



-
- 2** Does ‘Older’ mean ‘Wiser’?
K. Tout
- 8** The Madrid Plan on Ageing
A. Lencyk Pawliczko
- 11** Health seeking behaviour of Older persons in
Zimbabwe
A.C. Nyanguru
- 27** Water, Sanitation and Ageing in Nigeria
O. Martin Makinawa
- 32** Dairies

CONTENTS

DOES 'OLDER' MEAN 'WISER'?

KEN TOUT

In May 2007 an unusual meeting took place in South Africa. It proposed a forum of twelve "global elders" combining to discuss the future of the world. The group, termed "The Power of Twelve", would include Nelson Mandela, Kofi Annan, Muhammad Yunus, Mary Robertson and US ex-presidents Carter and Clinton. Similar meetings have taken place elsewhere, including a group of technology "elders" who have masterminded innovations of the computer age.

Will the wisdom of these elders make the world a better place? Perhaps a little cynically, viewing one or two of the names proposed, if they could not right the world when in power, why now lecture the following generation? Or does experience of failure contribute to wisdom?

Does "older" mean "wiser"? I sometimes say in jest that in the 20th century I travelled to over 100 countries to study ageing. But in the 21st century, as an octogenarian, I can study ageing simply by looking in the mirror each morning whilst shaving. And I ask myself, "Am I any wiser now?"

It has been widely assumed that in primitive societies older persons were made chiefs because of their wisdom. One of the earliest gerontologists, Leo Simmons in the 1940s, found that in 56 out of 71 pre-industrial societies older people were serving as chiefs. In the ancient Tihuanacu culture of Bolivia, the Reza-Lipichi used a symbol Achachi, a kind of upside-down, bent Y. much like that seen on traffic signs warning of elderly people in the road. Achachi meant "old", and "father", and also "God", a sign of great esteem.

Old and therefore senior

In the 1990s Rosenmayr and Traore investigated an enduring pre-industrial group, the Bambara of West

Africa. They expected to find that the elderly Bambara chiefs were appointed because of their wisdom. Instead they found that the elderly chiefs moved into power as a result of a hierarchy system of peer groups, commencing with successive years of babies, children, youths and continuing through all stages of life. Wisdom was incidental to seniority. Psychologist Erik Erikson has pointed to the interrelation of a person's developing biological, mental and social capacities, and asserted that we all pass through similar development stages, although not necessarily at the same pace. Each stage of life has its own unique task, he believes, and the final task in age is to review life.

I have often referred to my contact with the "Valley of the Aged", Vilcabamba in Ecuador. By the 1990s this culture was subsumed in the normal processes of a modern democratic nation, but in all village meetings it was always the oldest person present, invariably at least 100 years old, who made the first statement in our conferences. The mention of Vilcabamba takes me to another observation on the whole issue of ageing. At one time I devised a set of typical longevity scenarios and identified them by the name of the area where I had studied them.

In this system the "Vilcabamba factor" related to a primitive but pleasant society enjoying pure air, clean water, relatively unstressed agricultural work, where people were able and happy to continue working well past that magic 100 years mark. The "Potosi factor" related to an experience of high altitude, poor nutrition, virtual slave labour in deep mines of indescribable horror and other disadvantages leading to many male miners being physiologically aged, totally unable to work, by age 40. An old-time Mexican tribe, the Nahuatlacas had their own magic age of 52 at which a person became a senior in the tribe.

So, if older does mean wiser, is chronological age the benchmark? And are there relatively few wise persons in Potosi? In my own case, I am in touch with many chronological peers and it is only human to compare one's own positives and negatives with those of similar age. But do I perceive some of my peers to be wiser than others because they are ageing well? And are the wiser among them likely to survive the longest?

Some very pertinent questions

I therefore set myself a simple questionnaire, and tried to be objective in answering the questions:

- Am I generally wiser than an average 20 year old?
- Am I generally wiser than, say, a 40 year old?
- Was there an age at which I felt more competent to advise younger persons?
- As the body weakens, is there a sense of lesser ability to assess persons or events (if allowed access to adequate information)?
- Given modern computers, will greater available knowledge make younger people wiser than us who have not been reared to depend on such aids?
- Which is the best mark of wisdom, say, obtaining a university degree; achieving political success; writing a book; accumulating a big bank balance; or obtaining a grandchild's respect?

As I deliberated over my answers it occurred to me that my own peers might help in the solution of these queries. I therefore contacted 100 persons aged 60 to 95, from all walks of life, of all economic strata and living in culturally varying parts of the country. Some of the questions evoked a general consensus but others provoked differing views. In the following review I indicate by (K) my own answers.

Four persons out of the sample of 50 males and 50 females felt that they were not competent to answer questions on wisdom. Of the 96 responding, when asked "are older people (say over 60s) generally wiser than young people (say 20s)?" a clear majority, 75 (K) said "Yes, usually" with 19 saying "sometimes" and only 2 "No". This general opinion changed when comparison was made with persons

in their 30s and 40s. Only 28 then ventured the affirmative, with 65 (K) undecided on "sometimes" but still only 3 "No".

Will today's young people take advantage of the vast wealth of information from Internet and television sources to become generally wiser in older age than us of the present elderly cohorts? The respondents were divided with 40(K) saying "very likely" but 56 taking the pessimistic "probably not" view.

True markers of wisdom?

Given several possible indications of a person's wisdom, as quoted, a massive majority, 55, opted for the evidence of a grandchild's respect. 19 considered a university degree was a prime indicator of wisdom and 11 said the ability to write a book. Only 3 (K) thought political success was associated with wisdom (so what about our Power of Twelve elders?) whilst 13 considered that a substantial bank balance indicated exercise of wisdom.

Considerable variations arose when respondents were asked if there had been a time in their lives when they had felt more competent to advise younger persons, and, if so, at what approximate age. A minority 43 believed there had been no better epoch. Of the remaining 53, the majority 38 thought themselves most competent in the 40s and/or 50s age brackets; (K). 12 (mainly aged 80 plus) cited 60s or later. Only 3 mentioned an age under 40.

Crucially there was a strong response to the question "though the body weakens, do you have any sense of lesser ability to assess persons or comment on events (if given adequate information)." 66 respondents claimed an emphatic "No" (K), with 23 admitting to "somewhat less" but only 7 replying "much less".

When the first two comparison questions were phrased in a more specific way, there was a rather less positive result. The question was "In a mixed age group do you think your opinion would generally be more valid than that of, say, a 21 year old". Thus confronted with a specific, if imaginary situation, only 53 (as against 75 in the first question) stated

“yes usually”, with 40 moderating their view to “sometimes” but still only 3 on “No”. Significantly when the same question was related to competition with persons in the 30s/40s bracket, only 19 of those surveyed stayed with the definite “yes” and the 66 majority temporised with “sometimes”. A significant number, 11, felt that their opinions would not be as valid as those of the middle age group.

The average age of the sample surveyed was just over 79 and represented the accumulated opinions of 7602 years. This researcher was not able, as at this point, to repeat the questionnaire with lower age cohorts. The overall response indicated confidence in their own mental abilities on the part of the great majority of these elders but also a clear tendency to look at the middle age groups of our current society as having substantial claim to good judgement.

Analyse, evaluate, become wise

I believe that wisdom derives, to a large extent, from the ability to analyse and evaluate one’s own experience, with a particular emphasis on experience of failure. Where one has succeeded in life there may have been all kinds of positive factors which reduce one’s own exultation. But equally in the case of failure the question arises “Was one’s own wisdom at fault in producing the failure?”

A case in point could be my own experience at a certain time, in a certain country, respecting a certain infamy. History, as now written many years later, suggests that my own judgement on that situation at that time was flawed. But was this indeed so? Or will the subsequent rewriting of that history itself prove to be flawed, leaving my original judgement correct? Today’s history is not necessarily the history of today as it will be written a century later. Even the great Shakespeare was guilty of rewriting history to please his own ruling family. So, in pursuit of wisdom, the tactic of blaming oneself entirely for all past failures has to be undertaken with some caution.

In our survey a minister of religion quoted the proverb “The fear of the Lord is the beginning of wisdom”. In most religions divine injunctions are

handed down, by one process or another, and form a set of firm universal rules by which one’s own actions and decisions can be measured. However, the modern world tends to work towards breaking down the rule of universal truths and emphasising the individual right to form codes of conduct, or sometimes misconduct. Perhaps the pre-industrial elders were at an advantage in being able to refer to enduring universal truths, the received wisdom of the particular society.

This brings me back to my opening paragraph and the Power of Twelve idea. The inclusion of personalities such as Nelson Mandela and Kofi Anan may suggest that it is a reasonably simple task to choose a dozen such world elders as our intellectual saviours. But might not some of our younger, powerful, current leaders consider that they are more *au fait* than those who have relinquished the baton of power. The answer to this may lie in more tangible measures of intelligence or accomplishment than the abstract concept of “wisdom”.

In the first Power of Twelve meeting referred to, among the desirable parameters for elder wisdom were moral authority, public recognition and freedom from current political commitments. Unfortunately today’s world turns a blazing light of scrutiny on eminent people’s lives and the concept of ‘moral authority’ itself changes. It is not difficult to name more than one person of recent supreme eminence whose moral authority has been impeached. The old-time chiefs identified by Leo Simmons did not have the world’s media scanning their every pronouncement and action. Which factor does not necessarily invalidate the idea of a supreme world wisdom council of eminent elders.

Mental impairment in ageing

As I assess my own credentials for writing on this subject I am encouraged by a number of longitudinal studies. Schaie in Seattle found that, far from a move into old age leading automatically to impaired thought, intelligence may even increase in many people into the 70s. A 27 year Baltimore study found no significant change of personality due to ageing. When I tire of statistics I switch on some music by

Verdi who was composing masterpieces at age 80. It is said of him, that in contrast to the melodramatic robustness of his youth, his last two operas *Otello* and *Falstaff* were remarkable for extraordinary subtlety and sophistication. Advanced age does not mean intellectual redundancy.

Yet an opponent of the proposition that older means wiser could point to the general mental frailties of older persons. Yes, says the antagonist, there may well be occasional seers and sages of extreme age, but surely the mass of older people suffer from mental impairment. In Britain recently forecasts of mental illness at upper ages have reached panic intensity. One headline read “Elderly suffering a Mental Health PANDEMIC!” A study predicted that, ‘*unless* there are effective interventions, 35 million older people will have’ (not may have) “symptoms of depression, and almost one million ... dementia by 2021.”

I have been studying precise in-depth details of mental illness in an area of Britain and these reveal a rather different picture. One sub-area, X, is an industrial, lower income society whilst Z is a higher income residential location. X has a population over age 17 of 119,023 of which 27,497 are 60 plus. Z’s total over 17 is 60,430 with 17,813 in the upper brackets.

In X during the year to March 31 2007, treatment of serious mental illness was given to 2085 persons aged 17 to 59, or 2.28% of that group. The total treated over 60 was 949 or 3.45% of the group. In Z, demands were lower, with 524 of the lower age bands amounting to 1.23% and 415 older people, or 2.34%. The 60 plus percentages are not dramatically high and, from a service delivery point of view, it is people under 60 who are a gross majority. And these statistics do not include Learning Disabilities at ages under 17.

The worrying “Big A” word!

To delve further into these results, it is useful to highlight details on Alzheimer’s Disease. On my travels in one country a specialist said to me that, when an elderly person suffering from mental illness

was brought to a doctor, the case was almost automatically registered as Alzheimer’s. When I was speaking on this incident back in Britain another specialist remarked to me “That is still not unusual in this country, too” The term “Alzheimer’s” has for many older people acquired the horrific resonance that “Cancer” or the “Big C” has for some younger people.

In the larger administrative area of which locations X and Z are a part, the year’s total record of patients over 60 treated for mental illness was 1429. Only 361 of these were diagnosed as “Alzheimer’s Disease” or as “Dementia in Alzheimer’s Disease”. By contrast 281 were suffering from a “single depressive episode”, implying that they could end the treatment with the ability to continue rational life and in the hope of avoiding further mental affliction. Again, in contrast 497 persons between 17 and 59 were treated for mental problems resulting from substance abuse alone.

Whilst nobody can doubt the terrible ravages of Alzheimer’s and other mental illness in the elderly, records such as those above give a more balanced view of incidence. The figures quoted cover persons requiring diagnosis and treatment during one year, whether that treatment be long term residence, acute admission, out patient attention or care in the community, and also forensic referrals from the law courts.

They do not include previously diagnosed patients who are now maintained in the community on general practitioners’ repeat prescriptions. Nor do they estimate the “no shows” of people who do not seek treatment, perhaps because of the perceived stigma. Nor is there a count of the relatively minimal number of persons who can afford referral to extremely high cost private mental health facilities. These three categories have been estimated to double the statistic of recorded referrals in a year. However, the maintenance and ‘no show’ groups can be assumed to be living fairly normal lives at domicile, able to exercise reasonable sagacity and enjoying the stimulating fruits of experience, Wise if somewhat restricted in the actual practice of wisdom.

Literacy versus understanding

Returning to pre-industrial societies, it is clear that long experience of local climate, agricultural methods and human abilities gave the older person a store of knowledge, not available at the apprentice level, and which might be described as wisdom. Illiterate elders also developed and retained high mental abilities as the repositories of history and mythology, storing up incredible amounts of information such as details of ancestors going back to the Garden of Eden. It is also appropriate to state that in primitive societies, illiteracy did not mean ignorance or lack of intelligence. When there were no books to read older people carried the tribe's books in their brains.

It has been remarked that, in such a society, if a child learns 'ABC' this is the first step in undermining the elders' supremacy of long-acquired wisdom. The child learning to read has early access to vast stores of information not available to the elder. I have sat in on literacy classes in an illiterate community where grandparents were encouraged to accompany the children to learn the alphabet and all ensuing mysteries of writing and reading. The children quickly outpaced their grandparents in the first stages of comprehension. However, in some cases, the grandparents displayed more stamina and determination to continue learning after the children had become bored. The grandparents then again reverted into the teacher role.

It is necessary to move from the simple subject of reading skills to take account of the immensely more complicated calculations of what often seem to be self-motivated computers and micro-chips. Here we need to seek more relevant definitions of wisdom before deciding how far such innovations produce wisdom in practical human intercourse. On the other hand, might a computer one day synthesize and emit a definitive doctrine of wisdom?

Looking for a brief definition of that elusive term, I find Professor John Kekes declaring it to be "a form of understanding that unites reflective attitude and a practical concern", where computers would surely be at a loss.

He then enlarges this to 'Wisdom may be identified with good judgement about the evaluation of complex situations and conceptions of a good life in the light of reflective understanding of the human condition'. Not surprisingly he sees that "some who pursue wisdom per se, rather than seeking it in the actions of powerful politicians or successful industrialists, choose to explore 'the obscurities of oriental religions for enlightenment'.

Making up my mind

There is a modern vogue for ending literary endeavours, such as crime mysteries, without a satisfactory ending, as though the very writer has been unable to disentangle his own plot. So, having posed the question in my title I might be challenged to abandon speculation and propose a simple definition of wisdom. And then commit myself to an opinion as to whether older means wiser.

Whilst not hoping to cover all aspects of wisdom, I have no doubt that much wisdom lies in the ability to stand back from one's own preoccupations of the moment and analyse one's own experience, especially in respect of past failures. And also to assess other people's opinions and actions without fear or personal prejudice. This should yield a reasonable appreciation of the realities of human life in a natural world, an achievement perhaps not far from wisdom.

My attempted elucidation could therefore imply that those who have most life experience will have easier and greater access to wisdom. Older should be wiser. However there is the issue of the speed of appreciation of experience. Thus a particular younger person, willing to undertake the quest of this Golden Fleece, may achieve wisdom sooner than an older person who has no interest in such adventure.

As one approaches an age where the spectre of dementia may hover menacingly, challenging the perceptions of elderly wisdom, there is consolation in the expert words of Naomi Feil. She speaks of 'the wisdom of crystallized human experience and intuition' which can persist even through

disorientation. “Integrity in old age is recognizing one’s strengths in spite of weakness ... with integrity the old person counts on deep self-respect to heal the inevitable bruises that come with age.”

I can think of no better way to end than by quoting an epigram from Amadou Hapate Ba, an elderly philosopher from the African tribe of Peul nomads: “An old man who dies is like a library which burns down.”

References

Erikson, E., 1978, “Introduction: Reflections on Aging” in Spicker, S., etal (eds) *Aging and the Elderly*, Atlantic Highlands, N.J.: Humanities Press.

Feil, N., 1992, *Validation: The Feil Method*. Cleveland: Edward Feil Productions.

Kekes, J. 1996, *Moral Wisdom and Good lives*. Ithaca, N.Y.: Cornell University Press.

Rosenmayr, L., 1986, *More than Wisdom*. Vienna: University of Vienna.

Schaie, K. W., 1982, *Longitudinal Studies of Adult Psychological Development*. New York: Guildford Press.

Simmons, L., 1945, *The role of the aged in Primitive Societies*. New Haven, Conn.: Yale University Press.

Tout, K., 1989, *Ageing in Developing Countries*. Oxford: Oxford University Press.

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THE MADRID INTERNATIONAL PLAN ON AGEING

Policy Formulation, Planning, Implementation and Monitoring

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The first quarter of the twenty-first century has often been called the Age of Ageing. It is a well known fact that the world's elderly population is increasing by one million persons every month. In 1985, there were 427 million persons aged 60 and over constituting 8.8% of the world's total population. It is projected that by the year 2025, 14.3% of the world's population will be aged 60 and above. This number is expected to increase to two billion by the year 2050.

This demographic shift presents a major challenge to all countries and is having remarkable consequences on all aspects of society. To meet these challenges, the first World Assembly on Ageing was called by the United Nations in July 1982 and presented the World with what came to be called as the Vienna International Plan of Action on Ageing. It was reiterated that implementation of the recommendations made in this Plan depended on trained personnel at all levels.

The International Institute on Ageing, United Nations-Malta (INIA) was set up by a resolution of the UN Economic and Social Council which recommended to the UN Secretary-General the establishment of such an Institute to meet the need of trained personnel in the field of ageing especially from developing countries. The Institute was inaugurated on 15th April, 1988 by the then UN Secretary-General, H.E. Mr. Javier Perez de Cuellar.

In keeping with its mandate at developing better qualified personnel and based on the curricula and training materials recommended by the respective expert group meetings, the Institute annually holds four training programmes in the fields of Social Gerontology, Economic and Financial Aspects of

Ageing, Medical Gerontology and Demographic Aspects and its Implications for Socio-Economic Development, Policies and Plans. Moreover starting from 1995, INIA annually runs in-situ training programmes tailored to meet the needs of developing countries in the various areas of population ageing.

During the first week of December 2006, a small group of international experts met in New Delhi, India, to design a new training programme for senior government officials involved in policy- and decision-making and national focal points on ageing. The aim of this training programme is to strengthen national capacity to address the challenges of this global phenomenon. The two-week course, entitled *Policy Formulation, Planning, Implementation and Monitoring of the Madrid International Plan of Action on Ageing*, was designed by the United Nations Population Fund (UNFPA) and the International Institute on Ageing, United Nations-Malta (INIA) to assist governments to implement the recommendations of the *Madrid International Plan of Action on Ageing*.

The training programme is aimed at providing policy-makers with a basic understanding of the demography and dynamics of population ageing; the social, economic, cultural and psychological implications of the phenomenon; the challenges and opportunities which ageing presents for the individual, family, community and society; and ways to realize the opportunities and address the challenges. Particular attention will be paid to the Madrid International Plan of Action on Ageing and its implementation taking into account regional priorities. Participants will have an opportunity to share their country's experiences, good practices, lessons learned and constraints encountered in

implementing the Madrid Plan and the regional implementation strategies.

Programme topics include: conducting a needs assessment using the bottom-up approach called for in the United Nations Guidelines for the Review and Appraisal of the Madrid International Plan of Action on Ageing; data collection and analysis; involvement of stakeholders; the roles of government, the community and the family; mainstreaming ageing into national development frameworks and poverty reduction strategies; policy formulation; programme design and budgeting; fundraising and grant writing; and monitoring and evaluation.

The training programme consists of lectures by experts, discussion sessions, and group activities. Participants are encouraged to continue networking and maintain contacts with instructors and colleagues upon completion of the course.

Why a Training Programme on Ageing?

Population ageing is one of the most significant demographic processes of modern times. Today, one out of every nine persons is aged 60 or over. By 2050, almost 2 billion people, or one in every five persons, will be elderly.

Women comprise by far the greater number and proportion of older persons in almost all societies and the disparity increases with advancing age. The gender dimension of population ageing has important implications for policy formulation and programme planning.

Two thirds of all older persons live in developing countries. There are marked differences between regions in the percentage of elderly in the population. There are also marked differences in national experiences of the process of population ageing that are associated with differences in social and cultural values, levels of economic development, degree of government involvement and, above all, the speed with which fertility and mortality decline is ageing populations.

Population ageing is taking place at a much faster pace in developing countries at a time when they

are at much lower levels of economic development than developed countries were when they were ageing. Poor developing countries that have many competing priorities have few resources to address the challenges of population ageing and to meet the needs of older persons.

Rapid population ageing brings with it a host of new opportunities and challenges. The increasing number of the elderly in society calls for changes in the way we view population ageing and older persons. It also requires changes in policies and practices in order to improve the quality of life of older persons. It calls for ensuring the full realization of all human rights and fundamental freedoms for older persons; the empowerment of the elderly; the provision of opportunities for individual development; commitment to gender equality; provision of health care, support and social protection; and recognition of the crucial importance of the family. Rapid population ageing calls for the development of sound public policy to ensure the fair distribution of resources so that the needs of all age groups in society are adequately met.

Until recently, most governments focused their attention on the younger generation and little attention was paid to the ever-increasing numbers of older persons. Today, the elderly can no longer be ignored. Public policy must respond to the challenges posed by the individual, family, social, health and economic consequences of population ageing and meet the needs of older persons. The elderly must be included in the development process. Issues of older persons must be incorporated into poverty reduction strategies and national development frameworks. Population ageing has important implications for Government policies, especially those relating to health care, pension schemes and social security. There are many important issues to address to ensure that the needs of older persons are adequately met. These range from basic necessities such as food, clothing, shelter and health care to being treated with respect and feeling wanted and useful.

The elderly cannot be viewed only as a needy and dependent group. Negative stereotypes depicting older persons as frail, disabled, dependent and a

burden to society must be celebrated, and promoted. These contributions reach far beyond work-related activities. Many older persons continue to contribute their time and resources long after they have retired from paid employment. Many of their contributions are not measured in economic terms but are equally important: caring for grandchildren and other family members, housework and household maintenance, productive subsistence work, voluntary activities in the community. By taking care of grandchildren, older persons make it possible for younger women to be employed outside the home, raise household income and secure more resources for education and health care for the family. Older persons are also important vehicles for transmitting culture and traditions to the younger generations. Their experience is invaluable in preparing the future labour force.

In many parts of the world, older women, already living in difficult circumstances, are assuming the responsibility of taking care of adult children living with HIV/AIDS and orphaned grandchildren. In fact, older caregivers are the backbone of HIV/AIDS care in Africa. At a time when older persons were expecting to be cared for by their adult children, they are using their meager financial resources to pay for medication, burials, food, school fees and uniforms. As a result, many older persons who are already poor fall into a state of destitution.

The challenge for policy-makers today is to address the implications of population ageing and to meet the needs of older persons. This requires institutional capacity building and exchange of experiences and good practices. It also requires familiarity with the Madrid International Plan of Action on Ageing adopted by governments at the Second World Assembly on Ageing in 2002. Among the most important roles of the government is to mainstream ageing and the concerns of older persons into national development frameworks and poverty reduction strategies. Governments have the responsibility to formulate national policies on ageing and to implement programmes to address the needs of older persons. They are also the ones entrusted to protect the human rights of older persons. They should promote policies that support gender equality of older persons and combat discrimination, violence and abuse of the elderly.

The implementation of the Madrid International Plan of Action on Ageing and systematic review of progress in achieving its many recommendations requires strengthening national capacity to realize the opportunities and address the challenges of population ageing. The new training programme will help build institutional capacity and prepare policy makers to address these challenges in order to build a Society for All Ages.

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The Health-Seeking Behaviour of Older Persons in Zimbabwe

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Abstract

The poverty of older people in Africa translates into poor nutrition and health and sustaining burdens brought about by the HIV/AIDS epidemic. This further aggravates the search for income-generation opportunities. Their situation also affects health-seeking behaviour to attain well-being. All people have concepts about health and illness which are part of their culture. Every society also has beliefs about how to stay healthy, how to prevent illness, and how to treat people who are sick. yet no known study has been carried out regarding the health-seeking behaviour of older persons in Zimbabwe. The paper is based on a study of older people over 60 years of age living in Harare, Mutare and villages up to 50 kms from these cities. We studied older persons' choice of a health care provider and their reasons for doing so.

The results showed that slightly more than one tenth of the respondents used self-treatment, a third visited a clinic, another third a hospital, a fifth a private medical doctor. Traditional healers (n'angas) or religious practitioners were each used by less than 5 percent of the respondents. There were significant differences in the use of health care providers between older people living in rural areas and those in urban areas. Three-quarters of the respondents reported on the quick, good and efficient service they received from the use of their chosen health care provider, while the rest mentioned accessibility, affordability, availability, trust in and reliability of the health care provider as the reasons for their choice.

Key words: Health-seeking behaviour, health, care systems, elderly, Zimbabwe.

Background

The colonial era in Africa saw the introduction of Western "orthodox" methods of medicine and treatment. Little or no effort was made to determine the effectiveness of traditional healing methods. According to Le Beau (2002), colonial governments attempted to discourage the use of traditional medicine in the belief that it was not effective in the treatment of illness, and its use was based on simple ignorance and superstition (Chavunduka 1994:5-6). In many countries, including Zimbabwe, traditional healers were illegal under colonial rule because they were thought to encourage witchcraft (Neumann and Lauru 1982:1820).

Post-colonial discourse speaks directly to the shortcomings of the type of Western medicine introduced by colonial regimes with little regard for the existing medical systems or cultural beliefs on which these systems were based. The introduction of Western medicine was "mainly directed at the white population and health policies aimed at

Africans tended to be repressive" (Wallace, 1997:16). In Zimbabwe (then Rhodesia), a Witchcraft Suppression Act outlawed the practices of divination, spirit possession, and witchcraft accusation.

Western medicine provided to Africans under colonial rule was inferior in quality to that provided for their white counterparts in that advanced procedures were not available and medications were limited. Due to structural inequalities and technical inadequacies, Western medicine under colonial rule failed to meet the health care needs of the African population; it lacked relevant cultural explanations (etiology) of health and illness, and did not address the culturally defined needs of the population (Wallace 1997:17). Le Beau (2003) argues that the Western paradigm, by not recognizing and treating illness with social/ spiritual etiologies, left a gap that traditional medicine continues to fill. Thus, colonial knowledge and power was not able to extinguish traditional medicine in Zimbabwe.

Even after twenty-five years of independence, Zimbabwe had a dualistic form of western health care, with the majority of the population using government-run facilities, while the rich minority used expensive private health care, and even traveled to developed countries such as South Africa and Britain when sophisticated health care was required. This disadvantaged older people who are generally poor.

The medical system also operated under assumptions appropriate to European society and not to African societies. For example, the concept of a hospital or clinic implied certain pre-existing infrastructural supports such as a transportation network to move patients and supplies between the hospital's location and clients' residences; a reliable energy source such as electricity to maintain the cold chain for immunizations and to power technologically sophisticated equipment, etc.

Health-seeking behaviour

Typically when persons first determine that they are not well, they may seek the advice or help of friends, relatives or neighbours. They may, for a while, try different self-treatment methods. If these efforts are not successful, people re-evaluate their condition and determine what other treatments are available and necessary for reestablishing well-being. They can seek out either western or traditional medicine. (Le Beau (2002:94) suggests that the choice a patient makes is generally based on symptomatic manifestations, as well as the patient's belief in the cause of the illness. However, if the first choice in health care is not successful, they will reevaluate available health care options. The patient can continue with the health care option chosen, go to another health care provider within that system, or seek alternative forms of healing.

The state of older people's health

In developing countries numerous local and national surveys have shown that older people have a high prevalence of disability (Kalache and Sen, 1999). This is due in part to the long-term effects of diseases that occurred in childhood and early adult life such as poliomyelitis, leprosy, tuberculosis and infections

not properly treated in their early stages. In addition, common problems that can be successfully dealt with through secondary prevention, often lead to complications and permanent incapacities in poorer countries (Kumar, 1994; Shah, 1994; Nyanguru, 1990; 2000; WHO, 1998b). Examples are hypertension and stroke, diabetes mellitus and peripheral vascular disease, trachoma and blindness

Purpose of study

Many studies carried out nationally and internationally, including in Zimbabwe, have sought to identify the health problems of older people. No study, though, has been carried out in Zimbabwe to find out how older people choose health care options in order to restore well-being, although some studies have (Le Beau, 2002; Chavunduka, 1994) been carried out in the general population. Since many studies have shown that older people have more chronic conditions than the other groups in the population, this study sought to learn more about their healthseeking behaviour.

The paper is based on a number of theoretical postulates as proposed by Le Beau (2003) to explain and analyse the health-seeking behavior of older people in Zimbabwe. These include:

- (1) No one theory can explain all social (macro-level) and individual (micro-level) behaviour through the juxtaposition of place and time. A multi-theoretical paradigm is needed to understand and explain health-seeking behaviour within a multi-cultural society.
- (2) Western medicine under colonial and post-colonial rule was not successful in meeting all the health care needs of the Zimbabwean African population due to technical inadequacies combined with residual inequalities in access, as well as lack of cultural explanations for illness. These are significant reasons why Zimbabwe's African population still turns to traditional medicine to fulfill its health care needs.
- (3) Rapid social change causes social dislocation, which directly influences health-seeking behaviour.

(4) Micro-level choices are made within the rubric of the possibilities and constraints of the social structure. They are not always made proactively, and people may not always make the seemingly most rational choice. Choices are also influenced by the individual's previous health-seeking experiences, as well as personal means, goals, desires and emotional states.

The above postulates suggest that health care choices are made at both the social and individual level. There are social factors such as colonialism, post-colonial politics and multi-cultural realities which influence the forms that traditional and western medicine take in Zimbabwe. At the individual level there are personal factors, such as previous health alternatives, that influence health-seeking behavior. Both social and individual factors combine to create a need for a multi-faceted health-seeking model.

In the conclusion, the article provides some suggestions on how to mitigate the problems encountered by older people in Zimbabwe in accessing health care and enhancing their quality of life.

Methodology

The study examined the health-seeking behaviour of older people living in rural and urban areas in Zimbabwe. The study examined, among other things, their preferred system for health care provision—i.e., self-treatment, modern medical care, and traditional care, and the reasons for their choices. The research questions were: "Who would you go to first if you had a swollen leg?" and "Why?" A swollen leg is a universally recognized symptom—one that is frequently attributed to witchcraft, although it is sometimes conceded that swollen legs can have a natural etiology.

The data came from interviews conducted with 540 women and 272 men over 60 years of age living in Harare (capital city) and Mutare (the country's fifth largest city), and villages up to 50km from these cities. There were 400 respondents in the urban and 412 in the rural areas.

In Harare, the interviews were carried out in four suburbs (townships). These are known as "high density" suburbs because there are many people who live in these areas as compared to "low density" suburbs which were once exclusively for Europeans before independence. The suburbs selected for the study were Mbare, which is the oldest African suburb, and is extremely overcrowded, has old houses and a large rural bus terminus through which over a million people pass each day; Highfield, is the second oldest suburb, but the first to have a homeownership scheme. Kambuzuma had the first exclusively African homeownership township scheme. Last, there is Rugare, a suburb that serves exclusively as a residential area for employees of the National Railways of Zimbabwe.

In Mutare, interviews were carried out in Sakubva. Like Mbare, it is the oldest suburb in Mutare and has a big rural bus terminal. Houses are old and overcrowded. Dangamvura township is similar to Highfield, while Marymount is the only suburb which was designated a white residential or low density area before independence.

The study also looked at six rural areas around Harare and Mutare. Around Harare, interviews were carried out in Goromonzi and Domboshawa communal lands. Around Mutare, interviews were carried out in Mutasa, Zimunya/ Dora, Chipenje communal lands, and Penhalonga, a small mining town near Mutare.

The interviews were carried out by unemployed school leavers from the cities of Harare and Mutare who were specifically trained for the task. They were assigned sections in both rural and urban areas, and told to interview every person over 60 years they encountered, but no more than two per house. (There was no sampling framework available from which to select respondents). A pre-test of the data collection instrument was carried out in a suburb in Harare and a communal area 45km outside Harare.

Definition of Terms:

Clinic: a place where specialised medical treatment or advice is given. The clinics in urban areas are run

by municipalities; in rural areas, by district councils. Nominal fees have traditionally been charged for treatment.

Hospital: an institution providing medical and nursing care for the sick or injured. No fees are charged at government hospitals for people who are destitute and earn less than Z\$150 (\$US15) a month. These include the disabled and the destitute elderly, among others. Fees are charged at mission hospitals which are run by faith-based organizations.

Private medical doctor: a person who is qualified to practice medicine in private offices. This is the most expensive health care option. Patients must buy their own medicines and are often charged consultation and treatment fees.

Home Remedies/Self-treatment: the use of home-made or over-the-counter medicines for the treatment of an illness or injury. This is one of the least expensive options that can be used. Sometimes this treatment requires no out-of-pocket expense if patients are knowledgeable about herbs and where to find them. Some money might be needed to buy over the-counter medicines.

Traditional healer/N'anga: a person who uses traditional beliefs and customs handed down from generation to generation in the treatment of ailments. Traditional healers are generally cheaper than the clinic, the hospital, or the private medical doctor.

Religion/Faith: faith or spiritual healing for persons who neither believe in traditional nor in modern medicine. No money is expected from the patients.

A profile of the sample

**Table 1: Profile of Respondents by urban and rural location.
(percent)**

Characteristics	Location		Total
	Urban	Rural	
Gender			
Male	35.3	31.8	33.5
Female	64.7	68.2	66.5
Age group			
60 - 64	36.2	21.4	28.8
65 - 74	45.3	50.0	47.7
75 - 84	14.0	20.1	17.0
85+	4.5	1.9	6.5
Education			
None / pre-primary	37.5	44.7	41.1
Primary	40.5	41.3	40.9
Full primary	17.3	12.1	14.7
Secondary 1 - 4	4.7	1.9	3.3
Higher	4.7	1.9	3.3
Marital Status			
Widowed-divorced	44.6	44.9	44.8
Married (monogamous)	13.7	1.5	7.6
Married (polygamous)	13.7	1.5	7.6
Number	400	412	812

Gender

About a third of the respondents were men and about two-thirds women. There were more men in urban than in rural areas. However, there were significantly more women in rural than in urban areas. This is probably due to the practice of men migrating to the cities as migrant workers.

There were more widows than widowers. Most widows in Zimbabwe have few resources and are less educated than men generally. Few policies are enacted in Zimbabwe to protect women, especially older women.

Age

Almost 29 percent of the respondents were younger than 65 years. The majority were in the 65 - 74 year age group, with the smallest percentage in the 85+ age group. However, in the future, the older age groups (75+ years) will expand more rapidly than the younger age group (60-74 years) Madzingira (1999:4). Women will be more numerous than men in each of these age groups.

Education

The majority of respondents had completed seven years of formal education. Rural elderly people and women are generally disadvantaged in terms of education. Rural older people were more likely to have less formal years of education than their urban counterparts. The results of this study are consistent with findings of other studies (Nyanguru, 1991; Adamchak et al (1990); Wilson et al (1990).

Marital status

The large majority of marriages were monogamous (84%). Among urban respondents, 33% reported having polygamous marriages, in contrast to almost none in rural settings. The reason for this is probably that a number of men co-habit in towns and cities, having left their wives behind in rural areas. They have what is termed "Mapoto (pots) marriage".

Economic status

Slightly more than three-fifths of the respondents 62.5% reported cash incomes lesser than the minimum wage of \$150. per month. 37.5% reported incomes greater than the minimum wage. Only 11.0% reported incomes which were more than \$300. per month. More rural than urban older people reported cash incomes less than the minimum wage at 71.8% and 53.1% respectively.

Almost 24% of the respondents were not economically active; 37% were engaged in agriculture—the majority of these live in rural areas. The majority of the respondents who were formally employed did manual work. A few (18%) worked at a trade; the majority of these respondents lived in towns. Most were women who sold vegetables and other wares at market places. Very few respondents worked at non-manual jobs (3%).

Satisfaction with Health

Respondents were asked to put themselves on a ladder from a smiling face at the top (Level 7) to a frowning face at the bottom (Level 1) in terms of factors such as their marriage, children, house, income and standard of living, as well as health. Most were able to do this, and proved relatively satisfied with their lives on most of the variables (mean 4 or above), mode 5-6).

Slightly more than a fifth of the sample (10.6%) were very dissatisfied with their health, with slightly more urban older people (11.3%) reporting this than their rural counterparts (9.9%). Approximately the same number of respondents from both rural and urban areas—about two-fifths—reported dissatisfaction with their health. There were insignificant differences by location.

Almost half (49.6%) of older people living in both rural and urban areas were satisfied with their health, with rural older people slightly more satisfied (51.2%) than their urban counterparts (48.0%). Only 6.4% of the sample were very satisfied with their health; more urban older people reported this (7.1%) than did their rural counterparts (5.1%).

Table 4: Satisfaction with health status by location

Level of Satisfaction	Urban	Rural	Total
1-2	11.3	9.9	10.6
3	11.1	11.2	11.1
4	22.1	22.6	22.3
5	26.6	35.2	30.9
6	21.4	16.0	18.7
7	7.5	5.1	6.4
Total	100.0	100.0	100.0
N	400	412	81

Findings and discussion

Table 2: Respondents' Choice of health care provider to treat a swollen leg by location (percent)

Health care Provider	Urban	Rural	Total
Clinic	21.6	39.0	30.3
Hospital	30.9	24.3	27.5
Doctor	29.8	11.4	20.6
Self-treatment	10.3	13.3	11.8
Religion	4.1	6.7	5.4
N'anga	3.3	5.4	4.4
Total	100.0	100.0	100.0
N	400	412	812

Use of clinics

Slightly less than a third, 30.3% of the respondents used the clinic as a health care provider. It is the most extensively used health care option. There were significant differences in the use of the clinic since twice as many older people in rural areas used it compared with their urban counterparts (39.0% and 21.6% respectively). This is probably because, since independence in 1980, the Zimbabwean government

under Robert Mugabe has made a concerted effort to change the society it inherited in the direction of socialism, while maintaining a pragmatic approach to avoid alienating the white population which played a major role in the economy (Nyanguru and Peil, 1991:607; Nyanguru and Peil, 1993). The new government embarked on a massive programme to provide health for all under the theme "Health for all by 2000." Many clinics were built in both rural and urban areas, with a general hospital as a referral

facility for every district in the country. Massive extensions were made to existing hospitals and other medical health care facilities. All people who earned less than Z\$ 150.00 were treated at no out-of-pocket cost at government hospitals.

The government also embarked on a massive programme of training and recruiting medical personnel. Nurses and doctors were trained locally and abroad. The government was successful in expanding the health system and other systems like education by providing services more widely than in the past. Improvements in health care touched the lives of most people; clinics helped to fulfill aspirations for a better quality and standard of life.

The reasons given for the extensive use of clinics by respondents were that they were accessible, affordable and available. Some older patients could walk to the clinics, others could be carried on bicycles or wheelbarrows by children, neighbours and other relatives. In rural areas some patients would use ox-drawn carts to get to clinics. Similar results were found by Le Beau (2003) in Namibia and Staugard (1986) in Botswana.

The clinic was affordable to many older people in both rural and urban areas. They were run by local authorities, municipalities in urban areas and district councils in rural areas. Fees were charged at these facilities, but the fees were as moderate as those charged at government hospitals or by private medical doctors.

The most frequent users of the clinic were older people living in Mbare in Harare and Sakubva in Mutare. These are the oldest African suburbs in the two cities under study, and have many poor families living in unsanitary, crowded conditions. Many studies have shown the abject poverty of the population, and especially of older people, living in these suburbs (Muchena, 1978), Hampson (1993).

Respondents who chose the clinic as the first option for a health care provider mentioned the immediate attention they got from people who were professionals, who were familiar with all diseases that afflict man. From previous experience, they

mentioned that the service was good and there was a good referral system in the event of any complications. They also believed that the drugs administered were strong. For example, Simon, a 95 year old male ex-trader who lived in Kambuzuma in Harare stated that:

The clinic is smart and the medicine is germ-free. Nurses at the clinic are experienced, and if they find out that the illness is serious they get an ambulance to take you to the nearest hospital where there are qualified medical doctors.

Matilda, a 68 year old former female labourer now turned fish trader who lived in Danganvura, Mutare said:

At the clinic, I get an injection and the nurses know how to cure patients patiently. They know all kinds of diseases and illnesses and one receives immediate treatment. I will never visit a n'anga because they cheat.

Richard, an 84-year old ex-domestic worker who was a returnee migrant and lived in the Mutasa communal area showed his previous healthseeking behaviour, personal means and emotions when he retorted:

Nurses at the clinic do not discriminate against us old people. They do not charge any money for treating poor and old people. Again, everyone here goes to the clinic.

Use of hospitals

The hospital was the second most utilised health care system by older people in Zimbabwe. Slightly more than a fifth (27.5%) of the respondents reported that they used the hospital as their first choice when they were ill. The hospital was the most utilized health care system by urban older people at 30.9%. It was used by slightly less than one-fifth (24.2%), of their rural counterparts.

The reason for this utilisation could have been because of policies enacted by both colonial and post colonial governments, inequalities in access and previous individual health-seeking experiences.

Hospitals were also accessible, available and affordable. Hospitals were built in the rural areas and major extensions to existing hospitals were constructed in both rural and urban areas to expand delivery. Again, the unemployed, disabled and all destitute older people 60 years and older who earned less than Z\$150.00 were treated at no out-of-pocket charge in all government hospitals.

The reasons given for the use of a hospital as a health care provider were similar to those given for the use of a clinic or a medical doctor. Most trusted the knowledge of both doctors and nurses. The environment in a hospital was said to be "smart", and, powerful drugs were used to treat patients. Free treatment was also given as a reason for choosing the hospital as the first option for treatment.

However, the referral system from the clinic to a government hospital could also disadvantage poor older people in that some government hospitals were far from the homes of older patients. Further, one could not be treated at a government hospital without a referral letter from a local clinic. Some older people, through ignorance and the desire to be treated free of charge, would visit a government hospital without a referral letter, and then be turned away. A number of older people were referred to a hospital from a clinic, but could not afford the transport costs.

Use of private medical doctors

A fifth of the respondents in the sample (20.6%) used a private medical doctor as their first health care option. Approximately three urban older persons for every one rural older person used this option. Private medical doctors are more expensive than any other form of health care provision, although they are said to provide the best service among all the other options. Urban older people were more likely to use this option because they have more resources to use on medical care than their rural counterparts. Before and especially after independence, many African doctors opened surgeries in the high density suburbs targeting black clients. These health facilities are open during evenings, over weekends and on public holidays. Other health facilities, like clinics, close at 5.00pm,

over weekends and on public holidays. Private medical doctors assure their patients of confidentiality, and a personal relationship can grow between the health practitioner and the patient. In spite of high transport costs and medical fees, 11.3% of the rural older people used private medical doctors. This is because private medical doctors are thought to be professionally trained and provide a quick and reliable service.

Some respondents made private medical doctors their first choice of a health care provider because of the trust they had in their professional knowledge of illnesses. Private medical doctors were also said to use powerful drugs which healed illness fast. Many reported that they used a private medical doctor because they did not trust n'angas who, they said, were cheats and demanded high medical fees for nothing. Some respondents reported they used a private medical doctor because they were Christians. Maria, a 75 year old female trader from Rugare in Harare had this to say about medical doctors:

Medical doctors have more knowledge of diseases than n'angas. N'angas only bribe us out of our money. I do not trust them. Doctors on the other hand, use powerful drugs and patients are healed fast. Last year I was taken to a doctor and I was healed for the first time in the whole of my life.

Dorcas, a widow, 77 years of age and lives in Kambuzuma, Harare said:

I am a Christian. My husband was a priest in the Salvation Army. I do not visit a n'anga but a medical doctor. N'angas are cheats and some of them practice witchcraft.

Use of home remedies/self-treatment

The use of home remedies or self-treatment was the next most utilized form of health care provision employed by respondents after private physicians. Slightly more than a tenth of the respondents (11.8%) used self-treatment or home remedies. More rural (13.3%) than urban respondents (10.3%) used this option, perhaps because there are fewer affordable medical care options available in rural than in urban

areas. Respondents living in urban areas, who generally have more money to spend on medical care, can avail themselves of a broader array of health care provision, such as private doctors, hospitals and clinics. As in many developing countries, health and other social services, like education, are more likely to be found in urban areas. Because of poverty, for a number of urban older people living in poor, overcrowded 'high density' suburbs such as Mbare, in Harare and Sakubva in Mutare, and rural older people living in remote, poor villages, such as Domboshawa in Harare and Mutasa in Mutare, self-treatment is a viable option. Neighbours, relatives and friends come together in solidarity and mutual help for their own survival. They share any medication and medical knowledge among themselves, with the result that they use the other health care providers less often.

Self-treatment was used by about 6.7% of the sample because it was affordable and available. There was also an element of trust. Some reported that they knew of many clinically-useful herbs, and the knowledge of these herbs was handed down to them by their ancestors. Nyanguru (2005) in a recent study in Lesotho found a similar use of home remedies by older women caregivers of family members affected by HIV/AIDS. Like in the Zimbabwe study, they used some of the same herbs; some of their knowledge had been handed down to them by their forefathers.

Peter was a 70 year old black man with little formal education, who was a former tailor. He lived in Domboshawa, a rural area outside Harare. He had this to say about self-treatment:

I believe in African "muti" medicine, like our ancestors used to do long ago. I know the medicines and they are easily available in the bush. They are strong and powerful. At times, my ancestors showed me the medicine to use for a particular disease in my dreams. I don't waste money to visit a doctor, a hospital, a clinic or a n'ganga.

Another respondent who used self-treatment or home remedies was a 120-year old woman who lived alone in Sakubva high density suburb; all her

relatives had died except a married great-granddaughter. During fieldwork for this study she had appeared in the Manica Post, a local newspaper in Mutare. 'Mbuya' (grandmother) Mattie reported:

"I use "muti" for treatment. I know a number of traditional herbs from childhood. I am always happy when I am around my house and I borrow nothing from nobody. The only problem I have is that of the children next door who threaten my life with their noise."

Use of religion

Chavunduka (1994: 5) argues that missionary colonization has also negatively affected traditional medical practices because missionaries considered these practices pagan. In colonial Africa, health care was usually in the hands of missionaries, who offered competing ideologies. Local inhabitants were encouraged to attend school to learn to read the Bible, to go to church to save their souls, and to go to hospitals to save their bodies. Missionaries opposed the practices of possession and mediums because they thought such things were the work of one possessed by evil spirits (Firth, 1969).

In many southern African countries many churches broke away from missions and offered spiritual healing that was consistent with traditional ideologies as part of their ministries (West, 1975); DillonMalone 1988:1060 and Chavunduka (1994:5). The advent of indigenous churches has also had an effect on the traditional religio-medical complex in Southern Africa (Cavender, 1994: 5). Although some indigenous churches denounced traditional healers as "demonic", some healers incorporated Christian aspects of healing into their ceremonies, while spirit possession churches bear a striking resemblance to traditional ancestor spirit possession. Both Christianity and traditional religions are based on the Creator as overall protector, the maintenance of moral purity, and the belief in life after death (Mutambirwa, 1989:929). These similarities in religious paradigms have led some Christians to integrate traditional with Christian ideologies. In Zimbabwe, this has led to the birth of such indigenous churches as the Apostolic Faith, Zion, John Marange and WapusaWapusa.

Religion was the second least form of health care provision used by respondents (5.5%). More rural (6.7%) than urban older people (4.1%) used this health care option. People who used faith healing used neither modern nor traditional medicine. Instead, they use "holy water," which has been blessed by "prophets." They simply pray for the sick to get well.

Faith healing was used most in Highfield in Harare and Danganvura in Mutare. The reason is not so apparent, but it could be because the two suburbs were the first home ownership schemes for Africans. They allowed the blacks to build their own churches, and these broke away from the mainstream churches such as the Roman Catholic and Anglican churches.

Among rural respondents, Zimunya/ Dora in Mutare had the biggest percentage of respondents who used religion as a health care option. These people belonged to the John Marange (Masowe) religious sect founded by a man of the same name. Most reported that the system could be trusted and was free.

Mischek, a 60 year old trader who lived in Highfield, Harare, said:

"I believe in God and as a member of the Apostolic Faith Religious Sect, I do not go to clinics, hospitals, doctors or n'angas. I go to "prophets" who would pray for me until I am healed. I do not trust clinics, hospitals, doctors or n'angas".

Use of traditional healers/n'anga

A surprising result from the study was that the traditional healer or n'anga was the least utilized health care provider by respondents. Only 4.4% of the whole sample used this health care system, with slightly more rural than urban respondents using this option at 5.4% and 3.3% respectively. It was expected that older people would use the traditional healer more as a health care system because it is usually cheaper than other options and does not involve such extra expenses like consultation fees and transport. Most traditional healers live within walking distances from their patients and do not

charge consultation fees. Some even expect payment for their services when the patient has been healed, while others can accept payment in-kind, such as chickens or grain. Traditional healers are also found in urban areas and are very active in healing people with different ailments.

Le Beau (2003) also observed the use of traditional healers by urban dwellers in her study on health-seeking behaviour in Katutura Township, Windhoek in Namibia. In Botswana, a 1986 survey found that the majority of people used western health care, while two-thirds of the rural and one-third of the urban population had been to a traditional healer (Staugard, 1986:61-61). People in urban areas tended to use different types of traditional healers with about equal frequency. Data from this research indicated that users of traditional medicine were older, male, uneducated and poor. In South Africa, Legar (1993) in a study in Ciskei found that people had several types of health care facilities, private western doctors, and various traditional healers available to them.

Twenty-percent of those interviewed in the hospital said that family members had used traditional healers. They tended to visit both types of healers for the same illness, and traditional healers have been known to visit the local hospital wards when one of their patients is admitted.

One South African study found that 65% of illnesses brought to traditional healers were either psychological or psychosomatic (Hirst, 1990: 72). An earlier study noted a high prevalence of socialpsychological illnesses in the Zulu population (Lee, 1969: 134).

Research by Slikkerveer (1982) and Dillon-Malone (1988) indicate that rates for the utilisation of traditional healers, especially spirit mediums, have been increasing in the urban areas of many southern African countries. This has been attributed, in part, to urban dwellers' failure to uphold traditional values and perform necessary rituals to the ancestors, as well as suspicion of neighbours with whom they find themselves in close proximity and competition. Le Beau (2002) observed that urban patients in Namibia

seek traditional medicine for a range of social/spiritual etiologies, many of which are due to rapid social change and the experience of new and threatening situations.

How people attempt to deal with their new and threatening life experiences varies considerably. Social/spiritual explanations (such as witchcraft accusations, ancestor dissatisfaction, and the breaking of cultural taboos) are familiar explanations for social disruption and become important components for managing change and disequilibrium. Thomas (1991) points out in his study of seventeenth century Europe that the high incidence of witchcraft accusations was associated with rapid social change. In contemporary Africa, the most frequently given reason for the increased use of traditional healers in urban areas is the high prevalence of witchcraft accusations due to a breakdown in social relations or increased competition and jealousy (Dillon-Malone, 1988; Slikkerveer, 1982; Staugard, (1986). Traditional beliefs and behaviors are used in post-colonial Africa ..."especially in the efforts of people to empower themselves, thus asserting a measure of control over worlds often perceived to be rapidly changing" (Camaroff and Camaroff, 1993;xiv) .

Generally, the respondents who used a n'anga or traditional healer as the first option among the different health care providers mentioned that they trusted n'angas, and they had benefited from their healing expertise over the years. Traditional healers had spiritual powers, treated illness fast, used powerful medicines, and knew how to treat illnesses which medical doctors could not. They could also tell a patient the cause of his/her illness.

Violet, an 80 year old ex-female domestic worker who lived in Mbare in Harare, had this to say about the use of the services of a n'anga or traditional healer:

Our forefathers used medicine from n'angas and I follow what my ancestors did. N'angas have spiritual powers. They diagnose any illness quickly and they can tell you the cause of the illness. I trust them very much and they do not charge exorbitant fees like medical doctors do.

Martin, a 65 year old former social welfare officer at a mine and living in Penhalonga near Mutare said:

N'angas can treat diseases which 'modern' medical doctors cannot. I was very sick four years ago and I went to a medical doctor. He failed to cure me. I was cured only when I visited a n'anga. I trust the powerful herbs they prescribe and I strongly believe that they help.

In Zimbabwe, utilisation of traditional healers differs between urban and rural areas. Current utilization patterns in urban areas are guided to some extent by the Zimbabwe National Traditional Healers Association (ZINATHA) (Le Beau (2003). The organisation has published a report which outlines illnesses that are best treated by traditional medicine and those that should be summarily referred to western medical facilities. In Zimbabwe, researchers are studying the pharmacopoeia of traditional herbal medicines, the utilisation of traditional healers for AIDS information dissemination and for the relief of symptoms, as well as the role traditional medicine plays in the provision of primary health care (Gelfand, 1985; ZINATHA, 1993). The four health care areas in which traditional medicine has been found effective in Zimbabwe, as well as in other Southern African countries are mental health, obstetrics and gynecology, childhood illnesses, and general health practices (Chavunduka, 1994:19).

A collapsing health system

This article tries to argue that health care choices are made at both the social and individual level. There were social factors, such as colonialism, post-colonial politics, and multi-cultural realities, which influenced the forms that traditional and western medicine took in Zimbabwe. At the individual level there were personal factors, such as previous health-seeking behaviour and access to health care alternatives that influenced current health-seeking behaviour. Both social and individual factors combined to create a need for a multi-faceted health-seeking model.

However, gains in health care delivery to the citizens of Zimbabwe, especially the elderly, have been eroded because of a number of policies which were

instituted or adopted by the Government of Zimbabwe. These were: the introduction of structural adjustment programmes in the early nineties; the introduction of the land reform at the beginning of the millennium; and President Robert Mugabe's recent Project Murambatsvina (Shona for "Clean Up Trash Campaign." The structural adjustment programmes led to lay-offs in the formal labour force, especially in the civil service, as well as the imposition of fees for all services, including health and education which had been free. This affected older people who were the first to be laid off and who could not afford to pay for essential services such as health care. Accessibility, affordability and availability of health care from clinics changed for the worse.

The land reform programme also displaced many people in both rural and urban areas—perhaps as many as 800,000 since 2000 (Steinitz, 2005). Some people were forced to migrate to rural areas (Nyanguru, 2005). This movement might have affected their proximity to clinics and other health care facilities.

Project Murambatsvina also forcibly moved people from urban areas into rural areas. This exercise has, according to Steinitz (2005), displaced 700,000 people from their homes. Their health care protection has largely disappeared because there are no medical care facilities in the transit camps outside the main cities to which they were forced to move.

The combination of these measures together with the economic problems being experienced in Zimbabwe today has resulted in the collapse of the health care system. Many health care professionals left the country for greener pastures in South Africa, Britain, Canada, and other countries. Many destitute and poor people, like the elderly, are now forced to pay for their health care. Even if the consultation is free, older patients still have to buy the drugs on the open market since government pharmacies no longer have such drugs. And even if older patients had the money to utilise health care facilities, they may not be able to get to them because the public transport system has also collapsed because of acute fuel shortages.

Policy Implications:

Research indicates that older people make up a significant proportion of the poorest of the poor, and even without the added threats created by HIV/AIDS, many older people struggle to survive and suffer from poverty, social exclusion and age discrimination. In most countries of Africa and Asia, older people have few forms of support outside their families.

Health consistently ranks alongside material security as a priority concern for older people. Older people's poverty often manifests itself in poor quality housing and living conditions, which impact on their health, and that of those living with them. Older people's health may be further compromised by increased responsibilities in caring and providing for others, as they often forgo food and medicine for other members of the household, while continuing to undertake many additional tasks and responsibilities to try to make ends meet.

Despite its importance, health care remains unaffordable to some older people. Hospitals tend to be concentrated in urban areas, far from the rural areas where the majority of older people live. Older~people cannot afford to pay for transport to reach health services, let alone the medical fees. Even where hospitals are available there is no trained medical staff and or medicine. Social protection in the form of a low level of income guarantee would go a long way to offset the additional financial burdens associated with accessing medical care.

The government of Zimbabwe should consider non-contributory pensions (social pensions) for older people. Older people often form a large proportion of the very poor in a country. For example, in South Africa, non-contributory pensions programs reach a large number of poor older people (1.9 million) at relatively low cost (1.4% of GDP).

In recent study in Lesotho, Nyanguru (2005) found that the impact of the recently introduced non-contributory old age pension (November, 2004) for all older persons 70 years old and above had a significant impact on reducing poverty and

vulnerability among households with older people. As in South Africa, the pension reaches a large number of poor older people (69,046) in a country with a population of 2.2. million people, and at a relatively low cost (1.3% of GDP). Pensions can assist older people to pay for their health care. The money will enable older people to choose a health care provider from a larger number of options than are presently available.

Evidence from this study suggests that many poor older people cannot access medical care because they cannot afford to pay for it. If older people are helped to engage in income-generating activities they can earn money to pay for their own health care. Older people could be offered credit to enable them to start income-generating activities. At present, their low socio-economic status and lack of collateral at their disposal work against their obtaining loans from financial institutions to start their own businesses. Experience from some countries has shown that older people, especially older women, are creditworthy; they do not default on repayments.

A specific project related to both income generation and health care in which older people could be involved is the growing, processing and packaging of proven traditional medicines. Because of modernization. The government of Zimbabwe should consider non-contributory pensions (social pensions) for older people. Older people often form a large proportion of the very poor in a country. For example, in South Africa, non-contributory pensions programmes reach a large number of poor older people (1.9 million) at relatively low cost (1.4% of GDP).

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A specific project related to both income generation and health care in which older people could be involved is the growing, processing and packaging of proven traditional medicines. Because of modernization, industrialization and the degradation of the environment, a number of proven traditional medicines are no longer easily available in the forests. Older people could grow these for own use and sale.

The government of Zimbabwe could also introduce mobile clinics and "flying doctors" to reach out to remote rural communities where the majority of older people live. These units can perform simple operations like the removal of cataracts in older people.

There has been massive "brain drain" of professional medical personnel from Zimbabwe in recent years. Most medical doctors have emigrated to South Africa and nurses to Britain. The government should without delay enact policies to retain its professional medical personnel. There could also be the need to train more village health workers who live with people in the villages.

The Government of Zimbabwe and the Zimbabwe National Traditional Healers Association

(ZINATHA) should be commended for their efforts to integrate the traditional with the modern Western health care systems. More needs to be done. Currently, traditional medicine is seen as inferior to Western medicine, and is associated with witchcraft. Traditional health care has been found to play a positive role in primary health care, mental health, obstetrics and gynecology, child illness, and general health practice. More research should be directed to how Western medicine and traditional medicine could collaborate successfully, and even learn from one another. Medical doctors could learn when to refer patients to traditional healers, and vice versa. Studies carried out by Hirst (1999) and Lee (1969), for example, showed that traditional healers tended to see patients with psychological and psychosomatic illnesses.

We might even see the establishment of departments of traditional medicine in district hospitals, manned by traditional healers. By so doing, we will have combined both social and individual factors to create a multi-faceted health-seeking model. One would agree with Le Beau(2003) when she argues that the Western paradigm, by not recognising and treating illnesses with social/spiritual etiologies, left a gap that traditional medicine continues to fill.

Last, it is suggested that the Government of Zimbabwe should urgently address the political, economic, social and administrative problems facing the country in order to be able, once again, to offer quality health care to all its citizens, including its seniors.

References

- Adamchak, D. Nyanguru A. C. Hampson, J and Wilson, A (1990). "Elderly Support and Intergenerational Transform in Zimbabwe: an analysis by Gender, Marital Status and Place of Residence." *Gerontologist*, Vol., 31 (4): 505-513.
- Bourdillon, M. (1976) *The Shona People*. Gweru: Mambo Press.
- Cavender, A, (1991) "Traditional medicine and an Inclusive model of health-seeking behaviour in Zimbabwe" *Central African Journal of Medicine*, Vol. 37, No. 11, p. 362-368.
- Chavunduka, M. (1994). *Traditional Medicine in Modern Zimbabwe*, Harare, University of Zimbabwe.
- Comaroff, J and Comaroff, J (1993). *Modernity and its Malcontents: Ritual and Power in Post-colonial Africa*. Chicago, University of Chicago Press.
- Dillon-Malone, C. "Matumwa Nchimi Healers and Wizardry Beliefs in Zambia" *Social Science and Medicine*, Vol 26 (11): p. 1159-72.
- Ewing D. (1999). "Gender and ageing" in "The Ageing and development of the World's older People" *Helpage International*, London, Earthscan, p. 33-35.
- Firth, R. (1969) Forward, in Beattie, I and Middleton, J (eds) *Spirit mediumship and society in South Africa*, London: Routledge and Kegan Paul.
- Gelfand, M (1985) *The Traditional Medical Practitioner in Zimbabwe*, Harare, Mambo press.
- Hampson, J (1982). *Old Age: A Study of Ageing in Zimbabwe*. Gweru: Mambo Press.
- Hampson, J (1985). "Elderly People and Social Welfare in Zimbabwe", *Ageing and Society*, 5 (2): 39-67.
- Helpage International/DFID Project (2003) "Pensions and Poverty Prevention" 2003.

- Hirst, M.M. (1990). *The Healers Art: Cape Nguni Diviners in the Township of Grahamstown*, (Unpublished PHD dissertation, Rhodes University)
- Kalache, A and Sen. K. (1990). "Ageing and Health" in: "The Ageing and Development Report: Poverty, Independence for the World's Older People", *Helpage International*, Earthscan, p. 59-70.
- Kumar, V. (1994). *Public Health Implications of ageing in India*, ICMR, New Delhi, India.
- Le Beau, B. (2002). "Is Witchcraft Real? The Role of perception in Health-seeking Behaviour" (eds) Le Beau, D. and Goron, R, In: *Challenge for Renaissance: A Southern African Contribution*, University of Namibia, No. 1.
- Le Beau, D. (2003). *Dealing with Disorder: traditional and western medicine in Katutura (Namibia)*, University of Namibia, Rudeger Koppe Veelag Koln.
- Macleod, R. (1988) "Introduction", in Roy, Africa, 6 (2) 71 - 89.
- Macleod, R. (1988). "Introduction" in Roy, M. and Lewis, M. (eds), *Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, London.
- Madzingira, N. (1999). "Population ageing Zimbabwe: levels, patterns, and trends," *Southern African Journal of Gerontology*, Vol, 8 (1): 4-8.
- Muchena, O. (1978) *African aged in Town*, School of Social Work, Harare, Zimbabwe.
- Mutambirwa, A. (1989) "Health problems of Rural Communities in Zimbabwe", *Social Science and Medicine*, Vo. 29, No. 8, p. 927-932.
- Neumann, A. and Laura, P. (1982). "Ethno medicine and Biomedicine Linking" *Social Science and Medicine*, Vol. 16p. 1817-24.
- Nyanguru, A. C. (1990). "The quality of life of the Elderly living in Institutions and Homes in Zimbabwe," *Journal of Social Development in Africa*, 5 (2): 25-43.
- Nyanguru, A.C. (1991). "The Health Problems of the Elderly Living in Institutions and Homes in Zimbabwe," *Journal of Social Development in Africa*.
- Nyanguru, A. C. and Peil, M. (1991) "Zimbabwe since independence: A people's assessment," *African Affairs*, 90, 607-620.
- Nyanguru, A. C. (2005) "Elderly Women as Caregivers to Relatives affected by HIV/AIDS in Urban Lesotho," in *Gender, Generations and Urban Living in Southern Africa*. (Forthcoming)
- Nyanguru, A.C. and Peil, M. (1993). "Housing and the Elderly in Zimbabwe," *Southern African Journal of Gerontology* . 2(1): 3-9.
- Nyanguru, A.C. (1993). "The Impact of Changing Family Structures on the levels of Older Persons in Africa," Paper presented at the *Helpage International Regional Workshop*, Harare, Zimbabwe, 11 - 13 September, 2000.
- Nyanguru, A.C. (2005) "The Rights of the Elderly in Lesotho" *Journal For Social Development in Africa*, vol. 20 (Forthcoming) June, 2005.
- Nyanguru, A.C. (2005) "The Impact of the Old Age Pension in Lesotho," An Unpublished Preliminary UNICEF Report, London, U.K.
- Nyanguru, A.C. (2005) "Migration and ageing: The case of Zimbabwe" *Journal of Aging and Social Policy*, (forthcoming)
- Shah, B. (1994). *Ageing in India* ICMR New Delhi, India.
- Staugard, F. (1986). "Traditional Health Care in Botswana," in: Last, M and Chavunduka, G.L. (eds) *The Professionalization of African Medicine*, Manchester University Press.

- Segar, J (1993) "The Pursuit of Health in a Ciskean village, in from Reserve to Region: Apartheid and change in the Keiskammahoeck District of Ciskei 1950-1990: Pretoria: Human Research Council.
- Steintz, L.Y. (2005) "Eyewitness in Zimbabwe" July 31 - August, 4, 2005.
- Thomas, K. (1991). Religion and the Decline of Magic, London: Penguin Books.
- Vaughan, M. (1991). Curing their ills: Colonial Power and African
Illness, New York: Cambridge University Press.
- Wallace, M. (1997). Health and Society in Windhoek 1915-1945:8 (Unpublished PHD thesis, University of London).
- West, M. (1975) "Bishops and Prophets in a Black City: African Independent Churches in Soweto" Johannesburg, Cape Town, David Philip.
- Wilson, A. Nyanguru, A. Hampson, J. and Adamchak, D. (1990). "A study of well-being in Three Communities in Zimbabwe," Age and Ageing, Vol. 20:274-79.
- World Health Organisation (WHO) . (1978) . "The Promotion and Development of Traditional Medicine" Technical Report Series 622, Geneva, WHO.
- World Health Organisation (WHO). 15k98b). "World Health Report, WHO Geneva.
- Zimbabwe National Traditional Healers Association (ZINATHA) (1993) Cultural Behavioural Change to Fight AIDS, Zinatha, Harare.

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WATER, SANITATION AND THE AGEING IN NIGERIA

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INTRODUCTION

The issue of safe water and sanitation is of concern to the United Nations. This led to making this an important issue to be tackled by the commission via the Millennium Development Goals declaration which intends to reduce the number of people without access to safe water and sanitation facilities. According to UNFPA (2007), "The Millennium Declaration target is to halve the proportion of people without access to safe drinking water and basic sanitation by 2015. It is estimated that more than one billion people lack clean water and more than 2.5 billion live without adequate sanitation. Many countries facing water scarcity are low - income societies with rapidly growing populations that are generally unable to make costly investments in water - saving technologies. Providing safe drinking water becomes a greater challenge as economic development and population growth place increasing demands on limited water resources." Nigeria, although a leading producer of crude oil, is a low income country considering the per capita income level due to the ever increasing population associated with high growth rate. So, drawing inference from the above quotation, the country is finding it difficult to make remarkable investments in the provision of safe water.

Nigeria's ageing population is on the increase. This is in line with the world population estimates / projections. "The world's population is not only growing larger, it is also becoming older. Population ageing is an inevitable consequence of fertility decline, especially if it is combined with increases in life expectancy. The proportion of older persons is increasing at a faster rate than any other age segment. In developed countries, the proportion of older people already exceeds that of children. In developing countries, the growth of the older

population is occurring more rapidly due to the faster pace of fertility decline that has resulted from the success of reproductive health and family planning programmes" (UNFPA, 2007).

NIGERIA'S AGEING POPULATION

The result of the 2006 Population and Housing census indicates that over one hundred and forty million people were living within the boundaries of the nation as at March, 2006. More than fifty percent of this figure lives in the rural areas leaving the balance to live in urban and semi - urban settlements. The ageing population is higher in the rural areas because of low literacy level which has confined the people to the area right from the time they were born. As they were growing, they were engaged in farming and artisanship for survival. Their lack of education does not support them for city life although some of them do migrate to the urban centres as a sequel to the insistence of their children. Where this happens, they often find the urban centres not suitable for them hence making a return trip to the villages where they believe that they actually belong.

In most of Nigeria's urban centres, socio - economic indicators are lacking. The situation is worse in the rural areas because governments at various levels - Federal, state and local - do not have enough attention for the urban centres and still less for the rural areas. The level of government that is supposed to take care of the rural areas local government - is not playing its statutory roles satisfactorily due largely to paucity of funds and corruption.

The table below illustrates the demographic estimates / projections of population aged 65 years and above between the year 2000 and 2020.

Year	Population (65 years and above)			Percentage
	Male	Female	Total	
2000	1,701,983	1,539,625	3,241,608	2.8
2005	1,902,033	1,726,671	3,628,704	2.7
2010	2,264,287	2,096,605	4,360,892	2.7
2015	2,743,560	2,640,583	5,384,143	3.0
2020	3,370,142	3,140,484	6,150,626	3.3

STATE OF SAFE WATER AND SANITATION

One may need to ask the question: "What does the government have in stock for the ageing population in the area of provision of socio - economic facilities, most especially, safe water and sanitation? Ramashala (2000) states that "while the rapidly increasing numbers of older people throughout the world represent a biological success for humanity, the living conditions of the elderly in most countries have, largely, lagged behind those enjoyed by the economically active population". The living condition of the elderly in Nigeria is pitiable. These people lack almost everything ranging from good housing to good medical / health care, nutrition, social security, safe water and safe sanitation.

How does one explain the situation where an elderly person has to trek some metres or even kilometers to fetch a bucket of water? And what is the quality of the water that is available? By United Nations standard, access to safe water supply is the availability of at least 20 litres per person per day of improved water supply from a source within 250 metres of user's dwelling. Access to safe sanitation can be defined as the availability of improved disposal facilities of human wastes that can effectively prevent human, animal and insect contact with the human wastes. Although some promoters like government, NGOs, communities and donors do strive to provide safe water via sinking of boreholes (hand pump or motorized), digging of wells, etc. people in the rural areas often rely on natural sources like rivers, streams and ponds. These are unprotected sources which encourage the spread

of water related / borne diseases which affect the elderly greatly due to the level of body immunity to fight against these diseases. Again, the economic power is equally lacking. The current situation of safe water and sanitation in Nigeria led the nation's Senate President to make this statement on the occasion of the nation's 47 years independence celebration that "It is an embarrassment that after 47 years of independence, we cannot provide adequate water for the people of Nigeria". This is a statement from an urban resident. What then is the experience of the rural dwellers where most of the ageing population belongs? The answer is better imagined.

Despite the fact that there are many surface water sources in Nigeria, Nigerians suffer poor access to safe water still. According to Adeloje (2007), "although there seems to be a rise in budget provisions year after year, the lack of prioritization and awareness still remains a problem. For 2007, the sum of 422 billion was allocated to water. This is an improvement over 417 billion allocated in 2006. Between 2002 and 2005, allocations only reached 410 billion. Some three years ago, debt servicing was cited as the factors behind this. But with the virtual liquidation of Nigerian debts, improve funding is expected for the water sector".

The writer of this report was involved in a survey titled "National water supply and sanitation baseline survey" in 2006 / 2007. This survey, which was coordinated by the Federal Ministry of Water Resources, was to document the proportion of Nigerians that have access to safe water and

sanitation facilities. The survey cut across both the urban and rural areas. Although the findings have not been made known, empirical observation makes it explicit that the water situation in Nigeria in general and rural areas in particular is worrisome. A total of thirteen water related diseases were listed. The diseases were malaria, diarrhea, dysentery, typhoid, guinea worm, ring worm, scabies, cholera, trachoma, Hepatitis B., streptococci, onchocerciasis and schistosomiasis. The concern, therefore, is for the ageing who are struggling to survive when they are supposed to be 'resting'.

ANY SOLUTION IN SIGHT?

As confirmed by Adeloje (2007), "the Federal Government of Nigeria has received a credit from the World Bank towards implementing the National Urban Water Sector Reform Project. The project is one of the Millennium Development Goals. The project consists of four complementary components namely:

1. Water supply systems rehabilitation and expansion
2. Public - private partnership development
3. Capacity building and project management
4. Policy reform and institutional development

The Federal government is not alone in this; as the Federal government battles the massive problems, achieving the MDGs of halving the proportions of people without access to safe water and sanitation before 2015. Non-governmental organizations, which appeared to have sensed frustration on the government's part, have virtually taken up the challenge. This corroborates field observations in respect of water supply and sanitation baseline survey. The NGOs, communities and donors are collaborating with the government at all levels to provide safe water for the people. Even in the rural areas, community members are given some technical training to handle some of the technical faults of the facilities (where available). But it is interesting to note that most of the boreholes drilled in the rural areas dried up soon after commissioning due to lack

of supervision when they were being constructed or due to corrupt practices of the officials and contractors. The ageing bear the brunt of all these inadequacies /shortcomings. Many of the ageing are dependent on neighbours for support in most cases to get water for their use daily as their children are not with them in the rural areas (they are either attending schools or working in the towns). Although, they sometimes go to the villages to see their parents, such visits often terminate on the same day except during festive periods!

Adeloje (2007) stated further that the scenario playing itself out in the past two decades in Nigeria has been one where non - governmental organisations appeared to have taken up the principal responsibilities of the government in the area of water provision in Nigeria...multi lateral agencies, like the World Bank, among others, have also been noted to play significant roles, while the government and its agencies seemed to have made blame trading as their major hallmark. Recently, it was made known that the African Development Bank had approved \$79.4 million loan facility for water projects in some states to increase access to water to 100% by year 2015.

In Nigeria, how is the ageing population enjoying the last lap of their sojourn on earth? According to Help Age International (2002), "people around the world are living longer. But in developing countries and countries with economies in transition, living longer can too often lead to severe reduction in quality of life, due to a lifetime of poverty, illness, discrimination and neglect". This statement absolutely summarizes the experience of the ageing in Nigeria in the areas of provision of social and economic amenities, most especially, safe water and sanitation. It seems as if the older they grow in Nigeria, the lower the quality of life for the majority who can not afford good life on their own but depend on what the government provides.

DEMOGRAPHIC IMPLICATION

The health implication of lack of adequate care for the elderly in the society is enormous. At a certain age, there are lots of terminal diseases affecting the ageing population in Nigeria. Some of these are

induced by what these people take in as food and water, and the environment in which they live.

In Nigeria, life expectancy at birth which was 53.2 years in 1991 (53.8 years for females and 52.6 years for males), has declined to 43.9 years for females and 43.6 years for males in recent times (UNFPA, 2005). This is due to the level of poverty in the land which has direct relationship with the quality of life of the people. In essence, lack of safe / potable water for the populace in general, and the elderly in particular, has in no small way affected the life expectancy of the people. One can imagine a situation where villagers and cattle share water from the same source despite the fact that the villagers lack access to basic health care! Even in the urban, where piped water is available, most of the pipes are old and do burst very often. People still see the water from such sources as "precious" because it is a rare opportunity. As the water flows from the treatment plants, it is polluted along its course as a result of the openings in the pipes.

Agricultural practice is highly affected because the elderly are the ones left behind in the villages to produce the food to feed the rest of the population. Their death, therefore, has a multiplier effect on food production production. Lack of sufficient food leads to inflation and this, in turn, reduces the quality of life of the people.

The high death rate of the elderly will continue to have a negative effect on the fertility level thus making the population to remain a young population. A young population will increase the population further and encourage out - migration of the youth, thereby putting the future of the nation at risk.

CONCLUSION

One major problem with this report is non - availability of data on water related diseases as they affect the ageing class. The report is based on empirical observation backed only with some photographs taken on the field to support the findings.

Apart from other causes of death which are linked to the ageing process, safe water and sanitation are not expected to counter the death of the ageing via

water related / borne diseases. In Nigeria, the ageing have got enough neglect by the government, the communities and their neighbours. The economic situation in Nigeria has led to some sort of rejection of the ageing even by their children who are either unemployed or whose take home pay is not enough for their own upkeep, let alone of maintaining the ageing ones. With the HIV/AIDS prevalence rate of about 5% which affects mostly the youth population aged between 20 - 29 years, the aged are at the receiving end because they take care of the infected people and even their children (where available) with their meagre resources from farming, petty trading or other menial jobs. "At the individual level, the main goal (of successful ageing) is to enable older persons to maintain their dignity, physical and mental well - being and to ensure their continued participation in society. However, in order to realize the full potential of the elderly and to advance their well-being, countries and communities must provide conditions that promote their quality of life and enhance their ability to work and live independently for as long as possible. Hence, it is critical for countries to mainstream ageing and the concerns of the elderly into national development frameworks and strategies and to 'foster appropriate form of public and private partnerships to build a society for all ages, and to strengthen solidarity between generations' " (NPC, 2004). Whatever good programme the government intends to embark upon to make safe water and safe sanitation available in short distances would be commended so that the ageing could breathe a sigh of relief and enjoy a more qualitative life in their old age.

Nigerians generally deserve more attention from the government at various levels. But in particular, the situation of the ageing population should be considered. The people in this age group are supposed to be retiring and resting having contributed their own quota to national development in whatever way during their active years. Safe water and sanitation should not be items / facilities which the ageing are lacking. But "governments and international institutions are only now beginning to acknowledge that their growing populations of older people have a right to a fairer share of resources, including...clean water (Help Age, 2002).

REFERENCES:

- Adeloye Layi (2007): "Water; time to turn promises to action"
Saturday Punch, October 6 and 13, 2007 page 45.
- Help Age (2002): Tackling Older People's Poverty
Annual Review 2001/2002 pages 4 and 5
- NPC (2004): The Elderly: Nigeria Population Census; 1991 Analysis
National Population Commission, Abuja, Nigeria page I
- Ramashala (2000): "Living Arrangements, Poverty and the Health of Older
Persons in Africa" in the Elderly: Nigeria Population
Census; 1991 Analysis National Population Commission,
Abuja, Nigeria
- UNFP (2005): State of the World Population 2005. The Promise of Equality, Gender equity,
Reproductive health and the Millennium Development Goal. New York, United
Nations Population Fund (UNFPA).
- UNFP (2007): "Environmental Sustainability: Population, Poverty and the Environment"
www.unfpa.org
- UNFP (2007): "Population Ageing: A larger and older population" page 91 www.unfpa.org

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INIA'S ACTIVITIES 2008



19th - 24th January 2008	International Training Programme in SOCIAL GERONTOLOGY , Qatar
6th – 15th February 2008	46th Session of the Commission for Social Development (ECOSOC) New York (UNITED STATES OF AMERICA)
18th - 29th February 2008	International Training Programme in SOCIAL GERONTOLOGY , Malta
3rd - 14th March 2008	International Training Programme in ECONOMIC AND FINANCIAL ASPECTS OF AGEING , Malta
6th – 8th April 2008	Geriatrics Congress in Antalya, Turkey, organised by the Geriatrics Society of Turkey and supported by the International Association of Gerontology and Geriatrics (IAGG), the European Union Geriatric Medicine Society (EUGMS) and the International Institute on Ageing UN - Malta (INIA).
14th – 25th April 2008	International Training Programme in MEDICAL GERONTOLOGY (GERIATRICS) , MALTA
12th – 20th May 2008	International Training Programme to be held in Bucharest, Rumania.
23rd - 30th May 2008	International Training Programme to be held in Minsk, Belarus.
8th - 16th August 2008	International Training Programme to be held in Selangor, Malaysia.
18th - 29th August 2008	International Training Programme to be held in Singapore.
13th - 24th October 2008	International Training Programme in POLICY FORMULATION, PLANNING, IMPLEMENTATION AND MONITORING OF THE MADRID INTERNATIONAL PLAN OF ACTION ON AGEING , (MALTA)
October 2008 - June 2009	International POST GRADUATE DIPLOMA IN GERONTOLOGY AND GERIATRICS (P.G.Dip. Ger) European Centre of Gerontology and Geriatrics, (University of Malta), MALTA
8th - 15th November 2008	International Training Programme in collaboration with the Beijing Civil Affairs Bureau, Beijing, China.
16th - 22nd November 2008	International Training Programme in collaboration with the Ministry of Foreign Affairs, China.
17th - 28th November 2008	International Training Programme in DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC, POLICIES AND PLANS , (MALTA)
7th - 13th December 2008	International Training programme to be held in South Africa.

INTERNATIONAL DIARY 2008/09

17th - 20th March 2008 – Washington D.C.
2008 Joint Conference of NCOA and the American Society on Aging

6th - 8th April 2008 – Antalya, Turkey
Geriatrics Congress
Website: www.geriatrics2008.org

29th June - 2nd July 2008 - Seoul, Republic of Korea
Announcement of the XVIIth World Congress on Safety and Health at Work

16th – 19th March 2009 – Las Vegas N.V.
Conference of NCOA and the American Society on Ageing