LIVING ARRANGEMENTS, POVERTY AND THE HEALTH OF OLDER PERSONS IN AFRICA

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SUMMARY

The rapid growth in the number of older people worldwide has created an unprecedented global demographic revolution. Improvements in hygiene and water supply and control of infectious diseases during the past century have greatly reduced the risk of premature death. As a consequence, the proportion of the world's population aged 60 and over is increasing more rapidly than in any previous era. In 1950, there were about 200 million people aged 60 and over throughout the world. There are now about 580 million, and by 2025, the number of people over the age of 60 is expected to reach 1.2 billion.

For the first time in history, the majority of those who have survived childhood, in all countries, can expect to live past 50 years of age. Even in the world's poorest countries, those who survive the diseases of infancy and childhood have a very good chance of living to be grandparents. This suggests that the number of older people in developing countries will more than double over the next quarter century, reaching 850 million by 2025, that is, 12 per cent of their total population. By 2050, the proportion of older people is expected to increase to 20 per cent (HelpAge International, 1999).

The growth in life expectancy offers new opportunities but it also creates challenges for the future. In the developing world, populations are now ageing at an unprecedented speed, while most of their poor still live in poverty. Thus, the population ageing occurring in much of the third world is not accompanied by real socio-economic development. Large segments of the population continue to live at the margin. Furthermore, the traditional forms of care available to older generations until recently are under threat (Kalache, 1991). This is in major part because families have suffered from the impact of social changes, including urbanization, geographic spread, the trend towards nuclear families and the participation of women in the workforce. There is a cost for the failure to address the ageing-related problems of any society. Evidence is now emerging that a disproportionate amount of resources is being spent on the elderly population in some countries. Sen (1994) maintains that this is due to a combination of factors:

- The very nature of the problems of the elderly—long-term disabling conditions that often involve high-cost technology;

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- Families under strain, faced with chronic and complex problems, put pressure on authorities to institutionalize their elderly who require more extensive care;

- Social and geographic mobility, leading to situations where children are unable to provide the necessary care;

- In the absence of appropriate solutions, decision makers tend to emulate the institutionalized forms of care prevalent in many developed countries;

- Recently, the HIV/AIDS pandemic, which has created a crisis in the family structure in both rural and urban areas. The traditional/cultural practice of depending on children by older people is no longer in place, in large part because the younger generation is "dying off", leaving parents without resources as caregivers of grandchildren. This is having significant impact not only on living arrangements and conditions but also on the quality of life of grandparents.

As the number of older people in Africa continues to increase, particularly those who are aged 75 and over, growing public policy and service delivery attention must, of political and human necessity, be focused on the problems and needs of older people. Clearly, such needs as economic security, access to essential health and human services, adequate housing and personal safety exist, with variations, from region to region in the African continent. The issue of housing and living conditions, considering the rapid urbanization of young families away from parents, is especially illustrative of one of the more acute problems confronting these elders. Little is known about the needs of older people in Africa. Concern about population growth, basic health programmes and provision, mortality and morbidity rates and infectious diseases, especially the HIV/AIDS pandemic, has dominated collective attention in the continent. Therefore, while Africa will still not be an aged continent, it will begin to show signs of ageing, with its consequent benefits and problems. Hence, investing in policies that promote healthy ageing should produce high societal and health returns. One of the major problems confronting planners and policy makers is the absence of systematic reliable data on the needs of older Africans. Some data exist for relatively few countries, but the current lack of reliable national-level data about the older populations presents a major limitation to understanding problems and formulating interventions specifically for older people. Data specific to South Africa (Booysen, 2000) regarding the living conditions and life circumstances of those South Africans aged 65 and over, show that living arrangements and therefore living conditions follow the life patterns of the different racial groups of people in South Africa. Race, gender and place of residence, whether urban or non-urban, remain the most distinguishing features of

the society, revealing past discriminatory practices. Data show that Africans constitute the largest group of the aged population (67 per cent).

Because the incidence of chronic illness and disability increases with age, the longer one lives, the more likely one is to experience illness and disability. Chronic illness and disability, in turn, increase the likelihood that many very old people will no longer be able to live independently but will require care. Consequently, crises such as the need to change living arrangements, financial problems and the inability to perform self-care activities are ubiquitous events among the very old.

Policy considerations should take into account a broad-based approach that distinguishes between the well and active elderly, the disabled elderly and the frail elderly. Intervention options should consider inter-sectoral structures and multidisciplinary strategies to ensure that older people are well physically and psychologically and for as long as possible. This means families and local communities must be empowered with resources and technical assistance to care for older persons in the community, and this in turn means access to amenities ranging from water, sanitation, transport, housing, and access to health promotion, disease and disability-prevention strategies. The principal overriding goal should be formulating policies and interventions that result in the elimination of poverty as the first priority. This means we should strive to identify and modify, where possible, the broad range of high-risk situations that have long-term and devastating effects on older people.

National policies must incorporate the issue of ageing and appropriate support mechanisms for older people into the mainstream of their social and economic planning. Policies for employment, health, transport, housing and social care must take into account the variety of needs of older people. These sectoral targets must be integrated into broader social strategies. National Governments should seek the active involvement of older people themselves and of their families, communities and non-governmental organizations in research, planning and policy implementation on all issues that are of concern to older people.

OVERVIEW

Among the most significant demographic trends of the twentieth century has been the continued growth of elderly population age groups both in absolute terms and in relation to other segments of society.

Interest in the study of human ageing has grown steadily throughout the twentieth century, culminating in a spate of academic books and the development of postgraduate courses in social gerontology and geriatrics. Introductions to the study of human ageing have typically emphasized changes in demography, focusing on

"the ageing of populations", a trend that has characterized industrialized societies throughout the twentieth century but that in recent years has become a worldwide phenomenon. Even developing countries, with their myriad of challenges, have experienced increases in their older populations. This increase in the number of older people in society and the increase in the proportion of the population who are elderly has resulted in the study of human ageing, focusing on old age in general and the problems and challenges of old age in particular. Throughout the twentieth century, old age has been seen as a "social problem" and this predominant perspective is evident through the language used by policy makers and health and social service planners. While there is no denying either the poor quality of life experienced by many older people or the challenges faced by planners and other professionals in providing health and welfare services for the growing numbers of the frail elderly, it is disconcerting that the joys and triumphs of old age in the latter part of the twentieth century were not promoted with vigour.

Throughout the twentieth century, the proportion of people aged 60 and older has increased in all countries of the world. This trend started earlier in the industrialized countries, but countries in the developing world are experiencing the same changes in population structure. The convening of the World Assembly on Ageing in Vienna in 1982 was an acknowledgement of the fact that ageing could no longer be viewed as a phenomenon of the Western world. The Assembly provided, for the first time, a forum where both developed and developing countries could exchange ideas and information on their experience of the ageing process (Sen, 1994). It was evident from the demographic changes taking place that the ageing process was occurring at an unprecedented rate in most developing countries. By 2000, about two thirds of the estimated 600 million people aged 60 and older will be living in these countries. Kalache (1994) points out that ageing is basically the result of a two-dimensional demographic transformation: on the one hand, overall mortality declines, resulting in longer life expectancy, on the other, declines in fertility result in decreasing the proportion of children and young adults in the population and, consequently, in increasing that of older adults. This dynamic process, usually referred to as the demographic transition, was first observed in post-industrial revolution European societies in the nineteenth century. By and large, it was the result of gradual improvements in living standards among most of the population in countries such as France and the United Kingdom. With limited contributions from medical technology, people benefited from better housing, public sanitation and improved nutritional status: mortality started to fall and, subsequently, fertility decreased. "Ageing was therefore the long-term consequence of socio-economic development" (Sen, 1994). Most importantly, by the time a substantial proportion of the population had reached old age, many of the problems associated with classical under-development had already been solved. Resources were therefore potentially available to be diverted to an increasing elderly population. These were relatively affluent societies, with highly educated populations enjoying the best public services in the world. Yet, population ageing continues to be a significant challenge, requiring adequate societal responses on many fronts. If caring for their elderly remains a challenge for the

rich countries, which experienced a process of gradual ageing over many decades, what then about ageing in the developing world (Kalache, 1994)?

The demographic transition in many countries of the third world is now taking place in a much shorter period of time. Unprecedented declines in mortality rates in countries throughout Latin America, Asia and, more recently, Africa are largely the result of the availability of effective treatment and/or prevention of diseases previously responsible for huge numbers of premature deaths. The conditions that lead to these diseases still prevail and the morbidity they cause continues to be high. Population ageing occurring in much of the third world is not accompanied by real socio-economic development. Large segments of the population continue to live at the margin. However, they will live longer than their parents and will have far fewer children. Furthermore, the traditional forms of care available for older generations until recently are not easily available. This is not because families no longer care, but is the result of social changes that include urbanization, geographic spread, the trend towards nuclear families and the participation of women in the workforce (Sen, 1994; Kalache, 1994; Apt and Greico, 1994).

POVERTY, HEALTH AND AGEING

Poverty, with its deleterious effects on health, education, self-esteem, quality of life and lifestyle, is one of the major concerns of older people (Okie, 1991). Okie, in a study specific to the Black elderly in the United States of America, reported that so powerful is the impact of poverty that if differences in income, education and living conditions were eliminated the pattern of vulnerability to cancer would be reversed. The study also found that people of different races show differences in vulnerability to various tumours. But those differences, Okie reports, whether rooted in heredity or culture, are usually outweighed by the much greater influence of poverty, which raises cancer rates by reducing access to health care and education and by determining where and how people live. Health for the elderly may be conceptualized as the ability to live and function effectively in society and to exercise maximum self-reliance and autonomy; it is not necessarily the total absence of disease (Harper, 1988).

According to Rowe (1991), the health of older people has been approached from two different perspectives. The biomedical gerontological and geriatrics model, commonly held by physicians and other medical personnel, defines health in terms of the mechanisms and treatment of age-related diseases and the presence or absence of disease. The functional model, on the other hand, defines health in terms of older people's level of functioning; it is best summarized by a World Health Organization advisory group report:

> Health in the elderly is best measured in terms of functioning…. Degree of fitness rather than extent of pathology, may be used as a measure of the amount of services the elderly will need from the community (World Health Organization, 1989).

Elderly Africans, like elderly Black Americans, tend to perceive their health according to their ability to perform activities of daily living and not according to laboratory or x-ray findings (Harper, 1988). It may be elderly persons' assessments and perceptions of their health, in both cases, that contribute to their frequent delay in seeking care or reporting discomfort.

The observation that poverty and deprivation are concentrated on a substantial proportion of older people has been a recurring theme of research on ageing in all industrialized societies. In United Kingdom, for example, older people have been reported to be the largest group in the population living in poverty ever since data were first collected systematically. Subsequent research in other parts of the world has confirmed, repeatedly, the deep-seated nature and extent of poverty in old age. Additional data show that the risk of experiencing poverty is three times greater for older adults than it is for other age groups. Not only does poverty affect a substantial proportion of older people, but when it does, it is likely to be an enduring experience. The high incidence of poverty and low incomes among older people is reflected in other measures as well. Moreover, the problem of poverty in old age is not peculiar to industrialized societies; it is endemic among both Western and Eastern countries as well as third world countries.

Older people are consistently among the poorest in all societies, and material security is therefore one of the greatest preoccupations of old age. Many experience the same lack of physical necessities, assets and income felt by other poor people, but without the resources that younger, fitter and more active adults can use to compensate. The prevalence of poverty among older people is also linked to education levels, including differing levels of literacy (HelpAge International, 1999). Lack of material means is not the only problem of poverty. Another consequence is the inability to participate effectively in economic, social and political life. Older people living in poverty find themselves socially excluded and isolated from decision-making processes. This affects not only their income and wealth but also contributes to poor housing, ill health and personal insecurity.

Efforts to understand poverty have dominated much of the debate on development in recent years, but the poverty experienced by the majority of older people, particularly in developing countries, has been largely ignored. Moreover, during the colonial and post-colonial years in Africa, for example, issues relating to ageing were neglected. Competing interests such as education, health, housing, sanitation and water were considered more pressing. While the rapidly increasing number of older people throughout the world represent

a biological success for humanity, the living conditions of the elderly in most countries have by and large lagged behind those enjoyed by the economically active population.

LIVING ARRANGEMENTS AND OLDER PEOPLE

One of the most influential factors on all our lives is the environment in which we live. For older people, this may be particularly so since they spend more time in "the home" than many other groups in society.

Poverty and inadequate incomes are often associated with housing deprivation among older people and often reflect housing provision patterns in earlier life. Moreover, housing deprivation is also the result of paternalistic policies, with few appropriate housing options available to older people.

Although there exists some information about a few countries in the African continent (Apt, 1985, 1991, 1992, 1994, 1995, 1996; Addo, 1972; Brown, 1984; Cox and Mberia, 1977), any discussion of living arrangements in developing countries in general and in Africa in particular must take into consideration a multiplicity of factors. Ageing does not occur in a vacuum. It occurs in a context that includes the needs and resources of individuals, their patterns of activities, their relationships with others and their attachments to their surroundings. Ageing interacts with all these aspects of the physical and social environment. A great deal of what we experience in life is shaped by our circumstances. Considering the limitations of data on living arrangements in Africa in general, the discussion focuses on South Africa, in particular on the cumulative effect of socio-economic factors and their impact on ageing. Even for South Africa, data and therefore policies, with specific reference to living arrangements for older people, are limited. Reasonable-quality data are available mainly for White South Africans owing to selective data-collection policies—the historic legacy of apartheid.

To fully understand ageing in South Africa requires that we appreciate how the South African experience has affected its people, their needs, resources and life experiences.

Inequalities in South African society generated differences in the way Blacks and Whites have adjusted to ageing. These inequalities stem from stratification on the basis of age, sex and the possession of certain resources. Racial characteristics have been used to ascribe inferior status—both social and political—resulting in the unequal treatment of Black South Africans. Until recently, with the achievement of a democratic dispensation in April 1994, discrimination and segregation were used to maintain unequal status throughout the course of the lives of Black South Africans. Living arrangements, therefore, follow these life patterns for the different racial groups of older people in South Africa.

An obvious starting point for a discussion on living arrangements for older people, particularly older Africans, given the historical pattern of inequalities in the continent, is the family. In one of the few available studies on the elderly in historical perspective, Cain (1991) examines the situation of the elderly in contemporary South Asia and contrasts it with that of pre-industrial Europe. Cain suggests a strong correlation between the existence of the joint family and the well-being of the elderly in India and Bangladesh; that contrary to what many have suggested, social changes have not eroded the significance of the joint family in the context of South Asia. The majority of old people continue to live in the extended family network.

The historical role played by the family in Africa has been exhaustively presented by Apt (1999), who points out that "historically, African communities had well-articulated caring structures that preserved the quality of life for elder people, but this was linked to the low chance of the survival of large numbers of older persons" (p. 5). She further observes that "migration and urbanization have both separately and jointly been pinpointed as contributing to the destabilization of the value that in the past sustained older persons in a closely knit age-integrated African society" (p. 2). Such a practice had implications for the way older people were perceived within both the family and community structures.

A study initiated by the World Health Organization (WHO) in the mid-1980s and published in the United Kingdom in 1992 examined, from an international perspective, the important issues of providing support to the elderly (Kendig, Hashimoto and Coppard, 1992). This work questions and dispels many of the myths perpetuated by the modernization school, which has been so influential in evaluating the needs of the elderly in both developed and developing countries. The collection, which includes articles from countries as far apart as Sweden and Ghana, shows that the family played a central but very varied role in supporting the elderly. It illustrates that there is a considerable diversity in the experience of ageing owing to different levels of socio-economic and socio-demographic development. But the cases presented in the study also show that, in the absence of other forms of support (pension funds), older people continue to be economically active, particularly in the rural areas. From information based on rural areas, there are strong indications that a much higher proportion of older people are in the labour force in developing countries than in industrialized countries. The authors note that a key issue that requires further exploration is whether extended family households not only provide economies of scale in living costs but also facilitate the role of the aged as providers of child care and socialization.

Apt (1992) places the role of the family in the care of the elderly in the context of the political economy of the country (Ghana), particularly in relation to poverty and uneven development. She further points out that the majority of the population (69 per cent in 1984) continued to live in rural areas. A United Nations report

(1979), based on studies of Hong Kong, Jamaica and Lebanon, identifies some of the major problems facing the elderly in terms of their social, economic and psychological needs. The main conclusions are that slums and squatter settlements are an increasingly prominent feature of urban expansion and that a major course of this expansion has resulted from a process of rapid rural-urban migration. Phillips (1988), in his article on accommodation for elderly persons in newly industrialized countries, describes the experience of Hong Kong as an example of the provision of care and accommodation for the elderly in a newly industrialized area. The author shows that Hong Kong has embarked upon a comprehensive and integrated service for its elderly population, with a mixture of public and private enterprise. The developments in Hong Kong are not only related to the historical evolution of its social policy, following trends and developments in the United Kingdom, they are also a pragmatic response to the integration of traditional support for the elderly as a result of rapid social changes over the past decades. Various forms of residential, day and community-based services are provided. Phillips suggests that, while provision for the elderly has advanced quite rapidly in Hong Kong, its replication will only be possible in countries classified as newly industrialized. Among the problems associated with the rapid advance in provision for the elderly are the level of trained and qualified staff.

In a study on the developed world that has relevance for developing countries, Phillipson (1982) argues that the recession in the West of the past three decades affects the elderly as a group owing to the proportionate increase of the 60+ population in the total population. He focuses on social inequalities in the distribution of power in terms of income and property and observes that low income, poor housing and inadequate medical care constitute the main experience of people growing old. Kalache (1991), using Brazil as a case study, shows not only that there has been a rapid ageing of its population but also that the elderly are disproportionately represented among the poorest of the poor. He further points out that in many of the developing countries longevity among females means that poverty and chronic disability conditions affect women disproportionately.

For South Africa, census data (Booysen, 2000) indicate that women are likewise disproportionately represented in the aged population (61.4 per cent females to 38.6 per cent males). Moreover, the condition of functional ageing in the life circumstances of the majority of elderly women means that many could be ageing far earlier than the internationally designated age of either 60 or 65. This has far-reaching implications for the care of the elderly, especially by family members who themselves have few or no resources. In her paper, Apt (1999) has presented an exhaustive discussion on the historical and cultural context of ageing and the African family, with variations from country to country and region to region within the continent. In South Africa, three major factors have affected the living conditions and consequently the living arrangements of older people, particularly older non-Whites:

(a) Apartheid policies governing the previous urban-rural divide;
(b) Urbanization of young families;
(c) Migration labour policies.

These three factors combined have in turn determined the distribution of resources not only by region but by race as well, especially with the following effects:

- Creation of TBV states (Bantu homelands), which were mostly rural and consisted of predominantly older populations;

- The organization of the welfare system, with almost all welfare resources allocated for old-age homes for the White aged;

- Migration labour policies, with no pension provision for mining industry workers and other commercial sectors for non-Whites;

- South African labour policies, particularly mining labour policies, which affected not only South Africans but other surrounding African countries as well (Botswana, Lesotho, Malawi, Mozambique, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe);

- The broader policies specific to education, with poor education for Black people resulting in the lack of commercial understanding of retirement and the inability to make claims for retiring. This had a significant impact on older people, who then depended on "dislodged" age-old cultural/traditional patterns of children taking care of parents, with little or no resources; as Apt (1999) explains, this resulted not only in the breakdown of this tradition but also served as a significant stressor on young families;

- The HIV/AIDS pandemic, which has created a crisis in the family structure in both rural and urban areas. The traditional/cultural practice of older people depending on children is no longer intact, in large part because the younger generation is dying, leaving grandparents without resources as caregivers of grandchildren. This has had significant impact not only on the living arrangements of grandparents but on those of grandchildren as well. Unfortunately, data are not available to demonstrate the enormity of the consequences of the HIV/AIDS pandemic on older people in Africa as a whole.

The combination of poverty, natural disasters, violence, social chaos and the disempowered status of women facilitates the transmission of HIV. Conversely, the illness increases the risk of a household or individual becoming even more empoverished, and lowers the general level of health in communities because of its close relationship with other communicable and poverty-related diseases such as tuberculosis. Under apartheid, the poor were shifted to the margins of urban areas and, more importantly, to the margins of the country, thus focusing the core of South Africa's poverty in the rural areas. Moreover, the rural areas of South Africa suffer from a legacy of inappropriate investment decisions. For many rural people in the former homeland areas, economic and social decisions remain conditioned by their unequal and distorted access to markets, services and other opportunities.

THE WAY FORWARD: POLICY IMPLICATIONS

The issue of living arrangements in developing countries in general and in Africa in particular is closely related to the socio-economic empowerment of the people. Wilson and Ramphele (1989, p. 258) observed that poverty is not some morally neutral phenomenon that needs merely to be understood. It is an evil that must be rooted out. No single strategy against poverty is ever likely to be wholly effective. The many dimensions of poverty and its interlocking causes require a multiple strategy attack.

The struggle against poverty in South Africa is intertwined with the struggle against powerlessness. Power lies at the heart of the problem of poverty in southern Africa. Without it, those who are poor remain vulnerable to an ongoing process of impoverishment. A change in the political power structure in South Africa has occurred. What is now necessary is the infusion of a value system that would ensure that the process of transformation and the creation of a new society is of real benefit to all those living in it. There are several examples available in the history of other countries that serve as reminders that a political democracy by itself is not a sufficient condition for ensuring that the poorest, even if they have the right to vote, become full members of a more egalitarian society.

In an address to the National Education Crisis Committee in March 1986, Zwelakhe Sisulu made a distinction between the transfer of power and the shift in the balance of power in South Africa. The trade union movement in the 1970s and 1980s played a significant role in that it made and continues to make a substantial contribution to shifting the balance of forces in favour of the poor. In addition to the trade unions, an entire range of independent organizations not only made a difference in people's lives in the existing circumstances but also helped by transforming power relations to shift the balance of power towards the poor as well as laying foundations that would help determine the shape of South African society in the long run.

Thus, the problems of older people in Africa have to be addressed within a broader context that encompasses reforms at different levels, including legislative and administrative processes that result in benefit structures, health care and educational reforms.

What then are the principal challenges facing us on behalf of the elderly in the new millennium? The present paper has focused more on the relationship between poverty, health and living arrangements, with poverty as the overriding principal factor. Naturally, eliminating poverty is the first priority.

- We have to acknowledge that there is a serious housing problem for older people in Africa and that the problem will grow in magnitude.

- Lack of data. Little is known about the needs of older people in Africa. Concerns about population growth, basic health programmes and provision, mortality and morbidity rates and infectious diseases, especially the HIV/AIDS pandemic, have dominated collective attention. An additional concern, although more insidious, is the ageing of the African population. The current lack of reliable national-level data about the older population presents a major limitation to understanding interventions and problems associated with this population. Within the next 20 years, the total number of older people will increase from the current 580 million to over 1 billion. Close to three quarters of these older persons will live in developing countries. The number of Africans 60 years and older will grow from 39 million in 2000 to 80 million in 2025. The number of Africans 65 years of age and older will grow from 25 million in 1999 to 52 million in 2025. While the proportion of Africa's elderly population is growing, it is currently still low. However, it is expected to more than double by 2025 and the population 75 years and older will increase by over 400 per cent in many African regions. Therefore, while Africa will still not be an aged continent, it will certainly begin to show signs of ageing, with its consequent benefits and problems.

Hence, investing in policies that promote healthy ageing should produce high societal and health returns in developing countries. Healthy older people are a valuable social and economic resource to their families and communities, whereas the alternative is a drain on the already limited human, social and capital resources. Information currently collected by routine sources is fragmented, incomplete or not specific to older populations. Non-routine data sources provide data relevant to the health status of older populations but, again, may not be comprehensive or representative. Demographic, economic and social surveys provide data on proximate causes of impaired functioning such as individual and household earning, health, family and household size and structure, and social and economic roles culturally assigned by age and gender. The data, however, exist for relatively few countries in the African region. The recent strategy by WHO to encourage the collection of minimum data sets for the continent, with a specific focus on countries of sub-Saharan Africa, is encouraging. But we have to ensure that data include information that would provide the basis for more

creative policies, including strategies for poverty reduction, housing older people in a dignified way and providing a wide range of options that facilitate both healthy ageing and "ageing in place".

- The options have to distinguish between the well and active elderly, the disabled elderly and the frail elderly.

- The options have to be based on intersectoral structures to ensure that older people are well physically and psychologically and for as long as possible. What this means is that local communities must be empowered with resources and technical expertise to care for older persons in the community, and this in turn means access to amenities ranging from water, sanitation, transport, housing, and access to health promotion, disease and disability-prevention strategies.

- Options for disabled older people who are living at home under the care of family members. Studies have demonstrated that care for disabled older people, frequently around the clock, is a burden and a major stressor to younger people and in some cases results in neglect and abuse. Every effort should be made by the health and welfare sectors to provide community-based supportive care to older people as well as to caregivers. The limited data available from South Africa indicate that the institutionalization of older people is not a recommended strategy.

- The frail elderly who require intensive around-the-clock care need several levels of care, ranging from the provision of community-based respite care to short-term hospitalization, specifically focusing on physical and psychological problems.

- Most of the diseases that afflict older persons are the so-called lifestyle diseases, conditions like lung cancer, diabetes and heart disease, which are strongly linked to risk factors such as cigarette smoking, poor nutrition, lack of regular exercise and chronic stress. Simple preventative measures can significantly reduce the negative impact of lifestyle diseases on older people.

- The highest rates of accidental death and injury occur among older people. Relatively simple and inexpensive accident-prevention measures can significantly reduce the risk of accidental injury and death among older people.

- Strategies need to be devised for the reduction of crime and victimization and abuse of older people.

- Older people are in need of political empowerment and advocacy.

- Opportunities for the employment of older people should be enhanced.

- Gender-sensitive policies for older people need to be developed, recognizing particular vulnerabilities to long-term poverty in old age that result from women's lifelong disadvantages in health and nutrition, limited labour force participation and discrimination in the area of property ownership.

- Family support. In practice, family care remains the most widely used survival strategy for the majority of the world's older people, whether in the context of extended families or co-residence of parents with adult children.

- The rights of older people need to be respected.

CONCLUSION

As the number of older people in Africa continues to increase, particularly those who are 75 years of age and older, growing public policy and service delivery attention must, of political and human necessity, be focused on the problems and needs of older adults. Clearly, such needs as economic security, access to essential health and human services, adequate housing and personal safety exist without regard to region. For the rapidly growing number of Black elderly in South Africa, for example, many of these needs and the related problems are more acute. The area of housing, or living arrangements, considering the rapid urbanization of young families away from parents, is especially illustrative of one of the more acute problems confronting these elders.

One of the gaps in our knowledge and in our array of services for older people is alternative living arrangements, especially for the frail, the slightly impaired and those who need a range of sheltered housing but do not need nursing care. Almost everyone in the ageing field is aware of the concept that there is a continuum of living arrangements, ranging from living independently in one's own home to complete institutionalization.

Old age, has for many years, been seen as a social problem (MacIntyre, 1977) and this perspective has helped perpetuate ageism. As a result, in any discussion of living arrangements for older people there has usually been more emphasis on the needs of the frail elderly than on elderly people in general. Most older people live in "normal housing". Yet, generally, in everyday life, we associate old age with special housing. The variety of housing accommodation in the United States of America, for example, available to elderly

people is matched by the variety of institutional care used by very frail elderly people (Bond, 1990). Data that show the high concentration of older people in particular areas are often seen as supporting the predominant view that old age is a problem. Thus, we are regularly confronted with the "problems" associated with concentrations of people from different groups. To planners, such variations make the task of planning more difficult and challenging. Meeting the needs of a population with a high proportion of older people is not a short-term challenge. Meeting the needs of a population with a high proportion of older people who are poor and have health problems is even more complex, especially in a country or society with competing urgent needs for health care, education, sanitation, nutrition, housing and so forth, as is the case in South Africa.

Inadequate housing conditions are particularly problematic for older people who are impaired, handicapped or disabled. The unnecessary admission of older dependent people in homes for senior citizens has been attributed to the lack of adequate housing. One policy response to the severe reduction in public expenditures on housing has been the concept of "ageing in place". This policy aims at helping older people remain in their own homes more satisfactorily, through the work of voluntary non-governmental organizations, societies, and local authorities, rather than central or national Governments.

Policy on the provision of housing for older people has to take into consideration a range of issues, such as degree of dependence, health status, proximity to family and so forth, thus suggesting a continuum of living arrangements across the board. Awareness that there must be a variety of living arrangements to meet the needs of the older population is related to the heterogeneity of older people (Streib, 1982), who differ in income, family arrangements, level of health, mobility, and attitudes and personality. Providing supportive services to permit people to remain in their homes is considered the best option by many persons in the field of gerontology. For countries in Africa, it is perhaps the only option. Expensive institutional care is not an option for developing countries.

There have been a number of attempts to devise new family arrangements for older people as a means of solving many of their problems of economic security, dependency and isolation.

Policy makers and planners responsible for the quality of life, in the broader sense, of older people must envision a society that has large numbers of older persons of varying cultural and social backgrounds and having similar expectations from the public sector. Increasingly, the elderly will rely more on public service and welfare programmes than on family to meet some of their most serious needs. These needs relate to health care, housing, nutrition, safety and security and so on. The family will continue to meet some of the social and emotional needs of the elderly in any given society. Services can complement and, in many ways, enhance later-life individual and family relationships.

The field of alternate “continuum” living arrangements is just beginning. Policy makers, planners, managers and those who work in the field of gerontology, as well as families and communities, need all the ingenuity and initiative they can muster, and the flexibility to provide a range of services for older people to achieve healthy ageing and ageing in place.

REFERENCES

Primary sources

Booysen, D. (2000). Profiling those South Africans aged 65 years and older. Paper presented at the WHO workshop to create a minimum data set for research, policy and action on ageing and older adults in Africa, Harare, 22-24 January.

HelpAge International (1999). *The Ageing and Development Report: A Summary*. *Poverty, Independence and the World's Older People*. *Leading Global Action on Ageing*. London: Saffron Hill.

Secondary sources

Addo, N. O. (1972). Urban population and employment in Ghana. In *Population Growth and Economic Development in Africa*, S. Ominde and C. N. Ejiogu, eds. London: Heineman.

Apt, N. A. (1985). The role of grandparents in the care of children. In *Problems and Aspirations of Ghanaian Children: Implications for Policy Planning in Action*, P. A. Twumasi, and others, eds. Project report for Ghana National Commission on Children.

_____ (1991). Ghanaian Youth on Ageing. *Bold* (Malta), vol. 1, pp. 3-11.

_____ (1992). Family support to elderly people in Ghana. In *Family Support for the Elderly: The International Experience*, H. L. Kendig, A. Hashimoto and L. Coppard, eds. New York: Oxford University Press.

_____ (1994). The situation of elderly women in Ghana. Report to the United Nations. New York.

_____ (1995). Ageing in Africa: toward a redefinition of caring. In *An Ageing Population, an Ageing Planet and a Sustainable Future*, Stanley Engman, and others, eds., vol. 1, chap. 9. Texas Institute for Research and Education on Aging.

_____ (1996). *Coping with Old Age in a Changing Africa*. Aldershot, United Kingdom: Avebury.

_____ (1999). Rapid urbanization and living arrangements of older persons in Africa. Paper presented at the United Nations Technical Meeting on Population Ageing and Living Arrangements of Older Persons: Critical Issues and Policy Responses, New York, 8-10 February 2000.

_____, and M. Greico (1994). Urbanization, caring for the elderly and the changing African family: the challenge to social welfare and social policy. *International Social Security Review*. Geneva, pp. 111-122.

Bond, J. (1990). Living arrangements of elderly people. In *Ageing in Society: An Introduction to Social Gerontology,* J. Bond, and P. Coleman, eds. London: Sage Publications.

Brown, C. K. (1984). Improving the social protection of the ageing population in Ghana. Legon: University of Ghana, Institute of Statistical, Social and Economic Research.

Cain, M. (1991). Welfare, institutions in comparative perspective, the fate of the elderly in contemporary South Asia and pre-industrial Western Europe. In *Life, Death and the Elderly: Historical Perspective,* M. H. Pelling and R. M. Smith, eds. London: Routledge.

Cox, F. M. and N. U. Mberia (1977). *Ageing in a Changing Society: A Kenyan Experience*. New York: International Federation on Ageing.

Dowd, E., and P. Kowal (2000). Creation of "minimum data sets" for research on ageing in countries of the African region (with emphasis on countries of sub-Saharan Africa). Paper presented at the WHO workshop to create a minimum data set for research, policy and action on ageing and older adults in Africa, Harare, 22-24 January.

Harper, M. S. (1988). Behavioural, social and mental health aspects of home care for older Americans. *Home Health Care Services Quarterly*, vol. 9, No. 4, pp. 61-124.

Kalache, A. (1991). Ageing in developing countries. In *Principles and Practice of Geriatric Medicine*, 2nd edition, M. S. J. Pathy, ed. Chichester, United Kingdom: J Wiley.

_____ (1994). Forward. In *Ageing: Debates on Demographic Transition and Social Policy*, by Kasturi Sen. London: Zed Books Ltd..

Kendig, H. L., A. Hashimoto, and L. Coppard, eds. (1992). *Family Support for the Elderly: The International Experience*. New York: Oxford University Press.

MacIntyre, S. (1977). Old age as a social problem. In R. Dingwall, and others, eds. *Health Care and Health Knowledge*, London: Croom Helm, pp. 46-63.

Okie, S. (1991). Study links cancer and poverty: Blacks' higher rates are tied to income. *Washington Post*, (April 17) pp. A1 and A6.

Phillips, D. R. (1988). Accommodation for elderly persons in newly industrialized countries. *International Journal of Health Services*, vol. 18, No. 2.

Phillipson, C. (1982). *Capitalism and the Construction of Old Age*. London: Macmillan.

Rowe, J. W. (1991). Reducing the risk of usual ageing. *Generations*, vol. 15, No. 1, pp. 25-28.

Sen, K. (1994). *Ageing: Debates on Demographic Transition and Social Policy*. London: Zed Books Ltd..

Streib, G. F. (1982). The continuum of living arrangements. In *Ageing and The Human Condition*, vol. II. Frontiers in Ageing Series. Springfield, Illinois: Sangamon State University. New York: Human Sciences Press Inc..

United Nations (1979). The ageing in slums and squatter settlements. New York.

Wilson, F., and M. Ramphele (1989). *Uprooting Poverty: The South African Challenge*. a Report for the Second Carnegie Inquiry into Poverty and Development in South Africa. Cape Town/Johannesburg: David Phillip.

World Health Organization (1984). Health of the Elderly. WHO technical report series. Geneva.

_____ (1989). The uses of epidemiology in the study of the elderly. Report of a WHO scientific group on the epidemiology of ageing. Geneva.