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**13 Surviving without children: Childless Aged Women in Esan, Nigeria**

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# AGEING, WOMEN AND HEALTH: Emerging caregiving needs in sub-Saharan African countries

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As elsewhere in the world, more people in sub-Saharan African (SSA) countries are reaching old age than ever before. Although structural ageing in the sub-region will increase only modestly in the coming decades - the population aged 60 years and over constituted 4.8 per cent of the total population in 2008 (UNDP, 2008) and is projected to grow to 7.9 per cent by 2050 (USCB, 2007), the absolute number of older persons will rise steeply: from 37.1 million in 2005, to 155.4 million in 2050 (UN/DESA, 2007). Women in the sub-region have greater life expectancy than men (in 2005, 17 years for women, 15 years for men), and the majority of older persons are women (55 %) (UN/DESA, 2007). Women are disproportionately represented in older populations in rural areas (about 60 %), which areas are typically depopulated, with stagnant economies and poor infrastructure and services, and increase the women's vulnerability. Women age 80 years and over are the fastest growing age segment in the subregion's older populations, and these women may become progressively ill, disabled and/or frail. Hence, a sharp increase may be expected in the number of older women who need care and help with activities of daily living (ADLs), financial and subsistence support, and informal longterm care. However, despite health limitations, the majority of older women in the sub-continent continue to contribute to family and their community.

Older women in the sub-region have particular vulnerabilities. The majority are faced with a quadruple jeopardy of being old, poor, widowed and alone. Entrenched poverty and gender discrimination across the life course mean that the present cohort had few opportunities and little access to resources, and they are cumulatively disadvantaged in old age.

In most of the countries, older women are among the poorest of the poor. Moreover, they are more likely than older men to be widowed or divorced (only 39 per cent are married, compared to 85 per cent of older men (UN/DESA, 2005)). Women's greater survival, on average, than that of men, translates further into a greater burden of morbidity and disability in older women.

Policies and programmes to support older persons in SSA countries generally lack a gender perspective. The health systems of the countries typically marginalise female older clients, who consequently receive inadequate care in the public health care sector and cannot afford to access care in the private sector. Indeed, in most SSA countries, ageing is not a high priority socio-political issue; poverty, unemployment, education, infectious diseases, and child and maternal health care are priorities for the governments. Yet many features of the societies have a direct bearing on older women's health and well-being. The majority lack income security; very

few were ever employed in the formal sector and may have an occupational pension in retirement (Kakwani & Subbarao, 2005). Only six countries - Botswana, Lesotho, Mauritius, Namibia, Senegal and South Africa - operate a non-contributory pension programme under which poor women may benefit. A rapid urbanisation trend and changing family structures are diminishing the pool of kin available to support and care for ageing parents, especially in rural areas where the majority of older women reside. Older persons' access to health services in rural areas is especially poor (Ferreira, 2007).



African societies have deep gender divides and women's roles are clearly defined. Caregiving is traditionally performed by women, and even at an advanced age women continue to care for a spouse and family members. The HIV/AIDS epidemics are thrusting many older women back into the role of a primary child care provider to sick adult kin and vulnerable and orphaned grandchildren. Up to two-thirds of people living with AIDS are cared for by a parent in their sixties and seventies. More than 60 per cent of 11.4 million children orphaned by AIDS in SSA live in a household headed by a grandparent (HAI, 2008: 4). Caring for others takes a heavy toll on the women, while AIDS related mortality diminishes crucial support bases for them. Wide assumptions on the part of governments that families are willing and able to care for their elderly members may simply be an abrogation of the government's responsibility to this population, and contrary to growing evidence of changes in kin support systems.

Although older women share basic needs and concerns with older men, such as shelter, food, access to health services, dignity, functional independence and freedom from abuse, the differential impact of ageing on older women's situation and health in the sub-continent merit special public policy attention (see e.g. UNFPA/WHO, 2007; Hale, Joubert & Kalula, 2007). Scant data are available on the women's health, well-being and care needs, and neither on the extent to which their care and support needs are met. We draw primarily on South African evidence to demonstrate emerging caregiving needs of older women.

### **Levels of caregiving**

We discuss caregiving on three levels. We use the term "formal care" to refer to health and social care provided in the public sector, and the term "informal care" to refer to care provided to ill, disabled and/or frail persons by family members and others in the community. The term "nonformal care" is used to refer to care provided at an intermediary level by non-profit organisations (NPOs), both faith-based and non-governmental, often operated as service agencies for the government and delivered partly by volunteers. The types of services provided by

NPOs may range from auxiliary primary health care, to home nursing, to support groups, to residential care. In several cases services provided by NPOs to older clients have become best practices. A fourth level of care, discussed briefly, is that of self-care. In some cases, caregiving practices straddle two or more levels. We argue that older women's care needs are typically determined by their health status (or disease profile) and socio-economic status (or poverty situation), as well as the availability of kin to support and care for them.

### **Burden of disease in older women**

As in other developing regions, increases in longevity in the SSA sub-region are being accompanied progressively by an epidemiological (or health) transition, from a predominance of infectious and parasitic diseases, to an increased prevalence of chronic and degenerative diseases and disabilities. However, SSA countries still confront a double burden, of 1) fighting emerging and re-emerging communicable diseases, such as HIV/AIDS, tuberculosis and malaria, while 2) managing an increasing burden of non-communicable diseases (NCDs). Indeed, the countries are said to face a quadruple disease burden, through high prevalence rates of 3) injuries due to violence (vehicular accidents, stabbings, etc.), and 4) the impact of the HIV and AIDS epidemics (Joubert & Bradshaw, 2006). Disability, as a result of violence-related injuries and AIDS-related morbidity, and the effects of age-associated degenerative diseases, constitutes a considerable "burden of disease" for the governments.

Thus far, only 30 per cent of adult deaths in SSA countries are caused by NCDs, compared to 90 per cent in developed countries (Hale et al., 2007). The sub-regional countries constitute a high mortality region, due to underweight, unsafe water, poor sanitation, indoor smoke from solid fuels, and unsafe sex- all leading contributors to the disease pattern. The countries remain youthful moreover (a median age of 18.2 years (USCB, 2007)), and communicable diseases still constitute seven out of 10 causes of child deaths and 60 per cent of all child deaths (Hale et al., 2007). Hence, this disease pattern will continue

to prevail for some while, but the pattern of non-communicable disease is set to change. In South Africa, the prevalence of NCD and disability in 2000 was found to be responsible for 84 per cent of older person deaths; communicable diseases and nutritional deficiencies for 13 per cent; injuries for 3 per cent; and AIDS for 0.4 per cent (Joubert & Bradshaw, 2006). In the 2001 population census, 16 per cent of older persons (13 % aged 60-69 years, 17 % aged 70-79 years, 27 % aged 80+ years) reported having a disability - most commonly sight and physical, followed by emotional, intellectual and communication conditions (Joubert & Bradshaw, 2004).

The epidemiological transition in the sub-region, albeit it in an early stage, is being driven by a rapid urbanisation trend, as in-migrants to urban areas progressively adopt a Western lifestyle with a diet rich in fatty, sugary and salty foods, and increased tobacco use and alcohol consumption. Ample evidence exists of the contribution of such lifestyle risk factors to the progressive development of NCDs, such as hypertension, high cholesterol and obesity (Hale *et al.*, 2007; Joubert & Bradshaw, 2006). Overweight and obesity, for example, can lead to metabolic changes such as insulin resistance, increasing blood pressure, and high cholesterol and triglyceride levels, which are risk factors for cardiovascular disease (Joubert & Bradshaw, 2004).

The management and prevention of NCDs in SSA countries has been inadequate, as have the changing health behaviour patterns contributed progressively to the growing burden of chronic disease. In South Africa, high levels of hypertension in women age 65 years and over (60 %) (Joubert & Bradshaw, 2006) are typically combined with poor levels of awareness, monitoring, treatment and control; only 20 per cent of hypertensive females were found to have had their blood pressure measured in the past 12 months. Thirty-three per cent of older women were found to be obese (BMI > 30 kg/m<sup>2</sup>), at the same time that a sharp increase in underweight (BMI 18.5 kg/m<sup>2</sup>) was noted in this population. Only 7 per cent of older women currently smoke daily, but a quarter co-resides with smokers and is subjected to secondary inhalation. A fifth of women are

reported to currently consume alcohol and 12 per cent to be alcohol dependent (CAGE measurement) (Joubert & Bradshaw, 2006).

A profile of causes of death attributable to specific diseases in the older population may be used to represent the burden of disease (Joubert & Bradshaw, 2006), as well as indicate the implications of associated morbidity and disability for caregiving. In South Africa, cardiovascular disorders (CVD) are a primary cause of death (43 %) in older women; ischaemic heart disease and stroke, leading causes of disability, together account for almost a third of deaths. Malignant neoplasms are the second leading cause of death (16 %) in older females, with breast cancer leading, followed by lung, cervix, oesophageal and colorectal cancers. Respiratory disease accounts for 10 per cent of deaths; infectious and parasitic diseases (excluding HIV/AIDS) for 8 per cent; and diabetes mellitus for 6 per cent (Joubert & Bradshaw, 2006).

The socio-economic status of women may influence their susceptibility to NCDs and the treatment they receive. Where women have little, if any, education and had poor access to resources over the life course, they may have lacked opportunities for counselling by health professionals, which may have helped to reduce risks for, and to manage the diseases better. Hypertension and obesity are examples of such missed opportunities. Cancer is another example: detected typically at only an advanced stage and treatment often being unaffordable. An increase in cervical cancer may be due to non-negotiable sexual behaviour and sexually transmitted infections (STIs). Women may have had poor reproductive health care, and maternal anaemia, malnutrition and STIs, which together with excessive childbearing may have impacted their health long before they reached old age.

Neuropsychiatric conditions, such as depression, alcohol related problems and epilepsy, are increasingly common in older women in the sub-region. The prevalence of depression has been found to be 50 per cent higher for older women than older men (WHO, 2003); once again, gender and poverty may be powerful determinants of a risk for mental



illness. High rates of depressive symptomatology found in older women in South Africa have been attributed to stress experienced through an increasing burden of responsibilities and caregiving on them (e.g. Gillis, 1991). Older women are found moreover to suffer a greater burden of anxiety disorders and late-onset dementias than older men (WHO, 2003). Indeed, as more women in the sub-region live to an advanced age, dementia will contribute increasingly to disability and death (see e.g. Ogunniyi & Aboderin, 2007). As older women show significantly greater reductions in bone density and muscle mass than older men, they have a greater risk of loss of function (Hale et al., 2007). The reductions are likely to be exaggerated in women who have lived a life in poverty, engaged mainly in agriculture, and had poor nutrition, and little access to education and health care. Osteoarthritis and osteoporosis, which may follow, are associated with chronic pain, disability and poor quality of life. The burden of disability as a result of NCD thus not only has wide ranging effects on older women and their capacity to contribute, but in terms of their need for caregiving, on their family and the health care system as well.

Hence, the changing disease profile and disease burden, specifically that of older women, have implications for SSA governments, civil society, families and individuals who must prepare to meet the challenges of an increasing burden of chronic disease and disability, and associated caregiving needs. At the same time, most NCDs are preventable and greater efforts are required to reduce risk factors for the diseases and to manage them better across the life course.

### **Implications for health and social care provision**

Thus, the growing burden of NCD and associated morbidity and disability, together with older women's often invidious poverty situation have implications for policy and practice relating to caregiving - on multiple levels. To start, a demand for public health care services and medical costs will rise sharply. In most SSA countries, health care policy has emphasised a shift of service delivery to the primary care level (PHC), which prioritises

maternal and child health care, and the provision of geriatric health care services is deprioritised. The preventive, curative and rehabilitative needs of older health care clients are mainly integrated in general sessions at primary clinics, but in practice older clients are marginalised at these facilities, and few are referred to secondary or tertiary levels for investigation and management. Although there is a general lack of statistics on the quality of health services delivered to older clients, client dissatisfaction with such services has been documented in several studies (Joubert & Bradshaw, 2006; WHO, 2002). Complaints are directed mainly at several access barriers to care, and include costs; travel distance to a facility; discriminatory and rude attitudes of health professionals; overcrowded and understaffed clinics and long waiting times; shortages of medications; unavailability of assistive devices; and a perceived lack of interest and respect shown to older clients.

Very few residential care facilities exist for older persons in the sub-region. The majority of ill or frail older women are reliant on family for care - where indeed family members are available to care for them. Although household structures remain predominantly multi-generational, skipgeneration households and solitary living (11 % of older women live alone) are increasingly common (UN/DESA, 2005). In urban areas, NPOs may provide some supplementary home care services to ill, frail and homebound older women, but few such services are available in rural areas. Where kin are not available to care for elders and institutionalisation is not an option through non-availability or cultural rejection, ill, frail and socially indigent older women are at risk of neglect.

The implications of the growing burden of disease and disability in older women and their socioeconomic vulnerabilities for the provision of health and social care are compounded moreover by features of the societies that discriminate against women, and militate against their health and well-being. The governments of the countries, civil society, families and individuals must therefore plan to meet the increasing treatment and care needs of the population, and related costs - on multiple levels.



vulnerable socio-economically, and vulnerable due to poor health status and inadequate health care over the life course. Equally, their marital status and living arrangements may contribute to their vulnerability, especially where they are ill, frail or disabled. Widowed, divorced and childless women are likely to live alone, be isolated and prone to social exclusion, and suffer greater hardship than married older women. In general, women in the sub-region lack rights to land ownership. Some traditional practices, such as widow cleansing, polygamy and wife inheritance, may be harmful and subject them to degradation and extreme deprivation. The women may have low self-efficacy, and suffer a sense of helplessness and exhaustion as a consequence.

Older women who live alone, or alone with grandchildren in a rural area - when adult kin have migrated to a city or are deceased, have particular vulnerabilities and care needs. The women often receive little social support or financial help in the form of remittances from urban kin. Their dwelling is often in a poor state, and no able-bodied sons may be available to repair the dwelling or to help with subsistence agriculture. The women are typically burdened with fetching water and collecting firewood, and often lack access to transport and help resources. In both urban areas and rural areas, older women are at risk of gender based domestic violence and abuse. Older women who live alone are at particular risk of allegations of witchcraft by members of their family or community, especially where the women are depressed or show signs of dementia, and the dire consequences of such allegations for the safety of their person and assets are considerable and often fatal (Ferreira, 2004).

Thus, older women in SSA countries have varying levels of vulnerability, and the range of their caregiving needs are likely to intensify and expand. At a formal level, the women's care needs include better health care, with access to expanded, age-friendly health care services and better management and prevention of chronic conditions, as well as expanded income and social support from the government. At a non-formal (NPO) level, expanded community support and care systems are needed, ranging from senior centres and support groups, to

home care services, and other long term care options. At an informal level, if indeed family members are available to care for elders, the family Darers need to be equipped and supported to do so. At all levels, stronger support and help are needed for older women who are caregivers themselves, to sustain their functioning and contributions, and to reduce the burden of care on them (Ferreira et al., 2007).

### **Care and support best practices**

Several interventions in various SSA settings, mainly at an NPO (or non-formal) level, aimed either at rendering care services to, or supporting caregiving by older women have evolved into best practices. At an informal level, groups of volunteers, both younger and older women, run projects in their community, such as providing home care to frail older persons, often through their church group. Single best practices at different care levels are described briefly.

A best practice in South Africa are luncheon clubs operated at senior centres countrywide. Both the programme and the facilities are subsidised by the government. Members of a luncheon club meet on one to five days a week and are served a nutritious meal for a nominal fee. The clubs offer the members social, recreational, educational, spiritual and counselling opportunities. Some larger clubs dispense repeat prescription medications to members on behalf of their primary care clinic and pay out monthly pension benefits to registered beneficiaries (UN, 2002). In South Africa's Western Cape Province, the Abigail Women's Movement operates a community-based support system for older persons in Khayelitsha, a low-income township. The project was designed and implemented by older female volunteers, and provides practical home care to frail older persons with a strong spiritual component (Keikelame, 2000). Yet another best practice in South Africa is the NPO Grandmothers Against Poverty and AIDS (GAPA) programme, operated in three provinces by grandmothers, all carers to adult children with AIDS and/or affected grandchildren. GAPA members benefit from peer support, counselling and skills training, and engage in income generation activities. A creche bursary

scheme and an afterschool care centre offer the members respite from caregiving to children (see [www.gapa.org.za](http://www.gapa.org.za)).

In eastern Nigeria, where virtually no formal health care is available for persons with dementia, the project Support and Care for Persons with Dementia is operated by a group of physicians at the Nnamdi Asikiwe University Teaching Hospital and the Ukpo Dunukofia Community Health Centre. The project is aimed at the improvement of the health and well-being of these persons, their family members and other carers. Two geriatrics clinics have been established under the project, with an emphasis on dementia care. Support groups provide advice and counselling to family and carers; home assistance is provided to clients; and affiliated religious organisations raise awareness of dementia and support for project activities (Uwakwe & Modebe, 2007). The Nigerian project is an example of a collaboration of multiple agencies and agents at all care levels, to achieve a comprehensive response in an area in which there is a growing need for caregiving .

#### **What planning and provision are needed?**

Granted, SSA governments are confronted by multiple social and health challenges in a context of scarce resources, and the care needs of older persons are unlikely to be a priority in the coming decades. Yet, planning to meet the care needs of a growing number of older women who are poor and vulnerable, will live longer, will have more chronic disease and disability than previous cohorts, and may lack family to care for them, is needed urgently. A shift of attention and resources to the older female population in thus indicated, to develop a strengthened and integrated system of appropriate multi-level responses to its particular and expanding care needs.

First, it is incumbent on the governments of the countries to take cognisance of the implications of population ageing and the increasing number of poor and vulnerable older women, as well as the growing burden of chronic disease and disability, and to prepare to meet these challenges and emerging care

needs. Second, the governments must commit to implementation of relevant recommendations in the Madrid International Plan of Action on Ageing (MIPM)(UN, 2002) and the African Union Policy Framework and Plan of Action on Ageing (AU Plan)(AU/HelpAge International, 2003), to which they are signatories. Both plans of action recognise older women's vulnerability and make specific recommendations on how it may be reduced. Third, a gender perspective needs to be incorporated in all policies and action plans that follow. In short, policy action is needed to ensure that older women's health, well-being and quality of life are enhanced at all levels - both as care recipients and care providers.

A variety of responses to specific caregiving needs are required, and single responses, or recommendations for action are proposed according to care levels below. Several proposals in a recent UNFPA/WHO (2007) report that have specific relevance to the situation of older women in SSA countries are drawn upon. However, SSA countries must ultimately develop indigenous solutions to their caregiving challenges, and the countries will resist the imposition of culturally inappropriate and often costly Western type care models.

At a formal, or government level, strategies, practices and programmes to enhance older women's health and well-being, prevent morbidity and disability, and reduce a need for caregiving, as well as ensure sustainable livelihoods, may include:

- Better management of NCDs and co-morbidities, such as hypertension, obesity and diabetes, and better screening for cancer.
- Health promotion to encourage health behaviour modification and lifestyle changes, in order to reduce health risks for NCDs.
- Health care reforms, such as improved access to age-friendly services, and continued support in the community for women discharged from hospital, as in the case of stroke.
- Special education and training of health professionals in geriatric care in all relevant disciplines.



- Assessment and management of cognitive disorders at primary care level.
- Improvement of older women's mental health, through practices and programmes to encourage their socialisation and physical activity, and thereby to prevent or ease depression.
- Understanding on the part of health professionals of gender differences when prescribing and treating mental health problems.
- Understanding and special attention given to women who have been abused or experienced other forms of violence.
- Equal access to anti-retroviral therapy for older women infected with the Hi virus.
- The provision of information about healthy sexuality and the risks of AIDS and STIs.
- The provision of a basic income grant to socio-economically vulnerable older women.

At an informal care level, the capacity of families to care for elders needs to be strengthened

and supported. Family Carers to ill, disabled and frail older members thus need:

- To be supported to ease the financial, physical and emotional burden of caregiving, and the employment opportunity costs of this essential role.
- To receive financial support through subsidies, tax relief, or even payment for caregiving services and co-residency of an older member.
- To have access to income generation opportunities, where unemployed, to help them to tackle their household's poverty situation and cope better with caregiving.
- To be provided with information on health conditions, treatment, medications, warning symptoms and lifestyle modifications.

- To be equipped with caregiving skills, and trained in how to partner formal and non-formal health care providers, identify available resources, navigate systems and become advocates for care recipients.

- To be able to access respite programmes, and to have a forum such as a support group in which to verbalise their experience and receive peer support.

At a non-formal, or intermediary level, given the relative dearth of community based support services to vulnerable elders and informal carers, NPOs need:

- To be helped by the government, in partnerships, to provide community centres as meeting places for seniors' clubs and support groups, to support older carers, and to offer younger and older carers respite.

- To develop and implement programmes aimed at encouraging older women to remain socially and physically active, to make healthy choices, and to maintain a healthy weight and not to smoke.

- To carry out initiatives aimed at the removal of stigma associated with HIV/AIDS and mental illness.

- To foster intergenerational efforts and co-operation to improve the physical and emotional well-being of both older women and younger generations.

- To establish best practices relating to care provision and caregiving as personal, kin and government responsibilities.

- To promote awareness and education among older women on their human rights and avenues for legal recourse, and how to protect themselves from HIV infection.

- To contribute to the provision of long-term care options, both residential and in the community, for vulnerable older women. However, a need for an increase in the number of institutional care facilities is not clear and warrants investigation.

At an individual, or older person level, programmes and practices to empower older women, through expanded health care and health promotion, and



needs to be incorporated in all policies, programmes and legislation relating to support and care for older persons in the sub-region.

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# ***SURVIVING WITHOUT CHILDREN: LIFE HISTORIES OF CHILDLESS AGED WOMEN IN ESAN, NIGERIA***

**EBOIYEHI FRIDAY ASIAZOBOR**

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## **Abstract**

Most social research on ageing in sub-Saharan Africa has focused on care and support given by adult children and extended family members to their aged relatives suggesting that it is the responsibility of adult children and members of the extended family to cater for the needs of their aged relatives irrespective of whether they have children or not. However, this arrangement is diminishing. Yet, there is no formal established welfare programme in place to fill this gap. Drawing on data from life histories obtained purposively from selected childless aged women in two local Government Areas (LGAs) namely, Esan Central and Southeast, this paper examined on contemporary care and support system for the childless aged women and what alternatives are open to them in absence of children. The results indicated that childlessness has negative impact on the wellbeing of aged women in later life. The diminishing extended family ties and increasing social distance between the childless aged women and their extended family members also affect their care and support in old age. This trend was associated with emerging nuclear family structure, social changes towards westernization and coping strategies associated with decline in their real income as a result of the downturn of the Nigerian economy. Results showed that the childless aged women adopted various coping strategies ranging from subsistence farming, selling of some personal belongings for subsistence, begging for alms, petty trading and employing the services of housemaids. Only a few of the aged depended on pension or some support from their churches and extended family members. The three recorded formal services that were provided by two LGAs included relief scheme, roof repairs and provision of eyeglasses. In discussing these and related subjects, the paper suggested that there is need for cultural reawakening of extended family social security system toward the wellbeing of this population subgroup. This may be carried out within the framework of creative multitrack social policy intervention that will involve government, civil society and private sector partnership.

**Keywords: childlessness, Care and Support, Aged women, Nigeria**

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## **INTRODUCTION**

*A mother's son is a buttress. If you have none  
down falls the house.*

*A mother's daughter is your everyday apparel  
if you have none you are cold, exposed.*

(Ewe poem, adapted from June Ellis: *The Child in West Africa*, 1978)

Both sociological and demographic literature as well as gerontological researches have acknowledged the worth of familial relationships, particularly adult children, in providing care and support for their aged parents (Catted 1990; Apt, 1992; Apt and Greico 1994; Apt, 1995; 1996; Fajemilehin, 2000; Oppong, Zimmer and Dayton 2003; 2006). In most developing countries, particularly those in sub-

Saharan Africa, childlessness is the greatest tragedy and humiliation that could befall any couple. In most if not all these countries, anxiety, fear, societal pressures to conceive and social stigmatization usually mark the experience of childlessness. The anxiety arises as a result of the significant role children play in catering for their ageing parents. It is therefore, not amazing that in resource poor countries like Nigeria where high premium is placed on having children for social, cultural and economic reasons, childlessness often creates enormous problems in later life. In Nigeria as in other sub-Saharan African countries, children are so important that to be childless is undesirable and loathsome. The sentiments attached to children culturally include prestige and respect accorded to parents in the community. Apart from old age social security, children are also desirable for lineage continuation.





(Eboiyehi, 2008). At this age, the aged are well respected and held in high esteem and enjoyed a high status position in the family (Fajemilehin, Jinadu, Ojo and Feyisetan, 1996). They were seen as representatives of ancestors. The young members of the society looked up to them and sought advice from them on important matters (Faniran-Odekunle, 1978). Within the extended family, the aged played very crucial roles, which placed them in a unique position. They knew family history and preserved the family customs and ancestral values (Oyeneye, 1983; Fadipe, 1970) as it was also their responsibility to transmit the society's customs and skills to younger generations. They settled disputes and ensured proper conduct among family members. In addition, they controlled family lands and properties and ensured that family members had access to them when needed (Fajemilehin, 2000).

Sadly, the intergenerational relationships as described above have come under the influence of exogenous forces, which have not only transformed the society's orientation but also in some instances distorted the social system (Otaki, 1998; Akeredolu-Ale and Aribiah, 2001). Over the years, the resultant effects of modernization and western influence have led to the disintegration and weakening of the extended family system and communal ties. Consequently, the notion of "being your brother's keeper" is gradually being replaced by a biblical saying "to your tent o Israel". The strong trend towards nucleation of family structure and the absence of formal social welfare services and government's involvement in socio-economic support in Nigeria imply that the future standard of living for the growing number of the childless aged could be weakened. This demographic information raises a fundamental question about the ability of the childless aged to cater for themselves in the absence of children. The situation of the childless aged in rural areas is said to be particularly bad. Rural areas have particular infrastructural deficits. The aged with no existing children therefore find it difficult to perform household survival chores such as fetching water and carrying firewood, tilling lands, sowing and harvesting crops when they are too old to perform these tasks. The status accorded the childless aged in the traditional society is rapidly

changing in contemporary time, as they are now being perceived as a burden on the extended family due to their inability to cater for them (Mason, 1999; Amosun and Reddy, 1997). In some cases, childlessness often necessitates stigmatization, divorce and ostracism (Bergstrom, 1992). The social stigma of childlessness leads to isolation and abandonment in many developing countries (Ebomoyi and Adetoro, (1990). This unfortunate situation has led some of the childless aged particularly women to resort to begging or become destitute, an act, which was in the past considered demeaning and shameful to the entire extended family members (Togonu-Bickersteth, 1997). Exposure to manual and hard labour among the childless aged who are supposed to retire from such, has also been shown to be on the increase in many cities and especially amongst the low-income urbanites because there is nobody to cater for them. Survey by the National Population Commission, (NPC, 1991) on Nigeria indicates that majority of the street beggars in urban areas and institutions are the aged many of who have nobody to cater for them. Recently, Major (Mrs.) O. IdowuOkunsanya, the president of Agency for the Aged described the situation of a deceased childless aged man, deserted by his family as follows:

*"It is a shame to families whose elders are beggars... Papa Emmanuel Reis died recently at 88, he had no wife, no child of his and had been deserted by his own family but we took care of him till death. He was a nice old man. His death touched us all. How can the society neglect a childless person? It is unfair."* (The Nation on Sunday, September 2008).

The situation of the childless aged women is worse and pathetic due to the perception of people regarding childlessness. Such perception is often derogatory and judgmental. Among the Ijaws of south-south Nigeria for example, a childless woman is considered unfortunate being. Not only is she considered disadvantaged economically. since she has no children to cater for her, but childlessness also prevents her from attaining full adult womanhood (Hollos, 2005). Hollos (2005) states further:

*“A childless woman is considered to have a marginal status, she may be divorced by her husband; she has no child to help her economically and socially and morally. She is in-between status, which is not fully adult. The consequence is that a childless woman often leaves the community, to return to their paternal compound in old age. . .where members of her extended family may not recognize her.”*

In some societies, she is more or less treated as an outcast and as such, she is not invited to comment on public affairs as it is generally believed that she is the cause of her childlessness. In these societies, childlessness tends to be attributed to wickedness. The fact that a woman has no child is regarded as a proof that she is a bad person and that she is being punished with childlessness by God (June Ellis, 1978). Among the Esan, it is believed that a barren woman has a spiritual husband either in the rivers or in the spirit world and that it is this spirit husband that 'stands' on her way to give birth to children in the physical world. Her problem is compounded as she is denied access to her husband's and/or father's property and inheritance, basic healthcare and public assistance. This unfortunate situation has led many childless aged women to delve into so many unimaginable areas such as begging and destitution or doing all kinds of menial jobs for other people with meagre pay.

In Nigeria as in other sub Saharan African countries, the causes of childlessness may be attributed to ethnic wars, accidents of various types and of recent the much dreaded HIV/AIDS. Kreager and Schroder Butter-fill (2003) also identified five major factors of de facto childlessness. The first is out-migration, which may leave parents without source of support locally available. The second factor, divorce, can leave parents de facto childless if it results in loss of contact with children. A third group of de facto childless people are those with handicapped children who are unable to provide material and practical support, although their emotional support should not be underestimated. The fourth factor is a situation where there are less clear-cut cases of families in which, the younger generation is economically very unsuccessful or less successful than the parental generation. These children tend to be a net-drain on

parental resources, rather than a source of support. Finally, the fifth factor is a situation whereby aged people have become estranged from their children as a result of conflict.

The basic questions, which this paper addressed, are how do the aged women who have no children at all, survive in a society in which a great deal of care and support of the aged is undertaken by children? How does kinship function as a matrix for care and support for them in a country that does not have formal social security for the aged?

Despite the growing concerns for the most important welfare problems arising from a lack of children and gradual breaking down of the extended family system, little is known about care and support for childless women in Nigeria. Furthermore, the ways in which the childless aged women are surviving in the midst of childlessness and the downturn of the Nigeria economy have not been documented. This may be traced to the belief that traditionally it is the responsibility of the extended family members to cater for their ageing relatives. That unfortunately is no longer the case as the current socioeconomic change mainly due to nucleation, urbanization and western influence has compelled the childless aged to cater for themselves in advanced age.

Using life history data from six (6) childless aged women in Esan, Nigeria from a biographical viewpoint, the paper addressed through concrete ethnographic examples of contemporary care and support for the childless aged women and coping strategies in late life.

## CLARIFICATION OF CONCEPTS

The following concepts are defined within the context of this paper.

**Extended Family:** The term extended family refers to two or more nuclear families. It includes a woman, her husband, their children as well as her father and mother and their other children. It also includes her husband's brothers, sisters and their children.

**Care:** Care as used in this paper, is the process of providing physical, psychological care,



social assistance to an aged person. That is, providing what they need for their health and their general well-being.

**Support:** Support is an act of providing material or physical, social, emotional or moral assistance to the aged who are in need, to enable them survive in old age. In this paper, support has been considered to be essentially of four basic types namely:

(a) **Instrumental Support:** This includes all substantial assistance received by the aged such as housework, transportation, shopping and personal care.

(b) **Emotional Support:** This consists of assistance received by the aged person such as confiding, comforting, reassuring, listening to problems, in essence "being there" to listen to the problems and anxieties of the aged.

(c) **Informal Support:** This includes receiving advice when necessary, for instance, in seeking medical treatment, referrals to agencies, and sharing family news.

(d) **Financial Support:** This includes sending remittances, paying medical and electricity bills, sending money for feeding and farming.

**Aged Women:** The term aged women as used in this paper, implies those women aged 65 years or over.

**Old Age:** It is a period when the physical strength of an aged person begins to decline. Old age as used in this paper implies 65 years of age and above.

**Childlessness:** This is a state of having no surviving children as a result of bareness or death due to accident, war or HIV/AIDS.

**Infertility:** This refers primarily to biological inability of a woman to contribute to conception (i.e. not being able to produce a child).

#### **The Study Area**

Although the levels of childlessness and infant and child mortality experience by aged women during

childbearing are important to understanding current levels of their childlessness, accurate data on childless aged women in Nigeria has not - to our knowledge - been easy to estimate. In spite of this, evidence suggests that Nigeria has high rate of infertility (Hollo, 2005). Furthermore, despite the fact that there are no available data on infant and child mortality in Nigeria for the first half of the 20th century, evidence of infant mortality in much of the developing countries of which Nigeria is a part, has been estimated at 250 per thousand live births in the 1940s. Many currently aged women were giving birth in this period (Hugo, Graeme; Hull and Jones, 1997; Kreager and Schroder-Butterfill, 2003).

In line with the 1990 Nigeria Demographic and Health Survey (NDHS) about 4 percent of women over 30 years have no children. A recent population based survey of women of reproductive age in Ile-Ife, Nigeria, has also revealed that up to 20 percent of women suffer from infertility (Snow, Okonofua, Kane, Farley and PinQi 1995). In addition, the data collected by Adetoro and E. bomoyi (1991) also suggest that up to 30 percent of couples in some parts of Nigeria have difficulties in achieving a desired conception after two years of marriage. However, an analysis of data from Nigeria reveals that infertility has declined among all age-groups younger than 40 in the decade between the World Fertility Surveys and Demographic and Health Surveys (Larsen, 1995). In addition, the proportion of childless women in Nigeria declined from 6% to 4%. This decline could however, be attributed to improvement in medical technology witnessed in the later part of the 20th century. However, Larsen (1995), also reports that a substantial proportion of women (33%) suffer from infertility in Nigeria.

The Esan people of south-south Nigeria inhabit an area that lies between longitude 6° 5' and latitude 6° 5' in the geographical centre of Edo State, about 80 kilometers northeast of Benin city, the state capital. By this factor of proximity and the fact that they share a basic cultural substratum, they are regarded as neighbours to Bini (Bradbury, 1973:48). Esan is the ancestral home of the Esan people who trace their genealogy to a common ancestor. Thus,



*fourteen, my father's relatives insisted I must get married. They eventually forced me to marry a man who had already gotten married to three other wives.*

She stressed further:

*My husband was very nice to me. Because of the love he had for me, his people and his other wives became jealous of me. They hated my husband and accused me of turning my husband's eyes away from them. Later, they 'killed' him leaving me in the darkest side of life. This is the eleventh year since he died. Immediately after my husband's death, his family members including my co-wives' children threw me out of his house because I do not have children for him.*

With tears in her eyes, she said:

*They call me a witch. They say I ate all my children in the coven and even accused me of being responsible for my husband's death. I was made to swear to an oath if I knew something about my husband's death. I swore by drinking the water that was used in bathing his dead body (corpse) to prove my innocence.*

Madam Ojezele put the blame of her childlessness on jealousy and the activities of witches and wizards in her husband's family. According to her, "they did not want me to give birth to my husband". As at the time of this interview, she was living in a dilapidated house built with mud and corrugated iron roof, owned by a neighbour she fondly refers to as "a Good Samaritan" who decided to house her when the children of her late husband ejected her. Both internal and external surrounding of the house was not cemented. Water for domestic use and for drinking was supplied for sale by tanker drivers. Water for other domestic use was fetched mainly from a nearby pond, river or sometimes rain water stored in a local well. Occasionally, children and wives of the house owner assisted her in cooking, fetching water or running errands for her. When they are not available, she depends on her dwindling ability. Members of her household used pit latrine dug in the nearby bush.

She could not but sing the praise of her late husband repeatedly during the interview:

*My husband was one in a million. There is no man to be compared with him. He was not only a kind man but was loving, caring and did not allow me to suffer when he was alive. My only regret is that I did not have a child for him.*

She acknowledged she lived with her husband for fifty-seven years without a single quarrel. On how she has been able to cope until now, Madam Ojezele had this to say,

*Old age is a serious problem at least for those of us who have no children to lean on. When I was young, I used to trade. I used to go to Ozigono market to buy yam, rice, beans and fish, which I sold to buyers in the whole of this town. I later engaged in petty trading of selling kerosene and akara (bean cake) when I stopped going to Ozigono market, until about two years ago. Now I cannot do anything. I cannot even walk to our local market here to say the least of going to Ozigono market. Everyday I sit here watching people passing by. Now, I have no source of income again, except for some kind-hearted people and members of my church who give me food, money, clothes and even send their children to assist me. I would have since died if not for their kindness.*

Madam Ojezele's major problems and complaints were poor vision, joint pain, under feeding, neglect by members of her extended family and lack of assistance by her late husband's relatives. On occasion, she only has little food to eat. Sadly, she said:

*That was why I asked you if you were a drug seller so you could prescribe some drugs for me for my joint pain.*

On why she did not go and see a doctor, slowly she asked:

*Is it not when you have money that you can see a doctor? I do not have money to see a doctor. I would have loved to see one if I had such money. My major problem is ill health. I need money to buy drugs,*



*their ability. I know they would have done more, but the economy is bad. They have not forgotten how I took care of them after the death of their mother. But money and food are nothing when there is nobody to share your dreams and aspirations with. I am not happy that I do not have a child of my own; money is not everything. My greatest challenge is loneliness. You need to see how I feel. It is as if I am alone in the midst of a crowd. At my age, I need somebody around me to talk with, run errands for me, cook for me and discuss my problems with. What I did not do when I was young is what I am doing now: cooking, washing clothes and going to the market because there is nobody to send. It is as bad as that. It is very sad. How I wish I died before my husband.*

Mrs. Odiboh's major challenge in terms of its consequences is ill-health. Ill-health is a product of chronic disability, which affects her ability to perform her routine daily tasks. The fact that there is nobody to share her burdens with also gives her emotional stress.

### **Life History Three - Madam Alice Erewele: I Am Isolated by Community and Family Members**

Madam Alice Erewele was born at Akho in Esan Central Local Government Area. Like most of the aged interviewed, she did not know exactly when she was born because according to her, "there was no date then". By her calculation, she was over 90 years old, though she looked a little bit younger than that age. She was one of the two surviving children of her late parents. In her words:

*My parents gave birth to six of us - four boys and two girls. I am the fourth child of my parents. But, it is only my sister and I that are still alive. The rest have died.*

Madam, Erewele is a widow. Her husband, Chief Erewele died some ten years earlier after a protracted illness at the age of 112 years. Madam Erewele gave birth to three children. The three of them died in a ghastly motor accident on their way to Benin City (about 80 kilometres from Esan) two years before this interview was conducted. To her surprise, she

was accused of killing her own children because they were not supporting her. As a result, she was sanctioned by members of her family: nobody visits her and she was prevented from interacting with any of her extended family members. With tears in her eyes, she complained bitterly that since the death of her children everybody had abandoned her to her fate. In her words:

*They do not ask of me not to talk of visiting me. As you can see, I am living alone in the whole of this house. After the death of my children, the community members invited a witch doctor to ascertain what was responsible for their death. To my utmost surprise, the witch doctor accused me of killing my own blood (children) because they not taking care of me. I was accused of witchcraft. How could I have killed my children, my only source of joy?*

On how she has been coping without her children and support from extended family members, madam Erewele affirmed:

*God has been keeping me. In order to survive, I engage in subsistence farming and petty trading. I grow yam, cocoyam and cassava and sell garri and vegetables. I also receive material and financial assistance from Mr. Itamah (the Vice Chairman) of this local government area. God has been using him to meet my needs. When he saw how those of us without children were suffering, he introduced a scheme and called it "Scheme for the Aged, Destitute and the Childless" particularly those who have nobody to take care of them. He compiled our names and started paying us 200 Naira each per month although some of us are now dead. After the last rain, my house was one of the houses that were blown away by storm. Those of us who have nobody to cater for them were given some money to repair our houses. Apart from that, they bought glasses for some of us having sight problem.*

She stated further:

*I receive nothing from my husband's other children born for him by his other wives. The last time they came home was when they brought the corpses of my children. As I said, they do not ask after me to*

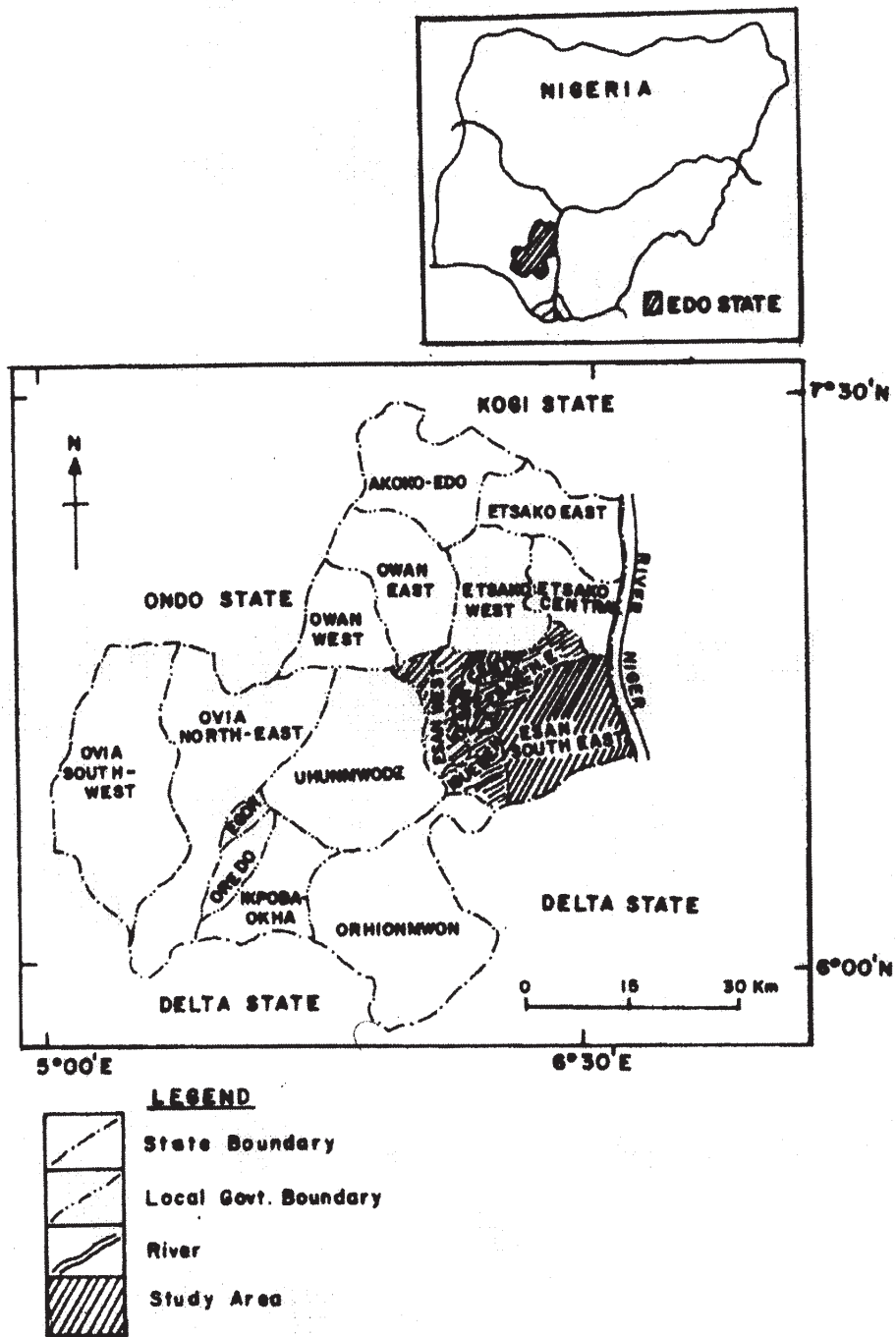


FIG. 1 : EDO STATE SHOWING THE STUDY AREA .



*say the least of sending me food and money. I have learnt to depend on my little efforts. The era of a childless aged being catered for by the extended family is gone because our society is moving towards nuclear family system. When I gave birth to my late children, I did what a good mother is supposed do for her children. Their father and I suffered to make sure they were properly trained thinking that they would take care of us when we are old and unable to support ourselves. But see what life has turned into - an object of ridicule. . .a witch. Life has been unfair to me. Now there is no one I could call my own child. I am not depending on my stepchildren for survival. By the grace of God I will not eat sand. When my neighbour's son saw my stepchildren and accused them of neglecting me, they told him that they have their own canoe to paddle. Even my children's wives are not looking at my direction. One would expect them to look after me now that that I am old.*

In addition she remarked:

*They used to send their children to spend their holidays with me assist me in the farm and perform other domestic work when my children were alive. But for the past four years, their mothers have refused them coming home during holidays. May be they thought I would bewitch them. But if I could not bewitch their husbands, tell me is it my grand children I will now bewitch?"*

#### **Life History Four - Lady Omosun Ehiagwina: I Thought Adopting a Child Would Solve my Problem of Childlessness**

Omosun Ehiagwina is a 75 year retired secondary school teacher. She taught for 32 year before her retirement in 1985. She lives in a modern painted house in Ubiaja (an urban area) built by her. Her first marriage was to a Secondary School Principal, Mr. Johnson in 1966. Her marriage with Mr. Johnson ended in 1975 when she was unable to have a child for him. After the dissolution of their marriage, she sought for a transfer to another secondary school in Uromi (about 20 kilometres from Ubiaja). There, she met Mr. Ewone Julius who was a District Police Officer at Uromi. When her second marriage to this

police also ended unsuccessfully, as she failed to get pregnant for him, she then became aware of her possible infertility. She then went the University of Benin Teaching Hospital (UBTH) where the doctors said she could not conceive because her womb was damaged and so, remains childless. Realizing that living alone at her age could be problematic, she decided to do something. Due to her high economic status, she was able to employ the service of a housemaid to help with washing dishes and running of errands for her. But just as she was getting use to a housemaid, the parent would come and say "we want our child back". Lady Omosun thought she could find a permanent solution to her childlessness and decided to do something about it. She decided to marry a girl for her sister's son (nephew) to provide substitute children for her. The marriage was however, blessed with four children (two boys and two girls) who she successfully acquired. Not quite long, she began to have problems with her nephew when he began to claim ownership of the children. According to her:

*Initially the wife and the children were assisting me and I thought my nightmares were over. The wife was doing most of the domestic work. She would cook, wash, and clean the house and go to market for me. I must also commend the children for running errands for me. I thought I had found permanent solution to my childlessness not knowing that I was making a big mistake - living in a fool's paradise. I thought having children via my nephew would solve my problem. One day we had an argument over a little issue and he told me categorically that he was taking his children away. All appeals by people to change his mind fell on deaf ears. That was how he took the wife and the children away to the city and now I am back to square one.*

In a separate interview with her nephew, an interesting conflict of the real ownership of the children ensued. While Omosun insisted that she married the wife and therefore the children belong to her by Esan custom, her nephew maintained that the children were his biological children. They went to court and she lost. One major problem confronting Lady Omosun was constant ill health. She stressed:



*childless woman who does not have anybody to cater for her must find a way to survive. Most of the widows and the childless women in the whole of this village are now farming. Now that I do not have enough strength to go to farm, I now help people to wash their clothes in exchange for money and food. When there are no clothes to wash, I beg people for food and money. If I do not beg I will die of hunger.*

### **Life History Six - Mrs. Ewanfoh Ekoh: Life Has Been Unkind To Me**

Mrs. Ewanfoh Ekoh is a widow. She lost her husband some fifteen (15) years prior to this interview. Although she was born into a royal family, she could not say precisely when she was born but believed that she was up to 88 years of age. Mrs. Ekoh had no surviving child of her own. When she got married to her husband (late Chief Ekoh of blessed memory), she had two daughters who died in mysterious circumstances. The second daughter died at the age of six while her first daughter died six months after childbirth. When Mrs. Ekoh could not have other children, she advised her husband to marry two other wives. She has two stepchildren from these two marriages of her late husband. Their mothers left because they too could not have other children and Madam Ekoh had to assist her husband to raise his two sons. Until twelve years ago, she was living in her husband's bungalow with her only grand daughter and her two stepchildren. Her stepsons had to move to Benin after securing employment opportunities in the bank and University of Benin Teaching Hospital respectively. Her grand daughter later got married. The daughter's husband later joined them in her husband house. Madam Ekoh had been living with her grand daughter and her husband until late 2004 when she too died in a ghastly motor accident. In her words:

*I have been living with her and her husband after their marriage. Unfortunately, for me, she tragically died in a motor accident, thrusting her three children and I into a period of despair. She had been my only daughter and my only source of joy in the world after the death of her mother. I had hoped she would be close-by to take care of me when I am too old to cater for myself.*

On assistance from her son-in-law, Madam Ekoh stressed:

*As you can see, I am the only one taking care of the three children she left behind with little or no assistance from their father. Initially, her husband was sending some money for the children's up-keep and other needs. Over a period of 18 months, my son-in-law, who was still living with us after the death of my grand daughter, became increasingly distancing himself from us. We hardly see him as he was receiving advice from bad friends and family members to get married and settled down for a new life. For the past one year, his contribution to the upkeep of his children has dwindled. Each time I asked of his sudden change of attitude, he became evasive. I learnt he is telling some people that nobody can stop him from re-marrying.*

When the news of her predicament got to one of her stepson by name Charles, he sent one of his daughters by name Lydia to be living with her to assist in running errands for her. Suddenly, Lydia left her unannounced to join her parents in Benin. Since she fell from the staircase, things had been so difficult that she needed somebody to help her to the toilet, wash her clothes, go to the market, cook for her and bathe her. Her stepchildren hardly come to see her. In her words,

*I do not blame them because they too have many responsibilities. They have their aged mothers to cater for and children to send to school. Nobody blames anybody these days. The economy is bad. I know that having no children of my own; will make me more vulnerable at my old age.*

When the suffering was getting too much, her niece came and took her and her little grandchildren to her house in a nearby town (Uromi). She did not like this treatment because of the promise she made to her husband not to abandon his house. According to her:

*I stayed with my niece for a few months and had to leave and come back to my husband's house. I want to die and be buried in my husband's house because he begged me to look after his house before he died.*

*My only wish is to be buried beside my husband when I die.*

She stressed that she was missing her husband, and her first daughter who were the major pillars in her life. She elaborated further:

*My husband and my daughter were the pillars of my life. Since their death, there is nothing to lean on except God.*

On how she was coping with her grandchildren despite the fact that help was not forthcoming from her son-in-law and stepchildren, Madam Ekoh had this to say:

*Life has taught me so many lessons. I have learnt to do things by myself by not relying on people because they can disappoint you when you least expected. I know that the God that feeds the birds in the air will feed us and take care of us. The gods of my ancestors are not asleep. They are using people to meet our needs. Whatever happens, I will not allow anybody to take my grandchildren from me. They are the only source of joy and hope for me in life.*

The question is who will take care of this aged woman with her grandchildren since her son-in-law is no longer fulfilling her fatherly obligation. Her response was, "God will take care of us."

### **Interpretation of Life Histories**

The above life histories indicate quite forcefully that not having children creates possible human and welfare problem for the aged in Esan society. The first life history supports previous research by Kreager (2006) that older people who have no children of their own to cater for them are likely to be vulnerable in old age. The experience narrated by Madam Ibhariale Ojezele in the first case study demonstrated an example of neglect and abandonment by members of her extended family. Scarcity of food, malnutrition and loneliness remains her specific problem unlike in the past when offspring rally around to provide the aged with food, comfort and company. She was not as lucky as Madam Princes Omiojie in Case Study 5 who at least

was receiving some support from her grand stepdaughter before abandoning her to meet her parents in the city or Mrs. Odiboh in the second case study who had the opportunity of being supported by her late sister's children she had helped to train to the university level. The latter case study supports the views of Fajemilehin (2000) that sublimation provides for psychological reassurances for a childless woman who freely utilizes the opportunity to care for the children of others. Her kindheartedness during the earlier stages of her life played an important role in the resolution of 'ageing crisis' later in her life. This finding also indicates that childless aged do have access to support from offspring who are not their biological children.

The cases of Madam Alice Erewele in case 3 and Mrs. Ewanfoh Ekoh in case study 6 who were both abandoned by their stepchildren are indications that having stepchildren does not provide solution to the problem of childlessness. As noted by Kreager and Schroder-Betterfill (2003), stepchildren are more likely to remain with their mother following a divorce or husband's death. Similarly, the case of Omosun Ehiagwina in the fourth life history is a description of traditional Esan family system in which a childless woman was allowed to marry a wife for any of her male relative in order to have a child for her. As has been observed in her case, this practice is far from being a straightforward solution to childlessness in modern Esan Society due to culture change.

The case of Mrs. Ewanfoh Okoh in sixth life history is a description of the values placed on children among the Esan particularly, among the older generation. Most aged gladly assume the role of surrogate parents in the event of death of their children as we have seen from the above case study. Having grandchildren to look after was often seen as compensation for another loss. Among the Esan, it is common for grand parents to address their grandchildren as "omimen" (my child).

The third and fifth case studies are indications of diminishing extended family networks as a result of social change and influence of western/formal education which has resulted in the neglect of the



childless aged. These findings corroborate earlier study by Apt (2000). She however noted that the strain on traditional family structure that is introduced by distance..., new life styles and changing values have all affected the entire society including the youth and, largely, affected their overall relationship with the aged now and

in the future Apt (1995). According to her, these factors have contributed to the destabilization of the values that have in the past, sustained the aged in a close-knit, ageintegrated African society. In addition, findings on attitudinal changes such as grandchildren not wanting to stay with their aged grandmothers because of school or daughters-in-law failure to cater for aged mothers-in-law have some similarities with that of Apt (1995).

Coping strategies employed by the aged women as shown in all the life histories include subsistence farming, selling of some personal belongings for subsistence, begging for alms, petty trading and employing the services of housemaids. Only a few of the aged depended on pension or some support from their extended family members. However, the emerging scenario in the study area is that care and support for the aged who have nobody to cater for them are gradually becoming the responsibility of social institutions like the church, local government or kind neighbours as observed in the cases of Madam Ibhariale Ojezele, Alice Erewele and Lady Omosun Ehiagwina. For instance, three recorded formal services that were provided by two LGAs included relief scheme, roof repairs and provision of eyeglasses.

## SUMMARY AND CONCLUSION

The continuity and survival of any society depends on the well-being of its members. A major determinant of a people's survival therefore is the way they members of that society cater for one another. In this study, survival of childless aged women in a society that does not have social security for the aged was examined. The changes in the care and support for this population subgroup and factors accountable for the changes were also identified and discussed. The results showed that there were indeed

declines in care and support system for the childless aged women. These were evident in the increase numbers of the aged women being neglected and abandoned by family members and are therefore being compelled to cater for their practical daily needs.

The diminishing extended family ties and increasing social distance between the aged women and their extended family members was the major factor responsible for the decline in their care and support in the study area. This trend is associated with social changes towards westernization and emerging nuclear family structure, consisting solely of parents and their children. This factor was found to have denied majority of the childless aged women the care and support they once received from extended family networks.

Although these causal factors are apparent in the study, they are not mutually exclusive. They are also related to other lower explanatory factors, which have direct impact on care and support for the childless aged women in the study area.

In an attempt to survive in a harsh Nigerian socio-economic environment, some of them solicit for alms while others depend on all kinds of odd jobs in spite of advanced age with minimal support from neighbours for their daily needs. These activities were found to be detrimental to their health of the aged and living conditions. III health in old age is endemic, which if not properly manage could result to untimely death.

## POLICY RECOMMENDATIONS

Based on the findings, the following recommendations are made:

- There is need for cultural re-awakening of extended family social security system toward the wellbeing of this population subgroup. This may be carried out within the framework of creative multi-track social policy intervention that will involve government, civil society and private sector partnership.



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## **MERCK INSTITUTE FELLOWSHIPS**



The International Institute on Ageing, United Nations – Malta has received a grant from the Merck Institute of Ageing and Health, Washington D. C. for Training Programmes, which are held in Malta. for 2 participants in the 9-month Postgraduate Diploma Course in Gerontology and Geriatrics at the European Centre for Gerontology, University of Malta.

Applications for the above Fellowships will be received by Professor Joseph Troisi, Director of the International Institute on Ageing, United Nations – Malta, 117, St. Paul Street, Valletta VLT 1216, Malta.

The closing date of applications can be obtained from the Institute's website, [www.inia.org.mt](http://www.inia.org.mt).





## INIA'S ACTIVITIES 2009



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24th - 31st January 2009	Training Programme in Ankara Turkey, in collaboration with Hacettepe University, GEBAM and Turkish Geriatrics society.
16th - 27th February 2009	International Programme in <b>SOCIAL GERONTOLOGY</b> .
16th - 27th March 2009	International Training Programme in <b>ECONOMICS AND FINANCIAL ASPECT ON AGEING</b> .
4th - 15th May 2009	International Training Programme in <b>MEDICAL GERONTOLOGY (GERIATRICS), MALTA</b> .
18th - 29th May 2009	Training programme in Tunisia, in collaboration with the Tunisian Association of Gerontology (ATUGER) and the Caisse Nationale di Securite Sociale (CNSS)
10th - 11th August 2009	International Conference on Ageing 2009: Integration of Policy, Research and Practice, jointly organised by th e Institute of Gerontology (IG), Universiti Putra Malaysia, the International Institute on Ageing, United Nations - Malta (INIA), the Malaysian Prime Minister's Office, the Malaysian Economic Planning Unit (EPU) and the Department of Social Welfare, Malaysia (JKM).
13th - 19th August 2009	Training programme Social, Health and Economic Issues on AGEing, jointly organised by the International Institute on Ageing, United Nations- Malta (INIA), and the Institute of Gerontology (IG), Universiti Putra Malaysia, Serdang, Selangor, Malaysia.
24th - 4th September 2009	TENTH ASEAN Gerontology course organised by ISACA, Singapore
1st October 2009 - 1st June 2010	International Post Graduate Diploma in Gerontology and Geriatrics (European Centre for Gerontology and Geriatrics, University of Malta)
12th - 23th October 2009	International Training Programme in <b>POLICY FORMULATION, PLANNING, IMPLEMENTATION AND MONITORING OF THE MADRID INTERNATIONAL PLAN OF ACTION OF AGEING</b> .
8th - 14th November 2009	Training Programme in Beijing, China in collaboration with the Beijing Civil Affairs Bureau(BCAB)
15th - 21st November 2009	Training Programme in Beijing,China in collaboration with the Social Welfare Centre, Ministry of Civil Affairs, People's Republic of China (SWC) and the Support and Nursing Committee for the Elderly, China, (NCE)
23rd Nov - 4th Dec 2009	International Training Programme in <b>DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC, POLICIES &amp; PLANS</b> .
5th - 11th December 2009	Training Programme in St. Petersburg in collaboration with City Geriatric Centre, St. Petersburg.

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## INTERNATIONAL DIARY 2009

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

**5th - 9th July 2009 - Paris, France**  
XIXth IAGG Congress



