (1994), the public provident fund in Zambia, which invested exclusively in public securities, lost 23% per year on average between 1981 and 1988, and more than half of the contributions were used for administrative purposes.

Housing

Under the Welfare Organisation Act, the government encourages the settlement of needy, homeless elderly people in old people's homes. Eighty such homes are operated, 20 of which do not charge residents fees. The government subsidizes the latter homes through grants. But how many elderly benefit from these homes and grants? Very few, if we consider that the majority of the older population resides in the rural areas and three-quarters of the homes are in the urban areas.

Health care provision

Another major problem is the provision of health-care services to the older population, which suffers a high prevalence of degenerative diseases. In general, the elderly consume a large portion of health-care resources, which places a burden on the state, communities and families. In Zimbabwe, the elderly account for almost 20% of all admissions to public hospitals, even though they constitute only 5% of the population (Government of Zimbabwe, 1994).

Now that Zimbabwe is faced with a growing demand for geriatric health care services, how will older persons be able to afford the medical care which they need to sustain good health? At present, due to economic hardships that burden their children, very few older Zimbabweans are sent remittances by children, i.e by children who live elsewhere. Older persons who live in rural areas are particularly unable to afford to pay for health care.

Consumption

Ageing of the population will influence consumption patterns in the country. Population ageing tends to produce a slow decline in the consumption of goods and services for children and a slow increase in the consumption of goods and services for older persons – for example, special housing and health aids. From the state's part, expenditure on inactive old people is entirely for consumption, especially in the case of costly medical-care services, with very little or no production in return.

Agricultural sector

The age structure of the Zimbabwean labour force is characterized by a remarkable change in the agricultural sector. The rural areas are experiencing a heavy decrease in workers who would normally be engaged in agriculture but who are migrating to the cities. The age structure of the rural population is thus growing increasingly older.

Elder care in Zimbabwe

The implications of population ageing for both society and individuals in Zimbabwe, especially older individuals, are obvious. What is being done about the effects of the demographic changes? An attempt is made to answer the question, albeit briefly and selectively, in terms of the role played by non-governmental organizations (NGOs) and legislation on the care of older persons.

HelpAge Zimbabwe is one of several NGOs involved in a variety of activities and projects aimed at alleviating the plight of the elderly in the country. Its programmes include the provision of meals-on-wheels, low-cost and subsidized housing, income-generating project support, institutional care, training, information services and advocacy – to raise awareness on issues affecting older persons. The activities mainly benefit destitute older persons.

Regarding legislation, it has been proposed that an act of government be established on elder care in Zimbabwe. The legislation should cover, among other things, family-focussed social welfare services – to promote community-based care, the protection of elderly consumers, the continued employment of older persons, income security and education. What remains, therefore, is for the government to develop a comprehensive, integrated and co-ordinated policy that incorporates the elderly. The elderly are not a separate segment of the population and the labour force, since any society consists of a population structured by age and gender with varied social, economic, cultural and biological functions, with each population segment being essential and intricately connected with every other segment.

An integrated and holistic approach to population ageing, taking social, economic, and cultural change into account, may be the only effective solution to the emerging problems.

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AIDS reduces African life expectancy

AIDS results in higher mortality rates in childhood, as well among young adults where mortality is otherwise low. Thus, AIDS-related deaths will have a greater impact on life expectancies than on some other demographic indicators in these countries.

The US Bureau of the Census suggests the following reduced life expectancies (in years) due to AIDS in African countries:

Botswana	62 to 40	Malawi	51 to 37
Burkino Faso	55 to 46	Namibia	65 to 42
Burundi	55 to 46	Nigeria	58 to 54
Cameroon	59 to 51	Rwanda	54 to 42
Central African Republic	56 to 49	South Africa	65 to 56
Republic of the Congo	57 to 47	Swaziland	58 to 39
Congo	54 to 49	Tanzania	55 to 46
Ethiopia	51 to 41	Uganda	54 to 43
Ivory Coast	57 to 46	Zambia	56 to 37
Kenya	66 to 48	Zimbabwe	65 to 39
Lesotho	62 to 54		

Excerpted from "AIDS sends African life expectancy plunging," *The Cape Argus*, March 18, 1999, p. 7.