



3 Venturing in Eastern Europe

Joseph Troisi

9 Country Report – BELARUS

Vladimir Kasutschik

13 Socio-Economic Support of Older People in Zimbabwe

Sitawa R. Kimuna

29 Discharge from Institutional Long Term Care

Ingrid Magro - Peter Ferry

32 International Diary and INIA Activities

CONTENTS

Venturing in Eastern Europe: Setting up a Satellite Centre in the field of Ageing

JOSEPH TROISI

POPULATION AGEING IN EUROPE

One of the most outstanding features of Europe's demography is population ageing. Viewed from a global perspective, Europe is by far the oldest region in the world. It is projected that, during 1998-2025, the proportion of older persons in Europe and North America, will increase from 20 to 28 percent and from 16 to 26 percent respectively. Without doubts, this demographic transformation has deep consequences on the social, economic, political, cultural, psychological and spiritual facets of humanity.

As was emphasised in the Berlin Ministerial declaration entitled "A Society for all Ages in the UNECE Region", the region does not only have the highest proportion of older persons but the countries within this region are experiencing unprecedented demographic changes. The Ministers who attended the UNECE Ministerial Conference on Ageing which took place in Berlin, Germany between 11-13 September 2002, unanimously agreed to take the necessary measures to fully respond to the challenges of population ageing. They promised to commit themselves, in close co-operation with civil society, to implement the Regional Implementation Strategy of the Madrid International Plan of Action on Ageing 2002 and to enable all persons to reach old age in better health and well-being while, at the same time, enhancing the recognition of the dignity and independence of older persons through an all-inclusive and sustainable approach.

The UNECE region is very heterogenous in nature. Substantial variations exist among the UNECE member states in economic, social, political, and cultural fields. The Regional Implementation Strategy (RIS) is very sensitive to the fact that a number of countries with economies in transition

are less equipped to face the challenges of population ageing. In fact, Commitment 3 of the RIS entitled "To promote equitable and sustainable economic growth in response to population ageing" points out that "the existing differences in the macroeconomic situation and capabilities between the Western part of the region and economies in transition... necessitate that economic and social policy reforms in these countries should respond to the challenges of their ageing populations".

Article 10 of the Berlin Declaration recommends greater co-operation among the UNECE member states in implementing the RIS. Furthermore it is said that "Such co-operation could be further enhanced by active collaboration among relevant United Nations departments and agencies and other intergovernmental organisations and institutions active in the field of ageing in the region as well as NGO networks".

INIA'S ROLE IN MEETING THE CHALLENGES OF POPULATION AGEING

The significant increase in life expectancy unavoidably implies not only a heightened demand for existing support services but also for new services and alternative approaches for the care of the older population. Consequently, new approaches to medical care and the delivery of social and economic services are needed. The non-achievement of such standards would result in dire consequences including unnecessary suffering and prolonged dependence among the older persons involved.

A serious deficiency being faced by many countries is the acute shortage of trained personnel at all levels, including the social and health professions. It is precisely to meet this need that both the Vienna and the Madrid International Plans of Action on Ageing

laid particular emphasis on the need of training all those who are actually working or who intend to work in the field of ageing or with older persons be it at home or in institutions, be they volunteers or family members, be they professionals or others.

The International Institute on Ageing (INIA) was the direct United Nations' result of the First World Assembly on Ageing. The ensuing Vienna International Plan of Action on Aging clearly stated (Recommendation 57) that the very implementation of several of the 62 recommendations fundamentally required trained personnel in the field of ageing. This recommendation was endorsed by the United Nations General Assembly in its Resolution 37/51 according to which the promotion of training and research, as well as the exchange of information and knowledge was a basic requirement in order to provide an international basis for social policies and action.

The United Nations Economic and Social Council, by its Resolution 1987/41 recommended to the UN Secretary General, the establishment of the International Institute on Ageing. On the 9th October 1987, the United Nations signed an official agreement with the Government of Malta to establish INIA as an autonomous body under the auspices of the United Nations. The Institute was inaugurated on the 15th April 1988 by the then United Nations Secretary-General, H.E. Mr. Javier Perez de Cuellar.

INIA's mandate is tripartite in nature, namely: 1) to train personnel from developing countries who are working or who intend to work in the field of ageing or with the elderly; 2) to act as a practical bridge between developing and developed countries in the area of information exchange in the field of ageing; 3) to provide advocacy to developing countries in matters concerning ageing and older persons.

INIA provides multi-disciplinary education and training in gerontology and geriatrics at various levels. To maximise the efficiency and effectiveness of its training, INIA has designed and implemented innovative training strategies and techniques. Since 1990, four training programmes in Social Gerontology; Economic and Financial Aspects of Ageing; Geriatrics; and Demographic Aspects of Population Ageing are conducted annually in Malta. During the past 15 years, 1,566 persons from 130 countries throughout the world have successfully

benefited from these training programmes which are run in collaboration with the United Nations Population Fund (UNFPA).

To meet the growing demands from various countries, in 1995, INIA started organising 'in situ' training programmes in various countries. During the past 10 years, INIA has conducted 37 'in situ' training programmes in 17 countries including Barbados, Belarus, Brazil, People Republic of China, Egypt, Ghana, India, Kuwait, Former Republic of Macedonia, Mexico, Panama, Philippines, Russian Federation, Singapore, South Africa, Thailand and Tunisia. These were attended by 1,306 persons. Although the majority of these 'in situ' programmes are run on a country basis, some were also carried out on a regional basis.

To ensure the highest possible form of professional training in the fields of Gerontology and Geriatrics, while stressing the totality of the human person, INIA makes use of a strong multi-disciplinary team of international and local experts. This enables the participants to benefit from the wide variety of the tutors' knowledge and expertise.

The training programmes conducted in Malta and also those 'in situ' have their own pros and cons. Thus the participants of the programmes held in Malta can, without doubt, benefit a lot from the very internationality and varied experience of the same participants. This is of great importance since a candidate is able, within the short span of two weeks, to appreciate better what is happening in other countries in the field of ageing, and what are the existing national and local policies and programmes being implemented to meet these challenges. Participants are also encouraged to discuss the successes, failures and difficulties encountered in the implementation of these policies and programmes.

On the other hand, the participants in the 'in situ' programmes tend to be more homogenous in nature and to be more familiar with the national or local situations. Consequently, within a shorter span of time, they would be better able to assess the needs and situations of older persons in their country. Furthermore, the 'in situ' programmes are more varied and interdisciplinary in nature dealing with various issues.

INIA's training programmes are oriented towards persons coming from developing countries, who hold positions as policy-makers, planners, programme executives, educators, professionals and para-professionals. Preference in the selection of candidates is given to those who are in a position to train others thus promoting the multiplier effect in their respective countries by becoming agents of change through the dissemination of the information and knowledge acquired, thereby influencing policy issues. It is very encouraging to note that the majority of INIA's 'in situ' training programmes were organised by persons who had participated in one of INIA's training programmes organised in Malta.

THE BELARUS EXPERIENCE

The training programme which INIA organised in Belarus between 24th January 2nd February 2005 was coordinated by Ms.Tatyana Haplichnik, UNFPA programme coordinator at the UN Office in Minsk, Belarus. Two years earlier, between 3-14 March 2003, she had participated in the Social Gerontology programme in Malta. She was ably assisted by Ms.Tatyana Pronko and also by Ms. Yemialyanava Alena Alexandrovna.

Following INIA's policy, and aware of the great heterogeneity which exists in the field of ageing and among the elderly themselves, these "in situ" training programmes are tailored to the specific needs and situations of the older persons in each of the countries or regions concerned. The training programme in Belarus was focussed on the demographic, economic and social issues of population ageing. The lecturers were Dr. Nikolai Botev, project manager, PAU/EAD from the UN Economic Commission for Europe, Geneva who dealt with the demographic issues; Dr. Raja Chakraborti from the department of South and South East Asian studies, Calcutta University, West Bengal, India who dealt with the economic issues, while Prof. Joseph Troisi, INIA's deputy director lectured on the social issues of ageing.

The programme, was conducted in collaboration with the Ministry of Labour and Social Welfare, government of Belarus, and by the United Nations Population Fund (UNFPA). In fact, the certificates of participation were signed by the Hon. Ms.A.P.Morova, Minister for Labour and Social Welfare. At the opening and closing ceremonies, the government of Belarus was represented by the Hon. Mr. Pavlov Valeriy Ivanovich, Deputy minister from the same ministry. The programme which was conducted in English with simultaneous translation in Russian, was attended by 32 participants, all of whom, except two who hailed from the Ukraine, were from Belarus. As expected, the majority of the participants came from the Ministry of Labour and Social Welfare. However, there were also representatives from the Ministry of Economy, from the Ministry of Statistics and Analysis and also from various districts in Belarus, including Berioza, Miadel, Minsk, Mogiliov, Narovlansk, Partizanskij, Smorgon, Voronov and Zavodskoj. The participants were professionals coming from different fields, including academics, demographers, economists, medical doctors, social workers and statisticians. All of them occupied high positions within their organizations.

The evaluation session which was conducted at the



*Minsk (Belarus)
24 January - 2 February 2005*

end of the programme proved to be a real eye opener to the government of Belarus. In fact, it was agreed that INIA was to conduct future training programmes in gerontology in Belarus in collaboration with the Ministry of Labour and Social Welfare, Republic of Belarus, and the United Nations Population Fund (UNFPA). The success of this first training programme augured well for the future in this country.

Training programmes in St. Petersburg

The first training programme to be run in the Russian Federation was conducted by INIA in St.Petersburg between 2-13 December 2002 in collaboration with the St.Petersburg School of Public Health, the St.Petersburg Medical Academy of Postgraduate Studies, and the St. Petersburg Society of Russian Academy of Science. The driving force behind this programme was Prof. Ella Pushkova, the Head Geriatrician of the Committee on Public Health of the Government of St. Petersburg, and Head of the City Geriatric Centre in St. Petersburg, Russia. The programme consisted of lectures, seminars and site-visits to local facilities. Besides Prof. Pushkova herself, the main lecturers included Prof. Vladislav Bezrukov from the Ukraine, Prof.O.Yakovlev from Samara, Professors Vladimir Anisimov, Vladimir Kh. Khavinson, Olga Kuznetsova, Alexander Lantsov from Russia and Professors Frederick Fenech and Joseph Troisi, INIA's director and deputy director respectively.

The programme attracted 24 participants from various districts within the Federation, as expected, the majority of the participants belonged to the medical field, many of them also occupying leading positions in their institutes, hospitals or centres. A Finnish medical doctor also participated. The programme was a success. In fact, on the 13th December, during the closing ceremony of the programme, an

agreement of collaboration in the field of ageing, aimed, among others, at running similar training programmes every alternate year, was signed.

The second training programme to be conducted in St.Petersburg was scheduled to take place at the end of October 2004. However, this had to be postponed. On November 16, 2004, Prof. Ella Pushkova passed away after a long illness. The training programme was actually run between 21-30 March 2005 in collaboration with the St. Petersburg City Geriatric Centre, the Gerontological Society of the Russian Academy of Science and the Institute of Bioregulation and Gerontology of the Russian Academy of Medical Science. 28 medical doctors and two nurses participated. Although the majority were from St. Petersburg, there were also participants from Moscow, Novgorod, the Smolensk region and the neighbouring country of Estonia. It was a fitting tribute to Prof. Ella Pushkova. As a result of her efforts, participants did not only receive INIA's Certificate of Attendance but were also given the Russian State Certificate in Gerontology and Geriatrics.

As part of the training programme which was conducted in Russian and English and which was coordinated by Prof. Vladimir Anisimov, President of the Gerontological Society of Russian Academy of Science, and Prof. Joseph Troisi, Deputy Director of INIA, participants were requested to prepare a written report about their work in the field of ageing.



These reports were then presented and discussed during the programme itself. The main lecturers included Professors Vladimir Anisimov, Vladimir Kh.Khavinson, Kirill L.Kozlov, Olga M.Lesnyak, Eugeny G.Zotkin, from the Russian Federation, Dr. Alexandre Sidorenko, the UN focal point on ageing, Prof. Joseph Troisi and Dr. Peter Ferry from INIA. One cannot but not mention the untiring work of Ms. Lubov Shenderova, the niece of Prof. Ella Pushkova, who left no stone unturned to ensure that the two training programmes were a success.

SATELLITE CENTRES

Fully aware of the demographic changes which are taking place in the majority of countries in Central and Eastern Europe resulting in a rapid population ageing, and the urgent need of capacity building and training to meet this challenge, during the days of the training programme, the possibility of setting up an INIA satellite centre in St. Petersburg to meet these needs within these countries was discussed in a number of meetings between the organisers of the training programme. On Wednesday, the 30th March 2005, an agreement was signed between Dr. Eugeny V. Dotsenko, head of the St. Petersburg City Geriatric Centre, Professor Vladimir N. Anisimov, president Russian Gerontological Society for the Russian side, and Professor Joseph Troisi, INIA's deputy director. As a result of this agreement, rightfully witnessed by all the participants of the training programme, the St. Petersburg City Geriatric Centre was nominated as INIA's satellite centre for the countries of Eastern Europe.

This is the third satellite centre which, within the last 3 years, INIA has set up in key parts of the world aimed at helping it in its UN mandate at capacity

building in the field of aging. On the 4th September 2002, the first satellite Centre was set up in Singapore in collaboration with the Singapore Action Group of Elders (Sage) a leading nongovernmental organisation in the field of ageing. It is responsible for the 10 ASEAN countries. Four months later, on the 27th January 2003, another satellite centre was set up in collaboration with CASP, a leading non-governmental organisation in the Indian city of Pune for the Indian sub-continent and the seven SARC countries. It is worth pointing out that prior to their being chosen as satellite centres, INIA had already conducted three 'in situ' training programmes both in Singapore and in India in the fields of Gerontology and Geriatrics.

The scope and function of each satellite centre is to a) promote INIA's training programmes both those held in Malta itself and also those to be held within the region; b) disseminate information on aging among the countries within the region; c) serve as a clearing house for INIA's publications and other UN material on aging; d) promote closer collaboration and advocacy in the field of aging between the countries within the region themselves; e) make INIA aware of any experts and scholars in the various fields of aging from among the countries within the region; f) help to promote and co-ordinate 'in situ' training programmes in the field of aging within the region; g) help in identifying prospective suitable candidates for INIA's training programmes.

Each satellite centre which is hyper-linked to INIA's worldwide web page, is directed by a Council consisting of persons nominated from the group of countries within the region. It is envisaged that INIA will set up similar satellite centres for groups of countries in Latin America and the Middle East.

Professor JOSEPH TROISI Ph.D., M.A., M.Th.
Deputy Director
INTERNATIONAL INSTITUTE ON AGEING
(UNITED NATIONS – MALTA)



INIA Training Programme in Minsk (Belarus) January - February 2005

MERCK INSTITUTE FELLOWSHIPS



The International Institute on Ageing, United Nations – Malta has received a grant from the Merck Institute of Ageing and Health, Washington D. C. for the years 2003, 2004 and 2005 for Training Programmes, which are held in Malta. These funds support the educational activities of 8 Fellows from developing countries participating in the Short Training Programmes in Social Gerontology, Economic and Financial Aspects of Ageing, Geriatrics and Demographic Aspects of Ageing as well as 2 participants in the 9-month Postgraduate Diploma Course in Gerontology and Geriatrics at the European Centre for Gerontology, University of Malta.

Applications for the above Fellowships will be received by Professor Frederick F. Fenech, Director of the International Institute on Ageing, United Nations – Malta, 117, St. Paul Street, Valletta VLT 07, Malta, e-mail ffen@inia.org.mt.

The closing date of applications can be obtained from the Institute's website, www.inia.org.mt.

Relax



LIPITOR
atorvastatin

Why choose any other
lipid lowering agent?

Abbreviated prescribing information:

Lipitor® Presentation: Lipitor is supplied as film coated tablets containing 10 mg, 20 mg, 40 mg of atorvastatin. **Indications:** In patients unresponsive to diet and other non-pharmacological measures, Lipitor is indicated for the reduction of elevated total cholesterol, LDL-cholesterol, apolipoprotein B, and triglycerides in patients with primary hypercholesterolaemia, heterozygous familial hypercholesterolaemia or combined (mixed) hyperlipidaemia. Lipitor also raises HDL-cholesterol and lowers the LDL/HDL and total cholesterol/HDL ratios. Lipitor is also indicated for the reduction of elevated total cholesterol, LDL-cholesterol, and apolipoprotein B in patients with homozygous familial hypercholesterolaemia. **Dosage:** The usual starting dose is one Lipitor 10 mg tablet daily. Doses should be individualised according to baseline LDL-C levels, the goal of therapy, and patient response. Doses may be given at any time of the day with or without food. The maximum daily dose is 80 mg. **Contra indications:** Hypersensitivity to any of the ingredients, active liver disease, unexplained elevations in serum transaminases, pregnancy and breast-feeding and in women of child-bearing potential not using contraception.

Market Authorisation Holder: Pfizer Hellas A.E. Greece

Further information is available on request from V.J. Salomone Pharma, Pfizer Division, Joe Gasan Street, Pietà, Malta

Legal Category: POM

Date of Revision: March 2004



LIP-advert-01.05

Country Report

BELARUS – Facts and Figures

VLADIMIR KASUSTCHIK

Population: 9,924,800 (2002) of which: male/female population – 46.9% / 53.1%
urban/rural population – 70.9% / 29.1%

Area: 207.600 km² (36% – forests, 45% – agricultural lands)

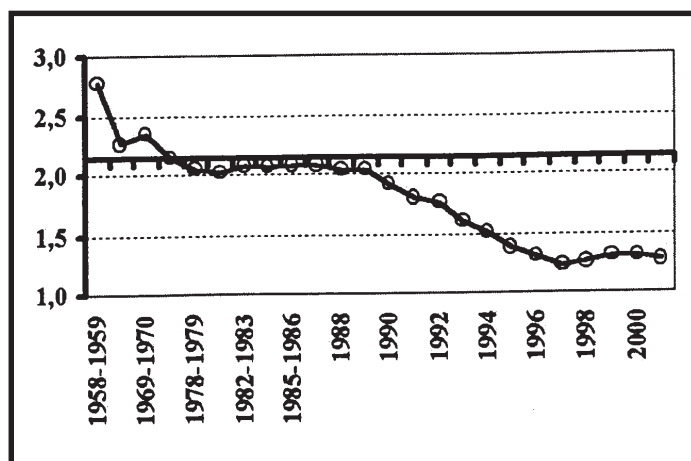
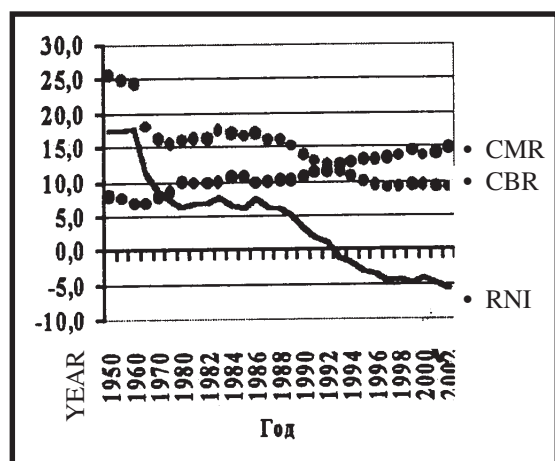
Capital: Minsk (population 1,719,4thsd. of which: male/female population – 46.7% / 53.3%)

Elevation: 345 - 80 m above sea level:

Average temperatures: January -6.7°C; July +17.8°C

Population Trends and Patterns

Since 1993 the crude mortality rate in Belarus exceeds the crude birth rate and hence the rate of natural population increase has become negative.

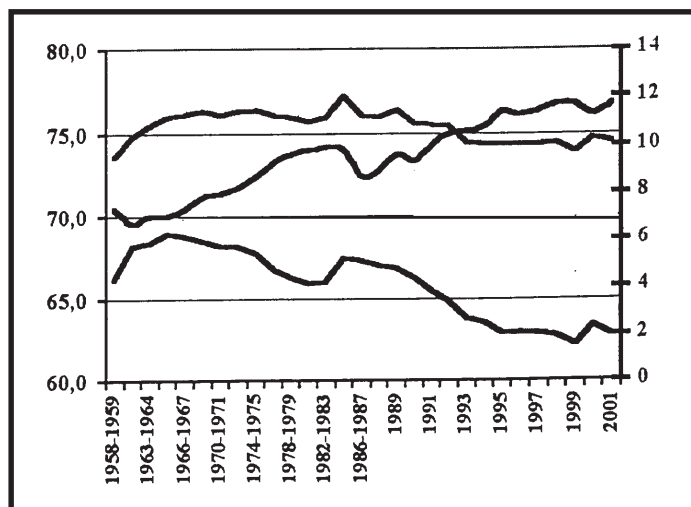
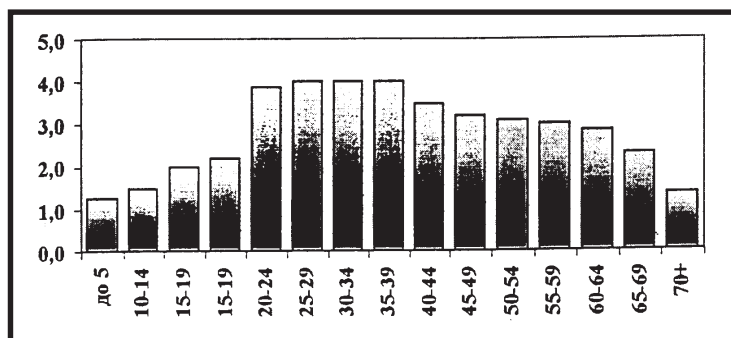
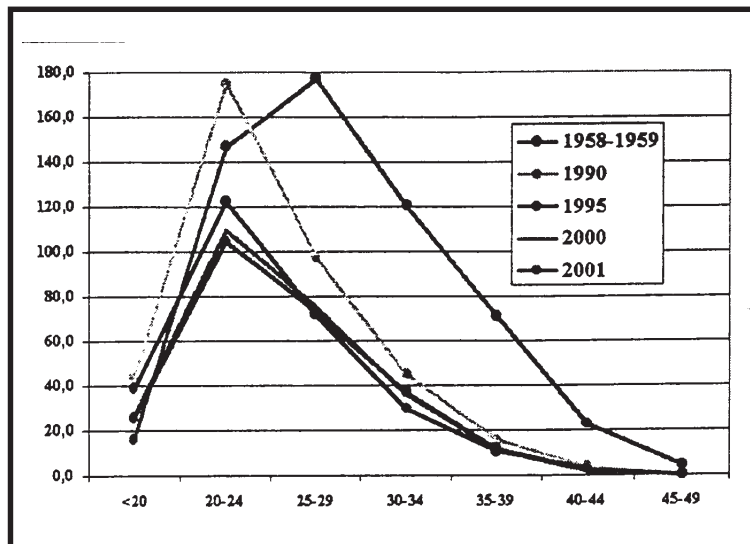


This is the consequence of the fact that the total fertility rate dropped below replacement level in the late 70s. During the last five decades we have witnessed a dramatic drop in age-specific birth rates, especially among women aged 24 - 29.

Extremely high mortality rates are observed among males aged 24 - 39, which exceed those of women of respective ages approximately four times.

Life expectancy at birth has changed from 71.1 years in 1990 to 68.5 years in 2001. Currently the difference in life expectancy of women is greater than that of the male population by almost twelve years.

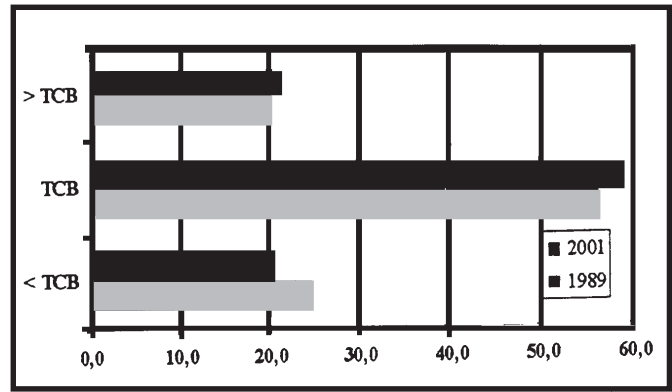
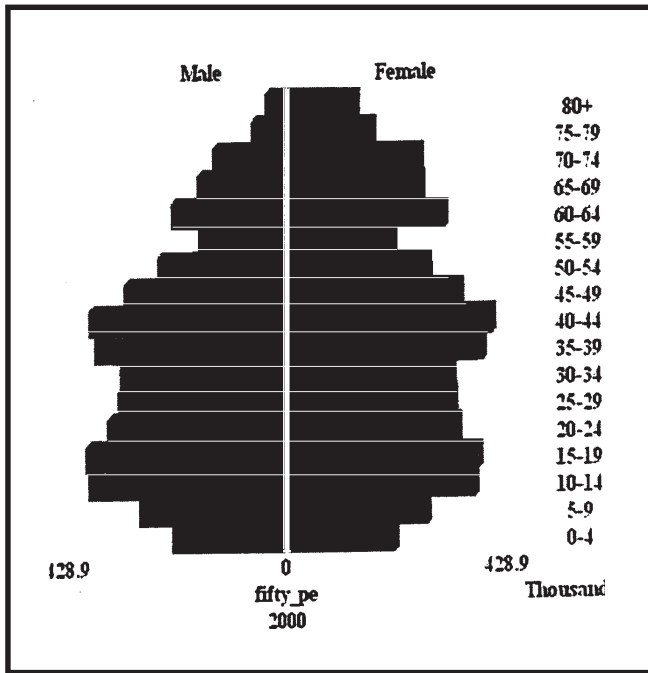
The current structure of population by sex and age is far from satisfactory. As in most developed countries the population is demographically aging. In 2001, as compared to 1989, the population under 16 years of



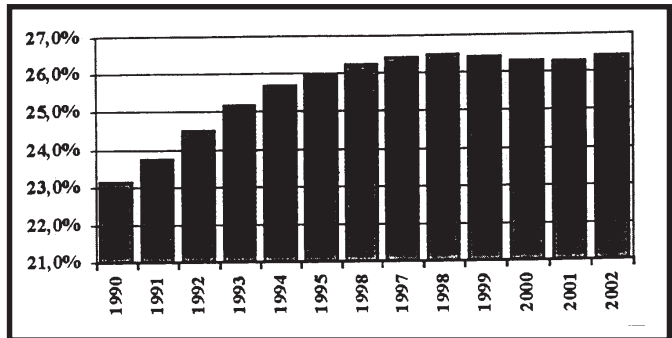
age diminished by approximately 5% while the figure of population of retirement age increased by 2.5%.

The able-bodied population increased due to considerably higher birth rates in the 80s by approximately 3%. Currently, those aged below 16 in the total population are 18.2% (1.8 million persons), those of retirement age – 20.8 % (2 million persons), while the able bodied population amount to 60.9% (6 million persons).

However, the future is not so bright: In 2025 these figures will be respectively 12.0% (963.9 thousand persons), 27.4% (2,194,000 persons), and 60.6% (4, 865,000 persons).

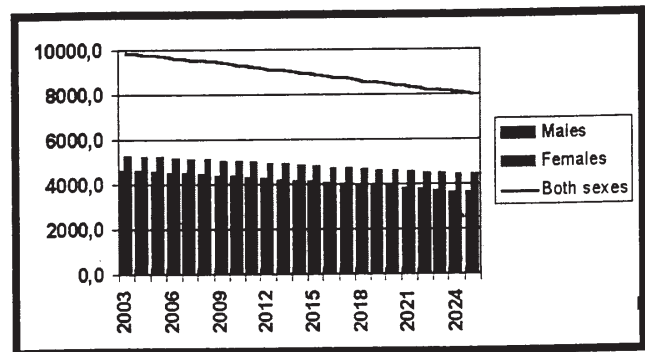


Note that while in 1990 the share of retirement age population was slightly over 23%, in 2002 it exceeded 26%.



According to official projections the total population of Belarus in 2025 is estimated to be 8,230,000 as compared to 9,860,000 thousand in 2003)

The numbers of the population younger than 16 will drop from 1,794,400 thousand to 963.9 thousand, those of able bodied population – from 6,165,000 to 4,865,4 00 while those of retirement age will increase from 2,572,000 to 2,193,900.

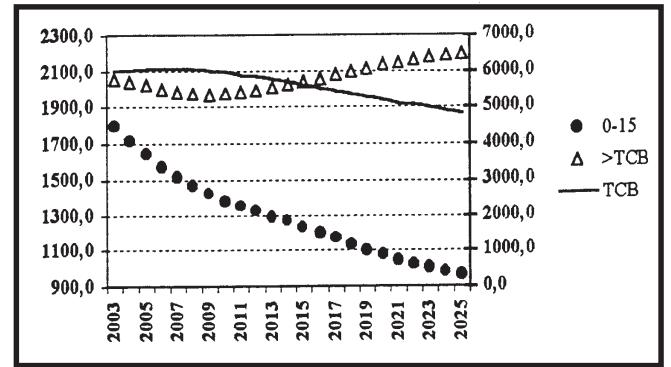
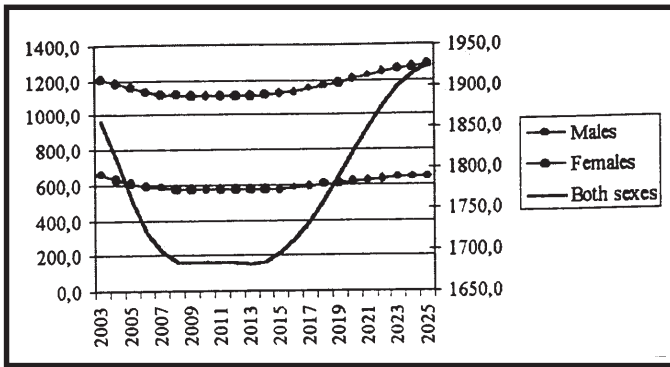


The percentage of females in population aged 660 and above during the period of 2003 - 2025 is estimated to be approximately 66%. The overwhelming majority of older people will be living in urban areas.

PENSIONS

Over 90% of pensioners in Belarus are beneficiaries of labour pensions, which are funded as per the PAYG system. While working, the future beneficiary pays 1% of his monthly earnings. The average amount of payments by employers is 29% of the total payroll. Those not eligible for labour pensions receive social pensions; 66.5% of those receiving labour pensions are women. The ratio of the average pension and average earnings in Belarus (41.6% in 2002) is one of the highest among the 'post-soviet' countries. In 2002 the average labour pension was 83,524 Belorussia roubles. In 2001 - 2002 expenditures of the state pension fund equalled 9% of the GDP.

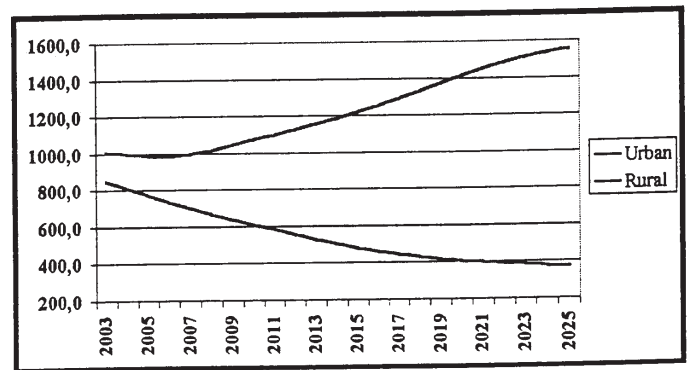
35.1% of women pensioners and 35.2% of men pensioners aged under 65 remain in the labour force.



Recent demographical and economical development of Belarus implies the necessity of modification of the present pension system. If the age of retirement remains unchanged, the potential support ratio (able bodied population/population 65+), which in 2000 equalled 2.7, by 2020 will drop to 2.2. If the retirement age will be increased by 5 years, PSR in 2020 would be twice as much – 4.4 (this value is typical for most developed countries).

SOCIAL PROTECTION

There are 65 social protection centres within the Ministry of Labour and Social Protection providing care for elderly and disabled persons which accommodate over 14,000 persons. Over 63,000 elders benefit from home services. Over 52.5% of these people, depending on their income, receive such services free of charge.



| Year | Population, millions | | | | K'PSR | K''PSR |
|------|--------------------------|--------------------------|----------------|----------------------|-------|--------|
| | men 16-64 women 16-59 | men 16-59 women 16-54 | both sexes 65+ | women 55+ men 59+ | | |
| 2000 | 6,31 | 5,84 | 1,34 | 2.13 | 2,7 | 2,7 |
| 2005 | 6,52 | 6,08 | 1,40 | 2,06 | 4,7 | 3,0 |
| 2010 | 6,57 | 6,03 | 1,27 | 2,08 | 5,2 | 2,9 |
| 2015 | 6,34 | 5,71 | 1,26 | 2,22 | 5,0 | 2,6 |
| 2020 | 6,02 | 5,37 | 1,37 | 2,39 | 4,4 | 2,2 |

VLADIMIR KASUSTCHIK
 Deputy Chief, Department of Population
 Ministry of Labour & Social Protection
 MINSK, BELARUS
 E-mail: Kasustchik@mail.yu

SOCIO-ECONOMIC SUPPORT OF OLDER PEOPLE IN ZIMBABWE

SITAWA R. KIMUNA

Abstract

Aging research in sub-Saharan Africa shows that intergenerational socioeconomic support from children to their aging parents has been reversed particularly due to the changes in the African family structure. Overtime, there have been changes that have had greater impact on the lives of older people in developing countries. Some of these changes have been the high prevalence of HIV/AIDS among the economically active adults and the reversal of older people's roles, which has included the care giving role. Using data from the 1994-1995 Zimbabwe Aging Survey, we examine socioeconomic support of older people. Findings show that socioeconomic support is constrained by the interplay of various social forces among which poverty and changes in the family structure.

Key words: Ageing, Socioeconomic Support, Older People, Zimbabwe

INTRODUCTION

The 21st century has begun with rapid increases in the proportion of the older population world wide. The age structures of many countries are becoming older as most countries experience declines in fertility and mortality rates, which have profound effects on the structure and role of families; on disease patterns and on social security and health service needs. In less developed regions of Africa, Latin America and the Caribbean, the average annual growth rate of older people (over 60 years) is more than three percent, which is almost double the overall population growth rate (UNFPA, 1999). Thus, the number of older persons being added to the world's population is now approaching nine million per year, or less than 10 percent of the annual increase. Currently about 77 percent of the increase in the older population is taking place in developing countries. By 2015 it will be more than 80 percent. Furthermore, the same basic measures, mortality and fertility have influenced the balance between the sexes. Despite the relatively high sex ratios at birth and the reductions in mortality, high age-specific mortality rates for males still persist. The result has been larger numbers and proportions of older women than men, which consequently raises important gender issues.

Although sub-Saharan Africa as a region has the lowest proportion of older people compared to other developing regions, the sheer numbers of older people (65 and over) will continue to increase rapidly from 29.7 million in 1995 to 61.2 million in the year 2025 (UNFPA, 1999). In addition, women will comprise by far the greater proportion of older populations. Given the current climate of poverty and the HIV/AIDS epidemic, governments of most sub-Saharan African countries cannot intervene in supporting the older populations. Most governments prefer to leave the care and support of the older populations to their families.

Research on socioeconomic support (social support/informal/formal support and other related concepts) in different cultures lacks the theoretical framework for understanding informal socio-economic support of older people. In the absence of such a framework, one possibility is to describe the environment of older people. Thus, in this paper we examined older people's support systems in Zimbabwe.

Demographic Profile of Ageing in Zimbabwe

Zimbabwe's population profile, which is characteristic of countries with high rates of both fertility and mortality, does not represent an ageing problem. However, when the rapid increase of the

sheer numbers of the older population is taken into account, it is noted that Zimbabwe's older population is indeed increasing. Thus, it is important for infrastructure planners and policy makers to be aware of these numbers.

Population ageing of a nation occurs due to changes in basic demographic processes. The Zimbabwean fertility rate started to decline in the late 1980s. The total fertility rate declined from 6 children per woman in 1985 to 3.6 children per woman to date (U.S. Bureau of the Census, 1999; Zimbabwe Demographic and Health Survey, 1999). With the declines in fertility and continuing declines in mortality, notwithstanding HIV/AIDS, Zimbabwe faces a new demographic challenge, population ageing. United Nations (1997) estimates showed that by 2010, more than four percent of the projected total population of 15.3 million will be 60 years of age and older. The people over 55 years will be almost six percent of the total population (see Table 1). With this rapid ageing of Socio-economic Support of Older People the population, continuing socioeconomic development, and changes within the

family, the government of Zimbabwe will have to plan ahead for the support of its older people.

As Table 1 indicates, the number of persons aged 55 and over was 622,000 in 1990, and estimated to have increased to 729,000 in 2000 and to increase further to 892,000 in 2010. In 2020, the population is estimated to increase to 1.3 million; in 2030 to 2.1 million, in 2040 to 3.3 million and in '050 to 4.8 million. The number of persons aged 60 and over was 425,000 in 1990, increased to 510,000 in 2000 and is expected to increase to 597,000 in 2010. Further increases are projected for the year 2020, which still see the elderly populations increasing to 901,000; to 1.4 million in the year 2030; to 2.1 million in the year 2040, and to 3.4 million in the year 2050. The proportion of people aged 55 and over and 60 and over to the total population in 1990 was 6.3 and 4.3 respectively. In the year 2000, the proportion of people aged 55 and over and 60 and over to the total population declined to 5.9 and 4.1 respectively. The decline will continue to 2010, registering at 5.8 and 3.9 for people aged 55 and over and 60 and over respectively. In 2020 the proportion for both groups

Table 1 Demographic Characteristics of the Aged in Zimbabwe, 1990 - 2050

| Year | Population ('000) | | Proportion Aged | | Percent Change | | SR(m/f) x 100 | |
|------|-------------------|------|-----------------|------|----------------|------|---------------|-----|
| | 55+ | 60+ | 55+ | 60+ | 55+ | 60+ | 55+ | 60+ |
| 1990 | 622 | 425 | 6.3 | 4.3 | - | - | 90 | 88 |
| 1995 | 687 | 477 | 6.1 | 4.2 | 10.5 | 12.2 | 90 | 88 |
| 2000 | 729 | 510 | 5.9 | 4.1 | 6.1 | 7.0 | 90 | 88 |
| 2005 | 773 | 552 | 5.6 | 4.0 | 6.0 | 8.2 | 89 | 87 |
| 2010 | 892 | 597 | 5.8 | 3.9 | 15.4 | 8.2 | 89 | 87 |
| 2015 | 1099 | 709 | 6.6 | 4.2 | 23.2 | 18.8 | 88 | 87 |
| 2020 | 1377 | 901 | 7.6 | 5.0 | 25.3 | 27.1 | 88 | 87 |
| 2025 | 1736 | 1151 | 9.0 | 6.0 | 26.1 | 27.8 | 89 | 86 |
| 2030 | 2180 | 1469 | 10.6 | 7.1 | 25.6 | 27.6 | 90 | 88 |
| 2035 | 2674 | 1852 | 12.3 | 8.5 | 22.7 | 26.1 | 90 | 88 |
| 2040 | 3304 | 2277 | 14.4 | 9.9 | 23.6 | 23.0 | 91 | 89 |
| 2045 | 4014 | 2818 | 16.7 | 11.7 | 21.5 | 23.8 | 91 | 89 |
| 2050 | 4861 | 3433 | 19.5 | 13.8 | 21.1 | 21.8 | 91 | 89 |

Source: United Nations, *The Sex and Age Distribution of the World Populations 1996 Revision*. UN 1997, New York. Median Variant Projections.
SR = Sex Ratio

increases to 7.6 and 5.0 respectively. It is expected to increase to 10.6 and 7.1 respectively in 2030, 14.4 and 9.9 respectively in 2040 and 19.5 and 13.8 respectively in 2050.

The sex ratio (SR) among the older population reveals an interesting aspect of population aging in Zimbabwe. Ewing (1999) noted that it was quite challenging to discuss the gender implications of global ageing and especially the many disadvantages that the life expectancy 'advantage' holds for women. As figures in Table 1 indicate, in 1990, the sex ratio (males per 100 females) among the older population (55 and older and 60 and older) was 90 and 88 respectively; it is expected to decline to 88 and 86 respectively in 2015 and is to gradually increase thereafter. It is interesting to note that despite the disadvantages experienced by women in paternalistic societies, as age advances, the sex ratio becomes more favorable to women. Thus, in old age, many more women than men will live alone because, on average, men marry younger women. In addition, widows are less likely to re-marry than widowers. If the general economic situation of women is taken into account, population ageing is definitely not just a demographic issue; it is also a gender issue. Among most sub-Saharan African countries that are grappling with the HIV/AIDS pandemic, including Zimbabwe, older people, and particularly older women, are the major sources of care giving for the HIV/AIDS orphaned children (Niatshalaga, 2004). This is an extra burden for older people's already precarious situation.

The demographic picture shows a rapid increase in the older population in the next three decades. Not only will the number of older people increase more rapidly in the future, but the length of time an older person will remain older will also increase. At the same time, the number of children, who are presumed to provide support for older people, will decrease. Furthermore, traditionally women have provided care, including caring for older people. Yet women, especially older women are one of the poorest population groups in sub-Saharan Africa (Ewing, 1999). They include rural grandmothers who have taken on the responsibility of caring for the most vulnerable in their communities, children with HIV/AIDS and HIV/AIDS orphaned

grandchildren in the absence of any state support. As noted earlier, this paper examined the informal socio-economic support of older people and how their personal attributes affect their support.

Informal Social Networks

While support may be predominantly guided by norms and cultural traditions, the capacity of the family to take care of the older people is not only affected by the demographic change, but also by broader structural changes that define and limit family expectations about responsibility for the older population. Influenced by the ongoing changes in Zimbabwean society, culture and economy, changes in the family and its roles are inevitable (Adamchak et al., 1991; World Bank, 1994; Kimuna and Adamchak, 1999). The traditional notions of familial or social support for older people are being redefined with growing rural to urban migration, urbanization, industrialization, and the high level of HIV/AIDS prevalence among the sexually and economically active adults. It is in this context of a growing elderly population and changing family structure in Zimbabwe that an examination of the integration of the older people in their families gains significance.

Informal social networks and particularly the family were the most important social institutions in the lives of older people. These networks permeated their daily life, organized and fulfilled individuals' demands and preferences. The networks complemented and paralleled formal institutions in areas where such formal institutions were inadequate or had not been developed to meet the needs of older people (Okojie, 1988; Adamchak et al., 1991; Apt, 1992; Adamchak, 1996). In fulfilling their roles toward older people, informal social networks and the family were governed by cultural traditions and norms. However, the rural/urban migration of the young, labour migration, heightened levels of literacy, and the general lack of resources for households all have interacted to affect older people's social support systems. In this paper we examined older people's support and how their attributes affected their support.

DATA AND METHOD

We used the 1994-1995 Zimbabwe Cross-Sectional

Aging Survey to examine older people's support systems and the effect of older people's attributes on their support. We identified several dimensions of support, including material and economic support: living arrangements and the contextual factors, such as family resources that influence social support. The data were collected by international researchers in collaboration with the University of Zimbabwe to provide a portrait of Zimbabwe's aging population. The protocol of the survey was to collect information on the demographic, social, economic, cultural, sources of support, life-style habits, health and access to health resources, activities of daily living (ADL) and physical characteristics of older adults. Trained and supervised indigenous interviewers used a standardized questionnaire to collect data from respondents during interviews in the respondents' homes. A total of 278 respondents aged 60 years and over from the sampled urban and rural areas were interviewed with nearly 100% response rate.

Sampling Design

The survey used a three stage random cluster sampling design to ensure that respondents were distributed throughout the targeted areas: Maramba, Pfungwe, Uzumba, Bindura and Marondera. The sample was planned to include representative rural and urban areas. The rural sample of 174 respondents was from Maramba, Pfungwe and Uzumba, in North Eastern Zimbabwe covering an area of 2646 km (CSO, 1992). The rural area's farthest point from the capital city of Zimbabwe, Harare, was 245 kilometers and its nearest point from Harare was 120 kilometers. The area was divided into 15 wards, each ward with six village development units (VDUs). Each VDU comprised 60100 households. The population in 1992 was 86,308, with 5.793 (6.7%) over 60 years. For each ward, one VDU was selected at random and interviewers proceeded to visit alternate households where members over 60 years were requested to participate in the survey.

The urban area sample of 104 respondents was from Chipadza in Bindura and Dombotombo in Marondera. Both towns were approximately 85 km from Harare. Bindura had a total population of 21,167, of whom 508 (2.4%) were aged over 60; the population of Marondera was 39,384, with 1,194 (3.0%) over 60, respectively. The urban townships

were organized on a grid pattern and respondents were selected from alternate houses within alternate streets, using the same criteria as rural respondents (Allain et al., 1997). In addition, for both rural and urban areas, wherever possible, males and females were selected alternately to obtain an equal sex ratio. However, when there was only one subject aged over 60 in the next household, they were asked to participate regardless of sex. This resulted in a slight excess of females in the study population. In the households where there was more than one eligible member of the same sex only one was counted (alternately the younger and the older of the pair). Many subjects did not accurately know their own age. For these subjects, age was estimated based on physical appearance, the ages of oldest children, grandchildren or great-grandchildren and memory of major historical events, such as the influenza epidemic of 1918, the locust plagues of the 1920s and the Second World War (when many Zimbabweans were conscripted). The appropriate institutional ethical review board in Zimbabwe approved the survey.

The majority of the sample (63%) was located in the rural area. Older people between the ages of 60 and 69 were almost 44%, while the majority (56.4%) were 70 years and over. The mean age of the study sample was 72 years of age. There were more females represented in the population sample, almost 56 percent (55.8%; N=155) than male population sample of 44.2% (N=123). Although the data set contains a considerable amount of information useful in the study of older adults, the size of the sample and limitations in the sampling area tend to restrict the representativeness of the sample.

RESULTS

Descriptive Analysis

The household composition pattern reflects high fertility which is indicated in the number of living children (see Table 2). A large proportion of older people (53.2%) have on average six living children. Slightly over 11 percent (11.2%) of grandchildren live with older people. This type of living arrangement may reflect a common practice of sending grandchildren to live with their grandparents. Almost 10 percent of older people live

alone. It is feared that the purported breakdown of the extended family system in a changing society has a negative effect on the living arrangements and social support of older people. Living arrangements of older people is one of the aspects of changing family structure and is important in older people's level of support. Studies that have examined living arrangements as an aspect of social support have been mainly concerned with differences in social support for older people living in the community and those living in institutional arrangements (Pearlman and Crown 1992). This perspective is not applicable to most developing countries where institutions for the elderly are not common. However, Adamchak and Wilson (1999) examined the effects of living arrangements on the well being of older Zimbabweans using a 1988 sample of 150 men and women aged 55 and older. Using four living arrangement types: living alone, nuclear family, extended family and complex family, they found that household composition (particularly in complex family) had a positive impact on older people's support and well being. Thus, the nature of the composition of the household also indicated the availability of physical care and companionship for its older members.

Sources of Support

The survey asked respondents to indicate the number of relatives who supported them, the type of support received from children and relatives and their sources of income. Almost 77 percent (76.6%) of the respondents reported that they received social support from their children. Categorizing this support by type showed that material goods were the most prevalent types of support provided. Slightly over 72 percent of older people reported that they had received clothes and almost 72 percent (71.8%) reported receiving food. Older females received more material support than older males. Among older females, nearly 77 percent (76.8%) had received clothes from their children and 78.1 percent had received food. Among older males, 66.4 percent had received clothes from their children and 64 percent had received food. Nearly 81 percent (80.5%) of older people in the rural areas received more support from children than older people in the urban areas (70.2%). Slightly over 76 percent (76.3%) of older people in the rural areas received clothes and nearly 75 percent (74.6%) received food. Whereas 65.4 percent of urban older people received clothes, only 25.3 percent received food.

Table 2 Household Composition and the Relationship of the Members to the Respondent (1994/1995 - N=278)

| | N | % |
|---------------------------------|-----|------|
| Number of Children Alive | | |
| None | 8 | 2.9 |
| 1 - 4 Children | 85 | 30.6 |
| 5 - 9 Children | 148 | 53.2 |
| 10+ Children | 37 | 13.3 |
| Total | 278 | 100 |
| Household Member | | |
| Spouse | 132 | 47.8 |
| Daughter | 33 | 12.0 |
| Son | 34 | 12.3 |
| Grandchild | 31 | 11.2 |
| Other relative* | 19 | 6.9 |
| Respondent lives alone | 27 | 9.8 |
| Total | 276 | 100 |

* includes step relatives and in-laws

On average, older people's children were the main source of income (59.2%). Older people living in rural areas received a larger proportion of income from children (65.3%). In addition, gender differences were observed in the support from children to older people. Sixty three percent of older women received income from children and almost 55 percent (54.5%) of men received income from children. Another major source of income was from agricultural production (39.7%) followed by the informal sector (28.8%) and rent (20.3%). Nearly 53 percent (52.9%) of older people in urban areas received rent from lodgers. Consistent with other research (Adamchak, 1999), older males rely less on children as well as agriculture and the informal sector as sources of income than older females. In addition, research has shown that older women are the primary subsistence farmers; also, they perform various activities in the informal sector. Pension was reported by nearly two percent (1.8%) of older people and 3.3 percent received some type of social welfare assistance (public assistance).

When the type of support was examined, it was further found that children provided monetary support (62.3%) as well as material support (74.8%). Support from other relatives was very little. Almost 8 percent (7.6%) of older people had received money from other relatives in the past year before the survey. Slightly more than 11 percent (11.2%) had received material goods during the same period. According to these figures, the majority of older people depended on their children. The indigenous ideology of the parent-child intergenerational contract of support may remain powerful, but there is a general unease at all levels about the current situation and future prospects of older people in sub-Saharan Africa.

Although the descriptive analyses gives an in depth picture of older people' s support, the quantitative analysis helps in accounting for all important factors and to generalize results. Therefore, logistic regression was performed on the influence of older people's attributes on their socio-economic support.

REGRESSION ANALYSIS

Definition of the Variables and Hypotheses

Table 3 presents the definitions of all the variables included in the statistical models. The variables encompass many of the older persons' attributes and their current and previous experiences. These attributes include age, gender, level of education, marital status, health, kin availability, economic status and place of residence. To determine the variable economic status as an independent variable, we used several critical household elements including where they got their drinking water (main source of water), toilet facilities, type of house and roofing material, main source of energy (firewood, paraffin or electricity). The study sample was predominantly rural (63%) and mainly peasant farmers (agricultural production). Thus, this study used ownership of house and farmland including peasant farming as a means of getting an income to determine economic status.

The degree of old age security usually varies according to several socio-demographic and socioeconomic factors. These factors associated with the living arrangements of older people in the developed countries have been widely studied (Phillipson, 1997). These studies found that the demographic and socioeconomic attributes of older people are significant determinants of their support. Adamchak (1996) found the dynamics of socioeconomic support differed by gender. The gender differences in socioeconomic support are reportedly attributed to women's role as principal caregivers, which intensify their emotional and psychological ties with their children and social network leading to higher levels of support compared to men.

Therefore, given that our descriptive results indicated that older women received more Support than older men, we hypothesize that older women are more likely to receive support than older men. Also, older people with adult living children are more likely to receive support. Older people who are married are more likely to receive support than those who are single. In addition, kinship network is an essential factor in the social support of older

Table 3 Definitions of the Dependent and Independent Variables Included in the Statistical Models of Social Support

| Variable | Definition |
|--|--|
| Socio-economic Support | |
| Receive support | 1 = if older person receives social support 0 = if older person does not receive social support |
| Type of Support | 1 = if older person receives monetary support 0 = if older person does not receive monetary support 1 = if older person receives material support 0 = if older person does not receive material support |
| Demographic variables | |
| Age 65+ | 1 = if age is between 65+ 0 = if age is not between 65+ |
| Female headed household 0 = if older person is not female and head of household | 1 = if older person is female and head of household |
| Married couple | 1 = older person is married 0 = older person is not married |
| Number of living children Has adult living children | continuous variable 1 = children age 18 and over 0 = if children are not age 18 and over |
| Dominant Proportion of Children are married | 1 = > 50% of children are married 0 = < 50% of children are married |
| Dominant proportion of children are | 1 = >50% of children are informally employed 0 = < 50% of children are informally employed |
| Suffers from a chronic illness | 1 = older person suffers from a chronic illness 0 = if older person does not suffer a chronic illness |
| Economic status | 1 = owns a house and farmland/Ag. Prod.+ 0 = does not own |
| Education < 7 years of education | 1 = if older person reported 7 years or more 0 = of >7 years of education |
| Living arrangements | 1 = live with family members 0 = living alone/with spouse only |
| Rural residence | 1 = if older person resides in the rural area 0 = if older resides in the urban area |

+Agricultural production (income from agricultural production)

people. Studies of kinship networks have emphasized the crucial role of women as primary care providers to older people followed by children when women are absent (Cattell, 1997; Kilbride & Kilbride, 1990). The role of older people's children in kinship networks heavily influence the adequacy of socioeconomic support. Thus, older people with a dominant proportion of children that are married are less likely to receive support because marriage imposes restrictions on the children's ability to provide for their elderly parents. This is because of the competing demands of a spouse and their own household members.

Furthermore, poor health and frailty are two of the most important indicators of needs for support. Social support has a dual effect on health. Research has shown that social support for older people is affected by their health status (Hermalin et al., 1992) and a high level of socioeconomic status has a positive and significant effect on the health of older people (House et al., 1988; Grundy et al., 1996). Thus, older people who experience poor health are more likely to receive support. Finally, older people's place of residence plays an important role in their social support. Scott and Roberto's (1987) study of the differentials in social support between rural and urban older people found that rural older people received and provided more support to their families and friends than urban older people. Thus, living in rural areas increases older people's likelihood of receiving social support.

Socio-economic Support as a Dependent Variable

The first stage of the analyses combined support from both children and relatives to create the dependent variable, socioeconomic support. The second stage analyzed types of social support. The analyses carried out in two models explored the financial, physical and material support for older people. The first model examined the relationship between receiving any type of support and the different attributes of older people. An examination of the full model was carried out through four nested models that introduced one group of attributes at a time. They presented the structure of the models, their log likelihood and degrees of freedom as well as their Gamma coefficients (see Appendices A, B,

C & D). The full model (Table 4) presents the odds ratios for logistic regression of older Zimbabweans on receiving socioeconomic support. The second stage extended the first by examining the effects of older people's attributes on types of support received from children (see Table 5).

Table 4 (full model) presents the odds ratios of all the models included in the analysis. It also examined the significant contribution to the model of independent variables as they were introduced. The odds ratios highlighted each independent variable's effect on older people's likelihood of receiving support (see also Appendix A (Model 10)). Older people over 65 and married couples were significantly (at $p < 0.05$ level) less likely to receive socioeconomic support. The effect of adding kin availability and their attributes significantly improved the fit of the model (significant at 0.0004 level also, see Appendix B (Model 2)). Additionally, older people with adult living children were significantly (at $p < 0.004$ level) more likely to receive socioeconomic support. Adding the two potential opportunities variables increased the likelihood of older people receiving support.

Similarly, as in Model 1, older people over 65 and married couples remained significantly (at $p < 0.02$ level) less likely to receive socioeconomic support in Model 2. In Appendix C (Model 3), we introduced one more of the potential opportunities variables, older people with a dominant proportion of children who were married and a health variable. These variables did not affect the likelihood of receiving support. In Appendix D (Model 4), the resource variables of economic status and level of education of the respondents as well as their living arrangements were added to the model. The socioeconomic factor measured by ownership of both farmland and a house and income from agricultural production including income from children had no effect on the likelihood of older persons receiving support. This factor could be because older people in this study neither had a high economic status nor had completed a primary school education.

It was also surprising to note that older women were less likely to receive support. Yet, research has

Table 4 Odds Ratios for Logistic Regression of Older Zimbabweans on Receiving Social Support (1994/1995 - N = 278)

| Independent Variables | Receiving Social Support vs. Not Receiving Social Support | | | |
|---|---|-----------|-----------|-----------|
| | Model 1 | Model 2 | Model 3 | Model 4 |
| Intercept | 2.3335 | 0.3920 | 0.2293 | -0.0405 |
| Age 65+ | 0.477* | 0.476* | 0.470* | 0.431** |
| Female headed household | 0.613 | 0.493 | 0.523 | 0.660 |
| Married couple | 0.519* | 0.448* | 0.463* | 0.442* |
| Rural residence | 1.533 | 1.271 | 1.328 | 1.653 |
| Has adult living children | ..... | 10.201** | 6.869* | 5.538* |
| Dominant proportion of children are informally employed | ..... | 1.442 | 1.275 | 1.147 |
| Dominant proportion of children are married | ..... | ..... | 1.639 | 1.971 |
| Suffers from a chronic illness | ..... | ..... | 1.389 | 1.306 |
| ≥ 7 years of education | ..... | ..... | ..... | 0.748 |
| Socio-economic status (land and home ownership) | ..... | ..... | ..... | 0.719 |
| Is living with kin | ..... | ..... | ..... | 1.604 |
| -2 log likelihood | 260.411 | 250.298 | 246.663 | 238.101 |
| X ² | 14,810** | 24.923*** | 27.212*** | 30.769*** |
| DF | 4 | 6 | 8 | 11 |
| Y | 0.365 | 0.404 | 0.435 | 0.457 |

Statistically significant levels at * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

shown that older women are more likely to care for the sick and grandchildren. Monasch and Boerma (2004) study noted that older women, who were heads of households, had a higher number of dependents than older men. In addition, WHO (2002) study noted that women were the main care givers in their households.

Source and Type of Support

To shed light on how selected attributes are associated with the type of social support, we analyzed the effects of older people's attributes on the type of support received. As noted earlier, children were the main source of socioeconomic support for older Zimbabweans. Thus, Table 5 examined the probability of receiving monetary and material support from children. The age factor was

recoded and age 65-74 variable was included as well as age group over 75 years. Results show that older people who were married were significantly (at $p < 0.05$ level) less likely to receive material support from children. An interesting surprise is that this factor contradicts the prevalent assumption in social support research that married couples are more likely to receive social support from children. This outcome may be because the type of support as coded in this study only measures material goods and not include in kind help.

Older people who had adult living children were significantly (at $p < 0.05$ level) more likely to receive money from children. This result once again confirms the substantial role played by the nuclear family in social support of older people. However,

Table 5 Unstandardized Coefficients of the Logistic Regression of Effects of Older People's Attributes on Type of Support

| Independent Variables | Money | | Material | |
|---|----------|-------|-----------|-------|
| | B | S.E | B | S.E |
| Intercept | -0.341 | 0.70 | 0.357 | 0.773 |
| Age 65-74 | -0.617 | 0.38 | -0.547 | 0.414 |
| Age 75+ | 0.166 | 0.43 | 0.762** | 0.520 |
| Female headed household | 0.004 | 0.37 | -0.523 | 0.439 |
| Married couple | -0.259 | 0.30 | -0.685* | 0.350 |
| Rural residence | 0.490 | 0.48 | 0.004 | 0.560 |
| Has living children | 0.088* | 0.04 | 0.075 | 0.053 |
| Dominant proportion of children are informally employed | -0.012 | 0.33 | 0.202 | 0.398 |
| Dominant proportion of children are married | 0.944** | 0.33 | 1.141*** | 0.359 |
| Suffers from a chronic illness | 0.448 | 0.30 | 0.642* | 0.349 |
| Socio-economic status (land and home ownership) | -0.292 | 0.45 | 0.091 | 0.536 |
| Is living with kin | ..... | ..... | ..... | 1.604 |
| -2 log likelihood | 327.838 | | 265.219 | |
| X ² | 28.257** | | 39.783*** | |
| DF | 13 | | 13 | |
| Y | 0.364 | | 0.490 | |

Statistically significant levels at * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$
S.E. = standard error

since we did not examine the amount of money older people received from their children, it is not clear whether the monetary support was enough to cater for older people's needs. In addition to adult living children, having a dominant proportion of children who were married significantly increased the likelihood of receiving both monetary (at $p < 0.05$ level) and material (at $p < 0.001$ level) support. Older people who suffered a chronic illness were significantly (at $p < 0.05$) more likely to receive material support from children. Since disability and illness significantly increased the likelihood of older people relying on children for financial and material support, it is likely that the children were in a position to give material support but unable to provide monetary support.

DISCUSSION

The argument that children can be viewed as assets by their elderly parents is built upon the premise that grown children, physically in their prime and economically possessing higher earning potentials than their parents, are the beneficiaries, either willingly or by custom, to the welfare of older people. However, this study has shown that old people in age group 65 and over were less likely to receive support. But, when we analyzed the effect of selected attributes of older people on receiving any type of support, age group 75 and over was more likely to receive material support. One explanation for the difference in outcome could be that in most African countries, the majority of old people have

to remain active because they cannot afford to retire. The mean age for the respondents in this study was 71 years and 63 percent of the respondents lived in rural areas and engaged in peasant farming or participated in petty trade (informal sector service). Furthermore, their children either were unemployed or were informally employed in which case; they were not in a position to financially support older people in this age group. Moreover, older people age 65-74 may be considered still strong enough to care for themselves whereas those in the age group 75 and over may be considered frail and not strong enough to care for themselves and thus needing support.

Also, data showed that factors underlying socioeconomic support for older people in Zimbabwe were not limited to their attributes, but included characteristics of their children, such as their marital status and employment. Although the study showed that children were the main providers of support, it was surprising to find that married couples had a significant negative effect on socioeconomic support. Older people who were married were significantly less likely to receive support. One explanation to this outcome is that children can no longer be relied upon to provide support for their older parents. As noted earlier, the adult children may themselves be in need of support due to unemployment, poverty and sickness. Thus, the traditional explanation that adult children are assets to the parents, who rely on family support in their old age is useful only as a notion, which cannot be applied in the present situation of older people in Zimbabwe and elsewhere in sub-Saharan Africa. Furthermore, recent World Health Organization (WHO, 2002) research on Zimbabwe also revealed that older people are taking on care giving roles with little or no source of support. In this study, we also found that older people with a dominant proportion of children who were married provided both monetary and material support (see Table 5). Although this variable was not significant in Table 4, where the dependent variable was socioeconomic support, the significant outcome in Table 5, where analysis was on type of support from children indicates that married children give both financial and material support. For example, children who are married may be able to combine resources to support

their ageing parents. They may also be in a position to provide in kind support.

The measure of health failed to identify older people at risk. However, several variables including the health variable approached significance (at $p < 0.10$ level) in Model 4 when the resource variables (level of education, economic status and living with kin) were introduced to the model. Although research has shown that older people suffer debilitating health conditions (Ferreira, 2004; HAI, 2001) as a consequence of a lifetime hardship and deprivation, older people do not have same access to health care as other age groups. For example, Help Age International (HAI, 2001) research in Kenya indicated that older people were more likely to stand in line for hours for medical services that would eventually be denied. This sort of treatment of older people reinforces the notion that older people waste public resources by seeking medical care for inevitable ageing conditions. This may affect the urgency of seeking medical care until their conditions have become debilitating.

Older people with adult living children were significantly more likely to receive support. We used this particular variable to highlight the precarious state of older people when their adult, economically active children fall sick and die of HIV/AIDS. We found that those older people with adult living children were more likely to receive support. However, HIV/AIDS is adding a harsh dimension to the family structure. As young adults with children die of HIV/AIDS, grandparents often assume full responsibility for the care and support of the grandchildren in the absence of any source of support. Whereas in this study the main source of support for older people was children, the WHO (2002) found that 45 percent of the older people cited family, friends and churches as sources of support. Although most families want to care for older people, they do not have the means to do so. Nonetheless, the resilience of the family care giving unit and the inability of governments in many sub-Saharan African countries to provide alternative forms of care means that the family will remain the primary care giving unit (Kimuna and Adamchak, 1999). At the same time, the stresses on the family's role in

providing support for older people are likely to increase the need for formal care systems.

Although it is untraditional to report non-statistical findings, there was an interesting finding in this study that merits comment. Older females, who were heads of their households, were less likely to receive support. This was surprising in view of the commonly held notion that older people, who are women tend to be the most vulnerable in terms of spousal availability and economic resources and, therefore, most in need of support from children. Furthermore, studies have shown that female-headed households with HIV/AIDS orphans have the highest dependency ratio (Monasch and Boerma, 2004; Matshalaga, 2004; UNICEF, 2003). Given the understanding that older women are more vulnerable, that they are the ones more likely to care for HIV/AIDS orphaned children, it would follow that they would be more likely to receive support.

However, as indicated in this study, they are less likely to receive support from children. This outcome could be because they have no adult living children to support them. Matshalaga (2004) noted in her study that these older women had lost their only sons and daughters to HIV/AIDS. These sons and daughters may have been the sole breadwinners and their illness and death had compounded their precarious situation. They now have to care for their orphaned grandchildren without any source of support. They may also be affected by the stigma that is associated with having cared for children who had died of HIV/AIDS. The older women may be blamed for their children's illness because of ignorance and thus suffer stigma and exclusion on economic and social grounds. Nonetheless, the WHO (2002) study noted that in addition to being compelled to provide care without any source of support, older people, especially older women felt a strong sense of responsibility. Thus, even when faced with surmounting obstacles, older people in general are taking on roles of care giving to the sick and the orphaned.

CONCLUSION

In a developing society such as Zimbabwe with more pressing social issues such as poverty and HIV/

AIDS, older people may need more than kin relationships to support them. In most sub-Saharan African countries, accentuating the family transformation is the HIV/AIDS epidemic. The changing social structure is prompting the violation of the traditional custom that obliges children to support their older parents. Conditions among nuclear families prevent the custom from being fulfilled. For example, older people are losing adult children to HIV/AIDS and are left to look after grandchildren orphaned by the epidemic.

Moreover, functions of the support systems for the older people are limited by economic development. Thus, limited resources of the household prevent the family from effectively supporting its older members. The picture in Zimbabwe as it emerged in the survey shows destitution. It seems the family remains the main source of support even in stressful periods but this is not enough. Although this research has made tentative observations about the challenges faced by older Zimbabweans, there are limitations. The inability to give the subject a more complete treatment reflects a dearth of published research and the low priority given to older people in policy.

The patterns and trends of older support found in this study have some significant implications for the evolution of social policies. Given the increased challenges of older people due to the changing structural and social patterns in Zimbabwe, the point of need in social support from kin must be noted. Programs that increase older people's sense of self-worth and value are particularly helpful. Policies that improve basic services in rural areas may have the effect of improving the functioning of older populations. As Lloyd Sherlock (1999) noted, it is important to move away from traditional assumptions that espouse older people's dependence. A better-articulated partnership between formal organizations and families, with community services playing a more active role as backup and in supplementation of family efforts to care for the older people should be examined. Furthermore, various themes need to be addressed within future research, including support of older women, empowerment of women and health care needs for older people.

References

- Adamchak, D.J. (1996). Population ageing: Gender, family support and the economic condition of older Africans. *Southern African Journal of Gerontology*, 5(2): 2-8.
- Adamchak, D. J. & Wilson, A. O. (1999). The situation of older people in Zimbabwe. In HelpAge International, *The ageing and development report. Poverty, independence and the world's older people*. London, England. Earthscan Publications Ltd.
- Adamchak, D.J., Wilson, A.O., Nyanguru, A., & Hampson, J. (1991). Elderly support and intergenerational transfer in Zimbabwe: An analysis by gender, marital status, and place of residence. *The Gerontologist*, 31(4): 505-513.
- Allain, T.J., Wilson, A.O., Gomo, Z.A.R., Mushangi, E., Senzanje, B., Adamchak, D.J. and Matenga, J.A. (1997). Morbidity and disability in elderly Zimbabweans, *Age and Ageing*, 26: 115-121.
- Cattell, M. G. (1997). The discourse of neglect: Family support for the elderly in Samia (pp. 157-183). In T. S. Weisner, C. Bradley, & P. L. Kilbride (Eds), *African families and the crisis of social change*. Westport, CT. Bergin & Garvey.
- Central Statistics Office, Zimbabwe. Census Population, 1992. Harare: Government Printer.
- Ewing, D. 1999. Gender and ageing (pp. 33-45). In J. Randel, T. German & D. Ewing (eds), *HelpAge International, The Ageing and Development Report: Poverty, Independence and the World's Older People*, Development Initiatives. London, England. Earthscan Publications Ltd.
- Ferreira, M. (2004). Older caregivers in African households affected by HIV/AIDS: supporting the caregivers and promoting family well-being. Paper presented at the African Conference on Ageing, Johannesburg. South Africa.
- Grundy, E., Bowling, A. & Farquhar, M. (1996). Social support, life satisfaction and survival at older ages. In G. Caselli and A Lopez (eds), *Health and mortality among elderly populations*. Oxford: Clarendon Press.
- Hermalin, A., Ofstedal, M. B. & Chang, M. C. (1992). Types of support for the aged and their providers in Taiwan. Comparative study of elderly in Asia: *Research Reports No. 92-14*. Ann Arbor, MI. Population Studies Center. University of Michigan.
- House, J.S., Umberson, D., & Landis, K.R. (1988). Structure and process of social support. *Annual Review of Sociology*, 14: 293-318.
- Kilbride, P. L. & Kilbride, J.C. (1990). *Changing family life in East Africa. Women and children at risk*. University Park: Pennsylvania State University Press.
- Kimuna, S. R. & Adamchak, D. J. (1999). Population aging and elderly support: A Kenya profile. *BOLD Journal of the International Institute on Ageing*, (United Nations-Malta), 10(1): 6- 16.
- Lloyd-Sherlock, P. (1999). Income security for poor older people in developing countries. *The Courier* (July-August), 176: 48-50.
- Matshalaga, N. (2004). Grandmothers and orphan care in Zimbabwe. SAFAIDS, Harare Zimbabwe.
- Monasch, R. and Boerma, J. T. (2004). Orphanhood and Childcare Patterns in sub-Saharan Africa: An analysis of National Surveys from 40 Countries. *AIDS*, 18(suppl 2):S55-S65.
- Okojie, F. A. (1988). Aging in sub-Saharan Africa: Toward a redefinition of needs research and policy directions. *Journal of Cross-Cultural Gerontology*, 3: 3-19.
- Pearlman, D. & Crown, W. H. (1992). Alternative sources of social support and their impact on institutional risk. *The Gerontologist*, 32 (4): 527-535.
- Phillipson, C. (1997). Family care in Great Britain: Sociological perspectives. *Ageing International*, XXIV (1): 63-80.
- Scott, J. P. & Roberto, K. A. (1987). Informal supports of older adults: Rural urban comparison. *Family Relations*, 36: 444-449.
- UNAIDS/UNICEF. (1999). *A review of household and community responses to the HIV/AIDS epidemic in the rural areas of sub-Saharan Africa*. Geneva, Switzerland. Joint United Nations Program on HIV/AIDS.
- United Nations. (1997). *The sex and age distribution of the world populations. The 1996 Revision*. New York, NY: United Nations.
- United Nations. (1997). *Demographic yearbook (1999 edition)*, New York, NY.
- UNICEF (2003). *Africa's Orphaned Generations*. November 2003. New York:
- WHO (2002). *Impact of AIDS on Older People in Africa. Zimbabwe Case Study*.
- UNFPA. (1999). *The state of the world population*.
- U.S. Bureau of the Census, Report WP/98. (1999). *World population profile:1998*. Washington, DC. U.S. Government Printing Office.
- World Bank. (1994). *Averting the old age crisis: Policies to protect the old and promote growth*. Published for the World Bank. New York, NY: Oxford University Press.
- Zimbabwe Demographic and Health Survey (ZDHS). (1999). Central Statistical Office, Harare, Zimbabwe and Macro International Inc. Calverton, Maryland, USA.

**Appendix A (Model 1) Unstandardised Logistic Regression Coefficients and Effects
(Odds Ratios) for Older People's Attributes on Receiving Social Support (1994/1995 - N = 278)**

| Independent Variables | Coefficients | (S.E.) | Odds Ratios |
|-------------------------|--------------|----------|-------------|
| Intercept | 2.3335 | | |
| Age 65+ | -0.7409* | (0.3215) | 0.477 |
| Female headed household | -0.4896 | (0.4103) | 0.613 |
| Married couple | -0.6549* | (0.3269) | 0.519 |
| Rural residence | 0.4275 | (0.3152) | 1.533 |
| -2 log likelihood | 260.411 | | |
| X ² | 14.810** | | |
| DF | 4 | | |
| Y | 0.365 | | |

Reference categories of the independent variables are age group 60 - 64, male headed household, unmarried older household and urban residence.

*Statistically significant levels at *p<0.05; **p<0.01; S.E. (Standard Error)*

**Appendix B (Model 2) Unstandardised Logistic Regression Coefficients and Effects
(Odds Ratios) for Older People's Attributes on Receiving Social Support (1994/1995 - N = 278)**

| Independent Variables | Coefficients | (S.E.) | Odds Ratios |
|--|--------------|----------|-------------|
| Intercept | 0.3920 | | |
| Age 65+ | -0.7426* | (0.3279) | 0.476 |
| Female headed household | -0.7072 | (0.4412) | 0.493 |
| Married couple | -0.8023* | (0.3490) | 0.448 |
| Rural residence | 0.2399 | (0.3437) | 1.271 |
| Has adult living children | 2.3225* | (0.8135) | 10.201 |
| Dominant proportion of children are informally employed | 0.3661 | (0.4086) | 1.442 |
| -2 log likelihood | 250.298 | | |
| X ² | 24.923** | | |
| DF | 6 | | |
| Y | 0.404 | | |

Reference categories for newly introduced variables, has no adult living children and 50% or less of children are informally employed.

*Statistically significant levels at *p<0.05; **p<0.01; S.E. (Standard Error)*

Appendix C (Model 3) Unstandardised Logistic Regression Coefficients and Effects (Odds Ratios) for Older People's Attributes on Receiving Social Support (N = 278)

| Independent Variables | Coefficients | (S.E.) | Odds Ratios |
|---|--------------|----------|-------------|
| Intercept | 0.2293 | | |
| Age 65+ | -0.7544* | (0.3315) | 0.470 |
| Female headed household | -0.6476 | (0.4449) | 0.523 |
| Married couple | -0.7704 | (0.3521) | 0.463 |
| Rural residence | 0.2840 | (0.3543) | 1.328 |
| Has adult living children | 1.9270* | (0.8492) | 6.869 |
| Dominant proportion of children are informally employed | 0.2431 | (0.4197) | 1.275 |
| Dominant proportion of children are married | 0.4944 | (0.3770) | 1.639 |
| Suffers from a chronic illness | 0.3285 | (0.3443) | 1.389 |
| -2 log likelihood | 246.663 | | |
| X ² | 27.212** | | |
| DF | 8 | | |
| Y | 0.435 | | |

*Reference categories for newly introduced variables, 50% or less of living children are married and does not suffer from a chronic illness) Statistically significant levels at *p<0.05; **p<0.01; S.E. (Standard Error)*

Appendix D (Model 4) Unstandardised Logistic Regression Coefficients and Effects (Odds Ratios) for Older People's Attributes on Receiving Social Support for Model 4 (1994/1995 - N = 278)

| Independent Variables | Coefficients | (S.E.) | Odds Ratios |
|--|--------------|----------|-------------|
| Intercept | -0.0405 | | |
| Age 65+ | -0.8411 | (0.3409) | 0.431 |
| Female headed household | -0.4155 | (0.4807) | 0.660 |
| Married couple | -0.8173* | (0.3688) | 0.442 |
| Rural residence | 0.5024 | (0.6625) | 1.653 |
| Has adult living children | 1.7117* | (0.8806) | 5.538 |
| Dominant proportion of children are informally employed | 0.174 | (0.4340) | 1.147 |
| Dominant proportion of children are married | 0.6785* | (0.3973) | 1.971 |
| Suffers from a chronic illness | 0.2666 | (0.3509) | 1.306 |
| ≤ 7 years of education | -0.2902 | (0.4063) | 0.748 |
| Socio-economic status (land and home ownership) is living with kin | -0.3303 | (0.6321) | 0.719 |
| | 0.4723 | (0.4396) | 1.604 |
| -2 log likelihood | 238.101 | | |
| X ² | 30.769*** | | |
| DF | 11 | | |
| Y | 0.457 | | |

*Reference categories for newly introduced variables, less than 7 years of education, does not own land or house, living alone /with spouse only) Statistically significant levels at *p<0.05; **p<0.01; S.E. (Standard Error)*

SITAWA R. KIMUNA Ph.D.
Associate Professor – Department of Sociology
East Carolina University Greenville, NC 27858 - 4353 U.S.A.
E-mail: kimunas@mail.eev.edu

ADVERT

Discharge from Institutional long-term care: does it really ever happen?

INGRID MAGRO – PETER FERRY

Chronic health problems increase the burden of disability on older persons. This could result in increased dependency on the older person's relatives and friends. When the former are inadequately supported by the available formal or informal community networks, an application is usually filed for admission into a long-term care institution.

The term 'long-term care' is a broad term, and encompasses that care, be it physical, social or psychological, that is given to individuals on a prolonged basis so as to promote independence and improve quality of life. Such care can be provided in a variety of settings - rehabilitation hospitals, day hospitals, and nursing homes (O'Brien, Topping 1995)

However, it is a well-known fact that older persons would rather continue living in their own homes (Bury 1992). Institutionalisation is also quite expensive and beds are often at a premium (Gonzi, Diamantopoulou 2003)

The final decision as to whether an older person should enter long term care must therefore be taken after adequate screening for reversible disability is carried out by an interdisciplinary geriatric rehabilitation team.

Ideally this assessment should be done prior to admission to a long-stay institution. An exercise carried out on applicants to Malta's largest long-term institution (St Vincent de Paule Residence - SVPR) found that 22% of applicants could have been supported in the community, 21% required rehabilitation, and only 57% truly required long-term care (Dimech, Fiorini 2003)

Currently in Malta, pre-admission assessments are not being carried out by an interdisciplinary geriatric

rehabilitation team. This may be resulting in an unknown number of older persons being admitted inappropriately to long-term institutions.

Post admission multidisciplinary assessment is currently being practised at SVPR. Although in the authors' experience these assessments frequently identify remediable problems that are many times reversed, it is not always possible to reverse the decision for long term institutionalisation.

The main reason for this is that most of the older persons and their families believe that entering long-term care is the end of the line and a point of no return. Research, however, shows that older persons who enter residences and receive rehabilitation often improve and are more likely to be able to return back to the community (Murray et al, 2003). Simply a short-term programme involving muscle reeducation can serve to improve physical function and decrease dependency in elderly residents (Fisher et al, 1991). Such results are however more difficult to obtain on the more frail residents (Mulrow et al, 1994).

The following are two case reports illustrating successful post admission assessment and rehabilitation in a long-term institution (SVPR) which resulted in successful discharge back into the community.

1. **Josephine** (name has been changed) is a 72 year old lady who up to a year and a half ago lived independently in her own home. At least three of her six children lived in close vicinity within the same village and would regularly drop in on her. However Josephine did not require any physical help in her activities of daily living: both personal and household.

In February 2004, Josephine fell and sustained a

fracture of her ankle for which she had to be admitted to the local acute hospital. Her condition was further complicated when she required a transfemoral amputation of that same leg due to circulatory insufficiency. Josephine was physically and psychologically very unwell after the operation. She felt unable to cope with this new situation and could not foresee herself coping alone at home. She even believed she would be passing away in the near future. She refused prosthetic rehabilitation and supported by her relatives, decided to apply for long-term care at SVPR. A social workers' assessment carried out at the hospital suggested that at that point Josephine was indeed a candidate for such care.

Josephine was transferred from the hospital to SVPR in October 2004, approximately 6 months after her amputation had taken place. She was admitted to the admission and assessment unit where within the first few days of her arrival she was assessed by all the resident members of the interdisciplinary team namely the doctor, nurse, physiotherapist and an occupational therapist. A social worker was also involved since within a few days of entering the residence Josephine expressed a wish to go back home, and there was obvious resistance from her children who felt they could not cope and were not ready to take on caring for their disabled mother on a full time basis. Therefore, if Josephine were to go home she would have to manage on her own with some help from community services which at that point were not enough to cater for her needs.

Assessment revealed that Josephine was depressed both due to her physical state and possibly due to this newly created adverse social situation. She was immediately started on antidepressants, which were effective. Josephine's morale improved. She understood that there was a possibility that she would be able to return home in the community if she underwent rehabilitation and became independent, so as not to have to depend on her children for care.

Josephine was given intensive physiotherapy and occupational therapy sessions. She trained in

independent transferring, continence and activities of daily living. She also started prosthetic rehabilitation and was eventually fitted with her prosthetic limb within 8 weeks.

A home visit was carried out at Josephine's house to ensure wheelchair accessibility and safety within the house. A number of changes had to be made within the house to be able to accommodate Josephine on the ground floor. Despite being adverse to the fact that their mother should return home for good, Josephine's sons were very co-operative in settling these changes. Once the alterations were made and tried out by Josephine herself in a follow up home visit, she could then go home for weekends to see if she could cope.

Josephine was discharged home from the residence in April 2005. She now lives independently in her own home even though one daughter lives on the upper floor with her two children. She regularly attends the physiotherapy department on an outpatient basis for progression in gait training. This also serves a dual purpose since in this way members of the team can keep contact with her and ensure that she remains well at home.

2. **Marianna** (name has been changed) was admitted to a long-term care residential setting from the community. She was on rotating care between two of her children. Marianna had her own home and lived there during the day however would not sleep alone at night. According to her children she also did not manage her activities of daily living independently and expected to be washed and dressed. Her children felt they could not cope any longer as this situation was placing strain on their own families since Marianna did not live in such close vicinity to any of them. It was clear however, that there was disagreement amongst the siblings regarding their mother's admission to the residence.

Marianna was assessed by members of the interdisciplinary team. Her main limiting factor was that she suffered from severe osteoarthritis in multiple joints particularly her knee and

shoulder joints. The latter affected largely her activities of daily living since due to muscle weakness and decreased range, Marianne was unable to wash and dress properly.

Within a few days of admission Marianna expressed a wish to go back home. This was initially met with resistance from the family; however considering the elderly lady's wishes, attempts were made to retrain ADLs with aids and to encourage Marianna to be independent.

Considering this, one of her sons offered to take on his mother to live with him and his family. A home visit was carried out to assess the home environment, and to assess washing and dressing at home. Marianne went home on a two week trial and having coped well was then discharged indefinitely. She will be regularly attending a Day Centre as she did before being admitted. Marianne did not require any follow up treatment but the family were assured that should any intervention be required they could feel free to contact any member of the team for advice.

REFERENCES

1. O'Brien K, Topping A, Institutional Health Services. In Pickles B. Compton A et al, eds (1995) *Physiotherapy with Older People* Chp 30 pp446 - 454, London: Saunders.
2. Bury M. The future of ageing - Changing perceptions and realities. In Brocklehurst J. Tallis RC, Fillit HM eds. (1992) *Textbook of Geriatric medicine and Gerontology* pp21 - 25, London Churchill Livingstone.
3. Gonzi L, Diamantopoulou A. (2003). Joint Memorandum on Social Inclusion of Malta. http://www.msp.gov.mt/documents/msp/ioint_inc_memo.pdf page 34 (accessed on 29/06/2005)
4. Dimech J., Fiorini A. (2003). Pre-Admission Assessment of Elderly Applicants to Long-Term Care. *Malta Medical Journal*; 15: 28-30.
5. Murray P, Singer M, Dawson N. (2003) Outcomes of rehabilitation services for nursing home residents. *Archives of Physical Medicine and Rehabilitation* 84: 1129- 1136.
6. Fisher NM, Pendergast DR, Calkins E (1991) Muscle rehabilitation in impaired elderly nursing home residents. *Arch Phys Med Rehabilitation* 72(3): 181 - 185.
7. Mulrow CD, Gerety MB, et al (1994) A randomised trial of physical rehabilitation for very frail nursing home residents. *JAMA* 271(7):519 - 524.

**INGRID MAGRO B.Sc.(Hons.); SRP; Dip.Gen.
Senior Physiotherapist**

**PETER FERRY M.D., M.Sc., MRCP., Dip.Gen.
Consultant Geriatrician
St. Vincent de Paule Residence, Malta**

INTERNATIONAL DIARY 2005

August 25th – 27th – Switzerland

AGE05 – International Sociological Congress on “Health and Ageing”

Website: www.age05.ch

E-mail: age05@bfs.admin.ch

September 7th – 9th – Republic of Azerbaijan

ISSA – European Meeting – Social protection of migrant labour and Globalization

Website www.issa.int

E-mail aiss@wanadoo.fr

September 20th – 24th – Stockholm, Sweden

12th Congress – International Psychogeriatric Association
Ageing with Dignity – new challenges – new possibilities – new solutions

Website: www.ipa-online.org

E-Mail: ipa2005@congrex.se

September 22nd – 23rd – Amsterdam

Older migrant women in Europe: on the Agenda!

Website: www.eurag-europe.org/AGE+.htm/ www.ageplus.nl

September 29th – October 1st - St. Gallen, Switzerland

1st World Ageing & Generations Conference

Website: <http://viva50plus.org>

E-Mail: info@viva50plus.org

September 29th – October 1st - Ljubljana, Slovenia

XVIII International EURAG Congress 2005

“Perspectives of older people in Europe”

Website: www.eurag-congress2005.org

October 5th – 7th – United Kingdom

British Geriatrics Society Autumn Meeting

Harrogate International Centre, UK

Website: www.bgs.org.uk

E-Mail: bgs@hamptonmedical.com

October 20th – Washington, DC

AARP Global Aging Programme

International Forum on Long-Term Care

Website: www.aarp.org/ltcforum

October 24th – 25th – Madrid, Spain

Age Discrimination, a Human Rights issue

Website: www.ceoma.org

E-mail: ceoma@ceoma.org

November 17th – 20th – Thessalonica, Greece

2nd International Congress on Brain and Behaviour

Website: www.psychiatry.gr

December 5th – 7th – Singapore

International Conference – Female Deficit in Asia: Trends and Perspective

Organized by CEPED – CICRED – INED

Website: www.cicred.org/Eng/Seminars/Femaledeficit.htm

INIA'S ACTIVITIES 2005

28th August – 9th September

In-Situ Training Programme in **GERONTOLOGY** in collaboration with the Singapore Action Group of Elders (SAGE), (SINGAPORE)

26th - 28th September

Inter-Regional Consultative Meeting on the **Preparation for the First Cycle of the Review and Appraisal (R & A) of the Madrid International Plan of Action on Ageing** organised by the UN Programme on Ageing, in co-operation with the UNECE Economic Analysis Division, Geneva (SWITZERLAND)

October 2005 - June 2006

International **POST GRADUATE DIPLOMA IN GERONTOLOGY AND GERIATRICS (Dip. Ger)** European Centre of Gerontology and Geriatrics, (University of Malta), (MALTA)

30th October – 5th November

In-Situ Training Programme in **GERONTOLOGY** in collaboration with the Beijing Civil Affairs Bureau (BCAB), **Huairou** (CHINA)

7th – 18th November

International Short Training Programme in **DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC, POLICIES AND PLANS**, (MALTA)

21st November

Workshop on **HIV/AIDS and the Elderly** organized by INIA and Help the Aged (UK) as part of the Citizens Forum during the Commonwealth Heads of Government Meeting (CHOGM), **Malta** between 21st and 27th November.

5th – 16th December

In-Situ Training Programme in **GERONTOLOGY AND GERIATRICS** in collaboration with Caisse Nationale de Securite Sociale (CNSS), **Tunis** (TUNISIA)